May 13, 2011

Behavioral Health Data Book

State of Louisiana
Capitated Adult Behavioral Health Program

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Contents

1

Introduction

Purpose of this Data Book

The intent of this Data Book is to summarize historical data on the Medicaid Fee-For-Service (FFS) cost and utilization patterns of behavioral health services by Medicaid-eligible adults for reference in the State of Louisiana's (State) procurement for a prepaid inpatient health plan (PIHP) contractor.

This data book has been produced by the State's actuarial contractor, Mercer Government Human Services Consulting (Mercer).

Contents of this Data Book

This book contains demographic, cost and utilization data related to Behavioral Health (BH) services only. Please note the following concerning this Data Book:

- The FFS cost and utilization information in this Data Book has been summarized from information contained in the State's FFS database. The demographic information was taken from the State's eligibility files. This Data Book contains claims and utilization data for recipients in the FFS program.

The users of this data book are cautioned that direct comparisons cannot be made between the information in this data book and raw FFS data. Mercer applied adjustments to the raw data. Please refer to Section 4 for adjustments reflected in this data book.

The FFS information in this data book is summarized for the following years (based on date of service):

- State Fiscal Year (SFY) 2008 — July 2007 to June 2008, paid through August 2010
- SFY 2009 — July 2008 to June 2009, paid through August 2010
- SFY 2009 — July 2009 to June 2010, paid through August 2010

These data were the most recent data available for Mercer to complete this analysis. Additionally, completion factors were applied to reflect claims not yet adjudicated in the FFS data. Please see Section 4 for more detail.

The users of this data book are cautioned against relying solely on the data contained herein. The State and Mercer provide no guarantee, either written or implied, that this book is 100% accurate or error free.

2

Covered Populations

This data book is summarized according to the rate cell structure listed below.

Rate Cell Structure

Mercer summarized the data for the eligible individuals into the following rate cell structure. This structure is based on Mercer's review of the historical cost and utilization patterns in the FFS experience. The historical behavioral health costs vary by age and eligibility category. Non-disabled Adults have significantly lower behavioral health costs compared to Disabled adults. In addition, the Aged population within the Non-disabled Adults has lower costs than other Non-disabled Adults. The following rate cell structure was designed to take these cost differentials into account. The managed care contractor will be responsible for delivering behavioral health services on a statewide basis; therefore, rate cells were not developed by region.

- Non-disabled Adults, Ages 21-64
- Non-disabled Adults, Ages 65+
- Disabled Adults, Ages 21+

The rate cell structure is summarized based on a combination of aid category and type case from the Louisiana Medicaid data.

Rate Cell	Aid Category	Type Case Codes
Non-disabled Adults, Ages 21-64	01 – Aged	001,003,005,018,019,021-027,043,045,046,050,051, 056,059,070,078-083,086,090,093,117,118,125,130-132,149,150,178
	03 – Families and Children	001,002,007,008, 013-015,020,052,053,055,071, 085,086,104, 151
	13 – Low-Income Families and Children	001, 009, 071, 085

Rate Cell	Aid Category	Type Case Codes
Non-disabled Adults, Ages 65+	01 – Aged	001,003,005,018,019,021-027,043,045,046,050,051, 056,059,070,078-083,086,090,093,117,118,125,130-132,149,150,178
	03 – Families and Children	001,002,007,008, 013-015,020,052,053,055,071, 085,086,104, 151
	13 – Low-Income Families and Children	001, 009, 071, 085
Disabled Adults, Ages 21+	02 – Blind	001,003,005,018,019,021,026,027,043,045,046,050, 059-061,070,076, 078, 081,082,088,090,093,117,118
	03 – Families and Children	021,090,148
	04 – Disabled	001,003,005,018,019,021-027,043,045,046,050, 051,056-061,070,076-083,086,088,090,093,117,118, 125,130-133,149,150,178

