ANALYSIS OF MEDICARE RISK CONTRACTORS' ACR DEVELOPMENT

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HMO RISK CONTRACTING UNDER MEDICARE

Table of Contents

Table of Contents

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ACR DEVELOPMENT

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CHAPTER 1: Concepts and Issues

1.1 Introduction

Three health maintenance organizations (HMOs) began serving Medicare beneficiaries under demonstration contracts with the Health Care Financing Administration (HCFA) in 1980. These demonstrations were the first instance of HMOs providing Medicare benefits under full-risk, prospectively determined capitation rates without HCFA retroactively adjusting the HMO's actual costs. Five additional HMOs joined this demonstration during 1981.

These demonstrations tested the assumption that prospective risk-contracting with HMOs can reduce Medicare costs while providing prepaid health plans sufficient financial incentive to offer Medicare beneficiaries coverage beyond existing Medicare Part A and Part B service limits. The Medicare reimbursement principles underlying these demonstrations have since been incorporated into law through passage of Section 114 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA authorizes the Medicare program to contract with HMOs and other eligible "competitive medical plans" at a rate equal to 95 percent of the Adjusted Average Per Capita Cost (AAPCC) for Medicare beneficiaries. The AAPCC is Medicare's actuarial method for estimating what HMO Medicare enrollees would have cost under fee-for-service.

This report documents how three of the eight HMO Medicare capitation demonstrations set prospective capitation rates. It presents detailed data on how these plans' actual cost and use experience compares with budgeted cost and use assumptions. Separate chapters analyze the rate-setting process and fiscal performance of the following demonstrations:

- Fallon Community Health Plan, Worcester, Massachusetts - The Fallon Community Health Plan (FCHP) is a group model HMO sponsored by the Fallon Clinic and Blue Cross of Massachusetts. It became operational in 1977, receiving federal qualification in November 1978. In December 1983, total plan enrollment was approximately 48,000, 17% (8220) of whom were Medicare beneficiaries enrolled in the demonstration project.

- Greater Marshfield Community Health Plan (GMCHP), Marshfield, Wisconsin - This group network model Plan is sponsored by the Marshfield Clinic, St. Joseph's Hospital, and Blue Cross Blue Shield United of Wisconsin. The Plan serves a ten county, primarily rural, area in North Central Wisconsin. The Plan is not a Federally qualified HMO. Nearly all health care providers in the area participate and about 40% of area residents belong to the Plan. When the Medicare demonstration ended in September 1982, 8902 Medicare beneficiaries were enrolled.

- Kaiser Permanente Medical Care Program (KPMCP-O), Portland, Oregon - The Kaiser Medical Care Plan is the largest

HMO network in the United States. At the initiation of the demonstration, conducted only in the Oregon region of the Kaiser system, Oregon Kaiser's membership was approximately 220,000 or about 20% of its service area. Approximately 16,000 were Medicare beneficiaries enrolled under a group practice prepayment plan (GPPP) contract between Kaiser and HCFA. At the outset of the demonstration, approximately 1500 GPPP members converted to the risk demonstration. These beneficiaries were joined by about 4000 new Medicare members within a few months of offering the demonstration, "Medicare Plus" package. In January 1984, demonstration enrollment was 7686.

The remainder of this chapter identifies six generic rate-setting issues for risk-based prepaid health plans based on the experience of the three demonstration plans. HMOs and competitive medical plans who choose to contract with the Medicare program under TEFRA may face some or all of these issues.

1.2 Deciding on a Rate-Setting Method

Each demonstration site had to decide on a total premium amount to cover the estimated cost of the Medicare benefit package. HCFA provided each HMO with estimates of the reimbursement rate HCFA would pay toward the HMO's monthly Medicare premium (i.e., percentage of AAPCC). This capitation payment served as the amount around which the demonstrations developed their benefit packages and determined the beneficiary's contribution toward the premium.

The experience of the demonstrations indicates Medicare HMO rate-setting is not simply an actuarial exercise but a judgmental process where rate computations interact with marketing and health care delivery system considerations. HCFA required that the HMO's basic benefit package provide more services than the usual Medicare Part A and Part B benefits. HCFA did not specify the extent to which HMOs should augment the standard Medicare package. HCFA constrained the beneficiary contribution toward the HMO's premium and cost-sharing requirements to the actuarial value of deductibles and co-insurance under the fee-for-service Medicare program. Marketing considerations, principally competition with supplemental Medicare insurance policies, also served to influence what the HMOs could charge the beneficiary.

Kaiser, Marshfield, and Fallon used a rate-setting approach based on an "adjusted community rate" (ACR). This rate-setting method will be used in TEFRA risk-based contracting. An ACR is based on a plan's community rate - a per capita average premium for the HMO's non-Medicare lines of business. This community rate is adjusted by taking into account expected use rates (i.e., Medicare beneficiaries will use more services); service intensity (i.e., Medicare beneficiaries will consume more staff time per encounter); and benefit package differences not reflected in the non-Medicare community rate (i.e., benefits included in the Medicare package might not be comparable to benefits offered non-Medicare members). An ACR should allocate the HMO premium requirement to the Medicare membership in proportion to the expected demands of Medicare enrollees on the organization's resources.

In theory, cross-subsidization between Medicare and non-Medicare lines of business should not occur.

Kaiser developed an ACR in the strictest sense -- establishing financial requirements for the delivery of the current statutory Medicare benefits. Kaiser calculated this ACR beginning with total plan financial need and allocating to the Medicare population. Fallon and Marshfield's ACR approach based their projected Medicare utilization and unit cost assumptions on data for non-Medicare membership. Neither Fallon nor Marshfield developed a separate ACR for the statutory Medicare benefit package, opting instead to develop one rate which included supplemental benefits.

1.3 Lack of Experience Data

TEFRA requires all prepaid health plans entering into risk-based Medicare contracts to document how their ACR was developed. In initial rate-setting, all three demonstrations used data on Medicare beneficiaries served by components of the Kaiser HMO system under Medicare cost-based reimbursement arrangements.

Fallon and Marshfield made extensive use of published Kaiser utilization statistics in adjusting their initial community rates. These plans assumed that the ratios of Medicare to non-Medicare use at Kaiser could be applied to their settings. For example, during 1977, Kaiser Health Plan - Northern California had a hospital use rate of 1,677 days per 1,000 members per year for Medicare members and 372 days per 1,000 for non-Medicare members. Fallon took the ratio of these two rates, 4.51, and applied this ratio to their non-Medicare hospital use rate of 510 days per 1000, yielding a projected hospital use rate of 2,300 days per 1,000 Medicare enrollees. Marshfield used Kaiser data in a similar fashion.

Unlike Marshfield and Fallon, the Kaiser-Portland demonstration did not lack Medicare data. Prior to the risk-based demonstration, Kaiser-Portland served approximately 16,000 Medicare beneficiaries under a cost-based, Group Practice Prepayment Plan contract with the Medicare program. Assuming that a prepaid health plan's management information system captures use data that can be arrayed by age and sex, HMOs choosing to contract with the Medicare program on a risk basis who have Medicare cost-based reimbursement contracts or who serve Medicare beneficiaries on a fee-for-service basis should have some data available to at least partially support initial ACR calculations.

1.4 Lag Time in Adjusting Rates to Reflect Actual Medicare Experience

A lack of data to support initial rate-setting is a temporary problem. In subsequent contracting periods, risk-based HMOs can apply their own experience to adjusting rates. However, in the demonstration, because of abbreviated initial contract periods, Fallon and Marshfield were unable to develop use statistics quickly enough to affect rate-setting in the second demonstration contract period. It was not until these demonstrations were well into their second contract period

that statistical evidence confirmed that initial use and cost assumptions were inaccurate.

Again, refining initial premium estimates was not an issue at Kaiser-Portland. Kaiser tracked use rates monthly; however, they did not anticipate the extent to which unauthorized, out-of-plan use occurred. The adverse fiscal impact of such out-of-plan use by demonstration enrollees was subsequently tightened through member education. This out-of-plan use experience was not the result of statistical lags in incorporating the use experience of enrollees into rate-setting calculations.

1.5 Risk Limitation Methods

Aged and disabled Medicare beneficiaries use more health services than persons free of disabilities who are under 65 years of age. As such, HMOs considering risk-based Medicare contracting may perceive Medicare beneficiaries as a high risk membership group. The two issues just discussed -- lack of experience data and lag time in applying experience data, may make it difficult for prepaid health plans to anticipate the extent of the risk they assume in a Medicare line of business. The three demonstrations used the following methods to limit risk:

- Purchase of excess risk insurance. For example, Fallon obtained four types of reinsurance from Blue Cross of Massachusetts: individual stop-loss, hospital aggregate stop-loss, insolvency, and out-of-area services.

- Provider subcontracts that pass on risk. Fallon, Kaiser, and Marshfield had capitation contracts with physician groups. These contracts shifted the actual costs of physician services to the medical groups, removing risk for excessive use or costs from the plans. Marshfield obtained per diem reimbursement rates from its three area hospitals, limiting its risk for actual hospital costs.

- Special arrangements with HCFA. For example, HCFA allowed Fallon to carry losses in one contract year forward into the development of future year rates, effectively adjusting the total percentage of the amount of revenue the Plan received from HCFA. At GMCHP, HCFA reimbursed the Plan at a level greater than 95% of the AAPCC as well as entered into a hospital risk sharing agreement with the Plan in the third benefit period.

These risk-limiting methods are stop-gap measures. If the HMO cannot control use or unit costs, reinsurance rates will rise or become unobtainable, provider capitation rates will rise, and loss carry-forward amounts will reach the ceiling of allowable AAPCC reimbursement. There is no alternative in the long-run except for the risk-based HMO to gain from its experience with Medicare enrollees and devise methods to control excessive use in order to curb costs.

1.6 Shift from APC to AAPCC

For Fallon and Marshfield, HCFA's initial capitation rate was a percentage of the area per capita costs (APC) rather than the AAPCC. The APC is the HMO's expected level of payment from HCFA based on the county of residence of the Medicare beneficiary, based on an initial assumption that distribution of HMO members by age, sex, institutional and welfare status will be the same as for Medicare beneficiaries in the county. The actuarial adjustments used in calculating a plan's Medicare reimbursement require either a known or assumed demographic mix (i.e., age, sex, welfare status, and institutional status) for the HMO's Medicare enrollees. Since Fallon and Marshfield did not have any Medicare enrollment, HCFA decided to base their initial capitation rates on area per capita costs (using plan enrollment projections by county) and not to assume a different demographic mix for plan enrollees. The HCFA capitation rate shifted to the AAPCC during second contract period rate-setting negotiations.

Shifting the basis of reimbursement from the APC to AAPCC reduced the HCFA capitation rate. Fallon and Marshfield enrolled beneficiaries whose demographic characteristics deviated from their service area's "average" in a way that lowered their level of reimbursement. The fiscal impact on Marshfield and Fallon of this shift was to compound the adverse effects of higher than expected use rates and unit costs.

Since Kaiser's initial rate development was based on the plan's prior experience with Medicare members, the new demonstration enrollees were assumed to be demographically similar to this pre-demonstration group. Kaiser's revenue projections based on HCFA's initial AAPCC rate-book thus proved relatively accurate.

1.7 Impact of the AAPCC Capitation Rate

By the beginning of the third contract period, Kaiser, Fallon, and Marshfield required a greater percentage increase in total revenue for Medicare members than had occurred in the AAPCC. Since the AAPCC limits HCFA's contribution to plan premium, short-falls must be made up through increasing the direct premium contribution of Medicare members.

The basis of HCFA's capitation rate is expected costs in the fee-for-service Medicare program. Thus, the percentage increase permitted in the AAPCC tends to be constrained by fee-for-service rates of increase. If a risk-based plan's costs increase at a faster rate than fee-for-service costs, the difference must be made up by the beneficiary; premiums or cost-sharing will increase or benefits will decrease. The beneficiary share of HMO premium did increase at all three demonstration sites in the first three benefit periods examined in this report.

1.8 Summary

The rate-setting issues discussed in this chapter are likely to apply to any HMO or eligible competitive medical plan undertaking a risk-based contract with HCFA. The remainder of this report details Kaiser's, Fallon's, and Marshfield's rate-setting experience. The next

chapter summarizes this experience and provides a discussion of projected adjusted community rates and actual cost and use results at these demonstrations. This chapter is followed by detailed presentations of how premiums were developed at the three sites. The data presented in these chapters is based on fiscal reports made by the plans to HCFA, augmented by information the plans supplied to HCFA's evaluator, Jurgovan and Blair, Inc. These chapters should serve as reference material for prepaid health plan fiscal managers and health care actuaries who need information to evaluate the cost and use assumptions underlying the build-up of a Medicare adjusted community rate under Medicare risk-based contracting.

CHAPTER 2: Summary of Rate-Setting Experience and Fiscal Performance, Fallon Community Health Plan (FCHP), Greater Marshfield Community Health Plan (GMCHP), and Kaiser Permanente Medical Care Group-Oregon (KPMCP-O) Medicare Capitation Demonstrations

This chapter summarizes for each demonstration:

- ACR development
- Premium development
- Comparison of budgeted versus actual experience

2.1 Fallon Community Health Plan (FGHP)

ACR Development

FCHP used a mixed approach in developing a single initial ACR that combined the aged and disabled Medicare populations. Where FCHP believed reliable use data existed, an actuarially based approach to ACR development was adopted. Where data was lacking, FCHP adjusted the experience of its under-65 membership. These adjustments were based on data from the Kaiser system; ratios of over-65 to under-65 Kaiser enrollees served as factors to adjust use and cost data for Fallon under-65 enrollees. Once FCHP could analyze the experience of its Medicare enrollees, the actual use and costs of these members formed the basis for ACR development.

Several observations are noteworthy concerning Fallon's rate-setting process:

- During the first two contract periods, FCHP applied Kaiser over-65 to under-65 hospital use ratios to the projected hospital use of its under-65 membership. Fallon has relied on the hospital experience of its Medicare enrollees to project the hospital component of the ACR in subsequent contract periods.

- During the first two contract periods, FCHP's skilled nursing facility use projections were based strictly on Kaiser data. In subsequent contract periods, the basis of budgeted SNF costs reflects Fallon's decision to contract for a specified number of bed-days from local SNFs.

- To set medical services capitation payments to the Fallon Clinic, FCHP divided the capitation into administrative and medical components. The medical services component was multiplied by both an over 65 to under 65 utilization ratio and an "intensity factor" of 1.2. The intensity factor is an assumption used by HCFA's Group Health Plan Operations in cost reimbursement contracts that Medicare beneficiaries use 20% more resources per encounter than under-65 HMO members. FCHP used this intensity factor weighting in all contract periods.

- In initial ACR development, FCHP built into its rate an allowance for risk-based contracting start-up costs, anticipating an impact of Medicare enrollment on overall plan operations. Examples of such costs include "threshold physicians;" "threshold administration;" and "incremental space."

- During the initial contract period, FCHP used an actuarial rate-setting approach for pharmacy services, eyeglasses and refractions and miscellaneous services. To produce these rates, FCHP consulted a variety of data sources. In subsequent contract periods, FCHP has relied on Medicare enrollees use experience to project these rates.

- Administrative costs represent the sum of capitation payments to Blue Cross of Massachusetts for administrative services rendered to the Medicare demonstration and an allocation of total in-house administrative costs between the Medicare and non-Medicare lines of business based on the percentage of total member-months in each category.

Revenue Determination

FCHP had two revenue sources -- the HCFA AAPCC payment and the beneficiary's premium contribution. HCFA reimbursed FCHP at 89.5% of the APC in contract period 1 and 95% of the AAPCC thereafter. The table below summarizes HCFA reimbursement levels and beneficiary premium contributions for four benefit periods:

	Benefit Period 1	Benefit Period 2	Benefit Period 3	Benefit Period 4	Benefit Period 5
APC	$133.15	--	--	--	--
AAPCC	--	$126.54	$152.49	$186.34	$204.92
ACR	$126.62	$127.69	$159.87	$192.02	$209.67
ACR as percentage of APC or AAPCC	95.1%	100.9%	104.6%	103.0%	102.3%
Beneficiary Premium	$7.50	$7.50	$15.00	$15.00	$15.00
HCFA Capitation	$119.12	$120.19	$144.87	$177.02	$194.67
HCFA Capitation as a percentage of APC or AAPCC	89.5%	95.0%	95.0%	95.0%	95.0%
HCFA capitation as a percentage of ACR	94.1%	94.1%	90.6%	96.2%	92.8%

The first contract period represents only four months' experience. The change to the AAPCC during the second contract period and the demographic differences in the mix of Medicare enrollees compared with Medicare beneficiaries in Fallon's service area led to the second contract period AAPCC being less than the initial APC. The first and second contract period ACRs were virtually the same.

FCHP set the beneficiary contribution to premium as the difference between its ACR and the HCFA payment. FCHP maintained the same premium for the first two contract periods and then doubled the Medicare beneficiary's contribution to $15.00 in the third contract period.

Reported Experience

Exhibit 2-1 summarizes the fiscal performance of the demonstration for the first four contract periods -- 1980 through 1983. In the first contract period, revenue exceeded expenses by $4.47 per member per month (PMPM). This represented a gain of $112,000. In the second contract period, expenses were $8.87 PMPM greater than revenues; a loss of approximately $571,000.

The major contributing factor to the second year loss was in institutional services. The loss due to excess hospitalization was $16.44 PMPM, representing 226 hospital days/1000 in excess of budgeted days and an average of $50.07 more per day from budgeted hospital costs. In the first contract period excess hospital use also occurred (i.e., 350 days/1000 more than budgeted with an $8.87 PMPM unfavorable variance in unit costs.) Losses for skilled nursing facility care also occurred in both the first and second contract periods.

To offset these initial losses, FCHP negotiated a loss carry-forward arrangement with HCFA. Under this arrangement, HCFA agreed to apply any first year institutional losses to FCHP's second year capitation payment subject to a capitation limit of 100% of the second year AAPCC. In computing the first year's loss, expenses incurred January-March 1981 were counted. Since FCHP received 95% of AAPCC as its reimbursement from HCFA, the size of the carry-forward could not exceed 5% of the 1982 AAPCC (i.e., $7.62 PMPM) multiplied by the number of member-months in 1983. Based on a 1982 membership totalling 73,900 member-months, the potential limit on the loss carry-forward was $560,000. In FCHP financial statements, the value of the loss carry-forward is $368,000 which is shown as an offset in the second contract year.

In the third year (1982) revenue exceeded expenses by $7.47 PMPM, with the major contributers to this position being favorable variances in hospitalization and reinsurance reimbursement. The gain in 1982 represented a $16.34 PMPM change from the prior year. In the fourth year (1983) revenue exceeded expenses by $23.51 PMPM which represented a $16.04 PMPM increase over the 1982 experience. The major contributers to this position were favorable variances in hospitalization ($15.83 PMPM net of the physicians' incentive payment) and medical serivces ($4.86 PMPM). The actual combined hospital payment and physician incentive payment increased 12.9% from 1982 to 1983 while budgeted hospitalization increased 24.2%

Other observations concerning FCHP's fiscal performance include:

EXHIBIT 2-1
FISCAL SYNOPSIS OF FCHP (FALLON) DEMONSTRATION

371-B/BC

PLAN REVENUE/EXPENSE ANALYSIS

	April 1980-December 1980		January 1981-December 1981		January 1982-December 1982		January 1983 - December 1983	
Membermonths	25,116		64,320		74,295		85,676	
	Dollars	PMPM	Dollars	PMPM	Dollars	PMPM	Dollars	PMPM
Revenue	$3,180,000	$126.62	$8,213,000	$127.69	$11,878,000	$159.87	$16,451,000	$192.02
Expense	3,068,000	122.15	8,784,000	136.56	11,323,000	152.40	14,437,000	168.51
Period Surplus (Deficit)	$112,000	$4.47	($571,000)	($8.87)	$555,000	$7.47	$ 2,014,000	$ 23.51
Cumulative Surplus (Deficit)	$112,000		($459,000)		$96,000	$7.47		

MAJOR CONTRIBUTORS TO PLAN'S SURPLUS (DEFICIT) POSITION (PMPM)

	Budgeted	Actual	Variance	Budgeted	Actual	Variance	Budgeted	Actual	Variance	Budgeted	Actual	Variance
Hospitalization	$57.31	$67.97	($10.66)	$60.11	$76.55	($16.44)	$87.41	$70.58	$16.83	$108.53	$75.34	$33.19
Skilled Nursing Services	$5.79	$1.44	$4.35	$2.42	$3.93	($1.51)	$5.00	$5.77	($.77)	$5.90	$4.62	$1.28
Medical Care Services	$43.07	$40.34	$2.73	--	--	--	--	--	--	$57.60	$52.74	$4.86
Reinsurance Reimbursement	--	($6.76)	$6.76	--	($4.35)	$4.35	--	($2.43)	$2.43	--	(1.44)	$1.44
HCFA Loss Carry Forward Payment	--	--	--	--	($5.73)	$5.73	--	--	--	--	--	--
Physicians Hospital Incentive Payment	--	--	--	--	--	--	--	$11.56	($11.56)	--	$17.36	($17.36)

BENEFICIARY MONTHLY PAYMENT	$7.50	$7.50	$15.00	$15.00
HCFA PROSPECTIVE REIMBURSEMENT CALCULATION	$119.12 (89.5% of APC)	$120.19 (95% of AAPCC)	$144.87 (95% of AAPCC)	$177.02 (95% of AAPCC)
PROJECTED ACR	$126.62	$127.69	$159.87	$192.02

371-J/BC/1

- Blue Cross of Massachusetts' reinsurance payments exceeded FCHP's reinsurance premiums for the first two contract periods. This experience led BC/M to significantly increase Fallon's reinsurance costs.

- The cost of additional benefits not covered by the Medicare program (i.e., vision care and prescription drugs) was $9.47 PMPM in the first contract period (i.e., 7.8% of the actual ACR) and $11.43 in the second year (8.4% of the actual ACR). During the first two contract periods, FCHP expended approximately $970,000 for these benefits.

- Expressed as the number of services per thousand per year, summary use statistics for the first four benefit periods are as follows:

	Benefit Period 1 (1980)	Benefit Period 2 (1981)	Benefit Period 3 (1982)	Benefit Period 4 (1983)
Ambulatory Encounters	5,454	7,327	6,970	6,934
Lab Tests	5,079	5,997	6,110	6,128
X-Rays	1,432	1,434	1,270	1,118
Prescription Drugs	9,400	10,700	--	--
Eyeglasses Dispensed	656	418	--	--

Summary

FCHP is delivering services to Medicare beneficiaries in its fifth benefit period. FCHP has experienced the following fiscal performance over the first four benefit periods:

	1980	1981	1982	1983	Cumulative
Membermonths	25,116	64,320	74,295	85,676	249,407
FCHP Gain (Loss) From Operations	$112,000	($571,000)	$555,000	$2,014,000	$2,110,000
HCFA Gain (Loss) As Measured Against APC/AAPCC	$352,000	$39,000	$566,000	798,000	$1,755,000

Including the loss carry-forward, FCHP has had a cumulative gain of $8.46 PMPM (i.e., $2,110,000 divided by 249,407). FCHP's cumulative surplus during these benefit periods reflects inclusion of a vision care and prescription drug benefit within budgeted ACR calculations. The budgeted premium value of these additional benefits was $9.47 in

the first benefit period and $11.43 in the second benefit period. Additionally, the beneficiary's contribution toward the premium, $7.50, was at least $15.00 per month less than roughly comparable Medicare supplemental coverage. Had FCHP chosen a more limited benefits package or higher enrollee premium, their gain would have been greater.

HCFA's gain is $7.04 PMPM ($1,755,000 divided by 249,407). HCFA's gain or loss from the demonstration merely represents the percentage of APC in the first benefit period and AAPCC in subsequent periods. An evaluation of "savings" to the government must take into account any evidence of biased selection among plan enrollees; had these enrollees remained in fee-for-service, what would they have cost the Medicare program? The analysis of this question will appear in subsequent evaluation reports.

2.2 Greater Marshfield Community Health Plan (GMCHP)

ACR Development

GMCHP used an adjusted community rate approach in developing the Medicare rate for the first two benefit periods. GMCHP then shifted to demonstration experience in developing third year rates. The Plan first established its community rate for each benefit category and then developed multipliers to adjust the community rate.

For GMCHP, developing a community rate is an interactive process among many parties. Each of GMCHP's organizational components (i.e., the Marshfield Clinic, St. Joseph Hospital, and Blue Cross Blue Shield of Wisconsin) first prepares separate budgets for the services they provide. Once these budgets are prepared, negotiations among the three parties occur. A community Health Plan Advisory Committee then reviews the rates which emerge from these negotiating sessions. Additional meetings are held with affiliated providers and final rates are decided upon.

Until the Medicare demonstration, GMCHP used the same unit cost assumptions and capitation rates for commercial, direct pay, Medicaid, and family health center members. The Medicare demonstration forced the Plan to establish a process to estimate anticipated costs for a specific population group. The Plan decided to adjust only those services where Medicare beneficiaries use would potentially increase their liability. In order to develop multipliers, GMCHP consulted a variety of sources including fee-for-service data from the Marshfield Clinic, data from other prepaid health plans, and data from HCFA.

Exhibit 2-2 shows the services for which multipliers were developed and the value of these multipliers for the first two benefit periods:

EXHIBIT 2-2
GMCHP ADJUSTMENT FACTORS BY BENEFIT PERIOD

	Benefit Period 1 (6/1-9/30/80)	Benefit Period 2 (10/1/80-9/30/81)
Affiliated Inpatient	4.54	3.997
ECF & Visiting Nursing	48.00	8.48
Clinic Capitation, Medical Portion	2.321	2.153
Affiliated Outpatient	1.71	1.59
Additional Benefits	1.78	1.65
Referral and Out-of-Area	4.61	
Inpatient Hospital		4.90
Outpatient Hospital		1.932
Professional Services		2.68

GMCHP's community rate adjustment process appeared to be unduly complex. For many benefits, GMCHP considered two or three approaches to adjusting its community rate, introducing such factors as "out-of-area" use estimates and enrollee mobility, among others. Observations about Marshfield's use of multipliers include:

- The hospital multiplier applied only to yearly community rate hospital use projections. Hospital per diem rates were set separately. In Year 1, the hospital multiplier was "backed into" (i.e., project a Medicare hospital use rate and divide by the projected under-65 hospital use rate). In Year 2, the Year 1 multiplier was adjusted.

- SNF and home health multipliers were also "backed into."

- For other relevant services, a multiplier was first developed and then applied to the community rate.

- GMCHP did not adjust the administrative component of its community rate for the Medicare population.

Projected ACRs

Negotiation played a major role in ACR development. Hospital providers agreed to a reduction in the initial year's inpatient care multiplier. So as to keep premium levels affordable, the primary inpatient provider, St. Joseph Hospital, agreed to a projected capitation based on a different multiplier than was used at two other affiliated hospitals. For the first two benefit periods, budgeted ACRs resulted from applying multipliers to the community rate. By the third benefit

period, GMCHP had one full year of experience data and used this information to develop the Medicare rate. GMCHP's initial calculations yielded an experience-based Medicare premium of $147.39; $67.43 above HCFA's 95% of AAPCC monthly reimbursement (i.e., $79.96 PMPM).

GMCHP also negotiated rate-setting with the government. The marketability of the Medicare demonstration was jeopardized because of the large negative difference between the AAPCC and the projected ACR. HCFA therefore agreed to set Marshfield's reimbursement at 99% of AAPCC, to recompute the AAPCC to assure the validity of HCFA's payment level, and to enter into a risk-sharing arrangement which would enable the Plan to reduce the projected hospital cost component of the ACR. HCFA's AAPCC recomputations resulted in increasing Marshfield's AAPCC from $84.17 PMPM to $88.34 PMPM; 99% of AAPCC resulted in a capitation payment of $87.46. As a result of the HCFA-GMCHP risk-sharing arrangement for hospital use, GMCHP was able to lower its projected hospital capitation from $74.81 to $41.82 PMPM.

Revenue Determination

There were two sources of revenue -- HCFA and beneficiary payments. The HCFA reimbursement was set at 99% of APC in benefit period 1; 98% of AAPCC in Year 2; and 99% of AAPCC in Year 3. The table below summarizes the APC/AAPCCs, HCFA payment levels, and beneficiary contribution toward premiums:

	Benefit Period 1	Benefit Period 2	Benefit Period 3
APC	$75.17	--	--
AAPCC	--	$75.69	$88.34
ACR	$96.09	$100.12	$119.46
ACR as a Percentage of APC or AAPCC	127.80%	132.3%	132.20%
Beneficiary Premium	$21.67	$25.94	$32.00
HCFA Capitation	$74.42	$74.18	$87.46
HCFA Capitation as a Percentage of ACR of AAPCC	99.00%	98.00%	99.00%
HCFA Capitation as a Percentage of ACR	77.40%	74.10%	73.20%

GMCHP determined the beneficiary premium by subtracting the HCFA payment from the ACR, even though a detailed "build-up" of the value of the premium was made for the first two benefit periods.

The table presented above relates to aged and disabled enrollees only. GMCHP also enrolled persons with end stage renal disease (ESRD) but did not calculate a separate ACR for this small but costly group of enrollees. HCFA's per member per month level of payment for ESRD patients at Marshfield was as follows:

	Benefit Period 1 (7/80-9/80)	Benefit Period 2 (10/80-9/81)	Benefit Period 3 (10/81-9/82)
ESRD Payment	$2,042.15	$2168.17	$2,301.21

Reported Experience

Exhibit 2-3 summarizes GMCHP's fiscal performance during the three benefit periods. Revenues exceeded expenses for the 4 month initial benefit period but expenses were greater than revenues for the next two years. The total loss over the three periods was approximately $1.79 million. Losses are attributable to negative variances in hospital, SNF, and home health costs. Another contributing factor to the loss was the shift from an APC to AAPCC basis for HCFA reimbursement in Year 2. In Year 2, operating expenses rose by 23.3% while total revenue increased only 4.1%. In Year 3, GMCHP experienced an increase in revenue of roughly 20% with expenses rising 8.9%.

Summary

GMCHP terminated its Medicare risk-based contract demonstration in September 1982. As shown in the table presented below, GMCHP's cumulative loss of $1.77 million is equivalent to $8.16 PMPM. Without inpatient risk-sharing with HCFA in the third benefit period, the loss would have been nearly $2,252,000. These figures do not include the reported sponsor losses. There is as yet no definitive explanation of this loss. The evaluation will produce detailed analyses of the use of GMCHP benefits by Medicare enrollees which may provide a clearer picture of why this loss occurred.

In the first benefit period as a percentage of the APC, and as a percentage of AAPCC in the second benefit period, HCFA realized a gain. However, due to the hospital risk-sharing arrangement, HCFA experienced a cumulative loss of $1,567,000 or $7.23 PMPM.

	Benefit Period 1 (7/80-9/80)	Benefit Period 2 (10/80-9/81)	Benefit Period 3 (10/81-9/82)	Cumulative
Membermonths	18,294	93,350	105,071	216,715
GMCHP Gain (Loss) From Operations	$54,000	($1,385,000)	($437,000)	($1,768,000)
HCFA Gain (Loss) As Measured Against APC/AAPCC	$14,000 (1% APC)	$141,000 (2% AAPCC)	($1,722,000) (18.55% AAPCC)	($1,567,000)

EXHIBIT 2-3

FISCAL SYNOPSIS OF GMCHP (MARSHFIELD) DEMONSTRATION

PLAN REVENUE/EXPENSE ANALYSIS

	June 1980-September 1980		October 1980-September 1981		October 1981-September 1982	
Membermonths	18,294		93,350		105,071	
	Dollars	PMPM	Dollars	PMPM	Dollars	PMPM
Revenue	$1,756,000	$95.97	$ 9,324,000	$ 99.88	$12,581,000	$119.74
Expense	1,702,000	93.01	10,709,000	114.72	13,018,000	123.90
Period Surplus (Deficit)	$54,000	$2.96	($1,385,000)	($14.84)	($437,000)	($4.16)
Cumulative Surplus (Deficit)	$54,000		($1,331,000)		($1,768,000)	

MAJOR CONTRIBUTORS TO PLAN'S SURPLUS (DEFICIT) POSITION (PMPM)

	Budgeted	Actual	Variance	Budgeted	Actual	Variance	Budgeted	Actual	Variance
Affiliated Inpatient/ Outpatient	$47.63	$45.21	$2.42	$46.82	$60.27	($13.45)	$45.02	$64.32	($19.30)
SNF/Home Health/Additional Benefits	$2.67	$1.03	$1.64	$2.86	$3.64	($.78)	$3.95	$6.61	($2.66)
HCFA Risk Sharing	--	--	--	--	--	--	--	($17.27)	$17.27

BENEFICIARY MONTHLY PAYMENT	$21.67	$25.94	$32.00
HCFA PROSPECTIVE REIMBURSEMENT CALCULATION	$74.42 (99% of APC)	$74.18 (98% of AAPCC)	$87.46 (99% of AAPCC)
PROJECTED ACR	$96.09	$100.12	$119.46

2.3 Kaiser Permanente Medical Care Program of Oregon (KPMCP-O)

ACR Development

KPMCP-O's rate-setting approach had three steps:

- Calculate a community rate.
- Divide this rate into specific components.
- Develop adjustment factors which recognize the service and resource requirements of the Medicare membership relative to the non-Medicare membership.

In developing a community rate, KPMCP-O synthesizes plan component budgets into an overall plan budget. Costs are then compared with projected revenue (i.e., revenue equals projected membership multiplied by per capita revenue for each membership group). If the plan's projected costs are greater than projected revenue, premium increases are recommended.

To prepare a Medicare rate, KPMCP-O rearranged the cost categories in the community rate as follows:

- Hospitals
  - Part A
  - Part B
- Medical Services
  - Medical
  - Administrative
- Home health
- Claims/ambulance
- Pharmacy/Optical

These categories closely match the Medicare program's delineation of standard benefits. The claims/ambulance category included in- and out-of-area claims, ambulance, and extended care use. Pharmacy/optical services were not a part of Kaiser's basic package. Not all community rate cost categories could be mapped into developing a Medicare rate so an additional "other Medicare benefits" category was used to account for services provided only by the Medicare program which are not included in benefit packages offered to the non-Medicare membership.

In adjusting its community rate, KPMCP-O considered two factors -- time and complexity and volume. For each benefit period, the Plan developed these adjustors and applied them to estimating hospital, medical, and home health service premium components. Exhibit 2-4 summarizes these adjustment factors for each benefit period. Observations concerning these multipliers are:

EXHIBIT 2-4
KPMCP-O ADJUSTMENT FACTORS BY BENEFIT PERIOD

	Hospitals		Medical Services		Home Health
	Part A	Part B	Medical	Administrative	
1980					
Aged					
VOL	4.2409	4.2409	1.9682	1.9682	9.2349
T/C	0.9220	0.4974	1.1697	1.0000	1.0000
COMP	3.9101	2.1094	2.3022	1.9682	9.2349
Disabled					
VOL	6.1539	6.1539	2.1928	2.1928	9.2349
T/C	0.9166	0.4968	0.9748	1.0	1.0
COMP	5.6407	3.0573	2.1375	2.1928	9.2349
1981					
VOL	4.22	4.22	2.15	2.15	8.95
T/C	0.90	0.51	1.16	1.0	1.0
COMP	3.80	2.15	2.49	2.15	8.95
1982					
VOL	4.37	4.37	2.33	2.33	10.10
T/C	0.9182	0.6524	1.1501	1.0	1.0
COMP	4.0125	2.8510	2.6797	2.33	10.10
1983					
VOL	4.1	4.1	2.34	2.34	10.70
T/C	0.9271	0.6159	1.1474	1.0	1.0
COMP	3.8011	2.5252	2.6849	2.34	10.7

- For the first benefit period, separate rates requiring two sets of adjustment factors were developed for aged and disabled Medicare beneficiaries. For subsequent benefit periods, KPMCP-O developed a single rate.

- For the first benefit period, KPMCP-O's 1978 experience with Medicare GPPP members was used to derive volume adjustors. In succeeding years, volume adjustors derived from a comparison of current year projections for Medicare enrollees and average plan membership. Hospital volume was based on days; medical services volume on encounters, which included physician office, hospital, and radiology visits.

- Time/complexity factors for hospital service and medical services relied on data from a prior year; initial calculations used 1978 and 1979 cost data and thereafter Medicare Plus experience applied. Hospital factor development depended on a comparison of per diem costs between Medicare experience and planwide data, for both Part A and Part B services. The comparative measure for medical services was encounters, with Medicare services adjusted by the HCFA-determined factor of 1.2 (i.e. Medicare beneficiaries require 20% more resources).

- Over time, time/complexity factors changed little. Changes did occur in volume adjustors; a decrease in the Part A and Part B hospital volume adjustors and an increase in the medical services volume adjustor.

The following table shows the adjusted community rate, the community rate, and the relationship between these rates:

	ACR	% Change By Year	CR	% Change By Year	Ratio of ACR to CR
1980	$ 98.98	-	$35.36	-	2.80
1981	114.72	15.9	41.77	18.1	2.75
1982	148.09	29.1	46.66	11.7	3.17
1983	168.68	14.6	57.69	23.6	2.94

This table indicates how rates increased after the first year of Medicare demonstration experience became available. Projected Medicare costs increased dramatically; between 1981-1982 the community rate increased by 11.7% while the ACR increased 29.1%.

Revenue Determination

There were two sources of revenue -- HCFA payments and beneficiary contributions. HCFA reimbursed the Plan under a rate book approach. In order to initiate this reimbursement procedure, an estimated AAPCC and thus an estimated HCFA payment was established at the beginning of each benefit period. Since the actual reimbursement could, and most likely would, vary from the projected monthly figure, KPMCP-O divided the projected capitation into two components -- one component representing the actual "fixed" HCFA capitation payment and

the other portion representing a payment into a fund to be held by HCFA, entitled the Benefit Stabilization Fund (BSF). Beneficiary contributions included premiums for the basic "Medicare Plus" benefit package; beneficiary premiums for three optional "Medicare Plus" plans; and beneficiary copayments on selected services.

Exhibit 2-5 summarizes HCFA and beneficiary revenue. For all benefit periods, the HCFA capitation was 95% of the projected AAPCC. KPMCP-O budgeted a contribution to the benefit stabilization fund for the first two benefit periods. During the third benefit period, the Plan budgeted a withdrawal of $2.17 PMPM for inclusion in the interim payment. This infusion of funds from the BSF resulted in the HCFA capitation being greater than 95% of AAPCC (i.e., 96.5%). For the first benefit period, the actual AAPCC was 2.1% greater than the estimated AAPCC; for the second benefit period, 1% greater.

As regards the beneficiary contribution to Plan premium, there are three types of revenue -- the beneficiary premium for the Medicare-Plus package; beneficiary copayments; and the projected enrollee payment. KPMCP-O calculated the value of the beneficiary premium by summing the estimated costs of Medicare Part A and Part B copayments and deductibles; costs for Medicare covered services provided by non-Kaiser providers; costs for additional services not covered by the Medicare program. Premium development for the first two benefit periods was based on KPMCP-O's prior experience with Medicare beneficiaries. The increase in premium for the third benefit period reflects the availability of actual demonstration experience. The following table shows the values for the components of this beneficiary premium contribution:

	1980	1981	1982	1983
Part A Deductible and Coinsurance	$ 3.34	$ 3.30	$ 4.03	$ 4.70
Part B Deductible and Coinsurance	10.55	12.58	17.14	18.48
Additional Costs For Medicare Covered Services	.31	1.94	1.05	1.13
Costs For Medicare Non-Covered Benefits	1.72	1.67	2.43	2.88
Administration	.33	--	1.00	1.00
Adjustment For Prior Year Overcharge	--	(.33)	(.95)	(.21)
Credit For Copayment	(1.07)	(1.03)	(1.27)	(1.24)
	$15.18	$17.13	$23.43	$26.74

During all benefit periods, the demonstration charged a copayment of $2.00 for each physician clinic visit and $3.00 for each physician home visit. The increase in the budgeted capitation value of these copayments results from higher projected physician use.

EXHIBIT 2-5

ANNUAL ACR, HCFA CAPITATION AND MEMBERSHIP PAYMENT STATISTICS

	Benefit Period 1 Estimated	Benefit Period 1 Actual	Benefit Period 2 Estimated	Benefit Period 2 Actual	Benefit Period 3 Estimated	Benefit Period 3 Actual	Benefit Period 4 Estimated
MEMBERMONTHS	--	22,856	--	90,463	--	--	--
AAPCC							
Aged	$101.90	--	--	--	--	--	--
Disabled	134.75	--	--	--	--	--	--
Combined	103.06	$105.22	$119.63	$120.77	$147.00	$148.25	$174.15
COMMUNITY RATE (CR)	33.21	--	39.25	--	46.66	--	57.69
OVERALL ACR							
Aged	$ 97.88	--	--	--	--	--	--
Disabled	129.08	--	--	--	--	--	--
Combined	98.98	$114.96	$114.72	$119.31	$148.09	$134.77	$169.68
NET ACR							
Aged	$ 77.48	--	--	--	--	--	--
Disabled	97.95	--	--	--	--	--	--
Combined	78.20	--	94.27	--	122.89	--	138.68
HCFA CAPITATION							
HCFA Interim Payment to Plan	$ 94.53	$ 94.77	$112.55	$112.79	$141.82*	$141.82	$164.42
Benefit Stabilization Fund (BSF)	3.38	3.38	1.10	1.10	—	--	1.02
Retroactive Adjustment to BSF	--	1.81	--	1.07	--	1.19	--
TOTAL HCFA CAPITATION	$ 97.91	$ 99.96	$113.65	$114.96	$141.82	$143.01	$165.44
MEMBERSHIP PAYMENT							
Beneficiary Premium (covered by HCFA capitation)	$ 15.18	$ 15.18	$ 17.13	$ 17.13	$ 23.43	$ 23.43	$ 27.74
New Member Entry Program (covered by HCFA capitation)	1.15	1.15	1.15	1.15	.50	.50	1.00
Copayment	1.07	--	1.07	--	1.27	--	1.24
Project Enrollee Payment	--	--	--	--	5.00	--	3.00
TOTAL OUT-OF-POCKET PAYMENTS	1.07	--	1.07	--	6.27	--	4.24
HCFA CAPITATION PERCENTAGE							
of AAPCC	95.0%	95.0%	95.0%	95.2%	96.5%	96.5%	95.0%
of Overall ACR	98.9%	87.0%	99.1%	96.4%	95.8%	106.1%	97.5%
HCFA INTERIM PAYMENT as a PERCENTAGE							
of AAPCC	91.7%	90.1%	94.1%	93.4%	96.5%	95.7%	94.4%
of Overall ACR	95.5%	82.4%	98.1%	--	95.8%	105.2%	96.9%

*The interim payment is calculated thusly: .95 x 147.00 + $2.17 contribution from the BSF

Under the basic "Medicare-Plus" plan, KPMCP-O did not charge the beneficiary a premium, subsuming the estimated beneficiary contribution in HCFA's AAPCC payment. However, in the third and fourth benefit periods, KPMCP-O introduced a "project enrollee payment" (i.e., $5.00 in 1982 and $3.00 in 1983). This payment attempted to cover the difference between total ACR requirements and the sum of the HCFA payment (i.e., 95% of AAPCC) and projected beneficiary copayments. Since the KPMCP-O assumed that HCFA's payment would cover the beneficiary premium for the basic "Medicare-Plus" package, the enrollee payment represented that portion of the premium which could not be covered by the HCFA payment.

