Oregon Health Authority – Office of Actuarial and Financial Analytics
October 28, 2022

BEHAVIORAL HEALTH DIRECTED PAYMENT GUIDANCE DOCUMENT & FAQ

The Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 C.F.R. §438 govern how states may direct plan expenditures in connection with implementing delivery system and provider payment initiatives under Medicaid managed care contracts. Effective January 1, 2023, the Oregon Health Authority (OHA) will implement four behavioral health directed payments (BHDPs) within the CCO contracts that will further the goals and priorities of the Medicaid program, as follows:

1. Tiered Uniform Rate Increase Directed Payment
2. Co-Occurring Disorder Directed Payment
3. CLSS Directed Payment
4. Minimum Fee Schedule Directed Payment

This document provides clarification on policy, operational and rate-setting considerations for each of the BHDPs. Additionally, there is a section with responses to frequently asked questions received as a follow up to the September Rate Workgroup meeting pertaining to BHDPs and from providers.

TIERED UNIFORM RATE INCREASE DIRECTED PAYMENT

Effective January 1, 2023, the Oregon Health Authority (OHA) will implement a managed care directed payment arrangement that will provide a uniform percentage increase payment to qualified network, contracted BH providers for services delivered during the contract year. The increase will be in addition to the contracted rates CCOs had in place for qualified BH providers effective January 1, 2022.

The payment increases have two tiers defined by whether the provider is a Medicaid Dominant or Non-Medicaid Dominant Behavioral Health Provider. The value of the percentage increase is based on whether the Provider is Medicaid-Dominant (defined as having at least fifty percent (50%) of its total patient service revenue derived from providing Medicaid services in the prior Contract Year), or whether the provider is Non-Medicaid-Dominant (defined as having less than fifty percent (50%) of its total patient service revenue from providing Medicaid services in the prior Contract Year). The QDPs provide for a uniform percentage increase to a Contractor's negotiated base rates in effect January 1, 2022 to qualified Participating Providers of ACT/SE services, MH Non-Inpatient and Substance Abuse services. The percentage increase for Medicaid-Dominant providers is 30% and the percentage increase for Non-Medicaid-Dominant providers is 15%.

IMPACTED SERVICES

The directed payment is limited to services on the Medicaid Fee-For-Service Behavioral Health Rate Increase Fee Schedule and in the ACT/SE, Mental Health Non-Inpatient and Substance Abuse categories of service (COS). The impacted COS services are defined using OHG financial criteria that was sent to CCOs on 3/9/2022. Refer to Appendix A for a crosswalk of OHG financial criteria to these COS.

WHAT SHOULD YOU DO?

Providers:

1. Providers should gather financial information to demonstrate its distribution of prior Contract Year patient services revenue between Medicaid and Non-Medicaid payors. If a provider believes they qualify as a Medicaid-Dominant tier (>=50% Medicaid revenue), they must notify the CCO(s) with which they contract and provide supporting documentation.

CCOs:

1. CCO must work with Participating BH providers to establish which of the payment tiers the individual providers qualify under (>=50% Medicaid revenue or <50% Medicaid revenue). BH providers that have not submitted documentation supporting qualification for the higher payment tier should be paid at the lower tier. Upon receipt of documentation supporting qualification for the higher tier, CCOs must pay the higher increase effective for services delivered on or after January 1, 2023 if provided by March 31, 2023. If provided after, CCOs must pay the higher increase effective the start of the quarter submitted. For example, if submission is received August 1, 2023 then the retroactive payment increase would be effective July 1, 2023.

2. No later than 30 calendar days after the start of the rating period, CCO shall provide OHA with a written attestation of compliance with the requirements of the BHDP. The attestation should include a list of all contracted BH providers and confirmation that negotiated rates comply with the parameters of the BHDP.

3. CCO may use existing contracted rates during the 30-day period described above. However, the total payments to providers for the rating period beginning on January 1, 2023 must comply with the payment levels described in the contract. Contractors must adjust any payments made to providers for eligible services during the 30 day period that do not comply with QDP reimbursement as described in the contract.

4. CCO must pay new providers and single case agreements similarly to existing providers after the tiered payment increase. CCO shall submit a revised written attestation of compliance on a quarterly basis if contracting with a new provider or renegotiating current provider contracts.

5. CCOs that utilize an alternative payment methodology (APM) may continue to use such alternative arrangements but must demonstrate to OHA that the APM has been modified to incorporate the directed payment increase. Please see examples in the FAQ document.

