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Department of Health Care Access and Information

OHCA Investment and Payment Workgroup

April 16, 2025

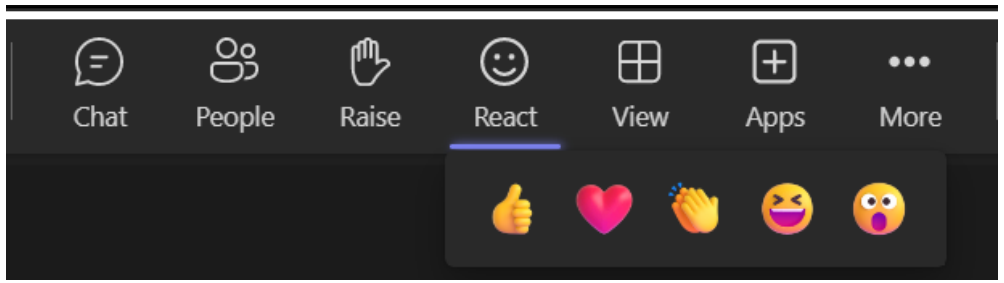
Agenda

9:00 a.m.	**1.**	**Welcome, Updates, and Introductions**
9:10 a.m.	**2.**	**Behavioral Health Investment Benchmark Considerations**
9:50 a.m.	**3.**	**Behavioral Health Non-Claims Payment Measurement**
10:05 a.m.	**4.**	**Claims-Based Behavioral Health Spending Measurement Methodology**
10:25 a.m.	**5.**	**Next Steps**
10:30 a.m.	**6.**	**Adjournment**

Meeting Format

Reminder: Workgroup members may provide verbal feedback during the meeting. Non-Workgroup members are welcome to participate during the meeting via the chat or provide written feedback to the OHCA team after the meeting.

- Workgroup purpose and scope can be found in the Investment and Payment Workgroup Charter
- Remote participation via Teams Webinar only
- Meeting recurs the third Wednesday of every month
- We will be using reaction emojis, breakout rooms, and chat functions:



Date: April 16, 2025

Time: 9:00 am PST

Microsoft Teams Link
for Public Participation:
Join the meeting now

Meeting ID: 289 509 010 938
Passcode: r5gbsW

Or call in (audio only):
+1 916-535-0978

Conference ID:
456 443 670 #

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Primary Care & Behavioral Health Investments

Statutory Requirements

- **Measure and promote a sustained systemwide investment in** primary care and **behavioral health.**
- **Measure the percentage of total health care expenditures allocated to** primary care and **behavioral health and set spending benchmarks**.
- Include an analysis of primary care and behavioral health spending and growth, and relevant quality and equity performance measures, in the annual report.
- Consult with state departments, external organizations promoting investment in primary care and behavioral health, and other entities and individuals with expertise in primary care, behavioral health, and health equity.
- Benchmarks and public reporting shall consider differences among payers and fully integrated delivery systems, including plan or network design or line of business, the diversity of settings and facilities through which primary care can be delivered, including clinical and nonclinical settings, the use of both claims-based and non-claims-based payments, and the risk mix associated with the covered lives or patient population for which they are primarily responsible.

Primary Care & Behavioral Health Investments

Statutory Requirements

Promote improved outcomes for behavioral health, including, but not limited to, health care entities making investments in, or adopting models that do, any or all of the following:

a. Integrate primary care and behavioral health services, including screenings for behavioral health conditions in primary care settings or delivery of behavioral health support.
b. Implement innovative approaches that integrate primary care and behavioral health with broader social and public health services.
c. Leverage APMs that provide resources at the practice level to enable improved access and team-based approaches for care coordination, patient engagement, quality, and population health.
d. Deliver higher value behavioral health services with an aim toward reducing disparities.
e. Leverage telehealth and other solutions to expand access to behavioral health, care coordination, and care management.

