OFFICE OF THE DIRECTOR
John A. Kitzhaber, MD, Governor

Oregon Health Authority

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January 7, 2014

The Honorable Senator Richard Devlin, Co-Chair
The Honorable Representative Peter Buckley, Co-Chair
Interim Joint Committee on Ways and Means
900 Court St, NE
H-178 State Capitol
Salem, OR 97301

Re: Report in Response to House Bill 5030 (2013) Budget Note for the Oregon Educators Benefit Board (OEBB)

Dear Co-Chairpersons:

NATURE OF REQUEST

The Oregon Health Authority (OHA) Oregon Educators Benefit Board (OEBB) requests receipt of this letter as required by the Budget Note in House Bill 5030 (2013).

House Bill 5030 directed the OEBB to appoint a workgroup to consider and prepare a report to be provided during the 2014 legislative session on payment and delivery reform options and transparency in health care costs.

AGENCY ACTION

The attached report is a result of the work of the OEBB Budget Note Workgroup. Also attached are the copies of the two studies and OEBB claims data referenced under the Health Care Data and Baseline for Health Care Costs section of the report.

ACTION REQUESTED

Acknowledge receipt of OEBB's budget note report on payment and delivery reform options and transparency in health care costs.

LEGISLATION AFFECTED

None

Sincerely,

Rick Shidaker, Chair
Oregon Educators Benefit Board

c: Ken Rocco, Legislative Fiscal Office
Linda Ames, Legislative Fiscal Office
Michelle Lisper, Department of Administrative Services
OEBB Board

A budget note attached to HB 5030 directed the Oregon Educators Benefit Board (OEBB) to appoint a workgroup to consider and prepare a report to be provided during the 2014 legislative session on the following:

- Payment and delivery reform options intended to incent the development of systems of care, in contrast to episodes of care

- A plan to implement approaches to better inform OEBB members of the benefits of their healthcare coverage, information to allow more informed choices, and out of pocket costs for care options

- Reimbursement and other data from health care entities, in a format useful to achieve the goals of transparency and development of a baseline for health care costs

The budget note included a statement that this task was not to apply to type A or B hospitals.

Workgroup members were to include the OEBB administrator, as well as members representing the OEBB board, the insurance carriers serving OEBB, hospitals and health systems, physician groups, and individuals receiving benefits from OEBB.

The Workgroup met on several occasions to review and discuss health care costs including findings of a recent study on OEBB hospital costs; claims data from past OEBB plan years and cost and utilization trends; tools and resources currently available to OEBB members to assist them in projecting future costs or comparing costs; and possible tools and resources to be considered in the future.

PAYMENT AND DELIVERY REFORM OPTIONS

The Workgroup was advised that during the prior two plan years more than 64 percent of OEBB members had used medical homes for their primary care and the use of medical homes is anticipated to increase during the current and future plan years. Effective October 1, 2013, under OEBB's contract with Moda Health, members who use network providers who are also certified by the Oregon Health Authority as Patient-Centered Primary Care Homes (PCPCHs) can significantly reduce their out-of-pocket costs. PCPCHs are paid differently than traditional fee-for-service medical care providers receiving additional pay as a reward for providing better managed and more coordinated health care. Kaiser Permanente continues to provide care under the PCPCH model.

The Workgroup also learned about a special program Moda Health implemented in conjunction with the creation and implementation of the Moda Medical Home model

called the Comprehensive Coordinated Care (C3) program. This program was designed to focus on the three to five percent of the OEBB members driving nearly 50 percent of the total health care costs. It focuses on members with chronic conditions and their families and provides additional resources and further reduced out-of-pocket costs for those electing to participate.

Recommendation:

The Workgroup recommends that OEBB continue to pursue strategies endorsing comprehensive coordinated care programs which engage the primary care model with the rest of the delivery system to deliver the highest quality, lowest cost care and improve the health of OEBB members.

INFORMED CHOICES AND TRANSPARENCY IN OUT-OF-POCKET COSTS

The Workgroup received a demonstration of a decision tool that was made available to nearly two-thirds of the OEBB population during the 2012 open enrollment period and the remaining one-third of the OEBB population during the 2013 open enrollment. The Informed Enrollment tool allows an OEBB member to compare the costs of each of the medical plans available to him or her prior to deciding which medical plan option to enroll in for the upcoming plan year. The tool takes into account the educational entity's contribution toward benefit plans and an estimate of the potential out-of-pocket costs for each plan. Out-of pocket health care costs are modeled for each medical plan based on actual medical claims during a prior 12-month period, if available, and allows the member to include adjustments due to scheduled or anticipated health care costs in the upcoming plan year (e.g., a planned birth, inpatient surgery, outpatient surgery, etc.). The tool also provides the member with an estimated total cost of the planned health care service. It is anticipated that the Informed Enrollment tool will continue to be available to all OEBB members during the annual enrollment period.

The Workgroup was also advised of several pricing tools currently available through the OEBB-contracted health insurance carriers, Moda Health and Kaiser Permanente. A pricing transparency tool recently released in New York State that compares the costs of conditions or procedures by hospital was also discussed. This tool provides the mean and median cost by procedure and makes allowances for the level of severity. Opponents and proponents of the database agree that developing useful information requires cooperative efforts by all stakeholders. The Workgroup also discussed an online data resource available through the Oregon Hospital Association that allows individuals to compare hospital costs that few of the Workgroup members were aware of.

Recommendation:

The Workgroup recommends OEBB continue to offer the Informed Enrollment decision tool to OEBB members at the time of open enrollment, develop ways to make members aware of tools available to them and encourage members to use available tools. They also recommend that OEBB evaluate the current tools available through medical carriers and the Oregon Hospital Association to assess if the information available can meet the needs of OEBB members interested in researching costs of health care services. The evaluation should identify areas for improvements and include recommendations on whether other means of making this information available should be considered. The Workgroup believes quality should be taken into account in addition to cost if at all possible. The Workgroup further recommends OEBB develop guidelines for price transparency and that those guidelines become expectations for contractual agreements.

HEALTH CARE DATA AND BASELINE FOR HEALTH CARE COSTS

The Workgroup reviewed hospital cost data that was collected during a special study procured by the Oregon Education Association (OEA) early in 2013. This study showed that the "allowed" amounts for hospital services provided to OEBB members during four quarters in 2011 and 2012 varied from 201 percent and 412 percent of the Medicare rate among DRG hospitals (non-A or –B hospitals), depending on the institution. The reports also showed that OEBB and the Public Employees' Benefit Board (PEBB) could have saved just over $16 million if the OEBB/PEBB "allowed" amount was capped at 272 percent of the Medicare rate, which was the average percentage for all DRG hospitals, and just over $157 million if the "allowed" amount was capped at 135 percent of the Medicare rate.

The Workgroup also reviewed utilization reports for the OEBB medical benefits program which showed the per member per month (PMPM) costs increasing from plan year to plan year, with more than 40 percent of the overall costs being associated with hospital costs. It was determined through a drill-down on the data that the increasing PMPM costs under the Moda Health plans were due to increasing costs for services for inpatient procedures, outpatient procedures, office visits and pharmacy, although a moderating trend was seen for some categories in the first six months of the 2012-13 plan year. Utilization of services had decreased in each of the plan years since OEBB was created and is projected to continue to decrease in the future. Unless the Board is able to find ways to address the steadily increasing costs, those rising costs will have a significant impact on the total cost of the program for educational entities and the state on the whole.

Recommendation:

It was beyond the limited timeframe of this workgroup to research other payment methodologies. While a percentage of Medicare is one possible methodology, there may be others that can help the state control the costs of OEBB without shifting all cost burdens to the member. The Workgroup recommends the 2014 Legislature consider directing OEBB to continue to work with key stakeholders to examine reimbursement methodologies and strategies for implementation of payment reform and report back to the 2015 Legislature.

OEBB Budget Note Workgroup Membership:

- Alison Little, MD, OEBB Board Member, Chair
- Aaron Crane, Chief Financial Officer, Salem Hospital
- James Gajewski, MD, Professor of Medicine, Oregon Health and Sciences University
- William Johnson, MD, President, Moda Health
- Patrick Hocking, Chief Administrative and Finance Officer, Asante Health System
- Keith Bachman, MD, Medical Director, Kaiser Permanente Northwest
- Joan Kapowich, OEBB Administrator
- Steve McNannay, OEBB Board Member

Interested Parties:

- Kelly Ballas, Chief Financial Officer, Oregon Health Authority
- Brian Boehringer, Government Relations, Oregon Medical Association
- Jeston Black, Sr. Labor Liaison, Kaiser Permanente Northwest
- Patricia O'Sullivan, Consultant, Oregon Association of Hospitals and Health Systems

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March 21, 2013

Jeston Black
Government Relations Consultant
Oregon Education Association
6900 SW Atlanta Street
Portland, OR 97223

Re: Modified Medicare Hospital Fee Schedule, State of Oregon

Dear Jeston:

At the request of the Oregon Education Association (OEA), Milliman has prepared a modified Medicare fee schedule for the State of Oregon to facilitate the percent of Medicare estimates sent in a separate report. The details of the fee schedule, as well as all assumptions are included below. We understand that OEA will consider these fee schedules in the development of potential legislation regarding OEBB/PEBB hospital payment levels. This information may not be appropriate for other purposes.

This report has been prepared for the sole benefit of OEA. Milliman has given OEA permission to distribute this report in its entirety to legislative stakeholders. Decision-makers should retain their own qualified professionals to interpret our report. Milliman does not intend to benefit, or to create any legal duty to, any third party recipient of this work.

This is subject to the terms and conditions of the Consulting Services Agreement between Milliman and OEA effective February 19, 2013. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report. The opinions reflected in this letter are those of the authors and not necessarily those of Milliman.

BACKGROUND

We understand the state is interested in limiting hospital payments using an equitable and comparable methodology. Medicare hospital payment methodologies are well known, transparent, and payments are generally equitable among hospitals. However, some elements of Medicare make it difficult to compare hospital reimbursement directly (e.g. disproportionate share increases for hospitals with a disproportionate share of lower paying patients)

As a solution to the complexity of the Medicare fee schedule, we prepared a modified Medicare fee schedule for many commercial payers, which simplifies the Medicare inpatient and outpatient fee schedules and creates a single base fee schedule, such that commercial payment percentages can be directly compared among hospitals. We will refer to this simplified and modified commercial fee schedule as Medicare Lite. The Medicare Lite fee schedule is derived from Medicare's actual fee schedules, with simplifications to make the fee schedule more transparent and less complex, while still closely mimicking the Medicare payment structure and payment level. The base fee schedule outlined here is the same for every hospital in the state so that multiples of the base are directly comparable.

We set the base fee schedule to Eugene geographic adjustments which are the highest in the state which will make the multiples of the base for each hospital lower than if we used nationwide (unadjusted) fees. Table 1 shows the Medicare geographic factors for Oregon.

Table 1
2012 Medicare Hospital Geographic Factors for Oregon

				Base CFs			Weighted Factors	
CBSA Code		Wage Inde	GAF	Operating	Labor %	Capital	Outpatient [1]	Inpatient [2]
OR-13460	Bend, OR	1.1147	1.0772	5,209.74	0.688	421.42	1.0688	1.0788
OR-18700	Corvallis, OR	1.0667	1.0452	5,209.74	0.688	421.42	1.0400	1.0458
OR-21660	Eugene-Springfield, OR	1.1391	1.0933	5,209.74	0.688	421.42	1.0835	1.0955
OR-32780	Medford, OR	1.0273	1.0186	5,209.74	0.688	421.42	1.0164	1.0188
OR-38900	Portland-Vancouver-Hillsboro, OR-WA	1.1078	1.0726	5,209.74	0.688	421.42	1.0647	1.0740
OR-41420	Salem, OR	1.1094	1.0737	5,209.74	0.688	421.42	1.0656	1.0751
OR-41999	Rural	1.0273	1.0186	5,209.74	0.688	421.42	1.0164	1.0188

1. Oupatient geographic adjustment is 60% of the Wage Index for most services (1.1147 x 0.60 +0.40=1.0688)
2. Inpatient geographic adjustment is the Wage Index times the Operating Base CF x the Labor % plus the Capital Base CF x GAF

RESULTS

We have attached the Medicare Lite fee schedule as an Excel workbook (2012 Medicare Lite OR.xlsb). An overview of the Inpatient and Outpatient components are included below. Details pertaining to each schedule are included in subsequent sections.

Inpatient

Attachment A-1 shows the first page of the Medicare Lite nationwide inpatient fee schedule. Attachment A-2 provides an overview of the inpatient adjudication logic, including the transfer reduction formulas and well-newborn vs. neonatal maternity logic and examples. Attachment A-3 shows the development of the maternity and neonate case rates and per diems. Attachment A-4 shows the development of the Eugene DRG base-rate. Attachment A-5 shows inpatient cost-to-charge ratios by facility, which are a component of the outlier fee calculations. Attachment A-6 shows a mapping from discharge status to transfer status.

Outpatient

Attachment B-1 shows the Medicare Lite outpatient fee schedule. Attachment B-2 provides a summary of the outpatient adjudication logic. Attachment B-3 provides a reference for the Oregon schedule amount for automated test panel pricing (ATP) codes. Attachment B-4 shows the development of the observation care per unit payment. Attachment B-5 shows a list of revenue codes where the Medicare payment is bundled. Attachment B-6 shows APC modifiers that impact Medicare payment and the corresponding payment multiplier.

INPATIENT

The inpatient fee schedule follows the Medicare fee schedule with a small number of adjustments/clarifications to simplify implementation and to make it more appropriate for commercial populations.

We have summarized the proposed adjustments below:

Table 2 – Inpatient Medicare Lite Decision Elements	
Element	**Milliman Recommendation**
Lesser of charges or set schedule	Lesser of charges
Outlier	Simplified Medicare outlier that pays 100% of cost beyond fixed loss threshold rather than Medicare's 80% of cost beyond the threshold
New Technology Add-Ons	None
Transfers to other hospitals	Use Medicare reduction formula: (LOS +1)/Medicare Average LOS, capped at 1.0
Discharge to post-acute care reduction (e.g. SNF, home health)	Use Medicare reduction formula: 0.5 + 0.5*[(LOS +1)/Medicare Average LOS], capped at 1.0
Psych and Substance Abuse	Use Medicare Acute Hospital DRG relative weights and Length of Stay to establish per diem.
Rehabilitation	Use Medicare Acute Hospital DRG relative weights and Length of Stay to establish per diem.
Skilled Nursing Facility	Set a fixed per diem and don't use CMS refined case rate methodology.
Adjust Relative Weights for Maternity and Newborns	Using adjusted relative weights for maternity and newborns.
Newborn Payment including NICU	Separately pay for newborns in addition to mother. Separate per diems established for NICU (neonate DRGs).
Burns and Trauma	We recommend no specific adjustment. This will be consistent with Medicare.
Transplants	We recommend no specific adjustment. This will be consistent with Medicare.
Disproportionate Share and Medical Education	Fee schedules will not be increased for DSH and IME.
Pass Through Per Diem	No payment for pass through per diem.

Further description for some elements:

Lesser of charges or set schedule

- Medicare has no "lesser of" consideration for inpatient services, but Medicare's discounts are so steep the issue is rare.
- We recommend using lesser of charges to prevent member coinsurance from being based on an allowed that is higher than charges.
- This logic should be applied after calculating the allowed amount using the fee schedule rules.

Outlier

- Medicare pays 80% of losses beyond the Fixed Loss Threshold, while our simplified approach pays 100% of these losses.
- The Medicare cost estimate has operating and capital components; we simplify the outlier calculation by using an aggregate cost-to-charge estimate.
- Hospital specific Cost to Charge Ratios were set using the 2012 Medicare provider specific file operating plus capital cost to charge ratios.

This is illustrated in Table 3:

Table 3 – Inpatient Medicare Lite Outlier Payment Illustration

	Admit A	*Admit B*	
A	$100,000	$1,000,000	Billed - Patient Specific
B	50.0%	50.0%	Cost-to-Charge Ratio
C=AxB	$50,000	$500,000	Estimated Cost
D	$10,000	$10,000	DRG Rate
E	$20,000	$20,000	Medicare Fixed Loss Threshold
F=C-D-E	$20,000	$470,000	Losses beyond Fixed Loss Threshold
G=D+F	$30,000	$480,000	Total Payments*
H=G/A	30.0%	48.0%	Total Paid as a Percent of Charges

* Note that Medicare pays 80% of losses beyond Fixed Loss Threshold rather than 100% as shown in these examples.

New Technology Add-Ons

- New technology costs are paid separately only if the new technology is proven to result in outcome improvement and is significantly higher cost than the old methodology (without a reduction in LOS and overall costs).
- New Technology add-ons are rare. There was only one type of new technology add-on in 2012 and it impacted less than 0.4% if Medicare discharges.
- Payments are very limited – around 50% of a very low cost estimate of the new technology.

Discharge to Post Acute Care (SNF and Home Health)

- Medicare payment rules vary by DRG:
    - 474 DRGs have no reduction,
    - 245 DRGs follow the acute transfer formula, and
    - 30 DRGs follow the dampened transfer formula (“Special Pay DRGs”).

- We recommend implementing the post-acute transfer rules as this will reduce payment for admissions where the hospital manages the length of stay and utilizes post-discharge care (e.g. home care).
- Ignoring the post-acute transfer rules would result in simpler claim adjudication but would not do as well in accounting for case mix differences among hospitals.

This transfer payment methodology is illustrated in Table 4:

Table 4
Transfer Reduction Illustrations

	Short Stay Example		**Post-Acute Transfer Example**	
Description	Value		Value	
Billed Charges	$35,500		$36,500	
Length of Stay	2	(a)	2	(a)
DRG	341		041	***Post-Acute Special Pay DRG***
Discharge Status	02	*Transfer to a short term hospital*	03	*Discharge to SNF*
DRG Relative Weight	2.357	(b)	2.178	(b)
DRG Medicare ALOS	5.0	(c)	5.1	(c)
National Base Rate	$8,785	(d)	$8,785	(d)
Outlier	$0	(e)	$0	(e)
Subtotal	$20,705	(f=b*d+e)	$19,128	(f=b*d+e)
Short Stay Factor (*max 1.0*)	0.600	(g=[a+1]/c)	0.794	**(g=0.5 + 0.5*[a+1]/c)**
Base Payment	$12,423	(h=f*g)	$15,190	(h=f*g)

Psych and Substance Abuse

- For hospitals with no distinct Psych unit, the proposed methodology matches Medicare.
- For hospitals with a distinct Psych unit, Medicare has a refined per diem methodology based on the DRG, the age/sex, the services performed and co-morbidities.

Rehabilitation

- Rehab is typically very small volume in commercial populations (<0.7% of inpatient).
- For hospitals with no distinct Rehab unit, the proposed methodology matches Medicare.
- For hospitals with a distinct Rehab unit, Medicare has a refined case rate methodology based on the services performed and the number of activities of daily living the patient can perform.

Skilled Nursing Facility

- SNF is typically small volume for commercial populations (<1.2% of inpatient).
- Medicare Resource Use Groups (RUGs) require administratively burdensome coding from hospitals in order to create case rate payments.
- Base per diem was set to approximate Medicare average cost per day for 2012.

Maternity Relative Weights

- Medicare has a very limited number of maternity discharges and eligible patients are typically disabled, so they have greater resource use and LOS than a commercial population.
- Milliman relative weights were set using all payer data (not just Medicare) and approximate Medicare after adjusting for demographic and morbidity differences.
- We used commercial hospital discharge data to develop reasonable commercial LOS assumptions.
- Maternity case rates including the normal newborn payment can be created by adding the DRG 795 case rate into the maternity case rate.

Newborn DRG Based Per Diems

- Medicare has almost no newborn discharges.
- Milliman relative weights were set using all payer data (not just Medicare) and approximate Medicare after adjusting for demographic and morbidity differences.
- Since LOS varies so much for neonates, Medicare Lite uses a per diem approach.

Newborn Separate Payment

- Often commercial maternity case rates are set to include well newborns, which results in an overpayment when the newborn is assigned to a neonatal DRG. For this reason, we recommend paying for all newborns as a separate discharge, according to their status (neonatal or well-newborn).
- Paying for all newborns as a separate discharge better aligns the payment with actual treatment costs.

Disproportionate Share and Indirect Medical Education

- Medicare has hospital specific increases for DSH and IME that typically vary from 0% to 40%, but will be decreasing dramatically (75% target) in the near term due to assumptions about the reduction in the number of uninsured persons.
- The Medicare Lite inpatient base rate does not incorporate DSH and IME adjustments.

Pass Through Per Diem

- Medicare pays a hospital specific per diem payment for inpatient stays to cover direct graduate medical education, transplant acquisition costs, and bad debt.
- The Medicare Lite inpatient base rate does not incorporate a pass-through adjustment.