CO-OCCURRING DISORDER DIRECTED PAYMENT

Effective January 1, 2023, the Oregon Health Authority (OHA) will implement a directed payment arrangement that will provide a uniform payment increase to Participating Providers of Outpatient Behavioral Health Services certified by OHA for integrated treatment of co-occurring disorders (COD) rendered by qualified staff per the forthcoming COD Rules. The payment increase must equal:

- 10% of the State Plan Medicaid Behavioral Health Fee-For-Service fee schedule rate effective 1/1/23 for covered non-residential services provided by providers below a Master's level, including peer service providers;
- 20% of the Medicaid fee schedule rate in effect on 1/1/23 for covered non-residential services for Master's level providers;
- 15% of the Medicaid fee schedule rate in effect on 1/1/23 for residential services providers.

The increase(s) will be in addition to the CCO negotiated base rates in place for qualified BH providers delivering services while meeting COD certification standards. The billing entity must be certified under the forthcoming COD rules.

IMPACTED SERVICES

The directed payment is limited to services on the Medicaid Fee-For-Service Behavioral Health Rate Increase Fee Schedule and in the A&D Residential, Mental Health Non-Inpatient, Mental Health Children's Wraparound and SUD categories of service (COS). Refer to Appendix A for a crosswalk of OHG financial criteria to these COS. The impacted COS services are defined using OHG financial criteria that was sent to CCOs on 3/9/2022. Additionally, a COD diagnosis must be present on the encounter. OHA will provide detailed diagnosis code lists in a separate COD implementation guide.

To receive the 15% of the Medicaid fee schedule rate increase, a residential CPT code from the following table must be present.

CPT	Modifier	Other conditions
H0010	HH	Certified SUD program
H0011	HH	Certified SUD program
H0018	HH	Certified SUD program
H0019	HH	None
H2013	Not HK	None

To qualify for the COD enhancements of the Medicaid fee schedule rate increase, the following criteria must be met:

(1) Provider Organization will possess a current OHA Certification of Approval (COA) to provide integrated Co-Occurring Disorders services per COD Rules.

(2) Provider staff rendering services will meet staff training and certification requirements per COD Rules.

WHAT SHOULD YOU DO?

Providers:

1. Providers who meet the COD certification standards at the organization and rendering provider level should notify the CCO(s) with which they contract and provide supporting documentation.
2. Providers should bill using the appropriate payment modifier when a service is provided to a member with qualifying diagnoses HO for services provided by approved providers with a Master's degree or above in a behavioral health field per Division Rule. HH for all other providers.

CCOs:

1. Upon receipt of documentation supporting qualification for the COD payment increase, CCOs must pay the rate increase effective for services delivered on or after the date of certification.

2. No later than 30 calendar days after the start of the rating period, CCOs shall provide OHA with a written attestation of compliance with the requirements of the BHDP. The attestation should include a list of all contracted BH COD providers and confirmation that negotiated rates comply with the parameters of the BHDP.

3. CCOs that utilize an alternative payment methodology (APM) may continue to use such alternative arrangements but must demonstrate to OHA that the APM has been modified to incorporate the directed payment increase. Please see examples in the FAQ document.

CULTURALLY AND LINGUISTICALLY SPECIFIC SERVICES DIRECTED PAYMENT

Effective January 1, 2023, the Oregon Health Authority (OHA) will implement a directed payment arrangement that will provide a uniform payment increase to qualified participating providers when they deliver culturally and/or linguistically specific services (CLSS), direct services in a language other than English or in an approved Sign language. CLSS are services that are centered on the cultural values of ethnic and minority communities in order to elevate the voices and experiences of those who have been historically oppressed and their aims are to provide safety, belonging, and encourage a shared collective cultural experience for healing and recovery and are provided by a culturally and/or linguistically specific organization, program or individual provider. The payment increase for qualifying providers and services must be 22% of the State Plan Medicaid Behavioral Health Fee-For-Service fee schedule rate in effect on 1/1/23 for covered services provided by non-rural providers and 27% of the Medicaid fee schedule rate in effect on 1/1/23 for rural providers. The increase(s) will be in addition to the CCO negotiated base rates in place for qualified BH providers delivering services while meeting CLSS certification standards.

IMPACTED SERVICES

The directed payment is limited to services on the Medicaid Fee-For-Service Behavioral Health Rate Increase Fee Schedule and in the ACT/SE, ABA, Mental Health Non-Inpatient, Mental Health Children's Wraparound and Substance Abuse COS. The impacted COS services are defined using OHG financial criteria that was sent to CCOs on 3/9/2022. Refer to Appendix A for a crosswalk of OHG financial criteria to these COS.