Excluded Populations

Populations that will not be covered under the capitation payment are as follows:

- All children defined as under the age of 21 (covered by PIHP on a non-risk basis)
- Qualified Medicare Beneficiaries (QMB-Only where State only pays Medicare premiums)
- Specified Low-income Medicare Beneficiaries (SLMB-Only where State only pays Medicare premiums)
- Individuals in intermediate care facilities for individuals with developmental disabilities
- Individuals enrolled in the Program for all-inclusive care for the elderly
- Legal and Illegal Aliens
- Refugees
- Individuals only eligible for family planning services

3

Covered Services

The specific services required under the BH contract are detailed in the contract between PIHP and the State.

FFS Data

The paid FFS claims for these services are summarized in Section 5 using the following logic. Note the claim category of service is a field generated by the State's FFS data system used to categorize claims. For certain categories, Mercer extracted only those claims with a primary diagnosis of behavioral health as defined by the diagnostic range 290.xx through 319.xx. These categories include Medicare cross-over claims for the dual eligibles covered under the contract.

Category of Service (COS)	Claim Category of Service	Extraction Logic	Type of Utilization
Inpatient	01 – Inpatient Service in General Hospital	Service Provider Type – '69' for Distinct Participating Psychiatric Units or Primary Diagnosis between 290.xx and 319.xx.	Days
	02 – Inpatient Service in Mental Hospital	Note: These claims are limited to adults over age 65 as these are claims associated with institutions for mental disease.	Days
Outpatient/ Emergency Room	08 – Outpatient Hospital Services	All claims with primary diagnosis between 290.xx and 319.xx.	Visits
	13 – Rehab Services		
	07 – Physician Services	All claims with primary diagnosis between 290.xx and 319.xx. Place of Service = 23, procedure codes 99281-99285 and revenue codes 450, 459, or	Vists

Category of Service (COS)	Claim Category of Service	Extraction Logic	Type of Utilization
		981.	
Clinic Services	11 – Clinic Mental Health	All Claims	Visits
	50 – Psychology Services	All Claims	
	67 – Social Work Services	All claims with primary diagnosis between 290.xx and 319.xx.	
	74 – Behavior Management Services	All Claims	
Mental Health Rehabilitation	42 – Rehab for the Chronically Mentally Ill	All Claims	Services
Psychiatrist Services	07 – Physician Services	Provider Specialty = 26 for Psychiatry	Visits
1915(b)(3) – Case Conference	N/A	1915(b)(3) rate has been modeled from other State experience	Visits

Please note in addition to the services identified above, the PIHP contractor will be required to provide treatment planning for the identified adult populations in the contract under regulatory authority 42 CFR 438.208(c). Treatment planning is an administrative function funded out of the administrative portion of the capitation rate as discussed in Section 6.

Mixed Services Protocol for Eligibles Covered by another Managed Care Program

The State is also implementing a managed care program for acute care services that includes a basic behavioral health benefit for enrollees in that program. The following services are covered by the Medicaid acute care MCOs and PCCMs for their enrollees and are excluded from the behavioral health PIHP prepaid rates.

- Acute Medical Detoxification Services
- Services provided by a federally qualified health center or a rural health clinic

For the small group of Medicaid eligibles that are eligible for the adult capitated behavioral health program that are not eligible for the Medicaid acute care managed care program, these services are the responsibility of the PIHP contractor.

In addition, Medicaid managed care enrollees in the MCOs and PCCMs will be enrolled in the behavioral health PIHP to receive specialty behavioral health services.

Excluded Services

- Physical health and other acute care services
- Services covered under a 1915(c) waiver. Note 1915(c) CSoC SED services are covered by the PIHP for children on a non-risk basis.
- Outpatient Prescription drugs (note: prescription drugs provided during an inpatient stay are the responsibility of the PIHP)
- Transportation services
- Intermediate care facility for the developmentally disabled services
- Nursing facility services
- Personal care services
- Dental services
- Independent Lab Services (note: lab charges incurred by the hospital during an inpatient stay are the responsibility of the PIHP)
- Services delivered in general physician offices that are not mental health or addictive disorder services (i.e., MD, DO, or RHC other than services provided by a psychiatrist).

