CONTRACT AMENDMENT NO. 1

Original Contract Routing Number 14-68960

1. PARTIES

This Amendment to the above-referenced Original Contract (hereinafter called the "Contract") is entered into by and between Rocky Mountain Health Maintenance Organization, Inc., 2775 Crossroads Blvd, Mesa, Colorado, 81506, (hereinafter called "Contractor"), and the STATE OF COLORADO, acting by and through the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 (hereinafter called "Department" or "State.")

2. EFFECTIVE DATE AND ENFORCEABILITY

This Amendment shall not be effective or enforceable until it is approved and signed by the Colorado State Controller or designee (hereinafter called the "Effective Date.") The Department shall not be liable to pay or reimburse Contractor for any performance hereunder, including, but not limited to, costs or expenses incurred, or be bound by any provision hereof prior to the Effective Date.

3. FACTUAL RECITALS

The Parties entered into the Contract to create a new payment reform pilot program within the Accountable Care Collaborative. The purpose of this Amendment is to modify requirements in the Statement of Work, update Exhibit F and modify the rates.

4. CONSIDERATION

The Parties acknowledge that the mutual promises and covenants contained herein and other good and valuable consideration are sufficient and adequate to support this Amendment.

5. LIMITS OF EFFECT

This Amendment is incorporated by reference into the Contract, and the Contract and all prior amendments thereto, if any, remain in full force and effect except as specifically modified herein.

6. MODIFICATIONS

The Contract and all prior amendments thereto, if any, are modified as follows:

A. Exhibit A, Statement of Work, Section 3.6.1.5.2.2. is hereby deleted in its entirety and replaced with the following:

3.6.1.5.2.2. Non-urgent, symptomatic care scheduled within ten (10) days of the Member's request for services.

B. Exhibit A, Statement of Work, Section 6.5.2.1.2. is hereby deleted in its entirety and replaced with the following:

6.5.2.1.2. HbA1c Poor Control (>9.0%) (HEDIS – CDC)

6.5.2.1.2.1. Target: twenty eight point ninety five percent (28.95%).

C. Exhibit A, Statement of Work, Section 6.5.2.2., Quality Targets Table, is hereby deleted in its entirety and replaced with the following:

6.5.2.2. Quality targets Table

Quality Measure	**Target(s)/ Deliverable(s)**	**Adjustment Made to the MLR if the Contractor meets the Target**
HEDIS: Adult Body Mass Index (BMI) Assessment	82.33%	Subtract two percent (-2%)
HEDIS: HbA1c Poor Control (>9.0%)	28.95%	Subtract two percent (-2%)
HEDIS: Anti-depressant Medication Management.	1. Effective Acute Phase Treatment: 56.05%. 2. Effective Continuation Phase Treatment: 40.06%	Subtract two percent (-2%)
Patient Activation Measure (PAM): Process Development and Screening Data Collection	1. Implementation of PAM in 10 PCMPs, serving at least 50% of the Contractor's enrollees. 2. PAM Assessment Report 3. PAM Roadmap Report	Subtract two percent (-2%)
Total		**Subtract eight percent (-8%)**

D. Exhibit C-1, Monthly Payment Rates, attached hereto and incorporated herein, is hereby added to the Contract. For the period beginning September 1, 2014 and ending on June 30, 2015, all references to Exhibit C are hereby deemed to reference Exhibit C-1.

E. Exhibit F, Covered Health Procedure Codes is hereby deleted in its entirety and replaced with Exhibit F-1, Covered Health Procedure Codes and Diagnoses, attached hereto and incorporated herein. All references to Exhibit F are hereby deemed to reference Exhibit F-1.

7. START DATE

This Amendment shall take effect on its Effective Date.

8. ORDER OF PRECEDENCE

Except for the Special Provisions and the HIPAA Business Associates Addendum, in the event of any conflict, inconsistency, variance, or contradiction between the provisions of this Amendment and any of the provisions of the Contract, the provisions of this Amendment shall in all respects supersede, govern, and control. The most recent version of the Special Provisions incorporated into the Contract or any amendment shall always control other provisions in the Contract or any amendments.

9. AVAILABLE FUNDS

Financial obligations of the state payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted, or otherwise made available to the Department by the federal government, state government and/or grantor.

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THE PARTIES HERETO HAVE EXECUTED THIS AMENDMENT

Persons signing for Contractor hereby swear and affirm that they are authorized to act on Contractor's behalf and acknowledge that the State is relying on their representations to that effect.

CONTRACTOR: Rocky Mountain Health Maintenance Organization, Inc.	**STATE OF COLORADO:** John W. Hickenlooper, Governor
By: ______________________ Signature of Authorized Officer	By: ______________________ Susan E. Birch, MBA, BSN, RN Executive Director Department of Health Care Policy and Financing
Date: ______________________	Date: ______________________
______________________ Printed Name of Authorized Officer	**LEGAL REVIEW:** John W. Suthers, Attorney General
	By: ______________________
______________________ Printed Title of Authorized Officer	Date: ______________________

ALL CONTRACTS REQUIRE APPROVAL BY THE STATE CONTROLLER

CRS §24-30-202 requires the State Controller to approve all State Contracts. This Contract is not valid until signed and dated below by the State Controller or delegate. Contractor is not authorized to begin performance until such time. If Contractor begins performing prior thereto, the State of Colorado is not obligated to pay Contractor for such performance or for any goods and/or services provided hereunder.

STATE CONTROLLER:

Robert Jaros, CPA, MBA, JD

By: ______________________
Department of Health Care Policy and Financing

Date: ______________________

EXHIBIT C-1, MONTHLY PAYMENT RATES

State of Colorado

Rocky Mountain 1281 Actuarial Certification

September 1, 2014 – June 30, 2015 Capitation Rate Ranges

Optumas
Risk • Strategy • Reform

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1. Background

This report provides documentation and actuarial certification for the Rocky Mountain Health Plan (RMHP) 1281 Program capitation rate range development for rates effective September 1, 2014 – June 30, 2015 (SFY15).

The 1281 Program is a pilot program beginning in SFY15. The pilot covers most adult populations within Regional Care Collaborative Organization (RCCO) Region 1 counties: Mesa, Montrose, Garfield, Delta, Gunnison, Pitkin and Rio Blanco. RCCO Region 1 is one of 7 RCCO regions that are part of the Medicaid Accountable Care Collaborative (ACC) in the state of Colorado.

The Medicaid ACC, initiated in the spring of 2011, is a Medicaid program designed to improve the quality and cost effectiveness of health care in Colorado through the use of coordinated, client-centered systems. These ACC members receive the full Medicaid benefit package, and are assigned to a specific regulated region, called a RCCO. Rocky Mountain is RCCO 1 of the 7 medically-managed organizations within the state.

A capitation payment rate range has been developed for the target populations within the RCCO 1 area. The aged, disabled, prenatal and adults with dependent children currently in the RMHP Prepaid Inpatient Health Plans (PIHP) are eligible for the 1281 program. The target population eligible members also include expansion adults who qualify on the basis of income, disability and full-benefit Medicaid-Medicare categories. The 1281 Initiative proposal, included in Appendix I, provides more background on the target populations and services covered under the pilot.

Rocky Mountain has proposed a 1281 payment reform pilot in response to the Colorado Department of HCPF request to the RCCO to create and implement a pilot program that establishes new payment methodologies in the Medicaid ACC Program. The proposed pilot includes reform initiatives that describe interventions designed to improve health outcomes, quality of care, as well as reduce cost for Medicaid patients. The model covers the full scope of covered physical health services and combines data from HCPF, the Statewide Data Analytics Contractor (SDAC) and RMHP for clients in the following adult eligibility groups: OAP-A, OAP-B, AND/SSI, AFDC, Expansion parents (100-133% FPL), BC Women, AwDC, and Adult Buy-in. The idea behind this approach is to achieve sustainability and create continuity of care as members move from one insurance type to another.

As a result of the initial proposal, HCPF requested that **Optumas** set a capitated rate for the proposed 1281 Program under Managed Care using a full-risk capitated Payment model that includes risk corridor arrangements surrounding the Adults without Dependent Children (AwDC) expansion population. The initiative would be implemented beginning September 1, 2014. The program enrollment projections for SFY14 are anticipated to exceed 10,000 members.

As the consulting actuaries to The Colorado Department of Health Care Policy and Financing (HCPF), **Optumas** ensured that the methodology used to develop the SFY15 1281 program rate

ranges complied with the Centers for Medicare & Medicaid Services (CMS) guidance, 42 CFR 438.6(c). In addition, the final capitation rates were developed using all of the applicable Actuarial Standards of Practice (ASOPs).

2. Rate Development Process

a. 2.01 Overview

In developing the September 1, 2014 – June 30, 2015 rate range, **Optumas** developed a methodology that adheres to guidance provided by CMS in accordance with 42 CFR 438.6(c), the CMS standards for developing actuarially sound capitation rates for Medicaid managed care programs. CMS defines actuarially sound rates as meeting the following criteria:

1. They have been developed in accordance with generally accepted actuarial principles and practices,
2. They are appropriate for the populations to be covered and the services to be furnished under the contract, and
3. They have been certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

In addition, **Optumas** ensured that all applicable Actuarial Standards of Practice were followed:

- ASOP 5 – Incurred Health and Disability Claim
- ASOP 23 – Data Quality
- ASOP 41 – Actuarial Communications
- ASOP 45 – The Use of Health Status Based Risk Adjustment Methodologies

Optumas applied this criteria in the development of the methodology for calculating capitation rate ranges for the September 1, 2014 – June 30, 2015 contract period. Appendix II(A) provides a brief summary of the CMS rate setting checklist with compliance to each section noted.

There were three sets of base data used to develop the September 1, 2014 – June 30, 2015 1281 Program rate ranges:

1. Rocky Mountain Administrative Services Organization (ASO) claims from FY11, FY12, and FY13 (July 1, 2010 through June 30, 2013), paid through January 31, 2014,
2. Rocky Mountain RCCO claims from FY11, FY12, and FY13 (July 1, 2010 through June 30, 2013), paid through January 31, 2014,
3. Fee For Service (FFS) claims from FY11, FY12, and FY13 (July 1, 2010 through June 30, 2013), paid through January 31, 2014. Eligibility from the same time periods were also used to calculate member months.

The adjusted base data was developed using a blend of these three base data extracts, the State and **Optumas** worked in partnership to determine all adjustments needed to ensure that the adjusted base data was an appropriate proxy for the expected experience in the contract period.

In order to translate the adjusted base data into capitation rates for the contract period, there were a series of adjustments applied, these are presented below in Figure 1.

Figure 1. Rate Development Process Adjustments

Adjustment	Overview
Base Data	Explanation of historical data used as the starting point for rate range development.
Base Data Adjustments	Adjustments to the base data including retrospective program changes.
Program Change Adjustments	Prospective program (population and benefit) changes not reflected in the adjusted base data.
Prospective Medical Trends	Accounts for the forecasted change in utilization and unit costs from the base to the contract period.
Managed Care Assumptions	Accounts for the change in delivery system from FFS to a managed care environment.
Expansion Population Development	Development of anticipated medical expenses for newly eligible expansion populations.
Non-Medical Loading	Administrative load to account for non-medical expenditures incurred by a MCO as well as a profit margin.
Rate Range Development	Assumptions used to develop actuarially sound rate ranges.

The remainder of this report provides further detail on each of the adjustment categories above.

b. 2.02 Base Data

Data Reporting

The base data used for the 1281 Program rate range development is comprised of two years of data with incurred dates July 1, 2011 to June 30, 2013, paid through January 31, 2014. There were three different data extracts, representing the following populations:

- Rocky Mountain Administrative Services Organization (ASO) enrolled members
- Rocky Mountain Regional Care Collaborative Organization (RCCO) ACC enrolled members
- All other Medicaid Fee-for-Service (FFS) members

The data was limited to 1281 program specific criteria which includes eligible members residing in counties Delta, Garfield, Gunnison, Mesa, Montrose, Pitkin or Rio Blanco. The aged, disabled, prenatal and adults with dependent children currently in the RMHP Prepaid Inpatient Health Plans (PIHP) are eligible for the 1281 program.

Each of the four data extracts contained:

1. Inpatient claims
2. Outpatient claims
3. Professional claims
4. Pharmacy claims

In addition, enrollment data was provided by the Department of Health Care Policy and Financing (HCPF) that corresponded to the four data extracts.