OUTPATIENT

The outpatient Medicare Lite fee schedule aggregates the following Medicare fee schedules into a single HCPCS based fee schedule with limited adjudication rules: APC, Clinical Lab, RBRVS, DME, PEN, Ambulance, and ASP. We have summarized the major decision elements below:

Table 5 - Outpatient Medicare Lite	
Decision Element	**Milliman Recommendation**
Lesser of charges or schedule	Lesser of charges at claim level (not claim line)
Outlier	Eliminate (<1% for Medicare, lower impact for commercial)
Implantable Device Reduction	Eliminate
Bundled Procedures	Follow Medicare and pay $0 for these services
Conditionally Bundled Procedures	Eliminate, and always pay these procedures
Composite APCs	Eliminate
Office Visits	Follow Medicare
Services with no Medicare fee	Limited impact (<1%), pay at cost to charge rate
Modifier Adjustments	Limited to adjustments for bilateral procedures, reduced and discontinued services
Multiple Surgery Reduction	Match Medicare and reduce additional services by 50%
Clinical Lab	Match Medicare and reduce panel test services
Observation	HCPCS schedule will have hourly rate
Partial Hospitalization	HCPCS schedule will have hourly rates
Multiple procedure reductions for physical therapy services	Do not apply
Edits	Use only CMS Medically Unlikely Edits (unit count limits)

Below we provide further description for some elements:

Bundled Services

- Medicare makes no payment for many services as they include the reimbursement as part of other "significant" procedures. It is critical to distinguish between bundled services and services that are non-bundled, but do not have a fee schedule amount.

Conditionally Bundled Services

- Eliminates payment when certain services are performed together.
- Always paying these procedures will result in increased payments to hospitals relative to Medicare.

Composite APCs

- Generally reduces payment when certain services are performed together.
- Eliminating this logic will result in increased payments to hospitals relative to Medicare.
- Total outpatient payments increase by about 1.1% under the 2012 fee schedules if you remove the conditional bundling and composite APC logic.

Office Visits in a Hospital Setting

- Medicare pays a set rate for physical therapy and several other services using RBRVS regardless of where the service is performed (office or facility setting) with no separate facility payment.
- Many commercial payers do not pay facility fees for office visits.
- Medicare overpays for office visits in a hospital setting in our opinion as shown in Table 5 below, which is based on LA payment rates, but the concept is universal:

Table 6

Medicare Office Visit* Allowed

2012 Los Angeles, CA

Location	*Professional*	*Facility*	*Total*
Hospital	$52.23	$81.20	$133.43
Office	$76.19	$0.00	$76.19

*HCPCS 99213 - Mid level visit for established patient

- MedPAC's March 2012 report recommends Medicare reduce the Facility payment for office visits to the difference between the non-facility and facility RBRVS payment. See page 74 of:

  http://www.medpac.gov/documents/Mar12_EntireReport.pdf

Services with no Medicare Fee

- Many services that are not covered by Medicare are covered by commercial payers.
- These are generally low volume services, but they are not bundled services and should not be paid at $0.
- These services are set to pay at the cost-to-charge ratio, but should be subject to defined coverage rules.

Medicare Payment Edits

- Many edits in Medicare system (e.g. service and diagnosis inconsistent) result in claim re-submission and payment with no cost reduction but increased administrative costs.

Clinical Lab

- For Oregon, Medicare has a single lab fee schedule, which is reflected in the Medicare Lite fee schedule.

Observation

- We used the Medicare per diem limits to set an hourly fee. See Attachment F for supporting details.

Physical Therapy and RBRVS Services

- Medicare pays for several outpatient hospital services using RBRVS. The Medicare Lite fee schedule is set using the Portland, Oregon GPCI factors which are the highest in Oregon.

NEXT STEPS

Please review these Oregon schedules and workbooks and let us know if these items will suit your needs, or if you would like to discuss potential modifications going forward.

Please call me at (206) 504-5569 or Kathryn at (206) 504-5771 if you have any questions.

Sincerely,

Will Fox, FSA, MAAA
Principal and Consulting Actuary

/jbw
Attachment

cc: Kathryn Rains-McNally, Milliman

Attachment A-1
Oregon Education Association
Allowable Fee by MS DRG v29 - FY2012
Oregon Rate

Oregon Base Rate (reflects highest wage index factor): $6,169.05

*Geometric mean LOS is set to Arithmetic mean LOS for maternity and newborn DRGs.

MS-DRG	Post-Acute DRG	Special Pay DRG	MS-DRG Title	Milliman Service Category	Weights	Geometric Mean LOS*	Arithmetic mean LOS	Selected Payment Basis	Adjusted Medicare Rates: Base Allowable Fee per Case	Adjusted Medicare Rates: Base Allowable Fee per Day
001	No	No	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	SURG	24.279	28.6	37.4	Case Rate	$149,780.94	
002	No	No	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	SURG	13.970	16.7	21.3	Case Rate	$86,181.69	
003	Yes	No	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	SURG	17.993	29.1	35.3	Case Rate	$110,997.95	
004	Yes	No	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	SURG	10.925	21.4	26.0	Case Rate	$67,397.54	
005	No	No	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	SURG	10.481	15.9	20.9	Case Rate	$64,660.33	
006	No	No	LIVER TRANSPLANT W/O MCC	SURG	5.106	8.2	9.4	Case Rate	$31,498.58	
007	No	No	LUNG TRANSPLANT	SURG	9.871	15.4	18.9	Case Rate	$60,894.74	
008	No	No	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	SURG	5.118	10.1	12.0	Case Rate	$31,570.75	
010	No	No	PANCREAS TRANSPLANT	SURG	3.890	8.5	9.9	Case Rate	$23,997.62	
011	No	No	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W MCC	SURG	4.997	12.1	15.2	Case Rate	$30,824.92	
012	No	No	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W CC	SURG	3.096	8.5	10.0	Case Rate	$19,097.54	
013	No	No	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES W/O CC/MCC	SURG	1.898	5.6	6.4	Case Rate	$11,710.72	
014	No	No	ALLOGENEIC BONE MARROW TRANSPLANT	SURG	10.279	18.0	24.8	Case Rate	$63,412.95	
016	No	No	AUTOLOGOUS BONE MARROW TRANSPLANT W CC/MCC	SURG	6.313	18.1	19.8	Case Rate	$38,943.39	
017	No	No	AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC	SURG	4.322	11.6	14.6	Case Rate	$26,665.12	
020	No	No	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	SURG	8.503	13.4	16.8	Case Rate	$52,457.32	
021	No	No	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	SURG	6.437	12.6	14.3	Case Rate	$39,709.59	
022	No	No	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	SURG	4.150	5.6	7.6	Case Rate	$25,601.58	
023	Yes	No	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W MCC OR CHEMO IMPL	SURG	5.363	8.4	11.7	Case Rate	$33,081.56	
024	Yes	No	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	SURG	3.633	5.4	7.5	Case Rate	$22,410.32	
025	Yes	No	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	SURG	4.693	8.5	10.9	Case Rate	$28,949.52	
026	Yes	No	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	SURG	2.977	5.5	7.0	Case Rate	$18,365.28	
027	Yes	No	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	SURG	2.132	2.9	3.7	Case Rate	$13,150.57	
028	Yes	Yes	SPINAL PROCEDURES W MCC	SURG	5.648	10.1	13.0	Case Rate	$34,840.35	
029	Yes	Yes	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	SURG	2.831	4.5	6.2	Case Rate	$17,463.36	
030	Yes	Yes	SPINAL PROCEDURES W/O CC/MCC	SURG	1.692	2.4	3.1	Case Rate	$10,440.51	
031	Yes	No	VENTRICULAR SHUNT PROCEDURES W MCC	SURG	4.453	8.7	12.5	Case Rate	$27,470.18	
032	Yes	No	VENTRICULAR SHUNT PROCEDURES W CC	SURG	1.949	3.5	5.2	Case Rate	$12,024.10	
033	Yes	No	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	SURG	1.409	2.0	2.6	Case Rate	$8,689.11	
034	No	No	CAROTID ARTERY STENT PROCEDURE W MCC	SURG	3.500	4.5	6.9	Case Rate	$21,593.54	
035	No	No	CAROTID ARTERY STENT PROCEDURE W CC	SURG	2.146	2.1	3.1	Case Rate	$13,238.17	
036	No	No	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	SURG	1.655	1.3	1.5	Case Rate	$10,209.79	
037	No	No	EXTRACRANIAL PROCEDURES W MCC	SURG	3.085	5.6	8.0	Case Rate	$19,028.45	
038	No	No	EXTRACRANIAL PROCEDURES W CC	SURG	1.580	2.4	3.5	Case Rate	$9,749.57	
039	No	No	EXTRACRANIAL PROCEDURES W/O CC/MCC	SURG	1.031	1.4	1.7	Case Rate	$6,357.21	
040	Yes	Yes	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	SURG	4.033	8.9	12.0	Case Rate	$24,880.41	
041	Yes	Yes	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIN	SURG	2.178	5.1	6.6	Case Rate	$13,433.12	
042	Yes	Yes	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	SURG	1.744	2.5	3.3	Case Rate	$10,760.07	
052	No	No	SPINAL DISORDERS & INJURIES W CC/MCC	MED	1.539	4.3	5.7	Case Rate	$9,494.18	
053	No	No	SPINAL DISORDERS & INJURIES W/O CC/MCC	MED	0.855	2.7	3.3	Case Rate	$5,277.01	
054	Yes	No	NERVOUS SYSTEM NEOPLASMS W MCC	MED	1.468	4.4	6.0	Case Rate	$9,056.17	

Attachment A-2
Oregon Education Association
Inpatient Payment Adjudication Logic

Claim Adjudication Rules

1. Claims are paid using a DRG case rate, the same as Medicare. Each discharge is assigned a MS-DRG and one payment is made per discharge.
2. Each MS-DRG corresponds with a DRG Relative Weight, which represents the relative cost of the DRG compared to an average.
3. With the exception of neonate, psych & substance abuse, rehab, and SNF discharges, the payment for each discharge is the DRG Relative Weight times the national-level base rate.
   Neonate discharges are paid on a per diem schedule that is based on Milliman *RBRVS for Hospitals* and reflects commercial lengths of stay.
   Psych & substance abuse and rehab discharges are paid on a per diem schedule that is consistent with Medicare's DRG Relative Weights and average length of stay.
   SNF discharges are paid a per diem that approximates Medicare payment levels.
4. Similar to Medicare, payment is adjusted in the following special cases:
   a) Outliers
   b) Short Stays
   c) Post-Acute Transfers
5. For all discharges except neonate, psych & substance abuse, and rehab discharges, payment equals:
   (DRG Relative Weight * national-level base rate + outlier) * short stay or transfer adjustment.
   For neonate, psych & substance abuse, and rehab discharges payment equals LOS times the DRG per diem payment rate.
   Examples of each type of discharge are provided below.

Claim Payment Examples

Note that the values shown in each example are illustrative. Actual values will be specific to the patient's discharge.

Typical DRG Case Rate Example

Description	Value	
Billed Charges	$8,020	
Length of Stay	1	
DRG	690	
DRG Relative Weight	0.787	(a)
Base Rate	$6,169	(b)
Outlier	$0	(c)
Subtotal	$4,855	(d=a*b+c)
Short Stay Factor (*max 1.0*)	1.000	(e)
Payment	$4,855	(f=d*e)

Neonate Per Diem Example

Description	Value	
Billed Charges	$7,953	
Length of Stay	3	(a)
DRG	791	*Prematurity W Major Problems*
Per Diem Rate	$1,093	(b)
Payment	$3,280	(c=a*b)

Maternity DRG Case Rate with Well Newborn Example

Description	Value	
Billed Charges	$5,311	
Length of Stay	1	
DRG (Maternity)*	775	*Normal Delivery w/o Complications*
DRG Relative Weight	0.371	(a)
Newborn DRG	795	*Normal Newborn*
DRG Relative Weight	0.108	(b)
Total DRG Relative Weight	0.479	(c=a+b)
Base Rate	$6,169	(d)
Outlier	$0	(e)
Subtotal	$2,955	(f=c*d+e)
Short Stay Factor (*max 1.0*)	1.000	(g)
Payment	$2,955	(h=f*g)

* Methodology applies to DRGs 765 - 768, 774, and 775.

Outlier Example

Description	Value	
Billed Charges	$388,129	(a)
Assumed Cost to Charge Ratio	0.457	(b)
Estimated Cost	$177,375	(c=a*b)
Length of Stay	31	
DRG	957	
DRG Relative Weight	6.602	(d)
Base Rate	$6,169	(e)
DRG Rate	$40,726	(f=d*e)
Medicare Fixed Loss Threshold	$22,385	(g)
Losses beyond Fixed Loss Threshold	$114,264	(h=c-f-g)
Assumed Marginal Cost Factor	1.000	(i)
Outlier Payment	$114,264	(j=h*i)
Payment	$154,990	(k=f+j)

Short Stay Example

Description	Value	
Billed Charges	$25,124	
Length of Stay	5	(a)
DRG	603	
Discharge Status	02	*Transfer to a short term hospital*
DRG Relative Weight	0.844	(b)
DRG Medicare Average Length of Stay	3.7	(c)
Base Rate	$6,169	(d)
Outlier	$0	(e)
Subtotal	$5,209	(f=b*d+e)
Short Stay Factor (*max 1.0*)	1.000	(g=[a+1]/c)
Payment	$5,209	(h=f*g)

Post-Acute Transfer Examples

Description	Value A		Value B	
Billed Charges	$10,987		$36,588	
Length of Stay	1	(a)	4	(a)
DRG	497	***Post-Acute Special Pay DRG***	470	***Post-Acute DRG (not Special Pay)***
Discharge Status	03	*Discharge to SNF*	03	*Discharge to SNF*
DRG Relative Weight	1.091	(b)	2.087	(b)
DRG Medicare Average Length of Stay	1.9	(c)	3.3	(c)
Base Rate	$6,169	(d)	$6,169	(d)
Outlier	$0	(e)	$0	(e)
Subtotal	$6,729	(f=b*d+e)	$12,872	(f=b*d+e)
Short Stay Factor (*max 1.0*)	1.000	**(g=0.5 + 0.5*[a+1]/c)**	1.000	**(g=[a+1]/c)**
Payment	$6,729	(h=f*g)	$12,872	(h=f*g)

Attachment A-3
Oregon Education Association
Maternity and Newborn Relative Weights

			(a)	(b)	(c)	(d)	(e=c*[d-b]+a)	(f)	(g)	(h=c*[g-b]+a)	(i)	(j)	(k=j*$6,169)	(l=j*$6,169/i)
			Milliman *RBRVS for Hospitals*™			**Nationwide Medicare**			**OR Area Adj. Commercial (HCGs)**		**Medicare Lite Case Rate/Per Diem**			
			Base	Base	Addt'l Day	Average	DRG Relativity		Average	DRG	Average	DRG	Nationwide Fee	
DRG	Description	Type	RVUs	LOS	RVUs	LOS	Milliman	Actual Medicare	LOS	Relativity	LOS	Relativity	Per Case	Per Day
001	Heart Transplant Or Implant Of Heart Assist System W Mcc	Other	5.648	1	0.454	37.4	22.1624	24.2794	43.4	24.8845	37.4	24.2794	$149,781	$0
…	…													
760	Menstrual & Other Female Reproductive System Disorders W Cc/Mcc	Other	0.332	1	0.149	3.6	0.7204	0.7892	2.2	0.5112	3.6	0.7892	$4,869	$0
761	Menstrual & Other Female Reproductive System Disorders W/O Cc/Mcc	Other	0.302	1	0.129	2.3	0.4701	0.5150	1.5	0.3668	2.3	0.5150	$3,177	$0
765	Cesarean Section W Cc/Mcc	Maternity	0.377	1	0.108	5.2	0.8295	1.2255	4.6	0.7648	4.6	0.8379	$5,169	$0
766	Cesarean Section W/O Cc/Mcc	Maternity	0.363	1	0.103	3.0	0.5703	0.8497	3.2	0.5910	3.2	0.6475	$3,994	$0
767	Vaginal Delivery W Sterilization &/Or D&C	Maternity	0.386	1	0.141	2.6	0.6113	0.8547	2.3	0.5690	2.3	0.6234	$3,846	$0
768	Vaginal Delivery W O.R. Proc Except Steril &/Or D&C	Maternity	0.423	1	0.151	5.8	1.1493	1.8180	3.4	0.7859	3.4	0.8610	$5,312	$0
769	Postpartum & Post Abortion Diagnoses W O.R. Procedure	Maternity	0.667	1	0.281	4.9	1.7641	1.5259	3.0	1.2296	3.0	1.3471	$8,310	$0
770	Abortion W D&C, Aspiration Curettage Or Hysterotomy	Maternity	0.454	1	0.141	1.9	0.5813	0.6353	1.4	0.5107	1.4	0.5595	$3,452	$0
774	Vaginal Delivery W Complicating Diagnoses	Maternity	0.239	1	0.104	3.4	0.4893	0.7406	2.6	0.4059	2.6	0.4446	$2,743	$0
775	Vaginal Delivery W/O Complicating Diagnoses	Maternity	0.233	1	0.095	2.3	0.3575	0.5283	2.1	0.3384	2.1	0.3708	$2,287	$0
776	Postpartum & Post Abortion Diagnoses W/O O.R. Procedure	Maternity	0.180	1	0.140	3.3	0.5012	0.6436	2.4	0.3756	2.4	0.4114	$2,538	$0
777	Ectopic Pregnancy	Maternity	0.603	1	0.211	2.0	0.8140	0.8133	1.6	0.7295	1.6	0.7992	$4,930	$0
778	Threatened Abortion	Maternity	0.124	1	0.094	2.7	0.2837	0.4646	3.2	0.3305	3.2	0.3621	$2,234	$0
779	Abortion W/O D&C	Maternity	0.242	1	0.127	2.2	0.3950	0.5134	1.4	0.2933	1.4	0.3213	$1,982	$0
780	False Labor	Maternity	0.115	1	0.102	1.3	0.1451	0.1947	1.3	0.1451	1.3	0.1590	$981	$0
781	Other Antepartum Diagnoses W Medical Complications	Maternity	0.181	1	0.117	3.8	0.5075	0.6674	2.8	0.3908	2.8	0.4281	$2,641	$0
782	Other Antepartum Diagnoses W/O Medical Complications	Maternity	0.144	1	0.093	1.8	0.2181	0.3175	2.6	0.2923	2.6	0.3202	$1,975	$0
789	Neonates, Died Or Transferred To Another Acute Care Facility	Neonate	0.327	1	0.196	1.8	0.4836	1.4933	5.7	1.2473	5.7	1.3664		$1,479
790	Extreme Immaturity Or Respiratory Distress Syndrome, Neonate	Neonate	0.567	1	0.177	17.9	3.5667	4.9243	27.0	5.1820	27.0	5.6770		$1,297
791	Prematurity W Major Problems	Neonate	0.380	1	0.145	13.3	2.1617	3.3631	13.9	2.2486	13.9	2.4634		$1,093
792	Prematurity W/O Major Problems	Neonate	0.141	1	0.105	8.6	0.9422	2.0293	5.1	0.5734	5.1	0.6282		$760
793	Full Term Neonate W Major Problems	Neonate	0.330	1	0.138	4.7	0.8391	3.4547	4.5	0.8116	4.5	0.8891		$1,219
794	Neonate W Other Significant Problems	Neonate	0.112	1	0.076	3.4	0.2945	1.2227	2.2	0.2034	2.2	0.2228		$625
795	Normal Newborn	Maternity	0.050	1	0.045	3.1	0.1434	0.1656	2.1	0.0988	2.1	0.1082	$667	$0

Notes:
(1) Milliman *RBRVS for Hospitals*™ is calibrated to the Medicare DRG Relativities for non-maternity and non-neonate DRGs, when using the Medicare Average Lengths of Stay. In other word, columns (e) and (f) are equal for all DRGs, except maternity and neonates DRGs.
(2) Using Medicare average lengths of stay and DRG Relativities for all types of DRGs, except maternity and neonate DRGs.
(3) For maternity and neonate DRGs we are using commercial average lengths of stay and the Milliman *RBRVS for Hospitals*™ DRG relativities.
(4) Neonate psych & substance abuse, and rehab DRGs are paid using a per diem fee. All other DRGs are paid using a case rate.