OHCA's Role in Improving Behavioral Health Outcomes

Systemwide Behavioral Health Goals

Behavioral health care that is:

- Accessible
- Comprehensive
- Coordinated
- Equitable
- High Quality

Motivate

Resulting In

California Stakeholder Actions

- Identify and support higher value care
- Build and sustain infrastructure and capacity
- Promote behavioral health integration with primary care and social and public health services
- Reduce disparities

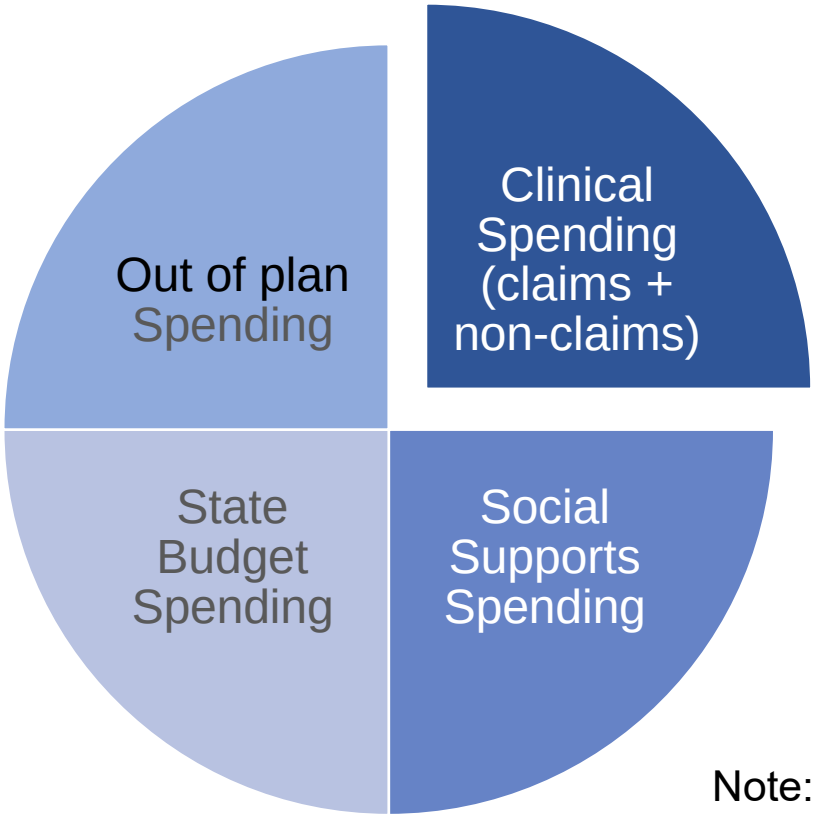
Supports

OHCA's Behavioral Health Workstream

- Promote sustained systemwide investment in behavioral health
- **Measure and report** the percentage of total health care expenditures allocated to behavioral health care
- Set focused **spending benchmarks** to support improved behavioral health outcomes
- Conduct analysis

Data Collection and Measurement Scope

Clinical services are services provided by medical and allied health professionals to prevent, treat, and manage illness, and to preserve mental well-being across the clinical care continuum, paid via claims and non-claims payments (e.g., outpatient therapy visit, day treatment programs).



- Initial focus on clinical services and health care payers (e.g., commercial and Medicare Advantage)
- Possibility of using supplemental data sources to capture spending from other categories in the future

Note: “Out of plan spending” includes spending by individuals on services not paid for by the plan. “Clinical spending” includes member cost share for services paid by the plan.

Adapted from Milbank Memorial Fund, April 2024. *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.* https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/

March Workgroup Meeting

Feedback

- Preventive services in behavioral health are critical, and measurement efforts should capture this spending to the greatest extent possible
- Support for including sub-clinical payments to peer support specialists in the measurement of non-claims payments for social care integration
- Clarification that mobile crisis services are included in the outpatient and community-based services proposed for the benchmark
- Spending for behavioral health screenings and assessments should be collected in each relevant subcategory, rather than grouped together in a separate category
- Interest in measuring and reporting behavioral health spending to be compared to the benchmark as a per member, per month amount, rather than as a percentage of total medical expenses

Timeline to Board Adoption of Behavioral Health Investment Benchmark

Apr

- Workgroup review/discuss key decisions
- Board discusses key decisions and receives update on Workgroup progress

May

- Workgroup reviews data and OHCA recommendations
- Board reviews data and Workgroup progress

June

- Workgroup finalizes recommendation
- Advisory Committee reviews draft recommendation and release for public comment