To ensure compliance with ASOP 23 – Data Quality, **Optumas** conducted data validation analyses and benchmarked the data to previous base data used for rate setting purposes in other Colorado Medicaid programs for reasonableness.

The data validation analyses included:

1. Referential Integrity Checks – ensured that all claims included in base data were incurred by a member with a valid eligibility span that coincided with the incurred date associated with the specific claim.
2. Volume Checks – **Optumas** checked both volume of claims and total expenditures by category of service by looking at totals longitudinal. This ensured that any gaps or spikes in the data were identified and addressed before creating the base data.

3. Benchmarked Summarization – **Optumas** compared summarized data to other base data summaries used in other programs within Colorado, such as FFS data from the Denver Health Metro Area used in the HMO rate development.

Covered Services

The Rocky Mountain 1281 pilot program covers a range of medically necessary acute care services to the eligible members. The covered medical services is shown in Appendix II(B).

Covered Populations

The base data reflects ASO, RMHP, and FFS claims for 1281 Program target populations in Colorado which includes members residing in Delta, Garfield, Gunnison, Mesa, Montrose, Pitkin or Rio Blanco counties who are aged, disabled, prenatal or adults with dependent children that are currently in the RMHP Prepaid Inpatient Health Plans (PIHP). The data was divided into thirteen rate cells. The purpose of the rate cells is to group similar risk together in order to create credible and homogenous cohorts that assist in better matching payment to risk with regards to developing capitation rates. Actuarially sound rate ranges are developed for each of these rate cells. The thirteen rate cells are shown in Appendix II(C).

c. 2.03 Base Data Adjustments

Once the base data, service categories and rating cohorts were developed, as discussed above, various adjustments were made in order to determine the adjusted base data that would be used for prospective rate development.

Source Development

Base data development, as well as the prospective rate range development, is created separately for four sources of data, ASO, RCCO, FFS and FFS Risk Adjusted. The ASO, RCCO, and FFS sources represent all experience from members who are in each respective program. The FFS Risk Adjusted source uses the FFS experience and applies a risk adjustment factor in order to project the FFS member experience on an ASO and RCCO acuity level. The risk adjustment factors used were developed using the Medicaid Rx risk assessment tool which uses National Drug Codes (NDCs) to assign members a risk score. The resulting factors used are shown in Appendix II(D) which represent the acuity difference from the FFS population to the ASO/RCCO populations.

Service Exclusions

In order to ensure that the rate ranges do not include any services that RMHP will not be responsible for under the capitation payment, **Optumas** has removed services stated as exclusions in the 1281 pilot contract. For the ASO members, **Optumas**, in working with HCPF and RMHP, determined that the current RMHP program inclusions are the same as those they will be responsible for in the 1281 pilot program. Because of this, any service not received as an ASO encounter has been removed from the ASO base data source as an excluded service. For the RCCO and FFS sources, **Optumas** worked with HCPF to identify service exclusions within the 1281 contract and has removed those services from the base data. The impacts of the service exclusions are shown in Appendix II(E).

Underreporting Adjustment

It was determined that the ASO data was underreported for the SFY12 and SFY13 time periods. Rocky Mountain provided supplemental data that was used to determine the distribution across service category for these dollars. A significant portion of the ASO underreported dollars was contained within the facility setting. The impacts of the underreporting are shown in Appendix II(F).

Pharmacy Reimbursement Adjustment

The MMIS data used for the ASO source was priced at Medicaid fee schedule levels. For the Pharmacy service category, it was agreed upon that RMHP would be reimbursed at Rocky Mountain reimbursement levels such that payment levels to RMHP would most appropriately align with payment levels made to providers. Utilizing data from RMHP that was priced at their reimbursement level, **Optumas** developed a downward adjustment to the Pharmacy service category to reflect the difference between Medicaid pricing and RMHP pricing. This adjustment resulted in an adjustment to the ASO source of -15.3% in SFY12 (-4.8% overall) and -15.3% in SFY13 (-4.0% overall).

COFRS Adjustment

In addition to the above adjustments, third party liability recoveries, unspecified adjustments and Colorado Financial Reporting System (COFRS) payments that are not attributed to individuals on a claim level have been applied as an adjustment to the SFY12 and SFY13 RCCO and FFS base data sources.

Unspecified Adjustments represent financial transaction dollars processed through the MMIS and placed into the appropriate service category. The financial transactions that are provider specific, but not client specific, are included as an "unspecified adjustment". Those financial

transactions impact the dollar amount of the RCCO and FFS claims at an aggregated level. The examples are included, but not limited to, all audits that resulted in the cost settlements by providers; any law suit settlement for a provider.

COFRS payments are any cost/claim settlements handled outside of the MMIS, for example lawsuit settlements. Since these are related to settlements for Medicaid members, they decrease the overall cost of the Medicaid program. An adjustment has been developed and applied to the fully incurred medical expenses, by category of service, to account for the RCCO and FFS portion of total COFRS claims.

As this is downward adjustments to the cost per member, we have accordingly adjusted the RCCO and FFS base data to reflect the lower cost. The impacts of the COFRS and unspecified adjustment are shown in Appendix II(G).

IBNR Adjustment

Estimates for the incurred but not yet reported (IBNR) expenditures were developed for each source of the data provided. As previously mentioned, the base data used to develop the 1281 rate ranges were SFY12 and SFY13 data paid through January 31, 2014. Because there was upwards of 7 months of run-out on the data, no IBNR adjustment was applied to the SFY12 time period and a minimal adjustment was applied to the SFY13 time period. The SFY13 IBNR factors are shown in Appendix II(H).

Retrospective Program Changes & Trend

In order to make both years on a SFY13 basis, programmatic changes and trend were applied to the SFY12 base data.

Retrospective program change adjustments recognize the impact of eligibility or benefit changes occurring during the base period. The following list summarizes all applicable retrospective program changes:

- A Pharmacy reduction of -0.7% resulting from the State maximum Allowable Cost expansion was applied in SFY13 was applied to SFY12. Note, this adjustment was not applied to the ASO source data as a separate Pharmacy adjustment was applied for the ASO source to reflect RMHP reimbursement.
- A home health increase of 4.5% resulting from provider rate increases in FY13 was applied to SFY12. Once again, this adjustment was not applied to the ASO source data as a separate the underreporting adjustment referenced above is considered to account for this impact.

Utilization and Unit Cost trends were applied to the SFY12 data to bring it to a SFY13 basis. The trends used were applied by service category and were based on historical data as well as

Optumas' experience in other States. An overall impact of approximately 4.5% was applied to each source. Specific historical trend factors are shown in Appendix II(I).

Data Year Blends

After applying the adjustments listed above, both years of base data were considered to be on a SFY13 basis. The two years were then blended together to form the final SFY13 adjusted base data for each of the four data sources. The weights given to each year are shown in Appendix II(J).

Data Source Blends

In conjunction with the year blend, the adjusted base data was developed using a blend of the ASO, RCCO, and FFS data extracts, along with the FFS Risk Adjusted experience. This source blend was developed as a proxy for the expected experience in the contract period. FFS Risk Adjusted experience was used for rate cells that had lower credibility due to membership levels in ASO. The weights given to each source of data by category of aid are shown in Appendix II(K).

d. 2.04 Prospective Program Changes Adjustments

Prospective program change adjustments recognize the impact of eligibility or benefit changes occurring after the base period. The following list summarizes all applicable prospective program changes:

- The following categories of service have been affected by a 2.0% proposed budget increase as of July 2013: DME, Emergency Room, Emergency Transportation, EPSDT, FQHC & Rural Health, Inpatient Hospital, Lab and X-Ray, Outpatient Hospital, and Physician Services. Additionally, Home Health will be affected by an 8.2% proposed budget increase as of July 2013. These increases resulted in an upward adjustment to the blended SFY13 base data.
- Beginning in February of 2013, Colorado moved to the Average Acquisition Cost (AAC) method for pharmacy reimbursement. An additional downward adjustment was made to reflect projected savings through the SFY15 contract period. This program change was applied to RCCO and FFS data sources only. The ASO data is adjusted to be priced at Rocky Mountain reimbursement levels and, therefore, this program change is not applicable.
- The Department has proposed an increase in reimbursement rates for high-value specialist services, which include specific Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes that are currently reimbursed as a percent of Medicare rates. Effective July 1, 2014,

Medicaid reimbursement rates for these specific services will be increased to 80% of Medicare. The initiative demonstrates the State's priority to pay for services that provide high value for patients, and results in an upward adjustment. A list of codes that apply to this policy change and a description of the reimbursement impacts are shown in Appendix II(L).

- Separate from the targeted high-value specialist services discussed above, the Department proposed an increase to general funding, as of July 2014, to ensure that reimbursements are sufficient in order to maintain provider participation and client access to health care. The request will result in an upward adjustments of 2.0% to the following categories of service: DME, Emergency Room, Emergency Transportation, FQHC & Rural Health, Inpatient Hospital, Lab and X-Ray, Outpatient Hospital, Dialysis, Physician, Specialist and Home Health Services.

The impacts of program changes by time period and service category are shown in Appendix II(M).

e. 2.05 Prospective Medical Trends

Trend factors were applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix of services) of services over time. These trend factors were used to project the costs from the base period to the future contract period. Trends were developed on an annualized basis and applied by major service category from the midpoint of the SFY13 base period to the midpoint of the SFY15 contract period. Prospective trends are listed in Appendix II(N).

f. 2.06 Managed Care Assumptions

The managed care assumptions assume efficiencies in utilization and cost due to changing from a FFS delivery model to managed care, with specific assumptions for each category of service and rating cohort. **Optumas** leveraged experience in other Medicaid programs in addition to an independent consulting physician with 30+ years of experience in Medicaid Managed Care to assist in determining initial and final assumptions. The assumptions imply the improvement of patient care and achievement of overall cost savings resulting from the implementation of the 1281 Program.

The managed care assumptions are not always a downward adjustment. Utilization reductions in some services may result in an increase in utilization for other services. For example, under managed care, more PCP visits will occur which will result in less unnecessary specialist visits and likely more prescriptions. However, the additional prescriptions will be offset through better overall pharmaceutical management.

The lower managed care savings assumption reflects the assumption that this population will have utilization patterns in the first year consistent with an underserved population. Typically,

underserved populations have increases in utilization in certain services due to increased access balanced by decreases in utilization due to better care coordination. Thus, our managed care assumptions reflect a "net" adjustment – we assume both increases and decreases in utilization due to increased access and increased care management. This net adjustment approach has been borne out by experience in expansion programs in Maine, Massachusetts, Connecticut, Ohio, Kansas, New Mexico, and California over the last 5 years. While we expect the MCO to have an impact on the utilization and reflected this is our net adjustment, in our experience, the bulk of this impact will materialize in the second year of program.

The final managed care assumptions that were used and applied to the Medicaid data are listed in Appendix II(O).

g. 2.07 Expansion Populations

With the implementation of the Affordable Care Act (ACA), beginning January 1, 2014 new populations will be eligible for Medicaid and the RMHP 1281 program. Prior to the Affordable Care Act Expansion, the AFDC Male and Female cohorts offered coverage to individuals within 61%-100% FPL range. The Expansion now offers coverage to 61%-133% FPL, and calls these newly eligibles the Expansion Parents. Additionally, some childless adults up to 10% FPL are covered by Medicaid. Separate rate cells and capitation rates were determined for these populations in addition to the rating cohorts referenced above.

Expansion Parents Medical Expense Development

The expansion parent population is broken out into the following categories of aid:

- Expansion Parent M (61%-133% FPL)
- Expansion Parent F (61%-133% FPL)

For the expansion parents both currently enrolled and newly eligible for Medicaid, ASO, RCCO and FFS risk adjusted data spanning from SFY12 to SFY13 was used to develop the base data. After accounting for base data adjustments, programmatic changes, trend and managed care assumptions, the AFDC/CWP Adults 19+ M rating cohort was used as a starting point for the Expansion Parent M rate development and the AFDC/CWP Adults 19+ F rating cohort was used as a starting point for the Expansion Parent F rate development.

