



**RFP 4116Z1  
Attachment C**

**DATA BOOK – STATEWIDE MANAGED BEHAVIORAL  
HEALTHCARE**

STATE OF NEBRASKA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF MEDICAID AND LONG-TERM CARE

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## Introduction

The State of Nebraska's Department of Health and Human Services, Division of Medicaid and Long Term Care (Department) retained Milliman to develop Medicaid behavioral health managed care capitation rates for September 1, 2013 – June 30, 2014 for the purpose of contracting with a statewide Behavioral Healthcare Organization (BHO). The Department contracted with Milliman to develop the proposed capitation rates and to certify that they are within an actuarially sound rate range for the purpose of seeking rate approval by the Centers for Medicare and Medicaid Services (CMS) under 42 CFR 438.6(c). Milliman is not aware of any Nebraska specific regulations pertaining to managed behavioral healthcare capitation rate development.

The intent of this Data Book is to provide interested parties with summarized fee-for-service (FFS) behavioral healthcare data on the cost and utilization patterns who will be enrolled in the managed behavioral healthcare program.

## Contents of the Data Book

The data contained in the Excel file which accompanies this document, reflect the relevant FFS experience for the entire State of Nebraska for the populations which will be enrolled in the managed behavioral healthcare program. The data also contain the services which have been covered under the FFS delivery system. The data was provided by the State of Nebraska and has been summarized to include data by:

- Incurred fiscal year (FY) (July 1 through June 30) 2009, 2010, 2011 and a restatement of FY11 based on programmatic changes which occurred after the historical experience shown. Restatement in this context refers to the adjustments made to the FY11 historical data to reflect the programmatic changes which were implemented after FY11. These adjustments are described beginning on Page 7 of this Data Book.
- Service Category
- Rating Category

The Excel file contains a Databook\_Contents tab which describes in detail what is contained in the file.

## DATA SOURCES AND DATA PROCESSING

The Department provided Milliman with detailed claim and membership data for FY09, FY10, and FY11 for all healthcare services. Milliman's data processing of this claim and eligibility data to prepare the behavioral healthcare Data Book included the following key components:

1. Apply the behavioral claim identification logic provided by the Department to identify the subset of claims from the complete Medicaid claims dataset for FY09 – FY11 which were for behavioral healthcare services.
2. Exclude any claims for eligibility groups who will not be part of the managed behavioral healthcare contract.
3. Assign each claim to a rating category based on the rating category mapping approved by the Department.
4. Assign each claim to a behavioral healthcare service category based on the service categories contained in Chapters 20, 32, and 35 from Title 471 of Nebraska Medicaid in effect during FY09 – FY11 based on age of Medicaid eligible.
5. Assign each claim to either mental health (MH) or substance abuse (SA) based on diagnosis code.
6. Calculate members by month and rating category.
7. Calculate utilizers, paid dollars, paid units of service, paid days (where appropriate), cost per unit, cost per day (where appropriate) and per-member-per-month (PMPM) cost by rating category, incurred month/year and behavioral healthcare service category.

## COVERED SERVICES

### *Service Category Assignment*

Generally speaking, the behavioral healthcare service categories which claims were mapped into for the purpose of data summarization and capitation rate development were those contained in Chapters 20, 32, and 35 from Title 471 of Nebraska Medicaid based on the age of the individual and Nebraska Medicaid policies in place at the time services were rendered. We did supplement these categories and combined or sub-divided some of them where it made sense to do so. Please note that the RFP lists six general categories of covered services whereas the Data Book contains much more detailed service categories. The level of detail included in the Data Book is the level of detail used in the capitation rate development.

Using a combination of our knowledge of behavioral healthcare claim coding and the fee-schedules for Nebraska Medicaid, we mapped claims into service categories using a combination of CPT / HCPCS /

REVENUE / PLACE OF SERVICE / PROVIDER TYPE codes. The specific combinations of these codes which we mapped into the particular service categories are included in in the Excel file.

Tables 1 and 2 below display the list of covered services included by age group for FY09 – FY11.