Attachment A-4
Oregon Education Association
2012 Medicare Inpatient Base Rate Development

MedicareID:	**380102**
Index:	38
Facility Name:	**Sacred Heart Medical Center - Riverbend**
Hospital Quality Indicator:	**1**

Operating Amount			
(a)	NAOSA, Labor		$3,584.30
(b)	Regional Wage Index	x	1.1391
(c)	**Adjusted Labor Amount (a)x(b)**		**$4,082.88**
(d)	NAOSA, Non-Labor		$1,625.44
(e)	COLA	x	1.00
(f)	**Adjusted NonLabor Amount (d)x(e)**		**$1,625.44**
(g)	**Total Adjusted Operating Amount (c)+(f)**		**$5,708.32**
Capital Amount			
(h)	National Capital Standard Federal Rate		$421.42
(i)	GAF	x	1.0933
(j)	**Adjusted Capital Amount (h)x(i)**		**$460.74**
Base Rate			
(k)	**Starting Base Rate (g)+(j)**		**$6,169.05**
(l)	SCH/MDH Adjustment	x	1.00000
(m)	Low Volume Adjustment	x	1.00000
(n)	**Final Base Rate (k)x(l)x(m)**		**$6,169.05**

Attachment A-5
Oregon Education Association
Inpatient Cost-to-Charge Ratios for Oregon Providers

Medicare	Facility Name	Inpatient Total CCR
380001	Mid-Columbia Medical Center	0.425
380002	Three Rivers Community Hospital	0.399
380003	Samaritan Pacific Communities Hospital	0.631
380004	Providence St Vincent Medical Center	0.439
380005	Ashland Community Hospital	0.527
380007	Legacy Emanuel Medical Center	0.383
380009	Ohsu Hospital And Clinics	0.457
380014	Good Samaritan Regional Medical Center	0.384
380017	Legacy Good Samaritan Medical Center	0.408
380018	Rogue Valley Medical Center	0.411
380020	Mckenzie-Willamette Medical Center	0.361
380021	Tuality Community Hospital	0.413
380022	Samaritan Albany General Hospital	0.457
380025	Legacy Mount Hood Medical Center	0.389
380029	Silverton Hospital Network	0.488
380033	Sacred Heart Medical Center - University District	0.611
380037	Providence Newberg Medical Center	0.618
380038	Providence Willamette Falls Medical Center	0.491
380040	St Charles Medical Center - Redmond	0.627
380047	St Charles Medical Center - Bend	0.464
380050	Sky Lakes Medical Center	0.370
380051	Salem Hospital	0.496
380052	St Alphonsus Medical Center - Ontario, Inc	0.420
380056	Santiam Memorial Hospital	0.653
380060	Adventist Medical Center	0.349
380061	Providence Portland Medical Center	0.476
380071	Willamette Valley Medical Center	0.272
380075	Providence Medford Medical Center	0.363
380078	Blue Mountain Hospital	0.964
380082	Providence Milwaukie Hospital	0.522
380089	Legacy Meridian Park Medical Center	0.406
380090	Bay Area Hospital	0.447
380102	Sacred Heart Medical Center - Riverbend	0.483
381301	Cottage Grove Community Hospital	0.452
381302	Samaritan North Lincoln Hospital	0.423
381303	Providence Seaside Hospital	0.423
381304	Southern Coos Hospital & Health Center	0.423
381306	Wallowa Memorial Hospital	0.423
381307	Harney District Hospital	0.423
381309	Lake District Hospital	0.423
381310	Pioneer Memorial Hospital	0.423
381311	Lower Umpqua Hospital District	0.423
381312	Coquille Valley Hospital District	0.423
381313	Pioneer Memorial Hospital	0.423
381316	Peace Harbor Hospital	0.452
381317	Tillamook County General Hospital	0.423
381318	Providence Hood River Memorial Hospital	0.423
381319	St Anthony Hospital	0.423
381320	Columbia Memorial Hospital	0.423
381321	Grande Ronde Hospital	0.423
381322	Curry General Hospital	0.423
381323	Samaritan Lebanon Community Hospital	0.423
381324	Mountain View Hospital District	0.423
381325	Good Shepherd Medical Center	0.423
130014	West Valley Medical Center	0.333
130013	Saint Alphonsus Medical Center - Nampa	0.451

Attachment A-6
Oregon Education Association
Discharge Status to Transfer Map

Discharge Status	Description	Medicare Transfer?
01	Home, self-care (Routine)	No
02	Short term hospital	Transfer
03	SNF	Post-Acute
04	Custodial/supportive care	No
05	Cancer/Children's Hospital	Post-Acute
06	Home Health Service	Post-Acute
07	Left Against Medical Advice	No
08	Home IV service	No
10	Neonate after care - other facility	No
13	Tertiary after care - other facility	No
20	Died	No
21	Court/law enforcement	No
22	Neonate after care	No
23	Tertiary after care	No
30	Still a patient	No
43	Federal Hospital	No
50	Hospice-home	No
51	Hospice-medical facility	No
61	Swing Bed	No
62	Rehab facility/rehab unit	Post-Acute
63	Long term care hospital	Post-Acute
64	Nursing facility-Medicaid certified	No
65	Psych hosp/unit	Post-Acute
66	Critical Access Hospital	No
70	Other Institution	No
71	OP services - other facility	No
72	OP services - this facility	No

Attachment B-1
Oregon Education Association
Simplified Medicare Outpatient Fee Schedule - 2012
Oregon Rate - Reflects Highest GAF in OR

HCPCS Code	Short Descriptor	Status Indicator	Oregon Base Fee	Source
10021	Fna w/o image	T	$120.13	APC
10022	Fna w/image	T	$341.02	APC
10040	Acne surgery	T	$65.48	APC
10060	Drainage of skin abscess	T	$105.90	APC
10061	Drainage of skin abscess	T	$105.90	APC
10080	Drainage of pilonidal cyst	T	$105.90	APC
10081	Drainage of pilonidal cyst	T	$978.42	APC
10120	Remove foreign body	T	$205.69	APC
10121	Remove foreign body	T	$1,267.83	APC
10140	Drainage of hematoma/fluid	T	$978.42	APC
10160	Puncture drainage of lesion	T	$105.90	APC
10180	Complex drainage wound	T	$1,533.02	APC
11000	Debride infected skin	T	$205.69	APC
11001	Debride infected skin add-on	T	$65.48	APC
11004	Debride genitalia & perineum	C	POC	POC
11005	Debride abdom wall	C	POC	POC
11006	Debride genit/per/abdom wall	C	POC	POC
11008	Remove mesh from abd wall	C	POC	POC
11010	Debride skin at fx site	T	$329.77	APC
11011	Debride skin musc at fx site	T	$329.77	APC
11012	Deb skin bone at fx site	T	$329.77	APC
11042	Deb subq tissue 20 sq cm/<	T	$205.69	APC
11043	Deb musc/fascia 20 sq cm/<	T	$205.69	APC
11044	Deb bone 20 sq cm/<	T	$616.84	APC
11045	Deb subq tissue add-on	T	$205.69	APC
11046	Deb musc/fascia add-on	T	$205.69	APC
11047	Deb bone add-on	T	$616.84	APC
11055	Trim skin lesion	T	$65.48	APC
11056	Trim skin lesions 2 to 4	T	$65.48	APC
11057	Trim skin lesions over 4	T	$111.74	APC
11100	Biopsy skin lesion	T	$111.74	APC
11101	Biopsy skin add-on	T	$65.48	APC
11200	Removal of skin tags	T	$65.48	APC
11201	Remove skin tags add-on	T	$65.48	APC
11300	Shave skin lesion	T	$65.48	APC
11301	Shave skin lesion	T	$65.48	APC
11302	Shave skin lesion	T	$65.48	APC
11303	Shave skin lesion	T	$111.74	APC
11305	Shave skin lesion	T	$65.48	APC
11306	Shave skin lesion	T	$65.48	APC
11307	Shave skin lesion	T	$65.48	APC

Attachment B-2
Oregon Education Association
Outpatient Payment Adjudication Logic

Claim Adjudication Rules

1. Claims are paid on a service line basis, the same as Medicare.
2. Units should be coded consistent with Medicare and will be subject to CMS limits.
3. There are no compositing or interaction fee adjustments with 2 exceptions:
    a. Multiple T status surgeries performed on the same patient on the same day will be reduced 50% after the first procedure.
    b. Medicare lab panel test payment limits will apply.
4. Observation service lines will only be payable if coverage criteria is met (similar to Medicare),
    a. Observation must be coded to the appropriate HCPCS (G0378 in 2012) and will be paid at an hourly rate.
    b. Total payment will approximate Medicare's daily rate when combined with base ED rate.
    c. Limited to 24 hours.
5. All HCPCS are subject to coverage limits.
6. Services with a bundled revenue code that do not have a payable HCPCS are paid at zero.

Base Fee Schedule Development High Level Summary

1. Base Fee Schedule is an aggregation of 2012 Medicare fee schedules - see Source column.
2. Status Indicators were adjusted for composite APC HCPCS to use the composite APC status indicator.
3. Observation hourly rate were set to approximate Medicare's daily rates when combined with base ED rates.
4. Partial hospitalization (P status codes) use office based HCPCS to set service fees for psychotherapy and set "G" HCPCS as bundled services.

Attachment B-3
Oregon Education Association
Automated Test Panel Pricing Codes

HCPCS	*Description*	*State-Specific Schedule Amount*
ATP02	Auto.Test Pane Pricing Code, 1-2 Tests	$7.37
ATP03	Auto.Test Pane Pricing Code, 3 Tests	$9.41
ATP04	Auto.Test Pane Pricing Code, 4 Tests	$9.94
ATP05	Auto.Test Pane Pricing Code, 5 Tests	$10.51
ATP06	Auto.Test Pane Pricing Code, 6 Tests	$11.11
ATP07	Auto.Test Pane Pricing Code, 7 Tests	$11.57
ATP08	Auto.Test Pane Pricing Code, 8 Tests	$11.98
ATP09	Auto.Test Pane Pricing Code, 9 Tests	$12.30
ATP10	Auto.Test Pane Pricing Code, 10 Tests	$12.30
ATP11	Auto.Test Pane Pricing Code, 11 Tests	$12.51
ATP12	Auto.Test Pane Pricing Code, 12 Tests	$12.79
ATP16	Auto Test Panel Pricing Code 13-16 Test	$14.97
ATP18	Auto Test Panel Pricing Code, 17-18 Test	$15.07
ATP19	Auto Test Panel Pricing Code, 19 Tests	$15.10
ATP20	Auto Test Panel Pricing Code, 20 Tests	$15.79
ATP21	Auto Test Panel Pricing Code, 21 Tests	$16.48
ATP22	Auto.Test Panel Pricing Code, 22 Tests	$17.15
ATP23	Auto.Test Panel Pricing Code, 23+ Tests	$17.15

Note

ATPxx codes shown above indicate the maximum payment per visit for the automated lab test HCPCS listed below. Each code below counts as one test. The number of automated lab test in a visit is used to determine the ATPxx code to use to cap payment. For example the total payment for all automated test HCPCS in a visit with three automated tests coded is capped at the ATP03 amount.

HCPCS: 82330, 84550, 84520, 84478, 84295, 84132, 84155, 84100, 83615, 82977, 82550, 82947, 82465, 82565, 82435, 82310, 82374, 82247, 82248, 84450, 84075, 82040, 84460.

Attachment B-4
Oregon Education Association
HCPCS G0378 Observation Care Per-Unit Payment Development

Group B HCPCS					Implied Observation Care Payment	
HCPCS	Description	2009 5% Sample Utilization (a)	Composite APC Payment (b)	HCPCS Payment (c)	Total (d = b-c)	Per Unit (Assuming 24 Units) (e = d/a)
Level I Extended Assessment & Management Composite (Composite APC 8002)						
G0379	Direct refer hospital observ	720	$393.61	$53.79	$339.82	$14.16
99205	Office/outpatient visit new	1,036	$393.61	$176.51	$217.10	$9.05
99215	Office/outpatient visit est	9,816	$393.61	$130.41	$263.20	$10.97
Level II Extended Assessment & Management Composite (Composite APC 8003)						
99284	Emergency dept visit	51,929	$720.11	$218.81	$501.30	$20.89
99285	Emergency dept visit	29,585	$720.11	$323.29	$396.82	$16.53
99291	Critical care first hour	1,782	$720.11	$465.75	$254.36	$10.60
G0384	Lev 5 hosp type B ED visit	78	$720.11	$263.25	$456.86	$19.04

Final Implied G0378 Observation Care HCPCS Payment **$18.13**

Utilization weighted average of HCPCS-Level payment.

Attachment B-5
Oregon Education Association
Listing of Bundled Revenue Codes

RevCode	Description
0250	Pharmacy; General Classification
0251	Pharmacy; Generic Drugs
0252	Pharmacy; Non-Generic Drugs
0254	Pharmacy; Drugs Incident to Other Diagnostic Services
0255	Pharmacy; Drugs Incident to Radiology
0257	Pharmacy; Non-Prescription
0258	Pharmacy; IV Solutions
0259	Pharmacy; Other Pharmacy
0260	IV Therapy; General Classification
0261	IV Therapy; Infusion Pump
0262	IV Therapy; IV Therapy/Pharmacy Svcs
0263	IV Therapy; IV Therapy/Drug/Supply Delivery
0264	IV Therapy; IV Therapy/Supplies
0269	IV Therapy; Other IV Therapy
0270	Medical/Surgical Supplies and Devices; General Classification
0271	Medical/Surgical Supplies and Devices; Non-sterile Supply
0272	Medical/Surgical Supplies and Devices; Sterile Supply
0275	Medical/Surgical Supplies and Devices; Pacemaker
0276	Medical/Surgical Supplies and Devices; Intraocular Lens
0278	Medical/Surgical Supplies and Devices; Other Implants
0279	Medical/Surgical Supplies and Devices; Other Supplies/Devices
0280	Oncology; General Classification
0289	Oncology; Other Oncology
0343	Nuclear Medicine; Diagnostic Radiopharmaceuticals
0344	Nuclear Medicine; Therapeutic Radiopharmaceuticals
0370	Anesthesia; General Classification
0371	Anesthesia; Anesthesia Incident to Radiology
0372	Anesthesia; Anesthesia Incident to Other DX Services
0379	Anesthesia; Other Anesthesia
0390	Administration, Processing and Storage for Blood and Blood Components; General Classification
0392	Administration, Processing and Storage for Blood and Blood Components; Processing and Storage
0399	Administration, Processing and Storage for Blood and Blood Components; Other Blood Handling
0621	Medical Surgical Supplies - Extension of 027X; Supplies Incident to Radiology
0622	Medical Surgical Supplies - Extension of 027X; Supplies Incident to Other DX Services
0623	Medical Supplies - Extension of 027X, Surgical Dressings
0624	Medical Surgical Supplies - Extension of 027X; FDA Investigational Devices
0630	Pharmacy - Extension of 025X; Reserved
0631	Pharmacy - Extension of 025X; Single Source Drug
0632	Pharmacy - Extension of 025X; Multiple Source Drug
0633	Pharmacy - Extension of 025X; Restrictive Prescription
0681	Trauma Response; Level I Trauma
0682	Trauma Response; Level II Trauma
0683	Trauma Response; Level III Trauma
0684	Trauma Response; Level IV Trauma
0689	Trauma Response; Other
0700	Cast Room; General Classification
0710	Recovery Room; General Classification

Attachment B-5
Oregon Education Association
Listing of Bundled Revenue Codes

RevCode	Description
0720	Labor Room/Delivery; General Classification
0721	Labor Room/Delivery; Labor
0732	EKG/ECG (Electrocardiogram); Telemetry
0762	Specialty services; Observation Hours
0801	Inpatient Renal Dialysis; Inpatient Hemodialysis
0802	Inpatient Renal Dialysis; Inpatient Peritoneal Dialysis (Non-CAPD)
0803	Inpatient Renal Dialysis; Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)
0804	Inpatient Renal Dialysis; Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)
0809	Inpatient Renal Dialysis; Other Inpatient Dialysis
0810	Acquisition of Body Components; General Classification
0819	Inpatient Renal Dialysis; Other Donor
0821	Hemodialysis-Outpatient or Home; Hemodialysis Composite or Other Rate
0824	Hemodialysis-Outpatient or Home; Maintenance - 100%
0825	Hemodialysis-Outpatient or Home; Support Services
0829	Hemodialysis-Outpatient or Home; Other OP Hemodialysis
0942	Other Therapeutic Services (also see 095X, an extension of 094x); Education/Training
0943	Other Therapeutic Services (also see 095X, an extension of 094X), Cardiac Rehabilitation
0948	Other Therapeutic Services (also see 095X, an extension of 094X), Pulmonary Rehabilitation

Attachment B-6
Oregon Education Association
CMS APC Modifier Adjustments

Modifier Adjustment are effective as of 1/1/2012

Modifier	Adjustment
52	0.5
73	0.5
50	1.5
GZ	0

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March 28, 2013

Jeston Black
Government Relations Consultant
Oregon Education Association
6900 SW Atlanta Street
Portland, OR 97223

Re: OEBB/PEBB Hospital Reimbursement Legislation

Dear Jeston:

At the request of the Oregon Education Association (OEA), we have prepared an analysis of the impact of limiting hospital reimbursement as Oregon considers legislation regulating commercial facility unit cost levels for Oregon Educators Benefit Board (OEBB) and Public Employees Benefits Board (PEBB). We understand that OEA will use this letter to inform legislative stakeholders. This information may not be appropriate for other purposes.

This report has been prepared for the sole benefit of OEA. Milliman has given OEA permission to distribute this report in its entirety to legislative stakeholders. Decision-makers should retain their own qualified professionals to interpret our report. Milliman does not intend to benefit, or to create any legal duty to, any third party recipient of this work.

This is subject to the terms and conditions of the Consulting Services Agreement between Milliman and OEA effective February 19, 2013. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report. The opinions reflected in this letter are those of the authors and not necessarily those of Milliman.

BACKGROUND

In an effort to control costs and promote equitable reimbursement, we understand that Oregon is considering legislation that would regulate commercial facility reimbursement levels for OEBB and PEBB. This letter provides hospital-specific metrics to help OEA and other stakeholders understand the potential impact of restrictions on OEBB/PEBB unit cost reimbursement levels.

When crafting legislation that sets commercial facility payment rates as a function of Medicare allowable, it is important to define Medicare allowable precisely. For example, teaching hospitals currently receive extra payments from Medicare in the form of medical education payments. Hospitals providing care to a disproportionate number of low income people receive disproportionate share hospital (DSH) payments. These payments can be significant, though the DSH payments are projected to decrease dramatically over the near term due to the ACA. In

writing legislation, and in analyzing the impact of payment cuts to hospital revenue, it will be important to clearly define whether the Medicare payment level includes DSH and/or Medical Education payments, and other Medicare provisions such as paying a portion of Medicare beneficiaries' bad debt. This will also make more equitable transparency comparisons among hospitals.

As a solution to the complexity of the Medicare fee schedule, we prepared a modified Medicare fee schedule, which simplifies the Medicare inpatient and outpatient fee schedules and creates a single base fee schedule, such that commercial payment percentages can be directly compared among hospitals. The "Medicare Lite" fee schedule is derived from Medicare's actual fee schedules, with simplifications to make the fee schedule more transparent and less complex, as well as more applicable for commercial patients (rather than the over age 65 population Medicare serves) while still closely mimicking the Medicare payment levels and methodology. The base fee schedule reflected in our results is the same for every hospital in the state so that multiples of the base are directly comparable. For more detail on the Medicare Lite fee schedule, please see our March 21, 2013 deliverable.

SB204 required OEBB and PEBB DRG hospitals to be paid based on Medicare but it was not specific enough so that hospitals would be directly comparable. The modified Medicare fee schedule we have used here would be much more appropriate and comparable for use by commercial payers. The modifications we have made are consistent with what commercial payers are doing across the country as they adopt Medicare based fee schedules for commercial hospital contracting.

RESULTS

Exhibit 1 shows total commercial allowed dollars, net revenue, an estimate of commercial payment as a percentage of Medicare Lite, and whether each hospital is a Medicaid DRG hospital for claims incurred 7/1/2011 – 6/30/2012. The right half of Exhibit 1 shows estimated OEBB/PEBB allowed amounts and the percent of commercial revenue that OEBB/PEBB represents. The last three columns show the estimated reduction to each DRG hospital if the OEBB/PEBB payment rate were capped at a target percentage of Medicare Lite (272% representing the DRG hospitals average), and the OEBB/PEBB payment reduction as a percentage of commercial and total revenue.

Exhibit 2 shows the same results for a 135% scenario and Exhibit 3 shows a 200% scenario.

METHODOLOGY

Exhibit 1 was developed using data from the Oregon DataBank and ODS's OEBB claims experience. We estimated the commercial payment as a percentage of Medicare Lite by repricing OEBB claims incurred 7/1/2011 – 6/30/2012 according to the Medicare Lite fee schedule that we created for OEA.

We relied on ODS for the OEBB allowed amounts by hospital. We estimated PEBB allowed amounts based on PEBB/OEBB January 2013 dental membership by MSA and OEBB's current allowed amounts. See Attachment A for the member counts and an illustration of the PEBB estimation using OHSU. We have assumed the PEBB hospital contracts are the same as the ODS OEBB hospital contracts in order to estimate the results in this letter. If desired, we could run PEBB data directly and get more accurate estimates.

The Oregon DataBank reports Medicare, Medicaid, Self-Pay and Other separately. We are using Other as a proxy for "commercial" payments in Exhibit 1 which includes payments by some non-commercial payers, such as TRICARE.

The reader should review our separate deliverable regarding the development of Medicare Lite, however, the percentages of Medicare Lite in the exhibits are consistent with percentages of actual Medicare with the following exceptions:

- We used the Eugene geographic adjustment factors for both inpatient and outpatient since they were the highest in the state. That will make Medicare Lite slightly higher than Medicare for other areas of the state so their actual percent of Medicare would be higher than is shown in our exhibits.
- Inpatient Medicare relative weights for maternity and newborns are not appropriate for commercial populations and were replaced in Medicare Lite which results in Medicare Lite being slightly lower than Medicare for maternity and newborns.
- Medicare Lite simplifies the inpatient outlier payment and results in slightly higher payments for outliers.
- We have excluded Medicare Disproportionate Share and Medical Education in our Medicare Lite inpatient schedule which we estimate to be approximately 10% for inpatient and outpatient combined. In other words if a hospital had 10% for DSH/IME that we excluded and was estimated to be reimbursed at 220% of Medicare Lite, all other things being held constant their percent of actual Medicare would be 200% (220%/110%).