The expansion parent populations 61%-133% FPL are a newly eligible group as of January 1, 2014. Because of this, there is an anticipated pent-up demand impact on this population who are expected to have additional utilization due to the previous lack of healthcare coverage. As the starting basis for the pent-up demand adjustment, **Optumas** used experience from the New Mexico State Coverage Insurance (SCI) population, which is a Medicaid waiver funded program that offers low cost health insurance through employer-based benefits. The analysis was a longitudinal study in which member costs were analyzed for the first 6-12 months of enrollment

compared to how the costs looked after the first year. The study then compared the costs by major category of service across those time periods. Two downward adjustments to these factors are then applied. First is a 0.75 factor to account for 'fading away' impacts of pent-up demand since the transitioning members will have already been eligible for Medicaid for half of a year prior to the FY15 RMHP 1281 program contact period. Second is a 0.50 factor to account for the portion of the population who are already covered by Medicaid within the AFDC male and female cohorts (adults 61%-100%). The final pent-up demand factors for the expansion parent populations are listed in Appendix II(P).

These new members are additionally expected to have a lower risk due to the higher income levels than those used for the starting basis for rate development. Multiple approaches were used to develop this acuity adjustment. As mentioned above, a portion of the expansion parent members are already covered by Medicaid within the AFDC male and female cohorts from 61%-100% FPL. Comparisons of PMPM expenditures using historical data for the AFDC male and female cohorts for FPLs 0%-60% were compared to those with FPLs 61%-100% FPL. Additionally, these two populations acuity were compared utilizing the Medicaid Rx risk score tool. For the Expansion Parent female cohort, both methods produced significantly similar results that suggest the higher FPL population acuity is between less than that of the lower FPL population acuity. For the Expansion Parent male cohort, results suggested similar acuity between the two populations. The final acuity factor used for the Expansion Parents female population was 91.6% and the final acuity factor used for the Expansion Parent male population was 100.0%.

New expansion populations will receive certain additional ABP rehabilitative services. As HCPF currently covers rehabilitative services, **Optumas** developed additional utilization assumptions that would result from the added Habilitative service coverage. The resulting impact is a 0.1%-0.2% increase to the expansion parent populations medical spend.

Expansion Childless Adults Medical Expense Development

The childless expansion population is currently covered in Medicaid FFS up to 10% FPL, and is now transitioning to cover members up to 133% FPL. Medical data was available for the 0-10% FPL AwDC cohort. While available CRG weights were compared for reasonableness, **Optumas** ultimately used data available for currently covered AFDC and disabled adults, in conjunction with self-reported Current Population Survey (CPS) data from the Bureau of Labor Statistics.

The CPS data has the following three classifications: Severe Work Disability, Non-Severe Work Disability, and No Work Disability. We assume that the first two classifications are more representative of a Disabled population while the third classification is more representative of a Non-Disabled population. In addition to the data observed from CPS, **Optumas** assumed take-up factors, to account for the level of risk that will enroll due to current health care needs. The combination of original CPS blend along with the take-up factors and emerging population data

specific to Colorado resulted in a blend of 46% non-disabled female, 40% non-disabled male and 14% disabled.

This yields a 14% disabled rate with roughly a 2.8 relativity for the lower bound Medical PMPM (disabled PMPM of $1,059.26 and blended AFDC PMPM of $372.38). The resulting acuity adjustment is $441.99/$372.38 or 19%.

In addition to the adjusted acuity of the AwDC population, there is an anticipated pent-up demand impact on this population who are expected to have additional utilization due to the current lack of healthcare coverage. As the starting basis for the pent-up demand adjustment, **Optumas** used experience from the New Mexico SCI population. The analysis was a longitudinal study in which member costs were analyzed for the first 6-12 months of enrollment compared to how the costs looked after the first year. The study then compared the costs by major category of service across those time periods. Two downward adjustments to these factors are then applied. First, a 0.75 factor is applied to account for 'fading away' impacts of pent-up demand since the transitioning members will have already been eligible for Medicaid for half of a year prior to the FY15 RMHP 1281 program contact period. Second, a 0.93 factor is applied to account for the portion of the population who are already covered by Medicaid within the AwDC cohort (Adults 0%-10%). The final pent-up demand factors for the AwDC population are listed in Appendix II(P).

Since the expansion adult rates have been developed using data that is already adjusted for a managed care environment, no new assumptions are required.

h. 2.08 Expansion Services

In addition to the newly eligible adults, beginning January 1, 2014 Colorado has implemented the Alternative Benefit Plan for its Medicaid members. While most of the additional benefits are covered FFS and out of the scope of the 1281 pilot, the following additional benefits will be new for 1281 members:

- Expanded Preventive services – This applies to all rating cohorts, including Expansion Parent Female, Expansion Parent Male and AwDC rating cohorts.
- Habilitative services – This applies only to the Expansion Parent Female, Expansion Parent Male and AwDC rating cohorts, as described above.

In order to develop a rate range for the expanded Preventive services, **Optumas** reviewed the new services being offered with its internal clinician, to develop research and clinical based utilization estimates. As HCPF currently covers rehabilitative services, **Optumas** developed additional utilization assumptions that would result due to the added Habilitative service coverage. The resulting additive PMPM rate ranges for the Preventive and Habilitative services are listed in Appendix II(Q) and II(R) respectively.

i. 2.09 AwDC Risk Corridor

As a result of the unknown risk level associated with the emerging AwDC population, the State has developed a risk corridor as a risk-mitigation strategy. To the extent that the selected rate is overstated or understated by certain barrier points, dollars would be paid to the MCO from the State or paid back to the State from the MCO respectively. The details of the risk corridor are included in Appendix II(S).

j. 2.10 Inclusion of Non-Medical Loading

Administrative and Profit Loading

The non-medical load measures the dollars associated with components such as administration, profit, risk, and contingencies and are expressed as a percentage of the capitation rate. **Optumas** utilized their experience with non-medical expenses in other states, on both a PMPM and percentage basis. The resulting administrative and profit ranges are listed in Appendix II(T).

Affordable Care Act Health Tax

Based on recent calls hosted by CMS, the Health Insurer Fee should not be applied to any populations that were not covered under managed care in the previous year on which the tax is based (such as expansion populations for CY14). The population that is covered by the 1281 demonstration was not covered under managed care in SFY13. Therefore**, Optumas** did not include the Health Insurer Fee for the 1281 program in SFY15. **Optumas** is working with HCPF and CMS to develop a methodology that will address the Health Insurer Fee that will be assessed in SFY16 based on SFY15 revenues.

k. 2.11 Development of Rate Ranges

In developing the capitation rates by rate cell, **Optumas** relied on multiple actuarial assumptions. These assumptions were estimates of the impacts of various components of the rate development methodology. Multiple sources of program-specific information, industry information and in-house proprietary actuarial tools were relied upon to ensure that these assumptions were well-informed, unbiased, and as accurate as possible. Per the CMS rate checklist, **Optumas**' approach to developing actuarially sound rate ranges required a review of all of the assumptions and adjustments used in the rate development process in order to determine PMPM costs at specific points in the rate ranges, including the lower and upper bounds.

The upper and lower bounds of the rate range are intended to represent amounts at which an appropriately managed MCO would be able to meet the access to care and quality of care standards as described in their contract. **Optumas** examined variations in each component of the rate development process to determine these specific points in the range. These variations, examined in isolation as well as in combination, resulted in a series of capitation rates that, when combined, defined the rate ranges.

To develop the rate ranges, we varied the trend (+/-.5%), managed care savings (+/-1.0%) and administration (+/-1.0%). In addition, to account for the variance inherent in the base data we developed a claims fluctuation component of the rate range using the 90th confidence interval. The variations were developed using the ASO and RCCO base data.

Each assumption was not developed in isolation, but instead were developed to reflect the interaction between actuarial assumptions. For example, if we assumed a lower trend and managed care savings on the lower bound, then we coupled that assumption with a higher administrative assumption knowing that more medical management efforts would be needed to achieve the lower trend and managed care savings.

The payment rates and rate ranges are shown in Appendix III.

3. Actuarial Certification

I, Zachary Aters, Senior Actuary at **Optumas** and Member of the American Academy of Actuaries (MAAA), am certifying the calculation of the rate ranges shown in Appendix III. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time to time by the Actuarial Standards Board.

The capitation rates provided with this certification are considered actuarially sound for purposes of the 42 CFR 438.6(c), according to the following criteria:

- The capitation rate ranges have been developed in accordance with generally accepted actuarial principles and practices;
- The capitation rate ranges are appropriate for the populations to be covered, and the services to be furnished under the contract; and
- The capitation rate ranges meet the requirements of 42 CFR 438.6(c).

Appendix II(A) contains a crosswalk between the CMS rate setting checklist and this certification letter.

The actuarially sound rate ranges that are associated with this certification are effective September 1, 2014 through June 30, 2015 for Colorado's 1281 Pilot Program.

The actuarially sound capitation rate ranges are based on a projection of future events. Actual experience will vary from the experience assumed in any rate picked within the rate ranges. The capitation rates offered may not be appropriate for any specific MCO. An individual MCO should review the rates in relation to the benefits that it is obligated to provide to the covered population. The MCO should evaluate the rates in the context of its own experience, expenses, capital, surplus, and profit requirements prior to agreeing to contract with the State. The MCO may require rates above, within, or below the actuarially sound rate range associated with this certification.

Should you have questions on any of the above, please feel free to contact me at 480.588.2495 for any additional information.

Sincerely,

(Signed version provided in PDF form, dated 7/1/2014)
Zachary Aters, ASA, MAAA
Senior Actuary

4. Appendices

1. Appendix I. Rocky Mountain 1281 Initial Proposal Language

Executive Summary

On behalf of our community partners in western Colorado, and throughout the Accountable Care Collaborative, Rocky Mountain Health Plans (RMHP) is pleased to submit the enclosed proposal for a payment reform pilot, pursuant to HB 12-1281 (C.R.S. § 25-5.5-415). We have created a Global Budget, Global Payment, reporting and gainsharing model that 1) encompasses the full scope of covered *physical health, behavioral health and substance use disorder services*; and, 2) aggregates data shared by the Department, the SDAC, the BHO and Rocky Mountain Health Plans – across the entire population below 250 percent of the Federal Poverty Level – without regard to coverage type. This structure will enable the Sponsors to achieve sustainability and create continuity of care as clients transition between Medicaid and private, subsidized coverage (a.k.a. "churn"). The Pilot will operate in seven RCCO 1 counties: **Mesa, Montrose, Delta, Gunnison, Pitkin, Garfield** and **Rio Blanco.**

Budget Neutrality and Savings

Our proposal is unequivocally **budget neutral** and will create **savings** for the Department in both **Year 1** and **Year 2** of the proposed Pilot. Beyond minimum savings attributable to the administrative simplification proposed by RMHP, there is significant additional savings potential for the Department associated with the Sponsors' interventions, logic model, Global Payment and gainsharing model.

The Sponsors' ability to produce budget neutrality and savings for the Department (as well as sustainability for themselves) is grounded upon: 1) An approach to patient activation, behavior change and self-management that reflects a large body of experience and evidence; 2) A logical re-alignment of enrollment, contracts, and payments, as follows:

	Pilot Year 1 (2014)	Pilot Year 2 (2015)	Combined Savings
Minimum Department Savings	$1,714,546	$3,135,668	$4,850,214
Potential Additional Department Savings for Target Population (Gainsharing)	$ 361,302	$ 590,714	$ 952,013
Potential Additional Department Savings in PCCM ("RCCO 1.0")	$2,140,782	$1,694,779	$3,835,561
Total Potential Department Savings	$4,216,630	$5,421,161	$9,637,791

Executive Committee

Principal RCCO partners in this effort include two community mental health centers - Colorado West Regional Mental Health Center and Midwestern Colorado Mental Health Center, both of which have been collaborating actively within the Region 1 RCCO since its inception, with support from Colorado Health Partnerships, the BHO. These partners have formed an **Executive Committee** to provide leadership and oversight for the project, which will also include the following members: a consumer, a Federally-Qualified Health Center (FQHC), a privately-practicing PCMP, a local public health department (LPHA), a hospital and a behavioral health

Executive Summary
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integration expert with the University of Colorado Department of Family Medicine (hereinafter referred to as "The Sponsors").

Enrollment and Payment

Target Population – The Target Population includes expansion adults who qualify on the basis of income, disability and full-benefit Medicaid-Medicare categories ("RCCO 2.0"). The Target Population accounts for 16% of the total enrollment in RMHP's existing PIHP agreement.