July

- Board reviews recommendation and public comments

Aug

- OHCA revises recommendation
- Board votes on final recommendation

Benchmark Adopted August 2025

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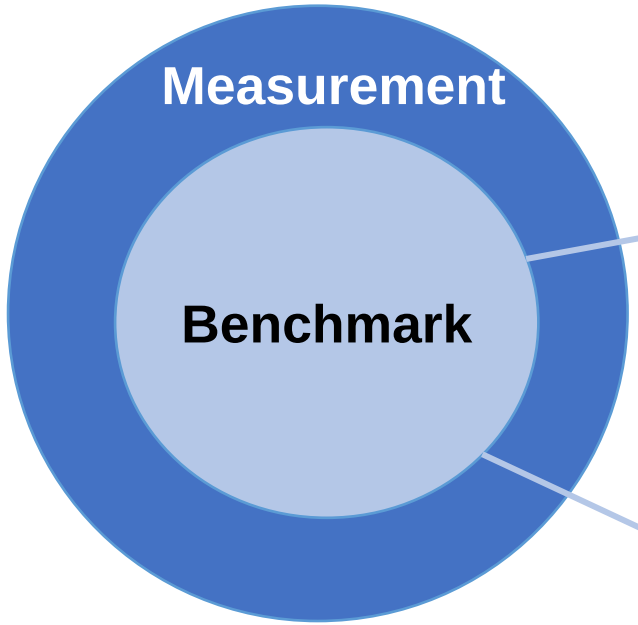
Behavioral Health Investment Benchmark Considerations

Debbie Lindes, Health Care Delivery System Group Manager
Mary Jo Condon, Principal Consultant, Freedman HealthCare

Recommendation: What is Included in the Benchmark



Outpatient/Community-Based Service Claims Subcategories:

- Community Based Mobile Clinic Services
- Outpatient Professional PC
- Outpatient Professional Non-PC
- Outpatient Facility

Non-claims payments in other Expanded Framework categories:

A: Population Health and Practice Infrastructure Payments
B: Performance Payments
D: Capitation Payments (outpatient/community-based service subcategories only)

Key Decisions for Benchmark Setting

- Should the benchmark be a percentage of total medical expenses or a per member, per month amount?
- Should the benchmark focus on incremental or long-term improvement, or some combination?
- What should the timeline be for achieving the benchmark?

Set a benchmark based on the percent of total medical expense or a per member, per month amount?

Statute suggests a preference for using percent of total medical expense (TME) as a basis for benchmarking, which would be consistent with other approaches.

Reasons for Percent of TME

- Statute suggests preference for this approach
- Communicates that increased spending on behavioral health care should reallocate rather than increase total spending
- Aligns with the approach to the primary care investment benchmark

Reasons for Per Member, Per Month (PMPM)

- Easier to reflect the cost of achieving behavioral health delivery goals
- May guard against the benchmark becoming unnecessarily inflationary if total medical expense increases are higher than expected
- More consistent with how payers typically measure health care costs and the only state benchmark

Workgroup Survey Results

- Should the benchmark be a percentage of total medical expenses or a per member, per month amount?

Option	Number of Responses
Percentage of total medical expenses	5
Per member, per month amount	12

Set an annual improvement or long-term investment benchmark? Or some combination?

An annual improvement benchmark meets each payer where they are today, and the long-term investment benchmark offers a vision for the future across all payers.

Reasons for Annual Improvement

- Consistent with statutory guidance to recognize differences across payers and patient populations
- Acknowledges care delivery transformation takes time
- Current and desired spending levels are unclear; annual improvement gives more latitude

Reasons for Long-Term Investment Goal

- Sets a vision for the future
- Can reflect the potential budget needed to develop necessary behavioral health infrastructure
- Can reflect current thinking on the “right” level of behavioral health care investment

Reason for Combination

- Allows all to succeed at a reasonable pace
- Aligns with the approach to the primary care investment benchmark

Workgroup Survey Results

- Should the benchmark focus on incremental or long-term improvement, or some combination?

Option	Number of Responses
Annual Improvement	3
Long-term Improvement	2
Combination	11

How long should the time horizon be for the behavioral health investment benchmark?

Considerations

- Benchmark should be aggressive in pursuit of the policy goals underlying it
- Benchmark should also reflect reasonable expectations of how long it will take to achieve
- Align benchmark with other adopted OHCA benchmarks:
  - Spending growth (2029)
  - Primary care investment and alternative payment model adoption (2034)
- Baseline for behavioral health spending is uncertain; shorter time horizon and less aggressive approach in earlier years might be appropriate

Options for Aligning with the Primary Care Investment Benchmark

Creating alignment between the behavioral health and primary care investment benchmarks can promote consistency for data submitters and simplify understanding for stakeholders and the public.