Supplemental Benefits

In addition to the basic "Medicare-Plus" package, KPMCP-O offered Medicare beneficiaries three optional packages with varying premiums. The Plan developed its first year premium for these optional packages based on its experience with Medicare members and on data from other Kaiser regions. While premiums were not increased in the second benefit period, by the third year premiums were adjusted upward. Premiums were as follows:

	1980/81	1982	1983
Plan B			
Rx, $1 Copayment	$ 4.45	$ 7.09	$11.23
Vision Care	1.00	1.71	1.80
Hearing Aids	.55	1.47	1.11
Total	$ 6.00	$10.27	$14.14
Plan C (Dental)	$ 9.81	$12.58	$17.78
Plan D (Plan B & Plan C)	$15.81	$22.85	$31.92

For the most comprehensive optional plan which included prescription drugs with a $1 copayment, vision care, dental care, and hearing aids the premium increased 44.5% in the third year and an additional 39.7% in the fourth year. Much of this increase can be attributed to increases in use and unit costs in the prescription drug benefit and an enhanced prosthetic dental care benefit.

Reported Experience

Exhibit 2-6 summarizes KPMCP-O's fiscal performance under the demonstration. Assuming a 100% collection of copayments, the fiscal impact for the first two benefit periods appears to be negative, with a favorable impact in the third benefit year.

EXHIBIT 2-6

FISCAL SYNOPSIS OF KPMCP-O (KAISER) DEMONSTRATION

PLAN REVENUE/EXPENSE ANALYSIS (Basic Benefit Package)

371-B/BC

	August 1980-December 1980		January 1981-December 1981		January 1982-December 19	
Membermonths	22,856		90,463		89,379	
	Dollars	PMPM	Dollars	PMPM	Dollars	PMPM
Revenue*	$2,309,000	$101.03	$10,496,000	$116.03	$13,342,000	$149.28
Expense	2,735,500	119.69	11,124,000	122.97	12,855,000	143.83
Period Surplus (Deficit)	($ 426,500)	($ 18.66)	($ 628,000)	($ 6.94)	$ 487,000	$ 5.45
Cumulative Surplus (Deficit)	($ 426,500)		($ 1,054,500)		($ 567,500)	

MAJOR CONTRIBUTORS TO PLAN'S SURPLUS (DEFICIT) POSITION (PMPM)

2-17

	Budgeted	Actual	Variance	Budgeted	Actual	Variance	Budgeted	Actual	Varianc
Extended Care	$3.00	$ 2.76	$ .24	$3.25	$3.97	($ .72)	$5.87	$3.12	$2.75
In/Out-of-Area Claims	$1.79	$22.64	($20.85)	$2.33	$8.95	($6.62)	$6.34	$2.87	$3.47
Other Benefits/Services	$2.00	$ .36	$ 1.64	$2.20	$1.75	$ .45	$1.95	$2.46	($ .51
Benefit Stabilization Fund	$3.38	$ 5.19	($ 1.81)	$1.10	$2.17	($1.07)		$1.19	($1.19
BENEFICIARY MONTHLY PAYMENT		--			--			$5.00	

HCFA PROSPECTIVE REIMBURSEMENT CALCULATION (95% of AAPCC)

	Budgeted	Actual	Variance	Budgeted	Actual	Variance	Budgeted	Acutal	Varianc
	$97.91	$99.96	($2.05)	$113.65	$114.96	($1.31)	$139.65	$140.84	($1.19
PROJECTED ACR		$99.98			$114.72			$148.09	

*There is not sufficient information available in any year to completely determine actual revenue.

371-C/BC/1

Observations about this performance are:

- The effect of the Benefit Stabilization Fund contributions of $5.19 PMPM in 1980 and $2.17 PMPM in 1981 do not enter into these estimates. Consideration of these monies would reduce the variance.

- KPMCP-O fully funded the beneficiary premium at $15.18 PMPM and the new member entry program at $1.15 PMPM within the HCFA capitation payment.

- In the first benefit period, In/Out-of-Area Claims were the greatest contributor to the negative variance (i.e., $20.85 PMPM). Total hospital use was 1647 days/1000 with 520 days/1000 occurring in non-Kaiser facilities. This out-of-plan use accounted for 32% of total hospital days and 33% of actual hospital costs.

- In the second benefit period, In/Out-of-Area Claims costs were again the major contributor to demonstration losses (i.e., $6.62 PMPM). Compared with a budget of 1800 days/1000, total hospital use was 1669 days/1000 with out-of-plan use contributing only 73 days/1000. Although it was only 4% of hospital days, out-of-plan use accounted for 12% of hospital costs.

- In the third benefit period, favorable variance for extended care and In/Out-of-Area claims accounted for the favorable fiscal impact. Hospital utilization was 1662 days per thousand at in-plan facilities.

KPMCP-O reported several ambulatory services use statistics for the first three years (all services are per thousand members per year):

	1980	1981	1982
Physician Visits	5677	5577	5808
Non-Physician Visits	2591	2389	2020
Laboratory	11,815	6918	-
X-Rays	1752	1129	-

Cost information was unavailable for the supplemental benefits. The following use of these benefits occurred during the first two benefit periods (all services are per thousand members per year):

	1980	1981
Prescription Drugs	9000	10700
Dental Visits	2300	3500
Dental Procedures	6600	9000
Eyeglasses (or contact Lenses) Dispensed	600	400
Hearing Aids Dispensed	60	120

Summary

KPMCP-O is operating in its fifth benefit period under the demonstration. Relevant financial statistics for the first three benefit periods are:

	Benefit Period 1	Benefit Period 2	Benefit Period 3	Cumulative
Membermonths	22,856	90,463	89,379	202,698
KPMCP-O Gain (Loss) From Operations	($426,500)	($628,000)	$487,000	($567,500)
HCFA Gain (Loss) as Measured Against APC/ AAPCC	$120,000	$547,000	$663,000	1,330,000

The cumulative loss for the Plan was the equivalent of $2.80 PMPM; the gain for HCFA was $6.56. KPMCP-O appears to have experienced a dramatic turn-around in the third benefit period. During the first two benefit periods, the cumulative loss was $628,000 for the basic Medicare-Plus package. This estimated loss should be seen from the perspective that the Plan had HCFA withhold $315,000 in a benefit stabilization fund and fully covered the beneficiary's contribution to premium and the enrollee education member entry program, foregoing potential revenue of over $1.8 million. Charging the beneficiary a premium would have easily negated these losses.

CHAPTER 3: Fallon Community Health Plan Rate Setting Discussion

3.1 Background

Fallon Community Health Plan (FCHP) is a group model HMO which began operations in February 1977, and became federally qualified in November 1978. Professional services are provided by the Fallon Clinic; a multi-specialty physician group practice in Worcester, Massachusetts. Blue Cross of Massachusetts (BC/M) provides the Plan with partial administrative services and reinsurance coverage.

FCHP initiated services under the Medicare Demonstration Project on April 1, 1980. Benefit periods are as follows:

- Year 1: April 1, 1980 - December 31, 1980
- Year 2: January 1, 1981 - December 31, 1981
- Year 3: January 1, 1982 - December 31, 1982
- Year 4: January 1, 1983 - December 31, 1983
- Year 5: January 1, 1984 - December 31, 1984

3.2 Description of the Benefit Package

Similar to Marshfield, FCHP offered only one set of benefits. Exhibit 3-1 outlines the initial year services compared with the standard Medicare package. The major variance in the benefits from the other sites is that FCHP included both prescription drugs (initially with a $1 copayment) and vision care as basic benefits costed in the ACR. The remainder of the benefit package contained similar enhancements provided at other sites:

- Full coverage of Part A and Part B copayments and deductibles.
- Expanded coverage of inpatient care to include unlimited number of days per admission at the semi-private room rate. Private room provided if medically necessary.
- Full coverage of care in a skilled nursing facility for up to 100 days per benefit period.
- Addition of preventive services such as physical exams, full coverage of immunizations, health education, allergy testing, hearing exams and vision exams.
- Increased mental health coverage, both inpatient and outpatient.

FCHP implemented three changes in the benefit package over the course of the demonstration, two of them in 1982. The prescription drug copayment was increased to $2 and the limitation on the number of vision exams within a time period was changed from 1 exam every 12 months to 1 exam every 24 months. The same change applied to dispensing of eyeglasses. For the 1984 benefit period, the Plan dropped the drug copayment.

SERVICES	MEDICARE PARTS A & B	
Inpatient Care	Part A Services: $180 deductible for first 60 days; copayment $45/day for days 61-90, $90/day for 60 lifetime reserve days	Covered in full - no limit
Outpatient Care & Physician Services Episodic	Part B Services: $60 deductible for calendar year; 80% reasonable charges	Covered in full - no limit
Lab & x-ray	[illegible]	[illegible]
Emergency Care	Part B [illegible] and 80% reasonable charges	Covered in full
Preventative 1-Physical Exam	Not covered	Covered in full
2-Immunization	Part B Services: Part of deductible & only for injury and immediate risk	Covered in full
3-Other	Not covered	Health education, allergy testing, hearing testing
Skilled Nursing Care	Part A Services: 20 days in full $22.50/day for days 21-100. 100 days per benefit period	Covered in full up to 100 per benefit period
Home Health Care	Part A Services up to 100 visits. Part B Services without prior hospitalization up to 100 visits, 80% coverage	Covered in full - no limit
Private Duty Nursing	Not covered	Covered in full

SERVICES	MEDICARE PARTS A & B	
Ambulance	Part B Services: 80% coverage	Covered in full
Mental Health Inpatient	Part A Services: $180 deductible and copayments as if an inpatient hospital above. 190 lifetime	Covered in full up to 90 days per benefit period in a psychiatric hospital and detoxification facility. General hospital stay covered in full.
Outpatient	Part B Services: Part of $60 deductible, but maximum of $250	Covered in full for 20 visits per calendar year or $500, whichever is greater.
Physical Therapy	Part A Services: Part of inpatient coverage	Covered in full
Radiation Therapy	Part A Services: Part of inpatient coverage	Covered in full
Hemodialysis Services	Special coverage. Covered in full	Covered in full
Prescription Drugs	Part A Services: Part of Inpatient coverage. Part B Services: Drugs that cannot be self-administered: 80% coverage	$1 copayment for drugs in Plan pharmacies
Eye Exam	Part B Services for eye surgery but not for eyeglasses	Covered in full for one examination per year
Eyeglasses	Part B Services. Coverage for contact lenses for post-cataract surgery patients. No other coverage	Coverage for only one set each year
Prosthetic Devices and durable Medical Equipment	Part B Services for devices that are used for internal organs and artificial limbs. No dentures; 80% coverage	Covered in full
Dental Care	Part B Services. Only if it involves surgery of jaw or setting of fractures	Oral surgical procedures and related x-rays. Routine care and peridonal surgery not covered

SERVICES	MEDICARE PART A & B	
Chiropractor Services	Part B Services: Only coverage for manipulation of spine to correct subluxation	Only coverage for manipulation of spine to correct subluxation when done at clinic
Podiatric Services	Part B Services: Coverage for all services except routine foot care	Coverage except for routine foot care or supportive devices.

3.3 Waivers and Variances

The Plan received prospective reimbursement, based upon a Plan established ACR, with no retrospective adjustments for the first four years. In 1984, the Plan was reimbursed under a rate book approach.

The waivers and variances relating to the health care delivery system were very similar to those in other sites. The Plan was allowed to reimburse providers in a manner not limited by Medicare reasonable cost guidelines. The existing criteria for admissions to SNFs were also relaxed, allowing flexible use of such facilities.

Enrollment related waivers and variances allowed the Plan to offer one basic benefit package. The Plan did not have to enroll ESRD eligibles or offer coverage to persons who only had Part B coverage.

As with the other sites, the Plan had minimal Medicare cost reporting requirements. HCFA also waived certain existing requirements as to the type of HMO with which they can contract, specifically the enrollment requirements.

3.4 Organization of the Medical Delivery System

Exhibit 3-2 describes the FCHP payment procedures for services and the risk sharing arrangement that the Plan employed. The Plan performs two types of activities; administrative services and medical care delivery. For administrative services, FCHP relies primarily on two sources; in-house staff and a capitation arrangement with Blue Cross of Massachusetts (BC/M). In FY81, administrative costs were $1,826,000; 41% paid to BC/M and the remainder spent in-house. In FY82 the administrative expenses were $2,519,000, with 39% paid to BC/M and in FY83 total administrative expenses were $3,088,000.

Medical services can be treated as either in-area or out-of-area. Overriding all of the medical services delivery is a reinsurance agreement with BC/M which initially afforded FCHP the following risk protection:

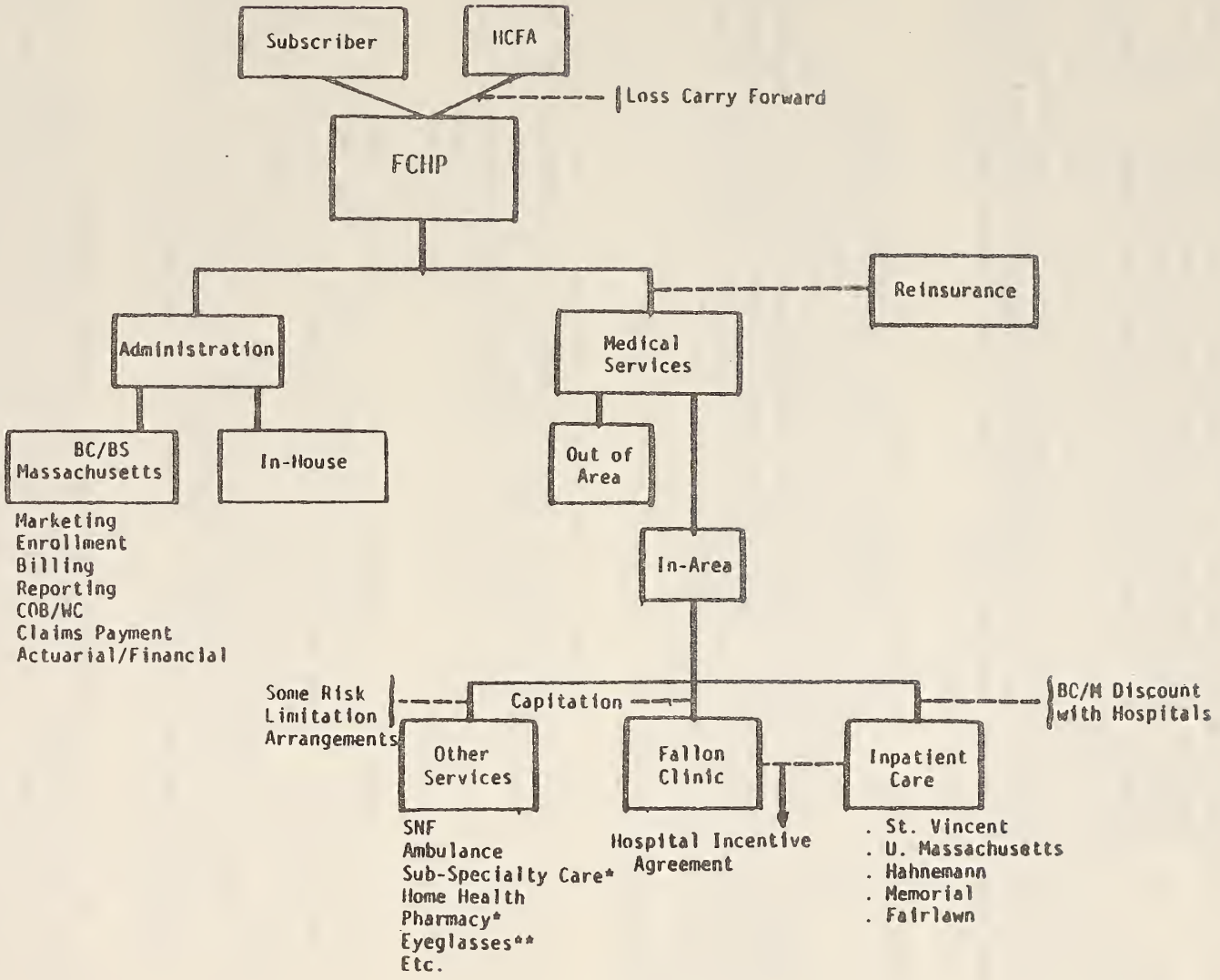
- Individual catastrophic occurrences. The deductible for the first three years was $25,000 per case, with an increase to $40,000 in 1983. In 1984, the Plan increased the deductible to $85,000. No mention of limit per case was provided in the reinsurance papers. The coverage above the deductible was 100%.

- Aggregate hospital utilization coverage. This service was only purchased for the first two benefit periods. In Year 1, coverage was provided if utilization exceeded 2,425 days/1,000 and in Year 2, this level was set at 2,530 days/1,000.

- Out-of-area emergency coverage. No deductibles or maximums were stated. BC/M processes and pays the FCHP out-of-area claims.

Exhibit 3-2

DIAGRAM OF FCHP's METHOD OF PAYMENT FOR SERVICE



*Capitated Beginning 1983
**Capitated Beginning 1980

- Insolvency. BC/M agrees to assume liability for all medical claims incurred and either reported or unreported prior to the time of insolvency. Additionally, BC/M agrees to provide care to individuals from the time of insolvency through the period for which the premium has been paid. Finally, conversion to BC/M group, non-group or Medex coverage is provided.

As mentioned, BC/M processes and pays all out-of-area claims. In-area services can be categorized as hospital inpatient, physician services or other services (e.g., vision care, skilled nursing care, and certain physician specialty care).

Inpatient Care

The Plan does not contract with any inpatient facility. FCHP reimburses hospitals through BC/M. FCHP contributes to a fund maintained by BC/M from which BC/M reimburses hospitals. Where BC/M receives a discount for hospital services, FCHP also receives this consideration in the final adjudication of the claim. Exhibit 3-2 shows the major FCHP inpatient providers.

Physician Services

The major provider of ambulatory services is the Fallon Clinic, which operates under a capitation arrangement for primary and general specialty care. Beginning in 1982, the Clinic accepted a capitation payment for rare and unusual services also denoted as sub-specialty care. The Clinic also capitates the Plan for physician services for the under-65 population.

The capitation arrangement and other operational elements between FCHP and the Fallon Clinic is outlined yearly in a memorandum of understanding. One feature of this agreement is a hospital incentive arrangement in which the clinic and FCHP share equally in savings below a pre-determined hospital use and per diem costs threshold. No incentive payments were made in 1980 or 1981, although $125,000 was advanced as an incentive for 1982, subject to re-evaluation after actual data became available. Actual incentive payments for 1982 were $859,000 and for 1983, _____.

An additional feature of the agreement between FCHP and the clinic is a referral trust fund managed by the Plan. Begun in 1982, the Plan places in a trust fund that portion of the Clinic's capitation designated for hospital outpatient, referral, and rare and unusual expenses. FCHP processes claims for these services and pays them from the fund. Prior to developing the fund, the clinic's liability of $1,567,000 for unpaid referral care had been paid by the Plan. A repayment schedule for this liability was also described in the 1982 memorandum.

Other Services

The other major services are prescription drugs, vision care, skilled nursing care, and physician sub-specialty care. The Clinic

provides prescription drugs and vision care on a capitated basis; vision care since the beginning of the demonstration and prescription drugs since 1982. The Clinic is responsible for collecting drug copayments.

FCHP contracted with a local skilled nursing facility for a set number of beds each month to assure access. The Plan initially guaranteed payment for two beds with access to four. This arrangement has grown to guaranteed payment for ten beds with availability of fourteen beds. Payment is based upon a negotiated per diem rate. The payment for physician sub-specialty care is now capitated by the Clinic. Ambulance and home health care are paid on the basis of prevailing charges.

3.5 Adjusted Community Rate Development and Fiscal Performance Benefit Period 1 (April - December, 1980)

FCHP used a mixture of approaches in calculating its initial ACR. FCHP used an actuarial approach where they believed reliable statistical information existed for the over-65 population. Where cost or use data were lacking, FCHP adjusted the experience of its under-65 enrollees. These adjustments borrowed data from the Kaiser program and applied these data to the experience of Fallon's under-65 enrollees. One rate was developed for a combined population of aged and disabled beneficiaries.

The major benefit categories were:

Institutional Services
Medical Care Services
New Services
Reinsurance
Administration
Bad Debt

Institutional Services

FCHP divided cost of institutional services into two major benefit categories, hospitalization and skilled nursing services.

1. Hospitalization

In establishing its Year 1 ACR, FCHP utilized data from the Medicare population served by Kaiser-Permanente of Northern California. The most current utilization figures (1977) from Kaiser indicated that the under-65 population's rate of hospital utilization was 372 days per 1000, and the over-65 population's rate of hospital utilization was 1677 days per thousand. For fiscal year 1980, FCHP projected its "under 65" hospital utilization to be 510 days per thousand. Therefore, the ratio of hospital utilization for the under-65 population between the two plans was 510 to 372, or 1.371 to 1.0. FCHP projected that this same ratio would hold for the over-65 population, and the level of utilization at Fallon would therefore be 1677 x 1.371 or 2300 days per thousand members. This application of ratios actually assumes a relationship of over-65 to under-65 bed day utilization within Fallon of 4.51 (2300/510).

Furthermore, FCHP projected a cost per day of hospital services at $299 per day, which translates to $57.31 per member per month (PMPM) for hospital services (i.e., 2.3 x $299/12).

2. Skilled Nursing Facility

Because the use of skilled nursing facilities represents a way an HMO can substitute for more expensive hospital days, FCHP desired to use HMO data to estimate SNF capitation, rather than relying on local fee-for-service data or adjusting the SNF experience of its under-65 enrollees. The most readily available information was from the Kaiser Foundation, which showed a use rate for Medicare beneficiaries of 1100 SNF days/1000 members.

To project the cost per day of SNF services, FCHP identified five facilities and averaged their daily costs. Incorporating an inflation factor yielded a projected daily cost of $63.16.

Medical Care Services

1. Fallon Clinic Services

FCHP contracts for professional services with the Fallon Clinic. During Year 1, this capitation included all primary and specialty referral care, with the exception of certain sub-specialty care (i.e., cardio-vascular surgery, neuro-surgery, thoracic surgery, plastic surgery and oral surgery). The Clinic agreed that in establishing a prospective rate for the over-65 population, the under-65 capitation would be inflated to account for the additional utilization per person, and for greater time required per visit.

Using statistics from seven other HMOs, an over-65/under-65 utilization ratio of 2.07 was established. In addition, the intensity factor of 1.2 used by HCFA's Group Health Plan Operations (GHPO) in cost contract reimbursement was applied. The negotiated under-65 capitation with Fallon Clinic was $15.30 for 1980. The initial calculation of the over 65 capitation yielded a figure of $38.00 (2.07 x 1.2 x $15.30). However, FCHP recomputed the capitation, applying the GHPO intensity factor only to costs directly involved in delivering care to patients. This recalculation resulted in a capitation of $37.53, with the following components:

Direct Patient Care Component:	$14.165 x 2.07 x 1.2	=	$35.185
Other Costs:	$1.135 x 2.07	=	2.349
		TOTAL	$37.534

Other costs included supplies and laundry, occupancy, insurance, telephone and depreciation.

2. Additional Benefits

The basic capitation of $37.53 was developed to cover the same set of benefits that FCHP had been delivering to their existing under-65 population. However, FCHP included additional benefits in its Medicare

capitation with Fallon Clinic. The cost for these services was developed separately from the cost of existing benefits, as follows:

- Refractions - FCHP provided eye examinations for prescribing, fitting, and changing of eyeglasses to Senior Plan members. The projected capitation assumed a rate of 66.7 refractions per 100 members per year. Using the known costs of the Fallon Clinic, a capitation of $1.62 was calculated and agreed upon between FCHP and the Clinic. Since this was a capitation, actual cost to FCHP was the same as projected cost.

- Miscellaneous - In order to ensure compatability with the Medicare program's benefits, prosthetic devices, durable medical equipment, installation of home hemodialysis equipment, physician visits for skilled nursing coverage in excess of 100 days per calendar year (100 days per benefit period covered), physician visits for patients in mental hospital and detoxification facility coverage in excess of 90 days per calendar year (90 days per benefit period covered), home visits, and home health aids were added to the FCHP standard benefit package. The total cost for these services was capitated at $.75 per membermonth.

3. Threshold Physicians

This provision in the agreement between FCHP and Fallon Clinic compensated the Clinic for newly hired physicians who initially may be underutilized. The Clinic hires most of its physicians during late summer; the traditional time when they become available upon completion of their residency. Since the Clinic hires partially in response to anticipated enrollment growth by FCHP, the Clinic requests FCHP's help in subsidizing the early stages of the physicians' employment. This concept was used in compensating the Clinic for new hires in anticipated response to both the under-65 population and the Medicare demonstration.

Based upon FCHP's projected year end enrollment, the Clinic was going to add three physicians. The cost of underutilization of these physicians until the membership forecast was attained was budgeted at approximately $85,000. Since FCHP projected 38,042 membermonths of care for the first year, the capitation payment was $2.23 PMPM (85,000/38,042). Specific contractual language provided for a decreased payment as enrollment increased. As the Plan grew and the size of the physician staff increased, the capability of the Clinic to accept a larger membership without threshold payments would increase. Therefore, both parties understood that the need for this special reimbursement might disappear.

4. Dedicated Space

A certain portion of fixed costs for physical plant was allocated to Senior Plan membership, projected to be 16% of the first year's total membermonths. However, the Plan felt that senior members would consume occupancy resources in a greater proportion than their percentage

of total plan membermonths. To quantify this increased demand, the Plan used the over/under ratio of 2.07 for physician services. Thus, the projected 38,042 Medicare membermonths would require occupancy resources as if it were 78,747 membermonths (2.07 x 38,042). After this calculation, Senior Plan enrollment represented 28.3% of "adjusted" annual membermonths, as noted below:

	Unadjusted Projections		Adjusted Projections	
Non-Senior Members	199,721	84.0%	199,721	71.7%
Senior Members	38,042	16.0%	78,747	28.3%
Total	237,763		278,468	

In the medical capitation, the Plan paid for one-half square foot per member year. Since the overall budget projected one square foot per member per year, the Plan rented from another source an additional 9,000 square feet of space, which was dedicated entirely to the Clinic operation. The provision of this space to the Clinic at no cost to the Clinic satisified the requirement that the Clinic be reimbursed for use of one square foot per member per year. The cost of this dedicated space was $92,032 and the resulting Senior Plan capitation was:

($92,032 x .281)/38,042 = $.68

5. Incremental Space

The Clinic was reimbursed for one-half square foot of space per member per year for the first 18,000 members, all within the existing medical capitation. The issue of dedicated space to cover the additional 9,000 square feet (1/2 x 18,000) has already been discussed. However, the Clinic noted they would need additional compensation when average membership exceeded 18,000. The calculation of adjusted membermonths shows an average enrollment of 23,206 (278,468/12), which represents 62,468 membermonths above the average of 18,000 members.

With this increased enrollment projection, more space would be needed. The same formula of reimbursing of one-half square foot per person per year was used. The cost of one-half square foot per month was $.56, translating into a cost of incremental space equal to $34,982 ($.56 x 62,468). The allocation to the senior program was:

($34,982 x .283)/38,042 = $.26 PMPM

6. Rare and Unusual Medical Expense

Subspecialty physician services were excluded from the Clinic capitation, and were FCHP's responsibility. The Plan was responsible for services including, but not limited to, cardiovascular surgery, neuro-surgery, and oral surgery. FCHP assumed that utilization of these services would be very infrequent. Additionally, the Plan had very little information upon which to base a projection. Therefore, the cost of these services was arbitrarily set at 1% of the Clinic capitation or $.37 PMPM. To this was added the services of a nephrologist, at an

estimated cost of $.31 PMPM. This cost was developed assuming .01 nephrologists/1000 members times the estimated cost of a full time nephrologist in private practice of $150,000 annually. To adjust this to an over-65 population, the intensity factor and the over/under multiplier were used as follows:

(.01 x $150,000 x 2.07 x 1.2)/12,000 = $.31

The total budget in the ACR was $.68.

New Services

"New services" refer to two items FCHP added to their basic benefit package; prescription drugs and eyeglasses.

1. Pharmacy

FCHP added pharmacy services to its benefit package. A $1.00 copayment was charged per prescription. The capitation amount was determined by first projecting utilization from a DHHS publication entitled "Inclusion of Pharmaceutical Services in Health Maintenance and Related Organizations." The average cost per prescription was estimated from the Medex program, Blue Cross' Medicare supplemental insurance program. Projected scripts per thousand enrollees per year was 11,600 at an estimated cost of $6.52 each; net of $1.00 copayment. This cost included the dispensing fee. The projected capitation was $6.30.

2. Eyeglasses

This benefit provided one pair of eyeglasses per year, including repairs. The Plan capitated the Clinic at $3.17 PMPM for this service, thus actual cost was equal to projected cost. The capitated amount was determined on the basis of .634 eyeglasses dispensed per person per year at a projected cost of $58.49 per pair of eyeglasses and .2 repairs per person per year at a cost of $5.00 per repair. If the cost of the repairs were added to the cost of the glasses, the combined statistics would be .634 eyeglasses per person per year at an overall cost of $60.00 per pair of eyeglasses.

Reinsurance

FCHP purchased four types of reinsurance coverage from BC/M:

- Aggregate Stop-Loss
- Individual Catastrophic
- Insolvency
- Out-of-Area

Reinsurance costs were capitated. Aggregate stop-loss cost $.59 PMPM and provided coverage if total hospitalization exceeded 2475 days per 1000. Individual catastrophic coverage cost $2.13 PMPM and provided reinsurance after medical expenses reached $25,000. Insolvency coverage, at $.27 PMPM, provided coverage for members if FCHP should fold. Out-of-area emergency reinsurance provided 100% coverage of all out-of-area emergency claims. This reinsurance cost $.36 PMPM.

Administration

1. Purchased Services

FCHP purchased certain administrative and marketing services from Blue Cross of Massachusetts. The agreed upon monthly fee was $3.225 per member. Since this was a cost pass through, actual and projected costs were identical.

2. Plan Administration

Included in the ACR calculations are salaries of plan administration personnel involved in administering the Senior Plan; a portion of plan overhead; HCFA specific costs; threshold administration (incremental costs to the clinic because of the Senior Plan) and bad debts. The HCFA specific costs included the cost of reporting individual Title XVIII accretions and deletions; the cost of an independently certified cost report and miscellaneous other expenses. These costs were allocated from total Plan budgeted costs based upon the percentage of Medicare membermonths.

FCHP Revenue, Benefit Period 1

FCHP collected revenue from two sources; HCFA and the beneficiary. HCFA's payment of $119.12 PMPM was 89.5% of the 1980 APC of $133.15. The ACR of $126.62 was very close to 95% of APC, and the Plan seriously considered not charging a premium. However, the Plan felt that should no initial premium be charged and costs escalated in Year 2 causing a premium requirement, it would be difficult to market the Plan. FCHP thus chose a monthly beneficiary premium of $7.50 reducing the HCFA reimbursement to $119.12 PMPM. The Plan has not reported any bad debt from failing to collect beneficiary premiums.

End Stage Renal Dialysis (ESRD) Beneficiaries

FCHP did not enroll ESRD eligibles under the demonstration and did not accept a capitation payment for anyone who became ESRD eligible after enrollment.

Fiscal Performance, Benefit Period 1
(April - December, 1980)

Exhibit 3-3 compares budgeted costs versus actual revenues. It shows revenues exceeding expenses by $4.47 PMPM for a surplus of $112,300. Analysis of the individual benefit categories follows.

1. Inpatient Care

For the nine-month benefit period, actual hospital use and cost were:

	Projected	Actual
Days Per Thousand Members Per Year	2300	2650
Cost Per Day	$299.00	$307.77
Resultant Capitation	$57.31	$67.97

EXHIBIT 3-3
FALLON COMMUNITY HEALTH PLAN
Year 1: April 1980 - December 1980
Capitation

	Budgeted	Actual	Variance Favorable	Variance Unfavorable
MEMBERMONTHS	38,042	25,116		12,926
EXPENSES				
• Institutional Services				
Hospitalization	$ 57.31	$ 67.97		$10.66
Skilled Nursing Services	5.79	1.44	$4.35	
• Medical Care Services				
Existing Benefits	37.53			
Refractions	1.62			
Miscellaneous	.75	40.34	2.73	
Threshold Physician	2.23			
Dedicated Space	.68			
Incremental Space	.26			
Rare and Unusual	.68	.19	.49	
• New Services				
Pharmacy (Net of Copayment)	6.30	6.30	--	
Eyeglasses	3.17	3.17	--	
• Reinsurance				
Hospital Aggregate Stop-Loss	.59	.59	--	
Individual Stop-Loss	2.13	2.13	--	
Insolvency	.27	.27	--	
Out-of-Area	.36	.36	--	
Reimbursement*	--	(6.76)	6.76	
• Administration				
Purchased	3.22	3.22	--	
In-House Salaries	1.59			
In-House Overhead	1.29	2.93	.80	
In-House HCFA Specific	.21			
Threshold Administration	.14			
• Bad Debt	.50			
TOTAL	$126.62	$122.15	$4.47	
REVENUES				
• HCFA	119.12	119.12	--	
• Beneficiary Premium	7.50	7.50	--	
TOTAL	$126.62	$126.62	--	
REVENUES LESS EXPENSES	$ --	$ 4.47	$4.47	

*Capitation includes the effect of the disputed aggregate stop-loss claims by FCHP.

These figures represent total hospital costs and bed days, inclusive of reinsurance reimbursement, incurred in the benefit period and reported as of June 1982.

For Year 1, FCHP's actual hospital capitation was 18.6% above budgeted costs. The negative variance of $10.66 per member per month can be completely attributed to excess utilization.

2. Skilled Nursing Facility

A comparison of projected versus actual cost for SNF services during 1980 was as follows:

	Projected	Actual
Days Per Thousand Members Per Year	1100	200
Cost Per Day	$63.16	$86.63
Resultant Capitation	$5.79	$1.44

FCHP discovered that local nursing homes tend to run at full capacity and could not guarantee a bed when needed. Unavailability of beds may have contributed to the large difference between projected and actual SNF use. By comparison, the Kaiser demonstration used 127 days/1000 in its first year and 563/1000 in its second year. While unit costs for SNF services were 37.2% greater than expected, under-utilization offset these higher costs.

Based on these results, FCHP contracted with a local nursing home to reserve two beds through guaranteed payment, with the option of up to four beds on an "as needed" basis. This arrangement has grown to 10 beds guaranteed, with an "as needed" availability of 14 beds. For example, in a 30-day month, FCHP will pay the nursing facility a payment equal to 30 times (i.e., 30 days x 10 beds) the negotiated per diem agreement.

3. Medical Care Services (Other Than Rare and Unusual Services)

Actual medical care payments to the Clinic for Year 1 were $2.73 PMPM less than the budgeted amount. The Clinic capitation for existing services was a negotiated, contractually obligated amount. Therefore, from the Plan's standpoint, actual costs and projected costs were the same. The variance was in the remaining medical care service categories.

It has yet to be determined whether the Clinic experienced a financial loss or surplus. The $37.53 medical services capitation is the price FCHP pays for professional services. Access to Clinic financial records is restricted. While Clinic costs of providing services to Medicare enrollees is not known, actual visits per member year were 10.27 for the Senior Plan and 5.09 for the under-65 group for the period April, 1980 through March, 1981; an "over/under ratio" of 2.02. This is very close to the projected weight of 2.07 that was used. Exhibit 3-4 shows selected utilization statistics.

EXHIBIT 3-4

SELECTED UTILIZATION STATISTICS[2] - YEAR 1

Ambulatory Encounters at Fallon Clinic (w/Refractions)		5,454
Office Visits	2,953	
Comp. Exam, Comp. Re-Exam and Limited Re-Exam	847	
Post-OP Visit	122	
Special Procedure - Office	226	
Complete Eye Exam	609	
Proctoscopic Exam	105	
Surgery - Office	59	
Complete Specialty Exam	234	
Limited Specialty Exam	137	
Remainder	162	
Hospital Encounters		331
Surgery Hospital	93	
Special Procedures - Hospital	56	
Consultant - Hospital	80	
Medical Hospital Care	102	
Miscellaneous Services		
Lab Tests	5,079	
X-ray	1,432	
Injections	335	

2 Note that all utilization numbers are presented in terms of number of services per thousand enrollees per year and were taken from the December 1980 utilization run.

4. Medical Care Services (Rare and Unusual Medical Expense)

Actual costs were $.19 PMPM. When compared with the budget of $.68 PMPM, a favorable variance of $.49 PMPM resulted.

5. Reinsurance

Reinsurance costs were fixed through capitation arrangements with BC/M. From FCHP's perspective, budgeted reinsurance costs equalled actual costs. Actual reinsurance costs and the extent of BC/M payments are, however, in dispute. Under aggregate stop-loss reinsurance, FCHP claims BC/M owes them $83,000; based on 281 excess hospital days. BC/M contends these hospital days have not been paid by FCHP, only accrued to hospital cost. For purposes of analysis, reinsurance reimbursement includes the $83,000. For individual catastrophic coverage, FCHP estimated BC/M's payment at $87,000. Therefore, FCHP reported approximately $170,000 in reinsurance reimbursement. It should also be noted that for out-of-area emergency reinsurance, BC/M paid out approximately $1200 more than they received in premium or about $.05 PMPM.

In summary, reinsurance, including the disputed aggregate stop-loss claim saved the Plan $6.76 PMPM in medical costs. Since BC/M was unaware of their true loss until the third benefit period, FCHP's reinsurance premium did not change during the second benefit period.

6. Prescription Drugs and Eyeglasses

For prescription drugs, actual expenses compared to projected use and costs are as follows:

	Projected	Actual
Scripts Per Thousand Per Year	11600	9400
Cost Per Script (net of $1.00 copayment, but includes dispensing fee)	$6.52	$8.04
Cost PMPM	$6.30	$6.30

The actual utilization of services was less than budgeted (9400 Rx/1000 versus 11600 Rx/1000) but the unit cost per Rx was greater ($8.04 versus $6.52).

For eyeglasses:

	Projected	Actual
Eyeglasses Dispensed Per Thousand Per Year	634	656
Cost Per Eyeglasses	$60.00	$48.22
Capitation	$3.17	$2.64

The actual numbers consisted of .656 eyeglasses dispensed per person per year at an average cost of $47.93 and .01 repairs per person per year at a cost of $19.02.

The actual cost to the Clinic of providing this service proved to be 17% less than projected, due largely to the positive variance on the unit cost of eyeglasses. However, since the Clinic was capitated, the cost to FCHP was equal to budget.

7. Administration

In-house administration costs were reported to be $2.93 PMPM; $.80 PMPM less than budgeted costs. The cost of purchased administrative services was equal to the agreed upon capitation of $3.22.

3.6 Adjusted Community Rate Development and Fiscal Performance Benefit Period 2 (January - December, 1981)

FCHP had to develop second year rates before the end of Year 1. Therefore, with only four months of enrollee experience upon which to base second year rates, FCHP's method for rate setting remained essentially unchanged. The Year 2 rates were basically developed by inflating the previous year's projections.

Institutional Services

1. Hospitalization

The budgeted number of hospital days was essentially the same as Year 1 (i.e., 2295 days/1000 members). When actual 1980 data revealed a much higher use rate, it was too late to adjust the 1981 budget. The projected per diem was $314.28, which was 5.1% greater than in Year 1.

2. Skilled Nursing Service

FCHP reduced budgeted utilization from 1100 days per thousand to 443 days per thousand. The initial results from Year 1 showed very little utilization. The cost per day for Year 2 was projected at $65.55: a 3.8% increase over the 1980 budget. This estimate was 30% less than the eventual actual Year 1 experience.

Medical Care Services

1. Existing Benefits

For Year 2, the capitation budget for existing benefits was $40.72. This number was derived by adjusting the under 65 capitation of $17.30 as follows:

	Under 65 Capitation	Senior Plan Capitation
Direct Medical Services	$15.31 x 1.2 x 2.00	= $36.74
Non-Medical Services	1.99 x 2.0	= 3.98
	$17.30	$40.72

An over/under multiplier of 2.0 was used and the GHPO intensity factor of 1.2 was applied only to the component of the under-65 capitation directly pertaining to the delivery of medical care. The remaining $1.99

of the under-65 capitation was for insurance, telephone, depreciation and occupancy, with occupancy costs being projected at 1.39 PMPM.

The actual component of the Year 1 existing benefit capitation which was budgeted for occupancy is not known. However, the $1.39 PMPM is quoted as "a considerable increase". Of the $40.72 number, $2.78 was for occupancy. With such a large component for occupancy, separate projections for incremental rent and dedicated space were not forecast. No separate projection for threshold physician was made.

2. Rare and Unusual

The budget for this category was projected as follows:

Subspecialty Care:	.01 x $40.72 =	$.41 PMPM
Nephrologist:	=	$.32 PMPM
		$.73 PMPM

3. Refractions

The assumption for refractions was the same as in Year 1 except that unit cost was increased from $29.14 to $30.00

4. Miscellaneous

All assumptions for this category remained unchanged. An 8% inflation factor was used to derive the $.81 PMPM.

New Services

1. Pharmacy

The projected capitation assumed 11.2 Rx/person per year. At a 1981 cost/Rx of $7.59 and a dispensing fee of $1.75/Rx, the budgeted capitation, net of the $1.00 copayment, was $7.78. The prescription budgeted utilization was 3.4% less than Year 1 budget but 19.1% greater than Year 1 experience.