DATA RELIANCE

This analysis relies on data from the Oregon DataBank and ODS. We have not audited the data but we have performed reasonableness checks. See Attachment B for a summary of the OEBB hospital claims used in our analysis. If the data we used is inaccurate or incomplete, then our analysis may be inaccurate or incomplete.

Future experience and actual commercial percentages of Medicare will vary from our estimates for many reasons, including simplifying assumptions included in our work, changes in provider contracts and the mix of services, and other non-random and random factors.

OTHER CONSIDERATIONS

These two issues may be obvious to the reader but we want to at least mention them. Reimbursement reductions may result in hospitals terminating their OEBB and/or PEBB contracts which may cause access issues or out of network issues.

Transparent, comparable prices can sometimes lead to lower cost hospitals increasing their reimbursement or members choosing the higher priced hospital because they think the quality is higher and they are not aware of the cost difference to them. Ideally, we recommend there be some incentive/reward for lower cost hospitals which can occur if simple member cost calculator tools are available for the member to see their direct cost at each facility. It also helps if members know how to access quality and satisfaction metrics for each hospital.

We appreciate the opportunity to assist you and your team. Please call me at (206) 504-5569 if you have any questions.

Sincerely,

Will Fox, FSA, MAAA
Principal & Consulting Actuary

/jbw
Attachments

cc: Kathryn Rains-McNally, Milliman

Exhibit 1
Oregon Educators Association
Evaluation of Impact of Potentially Legislated % of Medicare for DRG Hospitals - Limited to 272% of Medicare Lite

	DataBank Data Q3 2011 to Q2 2012		ODS OEBB Data - Inpatient and Outpatient				Estimated OEBB/PEBB - IP and OP		Reduction if Hospitals Limited to 272% of Medicare Lite		
	Commercial Allowed	Total Net Revenue - Includes Other Operating Revenue	OEBB Allowed	OEBB Medicare Lite	% of Medicare Lite	DRG Hospital	Estimated OEBB/PEBB Allowed	% of Commercial Allowed	$ Reduction	% of Commercial Allowed	% of Total Net Revenue
	(A)	(B)	(C)	(D)	(E)=(C)/(D)		(F)	(G)=(F)/(A)	(H)	(I)=(H)/(A)	(J)=(H)/(B)
Subtotal: DRG Hospitals	$4,189,972,275	$7,945,085,417	$155,564,991	$57,266,094	**272%**		$311,475,348	7%	$16,245,374	0.4%	0.2%
Subtotal: Non-DRG Hospitals	$648,982,999	$1,503,148,804	$39,213,385	$12,035,841	326%		$70,790,812	11%	$0	0.0%	0.0%
Grand Total	$4,838,955,274	$9,448,234,221	$194,778,376	$69,301,936	281%		$382,266,159	8%	$16,245,374	0.3%	0.2%
Hospital											
OHSU Hospital	$613,424,468	$1,205,952,454	$17,779,815	$7,824,889	227%	Y	$30,743,839	5%	$0	0.0%	0.0%
Providence St Vincent Medical Ctr	$524,134,000	$786,322,000	$11,677,840	$4,416,953	264%	Y	$20,192,652	4%	$0	0.0%	0.0%
Providence Portland Medical Ctr	$372,498,000	$659,266,000	$10,327,334	$4,050,741	255%	Y	$17,857,434	5%	$0	0.0%	0.0%
Legacy Emanuel Hospital & Hlth Ctr	$292,027,015	$515,609,291	$5,056,070	$2,203,586	229%	Y	$8,742,667	3%	$0	0.0%	0.0%
Salem Hospital	$280,931,463	$565,138,913	$14,302,397	$5,253,400	272%	Y	$42,355,683	15%	$38,935	0.0%	0.0%
Sacred Heart Medical Center At Riverbend	$261,893,825	$561,701,809	$14,932,959	$5,362,774	278%	Y	$32,386,703	12%	$750,873	0.3%	0.1%
St Charles Medical Center - Bend	$209,038,677	$433,756,014	$15,063,721	$5,102,233	295%	Y	$19,784,670	9%	$1,557,227	0.7%	0.4%
Good Samaritan Regional Medical Center	$195,757,187	$331,331,117	$9,361,507	$3,197,115	293%	Y	$40,292,775	21%	$2,863,737	1.5%	0.9%
Rogue Valley Medical Center	$173,606,364	$373,163,317	$6,177,697	$2,180,285	283%	Y	$11,357,825	7%	$454,704	0.3%	0.1%
Legacy Good Samaritan Hosp & Med Ctr	$168,021,616	$291,431,684	$3,389,837	$1,685,249	201%	Y	$5,861,512	3%	$0	0.0%	0.0%
Adventist Medical Center	$153,161,866	$308,812,227	$1,547,902	$710,676	218%	Y	$2,676,544	2%	$0	0.0%	0.0%
Legacy Meridian Park Hospital	$108,816,495	$174,409,238	$3,812,200	$1,828,794	208%	Y	$6,591,838	6%	$0	0.0%	0.0%
Mercy Medical Center	$87,334,750	$189,526,835	$6,225,157	$1,867,153	333%	Y	$10,092,547	12%	$1,858,766	2.1%	1.0%
Tuality Healthcare	$86,010,332	$183,065,082	$3,150,333	$1,130,046	279%	Y	$5,447,375	6%	$132,466	0.2%	0.1%
McKenzie-Willamette Medical Center	$84,552,492	$134,137,581	$3,014,651	$949,042	318%	Y	$6,538,195	8%	$939,650	1.1%	0.7%
Sky Lakes Medical Center, Inc	$80,453,693	$174,841,846	$7,067,864	$2,170,833	326%	Y	$11,458,787	14%	$1,885,835	2.3%	1.1%
Providence Medford Medical Center	$78,072,000	$170,789,000	$3,018,572	$944,010	320%	Y	$5,549,709	7%	$828,925	1.1%	0.5%
Samaritan Albany General Hospital	$66,948,319	$123,608,339	$4,256,747	$1,271,831	335%	Y	$6,901,259	10%	$1,292,733	1.9%	1.0%
Legacy Mount Hood Medical Center	$60,429,884	$106,846,166	$2,027,557	$946,752	214%	Y	$3,505,935	6%	$0	0.0%	0.0%
Willamette Falls Hospital	$53,758,374	$98,691,557	$1,949,353	$721,495	270%	Y	$3,370,710	6%	$0	0.0%	0.0%
Bay Area Hospital	$53,283,864	$134,966,835	$3,640,136	$1,163,845	313%	Y	$5,901,578	11%	$769,250	1.4%	0.6%
Asante Three Rivers Community Hospital	$51,948,107	$134,380,336	$1,096,336	$370,306	296%	Y	$1,777,437	3%	$144,461	0.3%	0.1%
Providence Milwaukie Hospital	$50,969,000	$92,638,000	$829,041	$325,015	255%	Y	$1,433,530	3%	$0	0.0%	0.0%
Willamette Valley Med Ctr	$46,879,426	$92,191,336	$4,674,012	$1,138,404	411%	Y	$8,082,034	17%	$2,727,813	5.8%	3.0%
Sacred Heart Medical Center	$36,021,058	$102,508,440	$1,185,957	$450,666	263%	Y	$2,572,111	7%	$0	0.0%	0.0%
Silverton Hospital	$57,520,090	$102,385,729	$3,679,971	$1,117,035	329%	N	$10,898,011	19%	$0	0.0%	0.0%
Providence Newberg Hospital	$56,349,000	$90,426,000	$2,744,758	$937,643	293%	N	$4,746,079	8%	$0	0.0%	0.0%
Mid-Columbia Medical Center	$44,863,704	$85,089,167	$2,816,458	$795,355	354%	N	$4,566,188	10%	$0	0.0%	0.0%
Good Shepherd Medical Center	$41,181,839	$81,096,456	$2,760,625	$821,765	336%	N	$4,475,668	11%	$0	0.0%	0.0%
Samaritan Lebanon Community Hospital	$37,055,911	$88,411,071	$2,038,146	$645,784	316%	N	$3,304,348	9%	$0	0.0%	0.0%
Providence Hood River Memorial Hospital	$33,228,000	$67,836,000	$1,545,508	$550,475	281%	N	$2,505,657	8%	$0	0.0%	0.0%
Columbia Memorial Hospital	$31,517,096	$68,269,822	$2,698,795	$663,572	407%	N	$4,375,427	14%	$0	0.0%	0.0%
St Charles Medical Center - Redmond	$30,376,404	$82,705,522	$2,138,475	$694,776	308%	N	$2,808,671	9%	$0	0.0%	0.0%
Grande Ronde Hospital	$28,030,430	$63,413,545	$1,710,701	$559,826	306%	N	$2,773,478	10%	$0	0.0%	0.0%
Samaritan Pacific Communities Hospital	$27,939,153	$67,576,969	$1,077,495	$304,921	353%	N	$1,746,890	6%	$0	0.0%	0.0%
Holy Rosary Medical Center	$27,570,212	$60,793,370	$1,605,555	$564,127	285%	N	$2,603,008	9%	$0	0.0%	0.0%
St Anthony Hospital	$26,539,714	$57,600,595	$3,581,601	$1,055,575	339%	N	$5,806,678	22%	$0	0.0%	0.0%
Tillamook County General Hospital	$25,685,485	$55,174,157	$1,400,686	$355,990	393%	N	$2,270,865	9%	$0	0.0%	0.0%
Ashland Community Hospital	$25,135,710	$50,462,555	$1,192,158	$439,865	271%	N	$2,191,808	9%	$0	0.0%	0.0%
Samaritan North Lincoln Hospital	$16,897,636	$47,061,501	$526,372	$147,113	358%	N	$853,382	5%	$0	0.0%	0.0%
Providence Seaside Hospital	$16,093,000	$46,655,000	$816,503	$227,452	359%	N	$1,323,757	8%	$0	0.0%	0.0%
Santiam Memorial Hospital	$15,992,187	$35,314,519	$877,769	$337,992	260%	N	$2,599,461	16%	$0	0.0%	0.0%
Peace Harbor Hospital	$15,556,563	$64,592,563	$400,920	$98,723	406%	N	$869,518	6%	$0	0.0%	0.0%
St Elizabeth Health Services	$13,852,732	$31,221,535	$0	$0		N	$0	0%	$0	0.0%	0.0%
Curry General Hospital	$10,962,102	$26,308,377	$352,090	$94,076	374%	N	$570,827	5%	$0	0.0%	0.0%
West Valley Hospital	$10,090,267	$22,821,505	$591,497	$177,851	333%	N	$1,751,682	17%	$0	0.0%	0.0%
Pioneer Memorial Hospital	$8,269,926	$27,414,184	$493,293	$154,544	319%	N	$799,752	10%	$0	0.0%	0.0%
Cottage Grove Community Hospital	$7,094,142	$27,048,048	$362,980	$111,461	326%	N	$787,233	11%	$0	0.0%	0.0%
Mountain View Hospital District	$5,946,744	$27,309,257	$778,952	$214,038	364%	N	$1,262,878	21%	$0	0.0%	0.0%
Lake District Hospital	$5,291,135	$16,989,558	$311,575	$94,882	328%	N	$505,141	10%	$0	0.0%	0.0%
Lower Umpqua Hospital	$5,154,286	$18,351,668	$336,515	$95,225	353%	N	$545,576	11%	$0	0.0%	0.0%
Coquille Valley Hospital	$5,001,610	$18,753,136	$391,686	$125,447	312%	N	$635,021	13%	$0	0.0%	0.0%
Wallowa Memorial Hospital	$4,787,203	$17,191,152	$489,691	$191,146	256%	N	$793,913	17%	$0	0.0%	0.0%
Harney District Hospital	$4,693,376	$16,046,530	$411,073	$145,548	282%	N	$666,452	14%	$0	0.0%	0.0%
Blue Mountain Hospital	$4,654,860	$17,272,965	$479,115	$151,986	315%	N	$776,766	17%	$0	0.0%	0.0%
Southern Coos Hospital And Health Center	$3,612,849	$15,100,617	$332,049	$86,145	385%	N	$538,335	15%	$0	0.0%	0.0%
Pioneer Memorial Hospital (Heppner)	$2,039,633	$6,455,731	$270,372	$75,504	358%	N	$438,341	21%	$0	0.0%	0.0%

Note: DRG flag and OEBB/PEBB estimated allowed provided by ODS.

Exhibit 2
Oregon Educators Association
Evaluation of Impact of Potentially Legislated % of Medicare for DRG Hospitals - Limited to 135% of Medicare Lite

	DataBank Data Q3 2011 to Q2 2012		ODS OEBB Data - Inpatient and Outpatient				Estimated OEBB/PEBB - IP and OP		Reduction if Hospitals Limited to 135% of Medicare Lite		
	Commercial Allowed	Total Net Revenue - Includes Other Operating Revenue	OEBB Allowed	OEBB Medicare Lite	% of Medicare Lite	DRG Hospital	Estimated OEBB/PEBB Allowed	% of Commercial Allowed	$ Reduction	% of Commercial Allowed	% of Total Net Revenue
	(A)	(B)	(C)	(D)	(E)=(C)/(D)		(F)	(G)=(F)/(A)	(H)	(I)=(H)/(A)	(J)=(H)/(B)
Subtotal: DRG Hospitals	$4,189,972,275	$7,945,085,417	$155,564,991	$57,266,094	**272%**		$311,475,348	7%	$157,328,659	3.8%	2.0%
Subtotal: Non-DRG Hospitals	$648,982,999	$1,503,148,804	$39,213,385	$12,035,841	326%		$70,790,812	11%	$0	0.0%	0.0%
Grand Total	$4,838,955,274	$9,448,234,221	$194,778,376	$69,301,936	281%		$382,266,159	8%	$157,328,659	3.3%	1.7%
Hospital											
OHSU Hospital	$613,424,468	$1,205,952,454	$17,779,815	$7,824,889	227%	Y	$30,743,839	5%	$12,477,865	2.0%	1.0%
Providence St Vincent Medical Ctr	$524,134,000	$786,322,000	$11,677,840	$4,416,953	264%	Y	$20,192,652	4%	$9,881,970	1.9%	1.3%
Providence Portland Medical Ctr	$372,498,000	$659,266,000	$10,327,334	$4,050,741	255%	Y	$17,857,434	5%	$8,401,616	2.3%	1.3%
Legacy Emanuel Hospital & Hlth Ctr	$292,027,015	$515,609,291	$5,056,070	$2,203,586	229%	Y	$8,742,667	3%	$3,598,742	1.2%	0.7%
Salem Hospital	$280,931,463	$565,138,913	$14,302,397	$5,253,400	272%	Y	$42,355,683	15%	$21,352,886	7.6%	3.8%
Sacred Heart Medical Center At Riverbend	$261,893,825	$561,701,809	$14,932,959	$5,362,774	278%	Y	$32,386,703	12%	$16,685,096	6.4%	3.0%
St Charles Medical Center - Bend	$209,038,677	$433,756,014	$15,063,721	$5,102,233	295%	Y	$19,784,670	9%	$10,737,961	5.1%	2.5%
Good Samaritan Regional Medical Center	$195,757,187	$331,331,117	$9,361,507	$3,197,115	293%	Y	$40,292,775	21%	$21,715,863	11.1%	6.6%
Rogue Valley Medical Center	$173,606,364	$373,163,317	$6,177,697	$2,180,285	283%	Y	$11,357,825	7%	$5,946,350	3.4%	1.6%
Legacy Good Samaritan Hosp & Med Ctr	$168,021,616	$291,431,684	$3,389,837	$1,685,249	201%	Y	$5,861,512	3%	$1,927,564	1.1%	0.7%
Adventist Medical Center	$153,161,866	$308,812,227	$1,547,902	$710,676	218%	Y	$2,676,544	2%	$1,017,583	0.7%	0.3%
Legacy Meridian Park Hospital	$108,816,495	$174,409,238	$3,812,200	$1,828,794	208%	Y	$6,591,838	6%	$2,322,805	2.1%	1.3%
Mercy Medical Center	$87,334,750	$189,526,835	$6,225,157	$1,867,153	333%	Y	$10,092,547	12%	$6,005,928	6.9%	3.2%
Tuality Healthcare	$86,010,332	$183,065,082	$3,150,333	$1,130,046	279%	Y	$5,447,375	6%	$2,809,461	3.3%	1.5%
McKenzie-Willamette Medical Center	$84,552,492	$134,137,581	$3,014,651	$949,042	318%	Y	$6,538,195	8%	$3,759,505	4.4%	2.8%
Sky Lakes Medical Center, Inc	$80,453,693	$174,841,846	$7,067,864	$2,170,833	326%	Y	$11,458,787	14%	$6,707,506	8.3%	3.8%
Providence Medford Medical Center	$78,072,000	$170,789,000	$3,018,572	$944,010	320%	Y	$5,549,709	7%	$3,206,673	4.1%	1.9%
Samaritan Albany General Hospital	$66,948,319	$123,608,339	$4,256,747	$1,271,831	335%	Y	$6,901,259	10%	$4,117,615	6.2%	3.3%
Legacy Mount Hood Medical Center	$60,429,884	$106,846,166	$2,027,557	$946,752	214%	Y	$3,505,935	6%	$1,295,891	2.1%	1.2%
Willamette Falls Hospital	$53,758,374	$98,691,557	$1,949,353	$721,495	270%	Y	$3,370,710	6%	$1,686,494	3.1%	1.7%
Bay Area Hospital	$53,283,864	$134,966,835	$3,640,136	$1,163,845	313%	Y	$5,901,578	11%	$3,354,283	6.3%	2.5%
Asante Three Rivers Community Hospital	$51,948,107	$134,380,336	$1,096,336	$370,306	296%	Y	$1,777,437	3%	$966,953	1.9%	0.7%
Providence Milwaukie Hospital	$50,969,000	$92,638,000	$829,041	$325,015	255%	Y	$1,433,530	3%	$674,834	1.3%	0.7%
Willamette Valley Med Ctr	$46,879,426	$92,191,336	$4,674,012	$1,138,404	411%	Y	$8,082,034	17%	$5,424,608	11.6%	5.9%
Sacred Heart Medical Center	$36,021,058	$102,508,440	$1,185,957	$450,666	263%	Y	$2,572,111	7%	$1,252,610	3.5%	1.2%
Silverton Hospital	$57,520,090	$102,385,729	$3,679,971	$1,117,035	329%	N	$10,898,011	19%	$0	0.0%	0.0%
Providence Newberg Hospital	$56,349,000	$90,426,000	$2,744,758	$937,643	293%	N	$4,746,079	8%	$0	0.0%	0.0%
Mid-Columbia Medical Center	$44,863,704	$85,089,167	$2,816,458	$795,355	354%	N	$4,566,188	10%	$0	0.0%	0.0%
Good Shepherd Medical Center	$41,181,839	$81,096,456	$2,760,625	$821,765	336%	N	$4,475,668	11%	$0	0.0%	0.0%
Samaritan Lebanon Community Hospital	$37,055,911	$88,411,071	$2,038,146	$645,784	316%	N	$3,304,348	9%	$0	0.0%	0.0%
Providence Hood River Memorial Hospital	$33,228,000	$67,836,000	$1,545,508	$550,475	281%	N	$2,505,657	8%	$0	0.0%	0.0%
Columbia Memorial Hospital	$31,517,096	$68,269,822	$2,698,795	$663,572	407%	N	$4,375,427	14%	$0	0.0%	0.0%
St Charles Medical Center - Redmond	$30,376,404	$82,705,522	$2,138,475	$694,776	308%	N	$2,808,671	9%	$0	0.0%	0.0%
Grande Ronde Hospital	$28,030,430	$63,413,545	$1,710,701	$559,826	306%	N	$2,773,478	10%	$0	0.0%	0.0%
Samaritan Pacific Communities Hospital	$27,939,153	$67,576,969	$1,077,495	$304,921	353%	N	$1,746,890	6%	$0	0.0%	0.0%
Holy Rosary Medical Center	$27,570,212	$60,793,370	$1,605,555	$564,127	285%	N	$2,603,008	9%	$0	0.0%	0.0%
St Anthony Hospital	$26,539,714	$57,600,595	$3,581,601	$1,055,575	339%	N	$5,806,678	22%	$0	0.0%	0.0%
Tillamook County General Hospital	$25,685,485	$55,174,157	$1,400,686	$355,990	393%	N	$2,270,865	9%	$0	0.0%	0.0%
Ashland Community Hospital	$25,135,710	$50,462,555	$1,192,158	$439,865	271%	N	$2,191,808	9%	$0	0.0%	0.0%
Samaritan North Lincoln Hospital	$16,897,636	$47,061,501	$526,372	$147,113	358%	N	$853,382	5%	$0	0.0%	0.0%
Providence Seaside Hospital	$16,093,000	$46,655,000	$816,503	$227,452	359%	N	$1,323,757	8%	$0	0.0%	0.0%
Santiam Memorial Hospital	$15,992,187	$35,314,519	$877,769	$337,992	260%	N	$2,599,461	16%	$0	0.0%	0.0%
Peace Harbor Hospital	$15,556,563	$64,592,563	$400,920	$98,723	406%	N	$869,518	6%	$0	0.0%	0.0%
St Elizabeth Health Services	$13,852,732	$31,221,535	$0	$0		N	$0	0%	$0	0.0%	0.0%
Curry General Hospital	$10,962,102	$26,308,377	$352,090	$94,076	374%	N	$570,827	5%	$0	0.0%	0.0%
West Valley Hospital	$10,090,267	$22,821,505	$591,497	$177,851	333%	N	$1,751,682	17%	$0	0.0%	0.0%
Pioneer Memorial Hospital	$8,269,926	$27,414,184	$493,293	$154,544	319%	N	$799,752	10%	$0	0.0%	0.0%
Cottage Grove Community Hospital	$7,094,142	$27,048,048	$362,980	$111,461	326%	N	$787,233	11%	$0	0.0%	0.0%
Mountain View Hospital District	$5,946,744	$27,309,257	$778,952	$214,038	364%	N	$1,262,878	21%	$0	0.0%	0.0%
Lake District Hospital	$5,291,135	$16,989,558	$311,575	$94,882	328%	N	$505,141	10%	$0	0.0%	0.0%
Lower Umpqua Hospital	$5,154,286	$18,351,668	$336,515	$95,225	353%	N	$545,576	11%	$0	0.0%	0.0%
Coquille Valley Hospital	$5,001,610	$18,753,136	$391,686	$125,447	312%	N	$635,021	13%	$0	0.0%	0.0%
Wallowa Memorial Hospital	$4,787,203	$17,191,152	$489,691	$191,146	256%	N	$793,913	17%	$0	0.0%	0.0%
Harney District Hospital	$4,693,376	$16,046,530	$411,073	$145,548	282%	N	$666,452	14%	$0	0.0%	0.0%
Blue Mountain Hospital	$4,654,860	$17,272,965	$479,115	$151,986	315%	N	$776,766	17%	$0	0.0%	0.0%
Southern Coos Hospital And Health Center	$3,612,849	$15,100,617	$332,049	$86,145	385%	N	$538,335	15%	$0	0.0%	0.0%
Pioneer Memorial Hospital (Heppner)	$2,039,633	$6,455,731	$270,372	$75,504	358%	N	$438,341	21%	$0	0.0%	0.0%

Note: DRG flag and OEBB/PEBB estimated allowed provided by ODS.