For more specific information on covered services, please refer to the mixed service agreement in the contract between PIHP and the State.

4

Adjustments Reflected in this Data Book

This Section lists the adjustments Mercer made to the FFS data. These adjustments are reflected in the summaries shown in Section 5.

Completion Factors

The FFS data in this data book include claims for dates of service from July 1, 2007 to June 30, 2010 and reflects payments through August 2010. Mercer developed completion factors to estimate Incurred But Not Reported claims (those claims not yet adjudicated). The following factors are applied to both dollars and utilization. Note that similar rate setting COS were rolled up when determining completion factors.

Completion Category of Service	Rate Setting Category of Service	SFY 2008	SFY 2009	SFY 2010
Inpatient	Inpatient Services	1.0000	1.0000	1.0416
Outpatient	Outpatient Services/ Emergency room Clinic Services Mental Health Rehab Psychiatrist	1.0000	1.0000	1.0228
Total		1.0000	1.0000	1.0348

Clinic Cost Settlement

Mental health clinic providers receive cost settlements based on a comparison of initial encounter rates to actual per encounter expenses from audited cost reports. An adjustment was calculated to reflect these cost settlements based on the utilization experience mental health clinic costs for Medicaid-eligible adults. The adjustment is a percent change to the Clinic Services COS dollars.

The following table shows the adjustments:

State Fiscal Year	Clinic Cost Settlement	
	Adjustment Factors	Adjustment Dollars
2008	38.0%	$ 2,346,309
2009	104.0%	$ 6,526,731
2010	102.8%	$ 6,148,246

The adjustment is applied as a multiplicative adjustment to the FFS claims data as (1+factor) multiplied by the FFS claims.

In the future, these providers will not be subject to cost settlement for the visits associated with Medicaid-eligible adults covered under the PIHP capitation.

Supplemental Hospital Payments

Certain inpatient psychiatric hospitals affiliated with Louisiana State University may receive supplemental payments up to the upper payment limit. These transactions occur outside of the FFS claims system and therefore must be considered through an adjustment. Mercer calculated an adjustment to reflect these transactions based on the proportion of inpatient psychiatric utilization for Medicaid-eligible adults. The adjustment is a percent change to the Inpatient COS dollars.

The following table shows the adjustments:

State Fiscal Year	Inpatient Cost Settlement	
	Adjustment Factors	Adjustment Dollars
2008	-0.4%	$ (172,819)
2009	7.7%	$ 3,413,832
2010	11.1%	$ 5,592,352

The adjustment is applied as a multiplicative adjustment to the FFS claims data as (1+factor) multiplied by the FFS claims.

In the future, these providers will not be subject to supplemental payments from the State for the stays associated with Medicaid-eligible adults covered under the PIHP capitation.

Disproportionate Share Hospital (DSH) Payments

The Federal Centers for Medicare and Medicaid Services (CMS) requires that all DSH payments be made directly by the State to the DSH facilities. Mercer confirmed that the FFS claims data did not reflect DSH payments. DSH payments are supplemental payments made directly to providers outside of the claims data. The PIHP is not responsible for DSH payments to the hospitals. Since the DSH payments are not captured in the FFS data, no adjustment was necessary.

Graduate Medical Education (GME)

GME factors are included directly in the calculation of FFS payment rates for the hospitals eligible for GME. The State does not make supplemental payments to hospitals for GME. The State has chosen to include the GME portion of the inpatient claims in the data and therefore in the capitation rates. This is allowable per CMS. The PIHP will negotiate their reimbursement with hospitals and will be expected to reimburse the GME hospitals using rates with GME included. Therefore, Mercer did not make an adjustment to remove these payments from the FFS claims data.