The projected unit cost was 27.9% greater than the Year 1 budget but only 3.7% greater than the final Year 1 experience.

2. Eyeglasses

Eyeglasses were budgeted at $3.31 PMPM, which was a 3.4% increase over the Year 1 projection.

Reinsurance

BC/M again provided reinsurance to FCHP on a contractual basis. FCHP's actual costs were thus equal to the budget. The quoted capitations were as follows, with the difference in coverage being the increase in aggregate stop-loss to a level of 2530 days/1000:

Hospital Aggregate Stop-Loss	$.71
Individual Stop-Loss	$2.81
Insolvency	$.30
Out-of-Area	$.50

The total projection of $4.32 PMPM represented a 29.0% increase over the Year 1 budget.

Administration and Bad Debt

The administrative capitation with BC/M was set at $2.52 PMPM, which was approximately 22% less than in 1980. The budget for the in-house portion of administrative costs and bad debt was:

Salaries	$1.56 PMPM
Overhead	$.83 PMPM
HCFA Specific	$.41 PMPM
Bad Debt	$.50 PMPM

The administrative costs were 13.5% less than budgeted in Year 1, with the major differences being a lower overhead forecast and no separate line item for threshold administration. Bad debt was the same as in Year 1.

Revenue Sources

Budgeted costs of $127.69 represented virtually no increase over FCHP's first year ACR. While the shift from APC to AAPCC reduced the base of the HCFA capitation approximately 5% (i.e., $133.15 to $126.54), HCFA reimbursement increased from 89% of the APC to 95% of the AAPCC (i.e., $119.12 to $120.19). The beneficiary premium remained unchanged at $7.50 PMPM.

Fiscal Performance, Benefit Period 2
(January - December, 1981)

Exhibit 3-5 provides a comparison of budgeted versus actual costs for the second year. The financial results for Year 2 were unfavorable with expenses exceeding revenues by $8.87 PMPM. On the basis of 64,320 membermonths for the year, plan expenses were approximately $571,000 over budget. An examination of the separate benefit categories follows.

1. Inpatient Care

Reported utilization was 2,521 days/1000 and cost per day was $364.35. Usage was 226 days/1000 over budget and per diem was $50.07 greater, resulting in an unfavorable variance of $16.44 PMPM. Note that this analysis does not consider the reinsurance reimbursement or the loss carry-forward payment, both of which are discussed later.

EXHIBIT 3-5
FALLON COMMUNITY HEALTH PLAN
Year 2: January 1981 - December 1981
Capitation

	Budgeted	Actual	Variance Favorable	Variance Unfavorable
MEMBERMONTHS	60,840	64,320	3,480	
EXPENSES				
• Institutional Services				
Hospitalization	$ 60.11	$ 76.55		$16.44
Skilled Nursing Services	2.42	3.93		1.51
• Medical Care Services				
Existing Benefits	40.72			
Refractions	1.67	43.41		.21
Miscellaneous	.81			
Rare and Unusual	.73	1.21		.48
• New Services				
Pharmacy				
(Net of Copayment)	7.78	8.12		.34
Eyeglasses	3.31	3.31	--	
• Reinsurance				
Hospital Aggregate Stop-Loss	.71	.71	--	
Individual Stop-Loss	2.81	2.81	--	
Insolvency	.30	.30	--	
Out-of-Area	.50	.50	--	
Reimbursement	--	(4.35)	4.35	
• Administration				
Purchased	2.52	2.52	--	
In-House Salaries	1.56			
In-House Overhead	.83	3.27	.03	
In-House HCFA Specific	.41			
• Bad Debt	.50			
• HCFA Loss Carry Forward	--	(5.73)	5.73	
TOTAL	$127.69	$136.56		$ 8.87
REVENUES				
• HCFA	120.19	120.19	--	
• Beneficiary Premium	7.50	7.50	--	
TOTAL	$127.69	$127.69	--	
REVENUES LESS EXPENSES	$ --	(8.87)		$ 8.87

2. Skilled Nursing Services

Utilization was 514 days/1000, representing a 71 day/1000 unfavorable variance from budget. The actual cost per day was $91.82 which was $26.27 higher than budget. The resultant capitation of $3.93 PMPM was $1.51 PMPM greater than budget. The lesser budget is explainable since even preliminary first year results indicated little utilization. However, after the contract with the local nursing home and some adjustment by the physician cadre, utilization increased.

3. Medical Care Services

Since these services remained capitated, budgeted and actual expenses are the same. However, it appears the Clinic experienced significant losses when compared with Year 1.

Exhibit 3-6 shows a 34% increase in the incidence of ambulatory services per thousand members per year, as well as an increase of over 100% in the incidence of hospital encounters. Coupled with this increased use are the following Year 1 versus Year 2 capitation experiences for selected medical services:

	Year 1	Year 2
Medical Referral (within existing benefits)	$4.61	$9.37
OPD Services	$1.19	$4.28
Rare and Unusual	$ .19	$1.21

For Rare and Unusual Services, the actual capitation was $1.21; an unfavorable variance of $.48 PMPM.

4. New Services

Pharmacy services showed an unfavorable variance of $.34 PMPM, mainly due to higher unit cost. For eyeglasses, the resultant capitation was $1.78, which was much lower than the budget. However, FCHP's cost was still $3.31 PMPM.

5. Reinsurance

As of the writing of the report, the only expected cost offset was for individual stop-loss for an amount of $4.35 PMPM.

6. Administration and Bad Debt

The cost of purchased services was as budgeted and the cost of in-house administration was reported to be $3.27 PMPM, $.03 PMPM less than budgeted.

7. Loss Carry-forward

In FCHP's contract with HCFA was a provision for a loss carry over from Year 1 to Year 2 for institutional services. After further discussions with HCFA, FCHP was allowed to compute the carry-forward based upon institutional losses in January - March, 1981. The size of

EXHIBIT 3-6
SELECTED UTILIZATION STATISTICS[3] - YEAR 2

Ambulatory Encounters at Fallon Clinic (w/Refractions)	7,327
Office Visits	4,297
Comp. Exam, Comp. Re-Exam and Limited Re-Exam	778
Post-Op Visit	238
Special Procedure - Office	304
Comp. Eye Exam	534
Procto	105
Surgery - Office	123
Comp. Specialty Exam	292
Limited Specialty Exam	289
Remainder	367
Hospital Encounters	682
Surgery Hospital	188
Specialty Proc. - Hospital	78
Consultation - Hospital	201
Medical Hospital Care	215
Miscellaneous Services	
Lab Tests	5,997
X-Ray	1,434
Injections	504

[3] Note that all utilization numbers are presented in terms of number of services per thousand enrollees per year and were taken from the December, 1981 utilization run.

this adjustment was $368,549, which has been shown as a $5.73 PMPM offset to costs in the second year ($368,549/64,320).

8. Revenue

Reported revenue was equal to budget.

3.7 Adjusted Community Rate Development and Fiscal Performance Benefit Period 3 (January - December, 1982)

Significant changes occurred in the ACR for this period. Basic to these changes was the availability of actual enrollee experience.

FCHP's budgeted capitation requirements increased 25.2% (i.e., $127.69 to $159.87), while Year 3 budgeted costs were 17.1% greater than Year 2 actual costs. FCHP doubled the enrollee premium to $15.00 PMPM, effective January 1, 1982.

The following discussion is restricted to rate development.

Institutional Services

1. Hospitalization

Projected hospital utilization for Year 3 increased to 2600 days per 1000 members, reflecting Fallon's experience. Budgeted unit hospital cost was $403.42 which generated a capitated amount of $87.41. This is an increase from a budgeted amount of $60.11 PMPM in the previous year but compares to the Year 2 actual costs of $76.55 PMPM.

2. Skilled Nursing Services

The Plan intended to lease an average of 10 beds which implied a financial obligation to pay for 3650 bed-days. The budgeted average annual enrollment was 6158 members. The resultant projected utilization per thousand members per year was 593 (3650/6158). This utilization was rounded to 600 days/1000 and at an average per diem of $100, the capitation was $5.00. This compared with an experience of $3.93 PMPM in 1981.

Medical Services

1. Existing Benefits

The adjustment to the under-65 capitation to develop the Senior Plan cost was:

	Under-65 Capitation		Senior Plan Capitation
Direct Medical Services	$16.98 x 1.2 x 2.0	=	$40.75
Non-Medical Services	2.21 x 2.0	=	4.42
	$19.19		$45.17

The $45.17 capitation represented a 10.9% increase from the Year 2 budget.

2. Rare and Unusual Medical Expense

The same assumptions as in the first two years were used with an inflation of 10.9% over Year 2 budget applied.

3. Refractions

The unit utilization was lowered to 400 refractions/1,000 and the $30 unit cost was inflated to $33.30 to yield the 1982 capitation estimate of $1.11.

4. Miscellaneous

For this category, the Year 2 budget was inflated 10.9%.

5. Auburn Medical Facility Occupancy Costs

Since November, 1980, FCHP has owned a 20,000 square foot facility in Auburn, Massachusetts and has leased the facility to the Fallon Clinic. However, the Clinic payments do not cover the entire cost of the facility. Uncovered costs were projected to be $214,700 for 1982. Using a similar methodology from prior years, since the senior program represented 16.2% of the unadjusted total membermonths, the senior membership was allocated 16.2% of the expense:

$$(\$214,700 \times .162)/73,900 = \$.47$$

New Services

1. Pharmacy

The pharmacy budget for Year 3 reflected an increase in copayments from $1.00/Rx to $2.00/Rx and a reduction in projected utilization from 11.2 prescriptions per person per year to 9.97. The resultant capitation was $7.09 as compared with a budget of $7.78 PMPM in Year 2 and an actual capitation of $8.12. Note that for Year 3, the Clinic was capitated for this service.

2. Eyeglasses

FCHP used actual experience from the first two years plus a reduction in the benefits to justify lowering the utilization and unit cost for this service. There were two components involved in pricing this service, the cost of new glasses and the cost of repairs. The new utilization assumptions were:

	Year 1 and 2 Utilization Assumptions	Year 3 Utilization Assumptions
New Glasses	634/1,000	283/1,000
Repairs	200/1,000	20/1,000

The cost for Year 3 was calculated as follows:

New Glasses	(283/1,000 x $56.01)/12 =	$1.32
Repairs	(20/1,000 x $19.48)/12 =	.03
		$1.35

Reinsurance

The Plan only purchased three types of coverage for 1983; individual stop-loss, insolvency, and out-of-area. The cost for individual stop-loss in excess of $25,000 increased to $3.09 PMPM from $2.81 PMPM the prior year. The cost for insolvency decreased, from $.30 PMPM to $.18 PMPM and the cost for out-of-area coverage jumped from $.50 PMPM to $1.11 PMPM.

Administration and Bad Debt

The cost for purchased services from BC/M dropped from $2.52 PMPM to $1.84 PMPM, while the projection for in-house administration rose from $2.80 PMPM to $3.34 PMPM. In-house administration was calculated as in the prior year, with an allocation of total plan administration to the Senior Plan based upon the percentage of total membership represented by the senior members and identification of specific Medicare marketing costs, as follows:

Allocation of Plan Administration	($1,335,224 x .162)/73,900 = $2.93
Senior Plan Specific	$27,189/73,900 = $.37

The Plan also increased the estimate for bad debt, from $.50 PMPM to $1.00 PMPM, justified because of the increase in the beneficiary premium:

.0667 x 15.00 = $1.00

Revenue Sources

The same two sources of reimbursement were projected as in prior years. The HCFA reimbursement was $144.87 which was 95% of the AAPCC (.95 x $152.49). The monthly beneficiary premium was raised from $7.50 to $15.00, a move that FCHP felt was necessary after comparing the ACR and the HCFA payment:

	ACR	$159.87
Less:	HCFA Payment	144.87
	Necessary Revenue	$ 15.00

Fiscal Performance, Benefit Period 3
(January - December, 1982)

FCHP's performance in Year 3 showed a marked turnaround from Year 2. Exhibit 3-7 presents a comparison of budgeted versus actual which shows that revenues exceeded expenses by $7.47 PMPM. The total dollar amount of the gain was $555,000 ($7.47 x 74,295). To understand

EXHIBIT 3-7
FALLON COMMUNITY HEALTH PLAN
Year 3: January 1982 - December 1982
Capitation

	Budgeted	Actual	Variance Favorable	Variance Unfavorable
MEMBERMONTHS	73,900	74,295	395	
EXPENSES				
• Institutional Services				
Hospitalization	$ 87.41	$ 70.58	$16.83	
Skilled Nursing Services	5.00	5.77		.77
• Medical Care Services				
Hospital Incentive Payment to Physicians	--	11.56		11.56
Existing Benefits	45.17			
Refractions	1.11	47.99		
Miscellaneous	.90			
Rare and Unusual	.81			
Auburn Medical Facility Occupancy Costs	.47	.52		.05
• New Services				
Pharmacy (Net of $2.00 Copayment)	7.09	7.18		.09
Eyeglasses	1.35	1.35	--	
• Reinsurance				
Hospital Aggregate Stop-Loss	3.09	3.09	--	
Individual Stop-Loss	.18	.18	--	
Out-of-Area	1.11	1.11	--	
Reimbursement	--	(2.43)	2.43	
• Administration				
Purchased	1.84	1.89		.05
In-House Salaries/Overhead	2.97	3.61	.73	
In-House HCFA Specific	.37			
• Bad Debt	1.00			
TOTAL	$159.87	$152.40	$ 7.47	
REVENUES				
• HCFA	144.87	144.87	--	
• Beneficiary Premium	15.00	15.00	--	
TOTAL	$159.87	$159.87	--	
REVENUES LESS EXPENSES	$ --	$ 7.47	$ 7.47	

the composition of this margin, an examination of the individual cost categories is necessary.

1. Inpatient Care

The most recent update of Year 2 hospital utilization showed a utilization of 1,878 days/1000, a cost per day of $451.00 and a capitation of $70.58. The utilization was 722 days/1000 less than budgeted (27.8% decrease) as well as 643 days/1000 less than the Year 2 experience. The cost per day was above projection by 11.9% and above the Year 2 experience by 23.8%.

2. Hospital Incentive Payment

FCHP has a hospital incentive arrangement with the Clinic, both for the Senior Plan and for the commercial population. The sharing formula allowed payments if either utilization and/or cost per day were below target. The dollar value of payment (per the 1982 audited financial statement) was $858,600, which represented a PMPM of $11.56 ($858,600 / 74,295). Since nothing was budgeted, this figure represents an unfavorable variance. However, this expense was incurred to assist in the lowering of inpatient utilization. The combination of the payment with inpatient cost shows a favorable variance of $5.27 PMPM ($16.83 - 11.56).

3. Skilled Nursing Services

Members used services at the rate of 535 days/1000 with an average cost of $108 per day. This experience translates into a capitation of $4.82. However, the Plan contracted for 4,284 days at an average cost of $100 per day, for a capitation of $5.76.

4. Medical Care Services

The payment to the Fallon Clinic equalled the budget for existing benefits, refractions, rare and unusual services and miscellaneous services. Actual expenses (less rental income) for the Auburn Facility was $.52 PMPM for all FCHP enrollees, with Medicare participants being costed equally with non-Medicare members.

Exhibit 3-8 presents selected utilization statistics for Year 3. The utilization per thousand members per year for total ambulatory encounters decreased by 4.9% from Year 2 to Year 3 hospital encounters declined by 12.8%, lab tests increased by 1.9% and X-ray procedures declined by 11.4%.

5. New Services

The pharmacy services experience was $7.18 PMPM (net of the $2.00 copayment), for an unfavorable variance of $.09 PMPM. The payment to the Clinic for vision care equalled the agreed upon capitation of $1.35.

EXHIBIT 3-8
SELECTED UTILIZATION STATISTICS[2] - YEAR 3

Ambulatory Encounters at Fallon Clinic (w/Refractions)		6,970
Office Visits	4,250	
Comp. Exam, Comp. Re-Exam and Limited Re-Exam	662	
Post-Op Visit	187	
Special Procedure - Office	291	
Comp. Eye Exam	301	
Procto	63	
Surgery - Office	123	
Comp. Specialty Exam	147	
Limited Specialty Exam	378	
Remainder	386	
Hospital Encounters		595
Surgery Hospital	116	
Specialty Pro. - Hospital	121	
Consultation - Hospital	176	
Medical Hospital Care	182	
Miscellaneous Services		
Lab Tests	6,110	
X-Ray	1,270	
Injections	490	

[2] Note that all utilization numbers are presented in terms of number of services per thousand enrollees per year and were taken from the December, 1982 year-to-date utilization run.

6. Reinsurance

Reinsurance costs were equal to costs budgeted and reimbursement payments were $2.43 PMPM as of the writing of this report.

7. Administration and Bad Debt

The reported cost of purchased services was 1.89 PMPM; $.05 PMPM over budget. The cost of in-house administration was reported to be $3.61 PMPM, which was $.73 PMPM less than budget.

8. Revenue

Reported revenue was equal to budget.

3.8 Adjusted Community Rate Development and Fiscal Performance Benefit Period 4 (January - December, 1983)

The final ACR for Year 4 (calendar 1983) was submitted in June of 1982. The cost analysis is similar to the prior years' submissions. The budgeted cost per member per month increased 20.1% over the 1982 budget and 26.0% over reported 1982 expenses. The projected HCFA payment increased 22.2% while the beneficiary premium remained constant. A brief description of the projections is given in this section.

Institutional Services

1. Hospitalization

FCHP projected 2,411 days/1,000 utilization at an average per diem of $540.19 to yield a capitation of $108.53. The Plan derived these estimates using volume and time and complexity factors applied to the under-65 budget as well as examining directly the cost and utilization experience of the Senior Plan through April 1982.

2. Skilled Nursing Services

FCHP leased 10 beds for 1983, with a guarantee of having 12 beds available at all times. The projected negotiated per diem was $115.12. The obligation to pay for 10 beds, assuming an average membership of 6,967 (83,600/12), translates into a utilization of 524 days/1,000:

$$(10 \times 365) / 6,967 = 524/1,000$$

If the Plan paid for 12 days, the utilization would be 629 days/1,000. The 1982 experience through April was 593 days/1,000. Therefore, FCHP budgeted 615 days/1,000, for a capitation of:

$$(615/1,000 \times \$115.12) / 12 = \$5.90$$

Medical Care Services

1. Existing Benefits

The development of the Senior Plan capitation was:

	Under 65 Capitation	Senior Plan Capitation
Direct Medical Services	$18.03 x 1.2 x 2.3	= $49.76
Non-Medical Services	$2.36 x 2.3	= 5.43
		$55.19

FCHP used more recent data to set the over/under ratio at 2.3. This compares with the ratio of 2.0 used in prior years.

2. Rare and Unusual

The actual cost of these services has proven to be much larger than budgeted. In 1981, per the Plan's financial statements, the cost was $1.21 PMPM. In 1982, FCHP again only budgeted .81 PMPM. However, for the 1983 benefit period, FCHP based their budget on the experience in 1981, with an adjustment for inflation. Their projection used an experience of $1.30 PMPM in 1981, inflated 10.7% to arrive at the budget of $1.44 PMPM for 1983. As in 1982, this service was capitated with the Clinic.

3. Refractions

An incidence of 310 refractions/1,000 at a unit cost of $37.50 was used to derive the capitation:

$$(310/1{,}000 \times \$37.50) / 12 = \$.97$$

This compared with 400 refractions/1,000 budgeted in 1982 at an average cost of $33.30.

4. Miscellaneous

FCHP actuarially determined that durable medical equipment would cost $.07 PMPM and home hemodialysis would cost $.02 PMPM. However, they stated in their submission that they had no adequate means to cost the additional items and thus were dropping this category as a separate capitated item. Since the projected cost in 1982 was $.90 PMPM, this decision to eliminate it is not a minor one. However, the existing benefits clinic capitation did increase by 22.2% ($55.19 versus $45.17). Therefore these costs have merely been included in this payment.

5. Auburn Occupancy Costs

This capitation was set at $.49, using the percentage of Senior Plan enrollment to total enrollment to apportion net Auburn Clinic costs:

$$(\$258{,}630 \times .157) / 83{,}600 = \$.49$$

New Services

1. Pharmacy

FCHP projected 10.7 Rxs per person per year at an average prescription price of $12.704. The cost per prescription was derived using the pure drug cost for January-April, 1982, inflated at an annual rate of 11.5% to derive a July 1983 cost plus a $2.25 dispensing fee. However, a $2.00 copayment was subtracted to yield a net prescription cost of $10.704 and a net capitation of:

$$(10,700/1,000 \times \$10.704) / 12 = \$9.55$$

2. Eyeglasses

Following the methodology from the Year 3 submission, the cost was:

New Glasses	(207/1,000 x $56.92) / 12 =	$.98
Repairs	(10/1,000 x $14.24) / 12 =	.01
		$.99

The utilization of new glasses was projected to drop from the Year 3 budget of 283/1,000 to 207/1,000.

Reinsurance

Again, only three components of reinsurance were purchased. The cost of individual stop-loss was $2.04 PMPM. However, this coverage was for claims in excess of $40,000 versus $25,000 in prior years. The same policy as was used in the first three years would have cost $4.94 PMPM. Insolvency cost increased from $.18 PMPM to $.28 PMPM and out-of-area remained at $1.11 PMPM.

Administration and Bad Debt

The cost for purchased services was set at $2.13 PMPM, an increase over the $1.84 budgeted in Year 2. In-house costs were budgeted at $3.34 PMPM, derived as follows:

Allocation of Plan Administration	($1,657,313 x .157)/83,600 =	$3.11
Senior Plan Specific	$18,968/83,600 =	.23
		$3.34

The bad debt calculation was lowered dramatically, from $1.00 PMPM to $.06 PMPM. This drop was based upon actual bad debt experience from April 1980 through December 1981.

Revenue Sources

The HCFA reimbursement of $177.02 PMPM was calculated at 95% of the AAPCC (.95 x $186.34). Using the ACR requirement of $192.02, the beneficiary premium was held at $15.00 per month:

	ACR	$192.02
Less:	HCFA Payment	177.02
	Necessary Revenue	$ 15.00

Fiscal Performance, Benefit Period 4
(January - December, 1983)

FCHP's Financial Performance for 1983 showed a dramatic improvement over prior years. Exhibit 3-9 gives a comparison of budgeted vs actual that shows revenues exceeding expenses by $23.51 PMPM, for a total dollar gain of $2,014,000 ($23.51 x 85676). The per member per month gain was 215% greater than the 1982 result. A discussion of the actual experience for each cost category is provided. FCHP reported 85,676 membermonths for the senior program in 1983 as of 9/84. For purposes of this analysis, the September count was used.

1. Inpatient Care

The most recent analysis of 1983 hospital usage was dated 9/84 and showed 13,900 days of care at a cost per day of $464.34. The utilization per thousand per year was 1,947 days and the actual PMPM was $75.34. Since September data was used, the reported information may vary slightly from the costs reported in the Plan's 1983 audited statements completed earlier in the year. Actual utilization was 19.2% lower than projected and 3.7% greater than 1982 experience. The cost per day was 3.0% greater than the prior year's experience and 14.0% less than projected.

2. Hospital Incentive Payment

The estimated physician incentive payment for 1983 was $1,487,000 which represented a PMPM of $17.36 (1,487,000/85,676). Since no budget was established, this figure represents an unfavorable variance. However, the combination of this payment with the inpatient cost shows a favorable variance of $15.83 PMPM ($33.19-$17.36).

3. Skilled Nursing Services

The experience for 1983, reported as of 9/84, showed a utilization of 541 days/1000 at an average cost per day of $102.29. The resultant PMPM was $4.62. Utilization was 1.1% greater than 1982 experience and 12% less than the 1983 budget. Similarly, the cost per day was 5.3% less than in 1982 and 11.1% less than budgeted.

EXHIBIT 3-9
FALLON COMMUNITY HEALTH PLAN
Year 4: January 1983 - December 1983
Capitation

	Budgeted	Actual	Variance Favorable	Variance Unfavorable
MEMBERMONTHS	83,600	85,676	2076	
EXPENSES				
• Institutional Services				
Hospitalization	$108.53	75.34	33.19	
Skilled Nursing Services	5.90	4.62	1.28	
• Medical Care Services				
Hospital Incentive Payment to Physicians	--	17.36		17.36
Existing Benefits	55.19	52.74	4.86	
Refractions	.97			
Rare and Unusual	1.44			
Auburn Occupancy Costs	.49	.33	.16	
• New Services				
Pharmacy (Net of $2 Copayment)	9.55	9.80		.25
Eyeglasses	.99	.99	-	
• Reinsurance				
Individual Stop-Loss	2.04	2.04		
Insolvency	.28	.28	-	
Out-of-Area	1.11	1.11	-	
Reimbursement	--	(1.44)	1.44	
• Administration				
Purchased	2.13	2.13	-	
In-House Salaries				
In-House Overhead	3.11			
In-House HCFA Specific	.23	3.21	.19	
• Bad Debt	.06			
TOTAL	$192.02	168.51	23.51	
REVENUES				
• HCFA	$177.02	177.02	-	
• Beneficiary Premium	15.00	15.00		
TOTAL	$192.02	$192.02		
REVENUES LESS EXPENSES	--	23.51		

4. Medical Care Services

The payment to the Fallon Clinic was budgeted at $57.60 PMPM. Of this amount, $4.60 PMPM was withheld as a loss carry forward for excess 1982 referral costs, $33.00 PMPM was paid directly to the Clinic and $20.00 PMPM was set aside as an escrow account for 1983 referral costs. The reported capitation payment to the Clinic was $52.74 PMPM, resulting in a favorable variance of $4.86 PMPM. Actual expenses (less rental income) for the Auburn Facility was $.33 PMPM for all FCHP enrollees, with Medicare participants being costed equally with non-Medicare members.

Exhibit 3-10 presents selected utilization statistics for Year 4. The utilization per thousand members per year for total ambulatory encounters was essentially equal to that experienced in 1982. Hospital encounter and lab utilization also varied less than 1% from the prior year. X-ray procedure usage declined by 6.5%.

5. New Services

The pharmacy services experience was $9.80 PMPM (net of the $2.00 copayment), for an unfavorable variance of $.25 PMPM. The payment to the Clinic for vision care equalled the agreed upon capitation of $.99.

6. Reinsurance

Reinsurance costs were equal to budgeted costs and reimbursement payments were $1.44 PMPM as of the writing of this report.

7. Administration and Bad Debt

The reported cost of purchased services was 2.13 PMPM. The cost of in-house administration was reported to be $3.21 PMPM, which was $8.19 PMPM less than budget.

8. Revenue

Reported revenue was equal to budget.

3.9 Adjusted Community Rate Development - Benefit Period 5 (January - December, 1984)

An interim ACR for Year 5 (calendar year 1984) was submitted in June, 1983, with the final submission in August, 1983. The cost analysis was similar to the prior years' calculations with three exceptions. First, a rate stabilization budget was introduced. Second, an expense for van service was proposed in the interim budget but dropped in the final submission. Finally, FCHP proposed that the ACR support a self insurance fund in the interim ACR development (budgeted at $3.00 PMPM). This request was dropped in the final submission. The ACR development in June projected a PMPM of $218.58 (assuming a HCFA reimbursement of $203.58) and the final ACR development estimated a PMPM of $209.67 (assuming a HCFA reimbursement of $194.67). The

EXHIBIT 3-10
SELECTED UTILIZATION STATISTICS[2] - YEAR 4

Ambulatory Encounters at Fallon Clinic (w/Refractions)	6,934
Office Visits	4,305
Comp. Exam, Comp. Re-Exam and Limited Re-Exam	669
Post-Op Visit	187
Special Procedure - Office	278
Comp. Eye Exam	350
Procto	70
Surgery - Office	147
Comp. Specialty Exam	257
Limited Specialty Exam	376
Remainder	295
Hospital Encounters	590
Surgery Hospital	98
Other - Hospital	113
Consultation - Hospital	176
Medical Hospital Care	203
Miscellaneous Services	
Lab Tests	6,128
X-Ray	1,188
Injections	543
Physical Therapy	391

[2] Note that all utilization numbers are presented in terms of number of services per thousand enrollees per year and were taken from the December, 1983 year-to-date utilization run.

decrease in the proposed ACRs was accounted for by decreases in the following cost categories:

	Interim ACR	Final ACR	Difference
Hospitalization	125.18	121.00	4.18
Clinic Capitation	59.01	58.01	1.00
Individual Stop-Loss	3.60	1.08	2.52
Plan Service	2	--	1.21

Although no actual data are available against which to measure the budget, a brief description of the projections is given in this section. A summary of the ACR is presented in Exhibit 3-11.

Institutional Services

1. Hospitalization

FCHP projected 2,400 days/1,000 utilization at an average per diem of $605.00 to yield a capitation of $121.00. The Plan derived these estimates using volume and time and complexity factors applied to the under-65 budget as well as examining directly the cost and utilization experience of the Senior Plan through June 1983. Although recent experience indicated a lower utilization estimate, the Plan budgeted a higher figure based on 1980/81 experience. Similarly, the Plan inflated the budgeted January 1, 1983 - September 30, 1983 per diem of $520.67 to derive the $605.00 1984 per diem. The hospital usage projection is 23.3% greater than the 1983 experience but essentially equal to the 1983 budget. The per diem is 12.0% greater than the 1983 budget and 30.3% greater than the 1983 experience.

2. Skilled Nursing Services

FCHP budgeted 615 days/1000 at an anticipated per diem of $120. As of the submission of the ACR, their experience was 554 days/1000, with a per diem of $104. The utilization budget is 17.4% greater than the 1983 budget and 13.7% greater than the reported experience for 1983. The projected cost per day is 4.2% over the 1983 budget and 1.7% above the 1983 experience.

Medical Care Services

1. Clinic Capitation

The budgeted capitation for this benefit was $58.01, derived as follows:

	Under 65 Medical Capitation		Time/ Complexity		Over/ Under		
• Medical	$21.05	x	1.2	x	2.1	=	$53.05
• Administrative	2.36	x		x	2.1	=	4.96
							$58.01

EXHIBIT 3-11
FALLON COMMUNITY HEALTH PLAN
Year 4: January 1984 - December 1984
Capitation

	Budgeted
MEMBERMONTHS	95,300
EXPENSES	
• Institutional Services	
Hospitalization	$121.00
Skilled Nursing Services	6.15
• Medical Care Services	
Clinic Capitation	58.01
Refractions	.63
Auburn Occupancy Costs	.39
• New Services	
Pharmacy (Net of $2 Copayment)	12.68
Eyeglasses	1.12
• Reinsurance	
Individual Stop-Loss	1.08
Insolvency	.30
Out-of-Area	.85
Reimbursement	--
• Administration	
Purchased	2.02
In-House Salaries	
In-House Overhead	2.95
In-House HCFA Specific	.39
• Bad Debt	.06
• Rate Stabilization	2.04
TOTAL	$209.67
REVENUES	
• HCFA	$194.67
• Beneficiary Premium	15.00
TOTAL	$209.67
REVENUES LESS EXPENSES	--

To develop an over/under multiplier, the Plan first compared over 65 utilization to under 65 utilization for ambulatory visits, inpatient visits, hospital outpatient visits and referrals outside the clinic. This ratio was 2.55. The final multiplier of 2.1 compared only ambulatory and inpatient visits. For 1984, the cost for rare and unusual services is also included with the existing benefits cost to determine the clinic capitation. The projected rate is 2.4% above the 1983 budget and 10.0% above the reported 1983 experience.

2. Refractions

An incidence of 200 refractions/1000 at a unit cost of $37.50 was used to derive the capitation:

$$(200/1000 \times \$37.50) / 12 = \$.63$$

This compared with 310 refractions/1000 budgeted in 1983 at an average cost of $37.50. The usage estimate was based on reported 1982 experience.

3. Auburn Occupancy Costs

This capitation was set at $.39, using the percentage of senior plan enrollment to total enrollment to apportion net Auburn Clinic costs:

$$(\$243,324 \times .153) / 95,300 = \$.39$$

This figure is 18.2% above the reported 1983 experience.

New Services

1. Pharmacy

FCHP projected 12.2 Rxs per person per year at an average prescription price of $12.47. The cost per prescription was derived using the pure drug cost for May '82 - April '83, inflated at an annual rate of 12.2% to derive a July 1984 cost plus a $2.25 dispensing fee. The PMPM calculation was as follows:

$$(12,200/1000 \times \$12.47) / 12 = \$12.68$$

The prescription drug benefit changed in 1984 such that no copayment was to be charged. The projected cost per member per month is 32.8% above the 1983 budget and 29.4% above the 1983 experience.

2. Eyeglasses

Following the methodology from the Year 4 submission, the cost was:

New Glasses	(225/1000 x $58.84) / 12 =	$1.10
Repairs	(30/1000 x $7.84) / 12 =	.02
		$1.12

The utilization of new glasses was based on the 1982 experience and represented an 8.7% increase over the 1983 budget.

Reinsurance

The Plan budgeted for three types of reinsurance - individual stop-loss, insolvency and out-of-area coverage. For individual stop-loss, FCHP purchased coverage for claims in excess of $85,000 at a cost of $1.08 PMPM. In the prior year, the Plan had purchased coverage above a threshold of $40,000 for $2.04 PMPM. The quote for the same policy in 1984 was $3.79 PMPM. Therefore, FCHP opted for the minimal coverage. In the interim submission, FCHP proposed to purchase individual stop-loss in excess of $110,000 at a cost of $.50 PMPM and to fund their exposure for the first $110,000 with a budget of $3.10 PMPM, resulting in a total projection of $3.60 PMPM. The BCBSM quotes for insolvency and out-of-area emergency were $.30 PMPM and $.85 PMPM respectively, as compared with $.28 PMPM and $1.11 PMPM in 1983.

Administration and Bad Debt

The cost for purchased services was set at $2.02 PMPM, a 5.2% decrease from the prior year. In-house costs were budgeted at $3.34 PMPM, derived as follows:

Allocation of Plan Administration	($1,837,484 x .153)/95,300	= $2.95
Senior Plan Specific	$36,845/95,300	= .39
		$3.34

The bad debt calculation was again calculated as .4% of $15.00 (.004 x $15.00)

Van Service

In order to provide increased access to ambulatory services at the Clinic, FCHP proposed to provide a transportation benefit for Medicare members. The budget for this service was $115,250 comprised of $45,000 for three vans, $56,250 for salary and fringe cost for three drivers and $14,000 for other related costs. The capitation calculation was:

$115,250/95,300 = $1.21

This cost was not included in the final ACR development.

Rate Stabilization

HCFA switched to a rate book reimbursement in 1984 from the fixed AAPCC methodology used in prior years. In order to provice for a constant premium rate during the year (which FCHP assumed in the cost development), the Plan proposed the establishment of a 1% reserve fund. If the HCFA funding remained at the projected level, the reserve would be used to stabilize future beneficiary premium levels. This fund was established at 1% of the budgeted HCFA reimbursement

estimated in the interim ACR proposal, i.e. .01 x $203.58 = $2.04 PMPM. In the final ACR development, this calculation was not changed.

Revenue Sources

In the final ACR development, the HCFA reimbursement of $194.67 PMPM was calculated at 95% of the AAPCC (.95 x $204.92). Using the ACR requirement of $209.67 the beneficiary premium was held at $15.00 per month:

	ACR	$209.67
Less:	HCFA Payment	194.67
	Necessary Revenue	$ 15.00

CHAPTER 4: Greater Marshfield Community Health Plan Rate Setting Discussion

4.1 Background

The Greater Marshfield Community Health Plan (GMCHP) is a prepaid group practice health plan established in 1971. The Plan was jointly sponsored by four organizations; the Marshfield Clinic, St. Joseph's Hospital, Wisconsin Blue Cross, and Surgical Care Blue Shield. Wisconsin Blue Cross and Surgical Care Blue Shield have since merged.

From its inception, GMCHP desired to provide access to all segments of the Central Wisconsin population. Prior to the demonstration, GMCHP had agreements with the Department of Health and Human Services, Bureau of Community Health Services and the Wisconsin Medicaid Program to enroll low income medically indigent persons. These contracts were negotiated with GMCHP's research, education, and community service foundation, the Marshfield Medical Foundation. When Medicare beneficiaries were included as GMCHP members, HCFA's contractual arrangement was with the foundation.

There are some characteristics which distinguish GMCHP from most other group model HMOs. First, GMCHP is not a corporate entity. The contractual arrangements among the four sponsors are shown in Exhibit 4-1. GMCHP described these arrangements in its protocol submitted to HCFA, November 1977:

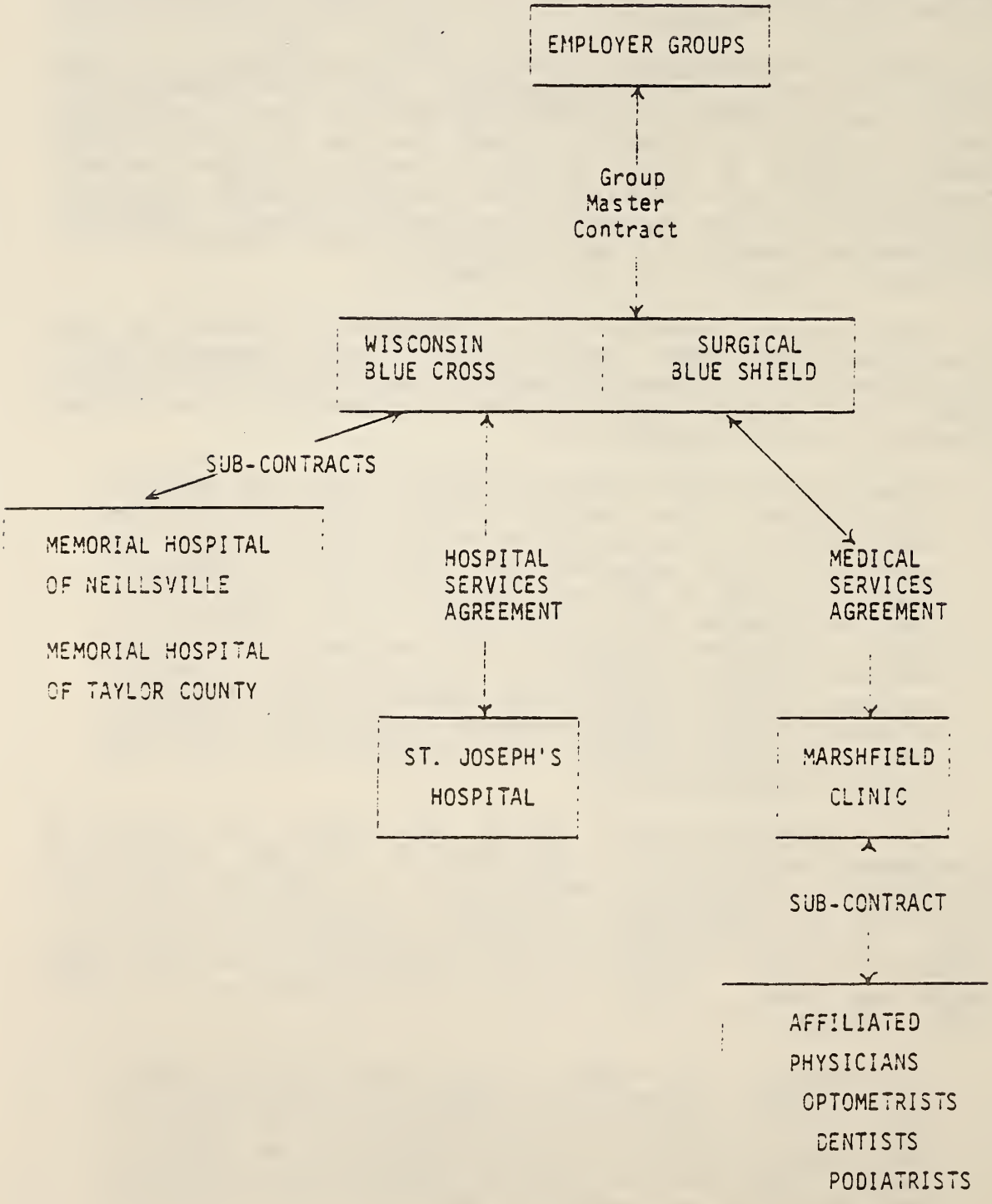
> There are three major contracts linking Health Plan sponsors and enrollees. The "Medical Services Agreement with the Marshfield Clinic" between Surgical Care Blue Shield and the Marshfield Clinic guarantees the provision of professional medical services to plan enrollees; the "Prepaid Group Practice Plan Hospital Service Agreement with St. Joseph's Hospital of Marshfield, Wisconsin, Inc." between Blue Cross of Wisconsin and St. Joseph's assures the provision of Hospital services; and the "Group Master Contract" held by employers on behalf of their enrolled employees represents the enrollee's contract with the delivery system (through Blue Cross and Surgical Care Blue Shield).

This contractual network defines the financial and risk-sharing arrangements among sponsors and providers. The four sponsors and the community share risk. Regardless of the population type being served and the contractual arrangements, a community risk pool is in effect, into which flow GMCHP revenues and from which all authorized obligations are paid. This risk pool is referred to as the "Blue Cross Health Plan Fund." GMCHP describes the administration of the Plan Fund as follows:

> The partners in the Health Plan are guaranteed their respective capitation and per diem payments for which they are at risk, while the community bears the risk for supplying sufficient funds to provide for the capitation and per diem payments. Should the Plan Fund be insufficient to cover Health Plan obligations, any one of the sponsors of the prepaid plan

Exhibit 4-1

Contractual Arrangements Establishing the GMCHP



may finance the deficit, which in turn would be recovered in subsequent years through premiums paid by the enrollees. Surplus Plan funds are held in reserve or returned to the community as part of a rate stabilization program. If the program should be dissolved, the four sponsors of the Health Plan, the Marshfield Clinic, St. Joseph's Hospital, Blue Cross of Wisconsin, and Surgical Care Blue Shield, would share equally in any Health Plan deficit. However, should a surplus be present, it would be returned to the community, on the basis of involvement in the Plan over the prior year.

The Medicare Demonstration Program at GMCHP began in June of 1980, with the following benefit periods:

- Benefit Period 1: June 1, 1980 - September 30, 1980
- Benefit Period 2: October 1, 1980 - September 30, 1981
- Benefit Period 3: October 1, 1981 - September 30, 1982

4.2 Description of the Benefit Package

The benefit package, which did not change over the period of the demonstration, included the following enhancements over standard Medicare coverage:

- Full coverage of Part A and Part B copayments and deductibles.
- Expanded coverage of inpatient care to include unlimited number of days per admission at the semi-private room rate. Private room provided, if medically necessary.
- Full coverage of SNF care for recovery of patient if requested by clinic physician.
- Addition of preventive services such as physical exams, full coverage of immunizations, health education, allergy testing, hearing exams and vision exams.
- Full coverage of home health and increased coverage of durable medical equipment.
- Increased mental health coverage, both inpatient and outpatient.