Possible areas for alignment:

- In-network, outpatient and community-based behavioral health spending increases at the same rate as primary care spend
- Behavioral health benchmark includes annual improvements
- Behavioral health benchmark is a percent of total medical expenses, as is primary care benchmark

Primary Care Investment Benchmark
• For each payer, 0.5 to 1.0 percentage points increase per year as percent of TME • By 2034, primary care is 15% of TME for all payers

Example: Alignment with Primary Care Benchmark Based on Rate of Growth

About 5-7% of health care spending is for primary care, according to a national study. California's annual improvement benchmark for primary care investment seeks to increase primary care spending 0.5 to 1.0 percentage points per year per payer. Using the 7% baseline, this is equivalent to an **annual growth rate in primary care spend of 7-14%** over five years.

If this rate of growth were applied to the categories of behavioral health spending subject to the benchmark...

Outpatient Behavioral Health Benchmark Spend (% TME)		
Year	7% per year increase	14% per year increase
Baseline*	3.0%	3.0%
1	3.2%	3.4%
2	3.4%	3.9%
3	3.7%	4.4%
4	3.9%	5.1%
5	4.2%	5.8%
Year 5 exceeds baseline by:	**40.3%**	**92.5%**

*Hypothetical

Source: Jabbarpour et al. Investing in Primary Care: A State-Level Analysis. Patient Centered Primary Care Collaborative, July 2019. https://www.milbank.org/wp-content/uploads/2019/07/2019-PCPCC-Evidence-Report-Final.pdf

Challenges in Establishing a Behavioral Health Benchmark

While aligning the behavioral health and primary care investment benchmarks might be desirable, there are several challenges in establishing the behavioral health benchmark that were not present in setting the primary care benchmark:

- Complete, reliable data on behavioral health spending are lacking, particularly at the detailed subcategory level and for certain payer types
- There is no track record of the structures, levels, or effectiveness of behavioral health investment benchmarks in other states
- There is a lack of national and international evidence for what constitutes the "right" or "desired" level of behavioral health spending

Example: Benchmark as a Per Member, Per Month Amount

Rhode Island's behavioral health benchmark – called the "behavioral health spending obligation" -- requires payers to increase per member, per month spending on community-based behavioral health care for commercially insured children and adolescents to 200% of baseline in three years (2022 baseline, goal is to reach benchmark in 2025).

Applying this benchmark structure to California...

Outpatient Behavioral Health Benchmark Spend (PMPM), per payer		
Year	PMPM Spend	Compared to Baseline
Baseline*	$10	100%
1	$12.50	125%
2	$17.50	175%
3	$20	200%

*Hypothetical

Discussion

- Should the benchmark be a percentage of total medical expenses or a per member, per month amount?
- Should the benchmark focus on incremental or long-term improvement, or some combination?
- What should the timeline be for achieving the benchmark?
  - 2029 to align with the spending growth targets?
  - 2034 to align with the alternative payment model goals and primary care investment benchmark?
  - Other?
- Should the behavioral health investment benchmark align with the primary care investment benchmark?

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Behavioral Health Non-Claims Payment Measurement

Mary Jo Condon, Principal Consultant, Freedman HealthCare

Overview of Recommended Non-claims Behavioral Health Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Spending
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	Include payments to behavioral health providers and provider organizations for care management/coordination and for integration with primary care or social care.
A2	Primary care and behavioral health integration*	
A3	Social care integration	
A4	Practice transformation payments	Limit the portion of practice transformation and IT infrastructure payments allocated to behavioral health spending to the proportion of total claims and capitation payments going to behavioral health.
A5	EHR/HIT infrastructure and other data analytics payments	
B	**Performance Payments**	
B1	Retrospective/prospective incentive payments: pay-for-reporting	Include performance incentives in recognition of reporting, quality, and outcomes made to behavioral health providers.
B2	Retrospective/prospective incentive payments: pay-for-performance	

*May be paid to primary care or multi-specialty provider organizations for this purpose.