<b>Table 1 – Service Categories for Members Age 21 and Over</b>
Inpatient Acute Psychiatric
Inpatient Mental Health and Inpatient Services Delivered in an IMD
Professional Inpatient Visits
Adult SubAcute Inpatient Hospital Psychiatric Services
Professional Inpatient SubAcute Visits
Adult Day Treatment Psychiatric Services
Electroconvulsive Therapy
Medication Checks
Psychiatric Evaluation/Psychological Evaluation/Testing
Individual Psychotherapy
Individual Substance Abuse Counseling
Group Psychotherapy
Group Substance Abuse Counseling
Family Psychotherapy Services
Family Substance Abuse Counseling
Family Assessment
MHSA Community Treatment/Support/Psychosocial Rehab
Physician Administered Outpatient Drugs
Outpatient Lab/Path/Other
Other

<b>Table 2 – Service Categories for Members Age 20 and Under</b>
Inpatient Acute Psychiatric
Inpatient Mental Health and Inpatient Services Delivered in an IMD
Professional Inpatient Visits
Residential Treatment Center
Treatment Group Home
Professional RTC/Group Home Visits
Treatment Foster Care
Day Treatment
Intensive Outpatient Services
Treatment Crisis Intervention
Medication Checks
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing
Individual Psychotherapy
Individual Substance Abuse Counseling
Group Psychotherapy
Group Substance Abuse Counseling
Family Psychotherapy Services
Family Substance Abuse Counseling
Family Assessment
Conferences with family or other responsible persons advising them on how to assist the client
MHSA Community Treatment/Support/Psychosocial Rehab
Physician Administered Outpatient Drugs
Outpatient Lab/Path/Other
Other

### *Determination of Units Counts*

Milliman used a combination of the reported units in the detailed claim data and other algorithms, when needed, to develop unit counts by service category from the detailed claim data.

Outpatient Professional Services – The outpatient professional services were the simplest to map into the service categories using CPT/HCPCS codes. Furthermore, counting units of service for these categories was also straightforward because the claim data contained reliable units of service on each claim record. We created different categories for MH and SA services for psychotherapy and counseling services. Following is a listing of outpatient professional services whose units of service were counted directly from units reported on the claim records:

Conferences with family or other responsible persons advising them on how to assist the client  
Electroconvulsive Therapy  
Evaluation by a supervising practitioner / Psychiatric evaluation / Psychological evaluation / Testing  
Family Assessment  
Family Psychotherapy Services  
Family Substance Abuse Counseling  
Group Psychotherapy  
Group Substance Abuse Counseling  
Individual Psychotherapy  
Individual Substance Abuse Counseling  
Medication Checks  
MHSA Community Treatment / Support / Psychosocial Rehab  
Psychiatric Evaluation/Psychological Evaluation / Testing

Outpatient Facility and Day Treatment Services – The outpatient facility services and day treatment services (i.e. intensive outpatient, partial hospitalization) were more complicated to map and count due to the different claim reporting methods used by the providers. In some instances, claims were reported for each individual day of service, and in other instances, claims were reported and billed for ‘courses of treatment’ which spanned multiple days. Furthermore, some claims were mapped from the professional file using CPT/HCPCS codes while other claims were mapped from the facility file using REVENUE codes.

We were able to identify claims in the data files we would consider outpatient facility and day treatment services using the combination of CPT / HCPCS / REVENUE / PROVIDER TYPE fields. Our approach to counting these services was to treat each day of service as a ‘case’ and the units metric reported in the Data Book is cases. All claims associated with a case were bundled together to obtain the total dollars. For example, if someone received intensive outpatient services and while at the facility also received psychotherapy and drugs, we combined all of the dollars incurred on that particular day in the case. Following is a listing of outpatient facility and day treatment service categories whose units of services were reported as cases:

Adult Day Treatment Psychiatric Services  
Day Treatment  
Intensive Outpatient Services

There were also claims reported in the data which appeared to be provided on an outpatient basis which were not associated with any day treatment services. These claims were outpatient drugs and outpatient pathology and laboratory services. We mapped these claims into either Physician Administered Outpatient Drugs or Outpatient Path/Lab/Other based on the codes reported on the claim records. The units counted were those reported on the claim record.

Inpatient, Residential Treatment Center and Group Home Services – Inpatient, residential treatment center, and group home services were relatively straightforward to map and count units of service. For any admission to an inpatient facility, residential treatment center, or placement into a group home, we identified the ‘admission’ and counted the number of admissions. We also counted days per admission and report that metric as well so that average lengths of stays can be calculated. Because residential treatment center is not listed as a separate service category for individuals 21 and older in Title 471 Chapter 20, we included all residential treatment in the Adult Sub-Acute Inpatient service category for this age group.