WHAT SHOULD YOU DO?

Providers:

1. Providers who deliver a CLSS service, a service in a language other than English or a service in an approved Sign language and have met eligibility requirements should bill using the appropriate payment modifier.

CCOs:

1. Designate your own providers or use the FFS State Plan criteria to identify providers who will receive reimbursement for CLSS. CCOs using their own criteria to identify providers qualifying for the CLSS increase must demonstrate to OHA that their criteria is not more restrictive than the FFS State Plan criteria.

2. Upon receipt of documentation supporting qualification for the CLSS payment increase, CCOs must pay the rate increase effective for services delivered on or after the date of certification.

3. No later than 30 calendar days after the start of the rating period, CCOs shall provide OHA with a written attestation of compliance with the requirements of the BHDP. The attestation should include a list of all contracted BH CLSS providers and confirmation that negotiated rates comply with the parameters of the BHDP.

4. CCOs that utilize an alternative payment methodology (APM) may continue to use such alternative arrangements but must demonstrate to OHA that the APM has been modified to incorporate the directed payment increase. Please see examples in the FAQ document.

MINIMUM FEE SCHEDULE DIRECTED PAYMENT

Effective January 1, 2023, the Oregon Health Authority (OHA) will implement a directed payment arrangement that will require CCOs to maintain the fee schedule for A&D Residential, Applied Behavior Analysis and MH Children's Wraparound services at no lower than the OHA State Plan Medicaid Behavioral Health Fee-For-Service fee schedule rate in effect at the date of service.

IMPACTED SERVICES

The directed payment is limited to services on the Medicaid Fee-For-Service Behavioral Health Rate Increase Fee Schedule and in the A&D Residential, Applied Behavior Analysis and MH Children's Wraparound COS. The impacted COS services are defined using OHG financial criteria that was sent to CCOs on 3/9/2022. Refer to Appendix A for a crosswalk of OHG financial criteria to these COS.

WHAT SHOULD YOU DO?

CCOs:

1. Ensure reimbursement is at least at the OHA State Plan Medicaid Behavioral Health FFS rate in effect on 1/1/23 for services provided beginning January 1, 2023.

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FREQUENTLY ASKED QUESTIONS

GENERAL

1. Is the expectation that the CCOs begin paying the increased rate beginning January 1, 2023?

   Response: The BHDPs are effective January 1, 2023 and CCO payments to eligible providers for services for the rating period beginning on January 1, 2023 must comply with the payment levels described in the BHDP preprints. However, federal regulations require CMS approval of the BHDP methodologies before the actual funding described in the BHDP can be paid under the contract. If CMS approves the BHDPs after the start of the rating period, CCOs must make providers whole for the amounts in the BHDP for services delivered on or after January 1, 2023. OHA encourages CCOs to set expectations with providers that retroactive increases back to January 1, 2023 may be needed depending on when OHA receives CMS approval and as appropriate documentation is gathered.

2. Please describe how the BHDPs are at-risk and different from the current hospital directed payments.

   Response: The BHDPs are included as a prospective rating adjustment in the capitation rates. The CCOs are at-risk for differences in actual utilization versus assumed utilization in the capitation rates similar to other components of the capitation rate. The current hospital and GEMT directed payments are not included as prospective rating adjustments and are instead paid as a separate payment term based on actual utilization as it occurs.

3. Due to the increased costs of implementing the BHDPs, will an additional administration component be considered in the capitation rates?

   Response: An administrative and underwriting gain load was assumed on the BHDP component of the capitation rates. The revised load in the capitation rate development is a weighted blend of the prior load percentage on the base capitation claims and a 1% administrative load plus the underwriting gain applied to the BHDP.

4. Are the BHDPs restricted to the Categories of Service (COS) in the preprints? How are the impacted COS defined?

   Response: The BHDPs are limited to services on the Behavioral Health FFS fee schedule and in the impacted COS as identified in the preprints submitted to CMS. The impacted COS services are defined using OHG financial criteria that was sent to CCOs on 3/9/2022.

5. Can you please clarify if the CCOs will receive additional BH funding in the capitation rates for the July – December 2022 time period?

   Response: There will be no additional funding increase for the CCOs in the capitation rates for the July – December 2022 time period.

6. Will the BHDPs apply to services rendered in Federally Qualified Health Center (FQHC) and Rural Health Clinics (RHC)?

   Response: The BHDPs will apply to services rendered in FQHCs and RHCs.