A benefit by benefit comparison with the standard Medicare package is given in Exhibit 4-2.

4.3 Waivers and Variances

The initial waivers and variances concerning reimbursement permitted prospective reimbursement, and provided absorption by the Plan of all "losses" or "savings." The first year's payment was set at 99% of the APC with future year's payments to be set not higher than 95% of the AAPCC. This payment methodology was further adjusted as the

Exhibit 4-2

DESCRIPTION OF GMCHP BENEFIT PACKAGE

SERVICES	MEDICARE PARTS A & B	GMCHP BENEFITS
npatient Care	Part A Services: $180 deductible for first 60 days; co-payment $45/day for days 61-90, $90/day for 60 lifetime reserve days	Covered in full - no limit
utpatient Care & hysician Services Episodic	Part B services: $60 deductible for calendar year; 80% reasonable charges	Covered in full - no limit
Lab & X-Ray	Part A & B Services: Part B $60 deductible for Part B and $180 for Part A	Covered in full - no limit
Emergency Care	Part B Services: $60 deductible and 80% reasonable charges	Covered in full
Preventative 1-Physical Exam	Not covered	Covered in full if related to care and treatment
2-Immunization	Part B Services: part of deductible & only for injury and immediate risk	Covered in full
3-Other	Not covered	Health education, allergy testing, hearing testing
Skilled Nursing Care	Part A Services: 20 days in full $22.50/day for days 21-100. 100 days per benefit period	Covered in full
Home Health Care	Part A Services up to 100 visits. Part B Services without prior hospitalization up to 100 visits, 80% coverage	Covered in full
Private Duty Nursing	Not covered	Not covered

Exhibit 4-2 (cont.)

DESCRIPTION OF GMCHP BENEFIT PACKAGE

SERVICES	MEDICARE PARTS A & B	GROUP BENEFITS
Ambulance	Part B Services: 80% coverage	Covered in full
Mental Health Inpatient	Part A Services: $180 deductible and copayments as if an inpatient hospital above. 190 lifetime	Covered in full, 70 day maximum. Renews after discharge of 90 days
Outpatient	Part B Services: Part of $60 deductible, but maximum of $250	Covered in full. 20 day maximum, Renews after discontinuance of 90 days
Physical Therapy	Part A Services: Part of inpatient coverage	Covered in full
Radiation Therapy	Part A Services: Part of inpatient coverage	Covered in full
Hemodialysis Services	Special coverage. Covered in full	Covered in full
Prescription Drugs	Part A Services: Part of inpatient coverage. Part B Services: Drugs that cannot be self-administered: 80% coverage	Same as Medicare
Eye Exam	Part B Services for eye surgery but not for eyeglasses	Covered in full, but does not include cost of frame or lenses except for cataract surgery
Eyeglasses	Part B Services. Coverage for contact lenses for post-cataract surgery patients. No other coverage	Covered in full for lenses for post-cataract surgery patients
Prosthetic Devices and Durable Medical Equipment	Part B Services for devices that are used for internal organs and artificial limbs. No dentures; 80% coverage	Covered in full except for non-rigid appliances or supplies
Dental Care	Part B Services. Only if it involves surgery of jaw or setting of fractures	Covered only for surgery of jaw or need caused by facial fracture

Exhibit 4-2 (cont.)

DESCRIPTION OF GMCHP BENEFIT PACKAGE

SERVICES	MEDICARE PARTS A & B	GMCHP BENEFITS
Chiropractic Services	Part B Services: Only coverage for manipulation of spine to correct subluxation	Only coverage for manipulation of spine to correct subluxation when done at clinic
Podiatric	Part B Services: Coverage for all services except routine foot care	Covered in full

demonstration proceeded, allowing HCFA payments at 98% in year 2 and 99% in year 3. Additionally, a special risk sharing formula was negotiated between GMCHP and HCFA which allowed further HCFA payments in the third year.

The major effects of the waivers and variances upon the delivery of health services:

- Allowed the Plan to reimburse hospitals, SNFs and home health agencies in a manner not limited by Medicare reasonable cost guidelines.
- Relaxed existing criteria for admissions to SNFs.
- Allowed the Plan to use SNFs that are Medicaid-certified but not Medicare-certified.

Enrollment related waivers and variances allowed the Plan to offer only one basic benefit package and to not have to offer coverage to beneficiaries eligible for Part B only. GMCHP did enroll ESRD eligibles, at a higher reimbursement level than for aged and disabled members.

As with the other sites, HCFA waived much of the required Medicare cost reporting requirements. Because of GMCHP's organizational structure, HCFA also waived certain existing requirements as to the type of HMO with which it could contract. Since GMCHP exists only through contracts between the sponsors, e.g., there is no plan Executive Director and no Board of Directors, the following exceptions were requested by GMCHP:

- Strict adherence pertaining to the composition of the Board of Directors.
- Requirement that the Plan be managed by an executive whose appointment and removal is under the control of the Plan's policy-making board.

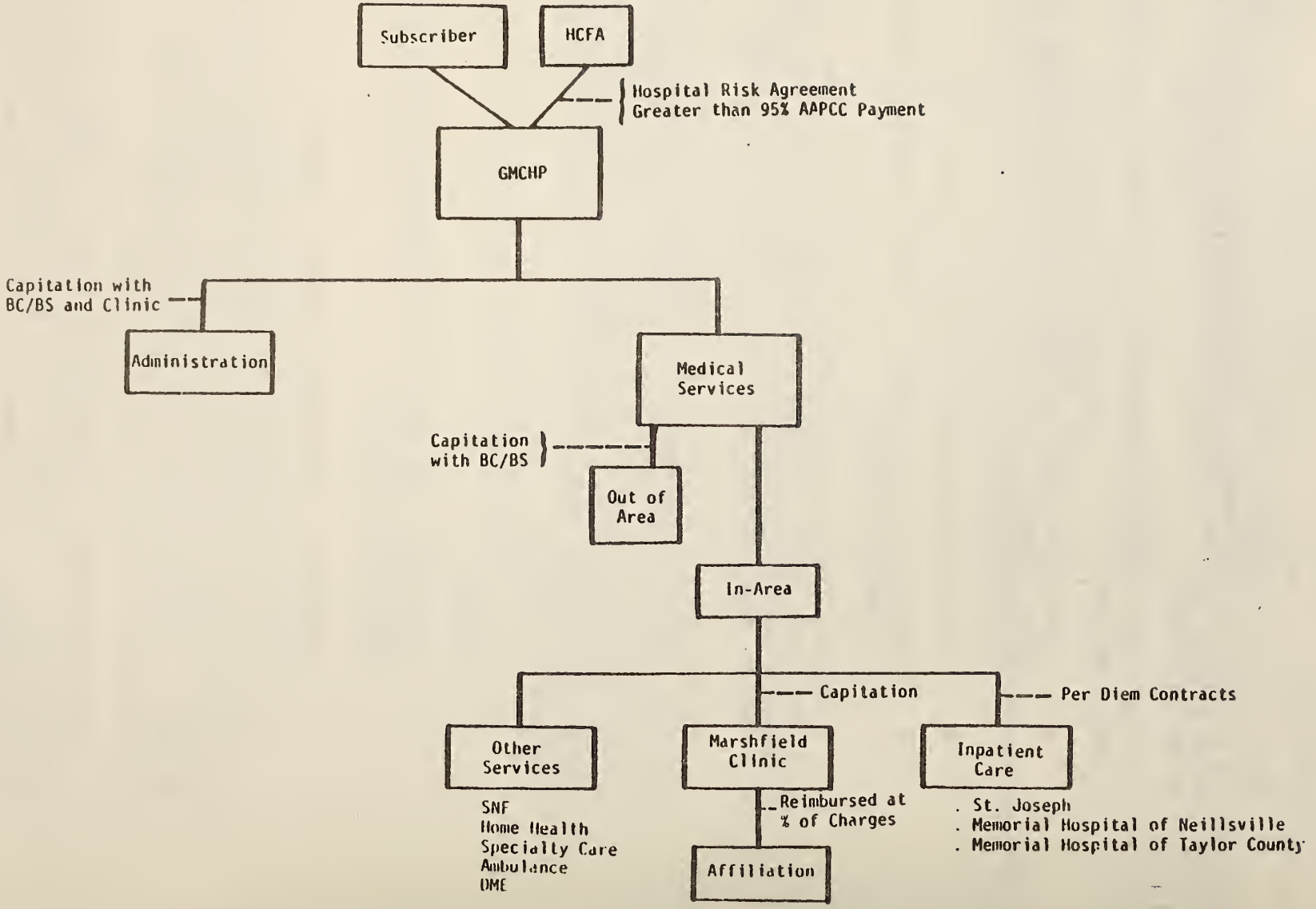
4.4 Organization of the Medical Delivery System

Exhibit 4-3 outlines GMCHP's payment procedures for services and the risk sharing arrangements that the Plan employed. Plan operations are divided into two activities; provision of medical and administrative services. GMCHP operations lack a distinct administrative staff and structure. Administrative services are provided through capitation arrangements with BCBSU and the Marshfield Clinic.

Medical services are either out-of-area or in-area. For out-of-area services, the Plan capitates BCBSU to provide all care; both inpatient and outpatient. The delivery of in-area services is more complicated, involving contractual arrangements for inpatient care, clinic services, and other services.

Exhibit 4-3

DIAGRAM OF GMCHP's METHOD OF PAYMENT FOR SERVICE



Inpatient Care

The Plan contracts with three hospitals to provide inpatient care, based upon per diem reimbursement arrangements. The primary hospital, and one of the three organizations instrumental in establishing GMCHP, is St. Joseph's Hospital. The other two facilities are Memorial Hospital of Neillsville and Memorial Hospital of Taylor County. A major guideline in setting per diems was to return to the facilities a targeted percentage of charges. In 1982, this target was 88% of charges.

Clinic Services

The major arrangement for physician services is between the Plan and the Marshfield Clinic. In return for a capitation payment, the Clinic agrees to deliver all in-area physician services and all out-of-area physician referrals. At the inception of the demonstration, the clinic was a 173 physician multi-specialty group practice.

Although the Clinic is the major provider of physician services in the GMCHP service area, the group has developed relationships with other local physicians to ensure an even broader delivery system. The Clinic reimburses these affiliate physicians, out of the Clinic's capitation payment, at a percentage of the particular affiliate's charges. The remaining percentage is retained by the Clinic and, if funds permit, distributed at the end of the year.

During the demonstration period, GMCHP made one change in the amount of risk assumed by the Clinic, pertaining to physician referrals. In the third year, the Clinic assumed fiscal responsibility for both the professional and hospital components of referrals made by the Clinic physicians. Prior to this time, these costs were the responsibility of BCBSU.

Other Services

The Plan delivers other services such as skilled nursing care, home health care, specialty services, ambulance and durable medical equipment by paying area prevailing charges.

4.5 Adjusted Community Rate Development and Fiscal Performance Benefit Period 1 (June - September 1980)

Community Rate Development

The first step in developing the ACR was finalizing the GMCHP community rate. In developing the community rate, the Marshfield Clinic, St. Joseph's Hospital, and BCBSU developed separate budgets for the services each provides. This rate-setting process involved examining historical information, determining values for each rate component, negotiating among the Plan sponsors, and submitting rates to the Plan's community advisory committee for review. This process can take up to two months. The community rate pertaining to the first demonstration period was the same rate applicable to the Plan's fiscal year, October 1979 - September 1980.

Using an ACR for Medicare enrollees departed from the Plan's strict philosophy of community rating for all enrollees. However, the sponsors decided to adjust the Plan's rate for Medicare beneficiaries because of their demonstrated higher health care use and costs. Building an adjusted community rate also involved a negotiating process. The first benefit period ACR and its relationship to the FY 1980 community rate is shown in Exhibit 4-4.

GMCHP adjusted the following rate components:

- Affiliated inpatient capitation
- SNF and visiting nurse calls
- Clinic medical services capitation
- Affiliated outpatient
- Additional benefits
- Referral and out-of-area emergency medical and accident

For the remaining components, the ACR estimate was the same as the commmunity rate projection.

In determining an ACR, GMCHP personnel first divided HCFA beneficiaries into three classes: non-renal aged, non-renal disabled, and renal enrollees. GMCHP then examined HCFA information which showed little variance in the cost of non-renal aged and disabled users, and decided to establish a single ACR for both groups. The first cost category to be addressed will be inpatient care.

Affiliated Inpatient Services

GMCHP negotiated per diem rates with three in-area hospitals: St. Joseph's Hospital, Neillsville Memorial Hospital and Memorial Hospital of Taylor County. In order to develop an overall in-area inpatient budget, three items had to be considered:

- The per diem to be paid per hospital
- The distribution of days among hospitals
- The total number of days of care to be delivered

For the initial year, the Plan agreed that the per diem payment per hospital would be the same for Medicare members as for non-Medicare enrollees. GMCHP did not provide data to support this assumption.

To estimate the distribution of days across the hospitals, the Plan used its experience with their non-Medicare population:

St. Joseph's	85.2%
Neillsville	6.4
Memorial	8.4

To estimate the total number of days of hospital care per thousand members per year, GMCHP constructed a ratio of over-65 hospital use to under-65 hospital use and multiplied this figure by projected hospital use by GMCHP under 65 enrollees. Estimates of the over-65 hospital factor came from four sources:

Exhibit 4-4

GREATER MARSHFIELD COMMUNITY HEALTH PLAN
COMMUNITY RATE AND ADJUSTED COMMUNITY RATE
10/1/79 - 10/1/80
(AGED AND DISABLED)

RATE COMPONENT	FINAL NONMEDICARE RATE 10/1/79-10/1/80	FINAL ACR MULTIPLIERS	FINAL MEDICARE ACR
Affiliated Inpatient (day rate/per diem/capitation):			
St. Joseph's - @$274.56 =	$ 9.69	*	$ 40.87
Neillsville - @ 160.56 =	.43	4.54	1.95
Medford - @ 178.57 =	.62	4.54	2.81
ECF & Visiting Nurse Calls & Charges	.05	48.00	2.40
Clinic Capitation:			
Medical Services	16.96	2.321	39.36
Admin. Services for GMCHP	.28	--	.28
Affiliated Outpatient @ 90%	1.17	1.17	2.00
Additional Benefits: Ambulance, Prosthetic Devices, etc.	.15	1.78	.27
Referral and Out-of-Area Emergency Medical and Accident	1.45	4.61	6.69
Blue Cross/Surgical Care Administrative	1.05	--	1.05
Special Marketing Expense	.02	--	.02
Other Coverage Savings	(.70)	--	(.70)
Total Expenses	$31.17		$97.00
Investment Income	(.09)	--	(.09)
Reserve Applied to Rate Stabilization	(.82)	--	(.82)
Total Subscription Fees	$30.26		$96.09
HCFA's AAPCC	$75.17	.99	$74.42
ENROLLEE PREMIUM			$21.67

*Explanation provided in narrative

- American Medical Association, "1973 Socioeconomic Issues of Health" -- Ratio of over-65 to under-65 per capita charges was 3.55

- Area fee-for-service -- Ratio of over-65 to under-65 days/1000 was 5.56

- HCFA data -- Over-65 day use rate of 2617 days/1000 beneficiaries in the region.

- Kaiser Health Plan -- 1974 over-65 to under-65 age-sex adjusted days/1000 ratio was 5.66; age-sex, unadjusted, 5.27; 1965/1966 unadjusted ratio, 3.96.

GMCHP chose the HCFA use rate of 2,617 days. The community rate estimate was 559/1,000; thus, the hospital adjustment factor was initially set at 4.68 (i.e., 2,617/559). The final hospital multiplier was 4.54. The use of a different factor for in-area projections resulted from applying a 1.25 out-of-area factor. To derive an estimate for the out-of-area adjustment, the Plan first examined hospital use for FY79. This analysis showed an out-of-area average of hospitalization of 10.9% for non-Medicare GMCHP enrollees (based upon days of care delivered). For the Medicare population, using HSA data showing Medicare FFS use by facility, GMCHP estimated an out-of-area average of 13.6%. The factor for the Medicare enrollees was then calculated at 1.25 (i.e., 13.6/10.9). The community rate projection of 559 days per thousand was comprised of 498 days in-area and 61 days out-of-area. When the 4.68 multiplier was applied to the 61 days, the result was 285 days/1,000. This estimate needed to then be adjusted for out-of-area (1.25 x 285 = 356). Since the total estimate was 2,617 days/1,000, the in-area component was 2,261 (2,617 - 356). Performing the appropriate division then yielded the new affiliated inpatient factor of 4.54 (2,261/498).

GMCHP made a final change in developing its estimate for St. Joseph's Hospital. To minimize enrollee payments, St. Joseph's agreed to lower its per diem requirement to approximately 93% of its under-65 rate (i.e., $255.06 versus $274.56). This lowered the St. Joseph's community rate capitation payment from $9.69 PMPM to $9.00 PMPM, yielding a Medicare capitation estimate of $40.87 associated with the use of this hospital (i.e., $9.00 x 4.54 = $40.87).

SNF and Home Health

In contrast to the method used for calculating clinic and hospital capitation rates, GMCHP did not use a multiplier to establish SNF and home health Medicare capitation estimates. GMCHP estimated the average cost of a day of skilled nursing care and the average cost of a home health visit in its service area and multiplied by a utilization factor. This methodology was applied because of the small percentage of the community rate represented by these benefits.

Unit cost data were obtained from the local providers of these services. For FY 1979-80, the average day rate for skilled nursing care was budgeted at $38.48, and $25.92 for home care services.

GMCHP then used HCFA supplied utilization data for these services to estimate utilization. The HCFA data and the resultant utilization estimates were:

	Aged	Disabled	GMCHP Weighted Estimate
SNF	500 days/1000	750 days/1000	520 days/1000
Home Health	350 visits/1000	200 visits/1000	340 visits/1000

Using this technique, Year 1 costs were projected to be $2.40 PMPM, $1.67 for SNF services and $.73 for home care.

Clinic Services

1. Administrative Services

There are two components to clinic services: administrative services and medical services. The Plan decided to extend the community rate for the administrative component to the Medicare population. Hence, no adjustment was made. The allocation was $0.28 per member per month (PMPM).

2. Medical Services

For medical services, the Plan used three sources to develop a multiplier for adjusting its projected community rate:

- Study of fee-for-service patient utilization and charges for Marshfield Clinic services for 1977 and 1978.
- Examination of prepaid population data for Marshfield Clinic (i.e., members under 65).
- Analysis of Kaiser data.

Since one capitation amount would be paid to the Marshfield Clinic for both outpatient and inpatient professional services, the final multiplier required two components; one for outpatient services and the other for inpatient professional services. To construct a composite multiplier, an appropriate weighting of these two factors was necessary.

To determine a multiplier for ambulatory care, GMCHP examined two elements of the fee-for-service (FFS) experience at the Marshfield Clinic -- utilization measured in services and charges measured in dollars. Fee-for-service clinic use was as follows:

	Ambulatory Encounter Rates		Adjustment Ratio
	Under 65	65 and Over	65+/Under 65
Non-Adjusted			
1977	3.20	5.84	1.83
1978	3.69	6.04	1.64

	Ambulatory Encounter Rates		Adjustment Ratio
	Under 65	65 and Over	65+/Under 65
Age/Sex Adjusted			
1977	3.28	5.79	1.77
1978	3.76	6.00	1.60

Charges data covers both outpatient and inpatient services:

	Charges/Patient/Year		Adjustment Ratio
	Under 65	65 and Over	65+/Under 65
Non-Adjusted			
1977	$178.72	$455.99	2.55
1978	235.24	533.58	2.27
Age/Sex Adjusted			
1977	183.63	452.84	2.47
1978	244.39	529.06	2.16

The charges were developed by multiplying services by the appropriate clinic charge schedule.

GMCHP, in its final protocol, discussed several methodological problems concerning the use of adjustment factors derived solely from encounters at the Marshfield Clinic. These problems were: (1) data reflect only those services performed at the Marshfield Clinic; (2) the utilization data were only for a subset of the population from the total Medicare service area; (3) the FFS information reflects clinic users and not a population-at-risk; and (4) initial factors were unadjusted for age/sex. GMCHP concluded encounter adjustment factors represent minimum estimators for the outpatient factor. The use of charges data raised similar methodological concerns. These measures, however, had the advantage of incorporating the effect of both outpatient and inpatient professional medical services and reflected case mix differences in services used.

GMCHP's prepaid experience in 1977 for the under-65 enrollees, unadjusted for age and sex, showed a prepaid ambulatory encounter rate 1.7 times greater than among fee-for-service Clinic users.

Finally, applying ambulatory utilization from the Kaiser program to GMCHP's projected population resulted in an outpatient adjustment factor of 1.78. To develop a multiplier for inpatient professional services, inpatient Kaiser utilization factors were combined with GMCHP population, yielding an inpatient factor of 5.66 based upon days of care and a 3.43 factor using discharge information. The Plan felt that the measure based upon discharges might be low but would be more appropriate than the measure based upon days. Thus, the adjustment factor used for inpatient professional services was 3.43.

The last piece of information needed was a projected mix of services between outpatient and inpatient. Using Clinic charges data, the following percentages were calculated:

	Inpatient Charges	Outpatient Charges
1977	37.01	62.99
1978	36.69	63.31
1979 (Nine Months)	37.27	62.73

GMCHP chose to use a distribution of 37% inpatient services to 63% inpatient services.

Thus the initial overall factor was:

$$(.37 \times 3.43) + (.63 \times 1.78) = 2.39$$

The resulting weight of 2.39 was within the range calculated from clinic charges data (2.16 - 2.55). Applying 2.39 to the community rate component of $16.96, yielded a capitation of $40.53. Two changes occurred at this point. The negotiation process resulted in a one dollar reduction, from $40.53 to $39.53. The resultant multiplier was then 2.33 ($39.53/$16.96). The capitation reduction was based on reconsidering the results of the clinic charges study.

The second adjustment concerned the expected increases in the out-of-area emergency and accident cost component. The community rate allocated $0.29 PMPM to this cost. Using the 2.33 medical services adjustment factor implies a $0.68 estimate for the ACR (2.33 x $0.29). However, GMCHP assumed that Medicare enrollees would spend more time out-of-area during the year than would under 65 members and thus would generate more out-of-area costs.

To estimate how much greater the out-of-area cost would be, the Plan used the out-of-area factor previously discussed. The final estimate for the out-of-area component was $0.85 PMPM ($0.68 x 1.25). Since $.68 PMPM had initially been allocated to out-of-area professional services, another $0.17 PMPM had to be added. This additional allocation was taken from the clinic services capitation, leaving a final estimate for in-area clinic services of $39.36 PMPM ($39.53-$0.17). The final multiplier was 2.321 ($39.36/$16.96).

Affiliated Outpatient

Affiliated outpatient services applied to in-area outpatient hospital services, either at the three affiliated hospitals or one of 10 other hospitals within or in close proximity to the GMCHP service area. A significant portion of these services was for in-area emergencies, but routine outpatient care was included as well.

To develop the projected capitation, two approaches were applied. The first method used data obtained from the fiscal intermediary for 13 local hospitals to estimate a use rate of 510 cases/1000 and a current reimbursement rate of $55.26 per case. The second projection assumed that the same relationship of outpatient hospital encounters to total encounters would hold for the Medicare as for the non-Medicare population. With this assumption, the community rate estimate of $1.17 PMPM was multiplied by the outpatient multiplier of 1.78 to yield an initial

capitation of $2.08. For purposes of projecting an ACR, the results of the second approach were used. Before the final rate was set, one further adjustment was made. This adjustment resulted from an application of the out-of-area factor to the $.32 PMPM budgeted for out-of-area outpatient hospital services. This change increased the out-of-area budget to $.40 PMPM. Since this component increased by $.08 PMPM, the in-area portion dropped by a similar amount. Thus the final estimate was $2.00, with a multiplier of 1.71 ($2.00/$1.17).

Additional Benefits

These were new benefits, including ambulance services, prosthetic devices, and durable medical equipment, which were first offered as a part of the benefit package for the under-65 GMCHP population in October, 1978. In calculating the Year 1 ACR, a weighting factor of 1.78 was applied to costs for the under-65 group. After adjusting the $.15 PMPM community rate, the Medicare budget was $.27 PMPM. The 1.78 multiplier was used because this is consistent with the multiplier applied to the outpatient portion of the Clinic medical services capitation rate.

Out-of-Area Emergency and Referral

This portion of budgeted expense consisted of out-of-area inpatient hospital services, outpatient hospital services, and professional services.

For out-of-area inpatient services, GMCHP started with a community rate of $.93 PMPM and multiplied by the 4.68 weight for in-area hospital services. Accounting for "out-of-area use difference" between its younger and older populations these costs were multiplied by 1.25 ($.93 x 4.68 x 1.25), yielding a projected cost of $5.44 PMPM.

For out-of-area professional services, the community rate of $.29 PMPM was multiplied by the 2.33 weight; the weighted average of inpatient and outpatient service multiplier used to calculate the ACR for capitated clinic services. This figure of $.68 PMPM was then multiplied by the 1.25 out-of-area factor, yielding a cost of $.85 PMPM.

For out-of-area outpatient hospital services, the community rate of $.18 PMPM was multiplied by the 1.78 weight derived from Kaiser data for outpatient services. The resulting figure of $.32 PMPM was then multiplied by the 1.25 out-of-area weight, yielding a projected capitation of $.40.

BCBSU Administration

GMCHP purchased certain administrative services from Blue Cross of Wisconsin and Surgical Care Blue Shield (BCBSU). GMCHP maintains the philosophy, consistent with the concepts of community rating, that the cost for this item should be shared equally, even though variations between subgroups, including Medicare, do exist. Therefore, GMCHP used the existing rate, $1.05 PMPM plus $.02 PMPM for special marketing expenses.

Expense Offsets

Offsets to expense included coverage savings through coordination of benefits and other adjustments, primarily investment income. Anticipated offsets were spread equally over all enrollees. The projected amounts for coordination of benefits and investments income were $.70 and $.91 respectively.

HCFA Capitation

The HCFA capitation was set at $74.42. This figure was 99.0% of the area prevailing cost. Since for most sites the HCFA capitation was set at the 95% level, GMCHP's reimbursement level departed from that used at the other sites.

Beneficiary Premium

The difference between the HCFA capitation of $74.42 and the adjusted community rate of $96.09 was the beneficiary premium (i.e., $21.67). Although GMCHP "backed into" this premium because it could not absorb these costs in its ACR, a seven page justification of this premium rate appears in GMCHP's protocol.

To estimate the value of copayments and deductibles, the Plan used HCFA's estimate of the actuarial equivalent of beneficiary cost-sharing (i.e., 27% of the Part B APC and 7% of the Part A APC). This yielded an estimate of $12.47. The Plan felt this number was low and did not account for Medicare services incurred but not billed or services incurred and billed but which did not exceed the deductible. GMCHP thus increased the copayment and decuctible estimate to $13.00.

To estimate the value of additional benefits, GMCHP completed a detailed comparison and cost adjustment between standard Medicare coverage and their benefit package, arriving at an estimate of $13.42. Exhibit 4-5 shows these calculations.

Thus, GMCHP projected a beneficiary premium of $26.42 for which they charged $21.67.

ESRD Beneficiaries

GMCHP agreed to enroll renal beneficiaries for a HCFA reimbursement calculated at 95% of the renal APC for the State of $2,149.63 PMPM. Thus, the reimbursement for these members was $2,042.15 PMPM from HCFA and $21.67 from the beneficiary. Plan statistics indicate that there were approximately 33 membermonths of care delivered for this sub-population.

Fiscal Performance, Benefit Period 1
(June - September 1980)

Exhibit 4-6 shows a favorable $2.96 PMPM for the abbreviated first year of operations. Revenues exceeded expenses by approximately

EXHIBIT 4-5

GMCHP/MEDICARE

BENEFIT DIFFERENCE LISTING

ITEM	CATEGORY	GMCHP	MEDICARE
1	General Hospital Inpatient	Unlimited Days except nervous and mental - 70 days/90 day separations extendable with peer review	90 days per illness/60 day separation plus 60 lifetime reserve days
2	Psychiatric Hospital Inpatient	Diagnostic Admission	Admissions for treatment of illness or injury
3	Psychiatric Hospital Inpatient	70 days/90 day separation extendable with peer review	Same as General Hospital Inpatient days except: a) Maximum 190 days lifetime b) Days spent in the 150 days prior to Medicare eligible date reduces the lifetime days available
4	Skilled Nursing Facility	Covered for noncustodial care No prior hospital stay requirement	100 days in Medicare certified facility and with 5 conditions met
5	Blood, Plasma & Processing Fee	Covered from first pint	Blood excluding first three pints
6	Hospital Outpatient	Diagnostic tests for physical exam	Not covered
7	Physician Services	Physical exams	Not covered
8	Physician Services	Diagnostic test for physical exams	Not covered
9	Physician Services	Oral surgery excluding gingevectomies	Not covered
10	Physician Services	Immunizations and immunization agents	Not covered
11	Physician Services	Eye examinations & prescription for glasses	Not covered
12	Physician Services	20 psychiatric visits per disability extendable with peer review	$250 per year at 50%

EXHIBIT 4-5 (continued)

GMCHP/MEDICARE

RATE DETERMINATION FOR BENEFIT DIFFERENCES

Item	Current GMCHP or Manual Rate		Other Modifier		Remove Retention	Cost of Service		Frequency	65+ Multiplier	Rate Per Month
1	$0.14		x		.88				4.68	$0.58
2	.32		x		.88				4.68	1.32
3	--									--
4	.02	x	.97						48.0	.93
5	.12		x		.88				4.68	.49
6	.32		x		.88				1.78	.50
7						$140	x	.60	1.00	7.00
8	.40		x		.825				2.33	.77
9	.39	x	.711	x	.825				2.33	.53
10	--									--
11						$ 32	x	.35 x 1.1	1.00	1.03
12	.66	x	.50	x	.825				1.00	.27
TOTAL										$13.42

EXHIBIT 4-6
GREATER MARSHFIELD COMMUNITY HEALTH PLAN
Year 1: June 1, 1980 - September 30, 1980
Capitation

	Budgeted	Actual	Variance Favorable	Variance Unfavorable
MEMBERMONTHS	21,300	18,294		3,006
EXPENSES				
• Affiliated Inpatient				
St. Joseph's	$40.87	$40.35		
Neillsville	1.95	2.34	$2.42	
Medford	2.81	2.52		
• SNF and Home Health				
SNF	1.67	1.03	1.64	
Home Health	.73			
• Clinic				
Medical Service	39.36	39.64	--	
Administration	.28			
Medical Director	--	--	--	
Newsletter	--	--	--	
• Affiliated Outpatient	2.00*			
• Additional Benefits	.27**			
• Out-of-Area Emergency/Referral				
Inpatient Hospital	5.44			
Outpatient Hospital	.40	6.69	--	--
Professional Services	.85			
• BCBSU Administration	1.05	1.13		.06
• Special Marketing Expense	.02			
• Other Coverage Savings	(.70)	(.15)		.55
• Other Adjustments	(.91)	(.54)		.37
TOTAL	96.09	93.01	3.08	
REVENUES				
• HCFA Payment	74.42	74.03		.39
• Individual Payment	21.67	21.94	.27	
TOTAL	$96.09	$95.97		.12
REVENUES LESS EXPENSES	--	2.96	$2.96	

*Included with affiliated inpatient for variance analysis.
**Included with SNF and Home Health for variance analysis.

$54,000 for non-renal Medicare enrollees. For renal beneficiaries, revenue exceeded expenses by over $8,700. While the projected surplus is slightly greater than 3% of costs, there is some question as to the proper accrual of hospitalization to benefit periods. GMCHP stated that BCBSU paid for hospital days incurred in FY80 on a two-month charge back basis. Therefore, any days incurred in FY80 but paid after December 1, 1980 were charged to FY81. Adjusting costs for these hospital expenses could turn this surplus into a loss of at least $100,000 for the first benefit period.

Performance of capitation components follows.

1. Hospitalization

Since GMCHP utilization data has yet to be directly analyzed, it is not possible to compare budgeted versus actual use and cost for in-area hospitalization because financial statements merge these costs with affiliated outpatient, SNF, and home health care.

GMCHP's Annual Report (November 30, 1981) reported hospital use of 2609.5 days/1000 for in-area care. The plan stated that these data included all days incurred in FY80, regardless of when paid. The Annual Report estimates the number of days not paid from fiscal year 1980 funds by Blue Cross in the final preparation of the financial report at 700-750 days for an additional cost of approximately $160,000. This difference in accounting for actual hospitalizaton will have to be examined further when the evaluation team gains access to actual utilization data.

From data reported by the Plan, analysis of days of care utilized from July 1, 1980 thru March 31, 1981 shows an in-area Medicare to non-Medicare ratio (based on days/1000 of utilization) of 5.17. This ratio is higher than the 4.54 used but is closer to the ratios developed from the analysis of the 1974 Kaiser information.

Since the affiliated inpatient costs included affiliated outpatient expenses, the only budgeted vs. actual cost comparison that is possible is:

	Budgeted	Actual	Variance
Affiliated Inpatient	$45.63		
Affiliated Outpatient	2.00		
TOTAL	$47.63	$45.21	$2.42

2. Nursing Home/Home Health Services

The projected capitation rate was $2.40 PMPM. The actual capitation was $1.03, resulting in a favorable variance of $1.64 PMPM. Included in these actual costs are expenses associated with additional benefits.

3. Clinic Services

From the audited financial statements for the year ending September 30, 1980, submitted to HCFA February 1982, total Medicare non-renal clinic payments were $725,174.16 for 18,294 membermonths of care. This represents a capitation payment of $39.64, matching the budget.

There are two comments concerning the actual clinic payments. First, from an analysis provided by GMCHP, the Clinic suffered a $67,400 loss for the demonstration enrollees in the four month period. This number was calculated by first adjusting Clinic revenues by the amount of affiliated provider payments. The subtraction of $117,200 left a net Clinic revenue for the demonstration members of $608,000. When compared with allocated Clinic expenses of $675,400, the result was a $67,400 loss. When the capitation is compared with the fee-for-service equivalent charges for the services provided, the "lost revenue" is even greater for the Clinic.

The second comment concerns the assumptions behind the multipliers. Analysis provided by the GMCHP shows the following actual vs. estimated elements:

	Actual	Initial Estimate	Final Estimate
Outpatient Multiplier	1.68	1.78	1.73
Inpatient Multiplier	3.41	3.43	3.33
% Services Inpatient	44.7%	37%	37%

The final estimates are extrapolations of the changes that occurred after the development of the initial capitation. The major discrepancy, from the Clinic's standpoint, seems to have been in the distribution of inpatient/outpatient services. Inpatient professional care was 21% higher than planned. The reported encounter rate at the Clinic was 6,323/1000.

4. Out-of-Area Services

Since these services were reimbursed on a capitation basis, from the plan's standpoint, actual cost equaled budgeted cost of $6.69 PMPM. Actual out-of-area use and unit cost information has not been analyzed.

5. BCBSU Administration

Actual GMCHP costs included the $1.07 PMPM payment (Administrative capitation plus special marketing) plus 3% of all outpatient expenses processed, the total of which equaled 1.13 PMPM; this resulted in an unfavorable variance of $.08 PMPM, for administrative services ($.06 PMPM when special marketing is included).

6. Expense Offsets

Coordination of benefits provided a $.15 PMPM cost offset and investment income gave a $.54 PMPM cost offset; the result was a $.92 PMPM unfavorable variance for these two categories.

7. Revenue

Reported revenue was $95.97 PMPM with HCFA payments showing an unfavorable variance of $.39 PMPM and the beneficiary payments showing a favorable variance of $.27 PMPM.

4.6 Adjusted Community Rate Development and Fiscal Performance Benefit Period 2 (October 1980 - September 1981)

In developing an ACR for the second benefit period, GMCHP faced many of the same problems as Fallon Community Health Plan. First, the initial benefit period was an abbreviated year (four months). There was little experience upon which to build the next benefit period's ACR. The Plan had to establish and negotiate the new rate without access to a limited first period data set. Finally, because of the adjustment of reimbursement to their specific population (i.e., shift from APC to AAPCC), the HCFA payment actually decreased for Year 2.

The rate-setting process was very similar to Year 1. First, the community rate was established (see Exhibit 4-7). Multipliers were estimated, the initial ACRs calculated, and the final rate negotiated. Exhibit 4-7 also shows the ACR and Year 1 and Year 2 multipliers. No changes in the benefit package occurred.

Affiliated Inpatient Services

Before developing the final multipliers, GMCHP staff calculated an APC and an AAPCC for their service area from rate tables supplied by HCFA. As shown below, GMCHP's calculations demonstrated a reduction in the rate because of the characteristics of the beneficiary group and the methodology of the AAPCC:

	1980/81 APC	1980/1981 AAPCC	% Reduction
Part A	$59.31	$52.21	11.97%
Part B	26.69	24.76	7.23%
Total	$86.00	$76.97	10.50%

Two changes occurred in establishing the Year 2 rates. First, the multiplier of 4.54 was lowered by the percentage reduction in the Part A component of the AAPCC discussed above, i.e., 4.54 x (1 - .1197) = 3.997. Second, a separate Medicare per diem was negotiated with each hospital. A comparison of the community rate per diems and Medicare per diems is:

	Community Rate Per Diem	ACR Per Diem	% Difference
St. Joseph's	284.00	267.00	6.0%
Neillsville	205.00	189.81	7.4%
Medford	231.00	192.15	16.8%

Second Year ACR per diems increased 4.7% at St. Joseph's; 18.2% at Neillsville; and 7.6% at Medford over first year per diems.

EXHIBIT 4-7

1980-1981 ACR
RATE DEVELOPMENT

Rate Component	Final Non-Medicare Rate 10/1/80-9/30/81	1979-1980 ACR Multipliers	1980-1981 ACR Multipliers		1980-1981 Final ACR
Clinic					
Medical	$18.51	2.321	2.153		$39.85
Administrative	.22	--	--		.22
Hospitals					
St. Joseph's @284.00	10.57	4.54	3.997	@267.00	39.70
Neillsville @205.00	.57	4.54	3.997	@189.81	2.12
Medford @231.00	.79	4.54	3.997	@192.15	2.61
Added Benefits	.24	1.78	1.65		.40
SNF and Home Health	.29	48.00	8.48		2.46
Affiliated Outpatient	1.50	1.71	1.59		2.39
Out-of-Area					
Inpatient Hospital	1.75	5.85	4.90		8.58
Outpatient Hospital	.36	2.225	1.932		.70
Professional Services	.33	2.913	2.68		.88
BCBSU Administration	1.06	--	--		1.06
Other Coverage	-.79	--	--		-.79
SUB-TOTAL	$35.40				$100.18
Investment Income	-.06	--	--		-.06
TOTAL	$35.34				$100.12

Capitation estimates using the community rate projection of days per 1000 per facility, the multiplier and the ACR per diems, were as follows:

	CR Days/1000	× Multiplier	× Per Diem	/12,000 = Capitation
St. Joseph's	446.4/1000	3.997	$267.00	= $39.70
Neillsville	33.6/1000	3.997	189.81	= 2.12
Medford	40.8/1000	3.997	192.15	= 2.61

In the face of an 11.97% reduction in Part A HCFA revenue resulting from the shift from APC to AAPCC reimbursement, GMCHP projected a hospital use 8.0% less than the first year period (i.e., 2261 days/1000 to 2081 days/1000) and reduced the hospital capitation payment 2.6% (i.e., $45.63 to $44.43).

SNF and Home Health

The SNF capitation was calculated by applying the Part A percentage reduction of 11.97% to Year 1 utilization and multiplying by the Year 2 projected cost per day of $39.96, i.e.:

520 days/1000 x (1 - .1197) x $39.26 divided by 12,000 = $1.50

For the home health capitation GMCHP used as a base the local utilization experience of 440 visits/1000. This utilization then was reduced by a combination of the Part A/Part B percentage reductions (9.28%). The final calculation incorporated the expected cost per visit of $28.74:

440 Visits/1000 x (1 - .0928) x $28.74 divided by 12,000 = $.96

The combined projection for this category was $2.46 and when this number was compared with the community rate, the 8.48 multiplier was "backed into." Combined SNF and home health capitation increased only $.06 PMPM over the first benefit period.

Clinic Services

To develop the medical service multiplier, the Year 1 factor of 2.321 was reduced by 7.23%, i.e., 2.321 x (1 - .0723) = 2.153. The resulting medical services capitation was $39.85, which resulted in only a 1.2% increase from year 1. As in Year 1, the administrative component multiplier was 1.0. The total Clinic services capitation was $40.07, with the administrative component actually $.06 PMPM less than in Year 1.

Affiliated Outpatient

The Year 1 multiplier, 1.71 was adjusted by the reduction in the Part B component of the AAPCC to develop a new multiplier, 1.59. The budgeted capitation was $2.39.

Additional Benefits

The Year 1 multiplier, 1.78 was adjusted by the reduction in the Part B component of the AAPCC to develop a new multiplier, 1.65. The budgeted capitation was $.40.

Out-of-Area Services

The development of the multipliers for Year 2 involved adjusting the Year 1 multiplier by the appropriate reduction factors (Part A or Part B) and by applying slightly reduced out-of-area factors. The actual derivation of these factors is not clear. The mechanics of the capitation development are:

	CR	x	Year 1 Unadjusted Factor	x	Population Reduction Factor	x	Out-of Area Factor	=	Capitation
Inpatient Hospital	$1.75		4.68		(1 - .1197)		1.19		$8.58
Outpatient Hospital	.36		1.78		(1 - .0723)		1.17		.70
Professional Services	.33		2.33		(1 - .0723)		1.24		.88

BCBSU Administration

The Year 2 budgeted capitation for administration services was $1.06.

Other Coverage Saving/Investment Income

GMCHP has not provided detailed information for establishing these capitation offsets. The FY80 estimate for coordination of benefits was $.70; actual experience for Medicare enrollees, $.15. The FY81 rate of $.79 PMPM was set before this actual experience was known. The budget for investment income was $.06 PMPM, compared with a budget of $.91 PMPM and experience of $.54 PMPM in Year 1.