Overview of Recommended Non-claims Behavioral Health Care Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Care Spending
C	**Payments with Shared Savings and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	Not Applicable
C2	Procedure-related, episode-based payments with risk of recoupments	
C3	Condition-related, episode-based payments with shared savings	Include spending for service bundles for a behavioral health-related episode of care.
C4	Condition-related, episode-based payments with risk of recoupments	
C5	Risk for total cost of care (e.g., ACO) with shared savings	Not Applicable
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	

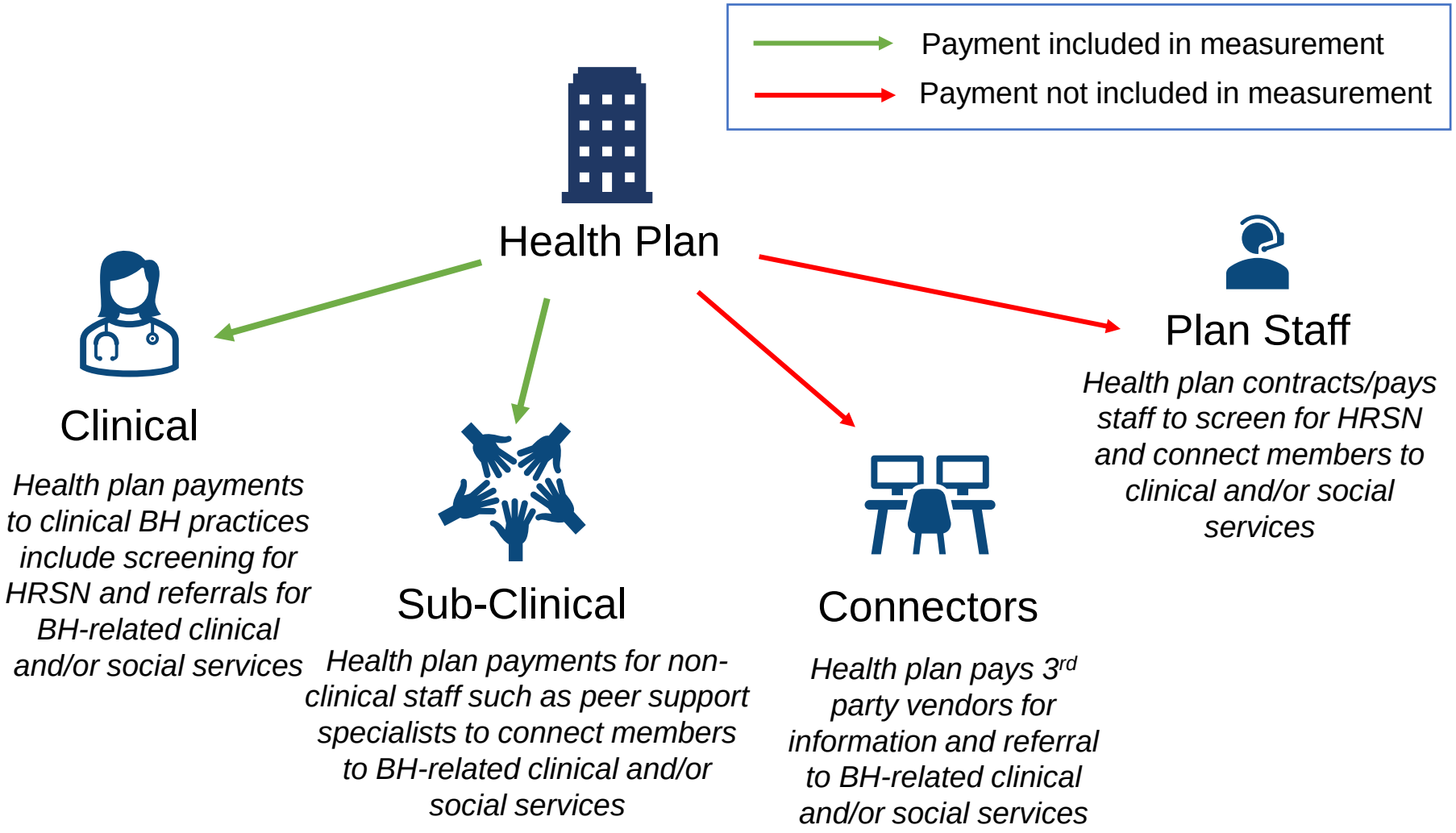
Overview of Recommended Non-claims Behavioral Health Spending Measurement Approach