5

FFS Data Summaries

At the top of each page, the rate cell is listed. The exhibit contains two years of data with the fiscal year identified near the top of each section. Below this information are the member months (MMs) associated with each rate cell. The member months are a count of Medicaid eligibles taken from the State's eligibility files.

The remaining columns on each page are described below.

- **Category of Service:** As described in Section 3, each of the covered services is listed
- **Expenses:** Amount paid for each service line item. These amounts are based on date of service and reflect the Medicaid FFS expenses
- **Utilization:** Utilization for each service line item. This represents the number of visits, days or services for each category (see chart in Section 3)
- **Users:** Unique user count, where available
- **Utilization Per 1,000:** Annual utilization for each service divided by total MMs multiplied by 12,000
- **Unit Cost:** Average cost of each service line item; paid claims divided by the utilization of services delivered
- **Per Member Per Month:** Paid claims divided by total MMs

Rate Cell: **Non-Disabled Adults, Ages 21-64**

Data Source: **Fee-For-Service**

	State Fiscal Year 2007-2008						State Fiscal Year 2008-2009						State Fiscal Year 2009-2010					
Member Months:	**989,462**						**1,042,377**						**1,115,270**					
Category of Service	**Expenses**	**Utilization**	**Users**	**Utilization Per 1,000**	**Unit Cost**	**PMPM**	**Expenses**	**Utilization**	**Users**	**Utilization Per 1,000**	**Unit Cost**	**PMPM**	**Expenses**	**Utilization**	**Users**	**Utilization Per 1,000**	**Unit Cost**	**PMPM**
Inpatient Services	$ 5,522,184	8,455	1,337	103	$ 653.13	$ 5.58	$ 5,682,134	7,252	1,244	83	$ 783.53	$ 5.45	$ 8,870,800	9,959	1,538	107	$ 890.69	$ 7.95
Outpatient Services/ Emergency Room	$ 942,490	6,920	3,366	84	$ 136.20	$ 0.95	$ 1,107,755	7,616	3,820	88	$ 145.45	$ 1.06	$ 1,244,124	9,982	4,213	107	$ 124.64	$ 1.12
Clinic Services	$ 918,672	6,687	1,942	81	$ 137.38	$ 0.93	$ 1,553,935	7,640	2,215	88	$ 203.39	$ 1.49	$ 1,662,146	8,196	2,388	88	$ 202.81	$ 1.49
Mental Health Rehab	$ 341,071	25,765	131	312	$ 13.24	$ 0.34	$ 558,677	42,228	213	486	$ 13.23	$ 0.54	$ 1,059,145	81,361	424	875	$ 13.02	$ 0.95
Psychiatrist	$ 446,825	6,762	1,772	82	$ 66.08	$ 0.45	$ 522,520	6,574	1,827	76	$ 79.48	$ 0.50	$ 648,378	8,030	2,384	86	$ 80.75	$ 0.58
1915(b)(3) - Case Conference	$ -	-	-	-	$ -	$ -	$ -	-	-	-	$ -	$ -	$ -	-	-	-	$ -	$ -
Total	**$ 8,171,242**	**54,589**	**5,616**	**662**	**$ 149.69**	**$ 8.26**	**$ 9,425,022**	**71,310**	**6,306**	**821**	**$ 132.17**	**$ 9.04**	**$ 13,484,594**	**117,528**	**7,203**	**1,265**	**$ 114.74**	**$ 12.09**