HCFA Capitation

The negotiated HCFA capitation was $74.18, which represented 98.0% of the AAPCC and, in effect, was a .3% decrease from the first year capitation.

Beneficiary Premium

The beneficiary premium was set at $25.94. This figure resulted from an analysis of what was needed after both the ACR and the HCFA capitation were finalized. As in the FY80 submission, there is a justification for this premium, (Exhibit 4-8) with documentation provided with the Year 2 rate submission. The components of a full charge were:

Copayment/Deductible (Using HCFA Assumptions)	$12.91
Added Benefits	14.44
Total	$27.35

EXHIBIT 4-8

GMCHP/MEDICARE

RATE DETERMINATION FOR BENEFIT DIFFERENCES

Item	Current GMCHP or Manual Rate		Other Modifier		Remove Retention	Cost of Service		Frequency	+65 Multiplier	Rate Per Month
1	$0.14		x		.88				4.120	$0.51
2	.32		x		.88				4.120	1.16
3	--									--
4	.16	x	.97						5.77	1.46
5	.12		x		.88				4.120	.44
6	.32		x		.88				1.65	.46
7						$154	x	.60	1.00	7.70
8	.40		x		.825				2.162	.71
9	.43	x	.711	x	.825				2.162	.55
10	--									--
11						$ 35.20	x	.35 x 1.1	1.00	1.13
12	.58	x	.50	x	.825				1.00	.32
TOTAL										$14.44

ESRD Beneficiaries

The FY 81 HCFA renal payment to the Plan was $2168.17 PMPM.

Fiscal Performance, Benefit Period 2
(October 1980 - September 1981)

Exhibit 4-9 shows a loss of $15.04 PMPM. This translates into approximately $1,404,000 (i.e., 93,350 member-months x $15.04 PMPM). For enrollees with end-stage renal dialysis, GMCHP financial statements show a $56,000 surplus.

Analysis of specific cost categories follows.

1. Affiliated Inpatient Care

From the audited financial statement, it is not possible to separate affiliated inpatient care from the category of affiliated outpatient. The total dollar payment for these benefit categories was $5,626,204.50 (including provisions for unpaid claims of $889,800). The resultant actual capitation was $60.27, compared with an overall budgeted capitation of $46.82 for all of these benefits. Within this budget, affiliated hospital was projected at $44.43. The budgeted utilization for affiliated inpatient care was 2,081 day/1000 for Medicare non-renal enrollees and 521 days/1000 for the community rate. From a BCBSU special analysis, the actual affiliated inpatient community rate for FY81 was reported to be 537 days/1000, with a total inpatient demand (both for affiliated and out-of-area) of 652 days/1000. The reported utilization for the non-renal Medicare enrollees was 2,593 days/1000 for affiliated inpatient care and 2,999 days/1000 for total hospitalization. It is not clear whether these statistics also count the 700-750 days not included in the initial period, which were mentioned in the discussion of the Year 1 ACR.

2. SNF and Home Health

The cost of "additional benefits" was included with SNF and home health. The Plan provided a capitation figure of $3.64, which was compared with the budget of $2.86 PMPM, resulting in a negative variance of $.78 PMPM. Home health use was 159 visits/1000 and SNF care use was 335 days/1000.

3. Clinic Services

GMCHP's financial statment shows Clinic payments of $3,740,527.19. For 93,350 member-months, the actual and budgeted capitation amounts are the same; $40.07 PMPM. However, it is clear the Clinic experienced a large loss through this capitation arrangement.

The Clinic estimated that for the first benefit period of four months, losses for demonstration enrollees were $67,400. For the first five months of FY81, the Clinic estimated losses of $407,400. The Clinic

EXHIBIT 4-9
GREATER MARSHFIELD COMMUNITY HEALTH PLAN
Year 2: October 1, 1980 - September 30, 1981
Capitation

	Budgeted	Actual	Variance Favorable	Variance Unfavorable
MEMBERMONTHS		93,350		
EXPENSES				
• Affiliated Inpatient				
St. Joseph's	39.70	$60.27		$13.45
Neillsville	2.12			
Medford	2.61			
• SNF and Home Health				
SNF	1.50	3.64		.78
Home Health	.96			
• Clinic				
Medical Service	$39.85	$40.07		
Administration	.22			
Medical Director	--	--		
Newsletter	--	--		
• Affiliated Outpatient	2.39*			
• Additional Benefits	.40**			
• Out-of-Area Emergency/Referral				
Inpatient Hospital	8.58			
Outpatient Hospital	.70	10.18		.02
Professional Services	.88			
• BCBSU Administration	1.06	1.14		.08
• Other Coverage Savings	(.79)	(.44)		.35
• Other Adjustments	(.06)	(.14)	$.08	
TOTAL	100.12	114.72		14.60
REVENUES				
• HCFA Payment	74.18	73.91		.27
• Individual Payment	25.94	25.97	.03	
TOTAL	$100.12	$99.88		$.24
REVENUES LESS EXPENSES	--	($14.84)		$14.84

*Included with affiliated inpatient for variance analysis.
**Included with SNF and Home Health for variance analysis.

estimated that the portion of the capitation payment retained after affiliated payments was only 59.1% of fee-for-service equivalent charges and 74.6% of allocated costs. The encounter rate at the Clinic was reported to be 6,406/1,000, compared with 6,323/1,000 in Year 1.

4. Affiliated Outpatient

Specific claims data is unavailable. GMCHP estimates these costs at $2.57 PMPM through April 1981, compared with the budgeted capitation of $2.39.

5. Additional Benefits

Preliminary data for June 1980 - May 1981 show cumulative costs of $1.09 PMPM. This compares with the budgeted amount of $.40 PMPM.

6. Out-of-Area

BCBSU data showed an actual cost for this service of $10.89 PMPM for hospital inpatient with outpatient cost being $10.19 PMPM and professional services cost being $.70 PMPM. BCBSU had budgeted $10.16 PMPM for all services, $9.28 PMPM for hospital inpatient and outpatient and $.88 PMPM for professional services.

From GMCHP's standpoint actual expense should equal budgeted expense, since BCBSU is capitated. From the financial statements, GMCHP reimbursed BCBSU $950,124.53 for out-of-area, equating to a capitation of $10.18. This slight difference from the budgeted capitation payment could easily be caused by a variance in membermonths.

7. BCBSU Administration

BCBSU's reported costs are as follows:

Year	Capitation
1979	$1.30
1980	1.55
1981 (estimated)	1.62

These amounts represent costs for all GMCHP members and not Medicare enrollees in particular.

This summary analysis indicates that BCBSU has been subsidizing GMCHP operations. Further analysis may determine the extent of administrative responsibility assumed by BCBSU. Year 2 experience was $1.14 PMPM, with the variance of $.08 PMPM created by the cost of processing outpatient claims.

8. Other Coverage Saving/Investment Income

From the financial statements, actual experience was $.44 PMPM, compared to a budget of $.79 PMPM.

9. Revenue

The actual revenue, from the financial statements, was $99.88, with actual HCFA payments being $73.91 PMPM and the beneficiary payments being $25.97 PMPM.

4.7 Adjusted Community Rate Development and Fiscal Performance Benefit Period 3 (October 1, 1981 - September 30, 1982)

GMCHP discontinued use of community rate multipliers and based the ACR on actual Medicare experience through May 1981. Because of the large losses experienced through Year 2, GMCHP negotiated a separate risk-sharing arrangement with HCFA for inpatient services. Exhibit 4-10 shows the Plan's experience through May 1981, the ACR prior to negotiations (i.e., initial ACR), and the final negotiated ACR.

The initial ACR was $147.39; an increase of 28.3% over FY81 actual costs. With an estimated HCFA payment of $87.46 PMPM, the beneficiary premium would have been $59.93 a month; an increase of over 130% from the previous benefit period. The final negotiated ACR resulted primarily from a $26.16 decrease in affiliated inpatient capitation and a $1.40 reduction in the out-of-area emergency and referral capitation. The resulting $119.46 ACR allowed GMCHP to set the FY82 beneficiary premium at a more marketable $32.00 PMPM.

Affiliated Inpatient Services

The basis for this capitation estimate were the following negotiated per diems and projected days/1000:

	FY82 Per Diem	Projected Days/1000
St. Joseph's	$325.00	1360.6
Neillsville	218.28	135.2
Medford	245.21	122.8
		1618.6

Per diems increased 21.7% at St. Joseph's; 15% at Neillsville; and 27.6% at Medford over FY81 amounts. The inpatient use assumption of 1618.6 days/1000 is much lower than the 2081 days/1000 budgeted for FY81, and the reported 2593 days/1000 experienced. Budgeted use in the final ACR was much less than the plan projected in their initial FY82 rate-setting deliberation -- 2882.5 days/1000 or $67.98 PMPM.

The lower hospital use projections were the result of a risk-sharing arrangement GMCHP negotiated with HCFA. Under this arrangement, HCFA agreed to the following risk-sharing formula:

Patient Days Per Thousand Participants Per Year (From-Through)	GMCHP Fund	HCFA	Marshfield Clinic
0 - 1618.6*	100.0%	--	--
1618.7 - 1652.7	--	100.0%	--
1652.8 - 2200.0	1.0%	99.0%	--

EXHIBIT 4-10

Comparative Data Used in FY82 ACR Development

Benefit Category	Fiscal Year 1980 Final ACR	Fiscal Year 1980 Actual	Fiscal Year 1981 Final ACR	Fiscal Year 1981 Actual	Experience (thru May 1981)	Initial FY 82 ACR	Final ACR
Clinic Services							
Medical Service	$39.06	$39.64	$39.85	$40.07	$50.98	$57.10	$58.32
Administration	.28		.22		.33	.48	.48
Medical Director	--		--		.16	.24	.24
Newsletter	--		--		.03	.05	.05
Affiliated Inpatient							
St. Joseph	40.87		39.70		53.93	59.59	36.85
Neillsville	1.95		2.12		3.88	4.46	2.46
Medford	2.81		2.61		3.42	3.93	2.51
Additional Benefits	.27	46.24	.40	63.91	1.09	1.36	1.36
SNF and Home Health	2.40		2.46		2.08	2.59	2.59
Affiliated Outpatient	2.00		2.39		2.57	3.20	3.20
Out-of-Area Emergency & Referral							
Inpatient Hospital	5.44		8.58		7.09	9.01	7.80
Outpatient Hospital	.40	6.69	.70	10.18	.61	.78	.69
Professional Services	.85		.88		.70	.87	.77
BCBSU Administration	1.05	1.13	1.06	1.14	1.55	1.81	1.70
Special Marketing Expense	.02	--	--		--	--	--
Other Coverage Savings	-.70	-.15	-.79	-.24	-.56	-.67	-.80
Total Expense	$97.00	$93.55	$100.12	$115.06	$127.86	$144.80	$118.22
Investment Income	-.09		-.06	-.14	-.09	--	-.05
Reserve Applied	-.82		--		--	--	--
Recovery Applied	--		--		--	2.59	1.29
Total Revenue Requirements	$96.09	$93.01	$100.12	$114.92	$127.77	$147.39	$119.46

*Hospital capitation includes Affiliated Outpatient costs.

2200.1 - 2400.0	5.0%	95.0%	--
2400.1 - 2500.0	10.0%	90.0%	--
2500.1 - 2600.0	37.5%	25.0%	37.5%
2600.1 - 2699.9	100.0%	--	--
2700.1 - 2830.0	--	--	100.0%
2830.1 - or Higher	100.0%	--	--

To examine the impact of this risk sharing arrangement, consider two cases. First, assume that the Year 3 affiliated inpatient usage is the same as that reported in Year 2, 2,593 days/1000. Applying the formula, HCFA would accept responsibility for the following days:

$$.25 \times (2{,}593 - 2{,}500) + (.9 \times 100) + (.95 \times 200) + (.99 \times 547.2) + 34$$
$$= 23.25 + 90 + 190 + 541.7 + 34$$
$$= 878.95 \text{ days/1000} = 879 \text{ days/1000}$$

The net utilization for GMCHP would then be 1,679 days/1000 (2,593 less 879 less 35 days which would be the responsibility of the Clinic) for an unfavorable variance of approximately 60 days (1,619 less 1,679).

In the second case, assume that a similar risk sharing arrangement had been in existence for Year 2, only that the Plan's responsibility had been their budget of 2,081 days/1000. Therefore, replacing 1,618.6 with 2,081 and retaining all of the other features of the arrangement, the reduction in affiliated inpatient usage would have been:

$$.25 \times (2{,}593 - 2{,}500) + .9 \times 100 + .95 \times 200 + .99 \times (2{,}200 - 2{,}081)$$
$$= 23.25 + 90 + 190 + 117.8$$
$$= 421.1 \text{ days/1000} = 421 \text{ days/1000}$$

Therefore, of the 2,593 days/1000 experienced, approximately 421 would have been covered by HCFA under this agreement leaving an adjusted utilization rate of 2,172 days/1000. Of the remaining amount, again 35 days/1000 would have been covered by the Clinic and 2,137 days/1000 by the Plan. This utilization would still have exceeded the budget.

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*1618.6 represents the budgeted days included in the projected hospital capitation of $41.82. The actual calculation of the Risk-Sharing may vary from 1618.6 because the actual average per diem payment may vary from the estimated average per diem payment. The $41.82 is the contractual basis for calculating the amount of the Risk-Sharing.

One final note concerning the administration of the risk sharing agreement. Payments from HCFA to the Plan were to be triggered during the year following receipt of quarterly reports, with total loss to be determined and all adjustments completed within six months of the close of the fiscal year (September 30, 1982).

SNF and Home Health

Information through May 1981 showed a cumulative capitation of $2.08 as of December, 1980. Applying a factor of 1.6% per month (15.3 months x .016 = 0.2448) the projection of $2.59 PMPM was derived:

$2.08 x 1.2448 = $2.59

This projection is similar to prior budgets.

Clinic Services

1. Medical Services

The medical services component was projected to be $58.32, which is composed of $57.10 (a 12% increase over actual Marshfield Clinic costs for the period October 1, 1980 through February 28, 1981), plus an estimate of $1.22 PMPM for out-of-area referrals. The actual medical services were estimated at $50.98 from the analysis performed by Marshfield Clinic personnel and addressed in the discussion of Clinic services in the Year 2 rate assessment. The $58.32 is a 46.3% increase over the FY81 capitation. Per the agreement between the Clinic and GMCHP, the Clinic would compute actual costs, compare them with capitation payments, have the analysis verified and refund to GMCHP any payments above cost.

2. Administrative Services

For benefit year 3, administrative services were subdivided into three components, with the following budgets:

Administration	$.48 PMPM
Medical Director	.24 PMPM
Newsletter	.05 PMPM

These numbers were developed by taking the Clinic budgets for FY '82 for all GMCHP enrollees and dividing to derive the capitations. Note that, altogether, administration increased from a budget of $.22 PMPM in Year 2 to $.77 in Year 3. Since this capitation is part of the overall GMCHP payment, it is subject to the same year end retroactive pay-back.

Affiliated Outpatient

From Exhibit 4-10, the experience for the period 6/1/80 - 2/28/81 (paid through April '81) was $2.57. This number was derived using BCBSU charge data, applying a completion factor of .9798 and a discount factor of 90% of charges. Since the midpoint of this time frame was November 1, 1980, an adjustment of 1.6% for 17 months was used to

move the cost into FY82 (17 months x 0.016 = .272). Also the new discount factor with the affiliated hospitals was 88%. Therefore, the projected capitation of $3.20 was derived as follows:

$2.57 x 1.272 x (.88/.90) = $3.20

This figure was a 34% increase over the prior projection.

Additional Benefits

The projection of $1.36 for this benefit was considerably higher than past budgets and more in line with actual experience. Through May 1981 the cumulative capitation (June 80 through May 81) was $1.09 PMPM. Based upon a weighting of member months, this experience was determined to be for a period centered around December 21, 1980. In order to project for fiscal year 1982 (midpoint March 31, 1982), a BCBSU factor of 1.6% per month was used to develop an overall adjustment of 1.2448 (15.3 months x 0.016 = 0.2448):

$1.09 x 1.2448 = $1.36

Out-of-Area Emergency

1. Inpatient Hospital

Again, BCBSU provided summary cost data for the period June 1980 through February 1981. This experience showed a capitation of $5.10 PMPM which was adjusted, using a BCBSU Medicare complimentary business completion factor of .7194, to an expected figure of $7.09 PMPM for the period. In the interim ACR, the budget of FY82 was 9.01, derived by multiplying 7.09 by 1.272. However, in the final ACR, the projection was $7.80. GMCHP does not explain this difference. As with the Clinic capitation, an independent audit will be performed of BCBSU costs and to the extent that revenues exceed costs, an appropriate refund will be paid to the health plan.

2. Outpatient Hospital

In a manner similar to the inpatient hospital services, the following data were provided for outpatient hospital:

Experience June 80 - Feb. 81 (Paid through April)	Adjustment for June 80 - Feb. 81 (Using .7194 Factor)	Interim FY82 ACR 7/6/81
$0.4413	$0.610	$0.78

The final ACR budget was 88% of $0.78, or $0.69.

3. Professional Services

The information used in developing this projection was:

Experience June 80 - Feb. 81 (Paid through April)	Adjustment for June 80 - Feb. 81 (Using .5702 Factor)	Interim FY82 ACR 7/6/81
$0.4002	$0.70	.87

To arrive at the $.87 estimate, the $0.70 number was multiplied by 1.238 (17 months at 1.4% per month). The final ACR projection was $.77. Again, no explanation was provided as to the reduction from the interim ACR submission, although both the outpatient and professional services were similarly decreased by 10.5%.

BCBSU Administration

In a memorandum dated November 17, 1981, BCBSU indicated that their plan-wide experience for calendar year 1980 was $1.55 PMPM. For the interim estimate, this capitation was projected at $1.81 PMPM and in the final ACR, the negotiated budget was $1.70 PMPM.

Other Coverage Savings

For the period October 1980 through April 1981, the actual experience was $.305 PMPM. Using the prior year's data, a completion factor of .544 was derived, which implies a projection for FY81 of $.56. This number was then increased to $.67 PMPM for the interim FY82 ACR for subrogation and other coverage and subsequently increased further to $.80 PMPM in the final ACR budget. No explanation was provided as to the increase from the interim report.

Investment Income, Reserve and Recovery Applied

From data for the period October 1980 through April 1981 for all plan members, the investment income was $.09 PMPM. However, in the interim ACR no investment income was budgeted and in the final ACR, the per member per month projection was $.05.

No reserve budget was set. However, a recovery of $.50 PMPM was initially budgeted for the base plan with a final community rate of $.25 PMPM holding. Using the hospital day rate multiplier of 5.17, the interim ACR component was $2.59 PMPM with a final projection of $1.29 PMPM. This recovery was treated as a cost to the program. The net cost estimate for this category was $1.24 PMPM.

Revenue Sources

- HCFA Capitation
  The agreed upon FY82 HCFA capitation payment was $87.46 which represented 99.0% of the AAPCC and was a 17.3% increase over the FY81 HCFA capitation.

- Beneficiary Premium
  The beneficiary premium requirement was set at $32.00. This represented an increase of 23.4% over the FY81 premium of $25.94. No detailed supporting documentation was provided.

- Renal Beneficiaries
  The agreed upon HCFA monthly per member payment for chronic renal disease beneficiaries was $2,301.21 PMPM. Additionally, these members reimbursed the Plan the monthly beneficiary premium of $32.00.

Fiscal Performance, Benefit Period 3
(October 1981 - September 1982)

Actual experience is given in Exhibit 4-11. Expenses exceeded revenues by $4.16 PMPM, which represented a loss to GMCHP of approximately $437,000. Without the HCFA risk sharing agreement, the loss would have been $21.43 PMPM (Approximately $2,252,000). The Plan reported a gain of $187,000 for the ESRD population.

A comparison of budgeted versus actual for each cost category is as follows:

1. Affiliated Inpatient Services

The reported hospital costs were $60.29 PMPM, which represented an unfavorable variance of $18.47 PMPM. At the close of the fiscal year, GMCHP submitted their final calculation of the HCFA risk payment. Their statistics showed inpatient utilization at 2,349.5 days/1,000 resulting in a total payment due of $1,853,705, of which $1,261,044 had already been paid. The results of the independent audit lowered the total HCFA risk share to $1,814,992, for a capitation of $17.27. The HCFA risk payment effectively lowered the hospital unfavorable variance to $1.20 PMPM.

2. SNF and Home Health

The capitation experience provided by the Plan for the third benefit period was $4.86, resulting in an unfavorable variance of $2.27 PMPM.

3. Clinic Services

Since this service was capitated, reported costs equaled the budgeted figures. Reported utilization was 7,405 encounters/1000.

4. Affiliated Outpatient

In prior years, the cost of this service had been included with affiliated inpatient care. For FY82, however, GMCHP separately reported experience of $4.03 PMPM for an unfavorable variance of $.83 PMPM.

EXHIBIT 4-11
GREATER MARSHFIELD COMMUNITY HEALTH PLAN
Year 3: October 1, 1981 - September 30, 1982
Capitation

	Budgeted	Actual	Variance Favorable	Variance Unfavorable
MEMBERMONTHS	111,996	105,071		6,925
EXPENSES				
• Affiliated Inpatient				
St. Joseph's	$36.85	$50.06		$13.21
Neillsville	2.46	4.60		2.14
Medford	2.51	5.63		3.12
• HCFA Risk Sharing	-	(17.27)	$17.27	
• SNF and Home Health				
SNF				
Home Health	2.59	4.86		2.27
• Clinic				
Medical Service	$ 58.32	58.32		-
Administration	.48	.48		-
Medical Director	.24	.24		-
Newsletter	.05	.05		-
• Affiliated Outpatient	3.20	4.03		.83
• Additional Benefits	1.36	1.75		.39
• Out-of-Area Emergency/Referral				
Inpatient Hospital	7.80	7.80		-
Outpatient Hospital	.69	.69		-
Professional Services	.77	.77		-
• BCBSU Administration	1.70	1.70		-
• Other Coverage Savings	(.80)	(.06)		.74
• Other Adjustments	1.24	.25	.99	-
TOTAL	$119.46	$123.90		$4.44
REVENUES				
• HCFA Payment	87.46	87.70	.24	
• Individual Payment	32.00	32.04	.04	
TOTAL	$119.46	$119.74	$.28	
REVENUES LESS EXPENSES	-	($4.16)		$4.16

5. Additional Benefits

The plan reported a capitation experience of $1.75 PMPM, resulting in an unfavorable variance of $.39 PMPM.

6. Out-of-Area Emergency/Referral

Since this service was capitated, actual GMCHP payments equaled the budgeted costs.

7. BCBSU Administration

The actual payments agreed with the budget since in Year 3 there were no additional charges for processing outpatient claims.

8. Other Coverage Savings

Actual reported savings were $.06 PMPM, resulting in an unfavorable variance of $.74 PMPM.

9. Investment Income and Recovery Applied

The Plan reported an actual expense of $.25 PMPM, with no detail as to the division between investment income and recovery.

10. Revenue

Actual reported revenue was $119.74 PMPM. This figure represented a favorable variance of $.28 PMPM; $.24 PMPM for the HCFA payments and $.04 PMPM for individual premiums.

4.8 Adjusted Community Rate Development Benefit Period 4 (October 1, 1982 - September 30, 1983

The medical service delivery component of the demonstration was scheduled to end September 30, 1982. Encouraged both by reported reductions in inpatient utilization through the early part of 1982 and the risk sharing agreement negotiated with HCFA, GMCHP desired to continue this portion of the demonstration. HCFA responded to GMCHP's overture by stating in January, 1982 that they would consider an additional year only under the condition that HCFA reimbursement would be set at 95% of the AAPCC. As a guide to measuring this reimbursement, HCFA's April estimate of the APC (using 1975 through 1979 data) was $119.82 PMPM. The revised APC (incorporating 1980 information) was $123.21 PMPM (provided in July) and the fiscal year 1983 AAPCC was calculated to be $105.42 PMPM (provided August 18, 1982). GMCHP submitted a draft ACR in June and a final ACR August 12, 1982. Accompanying the final ACR submission was a proposal to guarantee that the inpatient utilization would not exceed 2250 days/1000.

HCFA decided not to extend the demonstration by the end of September. In reaching this decision, the Plan reported that the government considered three options:

- The GMCHP August 12, 1982 ACR proposal.
- The original HCFA offer of 95% of the AAPCC.
- An arrangement similar to the one in Fiscal Year 1982, with more restrictive risk sharing levels.

The remainder of this section will discuss the three options considered by HCFA, the first option being the ACR submitted by GMCHP. A summary of the proposed ACR is given in Exhibit 4-12.

Affiliated Inpatient Services

The basis for this capitation estimate were the following negotiated per diems and projected days/1000:

	FY83 Per Diem	Projected Days/1000
St. Joseph's	371.53	1,882.3
Neillsville	250.00	223.3
Medford	287.41	264.4
		2,370.0

Per diems would have increased 14.3% at St. Joseph's; 14.5% at Neillsville; and 17.2% at Medford over FY'82 budgets. The 2370 days/ 1000 represented actual reported Plan experience for the Year ending June 30, 1982, and compared very closely with the reported 2349.5 days/1000 for Fiscal Year 1982.

Marshfield Clinic Risk Sharing

In order to lower the ACR from $123.50 to $120.00 PMPM, the Marshfield Clinic agreed to guarantee that the Plan's exposure of inpatient usage would not be above 2250 days/1000 vs the 2370 days/1000 originally budgeted. This reduction of $3.50 PMPM was calculated as follows:

	FY83 Per Diem	Days/1000 Reduction	Capitation
St. Joseph's	$371.53	95.3	$2.95
Neillsville	250.00	11.3	.23
Medford	287.41	13.4	.32
			$3.50

Clinic Services

1. Medical Services (Marshfield Clinic Costs)

The Marshfield Clinic estimated their cost for delivering benefits to enrollees to be $62.81 PMPM. This projection represented a 10% increase over the $57.10 budget for fiscal year 1982.

EXHIBIT 4-12
GREATER MARSHFIELD COMMUNITY HEALTH PLAN
Year 4: October 1, 1982 - September 30, 1983
Proposed Capitation as of August 12, 1984

	Budgeted
MEMBERMONTHS	114,000
EXPENSES	
• Affiliated Inpatient	
St. Joseph's	$ 58.28
Neillsville	4.65
Medford	6.33
• Clinic Risk Sharing	(3.50)
• Clinic	
Medical Service (Clinic Costs)	62.81
Medical Service (Clinic Referral Costs)	1.38
Medical Service (Affiliated Phys. Ref. Costs)	.36
Administration	.72
• Affiliated Outpatient	4.22
• Additional Benefits	7.45
• Out-of-Area Emergency/Referral	17.29
• BCBSU Administration	2.00
• Other Coverage Savings	(.13)
• Other Adjustments	3.14
TOTAL	$165.00
REVENUES	
• HCFA Payment	120.00
• Individual Payment	45.00
TOTAL	$165.00
REVENUES LESS EXPENSES	-

2. Medical Services (Marshfield Clinic Referral Costs)

This cost category represents the cost of institutional and professional charges associated with Clinic physician referrals out-of-area. The risk for this service was first assumed by the Clinic in FY'82, under a budget of $1.22 PMPM. A projection of $1.38 PMPM was established for FY'83, based upon the experience through June 30th, 1982 and adjusted using BCBSU factors.

3. Medical Services (Affiliated Provider Referrals Costs)

Effective October 1, 1982, the Clinic agreed to accept the risk for the cost of institutional charges associated with referrals made by affiliated providers. The BCBSU actuarial staff estimated their PMPM cost for this service to be $.40. The Clinic assumed that they could effect a 10% reduction and budgeted $.36 PMPM.

4. Administrative Services

Administrative services in FY'82 were subdivided into three components, with a total PMPM budget of $.77. The FY'83 projection was $.72 PMPM, representing a reduction due to increased efficiencies in claims processing and automation.

Affiliated Outpatient

The budget of $4.22 PMPM was based on actual experience for the year ended March 31, 1982, adjusted to the new fiscal year using a BCBSU factor of 1.6% per month. This budget was 31.9% greater than the prior year's projection and 4.7% greater than the final reported experience for FY'82. This increase was attributed to a substitution of outpatient services for inpatient services.

Additional Benefits

This category included costs for ambulance services, prosthetic devices and durable medical equipment in addition to nursing home care and home health care, which had been budgeted separately in prior years. The estimate of $7.45 PMPM was based upon actual experience for the year ending March 31, 1982, adjusted by the FY'83 BCBSU factor of 1.6% per month. This budget is 88.6% greater than the prior year's budget but only 12.7% greater than the final experience. The dramatic increase over budget was again attributed to increased utilization of nursing home and home health care as a substitute for use of hospital services.

Out-of-Area Emergency

The budget for this category was $17.29 PMPM, representing an increase of 86.7% over the prior year's budget. If the affiliated provider referral cost of $.40 PMPM (now a Clinic responsiblity) is added to the budget and compared with the prior year, the increase would have been 91.0%. BCBSU had assumed full risk for this service under a capitation arrangement from the inception of demonstration and had

reported losses of approximately $319,000 through March 31, 1982. The experience through the year ending March 31, 1982 and BCBSU actuarial inflation factors of 1.6% per month and a use trend of .6% per month were used to derive the FY'83 budget. This category also included payments to six area hospitals who were not affiliated with the Plan which resulted mainly because of enrollment growth at the periphery of the Plan's service area.

BCBSU Administration

BSBSU estimated their costs to be $2.00 PMPM for the upcoming year which was a 17.6% increase over the prior year's budget.

Other Coverage Savings

This budget was $.13 PMPM based on actual experience through March 31, 1982 and adjusted to FY'83 using a 1.6% per month factor. The budget for the prior year was $.80 PMPM, with the final experience being $.06 PMPM.

Loss Recovery, Interest Expense

The budget for this category was $3.14 PMPM and represented a five year amortization of expected program losses as of September 30, 1982. The prior year budget was 1.24 PMPM and the experience was $.25 PMPM.

Revenue Sources

- HCFA Capitation
  The requested reimbursement by GMCHP was $120.00 PMPM which represented a 37.2% increase over the amount budgeted in the prior year ($120.00/$87.46). The proposed payment also was 19.8% greater than the 95% of the AAPCC proposed by HCFA ($120.00/$100.15).

- Beneficiary Premium
  The beneficiary premium requirement was set at $45.00 PMPM, which represented a 40.6% increase over the prior year. No detailed documentation was provided.

Comparison of Proposed Options For Benefit Period 4
October 1982 - September 1983

Each of the options is examined, both from the standpoint of GMCHP and of HCFA. In this comparison, the payment by HCFA of the reimbursement amount requested by GMCHP in their ACR development was assumed to be the budget neutral position for GMCHP. The payment by HCFA of the 95% level of the AAPCC was assumed to be the budget neutral position for HCFA. The comparison of the three options, expressed in terms of dollars gained or lost from the budget neutral position for each organization, showed the following:

	Option #1	Option #2	Option #3
GMCHP	-	($2,260.000)	($59,000)
HCFA	($2,260,000)	-	($1,868,000)

These figures do not estimate total gain or loss of each organization but indicate financial position with respect to each group's most favorable situation.

1. Option #1 - HCFA Payment Per GMCHP Request

GMCHP requested a HCFA reimbursement of $120.00 PMPM, which would represent the best position for GMCHP under the three options. When compared with payment at the 95% AAPCC level, HCFA would spend approximately an extra $2,262,000 (114,000 x (120.00 - $100.15)).

2. Option #2 - HCFA Payment at 95% of the AAPCC

From the Plan's standpoint, payment at 95% of the AAPCC would show a similar negative position.

3. Option #3 - HCFA Reimbursement at 99% of the AAPCC with a Hospital Risk Sharing Agreement

The other HCFA proposal provided for reimbursement at 99% of the AAPCC, which would cover all Part B services and up to 1711 days/1000 of hospitalization. If the inpatient care usage experience went beyond this budget, the following Risk Sharing Agreement would apply:

Patient Days Per Thousand Participants Per Year (From-Through)	GMCHP Fund	HCFA
0 - 1711	100.0%	--
1711.1 - 1950.0	1.0%	99%
1950.1 - 2150.0	5.0%	95%
2150.1 - 2250.0	10.0%	90%
2250.1 - 2400.0	75.0%	25%
2400.1 - or higher	100.0%	--

Under this option GMCHP would have received a HCFA reimbursement of $104.37 PMPM (99% of the AAPCC) which would have covered up to 1733.29 days/1000. This utilization figure represents the first 1711 days/1000 plus GMCHP's share of days between 1711.1 and 2250 according to the risk sharing formula. Note that for purposes of this analysis, all days are assumed to have an equal cost of $350.68. Assuming that the HCFA reimbursement was set to cover all other costs completely as delineated in the GMCHP submission, then the reimbursement available for the above mentioned 1733.29 days/1000 would have been $50.13 PMPM. However, these days would have cost $50.65 (1733.29 x 350.68/12000). This under funding would have left GMCHP $59,000 short ($.52 x 114000).

To measure HCFA's financial position under this option versus their budget neutral option, two calculations are needed. First, HCFA's monthly payments would have been 4% greater, which would have meant appoximately $481,000 more ($104.37 - $100.15 x 114000). Second, the cost of the additional hospital utilization underwritten by HCFA (assuming utilization was at least 2250 days/1000) would have been $1,387,000. This amount was derived assuming a capitation of $12.17 (416.61 x .350.68/12000) times the projected 114000 member months. The total relative negative position would have been $1,868,000.

After discussions with the Plan and analysis of the three options, HCFA decided not to renew the demonstration.

CHAPTER 5: Kaiser Permanente Medical Care Program of Oregon Rate Setting Discussion

5.1 Background

The Kaiser-Permanente Medical Care Program (KPMCP) is the largest non-governmental health care provider in the United States, providing care to over 3.6 million individuals in 1979. Program operations are divided into seven regions, with regional operations coordinated by the following entities:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals, Inc.
- Medical Groups

All Kaiser operations are federally qualified health maintenance organizations. In the Oregon region (i.e., the Kaiser component participating in this demonstration) the Health Plan contracts for hospital, physician and dental care. Additionally, the Health Plan provides administrative services and operates pharmacies, medical and dental clinics.

The Plan began operations under the demonstration in 1980, with the following benefit periods:

Benefit Period 1	August 1980-December 1980
Benefit Period 2	Calendar Year 1981
Benefit Period 3	Calendar Year 1982
Benefit Period 4	Calendar Year 1983
Benefit Period 5	Calendar Year 1984

5.2 Description of the Benefit Packages

KPMCP-O divided the potential enrollee population into two groups. KPMCP-O offered one group the same package offered to those members currently enrolled in KPMCP-O's Section 1833 Group Practice Prepayment Plan (GPPP) contract with HCFA. This "Medicare Plus" coverage offers the following enhancements over standard Medicare benefits:

- Full hospital coverage, thus eliminating the standard Medicare deductible and coinsurance features.
- Full coverage for care in skilled nursing facilities, up to 100 days.
- Part B services in full with a $2 copayment on physician visits and a $3 copayment on house calls.
- Preventive services (e.g., physical exams and eye exams), subject to a $2 copayment.

Medicare-Plus was offered at no out-of-pocket cost to the beneficiary. Exhibit 5-1 provides a more detailed comparison of Medicare-Plus to standard Medicare coverage.

EXHIBIT 5-1

COMPARISON OF MEDICARE AND MEDICARE PLUS COVERAGE

	Medicare Only	Medicare Coordinated Coverage
Outpatient:		
Doctors Office Visit	Part B Services $60 Deductible 80% Allowable	$2/Visit
Physical Therapy-Inhalation Therapy		
Alcohol and Drug Abuse Treatment		
House Calls		$3/Visit
Radiation Therapy; Chemotherapy		Covered in Full
Lab/X-Ray Services		
Casts & Dressings		
Physical Exam/Eye Exam	Not Covered	$2/Visit
Inpatient:		
Room & Board	$160 Deductible 60 Days Copayment; $30/ Day 61-90 $80/Day against 60 Day Lifetime Reserve	Covered in Full No Limit
Special Nursing		
OP Room Anesthesia		
Drugs		
X-Ray/Lab		
Physical Therapy-Inhalation Therapy		
Casts & Dressings		
Speech Therapy		
Radiation Therapy; Chemotherapy		
Skilled Nursing Facility:		
Room & Board	20 Days in Full 80 Days w/$20 Deductible/Day For 100 Days	Covered in Full for 100 Days
Nursing		
Drugs		
Physical Therapy-Speech Therapy		
Home Health Care:		
Skilled Nursing Care	100 Visits as per Part B Benefits 80/20	Covered in Full
Physical Therapy		
Speech Therapy		
Ambulance to Hospital:	80/20 Per Part B Services	Covered in Full
Ambulance to Home:		Covered in Full
Immunizations	As per Part B Services: 80/20	Covered in Full
Eyeglasses:		
Contact Lenses for Post-Cataract Surgery Patients	Approximately 80/20 Per Part B Services	Same as Medicare Coverage - Covered in Full

EXHIBIT 5-1 (continued)

COMPARISON OF MEDICARE AND MEDICARE PLUS COVERAGE

	Medicare Only	Medicare Coordinated Coverage
Emergency Benefits:		
In Area Out of Area	Per Part A Inpatient Per Part B Outpatient	Covered in Full for Qualifying Emergency Service
Durable Medical Equipment: Certain Prosthetic Devices:	80/20 Per Part B 80/20 Per Part B	Same as Medicare Covered in Full
Mental Health Services:		
Outpatient (Non Psychiatric)	$60/Deductible 80/20 Coinsurance to $312.50 max/year	$2/Visit Unlimited
Inpatient	$160/Deductible and Copayments per Inpatient 190/Day Lifetime Limit	Covered in Full 190 Day Lifetime Limit

KPMCP-O also offered four plan options to the remaining enrollees:

- Medicare-Plus at zero premium.
- Medicare-Plus, plus prescription drugs with a $1 copayment, eyeglasses and hearing aids for a beneficiary premium of $6.
- Medicare-Plus, plus dental services for a beneficiary premium of $9.81.
- Medicare-Plus, plus prescription drugs, eyeglasses, hearing aids and dental services for a beneficiary premium of $15.81.

The vision care benefit provides for new or replacement lenses every 12 months if there is a change in the prescription, or every 24 months if there is no change. Contact lenses are provided only in special situations, up to a value of $80.00. The hearing benefit includes full testing and dispensing of the aid, as well as the device itself. The dental benefit covers at no charge diagnostic, preventive, restorative, oral surgery, endodontic services, periodontics, and prosthetic appliances (per schedule). In the third year of the demonstration, the prosthetic benefit was increased.

5.3 Waivers and Variances

The plan requested the following coverage extensions:

- Lifting of limitations on coverage of institutional services.
- Right to offer preventive services.
- Right to offer other additional services such as prescription drugs, dental care, eyeglasses and hearing aids.
- Right to offer a new member entry program.

The plan requested waivers and variances to permit prospective reimbursement at 95% of the AAPCC. KPMCP-O was reimbursed under a ratebook approach. This resulted in a retrospective adjustment of the AAPCC capitation payment based upon the demographic characteristics of plan enrollees.

Waivers and variances were not specifically directed at issues which affected health care delivery such as relaxing the method by which the Plan reimbursed hospitals or the criteria to use SNFs.

Enrollment related waivers and variances allowed the Plan to avoid enrolling individuals who were ESRD eligible at the time of enrollment. However, if a person became ESRD eligible after enrollment, the Plan was responsible for care. Separate APCs for this population were set, and paid to KPMCP-O. Other waivers and variances related to enrollment were:

- Limiting the number of enrollees in the demonstration and establishing a ratio of conversions from the existing cost contract to the risk-contract.

- Limiting enrollment to individuals who were both Part A and Part B eligible.

- Eliminating the annual open enrollment period.

Regarding waivers and variances which lifted general restrictions on prepaid-contracting with HCFA, major issues related to relaxing the Medicare cost reporting requirements and maintenance of records. No specific requests pertaining to HMO organizational type were made.

5.4 Organization of the Medical Care Delivery System

In its simplest form, Health Plan operations consist of an administrative component and a medical/dental component.

Exhibit 5-2 shows the KPMCP-O payment procedures for services and the risk sharing arrangements that the plan employed. Four entities comprise KPMCP-O: 1) Kaiser Foundation Health Plan of Oregon (KFHP-O) a 501(c)(4) corporation; 2) Kaiser Foundation Hospitals (KFH) a 501(c)(3) corporation; 3) Northwest Permanente, P.C., Physicians and Surgeons (NWP), an Oregon Professional Corporation; and 4) Permanente Dental Associates (PDA). All plan administration is handled in-house, with no significant outside relationships.

Medical and dental services can be treated as either out-of-area or in-area. For out-of-area services, the Plan accepts all risk and essentially self-insures. There are no special arrangements with any out-of-area providers. The delivery of in-area care can be divided into four components: inpatient care, physician services, dental services and other services.