Expanded Framework Category		Allocation to Behavioral Health Care Spending
D	**Capitation and Full Risk Payments**	
D1	Primary Care capitation	Not Applicable
D2	Professional capitation	Calculate a fee-for-service equivalent based on a fee schedule for primary care services multiplied by the number of encounters.
D3	Facility capitation	Not Applicable
D4	Behavioral Health capitation	Allocate full behavioral health care capitation amount to behavioral health care spending.
D5	Global capitation	Calculate a fee-for-service equivalent based on a fee schedule for primary care services multiplied by the number of encounters.
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	
E	Other Non-Claims Payments	Limit the portion of other non-claims payments* allocated to behavioral health spending the proportion of total claims and capitation payments going to behavioral health.
F	Pharmacy Rebates	Not applicable.

*May include retroactive denials, overpayments, payments made as the result of an audit, or other payments that cannot be categorized elsewhere.

Subcategory A3: Social care integration payments

Expanded Framework Definition:
Prospective non-claims payments **paid to health care providers or organizations*** to support screening for health-related social needs (HRSN), connections to social services and other interventions to address patients' social needs, such as housing or food insecurity, that are not typically reimbursed through claims.



*Would be paid to behavioral health providers and organizations, analogous to primary care providers and organizations for primary care spend.

Equation for Allocating Practice Transformation, EHR/HIT, and Other Non-Claims Payments to Behavioral Health

$$\text{Subcategory A4 Behavioral Health Spend*} = \Sigma \text{ Practice Transformation Payments} \times \frac{\text{Behavioral Health Claims + Behavioral Health Capitation}}{\text{Claims: Total Claims + Capitation and Full Risk Payments}}$$

*This equation would also be used to allocate Category A5 EHR/HIT Infrastructure and Data Analytics and Category E Other Non-Claims Payments to behavioral health.

Discussion

- Do the methods for determining how the various types of non-claims payments should be apportioned to behavioral health care seem appropriate?
  - The allocation formula for Subcategories A4 and A5, and Category E?
  - The types of services included as social care integration payments?

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Claims-Based Behavioral Health Spending Measurement Methodology

Debbie Lindes, Health Care Delivery System Group Manager

Code Set Table of Contents

- Overview
- Service Subcategories
- Service Codes
- Care Setting Codes
- Diagnosis Codes
- National Drug Codes
- Sources
- Primary Care Taxonomies

Approach to Defining Code Sets

Review Milbank definition

Review Department of Managed Health Care coverage requirements and Medi-Cal code sets; incorporate additions

Circulate draft code sets to Workgroup members for review and feedback

Milbank Memorial Fund, April 2024. *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.* https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/
CalAIM Reference Guides for CPT Codes, 2022. https://www.dhcs.ca.gov/services/MH/Pages/medccc-library.aspx
Department of Managed Health Care, n.d. Behavioral Health Care Compliance. https://www.dmhc.ca.gov/LicensingReporting/HealthPlanComplianceMedicalSurvey/BehavioralHealthCareCompliance.aspx

Process to Develop OHCA's Behavioral Health Code Set

- Discuss stakeholder interests and align with OHCA's data collection efforts
- Review Milbank-Freedman code set
- Review Medi-Cal service code sets and discuss with DHCS:
  - Non-Specialty Mental Health Services (fee-for-service and managed care)
  - Specialty Mental Health Services (County behavioral health plans)
  - Drug Medi-Cal (DMC) Organized Delivery System substance use disorder services (DMC Counties)
  - Children and Youth Behavioral Health Initiative
- Update OHCA's behavioral health in primary care module by expanding the primary care provider list to include additional integrated behavioral health services
- Map services and care setting code sets to stakeholder-informed reporting categories

Milbank Memorial Fund, April 2024. *Recommendations for a Standardized State Methodology to Measure Clinical Behavioral Health Spending.* https://www.milbank.org/publications/recommendations-for-a-standardized-state-methodology-to-measure-clinical-behavioral-health-spending/
CalAim Reference Guides for CPT Codes, 2022. https://www.dhcs.ca.gov/services/MH/Pages/medccc-library.aspx

Recommended Approach to Claims-based Behavioral Health Spending Measurement

Medical claims:

- ✓ The primary diagnosis is a behavioral health diagnosis
- ✓ Include a broad list of services defined as behavioral health
- ✓ Services provided by any provider taxonomy; not restricted

