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# SFY 14–15 BEHAVIORAL HEALTH TREATMENT SUPPLEMENTAL PAYMENT METHODOLOGY

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The California Department of Health Care Services engaged Mercer Government Human Services Consulting (Mercer) to develop actuarially sound behavioral health treatment (BHT) supplemental payments for use during the 2014–2015 state fiscal year (SFY 14–15). The SFY 14–15 period is from September 15, 2014 through June 30, 2015. Due to the lack of experience and uncertainties inherent within the BHT benefit, it has been determined that a supplemental (kick) payment, similar to maternity and Hepatitis C, is the most appropriate mechanism to match payment to risk. This document outlines Mercer's rate development methodology, including:

- Background
- Rate Development
- Plan Reporting for Payment

## Background

Autism spectrum disorder (ASD) is a developmental disability that can cause significant social, communication and behavioral challenges[1]. A diagnosis of ASD now includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified, and Asperger syndrome. These conditions are now all called ASD[2]. Currently, the Centers for Disease Control and Prevention estimates that approximately 1 in 68 children have been identified with ASD.

BHT services for children diagnosed with ASD (ages 0 to 21) became effective September 15, 2014 as a Medi-Cal managed care covered benefit. Historically, this benefit was not covered unless the beneficiary qualified through 1915(c) waiver authority and the beneficiary then received services through a regional center. These regional center beneficiaries will continue to receive BHT services under the waiver until their transition into managed care beginning in September 2015.

## Rate Development

### Base Data

#### *Regional Center Data*

The base data utilized for the SFY 14–15 supplemental payment was regional center experience for SFY 12–13 and SFY 13–14 (July 1, 2012 through June 30, 2013 and July 1, 2013 through June 30, 2014, respectively). The regional center experience encompasses the ~7,800 members

[1] See APL 14-011: Interim Policy For The Provision of Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder.
[2] See Diagnostic and Statistical Manual (DSM) V.

in regional centers who will transition their BHT services to Medi-Cal effective September 2015. Given that the utilizers of these services during the SFY 14–15 rating period will not include the regional center members, it was determined that a statewide rate was more appropriate given the uncertainties surrounding the non-regional center members utilizing BHT services.

In order to better match payment to risk, the data was segmented into two age bands: 1) 1–6; and 2) 7+. This results in the finalized base data (excluding the cost of providing comprehensive diagnostic evaluations [CDEs] which is explained in more detail below) for the SFY 14–15 BHT supplemental payment.

### *Comprehensive Diagnostic Evaluation*

The regional center data did not include any costs for CDEs. Based upon health plan provided information as well as other state's information for CDE costs, an assumption of $100 per hour of service was used in the rate development. In developing the utilization per 1,000 utilizers, an assumption was made relating to the utilization per 1,000 utilizers (this included an assumed need of 6.6 hours of CDE services for each new utilizer) for a non-regional center member. This assumption yielded a statewide utilization per 1,000 utilizers of 19,160. This assumption, coupled with the unit cost assumption above, yields a $159.66 per utilizer per month (PUPM) cost.

### Acuity

Being that only non-regional center members will be receiving services through Medi-Cal managed care during this initial period, an acuity adjustment was necessary to take into account differing service levels between regional and non-regional center members. Leveraging other state's information pertaining to the autism severity levels among membership, it was determined that non-regional center members utilize 5% less services (on a utilization per 1,000 utilizers basis) than regional center members. Given that the utilizers of these services during the SFY 14–15 rating period will not include the regional center members, the full 5% adjustment was implemented.

### Trend

Trend is an estimate of the change in the overall cost of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a future time period. Trend information and data were gathered from multiple sources, including other state's Medicaid experience (specific to BHT). The base data used was trended 19.2 months to the midpoint of SFY 14–15.

Given the information available at the time the rate ranges were developed, the range for the claim cost trend component is +/- 0.25% for the unit cost component. Just over a year and a half time period from the midpoint of the base period to the midpoint of SFY 14–15, this contributes approximately +/- 0.40% to the upper and lower bounds of the rate ranges.

## Network Adjustment

Given this is a new benefit to Medi-Cal managed care beneficiaries, the managed care organizations (MCOs) are required to develop an appropriate provider network to facilitate these services. With this in mind, Mercer analyzed regional center median rates in comparison to other states' rates for similar BHT services as well as commercial experience in the State of California related to BHT. It was determined that an adjustment was necessary to ensure the MCOs would have available providers given the potential volume of beneficiaries accessing services and market dynamics associated with individual MCOs contracting for services. This adjustment took into account differing trend adjustments (accounted for in the trend section above) from the base period of the regional center data to the SFY 14–15 rating period. The impact of the network adjustment was a 7.2% increase at the midpoint.

## Administration

The administration loading for the BHT supplemental payment is expressed as a percentage of the capitation rate (i.e., percent of premium). The administrative costs are reviewed to ensure that they are appropriate for the approved State Plan services and Medicaid-eligible members. Mercer also utilized its experience and professional judgment in determining the midpoint and lower and upper bound percentages to be reasonable. The midpoint administration load is 3.95%. The range for the administrative component is +/- 0.45% upper/lower bound from the midpoint value.

## Underwriting Gain

The midpoint underwriting gain is 3.0%. The range for the underwriting gain is +/- 1.0% upper/lower bound from the midpoint value. Mercer has implicitly and broadly considered the cost of capital within Mercer's rating assumptions. Mercer's conclusion is that Mercer's assumptions surrounding the underwriting load, as well as the income an MCO generates from investments, are sufficient to cover at least minimum cost of capital needs for the typical health plan.

## Plan Reporting for Payment

On a monthly basis, according to the sample file layout, plans will be required to report the following items at a member level of detail:

- Beneficiary Last Name
- Beneficiary First Name
- Client Index Number
- Health Care Plan Code
- Service Month
- 0–21 Years of Age and ASD Diagnosis (Y or N)
- Exhibit Presence of Excesses and/or Deficits of Behaviors (Y or N)
- Medically Stable and Without Need of 24-Hour Monitoring (Y or N)
- Completed CDE (Y or N)
- Prescription for BHT Services (Y or N)

Upon final approval of the file layout, the health plan will be required to submit this information on a monthly basis in order for payment to be released.