7. Please provide more details around the Alternative Payment Methods (APM) discussion during the meeting. For example, in 2023, if we utilized capitation agreements, would we compare the capitation paid versus an underlying FFS value (now including the new directed payments)?

   Response: CCOs are encouraged to continue to utilize APMs that are more advanced in the provider risk continuum than paying on a FFS basis. Overall pricing levels for these arrangements must be consistent with the BHDP reimbursement levels described in the preprints. The CCO must notify OHA of these arrangements, provide supporting evidence of equivalence with the notification and in the notification and identify the directed payment component of the APM reimbursement. Below are examples of how supporting evidence of equivalence could be demonstrated. These examples are not intended to be exhaustive or prescriptive.

   APM Example 1

   CCO contracts with subcontractor to provide MH Non-Inpatient services. Rate effective January 1, 2022 was $5 PMPM which is based on 150,000 projected member months. CCO determines 20% of utilization is associated with Medicaid-Dominant providers and 80% is associated with non-Medicaid Dominant-providers.

   - For the rate effective January 1, 2023, CCO determines the Tiered Uniform Rate Increase component of the directed payment ($5 * 20% * 30% + $5 * 80% * 15%) = $0.90 PMPM increase.
     - Additionally, the CCO projects there will be 500 units of 90837 provided in CY 2023 that would be eligible for the CLSS non-rural increase and no services that would be eligible for the COD increase.
   - For the rate effective January 1, 2023, CCO determines the CLSS Increase component of the directed payment = Number of units * State plan FFS fee schedule rate as of January 1, 2023 * Non-Rural CLSS increase = 500 * $172.72 * 22% = $18,999.20. Converting this to a PMPM equates to $18,999.20 / 150,000 = $0.13 PMPM increase.
     - The total subcontracted PMPM = $6.03 PMPM including $0.90 Tiered Uniform Rate Increase and $0.13 CLSS increase.

   OHA encourages CCOs to include a settlement or risk sharing arrangement related to COD and CLSS as these are new services.

   APM Example 2

   CCO contracts with subcontractor to provide MH Non-Inpatient services. Rate effective January 1, 2022 was $5 PMPM. CCO rebases the rate effective January 1, 2023 prior to consideration of the directed payment and determines the rate would be $4 PMPM due to decreased utilization from the prior year. The CCO then determines 20% of utilization is associated with Medicaid-Dominant providers and 80% is associated with non-Medicaid Dominant-providers.

   - For the rate effective January 1, 2023, CCO determines the Tiered Uniform Rate Increase component of the directed payment ($4 * 20% * 30% + $4 * 80% * 15%) = $0.72 PMPM increase.

- Additionally, the CCO modifies the contracted rate to pay out the enhanced COD and CLSS payments to providers on a FFS or non-risk basis outside of the at-risk subcapitation arrangement.

The total subcontracted PMPM = $4.72 PMPM excluding separate payments for the COD and CLSS directed payments.

8. Can OHA/Mercer provider greater details on the methodology in which CCO specific BH Directed Payments will be developed, inclusive of which current adjustments will or will not be applied (e.g. risk adjustment, hospital factors, regional factors)?

   Response: The behavioral health uniform increases and minimum fee schedule directed payments were calculated based on actual CY 2021 utilization by procedure code, COA, and CCO projected to CY 2023 utilizing assumptions and adjustments consistent with the CY 2023 capitation rate development. Additionally, below is detail on directed payment specific assumptions:

   — The Tiered Uniform Rate Increase Directed Payment assumptions were developed based on 1) a review of provider type/provider specialty descriptions 2) annual managed care spend per provider and 3) discussion with OHA on anticipated Medicaid-Dominant providers. Specifically, 50% of Mental Health Non-Inpatient, 50% of Substance Abuse and 100% of the ACT/SE utilization was assumed to be for Medicaid-Dominant providers. These assumptions did not vary by CCO.

   — The COD assumptions were developed based on review of eligible procedures meeting the COD diagnosis criteria provided by OHA. A utilization ramp up assumption was also used recognizing that not all current COD utilization will be performed by certified providers in the future and all eligible providers may not be certified as of January 1, 2023. These assumptions did not vary by CCO.

   — The CLSS assumptions were developed utilizing a list of anticipated CLSS-eligible providers by OHA with an assumption for potential new qualifying providers. Additionally, assumptions were varied by CCO with those serving urban locations projected to have a higher percentage of providers that are CLSS-eligible and would receive the non-rural increase.