Exhibit 3
Oregon Educators Association
Evaluation of Impact of Potentially Legislated % of Medicare for DRG Hospitals - Limited to 200% of Medicare Lite

	DataBank Data Q3 2011 to Q2 2012		ODS OEBB Data - Inpatient and Outpatient				Estimated OEBB/PEBB - IP and OP		Reduction if Hospitals Limited to 200% of Medicare Lite		
	Commercial Allowed	Total Net Revenue - Includes Other Operating Revenue	OEBB Allowed	OEBB Medicare Lite	% of Medicare Lite	DRG Hospital	Estimated OEBB/PEBB Allowed	% of Commercial Allowed	$ Reduction	% of Commercial Allowed	% of Total Net Revenue
	(A)	(B)	(C)	(D)	(E)=(C)/(D)		(F)	(G)=(F)/(A)	(H)	(I)=(H)/(A)	(J)=(H)/(B)
Subtotal: DRG Hospitals	$4,189,972,275	$7,945,085,417	$155,564,991	$57,266,094	**272%**		$311,475,348	7%	$83,109,883	2.0%	1.0%
Subtotal: Non-DRG Hospitals	$648,982,999	$1,503,148,804	$39,213,385	$12,035,841	326%		$70,790,812	11%	$0	0.0%	0.0%
Grand Total	$4,838,955,274	$9,448,234,221	$194,778,376	$69,301,936	281%		$382,266,159	8%	$83,109,883	1.7%	0.9%
Hospital											
OHSU Hospital	$613,424,468	$1,205,952,454	$17,779,815	$7,824,889	227%	Y	$30,743,839	5%	$3,683,136	0.6%	0.3%
Providence St Vincent Medical Ctr	$524,134,000	$786,322,000	$11,677,840	$4,416,953	264%	Y	$20,192,652	4%	$4,917,567	0.9%	0.6%
Providence Portland Medical Ctr	$372,498,000	$659,266,000	$10,327,334	$4,050,741	255%	Y	$17,857,434	5%	$3,848,814	1.0%	0.6%
Legacy Emanuel Hospital & Hlth Ctr	$292,027,015	$515,609,291	$5,056,070	$2,203,586	229%	Y	$8,742,667	3%	$1,122,037	0.4%	0.2%
Salem Hospital	$280,931,463	$565,138,913	$14,302,397	$5,253,400	272%	Y	$42,355,683	15%	$11,240,427	4.0%	2.0%
Sacred Heart Medical Center At Riverbend	$261,893,825	$561,701,809	$14,932,959	$5,362,774	278%	Y	$32,386,703	12%	$9,125,063	3.5%	1.6%
St Charles Medical Center - Bend	$209,038,677	$433,756,014	$15,063,721	$5,102,233	295%	Y	$19,784,670	9%	$6,382,138	3.1%	1.5%
Good Samaritan Regional Medical Center	$195,757,187	$331,331,117	$9,361,507	$3,197,115	293%	Y	$40,292,775	21%	$12,771,424	6.5%	3.9%
Rogue Valley Medical Center	$173,606,364	$373,163,317	$6,177,697	$2,180,285	283%	Y	$11,357,825	7%	$3,340,824	1.9%	0.9%
Legacy Good Samaritan Hosp & Med Ctr	$168,021,616	$291,431,684	$3,389,837	$1,685,249	201%	Y	$5,861,512	3%	$33,441	0.0%	0.0%
Adventist Medical Center	$153,161,866	$308,812,227	$1,547,902	$710,676	218%	Y	$2,676,544	2%	$218,824	0.1%	0.1%
Legacy Meridian Park Hospital	$108,816,495	$174,409,238	$3,812,200	$1,828,794	208%	Y	$6,591,838	6%	$267,345	0.2%	0.2%
Mercy Medical Center	$87,334,750	$189,526,835	$6,225,157	$1,867,153	333%	Y	$10,092,547	12%	$4,038,296	4.6%	2.1%
Tuality Healthcare	$86,010,332	$183,065,082	$3,150,333	$1,130,046	279%	Y	$5,447,375	6%	$1,539,354	1.8%	0.8%
McKenzie-Willamette Medical Center	$84,552,492	$134,137,581	$3,014,651	$949,042	318%	Y	$6,538,195	8%	$2,421,618	2.9%	1.8%
Sky Lakes Medical Center, Inc	$80,453,693	$174,841,846	$7,067,864	$2,170,833	326%	Y	$11,458,787	14%	$4,419,852	5.5%	2.5%
Providence Medford Medical Center	$78,072,000	$170,789,000	$3,018,572	$944,010	320%	Y	$5,549,709	7%	$2,078,544	2.7%	1.2%
Samaritan Albany General Hospital	$66,948,319	$123,608,339	$4,256,747	$1,271,831	335%	Y	$6,901,259	10%	$2,777,342	4.1%	2.2%
Legacy Mount Hood Medical Center	$60,429,884	$106,846,166	$2,027,557	$946,752	214%	Y	$3,505,935	6%	$231,796	0.4%	0.2%
Willamette Falls Hospital	$53,758,374	$98,691,557	$1,949,353	$721,495	270%	Y	$3,370,710	6%	$875,575	1.6%	0.9%
Bay Area Hospital	$53,283,864	$134,966,835	$3,640,136	$1,163,845	313%	Y	$5,901,578	11%	$2,127,807	4.0%	1.6%
Asante Three Rivers Community Hospital	$51,948,107	$134,380,336	$1,096,336	$370,306	296%	Y	$1,777,437	3%	$576,720	1.1%	0.4%
Providence Milwaukie Hospital	$50,969,000	$92,638,000	$829,041	$325,015	255%	Y	$1,433,530	3%	$309,536	0.6%	0.3%
Willamette Valley Med Ctr	$46,879,426	$92,191,336	$4,674,012	$1,138,404	411%	Y	$8,082,034	17%	$4,145,107	8.8%	4.5%
Sacred Heart Medical Center	$36,021,058	$102,508,440	$1,185,957	$450,666	263%	Y	$2,572,111	7%	$617,295	1.7%	0.6%
Silverton Hospital	$57,520,090	$102,385,729	$3,679,971	$1,117,035	329%	N	$10,898,011	19%	$0	0.0%	0.0%
Providence Newberg Hospital	$56,349,000	$90,426,000	$2,744,758	$937,643	293%	N	$4,746,079	8%	$0	0.0%	0.0%
Mid-Columbia Medical Center	$44,863,704	$85,089,167	$2,816,458	$795,355	354%	N	$4,566,188	10%	$0	0.0%	0.0%
Good Shepherd Medical Center	$41,181,839	$81,096,456	$2,760,625	$821,765	336%	N	$4,475,668	11%	$0	0.0%	0.0%
Samaritan Lebanon Community Hospital	$37,055,911	$88,411,071	$2,038,146	$645,784	316%	N	$3,304,348	9%	$0	0.0%	0.0%
Providence Hood River Memorial Hospital	$33,228,000	$67,836,000	$1,545,508	$550,475	281%	N	$2,505,657	8%	$0	0.0%	0.0%
Columbia Memorial Hospital	$31,517,096	$68,269,822	$2,698,795	$663,572	407%	N	$4,375,427	14%	$0	0.0%	0.0%
St Charles Medical Center - Redmond	$30,376,404	$82,705,522	$2,138,475	$694,776	308%	N	$2,808,671	9%	$0	0.0%	0.0%
Grande Ronde Hospital	$28,030,430	$63,413,545	$1,710,701	$559,826	306%	N	$2,773,478	10%	$0	0.0%	0.0%
Samaritan Pacific Communities Hospital	$27,939,153	$67,576,969	$1,077,495	$304,921	353%	N	$1,746,890	6%	$0	0.0%	0.0%
Holy Rosary Medical Center	$27,570,212	$60,793,370	$1,605,555	$564,127	285%	N	$2,603,008	9%	$0	0.0%	0.0%
St Anthony Hospital	$26,539,714	$57,600,595	$3,581,601	$1,055,575	339%	N	$5,806,678	22%	$0	0.0%	0.0%
Tillamook County General Hospital	$25,685,485	$55,174,157	$1,400,686	$355,990	393%	N	$2,270,865	9%	$0	0.0%	0.0%
Ashland Community Hospital	$25,135,710	$50,462,555	$1,192,158	$439,865	271%	N	$2,191,808	9%	$0	0.0%	0.0%
Samaritan North Lincoln Hospital	$16,897,636	$47,061,501	$526,372	$147,113	358%	N	$853,382	5%	$0	0.0%	0.0%
Providence Seaside Hospital	$16,093,000	$46,655,000	$816,503	$227,452	359%	N	$1,323,757	8%	$0	0.0%	0.0%
Santiam Memorial Hospital	$15,992,187	$35,314,519	$877,769	$337,992	260%	N	$2,599,461	16%	$0	0.0%	0.0%
Peace Harbor Hospital	$15,556,563	$64,592,563	$400,920	$98,723	406%	N	$869,518	6%	$0	0.0%	0.0%
St Elizabeth Health Services	$13,852,732	$31,221,535	$0	$0		N	$0	0%	$0	0.0%	0.0%
Curry General Hospital	$10,962,102	$26,308,377	$352,090	$94,076	374%	N	$570,827	5%	$0	0.0%	0.0%
West Valley Hospital	$10,090,267	$22,821,505	$591,497	$177,851	333%	N	$1,751,682	17%	$0	0.0%	0.0%
Pioneer Memorial Hospital	$8,269,926	$27,414,184	$493,293	$154,544	319%	N	$799,752	10%	$0	0.0%	0.0%
Cottage Grove Community Hospital	$7,094,142	$27,048,048	$362,980	$111,461	326%	N	$787,233	11%	$0	0.0%	0.0%
Mountain View Hospital District	$5,946,744	$27,309,257	$778,952	$214,038	364%	N	$1,262,878	21%	$0	0.0%	0.0%
Lake District Hospital	$5,291,135	$16,989,558	$311,575	$94,882	328%	N	$505,141	10%	$0	0.0%	0.0%
Lower Umpqua Hospital	$5,154,286	$18,351,668	$336,515	$95,225	353%	N	$545,576	11%	$0	0.0%	0.0%
Coquille Valley Hospital	$5,001,610	$18,753,136	$391,686	$125,447	312%	N	$635,021	13%	$0	0.0%	0.0%
Wallowa Memorial Hospital	$4,787,203	$17,191,152	$489,691	$191,146	256%	N	$793,913	17%	$0	0.0%	0.0%
Harney District Hospital	$4,693,376	$16,046,530	$411,073	$145,548	282%	N	$666,452	14%	$0	0.0%	0.0%
Blue Mountain Hospital	$4,654,860	$17,272,965	$479,115	$151,986	315%	N	$776,766	17%	$0	0.0%	0.0%
Southern Coos Hospital And Health Center	$3,612,849	$15,100,617	$332,049	$86,145	385%	N	$538,335	15%	$0	0.0%	0.0%
Pioneer Memorial Hospital (Heppner)	$2,039,633	$6,455,731	$270,372	$75,504	358%	N	$438,341	21%	$0	0.0%	0.0%

Note: DRG flag and OEBB/PEBB estimated allowed provided by ODS.

Milliman

Attachment A
PEBB Adjustment

MSA	Members as of January 2013 [1] *OEBB* (A)	*PEBB* (B)	*Adjustment Factor* 1+(B)/(A)
Bend, OR MSA	7,859	2,463	1.31
Corvalis, OR MSA	2,200	7,269	4.30
Eugene-Springfield, OR MSA	10,124	11,833	2.17
Medford, OR MSA	4,273	3,583	1.84
OR NonMetropolitan Area	35,451	22,024	1.62
Portland-Vancouver-Beaverton, OR-WA MSA	26,154	19,070	1.73
Salem, OR MSA	13,226	25,942	2.96

[1] Dental Members

Illustration of Estimated PEBB Allowed in Exhibits 1-3 for OHSU		
ODS OEBB Allowed	$17,779,815	Matches Exhibits 1-3
PEBB Membership/OEBB Membership	1.73	Adjustment Factor from above
Estimated OEBB and PEBB Allowed	$30,743,839	Matches Exhibits 1-3

Attachment B
OEBB Reconciliation
Claims Incurred 7/1/2011 - 6/30/2012

	Allowed	*Paid*
All Claims	$448,002,703	$376,846,665
Hospital Claims	$261,318,849	$216,105,976
Oregon Hospital Claims	$213,642,051	$176,871,617
Oregon Hospital Claims - Excluding COB	**$194,778,376**	$173,772,547

OEBB Budget Note Workgroup

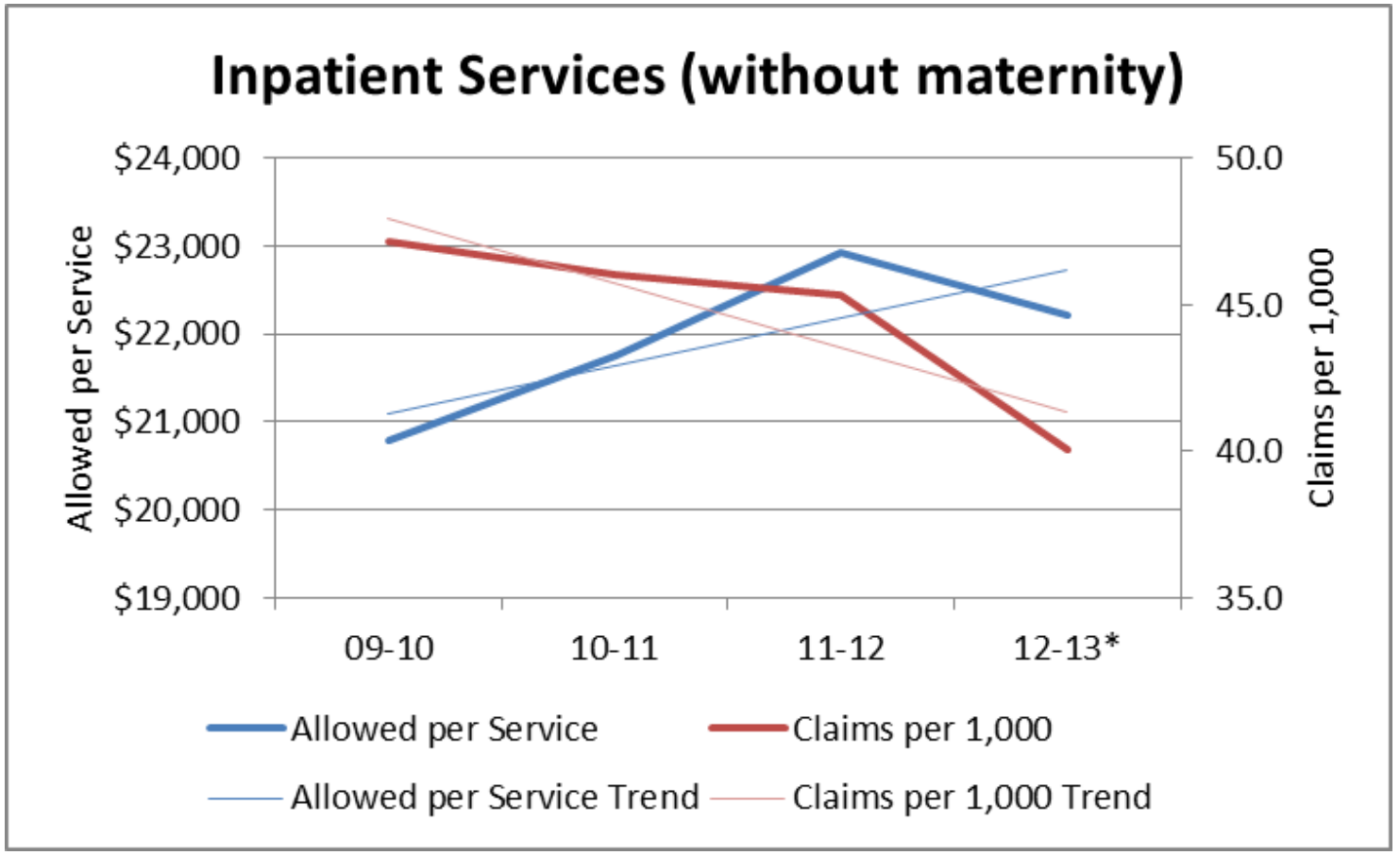
Data from Moda Health and Kaiser Permanente — Cost per Service & Utilization

Attachment 3

December 19, 2013

TOWERS WATSON

Inpatient Services (without maternity) — Moda Health

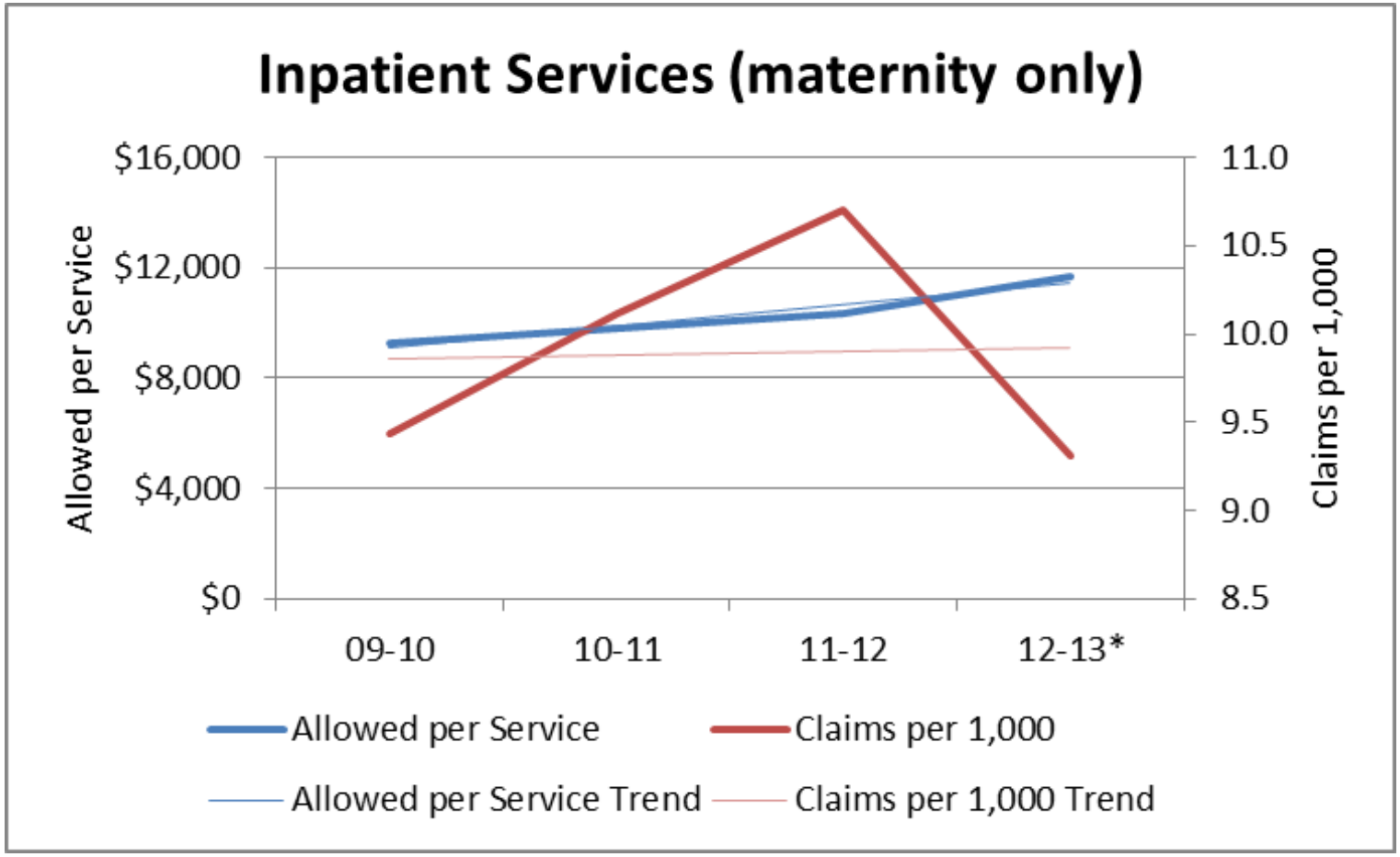


	Plan Year	09-10	10-11	11-12	12-13*
Inpatient Services (without maternity)	Allowed per Service	$20,783	$21,744	$22,919	$22,212
	Paid per Service	$18,543	$19,263	$20,328	$19,162
	Claims / 1,000	47.1	46.0	45.3	40.0