Broader Population – All other categories will be transitioned into the existing RCCO PCCM structure ("RCCO 1.0"). These categories currently account for 84% of the total population currently enrolled in RMHP's PIHP agreement. The Sponsors' planned interventions will encompass both the Target and the broader population, even though Global Payments will be made only for the Target Population. Consolidation of the PIHP population within the RCCO also assures compliance with the UPL requirement.

Global Payment, Gainsharing and Value - The RCCO will receive full-risk Global Payments from the Department for the Target Population. The Department will spend no more than 100% of FFS for Covered Services, and make lower administrative payments than it does under current contracts. BHO payment and contractual arrangements with the Department will remain unchanged. If actual costs for Covered Services in the Global Budget are lower than payments, 30% of the difference will be returned to the Department. The Sponsors will retain remaining gains - if and only if specific quality metrics are achieved. If costs are reduced but minimum quality targets are not achieved, 100% of the difference between projected and actual costs for Covered Services will be returned to the Department.

Primary Care - PCMPs will receive significantly enhanced PMPM payments, on a risk-adjusted basis, at a baseline equivalent to 125% of Medicaid FFS payments. Payments will be higher for patients with more complex needs to ensure that "cherry picking" does not occur. An additional 5% will be paid, contingent upon meeting quality targets (independently of cost). Further, 30% of any gains between Global Payments to the RCCO and actual costs for Covered Services will be paid to PCMPs. A 5% cost-accountability recoupment will be applied by the RCCO if actual costs exceed targets in the Global Budget for attributed patients. Enhancements above 100% of FFS will be made by RMHP, not financed by the Department through Global Payment.

Community Mental Health - CMHCs will receive direct payments via the RCCO for workforce development, as well as payments from PCMPs (financed by the RCCO, but controlled by the PCMPs) for integrated behavioral health services. Additionally, CMHCs will receive 30% of any gains, as outline above, and will carry risk for failure to achieve performance targets that is proportionate to their total share of the Global Budget.

Specialty Care - In order to ensure appropriate access and coordination, RMHP will make enhanced payments to specialists (equivalent to Medicaid + 30%) through a mix of fee and non-encounter payments for communication and co-management with PCMPs.

Description of Organization

Rocky Mountain Health Plans (RMHP) is honored to serve as the contracting Regional Care Collaborative Organization for Region 1 of the Accountable Care Collaborative (ACC). We fully support the Department's efforts to undertake an innovative approach to Medicaid reform. More importantly, we understand that sustainable reform is possible only through the creation of a collaborative structure, which promotes local leadership and data-driven accountability. RMHP supports the ACC because we know from experience that flexible partnerships among multiple public and private organizations operating with direct accountability to each other, as well as the communities they serve, is necessary to achieve the Triple Aim: better care and better health at lower costs.

Over the past three years, RMHP and several committed leaders have worked to promote a shared vision of *Community Integration*, in which we collectively invest in the development of new skills, tools and operating arrangements that are fundamental to the creation of value for both large purchasers and individual consumers alike. Our core principle in this work is simple: *walk the talk*. By investing in each other, holding ourselves to high standards, learning from our experiences and from others who share our vision, we have been able to create a tremendously valuable community infrastructure, which is essential to the successful execution of the enclosed proposal. This proposal includes:

- **Broad-based practice transformation, collaborative learning and measurement:** RMHP and its partners have been honored to receive national recognition for our role as a Beacon Community sponsor operating under a Cooperative Agreement with U.S. HHS/ONC. Further, in addition to being deemed an *Aligned Payer* within the Comprehensive Primary Care initiative, we are contracted to serve as a technical assistance provider on behalf of the CMS Innovation Center for western Colorado primary care practices – most of which are now also contracted as PCMPs within the ACC.

- **Advanced technology, data aggregation and use at the point of care:** RMHP and local physician groups, hospitals and community agencies have invested in and continue to expand data sharing relationships with Quality Health Network. QHN's infrastructure is producing very powerful results for PCMPs and the RCCO alike, as recently recognized by *Healthcare Informatics* with a 2013 Innovators Award for our work to make advanced patient engagement and risk stratification tools available to Medicaid PCMPs – at the point of care in regular clinical workflows.

- **Payment for behavioral health integration:** RMHP is investing heavily in behavioral health integration, and actively working to promote seamless care for both the body and mind. We recognize that evidence-based supports for ***behavior change, patient activation and self-management*** must be available to all individuals – not just people -as well as those with mental health diagnoses. As such, we are participating in the SHAPE (Sustaining Health Care across Integrated Primary Care Efforts) payment reform evaluation, in partnership with the Colorado Health Foundation, the Collaborative Family Health Care Association, and the University of Colorado Department of Family Medicine.

None of these efforts, however, will be sustainable without robust payment reform. To that end, we have created a diverse, but focused, **Executive Committee** to oversee implementation of our proposed pilot (as described in detail within the enclosed executive summary, and Attachment I – Business Structure). The Committee will provide monthly monitoring of the proposed Global Budget, and quarterly reports to the Department, with the expectation that our progress will be monitored closely and shared publicly with other stakeholders to accelerate learning throughout the Colorado ACC.

m. Appendix II. Rate Development Components

Appendix II(A) CMS Checklist

CMS Item#	Subject	Compliance	FY15 Colorado 1281 Program Rate Comments
AA.1.0	Overview of rate-setting methodology	✓	See Section 2.01.
AA.1.1	Actuarial Certification	✓	See Section 3.
AA.1.2	Projection of expenditures	✓	N/A
AA.1.3	Procurement, prior approval, and rate-setting	✓	State set rates are developed.
AA.1.4	N/A	✓	There is no item AA.1.4 in the CMS Checklist.
AA.1.5	Risk contracts	✓	N/A
AA.1.6	Limit on payment to other providers	✓	N/A
AA.1.7	Rate modifications	✓	The rates certified in this report have an assumed effective date of September 1, 2014 to June 30, 2015. If the effective date changes, these rates are subject to change.
AA.2.0	Base year utilization and cost data	✓	See Section 2.02.
AA.2.1	Medicaid eligibles under the contract	✓	Only program eligibles and cost data have been included in the rate base.
AA.2.2	Dual eligibles	✓	Dual eligible members are their own rating cell within the rate range development.
AA.2.3	Spend down	✓	Spend down eligibles are not part of the program.
AA.2.4	State Plan services only	✓	Only State Plan Services were included in the base data.
AA.2.5	Services that may be covered by a capitated entity out of contract savings	✓	N/A
AA.3.0	Adjustments to base year data	✓	See Section 2.03.
AA.3.1	Benefit differences	✓	See Section 2.04.
AA.3.2	Administrative cost allowance calculations	✓	See Section 2.10.

CMS Item#	Subject	Compliance	FY15 Colorado 1281 Program Rate Comments
AA.3.3	Special population adjustments	✓	As discussed in section 2.07 of this report, the rates were adjusted to reflect new Expansion populations
AA.3.4	Eligibility adjustments	✓	N/A
AA.3.5	DSH payments	✓	The 1281 Program rates do not include DSH payments.
AA.3.6	Third party liability (TPL)	✓	RMHP is responsible for collection of any TPL recoveries so the data used to create the base rates accordingly do not include these amounts.
AA.3.7	Copayments, coinsurance, and deductibles in capitated rates	✓	Rate ranges are developed net of copayments, coinsurance, and deductibles.
AA.3.8	Graduate medical education (GME)	✓	The 1281 Program rates do not include GME payments.
AA.3.9	FQHC and RHC reimbursement	✓	The capitation rate uses the rate under the alternative payment methodology approach. Reconciliations will be conducted to reflect changes in the FQHC encounter rate applicable during the term of the contract, as well as reported utilization.
AA.3.10	Medical cost trend inflation	✓	See Section 2.05.
AA.3.11	Utilization adjustments	✓	See Section 2.05.
AA.3.12	Utilization and cost assumptions	✓	The population in the base data is comparable to the population that will be covered from September 1, 2014 – June 30, 2015.
AA.3.13	Post-eligibility treatment of income (PETI)	✓	N/A
AA.3.14	Incomplete data adjustment	✓	See Section 2.03.
AA.4.0	Establish rate category groupings	✓	See Section 2.02.
AA.4.1	Age	✓	See Section 2.02.
AA.4.2	Gender	✓	See Section 2.02.
AA.4.3	Locality / Region	✓	See Section 2.02.
AA.4.4	Eligibility categories	✓	See Section 2.02.

CMS Item#	Subject	Compliance	FY15 Colorado 1281 Program Rate Comments
AA.5.0	Data Smoothing	✓	Data smoothing was guided by the reasonableness checks conducted on the data and described on Rate Certification Letter Section 3.
AA.5.1	Special populations and assessment of the data for distortions	✓	Outlier experience was reviewed and population-level distortion was addressed where necessary.
AA.5.2	Cost-neutral data smoothing adjustment	✓	No cost-neutral data smoothing adjustment was deemed necessary.
AA.5.3	Risk Adjustment	✓	FFS data was risk adjusted to approximate ASO/RCCO experience as referenced in Section 2.03.
AA.6.0	Stop loss, reinsurance, or risk sharing arrangements	✓	The Expansion AwDC population will have a risk corridor program as referenced in Section 2.09.
AA.6.1	Commercial reinsurance	✓	N/A
AA.6.2	Simple stop loss program	✓	N/A
AA.6.3	Risk corridor program	✓	The Expansion AwDC population will have a risk corridor program as referenced in Section 2.09.
AA.7.0	Incentive arrangements	✓	N/A

Appendix II(B) Covered Medical Services

Covered Services
Inpatient Hospital
Emergency Room
Home Health
FQHC & Rural Health Clinic
Outpatient Hospital
Laboratory & X-Ray
Physician - ER
Physician - IP
Physician - Office
Specialist
Emergency Transportation
Other
Pharmacy

Appendix II(C) Rate Cells

Population
AFDC/CWP Adults 19+ M
AFDC/CWP Adults 19+ F
BC Women
AND/AB - SSI Non-Dual <45
AND/AB - SSI Non-Dual 45+
OAP A – Non-Dual
OAP B - SSI Non-Dual
BUYIN Working Adult Disabled
DUAL
DUAL - Medicaid Full/Medicare Partial
Expansion Parent Male
Expansion Parent Female
AwDC

Appendix II(D) FFS Risk Adjusted Acuity Factors – ASO/RCCO → FFS

Population	SFY12	SFY13
AFDC/CWP Adults 19+ M	42%	28%
AFDC/CWP Adults 19+ F	32%	25%
BC Women	30%	23%
AND/AB - SSI Non-Dual <45	28%	20%
AND/AB - SSI Non-Dual 45+	40%	23%
OAP A – Non-Dual	35%	20%
OAP B - SSI Non-Dual	39%	29%
BUYIN Working Adult Disabled	N/A	N/A
DUAL	N/A	N/A
DUAL - Medicaid Full/Medicare Partial	N/A	N/A

Appendix II(E) Service Exclusion Impacts

Source	SFY12	SFY13
ASO	-1.7%	-2.6%
RCCO	-1.8%	-3.4%
FFS	-8.7%	-9.7%

Appendix II(F) Underreporting Factors

Covered Services	SFY12 ASO Underreporting Adjustment	SFY13 ASO Underreporting Adjustment
Inpatient Hospital	0.0%	2.9%
Emergency Room	1.6%	30.3%
Home Health	0.3%	6.1%
FQHC & Rural Health Clinic	0.0%	0.0%
Outpatient Hospital	0.8%	23.3%
Laboratory & X-Ray	0.0%	0.1%
Physician – ER	0.0%	0.6%
Physician – IP	0.0%	3.1%
Physician - Office	0.0%	3.0%
Specialist	0.0%	2.8%
Emergency Transportation	0.0%	0.0%
Other	0.5%	18.7%
Pharmacy	0.0%	0.0%
Total	**0.3%**	**8.9%**

Appendix II(G) COFRS Adjustment

Covered Services	SFY12 FFS/RCCO COFRS Adjustment	SFY13 FFS/RCCO COFRS Adjustment
Inpatient Hospital	-0.1%	-0.1%
Emergency Room	0.0%	0.0%
Home Health	-0.6%	0.0%
FQHC & Rural Health Clinic	0.0%	0.0%
Outpatient Hospital	-0.4%	-0.5%
Laboratory & X-Ray	-0.1%	0.0%
Physician - ER	-0.1%	-0.1%
Physician - IP	-0.1%	-0.2%
Physician - Office	0.0%	-0.1%
Specialist	0.0%	0.0%
Emergency Transportation	-0.2%	0.0%
Other	0.0%	0.0%
Pharmacy	0.0%	-0.1%
Total	**-0.1%**	**-0.1%**