Rate Cell: **Non-Disabled Adults, Ages 65+**

Data Source: **Fee-For-Service**

	State Fiscal Year 2007-2008						State Fiscal Year 2008-2009						State Fiscal Year 2009-2010					
Member Months:	620,284						618,202						616,601					
Category of Service	**Expenses**	**Utilization**	**Users**	**Utilization Per 1,000**	**Unit Cost**	**PMPM**	**Expenses**	**Utilization**	**Users**	**Utilization Per 1,000**	**Unit Cost**	**PMPM**	**Expenses**	**Utilization**	**Users**	**Utilization Per 1,000**	**Unit Cost**	**PMPM**
Inpatient Services	$ 2,115,618	10,403	2,379	201	$ 203.37	$ 3.41	$ 2,994,111	12,388	2,465	240	$ 241.69	$ 4.84	$ 3,871,784	16,718	3,112	325	$ 231.60	$ 6.28
Outpatient Services/ Emergency Room	$ 110,813	2,585	1,372	50	$ 42.87	$ 0.18	$ 110,617	2,249	1,552	44	$ 49.19	$ 0.18	$ 98,914	1,522	1,373	30	$ 64.98	$ 0.16
Clinic Services	$ 217,957	2,115	419	41	$ 103.05	$ 0.35	$ 425,761	3,613	497	70	$ 117.84	$ 0.69	$ 348,914	2,879	501	56	$ 121.19	$ 0.57
Mental Health Rehab	$ 67,060	7,366	13	143	$ 9.10	$ 0.11	$ 96,874	11,228	21	218	$ 8.63	$ 0.16	$ 108,210	12,069	20	235	$ 8.97	$ 0.18
Psychiatrist	$ 384,979	22,826	3,114	442	$ 16.87	$ 0.62	$ 446,610	23,031	3,407	447	$ 19.39	$ 0.72	$ 344,681	23,305	3,537	454	$ 14.79	$ 0.56
1915(b)(3) - Case Conference	$ -	-	-	-	$ -	$ -	$ -	-	-	-	$ -	$ -	$ -	-	-	-	$ -	$ -
Total	**$ 2,896,426**	**45,295**	**4,919**	**876**	**$ 63.95**	**$ 4.67**	**$ 4,073,973**	**52,509**	**5,160**	**1,019**	**$ 77.59**	**$ 6.59**	**$ 4,772,504**	**56,493**	**5,766**	**1,099**	**$ 84.48**	**$ 7.74**

Rate Cell: **Disabled Adults, Ages 21+**

Data Source: **Fee-For-Service**

	State Fiscal Year 2007-2008						State Fiscal Year 2008-2009						State Fiscal Year 2009-2010					
Member Months:	**1,384,221**						**1,429,357**						**1,480,447**					
Category of Service	**Expenses**	**Utilization**	**Users**	**Utilization Per 1,000**	**Unit Cost**	**PMPM**	**Expenses**	**Utilization**	**Users**	**Utilization Per 1,000**	**Unit Cost**	**PMPM**	**Expenses**	**Utilization**	**Users**	**Utilization Per 1,000**	**Unit Cost**	**PMPM**
Inpatient Services	$ 36,138,720	69,323	6,577	601	$ 521.31	$ 26.11	$ 42,553,108	70,698	6,771	594	$ 601.90	$ 29.77	$ 49,664,478	81,046	7,432	657	$ 612.80	$ 33.55
Outpatient Services/ Emergency Room	$ 3,417,127	26,408	9,935	229	$ 129.40	$ 2.47	$ 3,913,655	29,820	10,798	250	$ 131.24	$ 2.74	$ 3,785,764	32,230	10,888	261	$ 117.46	$ 2.56
Clinic Services	$ 8,116,354	61,778	10,605	536	$ 131.38	$ 5.86	$ 11,947,203	63,517	11,337	533	$ 188.09	$ 8.36	$ 11,811,936	63,540	11,670	515	$ 185.90	$ 7.98
Mental Health Rehab	$ 6,205,774	654,931	1,209	5,678	$ 9.48	$ 4.48	$ 6,567,458	688,319	1,366	5,779	$ 9.54	$ 4.59	$ 7,078,762	760,169	1,600	6,162	$ 9.31	$ 4.78
Psychiatrist	$ 2,899,924	70,303	9,610	609	$ 41.25	$ 2.09	$ 3,284,295	70,050	9,848	588	$ 46.89	$ 2.30	$ 3,324,629	75,389	10,755	611	$ 44.10	$ 2.25
1915(b)(3) - Case Conference	$ -	-	-	-	$ -	$ -	$ -	-	-	-	$ -	$ -	$ -	-	-	-	$ -	$ -
Total	**$ 56,777,899**	**882,743**	**23,306**	**7,653**	**$ 64.32**	**$ 41.02**	**$ 68,265,719**	**922,404**	**24,491**	**7,744**	**$ 74.01**	**$ 47.76**	**$ 75,665,568**	**1,012,374**	**25,826**	**8,206**	**$ 74.74**	**$ 51.11**