One important thing to note is the dollars for all services incurred during an admission were bundled together to calculate the cost of the entire stay, not just the room and board charges. The exception to this would be any professional visits from outside providers who visited the admitted individual or group home resident. It is common for these services to be billed separately by the individual provider and reported separately. We separated these services into their own service categories and called them Professional Inpatient Visits, Professional Inpatient Sub-Acute Visits, and Professional RTC/Group Home Visits. The admission based service categories follow:

Inpatient Acute Psychiatric  
Inpatient Mental Health and Inpatient Services Delivered in an IMD  
Professional Inpatient Visits  
Adult SubAcute Inpatient Hospital Psychiatric Services (21 and over)  
Professional Inpatient Sub-Acute Visits  
Residential Treatment Center  
Treatment Group Home  
Professional RTC/Group Home Visits

Foster Care Treatment and Crisis Intervention Treatment – Claims for these two service categories were reported in the claim data on a per diem basis. We counted the days of service using the units reported on the claim records and reported them as days.

Other Services – In the rare case where a claim could not be mapped into one of the service categories mentioned above, they were mapped into an ‘other’ category and the units of service were taken from the claim records.

## COVERED POPULATIONS AND RATE STRUCTURE

All Nebraska Medicaid eligibles will be included in the managed behavioral healthcare program except for the following individuals:

1. Medicaid members for any period of retroactive eligibility
2. Aliens who are eligible for Medicaid for an emergency condition only
3. Members who have excess income or who are designated to have a premium due
4. Members eligible during the period of presumptive eligibility
5. Participants in an approved DHHS PACE program
6. Clients with Medicare coverage where Medicaid only pays co-insurance and deductibles

These individuals were excluded from the data. The non-excluded populations were grouped into 8 different rating categories as shown in Table 3 below. A detailed description of each eligibility category which forms each rating category is included in the Excel file. As seen in this table, some eligibility categories were grouped together for rate development purposes, while other eligibility categories were divided into multiple rating categories based on age.

### Table 3 – Listing of Rating Categories

CHIP
Aged
Blind / Disabled 18 and under / Katie Beckett
Blind / Disabled 19 and over
Families 0 through 5
Families 6 through 18
Families 19 and over
Foster Care / Ward / Subsidized Adoption

Persons classified as Katie Beckett eligible had \$0 in behavioral spending in FY10 and FY11. We chose to group them with the Blind / Disabled 18 and under population for the purposes of this work. Both males and females are included in each rating category; there are no differences in rates by gender. As this is a statewide contract, there are no differences in rates by region.

Note that persons who become Medicaid eligible under the Medicaid expansion provisions of the Patient Protection and Affordable Care Act are not included in these rating categories and the rates developed are not appropriate for them.

#### DATA ACCURACY

In the course of developing the Data Book, we reconciled incurred claim dollars with the Department to ensure consistency with reported spending. Data inaccuracies could be present in the underlying data.

**Users of this Data Book are cautioned against relying solely on the data contained herein. The State and Milliman provide no guarantee, either written or implied, that this Data Book is 100% accurate or error free.**

## Adjustments to the FFS Base Data

The Excel file displays summarized data by rating category and service category for FY09, FY10, and FY11. It also displays summarized data for FY11 which has been adjusted / restated to reflect programmatic changes which occurred after the historical experience period ended. This restated period is what was used to project costs into the period from September 1, 2013 – June 30, 2014.

### *Base Period Data Adjustments*

The only adjustment made to the FY09 – FY11 data as displayed in the Excel file was for claim completion. Claim completion factors were developed using the developmental or lag methodology. Table 4 below displays the claim completion factors which were applied to dollars, units, and days.

<b>Table 4 – Claims Completion Factors</b>		
<b>Incurred Fiscal Year</b>	<b>Facility Claims</b>	<b>Professional Claims</b>
FY11	1.0034	1.0012
FY10	1.0005	1.0000
FY09	1.0000	1.0000

### *Adjustments Reflected in the Restated FY11 Data*

The following is a list of all data considerations and adjustments made to the completed FY11 claims and eligibility data to arrive at the restated FY11 data which is used to project costs into the period from September 1, 2013 through June 30, 2012.

**Data Smoothing** – No data smoothing adjustments were applied. Due to the nature of the services covered for mental health and substance abuse disorders, it is unlikely that large claims would cause significant distortion. Furthermore, the underlying populations are sufficiently large to be credible.