Appendix II(H) IBNR Adjustment

COS	IBNR Factor
Inpatient Hospital	0.998
Emergency Room	0.999
Home Health	0.996
FQHC & Rural Health Clinic	1.000
Outpatient Hospital	0.998
Laboratory & X-Ray	1.000
Physician - ER	0.998
Physician - IP	0.996
Physician - Office	0.998
Specialist	0.999
Emergency Transportation	0.994
Other	0.988
Pharmacy	1.000

Appendix II(I) Historical Trend Assumptions

COS	Source Blend Trend
Inpatient Hospital	5.5%
Emergency Room	3.5%
Home Health	2.5%
FQHC & Rural Health Clinic	3.5%
Outpatient Hospital	4.5%
Laboratory & X-Ray	7.5%
Physician - ER	3.5%
Physician - IP	5.5%
Physician - Office	3.5%
Specialist	3.5%
Emergency Transportation	4.5%
Other	3.5%
Pharmacy	4.5%
TOTAL	**4.5%**

Appendix II(J) Base Data Year Blend

Source	SFY12	SFY13
ASO	30.0%	70.0%
RCCO	0.0%	100.0%
FFS	30.0%	70.0%
FFS Risk Adjusted	30.0%	70.0%

Appendix II(K) Base Data Source Blend

Source	ASO	RCCO	FFS	FFS Risk Adjusted
AFDC/CWP Adults 19-44 M	85.0%	10.0%	0.0%	5.0%
AFDC/CWP Adults 45+ M	85.0%	0.0%	0.0%	15.0%
AFDC/CWP Adults 19-44 F	90.0%	10.0%	0.0%	0.0%
AFDC/CWP Adults 45+ F	85.0%	0.0%	0.0%	15.0%
BC Women	100.0%	0.0%	0.0%	0.0%
AND/AB - SSI Non-Dual <45	90.0%	10.0%	0.0%	0.0%
AND/AB - SSI Non-Dual 45+	90.0%	10.0%	0.0%	0.0%
OAP A – Non-Dual	60.0%	0.0%	0.0%	40.0%
OAP B - SSI Non-Dual	60.0%	0.0%	0.0%	40.0%
BUYIN Working Adult Disabled	85.0%	15.0%	0.0%	0.0%
DUAL	100.0%	0.0%	0.0%	0.0%
DUAL - Medicaid Full/Medicare Partial	100.0%	0.0%	0.0%	0.0%

Appendix II(L) High-Valued Specialty Program Change

Code	Code Type	Rate Impact Category	Program Change Description
99050	CPT	Extended Hours	Flat rate increase of $7.00
92002	CPT	Specialty	Currently reimbursed at 23% of Medicare, increase to 80%
92004	CPT	Specialty	Currently reimbursed at 18% of Medicare, increase to 80%
92012	CPT	Specialty	Currently reimbursed at 21% of Medicare, increase to 80%
92014	CPT	Specialty	Currently reimbursed at 21% of Medicare, increase to 80%
92018	CPT	Specialty	Currently reimbursed at 18% of Medicare, increase to 80%
92019	CPT	Specialty	Currently reimbursed at 32% of Medicare, increase to 80%
92020	CPT	Specialty	Currently reimbursed at 52% of Medicare, increase to 80%
92060	CPT	Specialty	Currently reimbursed at 39% of Medicare, increase to 80%
92502	CPT	Specialty	Currently reimbursed at 22% of Medicare, increase to 80%
92506	CPT	Specialty	Currently reimbursed at 14% of Medicare, increase to 80%
92511	CPT	Specialty	Currently reimbursed at 28% of Medicare, increase to 80%
92520	CPT	Specialty	Currently reimbursed at 77% of Medicare, increase to 80%
92545	CPT	Specialty	Currently reimbursed at 17% of Medicare, increase to 80%
92553	CPT	Specialty	Currently reimbursed at 33% of Medicare, increase to 80%
92555	CPT	Specialty	Currently reimbursed at 27% of Medicare, increase to 80%
92556	CPT	Specialty	Currently reimbursed at 34% of Medicare, increase to 80%
92563	CPT	Specialty	Currently reimbursed at 16% of Medicare, increase to 80%
92565	CPT	Specialty	Currently reimbursed at 30% of Medicare, increase to 80%
92567	CPT	Specialty	Currently reimbursed at 57% of Medicare, increase to 80%
92579	CPT	Specialty	Currently reimbursed at 42% of Medicare, increase to 80%
92585	CPT	Specialty	Currently reimbursed at 65% of Medicare, increase to 80%
92601	CPT	Specialty	Currently reimbursed at 65% of Medicare, increase to 80%
92607	CPT	Specialty	Currently reimbursed at 60% of Medicare, increase to 80%
92609	CPT	Specialty	Currently reimbursed at 39% of Medicare, increase to 80%

Code	Code Type	Rate Impact Category	Program Change Description
92625	CPT	Specialty	Currently reimbursed at 43% of Medicare, increase to 80%
93922	CPT	Specialty	Currently reimbursed at 43% of Medicare, increase to 80%
93923	CPT	Specialty	Currently reimbursed at 53% of Medicare, increase to 80%
93924	CPT	Specialty	Currently reimbursed at 46% of Medicare, increase to 80%
93925	CPT	Specialty	Currently reimbursed at 41% of Medicare, increase to 80%
93926	CPT	Specialty	Currently reimbursed at 63% of Medicare, increase to 80%
93930	CPT	Specialty	Currently reimbursed at 42% of Medicare, increase to 80%
93931	CPT	Specialty	Currently reimbursed at 48% of Medicare, increase to 80%
93965	CPT	Specialty	Currently reimbursed at 37% of Medicare, increase to 80%
93970	CPT	Specialty	Currently reimbursed at 31% of Medicare, increase to 80%
93975	CPT	Specialty	Currently reimbursed at 38% of Medicare, increase to 80%
93976	CPT	Specialty	Currently reimbursed at 51% of Medicare, increase to 80%
93978	CPT	Specialty	Currently reimbursed at 46% of Medicare, increase to 80%
93979	CPT	Specialty	Currently reimbursed at 47% of Medicare, increase to 80%
93990	CPT	Specialty	Currently reimbursed at 33% of Medicare, increase to 80%
95812	CPT	Specialty	Currently reimbursed at 16% of Medicare, increase to 80%
95813	CPT	Specialty	Currently reimbursed at 17% of Medicare, increase to 80%
95873	CPT	Specialty	Currently reimbursed at 24% of Medicare, increase to 80%
95874	CPT	Specialty	Currently reimbursed at 25% of Medicare, increase to 80%
95928	CPT	Specialty	Currently reimbursed at 39% of Medicare, increase to 80%
95929	CPT	Specialty	Currently reimbursed at 41% of Medicare, increase to 80%
95953	CPT	Specialty	Currently reimbursed at 57% of Medicare, increase to 80%
95954	CPT	Specialty	Currently reimbursed at 24% of Medicare, increase to 80%
95956	CPT	Specialty	Currently reimbursed at 16% of Medicare, increase to 80%
95958	CPT	Specialty	Currently reimbursed at 25% of Medicare, increase to 80%
96111	CPT	Specialty	Currently reimbursed at 76% of Medicare, increase to 80%
96440	CPT	Specialty	Currently reimbursed at 3% of Medicare, increase to 80%
96450	CPT	Specialty	Currently reimbursed at 16% of Medicare, increase to 80%

Code	Code Type	Rate Impact Category	Program Change Description
97001	CPT	Specialty	Currently reimbursed at 46% of Medicare, increase to 80%
97002	CPT	Specialty	Currently reimbursed at 55% of Medicare, increase to 80%
97003	CPT	Specialty	Currently reimbursed at 41% of Medicare, increase to 80%
97004	CPT	Specialty	Currently reimbursed at 43% of Medicare, increase to 80%
97597	CPT	Specialty	Currently reimbursed at 41% of Medicare, increase to 80%
G0365	CPT	Specialty	Currently reimbursed at 60% of Medicare, increase to 80%
G0389	CPT	Specialty	Currently reimbursed at 65% of Medicare, increase to 80%
G0202	CPT	Mammography	Currently reimbursed at 74% of Medicare, increase to 80%
G0204	CPT	Mammography	Currently reimbursed at 64% of Medicare, increase to 80%
G0206	CPT	Mammography	Currently reimbursed at 65% of Medicare, increase to 80%
92608	CPT	Complex Rehab	Currently reimbursed at 26% of Medicare, increase to 80%
97542	CPT	Complex Rehab	Currently reimbursed at 53% of Medicare, increase to 80%
97755	CPT	Complex Rehab	Currently reimbursed at 52% of Medicare, increase to 80%
S4993	HCPCS	Family Planning	Flat rate increase of $35.00
A4264	HCPCS	Family Planning	15% rate increase
A4550	HCPCS	Family Planning	15% rate increase
J1055	HCPCS	Family Planning	15% rate increase
J7302	HCPCS	Family Planning	15% rate increase

Code	Code Type	Rate Impact Category	Program Change Description
J7303	HCPCS	Family Planning	15% rate increase
J7304	HCPCS	Family Planning	15% rate increase
J7307	HCPCS	Family Planning	15% rate increase
J7307	HCPCS	Family Planning	15% rate increase

Appendix II(M) Program Change Adjustments

COA	SFY14	SFY15
Inpatient Hospital	2.0%	2.0%
Emergency Room	2.0%	2.0%
Home Health	8.2%	2.0%
FQHC & Rural Health Clinic	2.0%	2.0%
Outpatient Hospital	2.0%	2.5%
Laboratory & X-Ray	2.0%	2.0%
Physician - ER	2.0%	2.0%
Physician - IP	2.0%	2.0%
Physician - Office	2.0%	5.2%
Specialist	2.0%	5.9%
Emergency Transportation	2.0%	2.0%
Other	2.0%	2.0%
Pharmacy	-0.1%	0.0%
TOTAL	**1.4%**	**1.8%**

Appendix II(N) Prospective Trend Assumptions

COS	Source Blend	
	LB	UB
Inpatient Hospital	0.2%	1.8%
Emergency Room	1.5%	3.0%
Home Health	1.0%	2.5%
FQHC & Rural Health Clinic	2.3%	3.8%
Outpatient Hospital	0.5%	2.0%
Laboratory & X-Ray	1.5%	3.0%
Physician - ER	1.0%	2.5%
Physician - IP	1.0%	2.5%
Physician - Office	2.0%	3.5%
Specialist	2.0%	3.5%
Emergency Transportation	1.0%	2.5%
Other	3.0%	4.5%
Pharmacy	4.0%	6.6%
TOTAL	**1.9%**	**3.8%**

Appendix II(O) Managed Care Assumptions

COA	Managed Care Savings	
	Lower Bound	Upper Bound
Inpatient Hospital	-5.6%	-1.0%
Emergency Room	-15.5%	-3.5%
Home Health	0.0%	0.0%
FQHC & Rural Health Clinic	0.0%	0.0%
Outpatient Hospital	0.0%	0.0%
Laboratory & X-Ray	0.0%	0.0%
Physician - ER	-5.8%	-0.6%
Physician - IP	-3.8%	0.0%
Physician - Office	3.7%	0.6%
Specialist	0.0%	0.0%
Emergency Transportation	0.0%	0.0%
Other	0.0%	0.0%
Pharmacy	0.1%	0.0%
TOTAL	**-2.5%**	**-0.5%**

Appendix II(P) Expansion Population Pent-up Demand Factors

COS	Expansion	AwDC
Inpatient Hospital	100.0%	100.0%
Emergency Room	100.0%	100.0%
Home Health	100.0%	100.0%
FQHC & Rural Health	107.1%	113.3%
Outpatient Hospital	101.9%	103.5%
Laboratory & X-Ray	103.8%	107.0%
Physician	105.0%	109.4%
Specialist	105.0%	109.4%
Emergency Transportation	100.0%	100.0%
DME	106.4%	111.9%
EPSDT	105.0%	109.4%
Pharmacy	107.1%	113.3%