*2012-2013 data is from 10/12 - 3/13

Data received from Moda Health

Inpatient Services (maternity only) — Moda Health

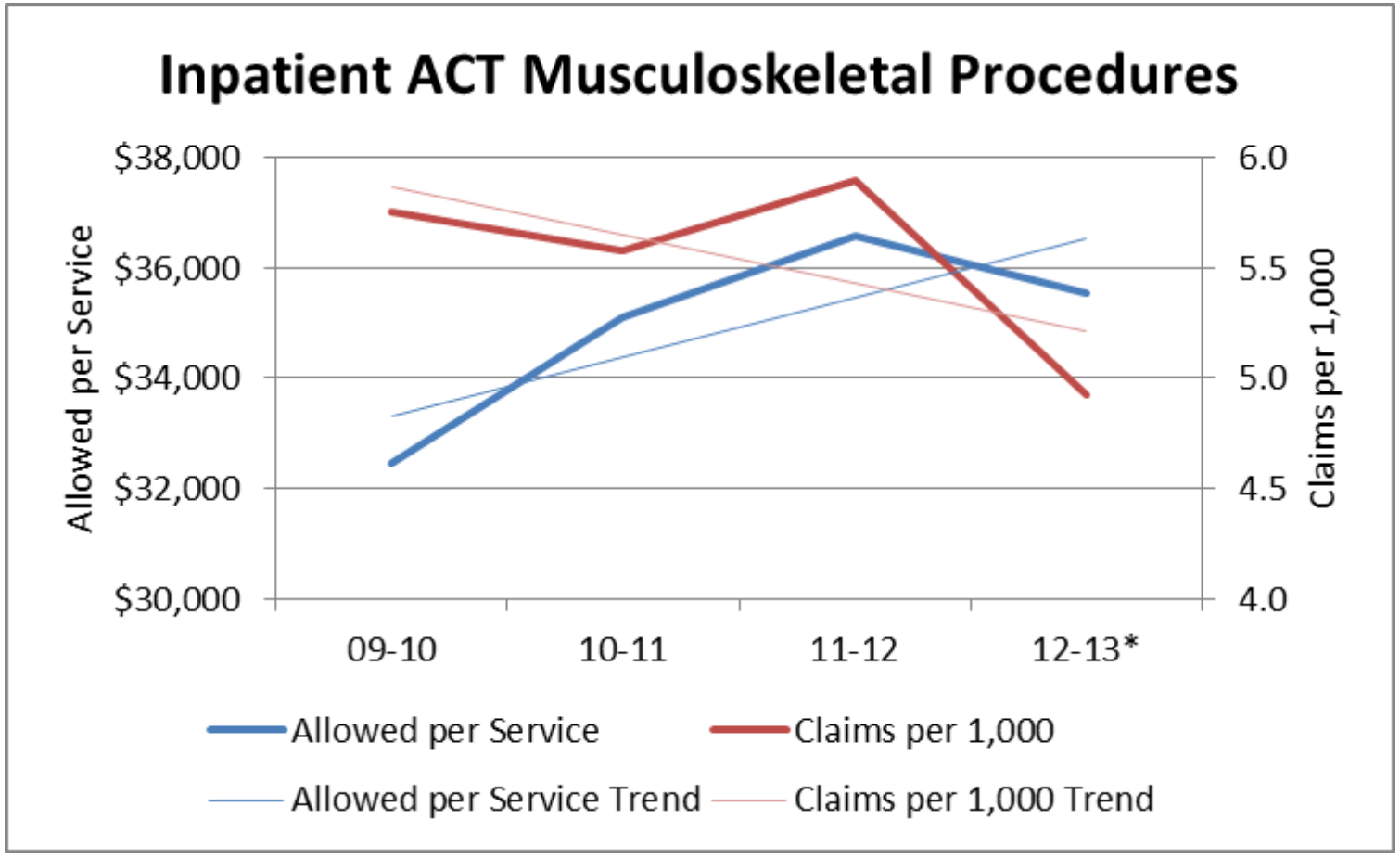


	Plan Year	09-10	10-11	11-12	12-13*
Inpatient Services (maternity only)	Allowed per Service	$9,294	$9,817	$10,345	$11,656
	Paid per Service	$8,091	$7,991	$8,320	$9,240
	Claims / 1,000	9.4	10.1	10.7	9.3

*2012-2013 data is from 10/12 - 3/13

Data received from Moda Health

Inpatient ACT Musculoskeletal Procedures — Moda Health

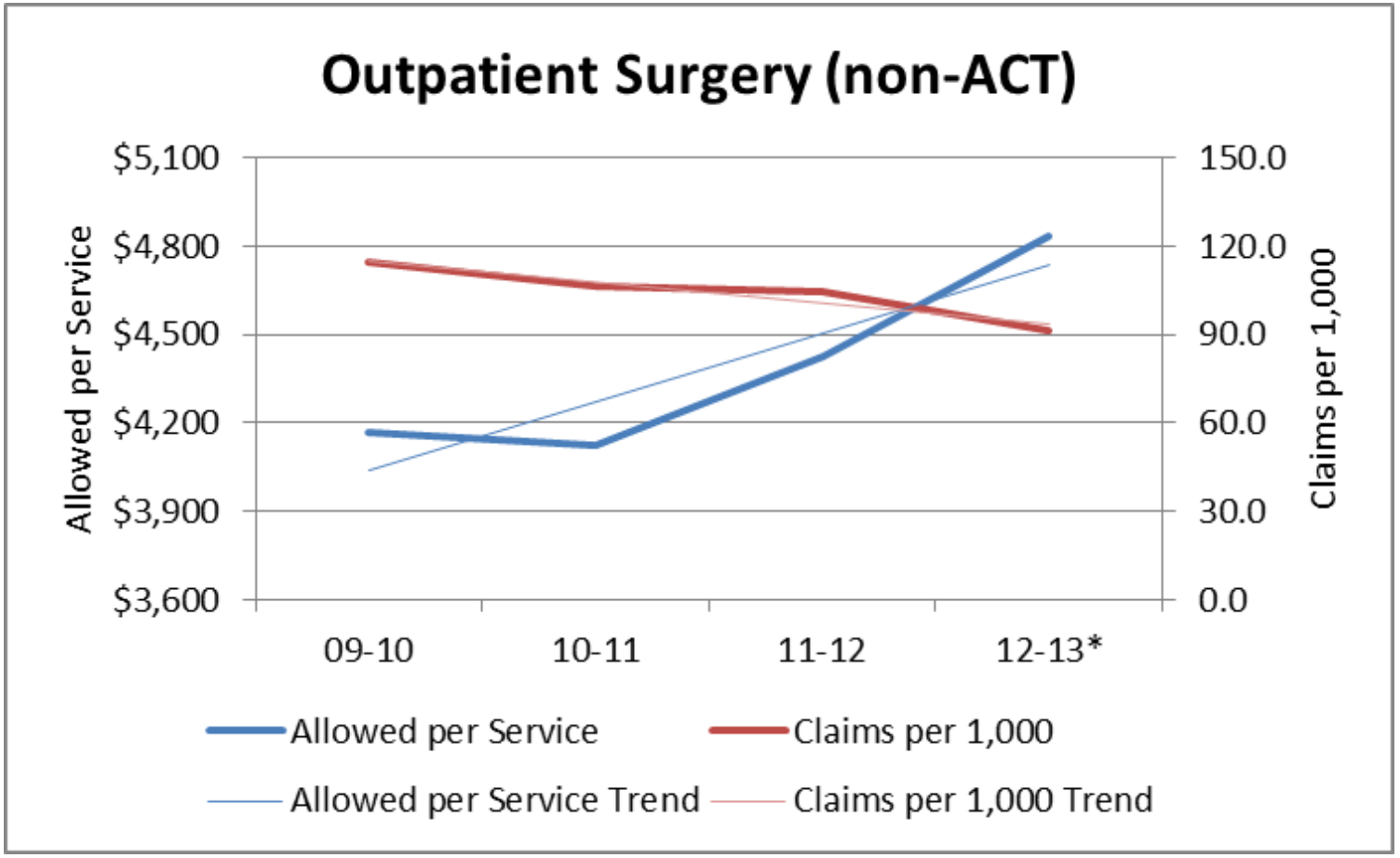


	Plan Year	09-10	10-11	11-12	12-13*
Inpatient ACT Musculoskeletal Procedures	Allowed per Service	$32,474	$35,110	$36,586	$35,531
	Paid per Service	$30,098	$32,234	$33,403	$30,980
	Claims / 1,000	5.8	5.6	5.9	4.9

*2012-2013 data is from 10/12 - 3/13

Data received from Moda Health

Outpatient Surgery (non-ACT) — Moda Health

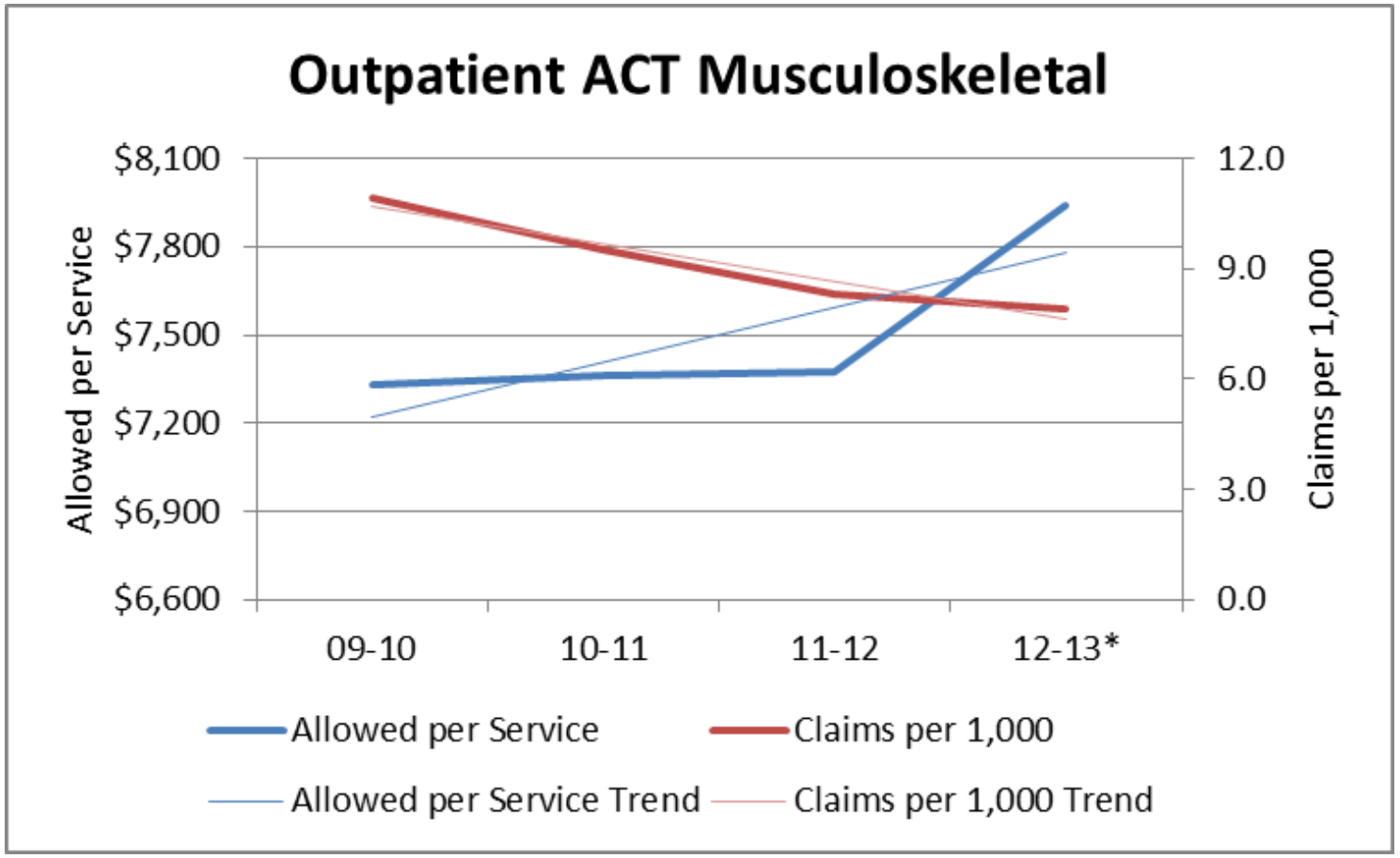


	Plan Year	09-10	10-11	11-12	12-13*
Outpatient Surgery (non-ACT)	Allowed per Service	$4,167	$4,125	$4,426	$4,836
	Paid per Service	$3,570	$3,361	$3,683	$3,938
	Claims / 1,000	114.3	106.7	104.6	91.0

*2012-2013 data is from 10/12 - 3/13

Data received from Moda Health

Outpatient ACT Musculoskeletal — Moda Health

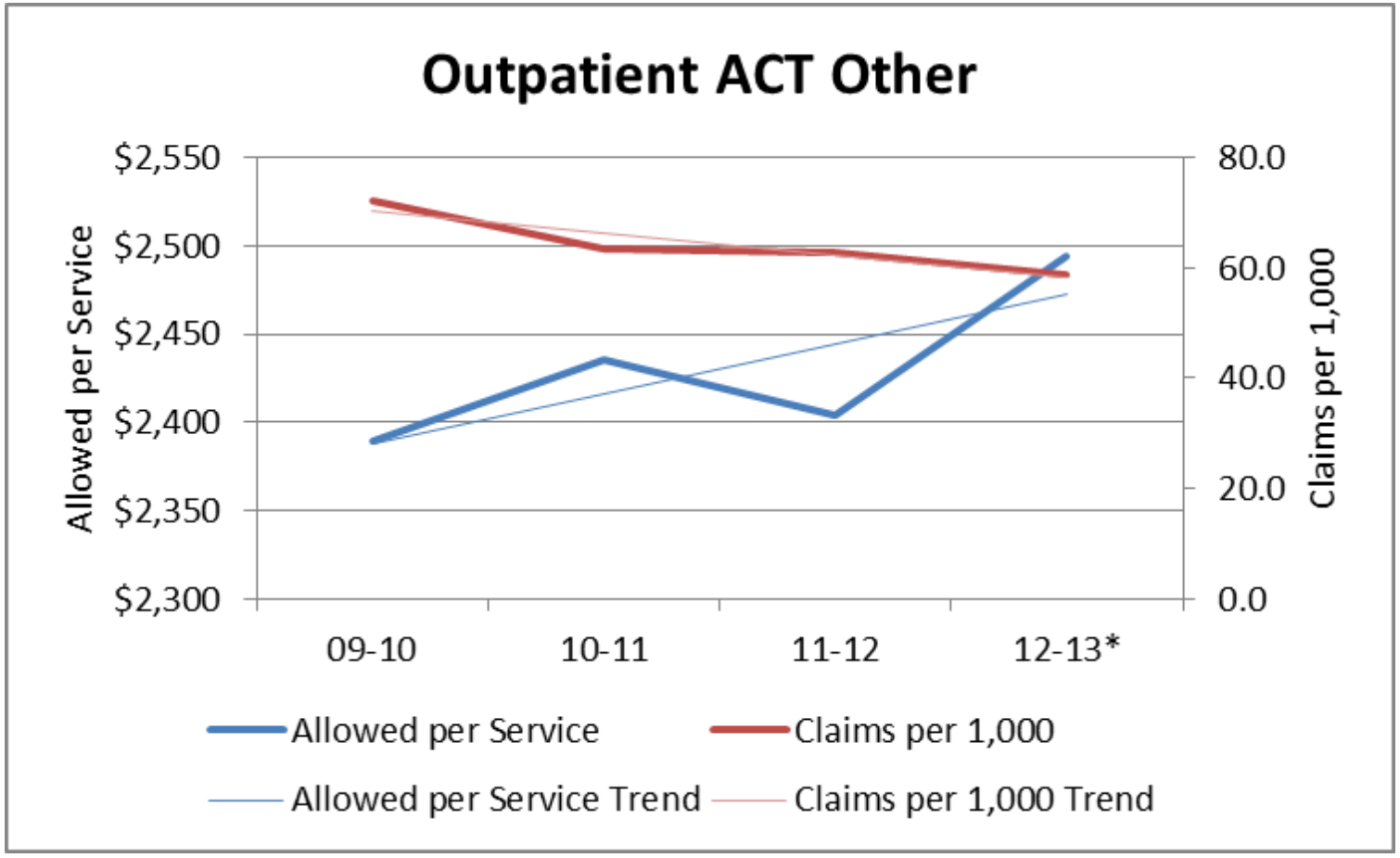


	Plan Year	09-10	10-11	11-12	12-13*
Outpatient ACT Musculoskeletal	Allowed per Service	$7,329	$7,361	$7,375	$7,940
	Paid per Service	$6,146	$5,850	$6,182	$6,338
	Claims / 1,000	10.9	9.5	8.3	7.9

*2012-2013 data is from 10/12 - 3/13

Data received from Moda Health

Outpatient ACT Other — Moda Health

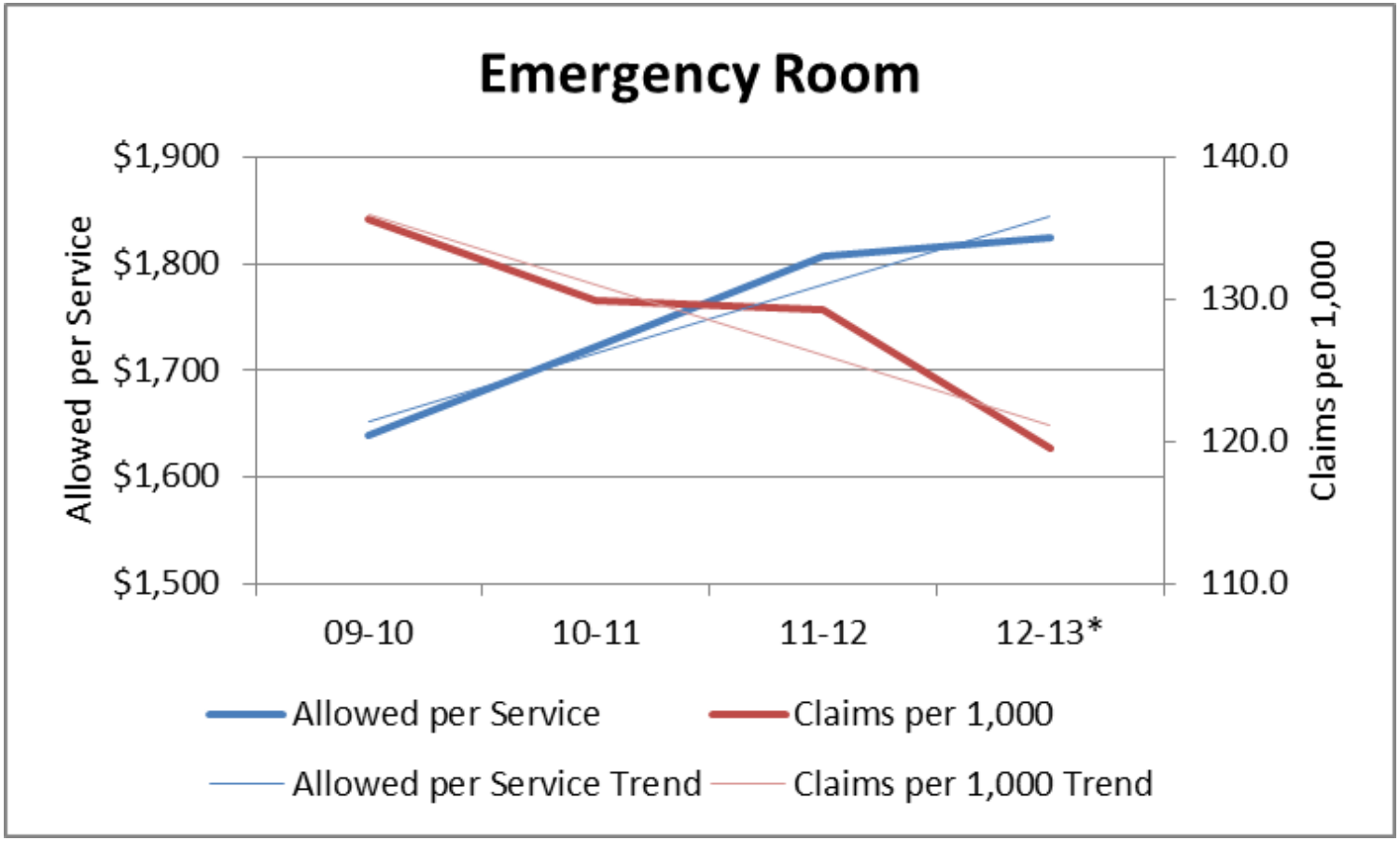


	Plan Year	09-10	10-11	11-12	12-13*
Outpatient ACT Other	Allowed per Service	$2,389	$2,435	$2,404	$2,494
	Paid per Service	$1,968	$1,859	$1,815	$1,819
	Claims / 1,000	72.1	63.6	62.9	58.7