Rate Cell: **All Adults**

Data Source: **Fee-For-Service**

	State Fiscal Year 2007-2008						State Fiscal Year 2008-2009						State Fiscal Year 2009-2010					
Member Months:	**2,993,967**						**3,089,936**						**3,212,318**					
Category of Service	**Expenses**	**Utilization**	**Users**	**Utilization Per 1,000**	**Unit Cost**	**PMPM**	**Expenses**	**Utilization**	**Users**	**Utilization Per 1,000**	**Unit Cost**	**PMPM**	**Expenses**	**Utilization**	**Users**	**Utilization Per 1,000**	**Unit Cost**	**PMPM**
Inpatient Services	$ 43,776,522	88,181	10,256	353	$ 496.44	$ 14.62	$ 51,229,354	90,338	10,446	351	$ 567.09	$ 16.58	$ 62,407,062	107,723	12,038	402	$ 579.33	$ 19.43
Outpatient Services/ Emergency Room	$ 4,470,429	35,913	12,306	144	$ 124.48	$ 1.49	$ 5,132,028	39,685	13,199	154	$ 129.32	$ 1.66	$ 5,128,802	43,734	13,270	163	$ 117.27	$ 1.60
Clinic Services	$ 9,252,983	70,580	12,808	283	$ 131.10	$ 3.09	$ 13,926,899	74,770	13,892	290	$ 186.26	$ 4.51	$ 13,822,997	74,615	14,389	279	$ 185.26	$ 4.30
Mental Health Rehab	$ 6,613,905	688,062	1,343	2,758	$ 9.61	$ 2.21	$ 7,223,010	741,775	1,583	2,881	$ 9.74	$ 2.34	$ 8,246,117	853,599	2,019	3,189	$ 9.66	$ 2.57
Psychiatrist	$ 3,731,728	99,891	14,416	400	$ 37.36	$ 1.25	$ 4,253,425	99,655	15,001	387	$ 42.68	$ 1.38	$ 4,317,688	106,723	16,575	399	$ 40.46	$ 1.34
1915(b)(3) - Case Conference	$ -	-	-	-	$ -	$ -	$ -	-	-	-	$ -	$ -	$ -	-	-	-	$ -	$ -
Total	**$ 67,845,567**	**982,627**	**33,574**	**3,938**	**$ 69.05**	**$ 22.66**	**$ 81,764,715**	**1,046,223**	**35,681**	**4,063**	**$ 78.15**	**$ 26.46**	**$ 93,922,666**	**1,186,394**	**38,490**	**4,432**	**$ 79.17**	**$ 29.24**

6

Adjustment Considerations Made to Calculate the Capitation Rate Ranges

This Section describes the adjustments that Mercer will consider to calculate the capitation rate ranges. Mercer makes adjustments to the base data to match the experience of an actuarially equivalent population. These adjustments are required by CMS in determining rates for Medicaid managed care programs. Mercer will certify to CMS that the final rates are actuarially sound.