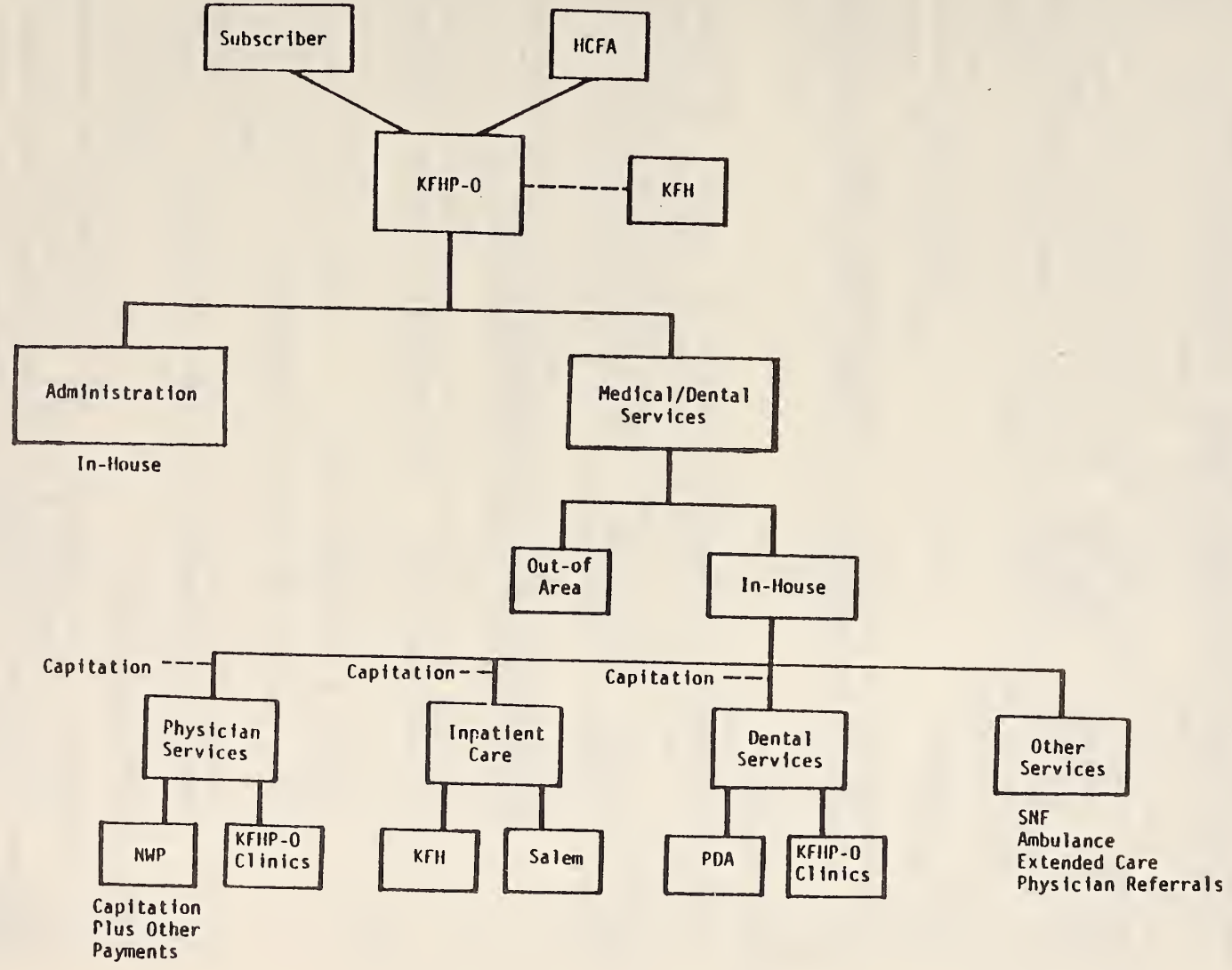
Inpatient Care

KFHP-O contracts with Kaiser Foundation Hospitals through a Hospital Service Agreement. KFH delivers services in the Portland Oregon area through two facilities, Bess Kaiser and Sunnyside. Additionally, KFHP-O has a separate contract with a hospital in the Salem, Oregon area (i.e., outside the demonstration service area).

KFH receives revenues directly from all third party payors and individuals who may not be Kaiser Health Plan members. After considering these resources, KPMCP-O provides additional monies to satisfy KFH's financial requirements. These financial requirements include operating expenses, debt services, and expansion funds. KFHP-O and KFH prepare a single financial statement. Once an annual budget for inpatient care is set for use of the Kaiser Foundation Hospitals, from the plan's standpoint a capitation payment is then establisned for each population type.

Exhibit 5-2

DIAGRAM OF KPMCHP-O's METHOD OF PAYMENT FOR SERVICE



Physician Services

KPMCP-O provides physician services primarily in two ways: a capitation arrangement with NWP or through clinics which KFHP-O operates. The agreement with NWP provides for a basic capitation payment plus other considerations (e.g., contributions by the Plan for physicians' retirement, an incentive payment to NWP contingent upon overall Plan financial performance, and support for allied health personnel costs). Kaiser also delivers care through clinics which it owns and operates. The chart of accounts indicates thirteen such clinics. In addition to these two physician arrangements, some out-of-plan physician referrals occur. As with inpatient care, once the annual budget is set, the plan in effect has a capitation arrangement for physician services.

Dental Services

Enrollees receive dental care through Permanente Dental Associates under a capitation arrangement and through Kaiser-owned and operated clinics.

Other Services

Assorted medical services are purchased as needed. No capitation arrangements are in effect with these providers. The Plan does receive a discount on ambulance services because of the large volume of services it purchases. Other types of care include skilled nursing facility services, physician referrals, extended care, and home health.

5.5 Adjusted Community Rate Development and Fiscal Performance Benefit Period 1 (August - December 1980)

KPMCP-O used an adjusted community rate approach to establish its initial Medicare capitation. The rate-setting process consisted of three steps:

- Calculate a community rate
- Divide the rate into specific components
- Develop adjustment factors which recognize the service and resource requirements of the Medicare population.

Community Rate Development

To develop an overall community rate requirement for the Oregon region, KPMCP-O established a budget for 1980 costs and capital requirements. Forecasted revenues did not assume a rate increase. A comparison of projected revenues with expenses identified a shortfall of 8.3%. A rate increase was then approved to cover this shortfall.

Exhibit 5-3 shows KPMCP-O's 1980 budget, including capitation payments. For example, the budget for "Contract Payments to Medical Group" is $19,661,000 which at an average membership of 249,000 yields a monthly capitation of $6.58. The gross 1980 capitation requirement was $35.56.

EXHIBIT 5-3

KAISER FOUNDATION HEALTH PLAN OF OREGON
AND KAISER FOUNDATION HOSPITALS
OREGON REGION

COMBINED STATEMENT OF REVENUES, COST AND CAPITAL REQUIREMENTS
($000's omitted)

	1980 Forecast	1979 Forecast	Per Member Per Month 1980	Per Member Per Month 1979
AVERAGE MEMBERSHIP	249,000	232,000		
REVENUES				
Rate Revenues before 1980 Community Rate Increase	$74,616	$66,725	$24.94	$23.92
Required 1980 Community Rate Increase	4,150	--	1.39	--
Supplemental Revenue from Members	8,145	7,768	2.72	2.78
Medicare	12,456	11,288	4.16	4.05
Non-Members	6,447	5,448	2.15	1.95
Other	579	480	.20	.17
TOTAL REVENUES	$106,393	$91,709	$35.56	$32.87
COSTS AND CAPITAL REQUIREMENTS				
Contract Payments to Medical Group	$19,661	$16,760	$ 6.57	$ 6.01
Medical Office Operating Expenses	27,280	24,265	9.12	8.70
Hospital Operating Expenses *	25,732	22,364	8.60	8.02
Health Plan Operating Expenses	1,654	1,477	.55	.53
General and Administrative Expenses	7,273	6,452	2.43	2.31
Costs of Providing Outpatient Drugs and Optical Services	7,463	6,790	2.50	2.43
Physicians' Retirement	1,664	723	.56	.26
Professional and Public Liability Insurance	3,154	2,274	1.05	.81
Community Service Program	1,194	1,007	.40	.36
In and Out-of-Area Claims	1,945	1,529	.65	.55
Ambulance Service	754	606	.25	.22
Start-Up Costs for New Facilities	370	382	.13	.14
Property Expenses:				
Depreciation	3,443	2,937	1.15	1.05
Interest	1,022	1,057	.34	.38
Rentals, Insurance, Taxes and Maintenance	1,083	876	.36	.31
Hospitals and Health Plan Capital Generation Requirements	2,701	2,210	.90	.79
TOTAL COSTS AND CAPITAL REQUIREMENTS	$106,393	$91,709	$35.56	$32.87

*Including Supplemental Beds

Exhibit 5-4 shows the allocation of this capitation to the plan's operating components. Adjustments to the overall capitation included $.37 PMPM for cost recoveries and $1.98 PMPM for non-member revenues. The resulting community rate was $33.21.

For purposes of preparing its Medicare rate, KPMCP-O reorganized the $33.21 community rate into the cost categories shown in Exhibit 5-5.

This categorization matches very closely the delineation of Medicare benefits. The claims/ambulance subset included in- and out-of-area claims, ambulance and extended care. For purposes of preparing the rate for the basic Medicare-Plus package, the pharmacy/optical category was not used since these services were not included in that package. Finally, a sixth category, entitled "Other Medicare Benefits", was added to account for services not covered by the community rate but which would be covered for the Medicare population, such as prosthetics.

Adjustment Factors

KPMCP-O used two types of adjustments to the community rate -- time/complexity and volume multipliers. These factors were developed for each benefit period for hospital, medical, and home health services.

Adjustment factors were based upon Kaiser-Permanente (KPMCP-O) 1978 data. The analysis of the time/complexity (T/C) factor consisted of two parts; one set for inpatient services (Exhibit 5-6) and one set for medical services (Exhibit 5-7). To derive the hospital factors, 1978 KPMCP-O enrollment was divided into three components: members 65 or older, Medicare-eligible disabled enrollees, and remaining enrollees. Actual per diems for each population, sub-divided into Part A and Part B components, were calculated and the adjustment factors were the ratios of the different population specific per diems to the average per diem.

Time and complexity factors for medical services derived from adjusting total services by enrollee category by a HCFA-determined intensity factor of 1.2 for aged members (i.e., Aged Medicare beneficiaries require 20 percent more time than under-65 enrollees). Services include doctor office visits, patient days, doctors' house calls, and radiologist visits. Exhibit 5-7 shows how the medical services T/C factors were calculated.

KPMCP-O developed volume multipliers by taking ratios of utilization of hospital, medical, and home health agency services for the aged and disabled enrollee categories to total plan utilization. Exhibit 5-8 shows these calculations.

Finalizing Initial Aged and Disabled ACRs

Final rate development entailed adjusting the community rate on a benefit-by-benefit basis using these multipliers. Exhibit 5-9 shows calculation of the aged rate. For example, the Part A hospital component of the community rate is multiplied by a composite rate derived from multiplying the T/C factor by the volume factor (e.g., for Part A hospital, 4.2409 x .9220 = 3.9101 composite). For basic services, the overall composite factor was 2.9008.

EXHIBIT 5-4
COMMUNITY RATE - COST ALLOCATION
1980 FORECAST

	PM/PM	Hospitals	Offices	Home Health Agency	Pharmacy/ Optical	Health Plan Admin	General & Admin	Claims/ Ambulance	Dental
Contract Payments to Medical Group	$ 6.57		$ 6.57						
Medical Office	9.12	$ .41	8.50		$ .21				
Hospital	8.60	7.43	.34	$ .20	.03		$ .60		
Health Plan	.55					$ .55			
General & Admin.	2.43						2.43		
Pharmacy/Optical	2.50	.28	.04		2.18				
Physicians Retirement	.56		.56						
Professional/Public Liability	1.05	.25	.80						
Community Service Program	.40	.35	.05						
In/Out of Area Claims	.65							$ .65	
Ambulance	.25							.25	
Start-up Costs	.13	.09	.04						
Property									
Depreciation	1.15	.44	.43		.05	.04	.19		
Interest	.34	.13	.12		.01	.01	.06		$ .01
Other	.36	.13	.13		.02	.01	.06		.01
Capital Generation	.90	.34	.34		.04	.03	.15		
Sub-Total	$35.56	$ 9.85	$17.92	$ .20	$2.54	$ .64	$ 3.49	$ .90	$ .02
Cost Recoveries	(.37)	(.11)	(.09)				(.05)		(.12)
G/A Allocation		1.23	1.79	.01	.12	.19	(3.44)		.10
Health Plan Allocation		.39	.39		.03	(.83)			.02
Ancillary		1.56	(1.64)	.02	.05				.01
Sub-Total	$35.19	$12.92	$18.37	$ .23	$2.74	-	-	$ .90	$ .03
Non-Member	(1.98)	(.86)	(1.12)						
TOTAL	$33.21	$12.06	$17.25	$ .23	$2.74	$ -	$ -	$ .90	$ .03

EXHIBIT 5-5

COMMUNITY RATE COMPONENTS

Components	1980 Community Rate
Hospitals:	
Part A	$ 11.43
Part B	.63
Sub-Total	$ 12.06
Medical Services:	
Medical	$ 16.86
Administrative	.39
Sub-Total	$ 17.25
Home Health Agency	.23
Claims/Ambulance	.90
Pharmacy/Optical*	2.77
TOTAL	$ 33.21

*Includes a $.03 per member per month interim subsidy to the Dental Program.

EXHIBIT 5-6

HOSPITAL TIME/COMPLEXITY FACTORS
BASED ON OREGON REGION 1978 COSTS

	-65	65+	Disabled	Total
Bess Kaiser				
Ancillary	$ 5,586,674	$ 1,253,958	$ 93,494	$ 6,934,126
Daily Care	5,767,345	1,823,369	130,337	7,721,051
Nursery	999,843			999,843
Sub-Total	12,353,862	3,077,327	223,831	15,655,020
Part B	734,863	105,365	7,765	847,998
TOTAL	$13,088,730	$ 3,182,692	$ 231,596	$16,503,018
SMC				
Ancillary	$ 2,462,739	$ 1,203,744	$ 86,720	$ 3,753,203
Daily Care	2,272,712	1,162,496	78,752	3,513,960
ICU	330,377	277,773	22,604	630,754
Sub-Total	5,065,828	2,644,013	188,076	7,897,917
Part B	472,979	78,848	5,551	557,378
TOTAL	$ 5,538,807	$ 2,722,861	$ 193,627	$ 8,455,295
Combined				
Sub-Total	$17,419,690	$ 5,721,340	$ 411,907	$23,552,937
Part B	1,207,847	184,213	13,316	1,405,376
TOTAL	$18,627,537	$ 5,905,553	$ 425,223	$24,958,313
Patient Days	64,980	23,863	1,728	90,571
Per Diem				
Sub-Total	$268.08	$239.76	$238.37	$260.05
Part B	18.59	7.72	7.71	15.52
TOTAL	$286.67	$247.48	$246.08	$275.57
Adjustment Factors Relative to All Ages				
Part A	1.0309	.9220	.9166	
Part B	1.1978	.4974	.4968	

	Hospital T/C Aged Multiplier	Hospital T/C Disabled Multiplier
Part A	.9220*	.9166
Part B	.4974	.4968

* The aged, Part A multiplier is calculated as follows:

Aged Part A Per Diem = $239.76
Plan Average Per Diem = $260.05
$239.76 Divided by $260.05 = 0.9220

EXHIBIT 5-7

TIME/COMPLEXITY FACTORS
MEDICAL

Health Plan Members	Services	T/C Adj.	T/C Adj. Services	T/C Relative All Ages
Under 65	626,240	1.00	626,240	.9748
65 and Over	93,892	1.20	112,670	1.1697*
Disabled	4,834	1.00	4,834	.9748
TOTAL	724,966	1.0259	743,744	

* The aged T/C multiplier for medical services is calculated as follows:

$$\frac{\text{65 and Over Adjusted Services}}{\text{Total Adjusted Services}} \text{ divided by } \frac{\text{65 and Over Unadjusted Services}}{\text{Total Unadjusted Services}}$$

$$\frac{112,670}{743,744} \text{ divided by } \frac{93,892}{724,966}$$

EXHIBIT 5-8

VOLUME FACTORS
BASED ON OREGON REGION 1978 UTILIZATION

	Health Plan Members			
	-65	65+	Disabled	Total
Medical Services				
Units of Service*	626,240	93,892	4,834	724,966
Members	202,707	14,325	662	217,694
Units/1000 Members	3,089	6,554	7,302	3,330
Adjustment Factors Relative to All Ages	.9276	1.9682**	2.1928	1.000
Hospital Services				
Patient Days	58,681	23,322	1,564	83,567
Members	202,707	14,325	662	217,694
Days/1000 Members	289.5	1,628.1	2,362.5	383.9
Adjustment Factors Relative to all Ages	.7541	4.2409	6.1539	1.000
Home Health Agency				
Visits	3,201	5,586		8,787
Members	202,707	14,987		217,694
Visits/1000 Members	15.79	372.72		40.36
Adjustment Factors Relative to All Ages	.3912	9.2349		1.000

*Units of Service are the sum of
a. Doctor Office Visits
b. Patient Days
c. Doctor House Calls
d. Radiologist Visits

**The aged, medical services volume factor is calculated as follows:

$$\frac{\text{65+ Medical Services Utilization/1000}}{\text{Total Plan Medical Services Utilization/1000}}$$

6,554 divided by 3,330 = 1.9682

EXHIBIT 5-9

1980 ESTIMATED ACR
AGED

	Community Rate	Volume Factor	Time/ Complexity Factor	Composite Factor	ACR Components
ospitals					
Part A	$11.43	4.2409	.9220	3.9101	$44.69
Part B	.63	4.2409	.4974	2.1094	1.33
edical Offices					
Direct Patient Care	10.78	1.9682	1.1697	2.3022	24.82
Indirect	6.47	1.9682	1.0000	1.9682	12.73
me Health Agency	.23	9.2349	1.0000	9.2349	2.12
Sub-Total	29.54			2.9008	85.69
harmacy/Optical	2.77				—
n/Out of Area Claims	.53			3.3394	1.77
Extended Care	.12				3.00
Ambulance	.25				1.27
Sub-Total	$33.21				$91.73
ther Medicare Benefits					2.00
Gross ACR					$93.73
ess M-Plan Dues Rate					15.18
Over-the-Counter Copayment					1.07
Net ACR					$77.48
verall ACR					
Gross ACR					$93.73
Benefit Stabilization Fund					3.00
New Member Entry Program					1.15
					$97.88

In addition to the basic Medicare benefits, a multiplier was used for out-of-area claims. A composite factor was developed by comparing aged experience to under-65 experience. This explains why this composite factor (3.3394) is greater than the basic services factor (2.9008).

To estimate costs for extended care, ambulance and other benefits, a different methodology was employed. For extended care and ambulance services, Kaiser used 1978 Medicare data. The remaining category, "other services", covers items not included in the community rate, such as prosthetics. No specifics of the $2.00 PMPM budget for these services was provided.

The "Gross ACR" which represents the projected cost of medical services and program administration, was $93.73 PMPM. The cost of the additional services rendered under the new member entry program ($1.15 PMPM) and the requirement for the benefit stabilization fund ($3.00 PMPM) were added to the Gross ACR, resulting in an overall ACR of $97.88.

A similar methodology was followed for the disabled enrollees. The "Gross ACR" was $114.20, with an "Overall ACR" equaling $129.08 PMPM (Exhibit 5-10).

HCFA Capitation (Aged and Disabled Members)

KPMCP-O estimated the HCFA capitation using a ratebook for the six counties in their service area. Exhibit 5-11 shows a portion of the ratebook applicable to Part A services for aged members.

The dollar values of the individual cells are the 95% level of projected 1980 costs. In addition to aged, Part A, HCFA prepared ratebooks for aged, Part B and disabled, Parts A and B.

KPMCP-O forecasted an age/sex mix for each county and calculated the Part A and B portions of the AAPCC for each county, for both aged and disabled members. These county rates were then weighted by their share of the six-county population to derive the non-institutionalized Part A and Part B components of the AAPCC. The cost for institutionalized members was then computed, assuming all such enrollees would reside in Multnomah County and that their age distribution would be similar to that of the total Medicare population projected for Multnomah County.

To derive the cost of Part A and Part B for both aged and disabled members, KPMCP-O weighted the cost for non-institutionalized Medicare members and institutionalized enrollees, assuming that only .5% of the membership would be institutionalized. This percentage was based upon KPMCP-O experience with its GPPP population where approximately 1% of Medicare members entered institutions annually. A summary of the calculations for the Part A and Part B components of aged and disabled members is given in Exhibits 5-12 and 5-13.

The final step combined the aged and disabled AAPCCs to determine an overall AAPCC. KPMCP-O staff assumed that 3.5% of enrollees

EXHIBIT 5-10

1980 ESTIMATED ACR
DISABLED

	Community Rate	Volume Factor	Time/ Complexity Factor	Composite Factor	ACR Components
Hospitals					
Part A	$11.43	6.1539	.9166	5.6407	$ 64.47
Part B	.63	6.1539	.4968	3.0573	1.93
Medical Offices					
Medical	10.78	2.1928	.9748	2.1375	23.04
Administrative	6.47	2.1928	1.0000	2.1928	14.19
Home Health Agency	.23	9.2349	1.0000	9.2349	2.12
Sub-Total	$29.54			3.5799	$105.75
Pharmacy/Optical	2.77				—
In/Out of Area Claims	.53			4.1212	2.18
Extended Care	.12	—	—		3.00
Ambulance	.25	—	—		1.27
Sub-Total	$33.21				$112.20
Other Medicare Benefits					2.00
Gross ACR					$114.20
Less M-Plan Dues Rate					15.18
Over-the-Counter Copayment					1.07
Net ACR					$ 97.95
Overall ACR					
Gross ACR					$114.20
Benefit Stabilization Fund					13.73
New Member Entry Program					1.15
					$129.08

EXHIBIT 5-11

1980 MEDICARE "AAPCC RATEBOOK" FOR AGED
MEDICARE MEMBERS ENROLLED IN DEMONSTRATION PROJECT[1]

PART A

	Clackamas	Columbia	Marion	Multnomah	Washington	Clark
Regular						
Males:						
65-69	47.38	48.41	34.78	65.27	55.87	39.94
70-74	54.15	55.32	39.75	74.59	63.85	45.65
75-79	67.69	69.16	49.69	93.24	79.81	57.06
80-84	81.23	82.99	59.63	111.89	95.78	68.74
85+	91.38	93.36	67.08	125.87	107.75	77.03
Females:						
65-69	40.61	41.49	29.81	55.94	47.89	34.24
70-74	47.38	48.41	34.78	65.27	55.87	39.94
75-79	60.92	62.24	44.72	83.92	71.83	51.36
80-84	74.46	76.07	54.66	102.56	87.79	62.77
85+	84.61	86.45	62.11	116.55	99.77	71.33
Welfare						
Males:						
65-69						
70-74						
75-79						
80-84						
85+						
Females:						
65-69						
70-74						
75-79						
80-84						
85+						
Institutionalized						
Males:						
65-69				191.14		
70-74				200.47		
75-79				219.11		
80-84				219.11		
85+				219.11		
Females:						
65-69				153.85		
70-74				177.16		
75-79				205.13		
80-84				205.13		
85+				205.13		

1 Rates computed by Keith Powell, Office of Financial and Actuarial Analysis, HCFA.

EXHIBIT 5-12

CALCULATION OF COMPOSITE AAPCC
FOR AGED MEDICARE BENEFICIARIES

County	PART A Rate[2]	PART A County Mix	PART A Weighted Rate	PART B Rate[2]	PART B County Mix	PART B Weighted Rate
Regular[1]						
Clackamas	$53.733	9.4%	$	$27.457	9.4%	$
Columbia	54.754	.9		22.790	.9	
Multnomah	76.690	63.8		30.011	63.8	
Washington	63.272	8.1		28.486	8.1	
Clark	45.002	17.8		23.621	17.8	
Total		100.0%	$67.607		100.0%	$28.445
Institutionalized						
Multnomah	$189.321	100.0%	$189.321	$57.352	100.0%	$57.352
Composite Calculation						
Regular	$ 67.607	99.5%[3]	$ 67.269	$28.445	99.5%	$28.303
Institutionalized	$189.321	0.5%[3]	.947	57.352	0.5	.287
			$ 68.216			$28.590

[1] Regular members are defined as all members who are not institutionalized or welfare eligible.

[2] Separate calculation of each county rate provided in KPMCP Rate Submission.

[3] KPMCP assumed that 99.5% of all members will be "regular" members and that 0.5% will be institutionalized.

EXHIBIT 5-13

CALCULATION OF COMPOSITE AAPCC
FOR DISABLED MEDICARE BENEFICIARIES

County	PART A Rate[2]	PART A County Mix	PART A Weighted Rate	PART B Rate[2]	PART B County Mix	PART B Weighted Rate
Regular[1]						
Clackamas	$ 76.020	10.2%	$	$37.770	10.2%	$
Columbia	69.581	1.9		31.182	1.9	
Multnomah	106.440	62.4		38.970	62.4	
Washington	82.349	7.0		34.386	7.0	
Clark	57.821	18.5		25.758	18.5	
Total		100.0%	$91.955		100.0%	$35.935
Institutionalized						
Multnomah	$101.742	100.0%	$101.742	$50.647	100.0%	$50.647
Composite Calculation						
Regular	$ 91.955	.995%[3]	$ 91.495	$35.935	99.5%	$37.755
Institutionalized	$101.742	0.5%[3]	.509	$50.647	0.5	.253
			$ 92.004			$36.008

[1] Regular members are defined as all members who are not institutionalized or welfare eligible.

[2] Separate calculation of each county rate provided in KPMCP Rate Submission.

[3] KPMCP is assumed that 99.5% of all members will not be institutionalized and that 0.5% will be institutionalized.

enrollees would be disabled. The following table summarizes these calculations:

	95% of Part A Cost	95% of Part B Cost	95% of Total Cost	100% of Total Cost
Aged	68.216	28.590	96.806	101.90
Disabled	92.004	36.008	128.012	134.75
Combined	69.049	28.850	97.898	103.05

Applying an assumed distribution of 3.5% disabled and 96.5% aged, the budgeted composite AAPCC was $103.05 PMPM; 95% of the AAPCC was $97.90 PMPM. Due to rounding in the calculations, the final budgeted AAPCC was $97.91.

Of the $97.91 HCFA capitation, $3.38 PMPM was placed in a Benefit Stabilization Fund (BSF) maintained by HCFA and $94.53 was paid monthly to KPMCP-O. Actual capitation in any given month could differ from $97.91 because the distribution of the enrollees across the cells of the ratebook could vary from the distribution used to calculate the projected AAPCC. KPMCP-O planned to use the BSF to handle such variations. In a "regular" month $3.38 PMPM would accrue to the fund. However, in most, if not all months, the actual payment would differ. KPMCP-O felt that by allocating a sufficient amount (approximately 3.5% of the total HCFA capitation) at no time would the membership distribution cause a variation in capitation revenue greater than $3.38 PMPM.

HCFA Capitation (ESRD Enrollees)

The payment to KPMCP-O for ESRD members was $1,981.12 PMPM (95% of the AAPCC). No separate ACR was developed for this population since the Plan had no experience with which to structure such a rate. The above payment included the monthly beneficiary premium for the basic package and new member services.

Developing an Enrollee Premium for the Basic Kaiser Medicare-Plus Plan

KPMCP-O offered the basic Medicare-Plus plan at no cost (i.e., premium) to Medicare beneficiaries. While Medicare could expect to save 5% of the estimated 1980 AAPCC per member per month for the standard Medicare benefit package (i.e.; approximately $5.15), the Medicare beneficiary would gain in reduced deductibles, coinsurance, and additional benefits not covered by Medicare. The estimated value of this Medicare-Plus Plan premium is shown in Exhibit 5-14.

The monthly dues rate was offset by $1.07 PMPM in co-payments. KPMCP-O 1978 data showed 6309 clinic visits/1000 and 61 house calls/100, subject to $2 and $3 copayments. The following calculation shows how the capitation offset was derived:

$$(6309 \times \$2) + (61 \times \$3)/12{,}000 = \$1.07 \text{ PMPM}$$

Since Medicare enrollees are non-group subscribers, a $.33 PMPM adjustment for administrative services was added to their dues consistent with Kaiser's policy for handling non-group subscribers under-65.

EXHIBIT 5-14

1980 MEDICARE PLUS PLAN "DUES"

Benefit	Monthly Dues Rate
Medicare Covered Services:	
1. Hospital Deductible	$ 2.71
2. Hospital Coinsurance	.13
3. Non-Covered Hospital Days	.44
4. Extended Care Facility Coinsurance	.50
5. Medical (Part B) Deductible	3.69
6. Medical (Part B) Coinsurance	6.67
7. "Provider" (Part B) Coinsurance	.19
8. Services by Non-Kaiser Providers	.30
9. Psychiatric Visits	.01
Sub-total	$14.64
Medicare Non-Covered Services:	
10. Routine Physical Exams, Immunizations and Pap Smears	.65
11. Eye Examinations for Glasses	.44
12. Homemaker Services	.16
13. Other Services *(i.e., private duty nursing nurse practitioners, hearing tests)	.03
Sub-total	$ 1.28
Credit for Co-payments	($ 1.07)
Sub-total	$14.85
Administrative Charge	.33
TOTAL	$15.18

In addition to the $15.18 basic premium, KPMCP-O charged $1.15 PMPM for new member entry services. KPMCP-O did not document how this charge was derived.

KPMCP-O thus projected that its ACR could cover both standard Medicare benefits and most of the out-of-pocket costs Medicare beneficiaries would experience for these services in the fee-for-service system.

Developing an Enrollee Premium for Optional Kaiser Plans

Exhibit 5-15 shows the premium charges for the optional benefit plans available to Kaiser enrollees.

Rates for specific benefits were calculated as follows:

1. Prescription Drugs

KPMCP-O assumed a rate twice that experienced for under-65 members. This ratio had been observed in other Kaiser regions and provided a utilization projection of 7600 Rxs/1,000. An in-house cost analysis showed a 1980 prescription cost of $6.80/Rx, with the Medicare cost projected as 20% higher at $8.16/RX. The copayment was $1.00 per Rx, the same as for the under-65 plan. However, the experience for the over-the-counter revenue per prescription was $1.14. KPMCP-O did not explain why the experience was greater than $1.00. The same $1.14 offset was used for the Medicare members, resulting in the following captition estimate:

7600 x ($8.16 - $1.14) divided by 12,000 = $4.45

2. Vision Care

KPMCP-O data from April 1978 through May 1979 showed a use rate of 182 prescriptions/1,000 per year for Medicare eligibles. The cost per frame was projected at $66.04, resulting in the following capitation:

182 x $66.04 divided by 12,000 = $1.00 PMPM

3. Hearing Aids

Data from Kaiser's Northwest California region were used to estimate 20 aids required/1000 members per year. Costs in this region were higher than was projected for the in-house delivery planned for KPMCP-O. An 11% downward adjustment resulted in a per case cost of $330:

20 x $330 divided by 12,000 = $.55 PMPM

4. Dental Services

The estimates for dental coverage were based upon KPMCP-O experience for the cohort aged 45-64. Using 1980 fee schedules, an average cost per procedure of $37.00 was calculated, resulting in the following capitation:

3180 x $37.00 divided by 12000 = $9.81 PMPM

EXHIBIT 5-15

SUPPLEMENTAL BENEFIT PLANS AND RATES FOR MEDICARE DEMONSTRATION PROJECT

Plan	Benefits	Monthly Rate
B	Rx, $1 Plan	$ 4.45
	Vision Care	1.00
	Hearing Aids	.55
	Total	$ 6.00
C	Dental Plan	$ 9.81
D	Rx, $1 Plan	$ 4.45
	Vision Care	1.00
	Hearing Aids	.55
	Dental	9.81
	Total	$ 15.81

Fiscal Performance, Benefit Period 1
(August 1980 - December 1980)

Exhibit 5-16 summarizes projected versus actual performance for this 5 month period. Budgeted figures represent a composite of the aged and disabled ACRs. The evaluator assumed a distribution of 96.5% aged and 3.5% disabled in calculating these composite figures. Actual results are based on 22,856 membermonths or 4,571.2 member years (22,856/5).

Since no KPMCP-O financial statements were available, comments will have to be restricted to the capitation analysis in Exhibit 5-16. The numbers given in this Exhibit, which represent the actual experience of the Plan, were provided directly by KPMCP-O. Since the evaluators were not supplied with the basic information, the figures cannot be verified. Assuming the full collection of the co-payment, the projected loss shown would be $18.66 PMPM or approximately $426,000.

As part of the on-going demonstration project, the Plan submitted annual cost reports, completed using the same methodology applied to GPPP cost contracts. Although these reports did not reflect the actual cost under the risk demonstration, they did detail costs as if the Plan had been reimbursed under an HCFA cost contract. Therefore, the discussion for each benefit category will involve both the results of the risk demonstration per se and the reported experience under a cost contract. Under this format, the reported cost of delivering only the Medicare mandated benefits was $92.15 PMPM (Exhibit 5-17). Thus, the Plan was able to deliver these services for less than the 95% reimbursement figure ($97.91). How much less has not been determined since the Part A co-insurance and deductible at out-of-plan hospitals and the cost of additional days was not provided.

1. Hospitalization

Once the in-patient budget was established, the Plan has stated that this, in effect, represented a capitation payment from the Plan to the KPMCP-O hospitals. Therefore, actual costs equaled budgeted. KPMCP-O estimated aged and disabled hospital days at 1,653.8 days/1,000 members (see Exhibit 5-8); 1,647.5 days/1000 were experienced. Use at Kaiser hospitals was 1127.8/1000; at other hospitals 519.7/1000. Overall length of stay was greater at non-Kaiser hospitals (i.e., 6.67 in-plan versus 7.38 out-of-plan). The overall effective cost per day for Part A services was $482.85 ($45.38 x 12,000/1127.8)

Under the cost contract reporting format, expenses were separated by in-plan and out-of-plan usage. For in-plan use at Bess Kaiser and Sunnyside Medical Centers, KPMCP-O reported costs of $714,462. For out-of-plan usage, KPMCP-O reported costs of $661,336. These figures also included the cost of extended care. The two Kaiser facilities itemized $46,620 that would have been collected in Part A deductibles and co-insurance. Using this information, the total in-patient cost was $60.19 ($1,375,798/22,856). The net cost, applying only the Part A deductibles and co-insurance applicable to the two Kaiser facilities, was $58.15 ($1,329,128/22,856). A portion of this applies to the In/Out-of-Area Claims category but the evaluator could not determine

EXHIBIT 5-16
KAISER-PERMANENTE MEDICAL CARE PROGRAM OF OREGON
Year 1: August 1980 - December 1980
Capitation

	Budget	Actual	Variance Favorable	Variance Unfavorable
MEMBERMONTHS		22,856		
EXPENSES				
• Hospitals				
Part A	$ 45.38	$ 45.38		
Part B	1.35	1.35		
• Extended Care	3.00	2.76	$ .24	
• Home Health	2.12	2.12		
• Medical Services				
In-Plan, Direct Patient Care	24.76			
In-Plan, Indirect Patient Care	12.28	37.54		
• Ambulance	1.27	1.20	.07	
• In/Out-of-Area Claims	1.79			$20.85
Part A		21.86		
Part B		.78		
• Other Benefits/Services	2.00	.36	1.64	
• Benefit Stabilization Fund	3.38	5.19		1.81
• New Member Entry Program	1.15	1.15		
TOTAL	$98.98	$119.69		$20.71
REVENUES				
• HCFA Capitation	$97.91	$99.96	$2.05	
• Member Copayment	1.07			
TOTAL	$98.98			
REVENUES LESS EXPENSES				

EXHIBIT 5-17

KAISER-PERMANENTE MEDICAL CARE PROGRAM - OREGON REGION
MEDICARE DEMONSTRATION PROJECT
HMO COST SUMMARY FOR PERIOD ENDED 12/31/81

	PART A	PART B	TOTAL
TOTAL COSTS:			
Hospitals:			
Bess Kaiser Medical Center	$ 298,163	$ 20,598	$ 318,761
Sunnyside Medical Center	416,299	14,398	430,697
Medical Services:		932,503	932,503
Home Health Agency:	6,983	6,336	13,319
SUB-TOTAL	721,445	973,835	1,695,280
Purchased Services:	661,336	64,960	726,296
TOTAL COST	$1,382,781	$1,038,795	$2,421,576
DEDUCTIBLE & COINSURANCE			
Hospitals:			
Bess Kaiser Medical Center	$ (20,520)	$ (3,141)	$ (23,661)
Sunnyside Medical Center	(26,100)	(1,904)	(28,004)
Medical Services:	---	(263,817)	(263,817)
Home Health Agency:	---	---	---
TOTAL	$ (46,620)	$ (268,362)	$ (315,482
COST NET OF DEDUCTIBLE & COINSURANCE	$1,336,161	$ 769,933	$2,106,094
Member Months			22,856
PMPM			$ 92.15

the amount. The total budget for hospital, extended care and in/out-of-area was $50.17 PMPM and the net hospital expenses reported under the cost contract equated to $58.15. Under the cost contract format, an obvious unfavorable variance existed. This variance was attributed to out-of-plan use in non-Kaiser hospitals with higher unit costs, not excessive hospitalization over what had been projected.

For the Part B component of hospitalization, KPMCP-O did not report utilization. However, under the cost reporting format in Exhibit 5-17, costs of $34,996 were reported by the two Kaiser facilities, with deductible and coinsurance offsets of $5,045. Using the total cost figure to calculate the actual capitation yielded $1.53 (34,996/22,856). When compared with the budget of $1.35 PMPM, the result was an unfavorable variance of $.18 PMPM. In actuality, this service was also part of the capitation arrangement between the plan and the hospitals.

2. SNF

The results of the risk demonstration reporting showed SNF costs equal to $2.76 PMPM or $.24 PMPM under budget. Reported usage was 127.3 SNF days/1000 with a discharge rate of 4.8/1000. Effective cost per day was $260.17 ($2.76 x12,000/127.3). When compared with SNF costs elsewhere, this cost per day is high. Under the cost reporting format, SNF costs were included in the overall inpatient costs.

3. Home Health

Home health services were also capitated, so actual costs equaled budgeted costs. However, under the cost reporting format in Exhibit 5-17, $13,319 of cost were reported which translates to a capitation of $.58 ($13,319/22,856). The reported costs were much less than the budget. The home health visit rate was 134.9/1000. Using the HCFA Form 2552, the average cost per visit was $51.82 ($13,319/257) and under the actual capitation arrangement, the effective average cost per visit was $188.58 ($2.12 x 12,000/134.9). Kaiser had projected a use rate of 372.72/1000 based on its GPPP 1978 experience (see Exhibit 5-8).

4. In-Plan Medical Services

KPMCP-O developed two budgets for medical services; direct patient care and medical administrative costs. The composite (i.e.; aged and disabled) estimated ACR was $24.76 PMPM for in-plan direct patient care and $12.78 for in-plan medical administrative costs; a total projected medical services capitation of $37.54. Since actual cost equaled budget, no variance is shown for this category. As reported later, the physician visit rate was 5875 visits/1000, which equates to an overall cost per visit of $76.68 ($37.54 x 12,000/5875).

As reported under the cost contract methodology, Exhibit 5-18 shows cost allocation methods used to calculate direct patient care costs for demonstration enrollees and Exhibit 5-19 demonstrates the computations. The allocation procedure is as follows:

- Total medical services costs for calendar year 1980 were $43,074,744.

- For cost estimation purposes "medical services" consist of doctor office visits, doctor house calls, hospital inpatient days, and radiologist visits. All Medicare members of KPMCP-O (i.e., risk-based demonstration and cost-based GPPP aged and disabled beneficiaries) used 16.93% of total medical services. The use of aged members, adjusted by a time and complexity of 1.2 yields an adjusted use of 19.52%.

- KPMCP-O demonstration enrollees used an estimated 1.99% of total in-plan medical services (i.e., 10.2% of Medicare membermonths are demonstration enrollees and all Medicare persons used 19.52% of total services -- (.102)(.1952) = .0199.

- Administrative costs associated with medical services were $79,784, based on an allocation using the unadjusted number of services.

In addition to capitation costs associated with these two core services, Medicare enrollees' in-plan medical services costs have one other component. HCFA allowed KPMCP-O to add an "equalization factor;" an allowable cost for plan expansion. This cost derives from $1.724 x number of membermonths (i.e., 22856) or $39,404.

Thus, the cost estimate of the Medicare capitation was:

• Direct Patient Care	$857,187
Capitation	$37.50
• Indirect Patient Care	
- Allocation	$ 79,784
- Equalization Factor	39,404
Total	$119,188
Capitation	$5.21

The total medical services cost is $976,375 which is larger than the $932,503 shown in Exhibit 5-17. This difference of $43,872 is attributed to the excluding of the costs of non-covered services (Exhibit 5-18). Also, $263,817 in deductible and co-insurance were reported for medical services. Thus, the net cost of medical services was:

	$976,375	
Less:	($ 43,872)	(Non-covered Services)
Less:	($263,817)	(Co-insurance and Deductible Payments)
	$668,686	

EXHIBIT 5-18

GROUP PRACTICE PREPAYMENT PLAN
MEDICAL SERVICES UTILIZATION DATA AND
COMPUTATION OF RATIO INCLUDING TIME FACTOR

January 1980 Through December 1980

LINE	ITEM	-65 PLAN MEMBERS (1)	65+ PLAN MEMBERS (2)	DISABLED ELIGIBLES FOR MEDICARE (3)	TOTAL (4)
1.	Doctor Office Visits	548,807	87,361	4,272	640,440
2.	Hospital Inpatient Days	57,359	27,548	1,669	86,576
3.	Doctor House Calls	347	958	29	1,334
4.	Radiologist Visits	11,160	3,957	93	15,210
5.	Total Services Rendered	617,673	119,824	6,063	743,560
6.	Time Factor	1.0	1.2	1.0	
7.	Total Adjusted Services	617,673	143,789	6,063	767,525
	Revision of 65+ Services to Part B Covered Basis				
8.	Total Part B Covered M/M, K.F.H.P. Records Project		22,068	788	22,856
9.	Total 65+ M/M, K.F.H.P. Records			8,436	224,089
10.	Ratio of Part B Covered to Total (line 8 divided by line 9)		.1023	.0934	.1020
11.	Total Adjusted 65+ Disabled Services (line 7, columns 2 and 3)		143,789	6,063	149,852
12.	Part B Covered Adjusted Services (line 10 times line 11)		14,710	566	15,276
13.	Ratio of Part B Covered Adjusted Services to Total Adjusted Services (line 12 divided by line 7)				.0199
	Carry line 13 to Face Page, line 2, Form SSA-2017				
14.	Total Services Rendered 65+ and Disabled (line 5, columns 2 and 3)		119,824	6,063	
15.	Ratio of Part B Covered to Total (line 10)		.1023	.0934	
16.	Total Part B Covered Services, Unadjusted for Time Factor (line 14 times line 15)		12,258	566	12,824
17.	Ratio of Part B Covered Unadjusted Services to Total Unadjusted Services (line 16 divided by line 5)				.0172
	Carry line 17 to Face Page, line 5, Form SSA-2017				

EXHIBIT 5-19

GROUP PRACTICE PREPAYMENT PLAN
STATEMENT OF REIMBURSABLE COST

January 1980 Through December 1980

1.	Total Cost - All Covered Medical Services	$43,074,744	
2.	Ratio - Utilization Services Medicare Members to all Members	1.99%	
3.	Total Medical Service Cost for all Medicare Members (line 1 times line 2)		$857,187
4.	Total Cost - Administration	$4,638,618	
5.	Ratio - Medicare Membership, Medicare Contract, or Utilization whichever applicable	1.72%	
6.	Total Administration Cost Applicable to Medicare Members (line 4 times line 5)		$ 79,784
6(a)	Excluded Services		$(43,872)
7.	Total Cost - Purchased Services Medicare Members		$ 64,960
7(a)	Equalization Factor		$ 39,404
8.	Total Allowable Cost (sum of lines 3, 6 and 7)		$997,463
9.	Less Annual Deductible		$(80,406)
10.	Cost Less Deductible (subtract line 9 from line 8)		$917,057
11.	80 Percent of Reimbursable Amount (line 10 times 80%)		$733,646
12.	Less Interim Payment Received During the Period		---
13.	Balance Payable to Plan		Not Applicable
14.	Balance Payable to SMI Trust Fund		Not Applicable

This figure translates to a capitation of $29.26 ($668,686/22,856) compared to the budget of $37.54 PMPM. Also, the Part B co-insurance and deductible payments by the beneficiaries would have been $11.76 ($268,862/22,856). This calculation includes the Part B in-patient co-payment and deductible figures. Finally, the projected cost of non-covered services such as physical exams and injections was $1.92 PMPM ($43,872/22,856).