*2012-2013 data is from 10/12 - 3/13

Data received from Moda Health

Emergency Room — Moda Health

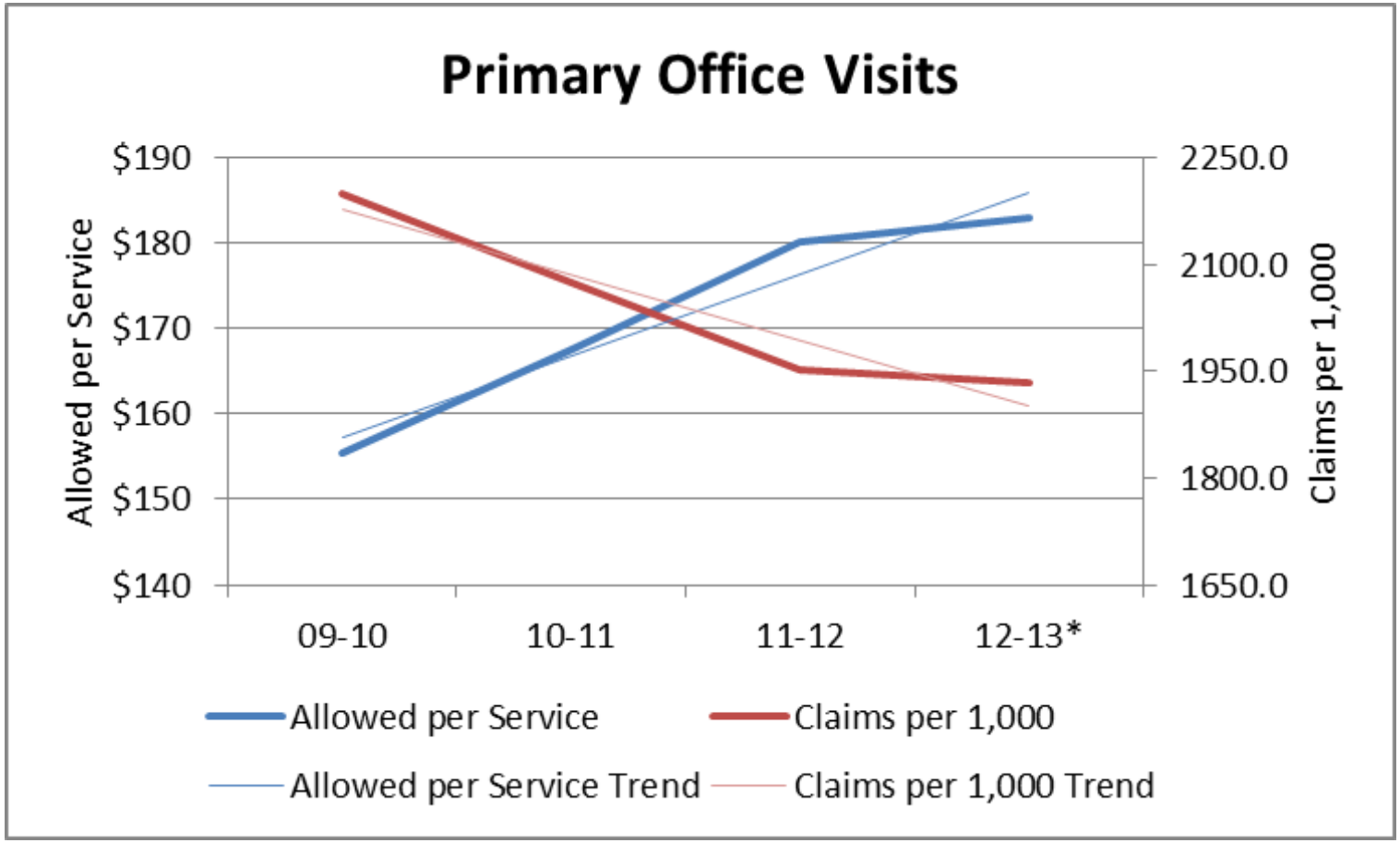


	Plan Year	09-10	10-11	11-12	12-13*
Emergency Room	Allowed per Service	$1,638	$1,723	$1,807	$1,825
	Paid per Service	$1,193	$1,185	$1,226	$1,172
	Claims / 1,000	135.6	129.9	129.2	119.4

*2012-2013 data is from 10/12 - 3/13

Data received from Moda Health

Primary Office Visits — Moda Health

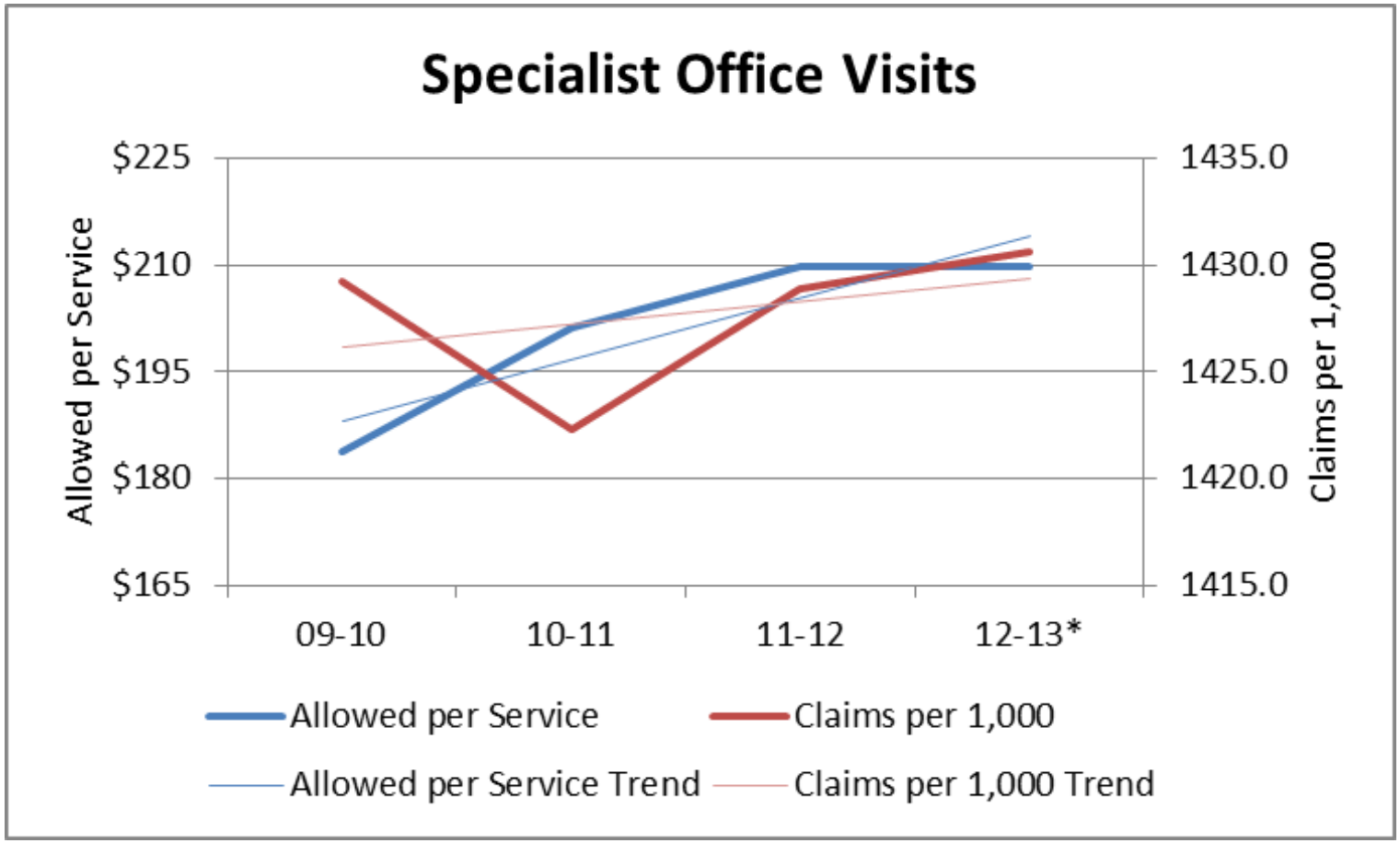


	Plan Year	09-10	10-11	11-12	12-13*
Primary Office Visits	Allowed per Service	$155	$168	$180	$183
	Paid per Service	$119	$114	$116	$102
	Claims / 1,000	2200.0	2074.0	1952.8	1933.6

*2012-2013 data is from 10/12 - 3/13

Data received from Moda Health

Specialist Office Visits — Moda Health

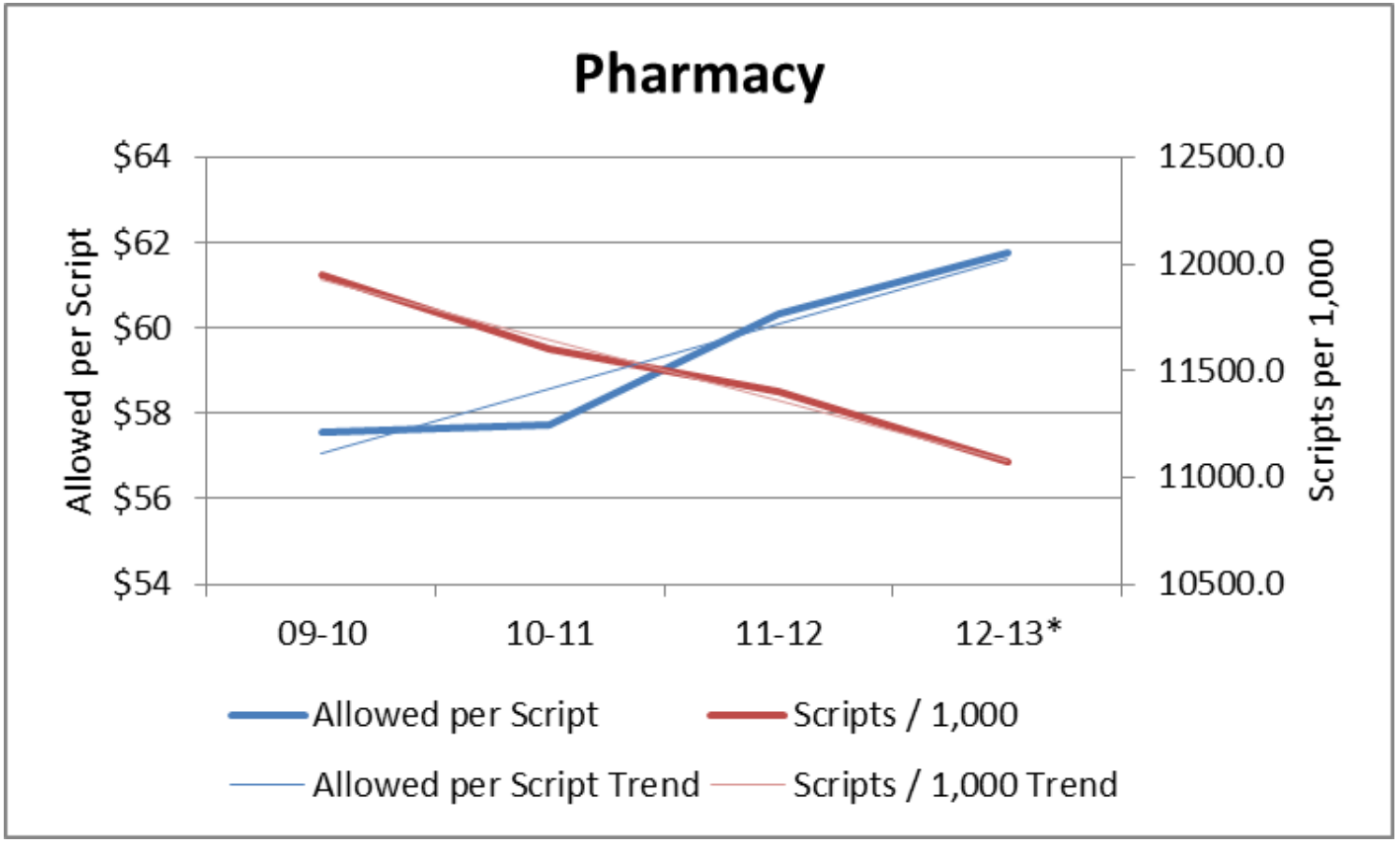


	Plan Year	09-10	10-11	11-12	12-13*
Specialist Office Visits	Allowed per Service	$184	$201	$210	$210
	Paid per Service	$137	$134	$128	$103
	Claims / 1,000	1429.2	1422.3	1428.9	1430.6

*2012-2013 data is from 10/12 - 3/13

Data received from Moda Health

Pharmacy — Moda Health

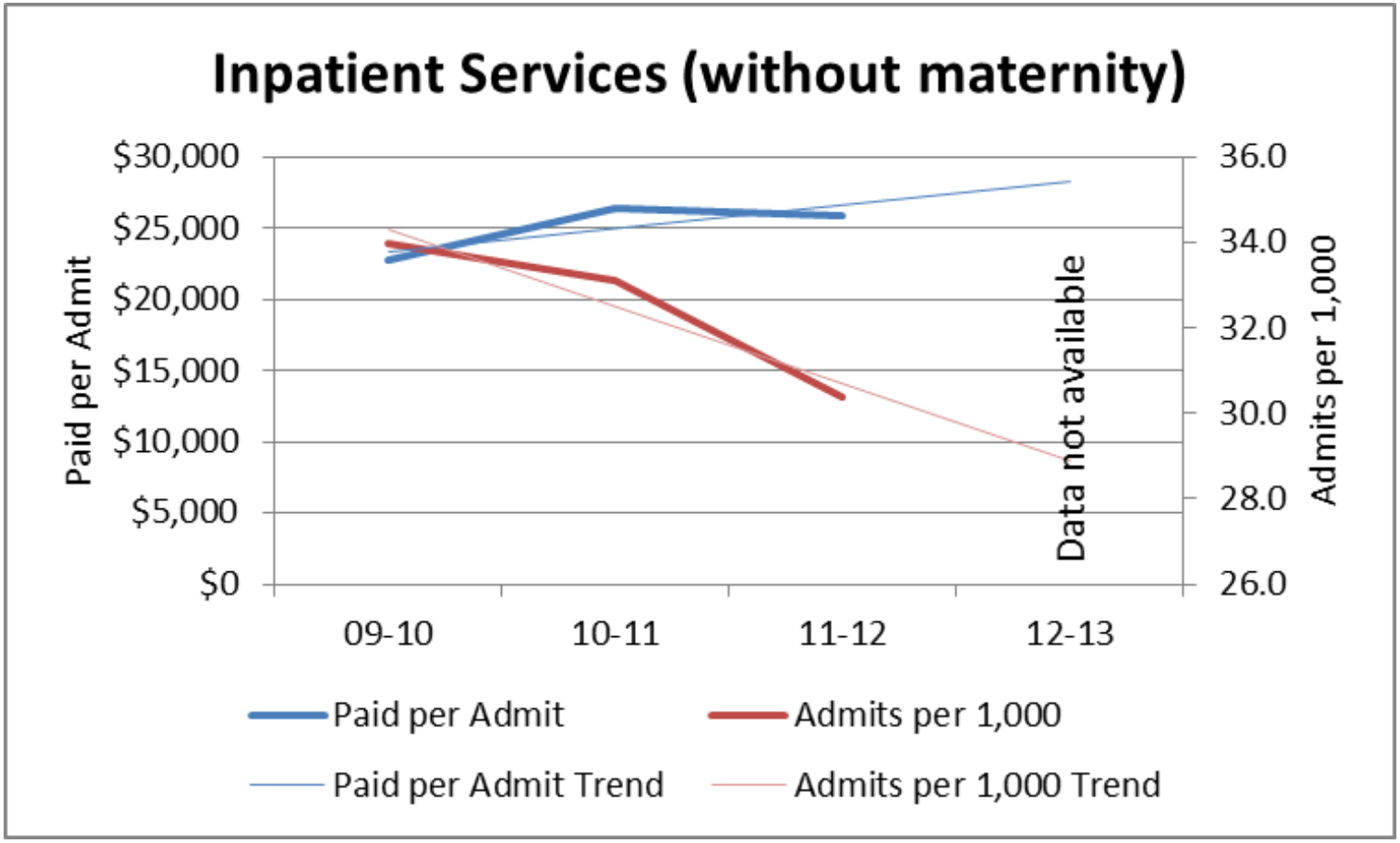


	Plan Year	09-10	10-11	11-12	12-13*
Pharmacy	Allowed per Script	$58	$58	$60	$62
	Paid per Script	$47	$45	$48	$49
	Scripts / 1,000	11949.1	11598.6	11398.8	11070.7
	Generic Usage Rage	75%	79%	82%	84%

*2012-2013 data is from 10/12 - 3/13

Data received from Moda Health

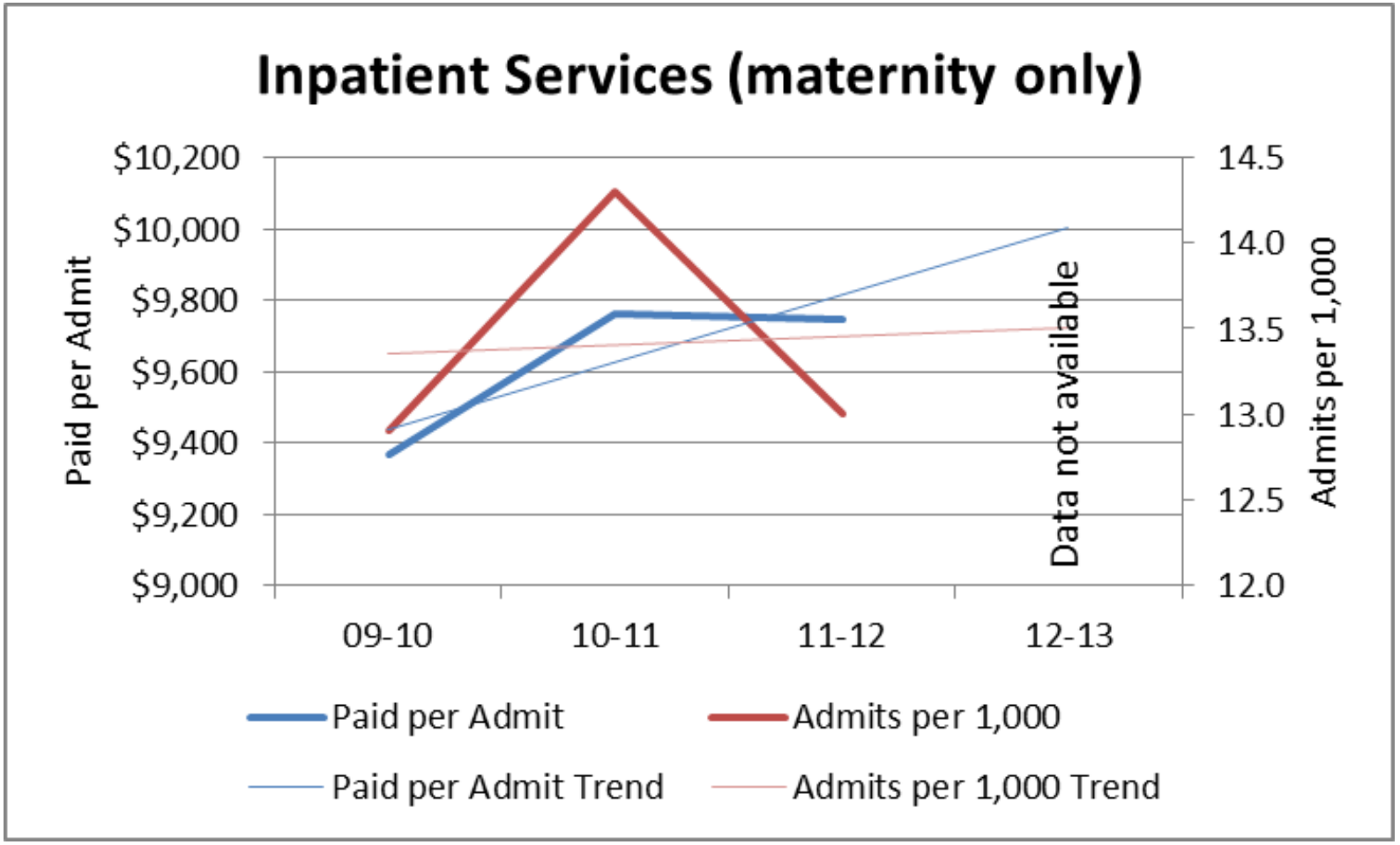
Inpatient Services (without maternity) — Kaiser Permanente