Appendix II(Q) Alternative Benefit Plan – Preventive PMPM Adjustments

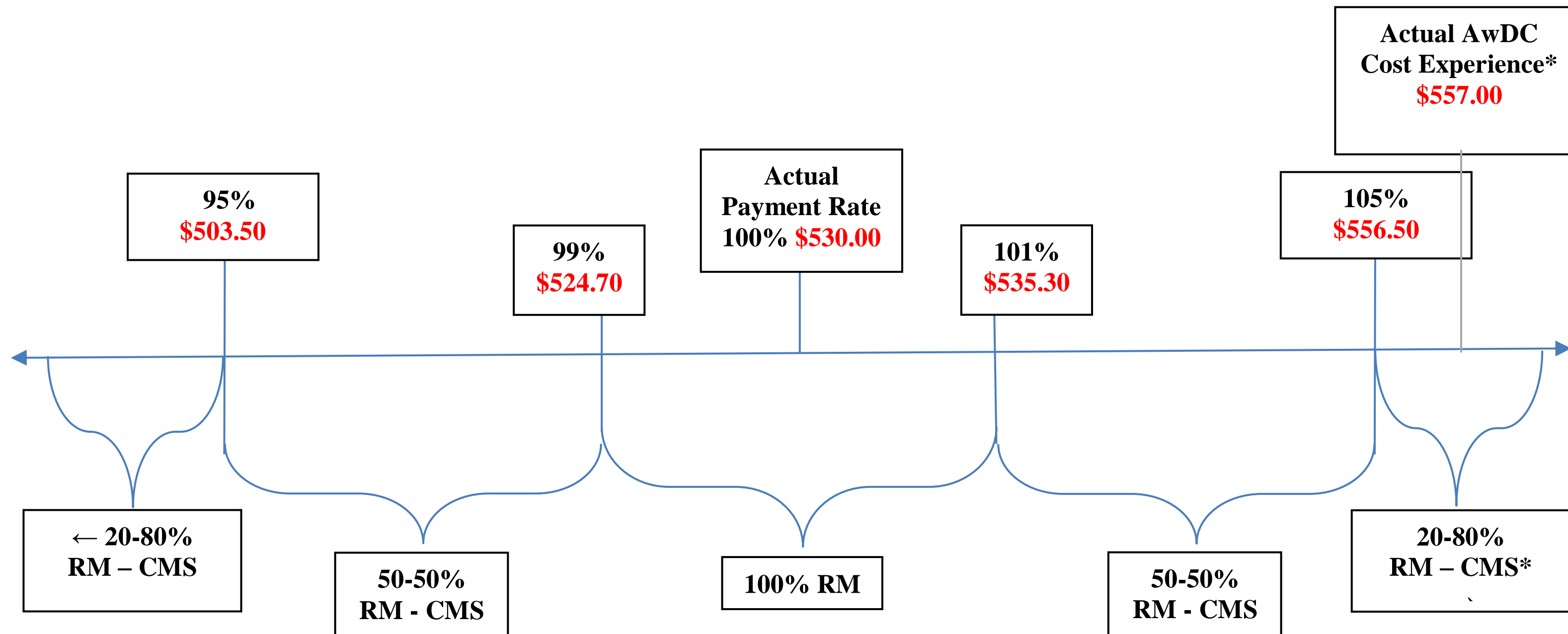
COA	Preventive Services Rate Range	
	LB	UB
AFDC/CWP Adults 19+ M	1.0%	2.0%
AFDC/CWP Adults 19+ F	0.9%	1.9%
BC Women	0.2%	0.5%
AND/AB - SSI Non-Dual <45	0.2%	0.4%
AND/AB - SSI Non-Dual 45+	0.2%	0.4%
OAP A – Non-Dual	1.1%	2.3%
OAP B - SSI Non-Dual	0.4%	1.0%
BUYIN Working Adult Disabled	0.4%	1.0%
DUAL	1.6%	3.1%
DUAL - Medicaid Full/Medicare	1.3%	2.4%
Expansion Parent M	N/A	N/A
Expansion Parent F	N/A	N/A
AwDC	N/A	N/A

Appendix II(R) Alternative Benefit Plan – Habilitative PMPM Adjustments

COA	Habilitative Services Rate Range	
	LB	UB
Expansion Parent M	0.1%	0.3%
Expansion Parent F	0.1%	0.2%
AwDC	0.1%	0.4%

Appendix II(S) AwDC Risk Corridor

Symmetrical AWDC Risk Corridor (Illustrative 1)



*The Department will calculate the Actual AwDC Cost Experience in accordance with standards of actuarial soundness for Medicaid MCOs.

Symmetrical AwDC Risk Corridor Calculations Example (Illustrative 1)

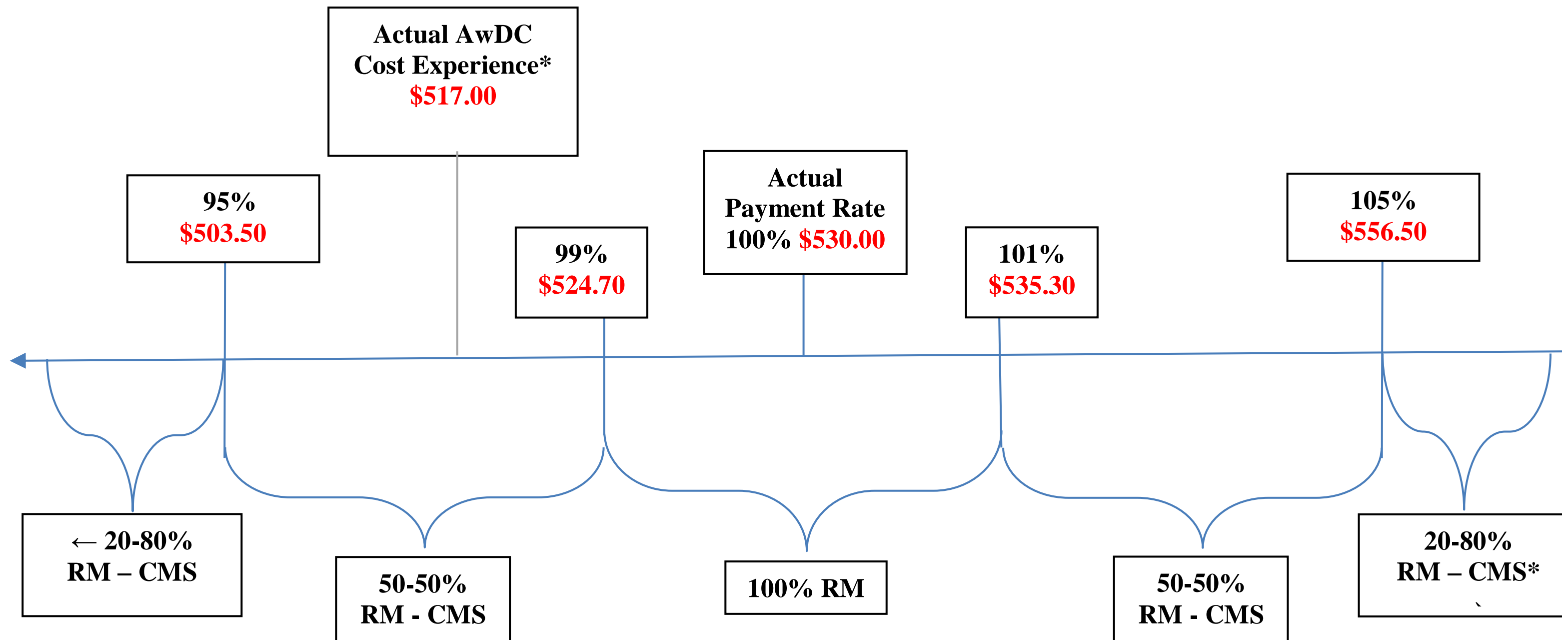
AwDC payment rate	$530.00
Actual AwDC Cost Experience	$557.00

MCO Bears Losses For:	
Inner Corridor (100 - 101%)	($535.30 - $530.00) *100% = **$5.30**
Middle Corridor (101 - 105%)	($556.50 - $535.30)*50% = **$10.60**
Outer Corridor (105+%)	($557.00 - $556.50)*20% = **$0.10**
Total Losses for MCO	$5.30 + $10.60 + $0.10 = **$16.00**

CMS Reimburses Rocky For:	
Middle Corridor (101 - 105%)	($556.50 - $535.30)*50% = **$10.60**
Outer Corridor (105+%)	($557.00 - $556.50)*80% = **$0.40**
Total CMS Reimbursement to MCO	$10.60 + $0.40 = **$11.00**

Net Loss for MCO:	$27.00 - $11.00 = **$16.00**

Symmetrical AwDC Risk Corridor Calculations Example (Illustrative 2)



*The Department will calculate the Actual AwDC Cost Experience in accordance with standards of actuarial soundness for Medicaid MCOs.

Symmetrical AwDC Risk Corridor Calculations Example (Illustrative 2)

AwDC payment rate	$530.00
Actual AwDC Cost Experience	$517.00

MCO Gains:	
Inner Corridor (99 - 100%)	($530.00 - $524.70) *100% = **$5.30**
Middle Corridor (95 - 99%)	($524.70 - $517.00)*50% = **$3.85**
Total MCO Gain	$5.30 + $3.85 = **$9.15**

MCO Reimburses CMS:	
Middle Corridor (95 - 99%)	($524.70 - $517.00)*50% = **$3.85**

Net Gain for MCO:	$13.00 - $3.85 = **$9.15**

Appendix II(T) Non-Medical Loading Assumptions

COA	Profit Loading	Rate Range Lower Bound Admin	 Upper Bound Admin
AFDC/CWP Adults 19+ M	1.0%	6.7%	4.8%
AFDC/CWP Adults 19+ F	1.0%	6.7%	4.8%
BC Women	1.0%	6.7%	4.8%
AND/AB - SSI Non-Dual <45	1.0%	6.7%	4.8%
AND/AB - SSI Non-Dual 45+	1.0%	6.7%	4.8%
OAP A – Non-Dual	1.0%	6.7%	4.8%
OAP B - SSI Non-Dual	1.0%	6.7%	4.8%
BUYIN Working Adult Disabled	1.0%	6.7%	4.8%
DUAL	1.0%	6.7%	4.8%
DUAL - Medicaid Full/Medicare	1.0%	6.7%	4.8%
Expansion Parent M	1.0%	6.7%	4.8%
Expansion Parent F	1.0%	6.7%	4.8%
AwDC	1.0%	6.7%	4.8%

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o. Appendix III. September 1, 2014 – June 30, 2015 Rate Ranges and Rate Selection

COA	Rate Summary		
	Lower Bound	Rate Selection	Upper Bound
AFDC/CWP Adults 19+ M	$294.00	**$324.60**	$327.56
AFDC/CWP Adults 19+ F	$428.55	**$438.29**	$452.51
BC Women	$876.81	**$968.86**	$1,029.30
AND/AB - SSI Non-Dual <45	$784.95	**$829.20**	$873.80
AND/AB - SSI Non-Dual 45+	$1,190.47	**$1,258.24**	$1,325.97
OAP A – Non-Dual	$595.16	**$647.74**	$698.66
OAP B - SSI Non-Dual	$1,086.03	**$1,181.01**	$1,274.90
BUYIN Working Adult Disabled	$1,003.74	**$1,091.94**	$1,178.30
DUAL	$96.31	**$103.74**	$111.25
DUAL - Medicaid Full/Medicare	$243.43	**$264.47**	$285.76
Expansion Parent M	$303.38	**$324.60**	$342.11
Expansion Parent F	$390.86	**$438.29**	$440.76
AwDC	$494.42	**$532.75**	$557.54

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EXHIBIT F-1
COVERED BEHAVIORAL HEALTH PROCEDURE CODES AND DIAGNOSES

Proc Code	Full description of the procedure codes
00104	Anesthesia for electroconvulsive therapy
90785	Interactive complexity (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient and/or family member
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90834	Psychotherapy, 45 minutes with patient and/or family member
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90837	Psychotherapy, 60 minutes with patient and/or family
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90846	Family psychotherapy (without the patient present)
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90870	Electroconvulsive therapy (includes necessary monitoring)
90875	Individual psycho-physiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes
90876	Individual psycho-physiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 45 minutes
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
96101	Psychological testing (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96102	Psychological testing (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face

96103	Psychological testing administered by a computer, with qualified health care professional interpretation and report.
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96120	Neuropsychological testing by a computer, with qualified health care professional interpretation and report.
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug) subcutaneous or intramuscular
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
98966	Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
98967	Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
98968	Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99221	Initial Hospital Care Low Complexity
99222	Initial Hospital Care Moderate Complexity
99223	Initial Hospital Care High Complexity
99231	Subsequent Hospital Care Low Complexity
99232	Subsequent Hospital Care Moderate Complexity
99233	Subsequent Hospital Care High Complexity
99238	Hospital Discharge Day Management/30 minutes
99239	Discharge day management; more than 30 minutes
99251	Initial Inpatient Consultation/20 minutes
99252	Initial Inpatient Consultation/40 minutes
99253	Initial Inpatient Consultation/55 minutes
99254	Initial Inpatient Consultation/80 minutes
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional.