   CCO-specific adjustments were developed and therefore the risk adjustment, hospital factors and regional factor adjustments were not applied to avoid double counting.

9. Please provide examples showing how CCOs should increase contracted rates if providers meet multiple directed payment criteria.

   Response: Please see the following examples.

   CALCULATION EXAMPLE 1

   Consider the following example for a provider who qualifies for the Tier 2 (30% of negotiated rate) increase, COD Master's increase (20% of State Plan fee schedule) and CLSS Non-Rural increase (22% of State Plan fee schedule):

   PROVIDER AND SERVICE CHARACTERISTICS

   — COS/CPT Code: Mental Health Non-Inpatient, 90837

- Medicaid Dominant/Non-Medicaid Dominant: Medicaid-Dominant
- CLSS Eligible: Yes, non-rural
- COD Eligible: Yes, non-residential, master's level
- CCO-contracted rate as of January 1, 2022 = $180.00
- State plan FFS fee schedule rate as of January 1, 2023 = $172.72

CY 2023 CCO PAYMENT

- Tier 2 base payment: = Contracted rate as of January 1, 2022 * Tier 2 uniform increase = $180.00 * 1.30 = $234.00
- COD Increase: State plan FFS fee schedule rate as of January 1, 2023 * Master's COD increase = $172.72 * 20% = $34.54
- CLSS Increase: State plan FFS fee schedule rate as of January 1, 2023 * Non-Rural CLSS increase = $172.72 * 22% = $38.00
- Total CCO payment = Tier 2 payment + COD Increase + CLSS increase = $234.00 + $34.54 + $38.00 = $306.54

CALCULATION EXAMPLE 2

Consider the following example for a provider who qualifies for the minimum fee schedule directed payment and COD residential increase (15% increase):

PROVIDER AND SERVICE CHARACTERISTICS

- COS/CPT Code: A&D Residential, H0019
- Medicaid Dominant/Non-Medicaid Dominant: N/A
- CLSS Eligible: N/A
- COD Eligible: Yes, residential
- CCO-contracted rate as of January 1, 2022 = $700.00
- State plan FFS fee schedule rate as of January 1, 2023 = $910.00

CY 2023 CCO PAYMENT

- Minimum fee schedule base payment: = State plan FFS fee schedule rate as of January 1, 2022 $910.00
- COD Increase: State plan FFS fee schedule rate as of January 1, 2023 * Residential COD increase = $910.00 * 15% = $136.50
- Total CCO payment = Minimum fee schedule base payment + COD Increase = $910.00 + $136.50 = $1,046.50

10. How will single case agreements be handled in the directed payment?

Response: Generally, the behavioral health directed payment parameters are for network, contracted providers. However, OHA expects that single case agreements will be paid at a similar rate when compared to a new provider doing equivalent services.

11. Will CCOs be required to pass along these reimbursement increases?

    Response: Yes, once approved by CMS, the CCOs have to comply with the BHDP reimbursement requirements as part of their contract.

12. Does CMS need to approve both the FFS schedule and the BHDP for these to be effective in the managed care contract?

    Response: Yes, the FFS proposed fee schedule submitted to CMS in August must be approved prior to the BHDP approval. OHA hopes both approvals are received prior to the end of 2022.

TIERED UNIFORM RATE INCREASE DIRECTED PAYMENT

13. Some CCOs increased their reimbursement rates to providers in 2022. Those increases would not count towards meeting the directed payment requirement as there must be further increases off negotiated rates from the rates as of June 30, 2022. We request the directed payment be based on negotiated rates as of January 1, 2022.

    Response: The tiered uniform increase directed payment was revised to be in addition to the rates in place for CCOs for qualified BH providers effective January 1, 2022.

14. How will providers who meet the Medicaid-Dominant/Non-Dominant criteria be identified? Can we receive a list of these providers?

    Response: The Tier 1 increase is for providers with less than 50% of BH revenue derived from providing Medicaid services in the prior CY and Tier 2 is for providers with 50% or greater of BH revenue derived from providing Medicaid services in the prior CY. OHA will not be providing a list of these providers. The CCOs must collect data from providers documenting the Medicaid portion of payment revenue in the prior year and identify whether they would meet the Medicaid-Dominant or Non-Medicaid-Dominant criteria. This supporting documentation must be provided to OHA upon request. **OHA is open to suggestions on how to make this a streamlined process for both providers and CCOs. Please provide feedback and suggestions by 11/14/22 to the Actuarial Services inbox: Actuarial.Services@odhsoha.oregon.gov.**

15. What is the process to document compliance with this directed payment to OHA? How frequently will providers need to be re-certified?