**Population Bias Selection** – No adjustment was necessary, since enrollment into the BHO program will be mandatory.

**Eligibility Adjustments** – Under the capitation arrangement, the BHO will not be held financially responsible for claims incurred while a Medicaid client is not enrolled in managed behavioral healthcare. There is typically a lag between when Medicaid eligibility is established and enrollment in managed care takes place. It was assumed that there is no utilization or cost differences during the period between when Medicaid eligibility is established and enrollment in managed behavioral healthcare begins and therefore no adjustment was necessary.

**Disproportionate Share Hospital (DSH)** – These are paid outside the capitation rate; no adjustment was necessary.

**Graduate Medical Education (GME)** – No GME payments are made to behavioral healthcare providers; no adjustment was necessary.

**Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)** – There are no reimbursement differences for FQHCs and RHCs for behavioral healthcare services, therefore no adjustment was necessary.

**Lincoln and Hastings Regional Center** – This state-operated facility is paid based on reasonable costs. An interim per diem is established annually and then there is a cost settlement at FY end. The cost settlement was not factored into the rate development and will be the responsibility of Nebraska Medicaid.

**Third Party Liability (TPL)** – An adjustment of -0.4% was made to reflect additional TPL recoveries not reflected in the FFS data received. This adjustment was based on data received from the Department.

**Risk Adjustment** - Milliman believes that the rating categories provide sufficient variation to account for differences in risk so that additional risk adjustment is not necessary.

Cost Sharing – Beginning in October of 2011, the following co-payments were added for clients ages 19 and over and the restated FY11 data reflects the addition of these copays:

- \$15 copay added to inpatient psychiatric hospital stays
- \$2 copay added to outpatient mental health and substance abuse visits for the following procedure codes / provider type combinations: 90801 (01, 02, 13, 19, 29, 67); 90804 (13, 39); 90805 and 90807 (01,13); 90806 (01, 13, 39, 67); 90808 (13, 39, 67); 90847 (01, 13, 39, 67); 90853 (67); 99213, 99214, 99215 and 99243 (01, 13); 99241 and 99244 (13) and substance abuse codes 90806 HF and 90847 HF (provider type 47)

The impact of the addition of these copays is displayed by service category below in Table 5. These impacts were only applied to the rating categories comprised of clients age 19 and over.

**Table 5 – Copay Adjustment Factors**

<b>Service Category</b>	<b>Factor</b>
Inpatient Acute Psychiatric	-0.39%
Inpatient Mental Health and Inpatient Services Delivered in an IMD	-0.94%
Professional Inpatient Visits	-0.34%
Adult SubAcute Inpatient Hospital Psychiatric Services	-0.25%
Professional Inpatient SubAcute Visits	-0.02%
Residential Treatment Center	0.00%
Treatment Group Home	0.00%
Professional RTC/Group Home Visits	-0.19%
Treatment Foster Care	0.00%
Adult Day Treatment Psychiatric Services	0.00%
Day Treatment	0.00%
Intensive Outpatient Services	0.00%
Electroconvulsive Therapy	0.00%
Treatment Crisis Intervention	0.00%
Medication Checks	0.00%
Psychiatric Evaluation/Psychological Evaluation/Testing	-0.70%
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	-0.50%
Individual Psychotherapy	-3.17%
Individual Substance Abuse Counseling	-3.17%
Group Psychotherapy	-0.13%
Group Substance Abuse Counseling	-0.13%
Family Psychotherapy Services	-2.39%
Family Substance Abuse Counseling	-2.39%
Family Assessment	0.00%
Conferences with family or other responsible persons advising them on how to assist the client	0.00%
MHSA Community Treatment/Support/Psychosocial Rehab	0.00%
Physician Administered Outpatient Drugs	0.00%
Outpatient Lab/Path/Other	0.00%
Other	0.00%

Fee Changes – In July 2011 (beginning of FY12), the fee-schedule was revised. The fee schedule was then revised again in July 2012 (beginning of FY13). In general, there was a rate reduction implemented in the FY12 fee schedule with a partial rate restoration implemented in the FY13 fee schedule. The restated FY11 data reflects these changes. The combined impact of both fee schedule changes by service category is shown below in Table 6.