In its 1980 annual report, KPMCP-O described the medical services use of demonstration enrollees by type of service. These statistics are as follows:

	Number of Visits (For Total Population)	Utilization (Services/1000) (Based Upon Total Population)
Physician visits	11,190	5,875.0
Non-physician visits	4,387	2,303.3
Day surgery	69	36.2
Mental health visits		
Physicians	19	10.0
Non-physician	3	1.6

A 25% sample of demonstration enrollees provides a more detailed breakdown of services:

	Rates/1000 (Based Upon 25% Sample)		
	Aged	Disabled	Total
Physician visits	5,610	7,620	5,677
Non-physician visits	2,536	4,200	2,591
Laboratory	11,850	10,800	11,815
X-Rays	1,755	1,680	1,752
ECGs and EKGs	1,034	840	1,027

Exhibit 5-20 shows medical service use by specialty.

5. Ambulance

Under the risk demonstration reporting, the actual capitation was $1.20. The cost reporting format showed $27,317 for a capitation of $1.20 ($27,300/22,856).

6. In and Out-of-Area Claims

The reported Part A cost was $21.86 PMPM and the reported Part B expense was $.78 PMPM, resulting in an unfavorable variance of $20.85 PMPM. The cost per day for the Part A service was $504.75 ($21.86 x 12,000/519.7). Under the cost contract reporting format, only $17,904 were reported for a capitation of $.78 ($17,904/22,856).

EXHIBIT 5-20

MEDICARE DEMONSTRATION PROJECT
AUGUST-DECEMBER 1980 OUTPATIENT UTILIZATION
FOR A 25% SAMPLE OF MEDICARE PLUS MEMBERS

Percentage Distribution and Annualized Rates/1000
Members for Visits by Provider Specialty

Provider Specialty	Percentage			Rates/1000		
	Physician Visits	Other Visits*	Total	Physician Visits	Other Visits*	Total
Internal Medicine	55.8	28.0	47.1	3170	724	3894
Dermatology	2.9	--	2.0	164	0	164
General Surgery	5.2	1.5	4.1	297	38	335
Ophthalmology	6.4	0.2	4.4	363	4	367
Otolaryngology	2.5	--	1.7	140	0	140
Orthopedics	2.5	4.7	3.2	144	122	266
Urology	3.4	--	2.4	194	0	194
Family Practice	11.8	2.3	8.8	670	60	730
E.R. Physicians	5.8	--	4.0	331	0	331
Nurse Pract. (Medicine)	--	16.8	5.3	0	437	437
Optometry	--	20.9	6.6	0	544	544
Phys. Ass'ts. (Medicine)	--	5.2	1.6	0	134	134
Other**	3.7	21.4	8.8	200	526	726
TOTAL	100.0% (n=2828)	100.0% (n=1291)	100.0% (n=4119)	5673	2589	8262

*Includes visits to nurse practitioners, physician's assistants, nurses, optometrists, mental health, and other allied health professionals, including home health.

**Includes neurosurgery/neurology, gynecology, mental health, psychiatry, allergy, gynecological and surgical physician's assistants, residents, and allied health personnel service not ordered by physicians (includes some flu shots and audiology visits).

7. Other Benefits/Services

Reported cost for the demonstration was $.36 PMPM. Under the cost contract reporting format, expenses of $19,739 were reported, which equates $.86 PMPM ($19,739/22,856).

8. Benefit Stabilization Fund (BSF)

KPMCP-O budgeted for a HCFA payment of $94.53 with a BSF contribution of $3.38; a total HCFA capitation of $97.91. KPMCP-O reported that a retroactive adjustment resulted in an additional payment of $41,323 to the BSF, bringing the total fund amount to $118,616 at the end of 1980. The adjustment equates to a capitation of $1.81. Therefore, the total contribution to the BSF was $5.19 PMPM as compared with $3.38 PMPM. If the BSF is treated as a cost, the result is a negative variance of $1.81 PMPM.

9. New Member Entry Program

KPMCP-O projected new member entry program costs of $1.15 PMPM. They did not document this rate. Costs for this service were reported equal to budget.

10. Revenues

KPMCP-O received revenues from two sources: the HCFA payment and member copayments. The total interim HCFA payments to the Plan were $2,166,000; $94.77 PMPM ($2,166,000 divided by 22,856). This per capita payment was $.24 PMPM greater than the budget of $94.53 PMPM. One explanation for the difference is that some members were ESRD eligible, with the HCFA capitation payment being much greater for those participants. The additional premium payment for those membermonths could cause the overall per capita reimbursement to rise. The total reimbursement from HCFA was $99.96, detailed as follows:

HCFA Payment	$94.77
BSF Contribution	3.38
Retroactive Adjustment	1.81
	$99.96

The result is a favorable variance of $2.05 PMPM; $1.81 PMPM as a retroactive adjustment and the $.24 PMPM.

11. Use of Additional Benefits

Cost information for Year 1 supplemental benefits were unavailable, but utilization statistics were as follows:

	Population at Risk	Total Services	Services/1000/Year
Audiology Visits	2140.6	247	276.9
Optical Visits	2140.6	518	580.8
Prescriptions	2140.6	8037	9010.9
Dental			
Visits	941.6	889	2265.9
Procedures	941.6	2590	6601.5

The population at risk figures are in person-years of exposure.

5.6 Adjusted Community Rate Development and Fiscal Performance Benefit Period 2 (January - December 1981)

KPMCP-O's projected community rate for the second year of the demonstration was $39.25 PMPM; an increase of 18.2% over the first period. Exhibits 5-21 and 5-22 show cost allocation and components of this community rate. KPMCP-O constructed second year rates before analyzing its experience during the first demonstration period.

As in first year rate-setting, KPMCP-O used two community rate adjustment factors; time/complexity and volume multipliers. The hospital and medical services volume factors derived from the relationship between Medicare use to total plan use over a five year period. Initial rate setting had relied on 1978 data only. Exhibit 5-23 shows hospital utilization rates, 1975-1980, used to derive the hospital volume factor of 4.22. Exhibit 5-24 shows the basis of the medical services adjustment of 2.15.

The time and complexity factor for medical services are presented in Exhibit 5-25. This calculation is identical to Year 1. The composite Medicare adjustment is 1.16:

$$\frac{126,652}{741,786} \text{ divided by } \frac{106,467}{721,601} = 1.1572$$

Exhibit 5-26 shows the hospital T/C multipliers:

Part A: $\frac{\$257.49}{\$287.16} = .8967$

Part B: $\frac{\$\ 8.52}{\$16.62} = .5126$

Finalizing Second Year KPMCP-O ACR

Exhibit 5-27 shows the projected ACR for the second year of the demonstration. The most notable change was in the projected costs of direct medical services, $31.35; an increase of 26.6% over the previous period. This change represents an increase of 16.7% in the medical services component of the projected community rate and an 8% increase in the composite adjustment factor. The gross ACR increased approximately 19.1% (i.e., $94.45 to $112.47).

EXHIBIT 5-21

KAISER FOUNDATION HEALTH PLAN OF OREGON
1981 FORECAST COMMUNITY RATE
COST ALLOCATION

Cost and Capital Requirement	PM/PM	Hospital	Medical Office	Home Health Agency	Pharmacy /Optical	Claims/ Ambulance	Community Service Program	Dental	General & Admin.
BCP to NWP	$ 7.51	$	$ 7.51	$	$	$	$	$	$
Hospital Operations	10.04	8.83	.40	.20	.04				.57
Clinic Operations	9.74		9.51		.23				
H.P. Administration	.68								.68
Regional Administration	2.39								2.39
Pharmacy	2.40	.34	.08		1.98				
Optical	.60				.60				
Claims	.63					.63			
Ambulance	.32					.32			
Other Benfits	.23					.23			
Referred Hospitalization	.50	.50							
Ref. Non-Physician Services	.34		.34						
Interest	.23	.07	.09		.01			.01	.05
Other Property	.33	.10	.13		.02			.01	.07
Physicians Retirement	.63		.63						
Professional Liability	1.00	.22	.78						
Community Service Program	.47	.08	.07				.32		
Start-Up Costs	.09		.09						
Other Administrative	.49								.49
ICP to NWP	.07		.07						
Gross Cash Generation									
Depreciation	1.41	.43	.59	.01	.07		.01		.30
4% Provision	.85	.26	.37		.04				.18
Earnings	.82	.25	.35		.04				.18
TOTAL	$41.77	$11.08	$21.01	$ .21	$3.03	$1.18	$ .33	$ .02	$4.91
Cost Recoveries	(.34)		(.08)				(.07)	(.09)	(.10)
G/A		1.96	2.48	.01	.11		.12	.13	(4.81)
Inpatient Ancillary		2.09	(2.25)	.02	.12			.02	
SUB-TOTAL	$41.43	$15.13	$21.16	$ .24	$3.26	$1.18	$ .38	$ .08	--
LESS NON-MEMBER	(2.18)	(1.17)	(1.01)						
	$39.25	$13.96	$20.15	$ .24	$3.26	$1.18	$ .38	$ .08	

EXHIBIT 5-22

COMMUNITY RATE COMPONENTS

Components	1981 Community Rate
Hospitals:	
Part A	$ 13.50
Part B	.84
SUB-TOTAL	$ 14.34
Medical Offices:	
Direct Patient Care	$ 12.59
Indirect	7.56
SUB-TOTAL	$ 20.15
Home Health Agency	.24
Claims/Ambulance	1.18
Pharmacy/Optical	3.34
TOTAL	$ 39.25

EXHIBIT 5-23

KAISER FOUNDATION HEALTH PLAN of OREGON

VOLUME FACTOR for HOSPITAL SERVICES

Historical Utilization Rates

Year	Medicare	Non-Medicare	Total
1975	1,647	323	408
1976	1,651	306	396
1977	1,735	297	396
1978	1.661	289	384
1979	1.805	294	399
1980[1/]	1.800	291	392

Forecast Utilization Rates (1981)

Medicare rate:	1,800
Non-Medicare rate:	291
Overall rate[2/]:	427

Forecast Volume Factor (1981)

1,800 ÷ 427 = 4.22

1/ Estimate based on data through July, 1980

2/ Assumes 9% of 1981 KPMCP membership to be Medicare.
427 = .09 x 1,800 + .91 x 291

EXHIBIT 5-24

CALCULATION OF VOLUME FACTORS
for
MEDICAL SERVICES

Based on Historical Utilization Ratio Trends, 1975-1979

Year	Utilization Rate Per 1000 Members: All Ages	Utilization Rate Per 1000 Members: Medicare	Ratio of Medicare To All Ages Utilization Rate	Annual Change In Ratio
Actual				
1975	3,647	6,854	1.88	--
1976	3,637	6,826	1.88	.00
1977	3,510	6,868	1.96	.08
1978	3,330	6,554	1.97	.01
1979	3,165	6,619	2.09	.12
Forecast[1/]				
1980			2.12	.03
1981			2.15	.03

1/ The average increase in the ratio between 1975 and 1979 was .05. It was assumed that the upward trend would continue into 1980 and 1981, but at a reduced rate, .03 per year.

EXHIBIT 5-25

TIME/COMPLEXITY FACTOR

MEDICAL

Health Plan Members	Services	T/C Adj.	T/C Adj. Services	T/C Relative All Ages
Under 65	615,134	1.00	615,134	.97
65 and Over	100,927	1.20	121,112	1.17
Disabled	5,540	1.00	5,540	.97
Total	106,467	1.19	126,652	1.16
TOTAL	721,601	1.03	741,786	

EXHIBIT 5-26

HOSPITAL TIME/COMPLEXITY FACTORS
Based on Oregon Region 1979 Costs

	65+/Disabled	Total
Bess Kaiser:		
Ancillary	$1,811,458	$ 8,164,422
Daily Care	2,445,515	8,608,684
Nursery	---	1,201,441
Sub-Total	$4,256,973	$17,974,547
Part B	153,261	1,006,386
TOTAL	$4,410,234	$18,980,933
SMC:		
Ancillary	$1,386,431	$ 4,463,450
Daily Care	1,590,239	4,535,349
ICU-CCU	350,618	802,755
Sub-Total	$3,327,288	$ 9,801,554
Part B	97,658	601,178
TOTAL	$3,424,946	$10,402,732
Combined:		
Sub-Total	$7,584,261	$27,776,101
Part B	250,919	1,607,564
TOTAL	$7,835,180	$29,383,665
Patient Days:	29,455	96,721
Per Diem:		
Sub-Total	$ 257.49	$ 287.16
Part B	8.52	16.62
TOTAL	266.01	$ 303.78
Adjustment Factors:		
Part A	.8967	
Part B	.5126	

EXHIBIT 5-27

1981 ESTIMATED ACR

	Community Rate	Volume Factor	Time/ Complexity Factor	Composite Factor	Components
Hospitals					
Part A	$13.50	4.22	.90	3.80	$ 51.30
Part B	.84	4.22	.51	2.15	1.81
Medical Offices					
Direct Patient Care	12.59	2.15	1.16	2.49	31.35
Indirect	7.56	2.15	1.00	2.15	16.25
Home Health Agency	.24	8.95	1.00	8.95	2.15
SUB-TOTAL	$34.73				$102.86
Pharmacy/Optical	3.34				--
In/Out of Area Claims	.63			3.70	2.33
Extended Care	.23				3.25
Ambulance	.32				1.83
SUB-TOTAL	$39.25				$110.27
Other Medicare Benefits					2.20
Gross ACR					$112.37
Less M-Plan Dues Rate					$(17.13)
Over-the-Counter Copayment					(1.07)
Net ACR					$ 94.27
Overall ACR					
Gross ACR					$112.47
Benefit Stabilization Fund					1.10
New Member Entry Program					1.15
					$114.72

HCFA Capitation

KPMCP-O estimated the HCFA capitation using a new ratebook prepared by HCFA. A summary of the calculations for the Part A and Part B components for aged and disabled members is shown in Exhibit 5-28. The estimated composite 95% level of AAPCC was $113.65; an increase of 16.1% The ratio of aged/disabled used to structure the AAPCC was 96.35% aged/3.65% disabled. Thus, while the gross ACR representing the projected cost of medical services and program administration increased approximately 19%, HCFA revenue to support the basic Kaiser package increased approximately 16%.

Of the $113.65 capitation, HCFA provided a $112.55 PMPM payment to the Plan and set aside $1.10 PMPM in the benefit stabilization fund. The HCFA capitation was also projected to cover the beneficiary premium of $17.13 and the cost of the new member entry program of $1.15 PMPM. The only out-of-pocket costs to each member were the same copayments as in Year 1, with the effective capitation revenue from these payments being budgeted at $1.07 PMPM.

Base Plan Beneficiary Premium Development

The cost for the supplemental benefits provided in the basic package was estimated to be $18.20, with a $1.07 offset for copayments reducing costs to $17.13. No documentation was provided for the development of this premium.

Rate Setting for Additional Demonstration Benefits

The coverage and premiums for the second year were the same as for the initial period:

Plan B Rx, $1 Plan Vision Care Hearing Aids	$6.00
Plan C Dental	$9.81
Plan D Plan B + Plan C	$15.81

End Stage Renal Dialysis (ESRD) Members

The payment to KPMCP-O for ESRD members was $2,305.42 PMPM (95% of the AAPCC). No separate ACR was developed for this population since the Plan had not analyzed its experience in order to structure such a rate. As in Year 1, the above payment included the monthly beneficiary premium for the basic package and new member services.

EXHIBIT 5-28

1981 RATES OF PAYMENT, BY COUNTY

MEDICARE DEMONSTRATION PROJECT[1]

CATEGORY	COUNTY	PART A	PART B	TOTAL
Aged	Clackamas	$ 63.47	$ 32.46	$ 95.93
	Columbia	62.16	26.74	88.90
	Marion	50.14	27.70	77.84
	Multonomah	88.50	35.70	124.20
	Washington	74.15	34.09	108.24
	Clark	50.23	27.89	78.12
	Composite	$ 78.29	$ 33.93	$ 112.23
Disabled	Clackamas	$ 96.01	$ 47.00	$ 143.01
	Columbia	69.36	30.88	100.24
	Marion	--	--	--
	Multonomah	119.82	44.96	164.78
	Washington	105.21	43.15	148.36
	Clark	71.67	32.49	104.16
	Composite	$108.12	$ 43.05	$ 151.17
Aged and Disabled Combined	Composite	$ 79.38	$ 34.27	$ 113.65

[1] The rates of payment shown here were determined by taking a weighted average of the rates of payment provided by HCFA and the forecasted membership.

Fiscal Performance, Benefit Period 2
(January - December 1981)

Exhibit 5-29 summarizes the projected versus actual performance for this 12 month period. Actual results are based on 90,463 member-months or 7,538.6 member years (90,463/12).

The expense variance under the risk demonstration was an unfavorable $8.25 PMPM. When combined with a positive revenue variance of $1.31 PMPM, the net impact was a minimum loss of $6.94 PMPM or approximately $628,000.

The Plan reported a cost of $99.37 PMPM (Exhibit 5-30) to deliver the mandated benefits, which was less than 95% of the AAPCC ($113.65). If the effect of the Part A co-payment and deductible at out-of-plan hospitals and the cost of additional days are considered, the reported cost of the mandated package would be even less.

1. Hospitalization

Since the budgeted payment to the hospitals served as a capitation, from the Plan's perspective actual cost equaled budget for in-area care in KPMCP-O facilities. The hospital use rate of 1,669.3 days/1,000 was slightly above the first year's experience of 1,647.5 days/1,000. The capitation estimate was based on 1,800 days/1,000. Overall length of stay remained longer at non-Kaiser hospitals but was reduced somewhat over first year experience (i.e., 7.03 versus 7.38 days). Kaiser hospital average length of stay increased from 6.67 to 6.99 days.

Under the cost contract reporting format, expenses were separated by in-plan and out-of-plan usage. For in-plan use at Bess Kaiser and Sunnyside Medical Centers, KPMCP-O reported costs of $4,285,765. For out-of-plan usage, KPMCP-O reported costs of $1,153,237. These figures included the cost of extended care. These facilities also itemized that $264,054 would have been collected in Part A deductibles and co-insurance. Using this information, the total in-patient cost was $60.12 ($5,439,002/90,463). The net cost, applying only the Part A deductibles and co-insurance applicable to the two Kaiser facilities, was $57.21 ($5,174,948/90,463). A portion of this cost applies to the In/Out-of-Area Claims category but the evaluator could not determine the amount. The total budget for hospital, extended care and in/out-of-area was $56.88 PMPM and the net hospital expenses reported under the cost contract equated to $57.15. Under the cost reporting format, the total in-patient cost was much closer to budget in the second year and the out-of-plan usage had decreased by over 50%.

For the Part B component of hospitalization, KPMCP-O did not report utilization. However, under the cost reporting format in Exhibit 5-30, costs of $207,817 were reported by the two Kaiser facilities, with deductible and co-insurance offsets of $29,052. Using the total cost figure to calculate the actual capitation yielded $2.30 (207,817/90,463), as compared to the budget of $1.81 PMPM. In actuality, this service was also part of the capitation arrangement between the plan and the hospitals.

EXHIBIT 5-29
KAISER-PERMANENTE MEDICAL CARE PROGRAM OF OREGON
Year 2: January 1981 - December 1981
Capitation

	Budget	Actual	Variance Favorable	Variance Unfavorable
MEMBERMONTHS		90,463		
EXPENSES				
• Hospitals				
Part A	$ 51.30	$ 51.30		
Part B	1.81	1.81		
• Extended Care	3.25	3.97		$ .72
• Home Health	2.15	2.15		
• Medical Services				
In-Plan, Direct Patient Care	31.35			
In-Plan, Indirect Patient Care	16.25	47.60		
• Ambulance	1.83	2.12		.29
• In/Out-of-Area Claims	2.33			6.62
Part A		7.15		
Part B		1.80		
• Other Benefits/Services	2.20	1.75	$ .45	
• Benefit Stabilization Fund	1.10	2.17		1.07
• New Member Entry Program	1.15	1.15		-
TOTAL	$114.72	$122.97		$8.25
REVENUES				
• HCFA Capitation	$113.65	$114.96	$1.31	
• Member Copayment	1.07			
TOTAL	$114.72			
REVENUES LESS EXPENSES				

EXHIBIT 5-30

KAISER-PERMANENTE MEDICAL CARE PROGRAM - OREGON REGION
MEDICARE DEMONSTRATION PROJECT

HMO COST SUMMARY FOR PERIOD ENDED 12/31/81

	Part A	Part B	Total
TOTAL COSTS:			
Hospitals:			
Bess Kaiser Medical Center	$1,931,428	$ 121,335	$2,052,763
Sunnyside Medical Center	2,354,337	86,482	2,440,819
Medical Services		4,051,992	4,051,992
Home Health Agency	160,062	21,120	181,182
SUB-TOTAL	$4,445,827	$4,280,929	$8,726,756
Purchased Services	1,153,237	599,212	1,752,449
TOTAL COST	$5,599,064	$4,880,131	$10,479,205
DEDUCTIBLE & COINSURANCE			
Hospitals:			
Bess Kaiser Medical Center	$ (128,796)	$ (17,326)	$ (146,122)
Sunnyside Medical Center	(135,258)	(11,756)	(147,014)
Medical Services	N/A	(1,196,754)	(1,196,754)
Home Health Agency	--	--	--
TOTAL	$ (264,054)	$(1,225,836)	$(1,489,890)
COST NET OF DEDUCTIBLE & COINSURANCE	$5,335,010	$ 3,654,305	$ 8,989,315
Member Months			90,463
PM/PM			99.37

2. SNF

The results of the risk demonstration reporting showed SNF costs equal to $3.97 PMPM or $.72 PMPM over budget. Reported usage was 563.4 SNF days/1000 with 14.0 admissions/1000. Effective cost per day was $84.55 ($3.97 x 12,000/563.4). This cost per day is 67.5% lower than that experienced in the first year. Using the cost reporting format, SNF costs are included in the overall inpatient costs.

3. Home Health

Home health services were also capitated, so actual costs equaled budgeted. costs. However, under the cost reporting format, $181,182 of cost was reported which translates to a capitation of $2.00 ($181,182/90,463). Comparing Year 1 and Year 2, the home health utilization rate increased over 300% (423.6 divided by 134.9). The Year 2 effective cost per visit of $60.91 was 67.7% lower than in Year 1.

4. In-Plan Medical Services

Because this service was capitated, actual costs equaled budget. The effective cost per visit was $104.23 ($47.6 x 12,000/5,480). This cost is 35.9% higher than the first benefit period.

As reported under the cost contract methodology, Exhibit 5-31 shows direct patient care costs.

- Total medical services costs for calendar year 1981 were $49,106,364.

- For cost estimation purposes, "medical services" consist of doctor office visits, doctor house calls, hospital inpatient days, and radiologist visits. All Medicare members of KPMCP-O (i.e., risk-based demonstration and cost-based GPPP aged and disabled) used 20.1% of total medical services. The use of aged members, adjusted by a time and complexity factor of 1.2, yields an adjusted use of 23.05%. Compared with the initial demonstration period, Medicare beneficiary use of total medical services increased approximately 3.5%.

- KPMCP-O demonstration enrollees used an estimated 7.24% of total in-plan medical services (i.e., 31.44% of Medicare member-months are demonstration enrollees and all Medicare persons used 23.05% of total services (.3144 x .2305 = .0724).

- KPMCP-P attributed 7.24% of total in-plan medical services costs or $3,555,301 to demonstration enrollees (i.e., $49,106,364 x .0724).

- Administrative costs associated with medical services were $342,181, based on an allocation using the unadjusted number of services.

EXHIBIT 5-31

GROUP PRACTICE PREPAYMENT PLAN
STATEMENT OF REIMBURSABLE COST

January 1981 through December 1981

1.	Total Cost - All Covered Medical Services	$49,106,364	
2.	Ratio - Utilization Services Medicare Members to all Members	7.24%	
3.	Total Medical Service Cost for all Medicare Members (line 1 times line 2)		$ 3,555,301
4.	Total Cost - Administration	$ 5,422,834	
5.	Ratio - Medicare Membership, Medicare Contract, or Utilization whichever applicable	6.31%	
6.	Total Administration Cost Applicable to Medicare Members (line 4 times line 5)		$ 342,181
6(a)	Excluded Services		$ (58,530)
7.	Total Cost - Purchased Services Medicare Members		$ 599,212
7(a)	Equalization Factor		$ 213,040
8.	Total Allowable Cost (sum of lines 3, 6 and 7)		$ 4,651,204
9.	Less Annual Deductible		$ (333,142)
10.	Cost Less Deductible (subtract line 9 from line 8)		$ 4,318,062
11.	80 Percent of Reimbursable Amount (line 10 times 80%)		$ 3,454,450
12.	Less Interim Payment Received During the Period		Not Applicable
13.	Balance Payable to Plan		Not Applicable
14.	Balance Payable to SMI Trust Fund		Not Applicable

The difference between the projected in-plan medical services capitation of $31.35 and actual capitation costs of $39.30 (i.e., $3,555,301/90,463) is an unfavorable $7.95 PMPM. In 1979, Medicare use was 6619 service units/1000; in 1980 it was 6741/1000. Actual 1981 risk-based demonstration and cost-based GPPP use was 6683.4/1000 (i.e., 160721 unadjusted service units/23980.5 members). Actual use thus appears similar to what KPMCP-O projected.

As in the Year 1 assessment, one additional cost component was used to derive the total medical services costs; namely, the equalization factor. The amount of the equalization factor represents the plan-wide allocation for expansion, adjusted for the Medicare capitation in proportion to the projected Part B capitations. To calculate this factor, plan-wide capitations for the 4% provision and depreciation were summed, multiplied by 46.67% to determine the proportion applicable to Part B services, adjusted for non-covered services and finally multiplied by the ratio of the Medicare medical services capitation divided by the plan-wide medical services per capita cost.

The costs used to develop the capitations were:

o Direct Patient Care	$3,555,301
Capitation	$39.30
o Indirect Payment Care	
- Allocation	$ 342,181
- Equalization Factor	213,040
Total	$ 555,221
Capitation	$6.14

The total medical service cost was $4,110,522, which is $58,530 greater than the $4,051,992 shown in Exhibit 5-30. This difference of $58,530 is equal to the value of the excluded services. The capitation of $.65 was 66.1% less than the first year figure of $1.92 PMPM. The cost contract estimated capitation of $45.44 was less than the budget of $47.60 PMPM.

In its 1981 annual report, KPMCP-O described the use of medical services by demonstration enrollees by type of service. These statistics are as follows:

	Number of Visits (For Total Population)	Utilization (Services/1000) (Total Population)
Physician Visits	41,312	5,480
Non-physician Vists	14,413	1,912
Mental Health Visits		
- Physician	143	19.0
- Non-Physician	108	14.3

More detailed information on physician and non-physician visits was available from the 25% sample, as shown below:

	Rates/1000
Physician Visits	5,567
Physician Assistant/Nurse Practitioner Visits	740
Allied Health Professional Visits	1,186
Other Visits	466
Total	7,959

The allied health professional category included optometry, audiology, mental health, physical therapy, dietary, occupational therapy and research personnel. The other category covered home health and the injection clinic. Exhibit 5-32 details physician and other encounter rates by specialty.

When compared with Year 1 use, the figures for Year 2 are all smaller, with dramatic decreases in the use of laboratory, X-ray, ECGs and EKGs:

	Year 1	Year 2	% Decrease
Laboratory	11,815	6,918	41.4%
X-Ray	1,752	1,129	35.6%
ECGs/EKGs	1,027	435	57.6%

5. Ambulance

The reported costs were equal to $2.12 PMPM, resulting in an unfavorable variance of $.29 PMPM. This same figure was also itemized under the cost reporting format.

6. In/Out-of-Area Claims

KPMCP-O reported experience of $7.15 PMPM for Part A and $1.80 PMPM, compared with an overall budget of $2.33 PMPM. Actual costs were 60.5% less than in the first year. Part A costs were 67.3% lower and Part B expenses were 130.8% greater. Under the cost contract reporting format, $163,066 were reported for a capitation of $1.80.

7. Other Benefits/Services

The Plan stated that these services cost $1.75 PMPM, as compared to the budget of $2.20 PMPM. Under the cost reporting format, the reported cost was $244,619 or $2.70 PMPM.

8. Benefit Stabilization Fund (BSF)

KPMCP-O budgeted for a HCFA payment of $112.55 with a BSF contribution of $1.10 to equal a total HCFA capitation of $113.65, which represented 95% of the estimated AAPCC of $119.63. It was reported that a retroactive adjustment resulted in an additional payment of approximately $97,000 to the BSF, bringing the total fund amount to $315,000 at the end of 1981. The adjustment equates to a capitation of $1.07 or a total BSF payment of $2.17 PMPM.

EXHIBIT 5-32

MEDICARE DEMONSTRATION PROJECT
1981 OUTPATIENT UTILIZATION
FOR A 25% SAMPLE OF MEDICARE PLUS MEMBERS

Percentage Distribution and Annualized Rates/1000
Members for Visits by Provider Specialty

Provider Specialty	Percentage			Rates/1000		
	Physician Visits	Other Visits*	Total	Physician Visits	Other Visits*	Total
Internal Medicine	54.1	23.4	44.9	3018	558	3576
Dermatology	3.6	0 2	2.6	201	5	206
General Surgery	6.1	1.4	4.7	342	32	374
Ophthalmology	6.9	--	4.9	387	0	387
Otolaryngology	2.7	--	1.9	148	0	148
Orthopedics	3.1	3.1	3.1	174	74	248
Urology	4.2	0.7	3.2	234	17	251
Family Practice	8 1	2.7	6.5	452	65	517
E.R. Physicians	6.6	0.9	4.9	370	21	391
Nurse Pract. (Medicine)	--	11.0	3.3	0	264	264
Optometry	--	17.8	5.4	0	427	427
Phys. Ass'ts.(Medicine)	--	6.2	1.9	0	151	151
Other**	4.6	32.6	11.7	241	778	1019
TOTAL	100.0% (n=11039)	100.0% (n=4728)	100.0% (n=15767)	5567	2392	7959

---

* Includes visits to nurse practitioners, physician's assistants, nurses, optometrists, mental health, and other allied health professionals including home health.

** Includes neurosurgery/neurology, gynecology, mental health, psychiatry, allergy, gynecological and surgical physician's assistants, residents, and allied health personnel service not ordered by physicians (includes some flu shots and audiology visits.

9. New Member Entry Program

The new member entry program was again projected to cost $1.15 PMPM. Actual costs were reported equal to budgeted.

10. Revenues

The two sources of revenues were the HCFA payment and the member copayments. No actual data were available assessing member out-of-pocket payments. The Plan received $10,203,000 in interim Medicare payments, which represented $112.79 PMPM ($10,203,000 divided by 90,463). Again, there was a favorable variance of $.24 PMPM which very likely is the result of having a few membermonths reimbursed at the higher ESRD rate.

11. Use of Additional Benefits

Although no cost information for the supplemental benefits for Year 2 was provided, some utilization information was available, as follows:

	Population At Risk	Total Services	Services 1000/Year
Hearing Aids Dispensed	4845.1	574	118.5
Eyeglasses Dispensed	4845.1	1948	402.1
Prescriptions	4845.1	51757	10682.3
Dental			
Visits	2125.8	7350	3457.5
Procedures	2125.8	19095	8982.5

The population at risk figures are in person years of experience, and were estimated by the Evaluation Team based upon the membermonths of care provided in the annual report and the membermonths given in the cost report.

5.7 Adjusted Community Rate Development And Fiscal Performance Benefit Period 3 (January - December 1982)

The procedure for ACR development remained more or less the same as the first two years. In year 3, KPMCP-O did have actual demonstration experience to apply to rate setting. KPMCP-O's projected community rate was $46.66; an increase of 18.9%. Exhibits 5-33 and 5-34 show cost allocation and components of this community rate.

As in the prior year rate settings, time and complexity (T/C) and volume adjustment were used. The 1982 factors were based on Medicare demonstration experience. The details of the calculation of the medical services volume factor are given in Exhibit 5-35. Four types of services were included in calculating the multiplier:

EXHIBIT 5-33

KAISER FOUNDATION HEALTH PLAN OF OREGON
1982 FORECAST COMMUNITY RATE
COST ALLOCATION

Cost and Capital Requirement	PM/PM	HOSPITAL	Medical Office	Home Health Agency	Pharmacy /Optical	Claims/ Ambulance	Community Service Program	Dental	General & Admin.
BCP to NWP	$ 8.53	$	$ 8.53	$	$	$	$	$	$
Hospital Operations	11.93	10.50	.51	.20	.05				.67
Clinic Operations	10.65		10.38		.27				
H.P. Administration	.76								.76
Regional Administration	2.48								2.48
Pharmacy	2.96	.60	.07		2.29				
Optical	.65				.65				
Claims	1.20					1.20			
Ambulance	.45					.45			
Other Benefits	.40					.40			
Referred Hospitalization	.81	.81							
Ref. Non-Physician Service	.43		.43						
Interest	.74	.20	.33		.04				.17
Other Property	.47	.13	.21		.02				.11
Physicians Retirement	.76		.76						
Professional Liability	1.01	.22	.79						
Community Service Program	.51	.08	.08				.35		
Start-Up Costs	.09	.06	.03						
Other Administrative	.56								.56
ICP to NWP	.09		.09						
Gross Cash Generation									
Depreciation	1.93	.52	.86	.01	.09		.01		.44
4% Provision	1.05	.28	.47		.05		.01		.24
Earnings	.58	.16	.26		.02		.01		.13
Total	49.04	13.56	23.80	.21	3.48	2.05	.38		5.56
Cost Recoveries	(.08)	.09	.19		(.07)		(.07)	(.13)	(.09)
G/A		2.08	2.92	.01	.17		.14	.15	(5.47)
Medical Office Reclasses		2.49	(2.61)	.03	.07			.02	
Sub-total	48.96	18.22	24.30	.25	3.65	2.05	.45	.04	
Less Non-Member	(2.30)	(.82)	(1.48)						
Total	$46.66	$17.40	$22.82	$ .25	$ 3.65	$ 2.05	$ .45	$ .04	

EXHIBIT 5-34

KAISER FOUNDATION HEALTH PLAN OF OREGON

COMMUNITY RATE COMPONENTS

Components	1982 Community Rate
Hospitals:	
Part A	$ 16.76
Part B	1.09
SUB-TOTAL	$ 17.85
Medical Offices:	
Direct Patient Care	$ 13.66
Indirect	9.16
SUB-TOTAL	$ 22.82
Home Health Agency	.25
Claims/Ambulance	2.05
Pharmacy/Optical[1/]	3.69
TOTAL	$ 46.66

[1/] Includes a $.04 per member per month interim subsidy to the Dental Program.

EXHIBIT 5-35

1982 FORECAST VOLUME FACTOR FOR MEDICAL SERVICES

Physician Office Visits

a.	January 1981 - September 1981 Medicare Plus Visits		32,689
b.	Average Medicare Plus membership		7,592
c.	Annualized utilization rate: $(32,689 \div 7,592) \times \frac{12}{9} \times .988$ [1/] =		5.672
d.	Forecast 1982 Medicare Plus utilization rate [2/]		5.600
e.	Forecast 1982 Medicare Plus office visits: 5.6 x 7,300 =		40,880
f.	Forecast 1982 total Health Plan visits		715,350

Hospital Days

a.	Forecast 1982 Medicare Plus days:	1.700 x 7,300 =	12,410
b.	Forecast 1982 total Health Plan days		100,390

Physician Home Visits

a.	January 1981 - September 1981 home visit utilization rates (visits per thousand, annualized):		
	Total Health Plan		4
	Over Age 65		28
b.	Forecast 1982 home physician visits:		
	Total Health Plan	257,925 x .004 =	1,032
	Medicare Plus	7,300 x .028 =	204

Radiology Visits

a.	January 1981 - September 1981 radiology visit utilization rates (visits per thousand, annualized):		
	Total Health Plan		62
	Over Age 65		191
b.	Forecast 1982 radiology visits:		
	Total Health Plan	257,925 x .062 =	15,991
	Medicare Plus	7,300 x .191 =	1,394

1/ Average 1977 - 1979 seasonality factor.

2/ The Medicare Plus rate has been declining during the past year. It is assumed that it will continue to decline, averaging 5.6 visits per member per year in 1982 (the same rate as the third quarter of 1981).

EXHIBIT 5-35 (Continued)

Forecast Utilization Rates		
Forecast Medical Services:[1/]		
Total Health Plan		832,763
Medicare Plus		54,888
Forecast Medical Services Utilization Rates:		
Total Health Plan	832,763 ÷ 257,925	3.229
Medicare Plus	54,888 ÷ 7,300	7.519
Forecast Volume Factor		
7.519 ÷ 3.229 =		2.33

1/ Forecast physician office visits, hospital days. physician home visits and radiology visits above.

	1982 Forecast			
	Demonstration		Plan-Wide	
	Total Visits	Visit Rate	Total Visits	Visit Rate
Physician Office Visits	40,880	5,600	715,350	2,774
Hospital Days	12,410	1,700	100,390	389
Physician Home Visits	204	28	1,032	4
Radiology Visits	1,394	191	15,991	62
Total	54,888	7,519	832,763	3,229

The overall volume multiplier was the ratio of the demonstration to the plan-wide utilization rates: (7519 divided by 3229 = 2.33).

The hospital volume factor of 4.37 results from dividing the 1982 inpatient day forecast for the demonstration enrollees (1700 days/1000) by the total plan expected 1982 utilization of 389 days/1000. The multiplier was higher than both the 1981 factor and the 1980 ratios.

The volume factor for home health was based on the home health experience for the period September 1980 through August 1981. For that timeframe, the utilization rate for the demonstration enrollees was 304 visits/1000 while it was 22 visits/1000 for the remaining population. Assuming a monthly enrollment of 7300 members for the demonstration and 250,625 for all other beneficiaries, a total plan use rate of 30.0/1000 was calculated:

$$\frac{(7300 \times 304) + (250{,}625 \times 22)}{257{,}925} = 30.0$$

The relationship of the demonstration utilization to the total plan use rate was then 10.1 (304 divided by 30.0).

The T/C factor for hospitalization is shown in Exhibit 5-36. Demonstration experience was used to calculate per diems. These ratios were:

Part A: $365.90/398.50 = .9182
Part B: $16.89/25.89 = .6524

The final multiplier was the medical time/complexity factor, which is presented in Exhibit 5-37. As with the other multipliers, Medicare demonstration experience was used to develop the factor. If the GPPP Medicare population's data had been used, the factor would have been slightly lower, i.e., 1.1469.

$$\frac{34{,}133}{423{,}702} \text{ divided by } \frac{28{,}647}{408{,}976} = 1.1501$$

EXHIBIT 5-36

1982 FORECAST HOSPITAL TIME/COMPLEXITY FACTORS
Based on Oregon Region 1981 Costs

	Medicare Plus-Aged/Disabled	Total
Bess Kaiser:		
Ancillary	$ 452,381	$ 5,135,895
Daily Care	569,779	5,784,105
Nursery	--	866,579
Subtotal	$1,022,160	$11,786,579
Part B	61,079	776,098
TOTAL	$1,083,239	$12,562,677
Sunnyside:		
Ancillary	$ 498,239	$ 2,939,000
Daily Care	596,063	3,237,328
ICU/CCU	144,808	518,800
Subtotal	$1,239,110	$ 6,695,128
Part B	43,275	424,814
TOTAL	$1,282,385	$ 7,119,942
Combined:		
Subtotal	$2,261,270	$18,481,707
Part B	104,354	1,200,912
TOTAL	$2,366,624	$19,682,619
Patient Days:	6,180	46,378
Per Diem:		
Subtotal	$ 365.90	$ 398.50
Part B	16.89	25.89
TOTAL	$ 382.79	$ 424.39
Adjustment Factors:		
Part A	.9182	
Part B	.6524	

EXHIBIT 5-37

1982 FORECAST MEDICAL TIME/COMPLEXITY FACTOR

Based on Oregon Region 1981 Statistics

Health Plan Members	Services	T/C Adj.	T/C Adj. Services	T/C Relative All Ages
Under 65	331,239	1.00	331,239	.9653
Medicare:				
65 and Over	46,196	1.20	55,435	1.1583
Disabled	2,895	1.00	2,895	.9653
Subtotal	49,091	1.1882	58,330	1.1469
Medicare Plus:				
65 and Over	27,432	1.20	32,918	1.1583
Disabled	1,215	1.00	1,215	.9653
Subtotal	28,647	1.1915	34,133	1.1501
TOTAL	408,976	1.0360	423,702	

Finalizing Third Year KPMCP-O ACR

Exhibit 5-38 shows the projected ACR for the third year of the demonstration. The third year gross ACR was $24.62 PMPM more than actual costs in the previous benefit period (i.e., $147.59 versus $122.97); an increase of 20.0%. The most important change was in Part A inpatient costs. The difference between budgeted costs in Year 2 and budgeted costs in Year 3 was 31.1% ($51.30 versus $67.25). Year 3 budgeted hospital costs of $67.25 were $8.80 PMPM greater than actual 1981 hospital Part A costs ($51.30 + $7.15)

From Year 2 to Year 3, budgeted in-plan direct medical services costs increased 16.7% (i.e.; $31.35 to $36.60), and indirect medical services increased 31.3% (from $16.25 PMPM to $21.34 PMPM). The In/Out-of-Area Claims budget was $6.34 PMPM or 172% greater than the Year 2 budget but 20.2% less than the Year 2 experience.