Behavioral health in primary care:

- ✓ Primary behavioral diagnosis not required for screenings and assessments
- ✓ Behavioral health professionals added to list of primary care providers to capture integrated care

Pharmacy claims:

- ✓ Include National Drug Codes for behavioral health pharmaceutical treatments

Questions to Consider for the Behavioral Health Code Set Review

1. Are there any reporting subcategories that seem to be missing?
2. Are there drug names on the current list that should not be included, or any currently missing that should be included?
3. Are there services you would recommend excluding or adding, especially any screening/assessment codes?
4. Are there diagnoses you would recommend excluding or adding, especially any Z codes?
5. Do the proposed primary care taxonomy additions represent behavioral health providers that may practice in an integrated or collaborative primary care setting?
   - Are there provider types included who are unlikely to provide services in an integrated primary care setting?
   - Are any provider types who provide integrated care missing from this list?

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Next Steps

Margareta Brandt, Assistant Deputy Director

Tentative Timeline for Behavioral Health Work

Between meetings, OHCA will revise draft behavioral health definitions and investment benchmarks based on feedback. OHCA is proposing to extend the Workgroup through August to allow for more time for discussion.

	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
Workgroup	X	X	X	X	X	X	X	X	X
Advisory Committee		X		X			X		
Board	X		X		X	X		X	✓

X Provide Feedback ✓ Board Approval

May Workgroup Meeting Preview

- Review behavioral health spending analysis data
- Preview draft recommendation for behavioral health benchmark based on spending analysis
- Discuss impact of benchmark focused on Outpatient and Community-Based Care spending based on spending analysis data

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Adjournment

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Appendix

Example: Rhode Island Behavioral Health Investment Benchmark

The Rhode Island Office of the Health Insurance Commissioner's (OHIC) **behavioral health spending obligation** focuses on community-based behavioral health care for commercial fully-insured children and adolescents, ages 0-18.

Spending obligation (benchmark):

- In 2025, carriers must increase per member, per month spending on community-based behavioral health care for target population to 200% of baseline (defined as calendar year 2022 spending)
- After 2025, carriers must have annual expenditures on community-based behavioral health care for the target population at the market average as determined by OHIC
- Includes claims and non-claims spending for community-based behavioral health care
- Applies to spending for residents of Rhode Island who receive care from providers located in Rhode Island
- If carriers do not reach the benchmark, they will be subject to penalties as determined by the Commissioner

Other OHCA Benchmarks

Health Care Spending Growth Target	• 3.5% in 2025 and 2026 • 3.2% in 2027 and 2028 • 3.0% in 2029 and beyond
APM Adoption	• Biannual improvement goals by payer type • By 2034: 95% for Commercial HMO and Medicare Advantage; 75% for Medi-Cal; 60% for Commercial PPO
Primary Care Investment	• For each payer, 0.5 to 1.0 percentage points per year as percent of TME • By 2034, 15% of TME for all payers

- Combine incremental and long-term goals
- Acknowledge payers' different starting points and capacity for short-term improvement
- Allow for adjustment as picture becomes clearer with more data
- Set a long-term vision aligned with state policy goals

Apportioning Professional and Global Capitation to Behavioral Health

Example for a Professional Capitation arrangement:

$$\frac{\Sigma\ (\#\ \text{of BH Encounters x FFS-equivalent Fee})_{segment}}{\Sigma\ (\#\ \text{of All Professional Encounters x FFS-equivalent Fee})_{segment}} = \text{Behavioral Health spend paid via professional capitation}$$

X Professional Capitation Payment

"Segment" means the combination of payer type (e.g., Medicaid, commercial), payer, year and region or other geography as appropriate.

Note: Methodology aligns with OHCA primary care approach.

Example of Non-Claims Capitation Formula

Payer A has four types of capitation arrangements with provider groups. Three of the arrangements cover some behavioral health services. The table below describes the portion of the payer's capitation payments that would be allocated to behavioral health.