99367	Medical team conference, with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician.
99368	Medical team conference with interdisciplinary team, patient and/or family not present, 30 minutes or more, participation by non-physician qualified health care professional
99441	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion
99442	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 11-20 minutes of medical discussion
99443	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 21-30 minutes of medical discussion
G0176	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more).
*H0001	Alcohol and/or drug assessment
H0002	Behavioral health screening to determine eligibility for admission to treatment program
*H0004	Behavioral health counseling and therapy, per 15 minutes
*H0005	Alcohol and/or drug services; group counseling by a clinician
*H0006	Alcohol and/or drug services; case management (targeted)
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem
H0019	Behavioral health; long-term residential (nonmedical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
*H0020	Medication Assisted Treatment
H0023	Behavioral health outreach service (planned approach to reach a targeted population)
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0031	Mental health assessment, by non-physician
H0032	Mental health service plan development by non-physician
H0033	Oral medication administration, direct observation
H0034	Medication training and support, per 15 minutes
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0037	Community psychiatric supportive treatment program, per diem
*H0038	Self-help/peer services, per 15 minutes
H0039	Assertive community treatment, face-to-face, per 15 minutes
H0040	Assertive community treatment program, per diem
H0043	Supported housing, per diem
H0044	Supported housing, per month
H0045	Respite care services, not in the home, per diem
H1011	Family assessment by licensed behavioral health professional for state defined purposes
H2000	Comprehensive multidisciplinary evaluation
H2001	Rehabilitation program, per 1/2 day

H2011	Crisis intervention service, per 15 minutes
H2012	Behavioral health day treatment, per hour
H2014	Skills training and development, per 15 minutes
H2015	Comprehensive community support services, per 15 minutes. Long definition: The purpose of Comprehensive Community Support Services is to coordinate and provide services and resources to individuals/families necessary to promote recovery, rehabilitation and resiliency. Comprehensive Community Support Services identifies and addresses the barriers that impede the development of skills necessary for independent functioning in the community; as well as strengths, which may aid the individual or family in the recovery or resiliency process. Community support activities address goals specifically in the following areas: independent living; learning; working; socializing and recreation. Comprehensive Community Support Services also include supporting an individual and family in crisis situations; and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices.
H2016	Comprehensive community support services, per diem
H2017	Psychosocial rehabilitation services, per 15 minutes
H2018	Psychosocial rehabilitation services, per diem
H2021	Community-based wrap-around services, per 15 minutes
H2022	Community-based wrap-around services, per diem
H2023	Supported employment, per 15 minutes
H2024	Supported employment, per diem
H2025	Ongoing support to maintain employment, per 15 minutes
H2026	Ongoing support to maintain employment, per diem
H2027	Psychoeducational service, per 15 minutes
H2030	Mental health clubhouse services, per 15 minutes
H2031	Mental health clubhouse services, per diem
H2032	Activity therapy, per 15 minutes
H2033	Multi-systemic therapy for juveniles, per 15 minutes
M0064	Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders
*S3005	Safety assessment including suicidal ideation and other behavioral health issues
S5150	Unskilled respite care, not hospice; per 15 minutes
S5151	Unskilled respite care, not hospice; per diem
*S9445	Drug screening and monitoring
S9453	Smoking cessation classes, non-physician provider, per session
S9454	Stress management classes, non-physician provider, per session
S9480	Intensive outpatient psychiatric services, per diem
S9485	Crisis intervention mental health services, per diem
T1005	Respite care services, up to 15 minutes
*T1007	Physical assessment of detoxification progression including vital signs monitoring
T1016	Case management, each 15 minutes
T1017	Targeted case management, each 15 minutes
*T1019	Provision of daily living needs including hydration, nutrition, cleanliness and toiletry for clients
*T1023	Level of motivation assessment for treatment evaluation

*Denotes services that have been approved by the Joint Budget Committee (JBC) for inclusion in the substance use disorder benefit.

The below list of Evaluation and Management codes are covered by the BHOs when they are billed in conjunction with a psychotherapy add-on from the above list or when used for the purposes of medication management with minimal psychotherapy provided by a prescriber from the BHO network.

Proc Code	Full description of the procedure codes
99201	Office or other outpatient visit, new patient/ 10 minutes
99202	Office or other outpatient visit, new patient/ 20 minutes
99203	Office or other outpatient visit, new patient/ 30 minutes
99204	Office or other outpatient visit, new patient/ 45 minutes
99205	Office or other outpatient visit, new patient/ 60 minutes
99211	Office or other outpatient visit, established patient/ 5 minutes
99212	Office or other outpatient visit, established patient/10 minutes
99213	Office or other outpatient visit, established patient/ 15 minutes
99214	Office or other outpatient visit, established patient/ 25 minutes
99215	Office or other outpatient visit, established patient/ 40 minutes
99217	Observation care discharge day management
99218	Initial observation / 30 minutes
99219	Initial observation care/ 50 minutes
99220	Initial observation care/ 70 minutes
99224	Subsequent observation care/ 15 minutes
99225	Subsequent observation care/ 25 minutes
99226	Subsequent observation care/ 35 minutes
99234	Observation or inpatient hospital care, patient admitted and discharged on same date of service, 40 minutes
99235	Observation or inpatient hospital care, patient admitted and discharged on same date of service/50 minutes
99236	Observation or inpatient hospital care, patient admitted and discharged on same date of service/ 55 minutes
99241	Office consultation/ 15 minutes
99242	Office consultation/ 30 minutes
99243	Office consultation/ 40 minutes
99244	Office consultation/ 60 minutes
99245	Office consultation/ 80 minutes
99255	Initial inpatient consultation/ 110 minutes.
99304	Initial nursing facility care/per day/ 25 minutes spent at bedside or on patient floor/unit
99305	Initial nursing facility care/per day/ 35 minutes spent at bedside or on patient floor/unit
99306	Initial nursing facility care/per day/ 45 minutes spent at bedside or on patient floor/unit
99307	Subsequent nursing facility care/per day/ 10 minutes spent at bedside or on patient floor/unit
99308	Subsequent nursing facility care/per day/ 15 minutes spent at bedside or on patient floor/unit
99309	Subsequent nursing facility care/per day/ 25 minutes spent at bedside or on patient floor/unit
99310	Subsequent nursing facility care/per day/ 35 minutes spent at bedside or on patient floor/unit
99315	Nursing facility discharge day management/ 30 minutes or less
99316	Nursing facility discharge day management; more than 30 minutes
99318	Annual nursing facility assessment/ 30 minutes spent at bedside or on patient floor/unit
99324	Domiciliary or rest home visit, new patient/ 20 minutes
99325	Domiciliary or rest home visit, new patient/ 30 minutes
99326	Domiciliary or rest home visit, new patient/ 45 minutes
99327	Domiciliary or rest home visit, new patient/ 60 minutes
99328	Domiciliary or rest home visit, new patient/ 75 minutes
99334	Domiciliary or rest home visit, established patient/ 15 minutes
99335	Domiciliary or rest home visit, established patient/ 25 minutes

99336	Domiciliary or rest home visit, established patient/ 40 minutes
99337	Domiciliary or rest home visit, established patient/ 60 minutes
99341	Home visit, new patient/20 minutes
99342	Home visit, new patient/30 minutes
99343	Home visit, new patient/45 minutes
99344	Home visit, new patient/60 minutes
99345	Home visit, new patient/75 minutes
99347	Home visit, established patient/15 minutes
99348	Home visit, established patient/25 minutes
99349	Home visit, established patient/40 minutes
99350	Home visit, established patient/60 minutes

Please Note: This list of covered procedures is to be used as a guideline rather than a contractual requirement. The Department and its Contractors will continue to refine and update the covered procedures list on an ongoing basis.

Part I- Mental Health Covered Diagnoses

Diagnosis Code	**Description**
295 - 298.9	
295	**Schizophrenic disorders**
	(the following fifth-digit sub-classification is for use with category 295)
0	unspecified
1	subchronic
2	chronic
3	subchronic with acute exacerbation
4	chronic with acute exacerbation
5	in remission
295.0	Simple type
295.1	Disorganized type
295.2	Catatonic type
295.3	Paranoid type
295.4	Acute schizophrenic episode
295.5	Latent schizophrenia
295.6	Residual type
295.7	Schizoaffective disorder
295.8	Other specified types of schizophrenia
295.9	Unspecified schizophrenia
296	**Episodic mood disorders**
	(the following fifth-digit subclassification is for use with categories 296.0-296.6)
0	unspecified
1	mild
2	moderate
3	severe, without mention of psychotic behavior

4	severe, specified as with psychotic behavior
5	in partial or unspecified remission
6	in full remission
296.0	Bipolar I disorder, single manic episode
296.1	Manic disorder, recurrent episode
296.2	Major depressive disorder, single episode
296.3	Major depressive disorder, recurrent episode
296.4	Bipolar I disorder, most recent episode (or current) manic
296.5	Bipolar I disorder, most recent episode (or current) depressed
296.6	Bipolar I disorder, most recent episode (or current) mixed
296.7	Bipolar I disorder, most recent episode (or current) unspecified
296.8	Other and unspecified bipolar disorders
296.80	Bipolar disorder, unspecified
296.81	Atypical manic disorder
296.82	Atypical depressive disorder
296.89	Other
296.9	Other and unspecified episodic mood disorder
296.90	Unspecified episodic mood disorder
296.99	Other specified episodic mood disorder
297	**Delusional disorders**
297.0	Paranoid state, simple
297.1	Delusional disorder
297.2	Paraphrenia
297.3	Shared psychotic disorder
297.8	Other specified paranoid states
297.9	Unspecified paranoid state
298	**Other nonorganic psychoses**
298.0	Depressive type psychosis
298.1	Excitative type psychosis
298.2	Reactive confusion
298.3	Acute paranoid reaction
298.4	Psychogenic paranoid psychosis
298.8	Other and unspecified reactive psychosis
298.9	Unspecified psychosis
300 - 301.99	
300	**Anxiety, dissociative and somatoform disorders**
300.0	Anxiety states
300.00	Anxiety state, unspecified
300.01	Panic disorder without agoraphobia
300.02	Generalized anxiety disorder
300.09	Other

300.1	Dissociative, conversion and factitious disorders
300.10	Hysteria, unspecified
300.11	Conversion disorder
300.12	Dissociative amnesia
300.13	Dissociative fugue
300.14	Dissociative identity disorder
300.15	Dissociative disorder or reaction, unspecified
300.16	Factitious illness with predominantly psychological signs and symptoms
300.19	Other and unspecified factitious illness
300.2	Phobic disorders
300.20	Phobia, unspecified
300.21	Agoraphobia with panic attacks
300.22	Agoraphobia without mention of panic attacks
300.23	Social phobia
300.29	Other isolated or specific phobias
300.3	Obsessive-compulsive disorders
300.4	Dysthymic disorder
300.5	Neurasthenia
300.6	Depersonalization disorder
300.7	Hypochondriasis
300.8	Somatoform disorders
300.81	Somatization disorder
300.82	Undifferentiated somatoform disorder
300.89	Other Somatoform disorder
300.9	Unspecified nonpsychotic mental disorder
301	**Personality disorders**
301.0	Paranoid personality disorder
301.1	Affective personality disorder
301.10	Affective personality disorder, unspecified
301.11	Chronic hypomanic personality disorder
301.12	Chronic depressive personality disorder
301.13	Cyclothymic disorder
301.2	Schizoid personality disorder
301.20	Schizoid personality disorder, unspecified
301.21	Introverted personality
301.22	Schizotypal personality disorder
301.3	Explosive personality disorder
301.4	Obsessive-compulsive personality disorder
301.5	Histrionic personality disorder
301.50	Histrionic personality disorder, unspecified
301.51	Chronic factitious illness with physical symptoms