HCFA Capitation

KPMCP-O received a 1982 ratebook (Exhibit 5-39) from HCFA, with county calculations based on plan enrollment as of August 1981. The estimated composite 95% of AAPCC was $139.65 PMPM; an increase of 22.9%. While the overall 1982 ACR increased 24.8% over actual 1981 costs (i.e., $148.09 versus $118.66), estimated HCFA revenues to support these cost increases grew only 22.9%. The rate of aged/disabled used in structuring the AAPCC was 96.67% aged/3.33% disabled.

In 1982 no HCFA revenue was contributed to the benefit stabilization fund. KPMCP-O received the entire capitation payment. The Plan continued to be reimbursed by the ratebook approach, making a retroactive adjustment likely. The HCFA capitation covered the beneficiary premium ($23.43 PMPM) and the cost of special services ($.50 PMPM), which represented new member entry program costs.

During the third year, KPMCP-O requested additional monthly reimbursement from the BSF in the amount of $2.17. The fund handles year end retroactive adjustments between the estimated and actual AAPCCs and ensures provision of benefits at the minimum cost to the member in future years. The Plan felt that such services could not be provided in 1982 without support from the fund.

At a capitation of $2.17, the existing level of $315,000 could support 145,000 membermonths for a year, far more than would probably be enrolled in KPMCP-O in 1982 (87,600 membermonths projected). Therefore, the total projected monthly payment from HCFA was $141.82 ($139.65 + $2.17). This represented a 26.0% increase over the prior year's projected reimbursement ($141.82 divided by $112.55); and a 50% increase over the Year 1 projected payment ($141.82 divided by $94.53).

EXHIBIT 5-38

1982 ESTIMATED ACR

	Community Rate	Volume Factor	Time/ Complexity Factor	Composite Factor	ACR Components
Hospitals					
Part A	$16.76	4.37	.9182	4.0125	$ 67.25
Part B	1.09	4.37	.6524	2.8510	3.11
Medical Offices					
Direct Patient Care	13.66	2.33	1.1501	2.6797	36.60
Indirect	9.16	2.33	1.00	2.33	21.34
Home Health Agency	.25	10.10	1.00	10.10	2.53
Sub-Total	$40.92			3.1972	$130.83
Pharmacy/Optical	3.69				--
In/Out of Area Claims	1.20				6.34
Extended Care	.34				5.87
Ambulance	.45				2.60
Other	.06				1.95
Sub-Total	$ 2.05				$ 16.76
Gross ACR	$46.66				$147.59
Less Supplemental Plan Dues Rate					(23.43)
Over-the-Counter Copayment					(1.27)
NET ACR					$122.89
Overall ACR					
Gross ACR					$147.59
Benefit Stabilization Fund					--
New Member Entry Program (Special Services)					.50
					$148.09

EXHIBIT 5-39

1982 RATES OF PAYMENT, BY COUNTY

AUGUST 1981

CATEGORY	COUNTY	PART A	PART B	TOTAL
Aged	Clackamas	$ 76.83	$ 39.77	$116.60
	Columbia	73.57	31.91	105.48
	Marion	56.18	32.54	88.72
	Multonomah	109.21	44.15	153.36
	Washington	89.47	41.28	130.74
	Clark	63.18	35.21	98.39
	Composite	$ 95.94	$ 41.86	$137.80
Disabled	Clackamas	$110.81	$ 63.68	$174.49
	Columbia	84.90	43.87	128.77
	Marion	.00	.00	.00
	Multonomah	150.98	66.49	217.47
	Washington	136.01	65.83	201.84
	Clark	80.08	43.49	123.57
	Composite	$131.47	$ 61.83	$193.30
Aged and Disabled Combined	Composite	$ 97.13	$ 42.52	$139.65

Beneficiary Payments

KPMCP-O could have requested the beneficiary to pay for four costs associated with Medicare-Plus:

- Special Services $.50
- Beneficiary Premium $23.43
- Copayment $1.27
- Project Enrollee Payment $5.00

The special services requirement and the beneficiary premium continued to be covered by the HCFA payment. To continue this coverage, the Plan had to utilize the BSF.

For the remaining two items, the Medicare member reimbursed the Plan. The copayment level remained the same -- $2 for office visits and $3 for home visits. In the first two years, the copayment revenue was projected at $1.07 PMPM, based upon an analysis of all plan Medicare members. For 1982, an analysis of the Medicare demonstration enrollees (August 1980 through July 1981) showed an office visit rate that was 23% higher than cost-based Medicare members. Therefore, to project the effect of the copayment for the demonstration participants, a 1.2 factor was applied to the $1.06 PMPM forecast for regular Medicare members to derive the effective copayment revenue (1.2 x $1.06 PMPM = $1.27 PMPM).

The final item was a $5.00 PMPM payment requested of the member and labeled "project enrollee payment". Even though KPMCP-O projected that the HCFA payment would cover the beneficiary premium and the $.50 service charge, in effect, this payment was a $5.00 charge applied to the beneficiary premium.

Beneficiary Premium Development

The beneficiary premium for demonstration participants was initially derived from adjusting the cost-based GPPP Medicare member premium. During Year 1, the value of this premium, which was covered by the HCFA capitation, was $15.18. In Year 2, projected premium costs increased 12.8% to $17.13.

KPMCP-O's analysis of certain program use and cost relationships between cost-based GPPP and risk-based demonstration enrollees revealed a need to increase the third year premium 30.9%; from $17.13 to $22.43. These relationships are as follows:

Cost Category	Relationship Regular Medicare to Medicare Plus	Regular Medicare Premium	Adjusting Factor	Medicare Plus Premium
Part B Coinsurance	121%	$8.71	1.2	$10.45
Copayment Offset	123%	($1.06)	1.2	(1.27)
All Other Costs	97%-200%	$13.35	1.0	13.25
				$22.43

The "all other costs" category includes the Part A deductible payments which showed demonstration costs at 97% of GPPP enrollees. In contrast to this indicator of lower hospital use, analysis of use of physical exams indicated demonstration costs at 200% of the cost-based plan.

To develop the final premium, KPMCP-O added a $1.00 administrative loading to the $22.43; a standard charge for all non-group contracts.

Rate Setting for Additional Demonstration Benefits

Premium charges for the additional benefits remained constant for the first two benefit periods. A rather significant increase occurred in Year 3:

	1980/81 Premium	1982 Premium	Percent Change
Plan B			
Rx, $1 Plan	$ 4.45	$ 7.09	59%
Vision Care	1.00	1.71	71%
Hearing Aids	.55	1.47	167%
Total	$6.00	$10.27	71%
Plan C - Dental	$9.81	$12.58	28%
Plan D (Plan B + Plan C)	$15.81	$22.85	45%

To calculate the new premiums, actual Medicare Plus experience was examined for the period August 1980 through July/August 1981. Rate-setting for each of the benefit components is as follows:

1. Prescription Drugs

For the first 12 months of the demonstration, KPMCP-O reported a use rate of 9740 Rxs/1000. When compared with the regular Medicare usage of 7700/1000, the demonstration project has been experiencing a 26.5% higher prescription drug demand (9740 divided by 7700). For purposes of the 1982 projection, the regular Medicare premium of $5.67 (net of the $1 copayment) was multiplied by a 1.25 factor to derive the $7.09 PMPM figure. At an expected utilization of 9740, this implies an $8.74 Rx cost ($9.74 including the $1 copayment). From the initial projections (1980) the Rx cost has increased 19.4% ($9.74 divided by $8.16) and the utilization estimate is 28.2% higher (9740 divided by 7600). The 9740 utilization is between the 9010 Rxs/1000 reported for Year 1 and the 10700 Rxs/1000 used for the entire second benefit period.

2. Vision Care

During the first 13 months of the demonstration, members required 446 optical appliances/1000 (eyeglasses or contact lenses) as opposed to 188/1000 projected for 1982 for the regular Medicare population. This data indicated a multiplier of 2.37 (446 divided by 188). However, the Plan used a ratio of 1.25 instead of 2.37. The rationale was that as time passes, fewer of the beneficiaries will be eligible since the Plan offers only one pair of glasses every two years. Therefore, the higher initial utilization will be lowered.

The 1982 regular Medicare benefit was priced at $1.37 PMPM. This implies a cost of $1.71 PMPM (1.25 x $1.37) for the Medicare Plus option. Futhermore, at a utilization of 235 devices/1000 (1.25 x 188), the unit cost would be $87.32. This projection represents a 29.1% increase in estimated utilization from 1980 (235 divided by 182) and a 32.2% increase in appliance cost ($87.32 divided by $66.04). The utilization for the first five months was 580 appliances/1000 and for the next twelve months was 400 appliances/1000.

3. Hearing Aids

The Medicare Plus experience for this benefit was reported at 106 aids/1000 and 53 ear molds/1000 and the projected 1982 regular Medicare utilization was 95 aids/1000 and 48 ear molds/1000. Here, the demonstration utilization was only 10% greater than the regular Medicare usage. Using the same reasoning as with vision benefits, the Plan projected a decrease in the demonstration use rate, to the same level as for the regular Medicare population. The benefit was costed as follows, considering both materials and labor (for evaluation, fitting and efficiency checks):

Materials:				
	Aids ($148.88 x 95)/12000	=	1.18	
	Molds ($7.13 x 48)/12000	=	.03	
				$1.21
Labor:	(95 hours x $32.79)/12000	=		.26
				$1.47

Examining this capitation from another viewpoint, the $1.47 PMPM translates into 95 aids/1000 at a composite cost of $185.68. This represents a 44% decrease in cost from 1980 ($185.68 divided by $330) and 375% increase in utilization (95 divided by 20). The projected utilization of 95/1000 compares with 119/1000 as experienced for all of 1981.

4. Dental Services

The basic dental package was projected to cost $11.76 PMPM as opposed to $9.81 PMPM in 1980. No specifics of the derivation of the $11.76 were provided. In addition, as stated at the beginning of the demonstration, the prosthetics benefit would be "bought out" by the experiment: i.e., this service would be added as a benefit in later years. For the first two years, the prosthetic services were provided according to a fixed fee schedule. The utilization of the prosthetics services was 259 services per thousand at an average charge of $54.35 (for the period August 1980 through July 1981).

To estimate the cost of the additional benefit (full coverage of prosthetics) the Plan assumed a 30% decrease in utilization to a projected figure of 181 services/1000 at the same charge of $54.35. The result is a capitation of $.82 (181 x $54.35 divided by 12000 = $.82). The complete 1982 dental supplemental premium was then $12.58.

End Stage Renal Dialysis (ESRD) Payments

The payment to KPMCP-O for ESRD members was set at $2,479.38 PMPM for Oregon beneficiaries and $1,532.09 PMPM for Washington State beneficiaries. (Both numbers represent 95% of the AAPCC). These figures also contain the beneficiary premium and special services charges.

Fiscal Performance, Benefit Period 3
(January - December 1982)

Exhibit 5-40 summarizes the projected versus actual performance for calendar year 1982. Actual results are based on 89,379 member-months or 7,448.3 member years (89,379 divided by 12).

The expense variance is a favorable $4.26 PMPM. Although all revenue information is not available, the most favorable case would have had the Plan collect all copayments and member payments. That situation would produce a favorable revenue variance of $1.19 PMPM and a net impact of a gain of $5.45 PMPM or approximately $487,000. The large increase in the AAPCC (22.5% over 1982), the additional revenue sources ($7.17 PMPM) and the continued control over inpatient usage were the significant reasons for the large gain in Year 3 as compared to the losses of the first two years.

The Plan reported a cost of $111.85 PMPM (Exhibit 5-41) to deliver the mandated benefits, which was less than 95% of the AAPCC ($139.65). To determine to measure the actual cost of delivering the mandated benefits, the reported cost of $111.85 would have to be reduced by the value of the Part A co-payments and deductibles at out-of-plan hospitals and by the value of the additional days of care provided above the present Medicare limits.

1. Hospitalization

Actual costs were equal to budgeted because of the nature of the arrangement between the Plan and the In-Plan hospitals. The hospital use rate was 1662 days/1000 for Kaiser or community hospitals (when Kaiser facilities were full). This figure does not include referrals to non-plan facitilities. The average length of stay in the Kaiser Facilities was 6.87 days, which was 2.3% less than in Year 2.

For the Part B component of hospitalization, no utilization data were provided. However, under the cost contract reporting format, costs of $268,517 were reported by the two Kaiser facilities, with deductible and coinsurance offsets of $44,090. Disregarding the offsets, the Part B costs were $3.00 PMPM ($268,517 divided by 89,379) (Exhibit 5-41). This capitation compares with a budget of $3.11 PMPM for an favorable variance of $.11 PMPM. Per the arrangement with the hospitals, actual costs equaled budget.

EXHIBIT 5-40
KAISER-PERMANENTE MEDICAL CARE PROGRAM OF OREGON
Year 3: January 1982 - December 1982
Capitation

	Budget	Actual	Variance Favorable	Variance Unfavorable
MEMBERMONTHS		89,379		
EXPENSES				
• Hospitals				
Part A	$ 67.25	$ 67.25		
Part B	3.11	3.11		
• Extended Care	5.87	3.12	$2.75	
• Home Health	2.53	2.53		
• Medical Services				
In-Plan, Direct Patient Care	36.60			
In-Plan, Indirect Patient Care	21.34	57.94		
• Ambulance	2.60	2.86		$ .26
• In/Out-of-Area Claims	6.34		3.47	
Part A		1.55		
Part B		1.32		
• Other Benefits/Services	1.95	2.46		.51
• Benefit Stabilization Fund	-	1.19		1.19
• New Member Entry Program	.50	.50		
TOTAL	$148.09	$143.83	$ 4.26	
REVENUES				
• HCFA Payment	$139.65	$140.84	$1.19	
• Member Copayment	1.27			
• Benefit Stabilization Fund	2.17	2.17		
• Project Member Payment	5.00			
TOTAL	$148.09			
REVENUE LESS EXPENSES				

EXHIBIT 5-41

KAISER-PERMANENTE MEDICAL CARE PROGRAM - OREGON REGION

MEDICARE DEMONSTRATION PROJECT

HMO COST SUMMARY FOR PERIOD ENDED 12/31/82

	Part A	Part B	Total
TOTAL COSTS:			
Hospitals:			
Bess Kaiser Medical Center	$2,468,722	$ 158,840	$ 2,627,562
Sunnyside Medical Center	2,190,739	109,677	2,300,416
Medical Services		4,960,263	4,960,263
Home Health Agency	283,053	--	283,053
SUB-TOTAL	$4,942,514	$ 5,228,780	$10,171,294
Purchased Services	877,817	862,853	1,740,670
TOTAL COST	$5,820,331	$ 6,091,633	$11,911,964
DEDUCTIBLE & COINSURANCE			
Hospitals:			
Bess Kaiser Medical Center	$ (172,731)	$ (26,503)	$ (199,234)
Sunnyside Medical Center	(186,225)	(17,587)	(203,812)
Medical Services	N/A	(1,511,785)	(1,511,785)
Home Health Agency	--	--	--
TOTAL	$ (358,956)	$(1,555,875)	$(1,914,831)
COST NET OF DEDUCTIBLE & COINSURANCE	$5,461,375	$ 4,535,758	$ 9,997,133
Member Months			89,379
PM/PM			$ 111.85

2. SNF

The results of the risk demonstration reporting showed SNF costs equal to $3.12 PMPM or $2.72 PMPM under budget. Reported usage was 481.2 SNF days/1000 with 17.5 admissions/1000. Effective cost per day was $77.81 ($3.12 x 12,000/481.2). This cost per day is 8.0% lower than that experienced in the second year. Using the cost reporting format, SNF costs are included in the overall inpatient costs.

3. Home Health

Home health services were also capitated, so actual costs equaled budgeted costs. However, under the cost reporting format, $258,053 of cost was reported which translates to a capitation of $2.89 ($258,053/89,379). The use rate was 649.2/1000. The effective cost per visit under the risk demonstration was $46.76 as compared with $58.54 reported under the cost contract format.

4. In-Plan Medical Services

Because this service was capitated, actual costs equaled budget. The effective cost per visit was $119.71 ($57.94 x 12,000/5,808). This cost is 14.9% higher than that experienced in the second benefit period. As reported under the cost contract methodology, Exhibit 5-42 shows direct patient care costs.

- Total medical services costs for calendar year 1982 were $54,843,549.

- For cost estimation purposes, "medical services" consist of doctor office visits, doctor house calls, hospital inpatient days, and radiologist visits. All Medicare members of KPMCP-O (i.e., risk-based demonstration and cost-based GPPP aged and disabled) used 21.3% of total medical services. The use of aged members, adjusted by a time and complexity factor of 1.2, yielded an adjusted use of 24.4%. Compared with the Year 2 period, Medicare beneficiary use of total medical services increased approximately 5.9%.

- KPMCP-O demonstration enrollees used an estimated 7.8% of total in-plan medical services (i.e., 31.97% of Medicare member-months were demonstration enrollees and all Medicare persons used 24.4% of total services (.3197 x .244 = .078).

- KPMCP-P attributed 7.8% of total in-plan medical services costs or $4,277,797 to demonstration enrollees (i.e., $54,843,549 x .078).

- Administrative costs associated with medical services were $416,397, based on an allocation using the unadjusted number of services.

EXHIBIT 5-42

GROUP PRACTICE PREPAYMENT PLAN
STATEMENT OF REIMBURSABLE COST
January 1, 1982 Through December 31, 1982

1.	Total Cost - All Covered Medical Services	$54,843,549	
2.	Ratio - Utilization Services Medicare Members to all Members	7.80%	
3.	Total Medical Service Cost for all Medicare Members (line 1 times line 2)		$4,277,797
4.	Total Cost - Administration	$ 6,123,492	
5.	Ratio - Medicare Membership, Medicare Contract, or Utilization whichever applicable	6.80%	
6.	Total Administration Cost Applicable to Medicare Members (line 4 times line 5)		$ 416,397
6(a)	Excluded Services		$ (27,988)
7.	Total Cost - Purchase Services Medicare Members		$ 862,853
7(a)	Equalization Factor		$ 294,057
8.	Total Allowable Cost (sum of lines 3, 6 and 7)		$5,823,116
9.	Less Annual Deductible		$ (433,952)
10.	Cost Less Deductible (subtract line 9 from line 8)		$5,389,164
11.	80 Percent of Reimbursable Amount (line 10 times 80%)		$4,311,331
12.	Less Interim Payment Received During the Period		Not Applicable
13.	Balance Payable to Plan		Not Applicable
14.	Balance Payable to SMI Trust Fund		Not Applicable

The difference between the projected in-plan medical services capitation of $36.60 and actual capitation costs of $47.86 (i.e., $4,277,797/89,379) is an unfavorable $11.26 PMPM. Actual 1981 risk-based demonstration and cost-based GPPP use was 6683.4/1000 (i.e., 160,721 unadjusted service units/23,980.5 members). Actual use by demonstration enrollees in 1982 was 7548 services/1000, an increase of 13% over Year 2.

As in the prior Years' assessments, one additional cost component was used to derive the total medical services costs; namely, the equalization factor. The amount of the equalization factor for 1982 was $294,057.

The costs used to develop the actual capitations were:

• Direct Patient Care	$4,277,797
Capitation	$47.86
• Indirect Payment Care	
- Allocation	$ 416,397
- Equalization Factor	294,057
Total	$ 710,454
Capitation	$7.95

The total medical service cost was $4,988,251, which is $27,988 greater than the $4,960,263 shown in Exhibit 5-41. This difference of $58,530 is equal to the value of the excluded services, which equate to a capitation of $.65 PMPM.

The total budget for medical services was $57.94 PMPM ($36.60 PMPM for direct patient care and $21.34 PMPM for indirect patient care). The actual capitation was $55.81. If the budget for new member entry is included with the indirect patient care, the overall variance is a favorable $2.63 PMPM ($58.44 PMPM less $55.81 PMPM). This variance was comprised of a loss of $11.26 PMPM for direct patient care and a gain of $13.89 PMPM for indirect patient care. Again, as in prior years, there was a capitation agreement with the physician group, the dollar value of which was unknown. If the capitation agreement was set equal to the budget, the loss to the Plan was, in effect, zero.

In its 1982 annual report, KPMCP-O described the medical services use of demonstration enrollees by type of service. These statistics are as follows:

	Number of Visits (For Total Population)	Utilization (Services/1000) (Total Population)
Physician Visits	43,259	5,808
Non-physician Vists	15,042	2,020
Mental Health Visits		
- Physician	160	21.5
- Non-Physician	152	20.4

Further detailed information provided in prior years was not supplied for Year 3.

5. Ambulance

The reported costs were equal to $2.86 PMPM, resulting in an unfavorable variance of $.26 PMPM. This same figure was also itemized under the cost reporting format.

6. In/Out-of-Area Claims

KPMCP-O reported experience of $1.55 PMPM for Part A and $1.32 PMPM, compared with an overall budget of $6.34 PMPM. The experience of $2.87 PMPM was 68% less than the Year 2 experience and $3.47 PMPM less than the Year 3 budget.

7. Other Benefits/Services

The Plan stated that these services cost $2.46 PMPM, as compared to the budget of $1.95 PMPM. Under the cost reporting format, the reported cost was $488,862 or $5.47 PMPM.

8. Benefit Stabilization Fund (BSF)

KPMCP-O budgeted for a HCFA payment of $139.65 with no contribution to the BSF. HCFA payments were reported to be $106,000 greater than budgeted, resulting in a $1.19 PMPM payment to the fund. Additionally, KPMCP-O budgeted a $2.17 PMPM withdrawal from the fund, which was reported received.

9. New Member Entry Program

The new member entry program was projected to cost $.50 PMPM. Actual costs were reported equal to budgeted.

10. Revenues

Four sources of revenue were budgeted: the HCFA payment, a member copayment, a contribution from the BSF and a project member payment. No data were available pertaining to the member payments. The HCFA payment was reported to be $1.19 PMPM greater than budgeted and the BSF payment was reported as budgeted.

11. Use of Additional Benefits

No cost information for the supplemental benefits for Year 3 was provided; however, some utilization information was available.

	Population At Risk	Total Services	Services 1000/Year
Hearing Aids Dispensed	4721.5	310	65.7
Eyeglasses Dispensed	4721.5	1198	253.7
Prescriptions	4721.5	58,869	12468.5
Dental			
Visits	1962.2	5,693	2901.3
Procedures	1962.2	13,536	6898.3

The population at risk figures are in person years of experience, and were estimated by the Evaluation Team based upon the membermonths of care provided in the annual report and the membermonths given in the cost report.

5.8 Adjusted Community Rate Development, Benefit Period 4 (January - December 1983)

The procedure for the development of the ACR continued to follow closely the rate setting procedure in the first three years. The cost allocation and components of the community rate are given in Exhibit 5-43 and 5-44. After consideration of non-member revenue and cost recoveries, the projected net community rate was $55.04 PMPM; an increase of 18.0% over the 1982 figure.

The details of the calculation of the medical services volume factor are given in Exhibit 5-45. Four types of services were included in the sizing of the multiplier:

	1983 Forecast			
	Demonstration		Plan-Wide	
	Total Visits	Visit Rate	Total Visits	Visit Rate
Physician Office Visits	42,675	5,690	701,000	2,782
Hospital Days	12,000	1,600	98,280	390
Physician Home Visits	772	103	2,772	11
Radiology Visits	1,500	200	15,624	62
Total	56,947	7,593	817,676	3,245

Most utilization rates remained very close to those budgeted for 1982 with the exception of hospital utilization for the demonstration enrollees which dropped from 1,700 to 1,600 days/1000 and physician home visits which were dramatically increased for both the demonstration population (103 versus 28 visits/1000) and the plan-wide membership (11 versus 4 visits/1000). The overall volume multiplier was then the ratio of the two utilization rates: (7,593 divided by 3,245 = 2.34).

The hospital volume factor of 4.10 was the result of dividing the 1983 inpatient day forecast for the demonstration enrollees (1,600 days/1000) by the total plan expected 1983 utilization of 390 days/1000. The multiplier represented approximately a 6% reduction from the 1982 factor.

The volume factor for home health utilized the home health experience for the period July 1981 through June 1982. For that timeframe, the utilization rate for the demonstration enrollees was 547 visits/1000 while it was 36 visits/1000 for the remaining population. Assuming a monthly enrollment of 7,500 members for the demonstration and 244,500 for all other beneficiaries, a total plan use rate of 51.2/1000 was calculated:

$$\frac{(7{,}500 \times 547) + (244{,}500 \times 36)}{252{,}000} = 51.2$$

The relationship of the demonstration utilization to the total plan use rate was then 10.7 (547 divided by 51.2).

EXHIBIT 5-43

1983 FORECAST COMMUNITY RATE
COST ALLOCATION

Cost and Capital Requirement	PM PM	Hospital	Medical Office	Home Health Agency	Pharmacy	Optical	Claims/ Ambulance	Community Service Program	Dental	General & Admin.
Contract Payments to NWP:										
BCP	$10.07	$ ---	$10.07	$ ---	$ ---	$ ---	$ ---	$ ---	$ ---	$ ---
Physician Retirement	.76	---	.76	---	---	---	---	---	---	---
Hospital Operations	13.62	11.79	.82	.26	.08	.03	---	---	---	.64
Referral Hospitalization	1.43	1.43	---	---	---	---	---	---	---	---
Clinic Operations	12.53	---	12.15	---	---	.32	---	---	---	.06
Referral Non-Physician Services	.58	---	.58	---	---	---	---	---	---	---
Health Plan Administration	.93	---	---	---	---	---	---	---	---	.93
Regional Administration	3.06	---	---	---	---	---	---	---	---	3.06
Other Administration	.61	---	---	---	---	---	---	---	---	.61
Pharmacy	3.54	.82	.08	---	2.64	---	---	---	---	---
Optical	.78	---	---	---	---	.78	---	---	---	---
Ambulance	.56	---	---	---	---	---	.56	---	---	---
Claims	1.31	---	---	---	---	---	1.31	---	---	---
Other Benefits	.48	---	---	---	---	---	.48	---	---	---
Professional & Public Liability	1.29	.27	.99	---	---	---	---	---	---	.03
Community Service Program	.61	.14	.10	---	---	---	---	.37	---	---
Start-Up Costs	.16	.04	.12	---	---	---	---	---	---	---
Interest	1.89	.45	.90	---	.06	.06	---	---	---	.42
Other Property Costs	.40	.10	.18	---	.01	.01	---	---	.01	.09
Gross Cash:										
Depreciation	3.12	.77	1.51	---	.07	.10	---	.02	---	.65
Earnings	(.04)	(.01)	(.02)	---	---	---	---	---	---	(.01)
Subtotal	57.69	15.80	28.24	.26	2.86	1.30	2.35	.39	.01	6.48
Cost Recoveries	(.12)	.11	.17	---	(.06)	(.01)	---	(.08)	(.11)	(.14)
G/A	---	2.44	3.41	.01	.16	.06	---	.08	.18	(6.34)
Medical Office Reclasses	---	2.70	(2.81)	.01	.06	.03	---	---	.01	---
Subtotal	57.57	21.05	29.01	.28	3.02	1.38	2.35	.39	.09	---
less: Non-Member	(2.51)	(1.10)	(1.43)	---	---	---	---	---	---	---
COMMUNITY RATE ALLOCATION	$55.04	$19.95	$27.58	$.28	$3.02	$1.38	$2.35	$.39	$.09	$ ---

EXHIBIT 5-44

COMMUNITY RATE COMPONENTS

Components	1983 Community Rate
Hospitals:	
Part A	$19.10
Part B	1.24
Subtotal	$20.34
Medical Offices:	
Direct Patient Care	$17.11
Indirect	10.47
Subtotal	$27.58
Home Health Agency	.28
Claims/Ambulance	2.35
Pharmacy/Optical[1/]	4.49
Total	$55.04

[1/] Includes a $.09 per-member, per month interim subsidy to the Dental Program. Pharmacy, optical (except for eye exams) and dental costs are removed from the ACR as part of the calculation in Table 11, Exhibit 5-48.

EXHIBIT 5-45

1983 FORECAST VOLUME FACTOR FOR MEDICAL SERVICES

Physician Office Visits

a.	July 1981 - June 1982 Medicare Plus visits		42,869
b.	Average Medicare Plus membership		7,536
c.	Utilization rate		5,689
d.	Forecast 1983 Medicare Plus utilization rate		5,690
e.	Forecast 1983 Medicare Plus office visits		42,675
f.	Forecast 1983 total Health Plan visits		701,000

Hospital Days

a.	Forecast 1983 Medicare Plus days:	1.600 x 7,500 =	12,000
b.	Forecast 1983 total Health Plan days		98,280

Physician Home Visits

a. July 1981 - June 1982 home visit utilization rates (per thousand):

Total Health Plan	11
Over Age 65	103

b. Forecast 1983 home physician visits:

Total Health Plan	252,000 x .011 =	2,772
Medicare Plus	7,500 x .103 =	772

Radiology Visits

a. July 1981 - June 1982 radiology visit utilization rates (visits per thousand):

Total Health Plan	62
Over Age 65	200

b. Forecast 1983 radiology visits:

Total Health Plan	252,000 x .062 =	15,624
Medicare Plus	7,500 x .200 =	1,500

EXHIBIT 5-45
(Continued)

Forecast Utilization Rates

Forecast Medical Services:[1/]

Total Health Plan	817,676
Medicare Plus	56,947

Forecast Medical Services Utilization Rates:

Total Health Plan	817,676 ÷ 252,000 =	3.245
Medicare Plus	56,947 ÷ 7,500 =	7.593

Forecast Volume Factor

7.593 ÷ 3.245 =	2.34

[1/] Forecast physician office visits, hospital days, physician home visits and radiology visits above.

The T/C factor for hospitalization is presented in Exhibit 5-46. The methodology was the same as used in 1981. The ratios were:

Part A: $381.59/$411.60 = .9271
Part B: $ 18.97/$30.80 = .6159

The Part A factor is approximately 1% greater than the same number for 1982 and the Part B factor is roughly 5.5% less than the 1982 figure.

The final multiplier is the medical time/complexity factor, which is presented in Exhibit 5-47. The mechanics of the operation were:

$$\frac{33,095}{435,177} \text{ divided by } \frac{27,753}{418,713} = 1.1474$$

The 1983 medical T/C multiplier is slightly less than the projection for 1982 (1.1474 versus 1.1501).

Finalizing of Fourth Year KPMCP-O ACR

The 1983 ACR is shown in Exhibit 5-48, with the different cost categories multiplied by the appropriate combinations of volume and T/C factors developed in the previous section:

	Volume	T/C
Hospital		
Part A	4.10	0.9271
Part B	4.10	0.6159
Medical Services		
Direct Patient	2.34	1.1474
Indirect Patient	2.34	1.0000
Home Health	10.70	1.0000

Note that for indirect medical services and home health T/C multipliers, the value of 1.0 was assumed. After application of the different multipliers, the overall composite factor for the basic services provided in 1983 was 3.0948 ($149.17 divided by $48.20).

To complete the ACR, different assumptions were used to cost the services of extended care, ambulance and other benefits. No specifics of these assumptions were provided. For the remaining category, in/out-of-area claims, actual Medicare Plus information was used to forecast the capitation.

HCFA Capitation

KPMCP-O again calculated an estimated AAPCC (Exhibit 5-49) using the rate cells prepared by HCFA and the average plan population distribution for the period August through October, 1982. Note that the rate cells are already at the 95% level of area costs. The estimated composite 95% level of AAPCC was $165.44 PMPM which implies that the AAPCC for Kaiser was $174.15 PMPM. The ratio of aged/disabled used in structuring the AAPCC was 97.4% aged/2.6% disabled.

EXHIBIT 5-46

1983 FORECAST HOSPITAL TIME/COMPLEXITY FACTORS
Based on Oregon Region 1982 Costs

	Medicare Plus	Total
Bess Kaiser:		
Ancillary	$ 480,095	$ 5,977,286
Daily Care	473,592	5,657,062
ICU/CCU	92,517	857,435
Nursery	---	969,435
Subtotal	$1,046,204	$13,461,218
Part B	64,359	1,000,206
Total	$1,110,563	$14,461,424
Sunnyside:		
Ancillary	$ 445,616	$ 3,382,036
Daily Care	534,029	3,677,164
ICU/CCU	66,735	612,363
Subtotal	$1,056,380	$ 7,671,563
Part B	40,186	581,134
Total	$1,096,566	$ 8,252,697
Combined:		
Subtotal	$2,102,584	$21,132,781
Part B	104,545	1,581,340
Total	$2,207,129	$22,714,121
Patient Days	5,510	51,343
Per Diem:		
Subtotal	$ 381.59	$ 411.60
Part B	18.97	30.80
Total	$ 400.56	$ 442.40
Adjustment Factors:		
Part A	.9271	
Part B	.6159	
	.9054	

EXHIBIT 5-47

1983 FORECAST MEDICAL TIME/COMPLEXITY FACTOR
Based on Oregon Region 1982 Statistics

Health Plan Members	Services	T/C Adj.	T/C Adj. Services	T/C Relative All Ages
Under 65	332,733	1.00	332,733	.9622
Medicare:				
65 and Over	55,608	1.20	66,730	1.1546
Disabled	2,619	1.00	2,619	.9622
Subtotal	58,227	1.1910	69,349	1.1460
Medicare Plus:				
65 and Over	26,709	1.20	32,051	1.1546
Disabled	1,044	1.00	1,044	.9622
Subtotal	27,753	1.1925	33,095	1.1474
Total	418,713	1.0393	435,177	

EXHIBIT 5-48

1983 FORECAST ACR

	Community Rate	Volume Factor	Time/ Complexity Factor	Composite Factor	ACR Components
Hospitals:					
Part A	19.10	4.10	.9271	3.8011	72.60
Part B	1.24	4.10	.6159	2.5252	3.13
Medical Offices:					
Direct Patient Care	17.11	2.34	1.1474	2.6849	45.94
Indirect	10.47	2.34	1.0000	2.34	24.50
Home Health Agency	.28	10.70	1.0000	10.70	3.00
Subtotal	$48.20			3.0948	$149.17
Pharmacy/Optical	4.49				.90
In- & Out-Of-Area Claims	1.31				7.46
Extended Care	.39				4.48
Ambulance	.56				3.11
Other	.09				2.54
Subtotal	$ 2.35				$ 18.49
Gross ACR	$55.04				$167.66
Less Supplemental Plan Dues Rate					(27.74)
Over-The-Counter Copayment					(1.24)
Net ACR					$138.68
Overall ACR					
Gross ACR					$167.66
Benefit Stabilization Fund					1.02
New Member Entry Program (Special Services)					1.00
					$169.68

EXHIBIT 5-49

1983 RATES OF PAYMENT BY COUNTY

Category	County	Part A	Part B	Total
Aged	Clackamas	$ 93.30	$55.32	$148.62
	Columbia	89.97	40.93	130.90
	Marion	0.00	0.00	0.00
	Multnamah	130.12	50.89	181.01
	Washington	109.14	50.14	159.28
	Clark	73.90	35.92	109.82
	Composite	$114.51	$48.95	$163.46
Disabled	Clackamas	$155.60	$83.80	$239.40
	Columbia	106.92	54.32	161.24
	Marion	0.00	0.00	0.00
	Multnomach	182.21	76.29	258.50
	Washington	166.18	78.31	244.49
	Clark	101.96	53.11	155.07
	Composite	165.50	73.82	239.32
Aged and Disabled Combined	Composite	$115.84	$49.60	$165.44

Reverting back to the policy of the first two years of operation, a contribution to the BSF was budgeted. This contribution was estimated at $1.02 PMPM, resulting in a monthly HCFA payment of $164.42 PMPM to KPMCP-O. The Plan will continue to be reimbursed by the ratebook approach so that at the close of the year there will most likely be a retroactive adjustment. As in the initial time periods, the HCFA capitation covered the beneficiary premium ($27.74 PMPM) and the cost of special services ($1.00 PMPM), which represents the new member entry program costs.

Beneficiary Payments

There were four potential payments that could have been requested of the beneficiary to cover the cost of the basic plan, namely:

• Special services	$1.00
• Beneficiary Premium	$27.74
• Copayment	$1.24
• Project Enrollee Payment	$3.00

As stated in the previous section, the special services requirement and the beneficiary premium were covered by the HCFA payment. Details of the development of the beneficiary premium are provided in the following section.

For the remaining two items however, the enrollee reimbursed the Plan. The copayment levels remained the same - $2 for physician visits, emergency care, physical therapy, vision and hearing exams and preventive health care services and $3.00 for home visits. To project the effect of the copayment for the demonstration participants, the same 1.2 factor (as in 1982) was applied to the 1.03 PMPM forecast for the non-demonstration Medicare enrollees to derive the effective copayment revenue (1.2 x $1.03 PMPM = $1.24 PMPM).

The final item was a $3.00 PMPM payment requested of the member and labeled project enrollee payment. Even though the HCFA payment was projected to completely cover the beneficiary premium and the $1.00 service charge, in effect, the payment covered all but $3.00 of the charge.

Beneficiary Premium Development

The beneficiary premium for the demonstration participants was derived as an adjustment to the regular Medicare member premium. An analysis of the demonstration program utilization and cost showed certain relationships between the regular and demonstration Medicare programs which were used to develop the adjustment factors. The details of the rate setting are as follows:

Cost Category	Regular Medicare Premium	Adjusting Factor	Medicare Plus Premium
Part B Deductible and Coinsurance	$ 4.00	1.0	$ 4.00
Part B Coinsurance	9.44	1.2	11.33
Copayment Offset	(1.03)	1.2	(1.24)
All Other Costs	11.50	1.1	12.65
			$26.74

To the $26.74 medical services premium was added a $1.00 administrative loading which is standard for all non-group KPMCP-O contracts. Note that the the office and home visit copayments, which are paid separately by the member, are netted out of the premium. The budgeted revenues and expenses for the basic set of services are now established and are summarized in Exhibit 5-50.

Rate Setting for Additional Demonstration Benefits

A comparison of the 1982 premiums for additional benefits versus the 1983 premiums is presented below:

	1982 Premium	1983 Premium	Percent Change
Plan B			
Rx, $1 Plan	$ 7.09	$11.23	58.3%
Vision Care	1.71	1.80	5.3%
Hearing Aids	1.47	1.11	(24.5%)
Total	$10.27	$14.14	37.7%
Plan C - Dental	$12.58	$17.78	41.3%
Plan D (Plan B + Plan C)	$22.85	$31.92	39.7%

To size the new premiums, actual Medicare Plus experience was examined for the period August 1980 through August 1982. Each of the benefit is discussed, beginning with prescription drugs.

1. Prescription Drugs

When compared with the regular Medicare projection of 9,200/1,000, the demonstration project had been experiencing a 32.6% higher prescription drug demand for the period September 1981 through August 1982 (12,200 divided by 9,200). For purposes of the 1983 projection, the regular Medicare premium of $8.44 (net of the $1 copayment) was multipled by a 1.33 factor to derive the $11.23 PMPM figure. At an expected utilization of 12,200, this implies an $11.05 Rx cost ($12.05 including the $1 copayment). These projections represent a 25.2% increase in budgeted utilization from 1982 (12,200 divided by 9,740) and a 23.7% increase in Rx cost ($12.05 divided by $9.74).

EXHIBIT 5-50

Year 4: January 1983 - December 1983
Capitation

	Budget
MEMBERMONTHS	
EXPENSES	
. Hospitals	
Part A (In-Plan, Out-of-Plan)	$ 72.60
Part B	3.13
. Extended Care	4.48
. Home Health	3.00
. Medical Services	
In-Plan, Dir. Pat. Care	45.94
In-Plan, Indirect Pat. Care	24.50
. Pharmacy/Optical	.90
. Ambulance	3.11
. In/Out-of-Area Claims	7.46
. Other Benefits/Services	2.54
. Benefit Stabilization Fund	1.02
. New Member Entry Program	1.00
TOTAL	$169.68
REVENUES	
. HCFA Payment	165.44
. Member Copayment	1.24
. Project Member Payment	3.00
TOTAL	$169.68
REVENUE LESS EXPENSES	--

2. Vision Care

The use rate for optical appliances (eyeglasses or contact lenses) for the Medicare plus population has demonstrated the following pattern:

September through December 1980:	559/1000
Calendar Year 1981:	395/1000
January through August 1982:	294/1000
September 1981 through August 1982:	302/1000

To compute the cost of the 1983 vision care benefit for the regular KPCMP-O Medicare population, a unit utilization of 190 appliances/1000 was used with a unit cost of $103.58. Even though the latest utilization figures for the Medicare plus plan were much higher than for the regular group (302/190 = 1.59), KPMCP-O assumed that the downward trend in use would continue. Therefore, an expected requirement of 209 appliances/1000 was projected. The 1983 capitation for the demonstration program was then:

(209/1000 x $103.58) / 12,000 = $1.80 PMPM

3. Hearing Aids

The Medicare Plus experience for this benefit was reported at 83 aids/1000 and 46 ear molds/1000 for the timeframe from September 1981 through August 1982. For purposes of this projection, the utilization of services was assumed to more closely resemble the experience of the first eight months of 1982. The unit cost represents a 5% increase over 1982 costs for materials and 9% for labor. The benefit was costed as follows, considering both materials and labor (for evaluation, fitting and efficiency checks):

Materials		
Aids ($139.46 x 70)/12,000	=	$ .81
Molds ($7.42 x 40)/12,000	=	.02
		$ .83
Labor: (70 hrs x $48.07)/12,000	=	.28
		$1.11

Overall, the cost of this benefit was budgeted to decline by 24.5%.

4. Dental Services

The historical utilization relationship between the Medicare plus (M+) population and the regular Medicare program, as measured using fifty-eight common dental procedures, is as follows:

	M+/Regular M
Calendar 1981	2.10
February through September 1981	1.82

This same ratio, when forecast for 1983, was 1.72. Since the benefit for the regular Medicare population was costed at $11.85 PMPM, using the 1.72 factor would imply the following premium for the Medicare plus enrollees:

1.72 x $11.85 = $20.38 PMPM

This premium would represent a $7.80 PMPM increase over the $12.58 PMPM charged in 1982. In order to maintain rate stability, KPMCP-O decided to pass on 66.7% of the increase to 1983 ($5.20 PMPM) and the remainder in 1984. Thus, the projected 1983 dental premium was $17.78 PMPM ($12.58 + $5.20).

End Stage Renal Dialysis (ESRD) Payments

The payment to KPMCP-O for ESRD members was set at $2,742.78 PMPM for Oregon beneficiaries and $1,657.60 PMPM for Washington State beneficiaries. (Both numbers represent 95% of the AAPCC). As with the aged and disabled members, ESRD eligibles had to contribute copayments and the monthly project member payment.