	Total Dollars Paid Via Capitation Category	Dollars Attributed to Behavioral Health	Dollars Attributed to Behavioral Health Equal To
Behavioral Health Capitation	$100,000,000	$100,000,000	Total amount paid in behavioral health capitation
Professional Capitation	$250,000,000	$5,000,000	Use formula on the previous slide to calculate FFS equivalents for behavioral health services.
Global Capitation	$1,000,000,000	$10,000,000	Use formula on the previous slide to calculate FFS equivalents for behavioral health services.
Facility Capitation	$500,000,000	$0	N/A

Service Codes (1 of 2) (586 total)

Reporting Category	Examples
Outpatient/ Community-Based	• Psychotherapy • Pharmacologic Management • Transcranial Magnetic Stimulation and Electroconvulsive Treatments • Psychological Testing and Evaluation • Health Behavior Assessments and Interventions • Adaptive Behavior Treatment • Care Management • Telehealth Assessment and Management • Preventive Services • Medication Assisted Treatment • Treatment for Substance Use Disorders • Detoxification Services (Non-residential) • Community Support and Peer Services • Suicide Risk Assessment
Emergency Department	• ED Visit for E/M of Patient with a Behavioral Health Disorder • Critical Care, E/M of the Critically Ill or Injured Patient • Level 1-5 ED Visits • Emergency Telehealth Services

Service Codes (2 of 2) (586 total)

Reporting Category	Examples
Inpatient	• Initial and Subsequent Hospital Care for E/M of a Patient with a Behavioral Health Disorder • Hospital Discharge/Day Management • Inpatient Consultations • Inpatient Telehealth Pharmacologic Management • Detoxification Services
Long-Term Care and Residential	• Non-Acute Behavioral Health for Patients in Long-Term Residential Facility • Detoxification Residential Addiction Programs

Care Setting Codes (238 total)

Includes CMS Place of Service and Revenue Codes

Reporting Category	Subcategories	Place of Service Code Examples	Revenue Code Examples
Inpatient	• Inpatient – Facility • Inpatient - Professional	Intermediate Care Facility, Residential Substance Use Disorder Treatment	Detoxification, Psychiatric, Intensive Care Units
Emergency Department	• ED/Observation – Facility • ED/Observation - Professional	Emergency Room, Ambulance - Land or Air or Water	Emergency Room, Medical Screening Services, Professional Fees, Specialty Services - Treatment Room and Observation Hours
Long-term Care and Residential	• Long-term Care • Residential	Psychiatric Residential Treatment Center	Nursing Home (for Hospitalization), Respite, Rehabilitation, Residential Treatment, SNFs
Outpatient/ Community-Based	• Mobile services • Outpatient professional – PC • Outpatient professional – non-PC • Outpatient Facility	School, Home, Indian Health Service and Tribal Facilities, Telehealth, Office, FQHCs, Partial Hospitalization, Non-Residential Substance Use Disorder Treatment Assisted Living Facility, Temporary Lodging, Place of Employment, Outreach Site/Street, Comprehensive Outpatient Rehabilitation	Outpatient Services, Clinics, FQHCs, Shortage Area, Telemedicine, Electroshock, Professional Fees, Rehabilitation, Alternative Therapy Services, Adult Care
Pharmaceutical	• MH Rx Treatments • SUD Rx Treatments	n/a	n/a
Other	• Other BH Services		

Diagnosis Codes (2,950 total)

Examples of Diagnoses Included
• Anxiety, Dissociative, Stress-Related, Somatoform and Other Nonpsychotic Mental Disorders • Behavioral and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence • Behavioral Syndromes Associated with Physiological Disturbances and Physical Factors • Dementia • Disorders of Adult Personality and Behavior • External Causes of Morbidity • Factors Influencing Health Status and Contact with Health Services • Injury of Unspecified Body Region • Injury, Poisoning and Certain Other Consequences of External Causes • Mental and Behavioral Disorders due to Psychoactive Substance Abuse • Mental Disorders Due to Known Physiological Conditions • Mood [Affective] Disorders • Pervasive and Specific Developmental Disorders • Schizophrenia, Schizotypal, Delusional and Other Non-Mood Psychotic Disorders • Symptoms and Signs Involving Cognition, Perception, Emotional State and Behavior

National Drug Codes (164 drugs)

Examples Of Disorders Included NDCs Treat
• ADHD and similar Disorders • Anxiety and Panic Disorders • Bipolar Disorder • Dementia • Depression • Mood Disorders • Obsessive Compulsive Disorder • Postpartum Depression • Post Traumatic Stress Disorder • Substance Use Disorders • Schizophrenia • Sleep Disorders