    Response: The CCO must provide OHA with a written attestation of compliance with the tiered uniform rate increase requirement on an annual basis. The attestation should include a list of all contracted providers eligible for the tiered uniform rate increase payment and confirmation that negotiated rates comply with the parameters of the directed payment. The health plan shall submit a revised written attestation of compliance on an annual basis if contracting with a new provider or renegotiating current provider contracts. Additional supporting documentation of each provider's prior CY Medicaid percentage of total revenue must be provided to OHA upon request.

CO-OCCURRING DISORDER DIRECTED PAYMENT

16. We understand that OHA will be certifying co-occurring disorder (COD) providers. Once all qualified statewide BH COD providers are certified, can OHA share the statewide list with CCOs to assist with implementing the rate increases to certified outpatient COD and residential providers?

    Response: The billing entity must be certified under the forthcoming COD rules to be eligible for this directed payment. OHA will provide a list of certified providers once available.

CULTURALLY AND LINGUISTICALLY SPECIFIC SERVICES DIRECTED PAYMENT

17. We understand that OHA will be certifying culturally and linguistically appropriate service providers who meet OHA standards. Can OHA share the list of these statewide certified providers along with those that qualify as rural and non-rural?

    Response: The billing entity will no longer be required to be certified by OHA but they must meet eligibility requirements under the forthcoming CLSS rules to be eligible for this directed payment or designated by a CCO (see description above). OHA will provide a list of eligible providers once available. Rural and non-rural will be defined in the rules.

APPENDIX A – COS CROSSWALK

OHG DESCRIPTION	CLAIM TYPE	CATEGORIES OF SERVICE	DIRECTED PAYMENT			
			Min FS	Tiered	COD	CLSS
PROF-MH-ABA-SERVICES	Professional	Applied Behavior Analysis (ABA)	X			X
PROF-MH-ACT	Professional	ACT/SE		X		X
PROF-MH-SUPPORT-EMPLOYMENT	Professional	ACT/SE		X		X
OP-MH-OTHER	Outpatient	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-ALT-TO-IP	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-ASSESSMENT-EVALUAT	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-CASE-MANAGEMENT	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-CASE-MGT	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-CONSULTATION	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-CRISIS-SERVICES	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-EVAL-MGMT-PCP	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-INTERP-SERVICES	Professional	Mental Health Services Non-Inpatient		X	X	
PROF-MH-MED-MGT	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-MST	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-OP-THERAPY	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-PDTS	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-PHYS-OP	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-PRTS-CHILD	Professional	Mental Health Services Non-Inpatient		X	X	
PROF-MH-RESPITE	Professional	Mental Health Services Non-Inpatient		X	X	
PROF-MH-SKILLS-TRAINING	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-SUBACUTE	Professional	Mental Health Services Non-Inpatient		X	X	
PROF-MH-SUD-UNBUCKETED	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-SUPPORT-DAY	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-THERAPY	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-MH-THERAPY-INPATIENT	Professional	Mental Health Services Non-Inpatient		X	X	
PROF-MH-UNBUCKETED	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-PHYS-OTHER-E-M-MH	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-PHYS-PRIMCARE-E-M-MH	Professional	Mental Health Services Non-Inpatient		X	X	X
PROF-PHYS-SOMATIC-MH	Professional	Mental Health Services Non-Inpatient		X	X	X

OP-CD-A	Outpatient	Substance Abuse		X	X	X
OP-CD-B	Outpatient	Substance Abuse		X	X	X
PROF-MH-WRAPAROUND-SERVICE	Professional	MH Children's Wraparound	X		X	X
PROF-CD-ASSESS-SCREENING	Professional	Substance Abuse		X	X	X
PROF-CD-METHADONE-AMH	Professional	Substance Abuse		X	X	X
PROF-CD-METHADONE-TREAT	Professional	Substance Abuse		X	X	X
PROF-COMMUNITY-DETOX	Professional	Substance Abuse		X	X	X
PROF-SBIRT-A	Professional	Substance Abuse		X	X	X
PROF-SBIRT-B	Professional	Substance Abuse		X	X	X
PROF-SUD-UNBUCKETED	Professional	Substance Abuse		X	X	X
PROF-CD-RES-ADULT	Professional	A&D Residential	X		X	
PROF-CD-RES-CHILD	Professional	A&D Residential	X		X	