These adjustments have **not** been reflected in the data book pages:

- Anomalies may exist in the data; therefore, all of the historical data are considered when setting the rates. Mercer will blend the data placing the most reliance on the most recent full year of data.
- Mercer will project costs and utilization as part of the rate development. The trends used to project these costs will be based on historical FFS data trends across different years and services in the State. In addition to the FFS data, Mercer will review CPI and DRI indices, and similar trend information from surrounding states.
- Cost and utilization will be trended to the midpoint of the rate year.
- In addition to making the above adjustments, Mercer will adjust for programmatic changes:
  - Those that occurred during the base years (July 2007 through June 2010) and are not fully reflected in the data;
  - Those that occurred after the base data time periods;
  - Mental Health services provided to Medicaid-eligible adults through the Office of Behavioral Health mental health (OBH-MH) program (see below)

    OBH-MH has provided services to Medicaid-eligible adults through contracts held by the regions, districts or authorities. The State has reviewed these contracts and identified contracts for services which will become covered under the State Plan once the State Plan Amendment is approved. Mercer collected historical expenditure data for these contracts.

Contract Service	Annual Historical Expenses
Day Treatment and MH Counseling Services	$1,255,425
Assertive Community Treatment Team	$3,943,303
Peer Support Services	$268,506
Case Management	$1,498,291
Crisis Services	$998,885
Total	$7,964,411

The overall expenses for each service have been allocated to the Medicaid population based on the proportion of adults who utilized clinic services through OBH and had Medicaid eligibility. Based on OBH utilization data, the percentage of adults served with Medicaid eligibility was 41%. The table above illustrates the portion of these OBH-MH expenses related to the Medicaid population.

These expenses are excluded from the data exhibits and will be incorporated into the capitation rates through an explicit adjustment

– OBH-Addictive Disorder services provided to Medicaid-eligible adults funded through OBH-AD contracts and providers (see below)

Addictive disorder services were not Medicaid State Plan services during SFY 2008 through SFY 2010. OBH-AD provided services to Medicaid-eligible adults funded through OBH-AD contracts and providers. The State has decided to modify the State Plan to include addictive disorder services once the State Plan Amendment is approved. Mercer collected historical expenditure data for these services.

Rate Setting Category of Service	Annual Historical Expenses
Inpatient D&A	$6,347,171
Intensive Outpatient D&A	$1,009,650
Outpatient D&A	$2,247,285
Detox	$666,375
Total	$10,270,480

The overall expenses have been allocated to the Medicaid population based on the proportion of adults who utilized addictive disorder services and had Medicaid eligibility. Based on OBH-AD utilization data, the percentage of adults with Medicaid eligibility that utilized addictive disorder services was 33%. The table above illustrates the portion of addictive disorder service expenses related to the Medicaid population.

These expenses are excluded from the data exhibits and will be incorporated into the capitation rates through an explicit adjustment.

Additional information on any other programmatic changes included in the rate development will be provided at a later date, as necessary.

- Mercer will make adjustments to the unit costs and utilization for certain services. These adjustments will adjust the FFS data to reflect the typical changes that occur when a managed care program is in place. For example, under managed care, inpatient utilization typically decreases while certain outpatient services may increase. Mercer will review the experience of other state behavioral health managed care programs to inform the adjustments.
- An administrative assumption to account for PIHP's administrative expenses will be applied in the capitation rate development process. This amount will include consideration for treatment planning responsibilities of the PIHP.
- Separate Capitation rate calculations for State Plan and 1915(b)(3) services. In the 1915(b) waiver, the State has requested authority to provide physician case consultation as a 1915(b)(3) service. As part of the capitation rate calculation, Mercer will include consideration for this service in the development of the capitation rate. Per federal regulations, the 1915(b)(3) rate will documented separately from the State Plan rate. For reference, the 1915(b) waiver, includes approximately $0.13 PMPM related to case conferences.

MERCER

Government Human Services Consulting
333 South 7th Street, Suite 1600
Minneapolis, MN 55402-2427
612 642 8600

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