**Table 6 – Fee Schedule Impact Adjustments**

<b>Service Category</b>	<b>Adjustment</b>
Inpatient Acute Psychiatric	-1.00%
Inpatient Mental Health and Inpatient Services Delivered in an IMD	-1.00%
Professional Inpatient Visits	-0.84%
Adult SubAcute Inpatient Hospital Psychiatric Services	0.45%
Professional Inpatient SubAcute Visits	-1.00%
Residential Treatment Center	0.00%
Treatment Group Home	-1.05%
Professional RTC/Group Home Visits	-1.16%
Treatment Foster Care	-1.00%
Adult Day Treatment Psychiatric Services	-1.14%
Day Treatment	-0.38%
Intensive Outpatient Services	-1.03%
Electroconvulsive Therapy	-1.00%
Treatment Crisis Intervention	-1.00%
Medication Checks	-0.61%
Psychiatric Evaluation/Psychological Evaluation/Testing	-2.20%
Evaluation by a supervising practitioner/Psychiatric evaluation/Psychological evaluation/Testing	-1.89%
Individual Psychotherapy	-0.38%
Individual Substance Abuse Counseling	-0.38%
Group Psychotherapy	-3.84%
Group Substance Abuse Counseling	-3.84%
Family Psychotherapy Services	1.53%
Family Substance Abuse Counseling	1.53%
Family Assessment	-1.67%
Conferences with family or other responsible persons advising them on how to assist the client	3.72%
MHSA Community Treatment/Support/Psychosocial Rehab	-1.12%
Physician Administered Outpatient Drugs	-0.44%
Outpatient Lab/Path/Other	-1.00%
Other	-1.00%

Reimbursement Restructuring and Service Category Changes – The reimbursement methods for some service categories were restructured and, in some instances, service categories were changed with some procedure codes becoming obsolete and replaced with others. Below is a listing of the changes and the aggregate impact assumed (if any) which is reflected in the restated FY11 experience shown in Attachment 1. We provide this restatement of FY11 experience to show what we estimate the impact would have been had these changes been in place during all of FY11, the base year for the September 1, 2013 through June 30, 2012 projections.

- Intensive Outpatient Services (IOP) – Effective July 1, 2011, Medicaid “unbundled” the services provided under a per diem IOP code and added a new procedure code for the unlicensed staff who were supervised by licensed program staff. A modifier was assigned to the practitioners’ services and a separate provider number assigned. No adjustment was made to the children’s IOP services for this change.
- Day Treatment Services – Effective July 1, 2011, these services were “unbundled” similarly to the IOP services described above. No adjustment was made to the children’s day treatment services for this change.

- Treatment Foster Care (TFC) – Effective July 1, 2011, TFC services for children ended and Professional Resource Family Care (PRFC) was initiated. While similar to TFC, services are also “unbundled” with a procedure code assigned for PRFC parent services as well as licensed staff provider psychotherapy. No adjustment was made to the treatment foster care services for this change.
- Treatment Group Home (TGH) – Effective July 1, 2011, TGH services ended and were replaced by Therapeutic Group Home services, which are unbundled with modifiers for psychotherapy services and a new procedure code for unlicensed staff who are supervised by licensed staff. No adjustment was made to the children’s treatment group home services for this change.
- Residential Treatment Centers (RTC) – Effective July 1, 2011, RTC services ended and were replaced by Psychiatric Residential Treatment Facility services (PRTFs). PRTF services are a bundled service where room and board is paid by Medicaid. The adjustment to the residential treatment services for this change is -6.9%.

Definition of a Child Based on Age – The historical data we relied on was for FY09 – FY11. During this period, a Child according to Nebraska Medicaid was anyone under 21 years of age. Going forward, according to Nebraska Medicaid, a Child will be anyone under 19 years of age. Because the historical data was summarized using Chapters 20, 32, and 35 of Title 471 in effect during the historical data period (which defined covered services differently for the 0-20 year olds and those 21+), there is a natural disconnect between the services which were available to those persons ages 19 and 20 in FY09 – FY11 and those services available to persons ages 19 and 20 under this new contract. Below is a listing of services from Chapters 20 and 32 from Title 471 which had non-zero costs in FY11 which was used as the basis of our projections.

- Treatment Crisis Intervention
- Intensive Outpatient Services
- Day Treatment
- Residential Treatment Center
- Professional RTC Visits
- Evaluation by a supervising practitioner/Psychiatric Evaluation/Psychological Evaluation/Testing

For all services in this list, with the exception of Treatment Crisis Intervention, there are analogous covered Adult services (e.g. Adult Sub-Acute for Residential Treatment Center) and therefore no adjustment was made. We believe Treatment Crisis Intervention would be entirely eliminated for persons ages 19 and 20 who will no longer be eligible to receive this service. Therefore, in the FY11 restated data, we have eliminated the costs for Treatment Crisis Intervention for the Blind / Disabled 19 and over and the Families 19 and over rating categories. These are the only two rating categories which contain people who would have been considered a Child during the historical data period and would now be considered Adults.

