

to: **Nora Leibowitz** date: **November 17, 2004**
from: **Sandi Hunt** subject: **Follow up to Non-Par Hospital Analysis**

As follow-up to the telephone conference call held on November 15th, hospitals and health plans requested certain information to clarify the source of the calculations and the results of certain of the calculations. Most of that information is provided in this memo and its attachments; certain information remains to be developed. However, because you are holding a regularly scheduled meeting with health plans today, we thought it best to provide the information that is available now, and follow with the remaining items later.

Starting Value for “Column A” in Exhibit

A question was raised regarding how the starting value of \$227,612,443 was obtained. This value serves as the numerator for the calculation of average cost per case.

The calculation is as follows:

1. Starting billed charges, including all IP encounters except crossovers, for all hospitals: **\$419,485,885** for the data period of July 1999 – June 2001.

Of this, 86.7% is attributable to DRG hospitals and the rest to A&B hospitals. The 86.7% is an accepted value - for example, note that $(72\%)*(0.867)+(100%)*(1-0.867) = 76\%$ (the adjustment required for the change in hospital reimbursement).

2. Multiply the above by **72%**, by an IP cost-to-charge ratio of **65.394%**, by a data period cost trend factor of **1.05868**, and by a projection period cost trend of **1.08854** (=1.03133 raised to the 2.75 power, i.e. appropriate for FY05 rates) to yield **\$227,612,443**.

These adjustments are reported in our per capita cost report for the 03-05 biennium.

Geographic Factors

A separate question was raised regarding the geographic factors used. The factors are those reported in the Federal Register for FFY 2004. While the 2005 factors have now been published, they were not available at the time this work was started. The accompanying Table 1 shows the calculations.

Distribution of Case Mix Index by Plan

A request was made for the distribution of the Case Mix Index by plan for Version 22 of the DRG grouper. The following table provides the calculated Case Mix Index for Version 19 through 22 so that DHS and plans can identify the source of change from the version of the DRG grouper used in the original calculation. As you can see, the most important change occurred in the move to Version 20, with only nominal additional changes resulting from the updates to Versions 21 and 22.

OREGON HEALTH PLAN

Case Mix by Plan

July 1999 - June 2001 encounter data, DRG hospitals only, excluding dual eligibles

	V19	V20	V21	V22
Plan A	1.1811	0.9666	0.9819	0.9582
Plan B	1.0602	0.8597	0.8687	0.8437
Plan C	0.9942	0.7904	0.8109	0.7848
Plan D	1.0014	0.8300	0.8400	0.8188
Plan E	1.1174	0.9762	0.9807	0.9568
Plan F	0.8164	0.7311	0.7301	0.6985
Plan G	0.9212	0.7726	0.7708	0.7540
Plan H	0.9465	0.7575	0.7629	0.7467
Plan I	1.1773	1.0198	1.0261	0.9981
Plan J	0.8251	0.6748	0.6892	0.6710
Plan K	0.7984	0.6727	0.6747	0.6560
Plan L	1.0952	0.9466	0.9531	0.9295
Plan M	1.0510	0.8689	0.8780	0.8553
Minimum	0.7984	0.6727	0.6747	0.6560
Maximum	1.1811	1.0198	1.0261	0.9981
Weighted Average	1.0272	0.8621	0.8702	0.8474

Hospitals asked for similar information; that work is under development.

We will also provide you with detailed information to distribute individually to the health plans.

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I hope this information is helpful and resolves some of the questions raised by hospitals and plans on the call on Monday. Please let me know if you have further questions.