	Plan Year	09-10	10-11	11-12	12-13
Inpatient Services (without maternity)	Paid per Admit	$22,733	$26,425	$25,966	
	Admits / 1,000	34.0	33.1	30.4	

Data received from Kaiser Permanente

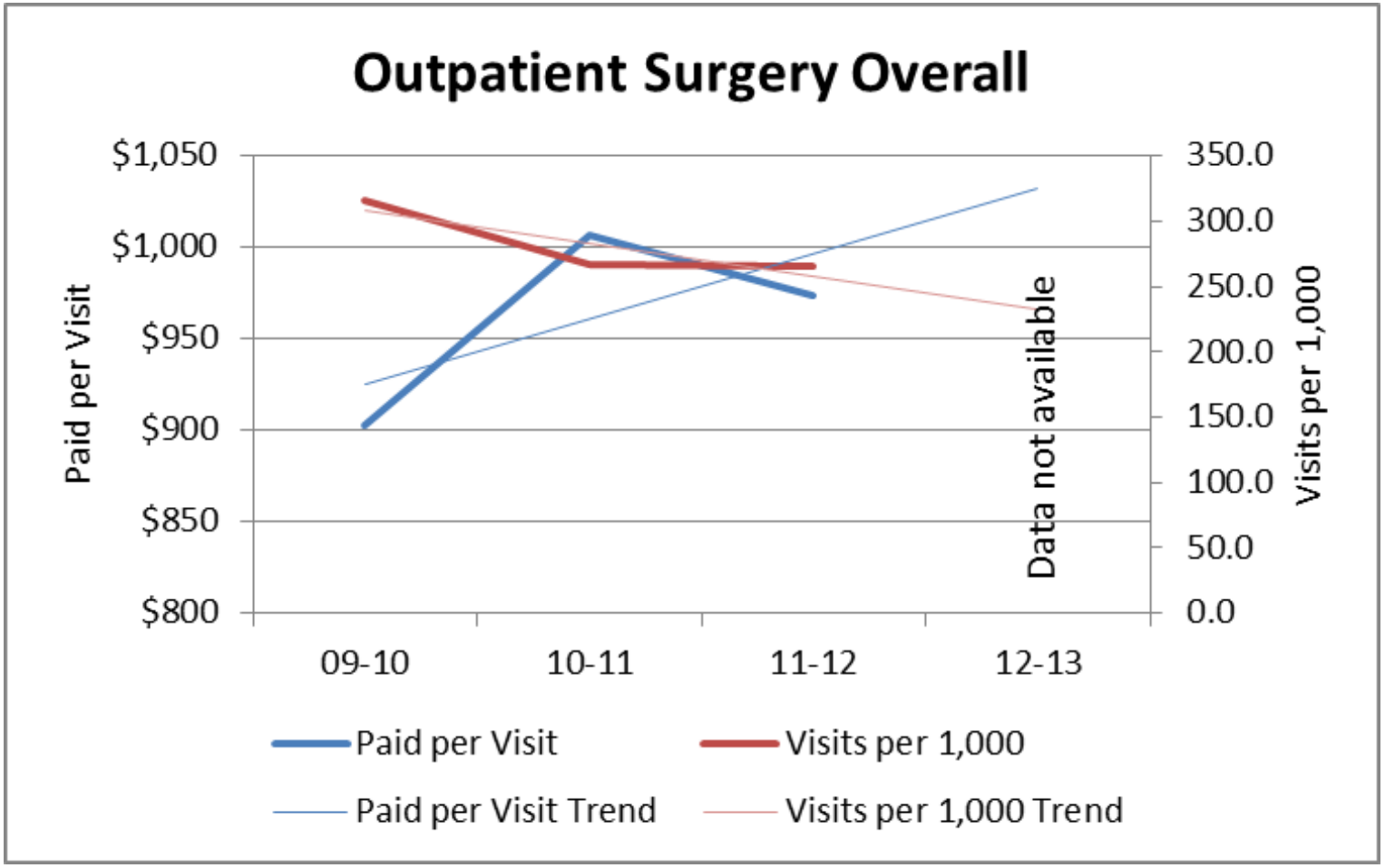
Inpatient Services (maternity only) — Kaiser Permanente



	Plan Year	09-10	10-11	11-12	12-13
Inpatient Services (maternity only)	Paid per Admit	$9,367	$9,759	$9,748	
	Admits / 1,000	12.9	14.3	13.0	

Data received from Kaiser Permanente

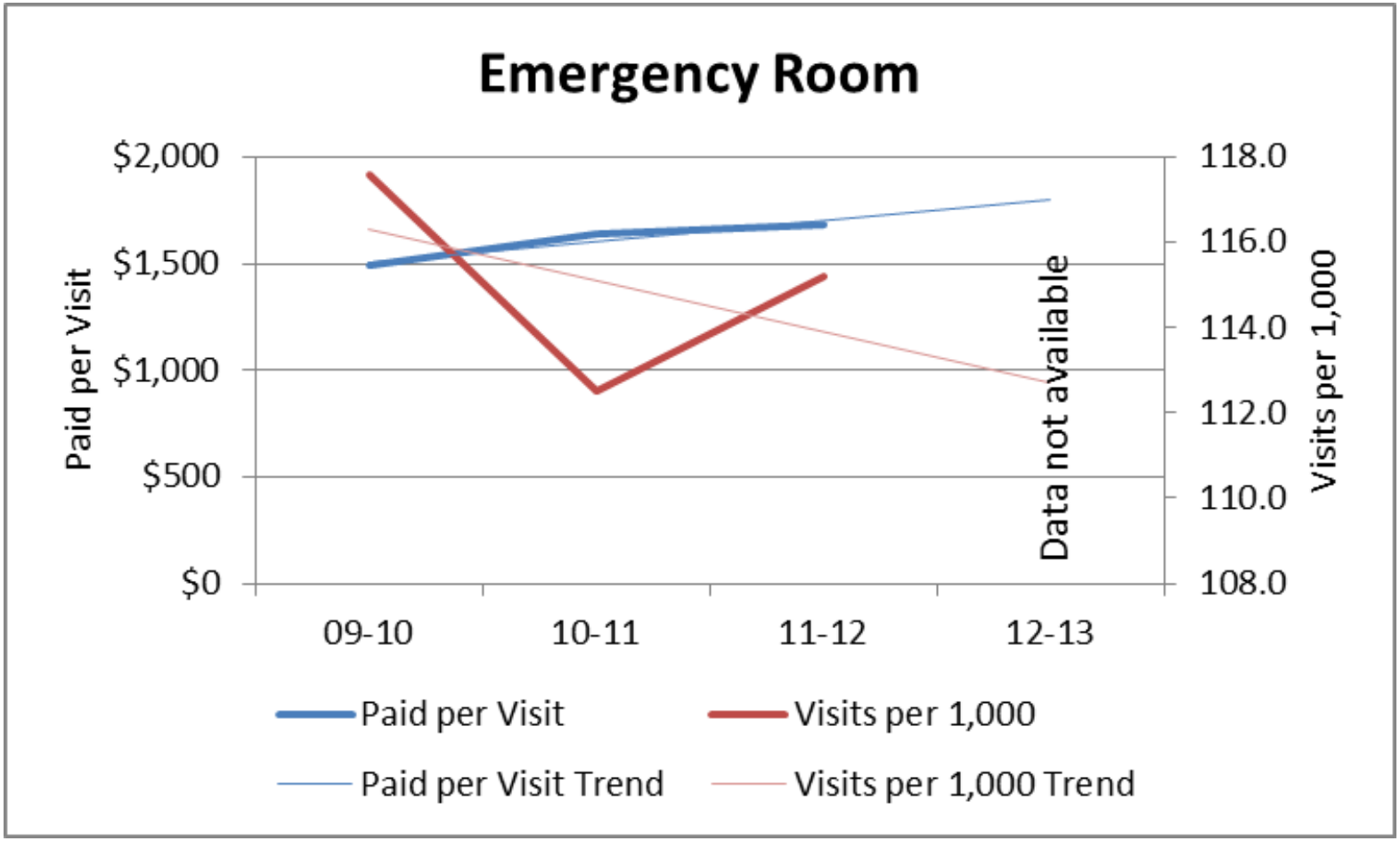
Outpatient Surgery Overall — Kaiser Permanente



	Plan Year	09-10	10-11	11-12	12-13
Outpatient Surgery Overall	Paid per Visit	$903	$1,006	$974	
	Visits / 1,000	316.5	267.5	265.5	

Data received from Kaiser Permanente

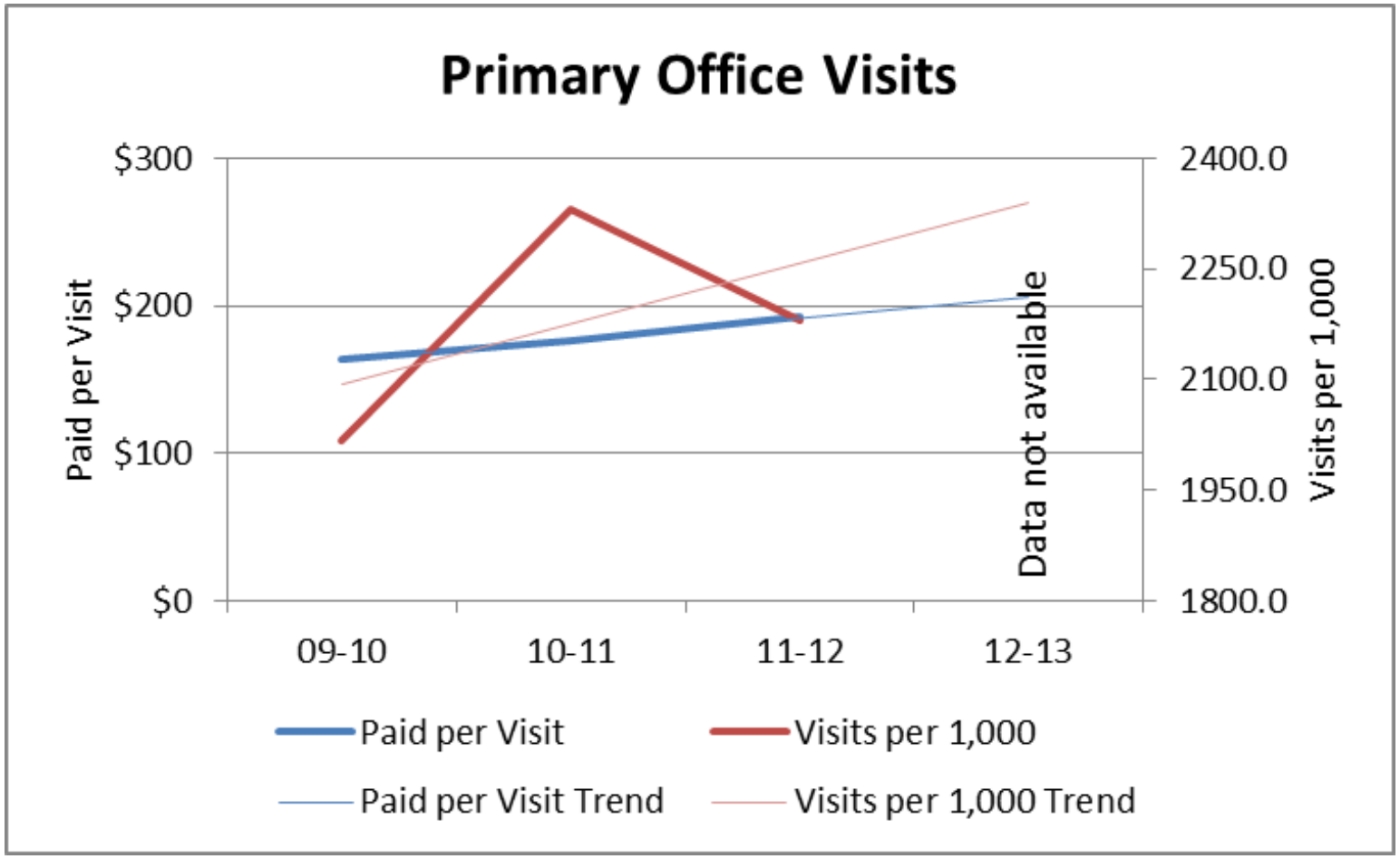
Emergency Room — Kaiser Permanente



	Plan Year	09-10	10-11	11-12	12-13
Emergency Room	Paid per Visit	$1,491	$1,645	$1,684	
	Visits / 1,000	117.6	112.5	115.2	

Data received from Kaiser Permanente

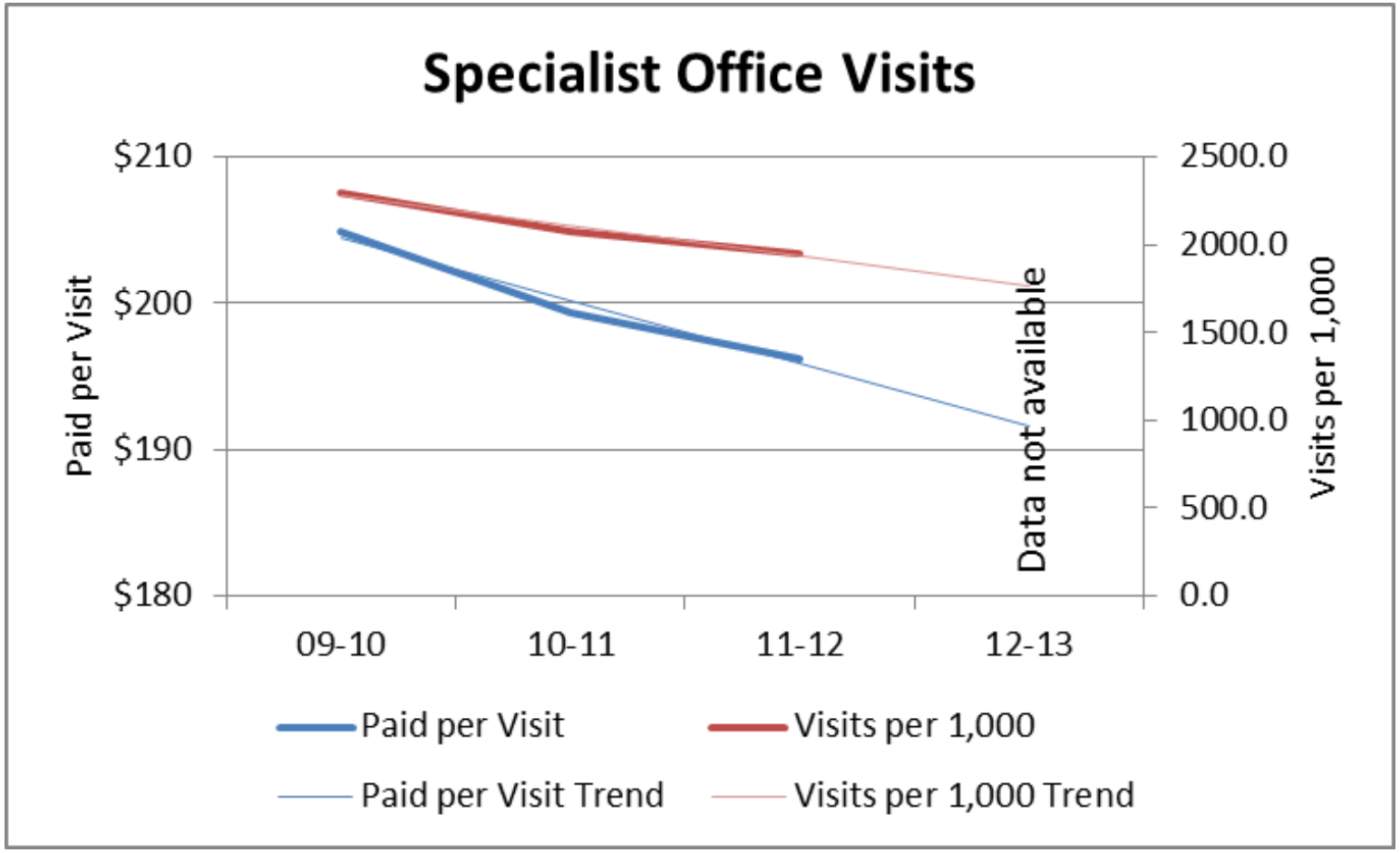
Primary Office Visits — Kaiser Permanente



	Plan Year	09-10	10-11	11-12	12-13
Primary Office Visits	Paid per Visit	$163	$176	$192	
	Visits / 1,000	2017.3	2330.4	2180.9	

Data received from Kaiser Permanente

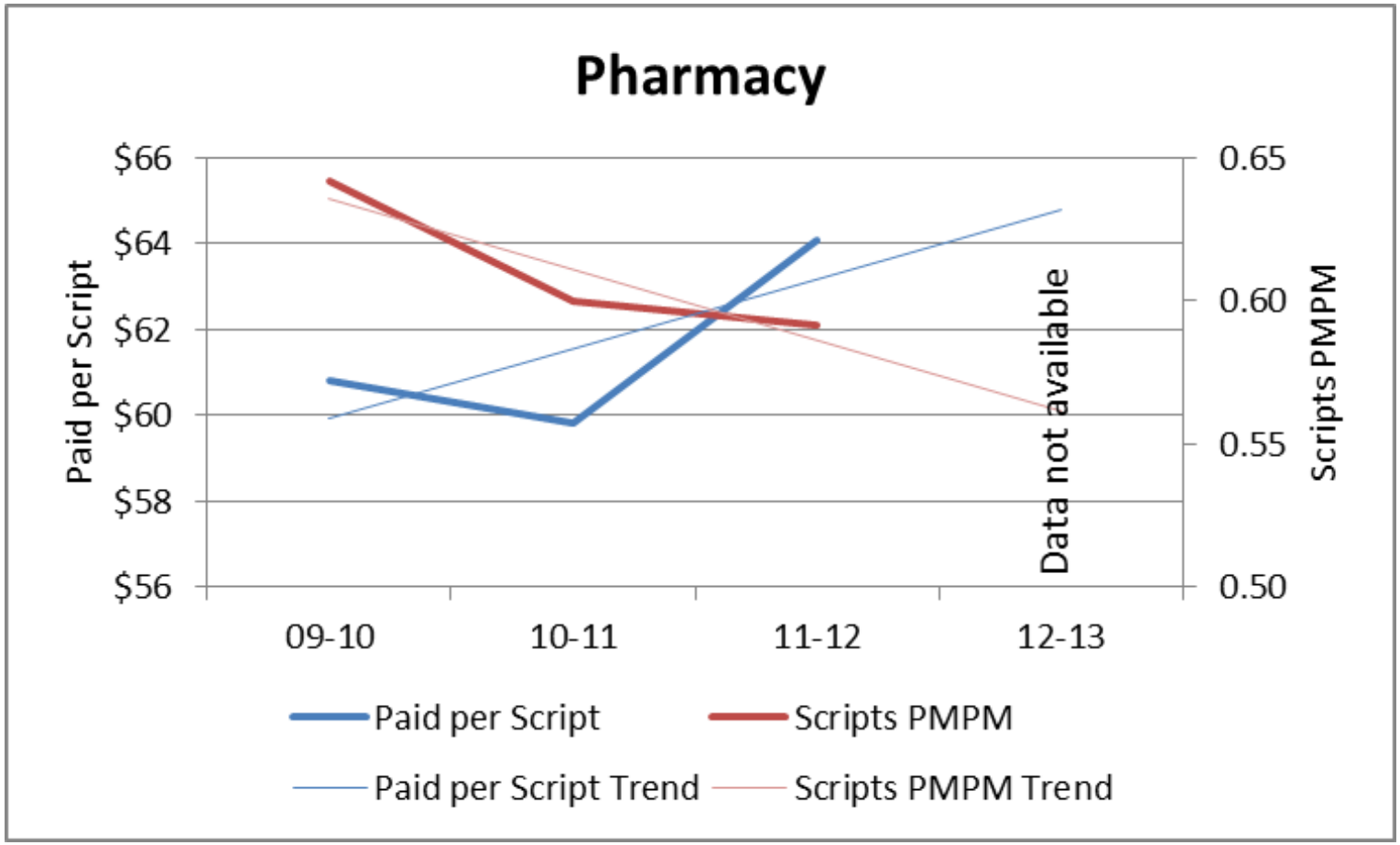
Specialist Office Visits — Kaiser Permanente



	Plan Year	09-10	10-11	11-12	12-13
Specialist Office Visits	Paid per Visit	$205	$199	$196	
	Visits / 1,000	2296.0	2073.3	1952.3	

Data received from Kaiser Permanente

Pharmacy — Kaiser Permanente



	Plan Year	09-10	10-11	11-12	12-13
Pharmacy	Paid per Script	$61	$60	$64	
	Scripts PMPM	0.64	0.60	0.59	
	Generic Usage Rage	85.7%	86.1%	86.2%	

Data received from Kaiser Permanente