## Capitation Rate Range Development

According to CMS regulations, the capitation rates must be within actuarially sound rate ranges. Milliman will certify the actuarial soundness of the rate ranges which were developed using generally accepted actuarial practices and principles.

This section describes the additional adjustments which have not yet been mentioned to calculate the final capitation rate ranges. These adjustments are not reflected in the restated FY11 data which was used to project costs into the period from September 1, 2013 through June 30, 2014.

### *Trend*

Milliman reviewed detailed utilization and cost patterns by service category and rating category for the FY09 – FY11 experience period to develop trend rates to forecast September 1, 2013 through June 30, 2014 utilization and cost levels. This was done after removing the impact of any fee-schedule changes which took place during the historical data period. CMS requires that the fee-for-service data be trended forward from the base period to the contract period, and that actual experience is used to the extent possible. Milliman also reviewed CPI indices, Milliman trend reports, and behavioral healthcare trends in other states to establish trend assumptions that were applied to project the base data from the midpoint of the restated base period (FY11) to the midpoint of the contract period (September 1, 2013 through June 30, 2014), which is February 1, 2014. The trend rates used in this rate development vary by both service category and rating category. Milliman believes that the trend rates that were developed are both reasonable and appropriate. The resulting aggregate rounded annualized trend assumptions across all service categories by rating category are shown in Table 7.

<b>Table 7 – Aggregate Annualized Trend Assumptions by Rating Category</b>	
<b>Rating Category</b>	<b>Annualized Trend Assumption</b>
CHIP	0.0%
Aged	0.6%
Blind / Disabled 18 and under / Katie Beckett	-2.3%
Blind / Disabled 19 and over	-0.5%
Families 0 through 5	0.0%
Families 6 through 18	-1.7%
Families 19 and over	-1.8%
Foster Care / Ward / Subsidized Adoption	-2.7%

### *Managed Care Savings*

Milliman developed adjustments to account for the difference between a fee-for-service program and a managed care program for behavioral healthcare services. For example, service utilization for some services are reduced, such as inpatient hospital care and PRTF, as managed care organizations implement their medical necessity criteria and add utilization management protocols. Additionally, more use of cost-effective alternatives to inpatient and residential services are also common, and our managed care assumptions reflect increased use of certain services. These assumptions are based on our knowledge of managed behavioral healthcare and internal Milliman Medicaid data. These adjustments vary by both service category and rating category. The resulting aggregate rounded managed care assumptions applied to the trended costs by rating category are shown in Table 8.

**Table 8 – Aggregate Managed Care Impact Assumptions by Rating Category**

<b>Rating Category</b>	<b>Managed Care Impact Assumption</b>
CHIP	-9.5%
Aged	-8.4%
Blind / Disabled 18 and under / Katie Beckett	-11.4%
Blind / Disabled 19 and over	-13.4%
Families 0 through 5	-2.1%
Families 6 through 18	-8.2%
Families 19 and over	-10.4%
Foster Care / Ward / Subsidized Adoption	-18.6%

#### *Administrative Costs*

CMS regulations require an administrative load for costs directly related to the provision of approved Medicaid State Plan services. Further, Nebraska Bill 1158 requires all contracts and agreements relating to the medical assistance program governing at-risk managed care service delivery for behavioral health services entered into by the Department on or after July 1, 2012 shall provide:

- (1) a definition and cap on administrative spending that (a) shall not exceed 7% unless the implementing department includes detailed requirements for tracking administrative spending to ensure (i) that administrative expenditures do not include additional profit and (ii) that any administrative spending is necessary to improve the health status of the population to be served and (b) shall not under any circumstances exceed 10%;
- (2) provide a definition of annual contractor profits and losses and restrict such profits and losses under the contract so that (a) profit shall not exceed three percent per year and (b) losses shall not exceed three percent per year, as a percentage of the aggregate of all income and revenue earned by the contractor and related parties, including parent and subsidy companies and risk-bearing partners under the contract.

Thus, the capitation rates include a 7% administrative load and a 3% risk margin.