301.59	Other histrionic personality disorder
301.6	Dependent personality disorder
301.7	Antisocial personality disorder
301.8	Other personality disorders
301.81	Narcissistic personality disorder
301.82	Avoidant personality disorder
301.83	Borderline personality disorder
301.84	Passive-aggressive personality
301.89	Other
301.9	Unspecified personality disorder
307.1 - 309.99	
307	**Special symptoms or syndromes, not elsewhere classified**
307.1	Anorexia nervosa
307.2	Tics
307.20	Tic disorder, unspecified
307.21	Transient tic disorder
307.22	Chronic motor or vocal tic disorder
307.23	Tourette's disorder
307.3	Stereotypic movement disorder
307.4	Specific disorders of sleep of nonorganic origin
307.40	Nonorganic sleep disorder, unspecified
307.41	Transient disorder of initiating or maintaining sleep
307.42	Persistent disorder of initiating or maintaining sleep
307.43	Transient disorder of initiating or maintaining wakefulness
307.44	Persistent disorder of initiating or maintaining wakefulness
307.45	Circadian rhythm sleep disorder of nonorganic origin
307.46	Sleep arousal disorder
307.47	Other dysfunctions of sleep stages or arousal from sleep
307.48	Repetitive intrusions of sleep
307.49	Other
307.5	Other and unspecified disorders of eating
307.50	Eating disorder, unspecified
307.51	Bulimia nervosa
307.52	Pica
307.53	Rumination disorder
307.54	Psychogenic vomiting
307.59	Other
307.6	Enuresis
307.7	Encopresis
307.8	Pain disorders related to psychological factors
307.80	Psychogenic pain, site unspecified

307.81	Tension headache
307.89	Other
307.9	Other and unspecified special symptoms or syndromes, not elsewhere classified
308	**Acute reaction to stress**
308.0	Predominant disturbance of emotions
308.1	Predominant disturbance of consciousness
308.2	Predominant psychomotor disturbance
308.3	Other acute reactions to stress
308.4	Mixed disorders as reactions to stress
308.9	Unspecified acute reaction to stress
309	**Adjustment reaction**
309.0	Adjustment disorder with depressed mood
309.1	Prolonged depressive reaction
309.2	With predominant disturbance of other emotions
309.21	Separation anxiety disorder
309.22	Emancipation disorder of adolescence and early adult life
309.23	Specific academic or work inhibition
309.24	Adjustment disorder with anxiety
309.28	Adjustment disorder with mixed anxiety and depressed mood
309.29	Other
309.3	Adjustment disorder with disturbance of conduct
309.4	Adjustment disorder with mixed disturbance of emotions and conduct
309.8	Other specified adjustment reactions
309.81	Post-traumatic stress disorder
309.82	Adjustment reaction with physical symptoms
309.83	Adjustment reaction with withdrawal
309.89	Other
309.9	Unspecified adjustment reaction
311 - 314.9	
311	**Depressive disorder, not elsewhere classified**
312	**Disturbance of conduct, not elsewhere classified**
	(the following fifth-digit sub-classification is for use with categories 312.0-312.2)
0	unspecified
1	mild
2	moderate
3	severe
312.0	Undersocialized conduct disorder, aggressive type
312.1	Undersocialized conduct disorder, unaggressive type
312.2	Socialized conduct disorder
312.3	Disorders of impulse control, not elsewhere classified
312.30	Impulse control disorder, unspecified

312.31	Pathological gambling
312.32	Kleptomania
312.33	Pyromania
312.34	Intermittent explosive disorder
312.35	Isolated explosive disorder
312.39	Other
312.4	Mixed disturbance of conduct and emotions
312.8	Other specified disturbance of conduct, not elsewhere classified
312.81	Conduct disorder, childhood onset type
312.82	Conduct disorder, adolescent onset type
312.89	Other conduct disorder
312.9	Unspecified disturbance of conduct
313	**Disturbance of emotions specific to childhood and adolescence**
313.0	Overanxious disorder
313.1	Misery and unhappiness disorder
313.2	Sensitivity, shyness, and social withdrawal disorder
313.21	Shyness disorder of childhood
313.22	Introverted disorder of childhood
313.23	Selective mutism
313.3	Relationship problems
313.8	Other or mixed emotional disturbances of childhood or adolescence
313.81	Oppositional defiant disorder
313.82	Identity disorder
313.83	Academic underachievement disorder
313.89	Other
313.9	Unspecified emotional disturbance of childhood or adolescence
314	**Hyperkinetic syndrome of childhood**
314.0	Attention deficit disorder
314.00	Without mention of hyperactivity
314.01	With hyperactivity
314.1	Hyperkinesis with developmental delay
314.2	Hyperkinetic conduct disorder
314.8	Other specified manifestations of hyperkinetic syndrome
314.9	Unspecified hyperkinetic syndrome

Part 2- Substance Use Disorder Covered Diagnoses

ICD-9		**DSM-IV**	
Alcohol Use Disorders			
291	Alcohol-induced mental disorders	--	No equivalent DSM-IV code
303	Alcohol dependence syndrome	--	No equivalent DSM-IV code

303.9 [0-3]*	Other and unspecified alcohol dependence	303.90	Alcohol dependence
305.0 [0-3]	Alcohol abuse	305.00	Alcohol abuse
305	Nondependent abuse of drugs	--	No equivalent DSM-IV code
Alcohol-Induced Disorders			
303.0 [0-3]	Acute alcohol intoxication	303.00	Alcohol intoxication
291.81	Alcohol withdrawal	291.81	Alcohol withdrawal
291.0	Alcohol withdrawal delirium	291.0	Alcohol withdrawal delirium
291.0	Alcohol intoxication delirium	291.0	Alcohol intoxication delirium
291.1	Alcohol induced persisting amnesic disorder	291.1	Alcohol induced persisting amnesic disorder
291.5	Alcohol induced psychotic disorder with delusions	291.5	Alcohol induced psychotic disorder with delusions
291.3	Alcohol induced psychotic disorder with hallucinations	291.3	Alcohol induced psychotic disorder with hallucinations
291.89	Other alcohol induced mood disorder	291.89	Alcohol induced mood disorder
291.89	Other alcohol induced anxiety disorder	291.89	Alcohol induced anxiety disorder
291.89	Other alcohol induced sexual dysfunction	291.89	Alcohol induced sexual dysfunction
291.82	Alcohol induced sleep disorders	291.82	Alcohol induced sleep disorders
291.9	Unspecified alcohol induced mental disorders	291.9	Alcohol-related disorder not otherwise specified (NOS)
Amphetamine Use Disorders			
304	Drug dependence	--	No equivalent DSM-IV code
304.4 [0-3]	Amphetamine and other psychostimulant dependence	304.40	Amphetamine dependence
305.7 [0-3]	Amphetamine or related acting sympathomimetic abuse	305.70	Amphetamine abuse
Amphetamine Induced Disorders			
292	Drug-induced mental disorders	--	No equivalent DSM-IV code
292.89	Other specified drug induced mental disorder	292.89	Amphetamine intoxication
292.0	Drug withdrawal	292.0	Amphetamine withdrawal
292.81	Drug induced delirium	292.81	Amphetamine intoxication delirium
292.11	Drug induced psychotic disorder with delusions	292.11	Amphetamine induced psychotic disorder with delusions
292.12	Drug induced psychotic disorder with hallucinations	292.12	Amphetamine induced psychotic disorder with hallucinations

292.84	Drug induced mood disorder	292.84	Amphetamine induced mood disorder
292.89	Drug induced anxiety disorder	292.89	Amphetamine induced anxiety disorder
292.89	Drug induced sexual dysfunction	292.89	Amphetamine induced sexual dysfunction
292.85	Drug induced sleep disorder	292.85	Amphetamine induced sleep disorder
292.9	Unspecified drug induced mental disorder	292.9	Amphetamine related disorders not otherwise specified
Cannabis Use Disorders			
304.3 [0-3]	Cannabis dependence	304.30	Cannabis dependence
305.2 [0-3]	Cannabis abuse	305.20	Cannabis abuse
Cannabis Induced Disorders			
292.89	Other specified drug induced mental disorders	292.89	Cannabis intoxication
292.81	Drug-intoxication delirium	292.81	Cannabis intoxication delirium
292.11	Drug induced psychotic disorder with delusions	292.11	Cannabis induced psychotic disorder with delusions
292.12	Drug induced psychotic disorder with hallucinations	292.12	Cannabis induced psychotic disorder with hallucinations
292.89	Drug induced anxiety disorder	292.89	Cannabis induced anxiety disorder
292.9	Unspecified drug induced mental disorder	292.9	Cannabis related disorders not otherwise specified (NOS)
Cocaine Use Disorders			
304.2 [0-3]	Cocaine dependence	304.20	Cocaine dependence
305.6 [0-3]	Cocaine abuse	305.60	Cocaine abuse
Cocaine Induced Disorders			
292.89	Other specified drug induced mental disorder	292.89	Cocaine intoxication
292.0	Drug withdrawal	292.0	Cocaine withdrawal
292.81	Drug intoxication delirium	292.81	Cocaine intoxication delirium
292.11	Drug induced psychotic disorder with delusions	292.11	Cocaine induced psychotic disorder with delusions
292.12	Drug induced psychotic disorder with hallucinations	292.12	Cocaine induced psychotic disorder with hallucinations

292.84	Drug induced mood disorder	292.84	Cocaine induced mood disorder
292.89	Drug induced anxiety disorder	292.89	Cocaine induced anxiety disorder
292.89	Drug induced sexual dysfunction	292.89	Cocaine induced sexual dysfunction
292.85	Drug induced sleep disorder	292.85	Cocaine induced sleep disorder
292.9	Unspecified drug induced mental disorder	292.9	Cocaine related disorders not otherwise specified (NOS)

Hallucinogen Use Disorders			
304.5 [0-3]	Hallucinogen dependence	304.50	Hallucinogen dependence
305.3 [0-3]	Hallucinogen abuse	305.30	Hallucinogen abuse
Hallucinogen Induced Disorders			
292.89	Other specified drug induced mental disorders	292.89	Hallucinogen intoxication
292.89	Other specified drug induced mental disorders	292.89	Hallucinogen persisting perception disorder (flashbacks)
292.81	Drug induced delirium	292.81	Hallucinogen intoxication delirium
292.11	Drug induced psychotic disorder with delusions	**292.11**	**Hallucinogen induced psychotic disorder with delusions**
292.12	Drug induced psychotic disorder with hallucinations	**292.12**	**Hallucinogen induced psychotic disorder with hallucinations**
292.84	Drug induced mood disorder	292.84	Hallucinogen induced mood disorder
292.89	Drug induced anxiety disorder	292.89	Hallucinogen induced anxiety disorder
292.9	Unspecified drug induced mental disorder	292.9	Hallucinogen related disorders not otherwise specified (NOS)
Inhalant Use Disorders			
304.6 [0-3]	Other specified drug dependence	304.60	Inhalant dependence
305.9 [0-3]	Other, mixed, or unspecified drug abuse	305.90	Inhalant abuse
Inhalant Induced Disorders			

292.89	Other specified drug induced mental disorders	292.89	Inhalant intoxication
292.81	Drug induced delirium	292.81	Inhalant intoxication delirium
292.11	Drug induced psychotic disorder with delusions	292.11	Inhalant induced psychotic disorder with delusions
292.12	Drug induced psychotic disorder with hallucinations	292.12	Inhalant induced psychotic disorder with hallucinations
292.84	Drug induced mood disorder	292.84	Inhalant induced mood disorder
292.89	Drug induced anxiety disorder	292.89	Inhalant induced anxiety disorder
292.9	Unspecified drug induced mental disorder	292.9	Inhalant related disorders not otherwise specified
Opioid Use Disorders			
304.0 [0-3]	Opioid type dependence	304.00	Opioid dependence
305.5 [0-3]	Opioid abuse	305.50	Opioid abuse
Opioid Induced Disorders			
292.89	Other specified drug induced mental disorders	292.89	Opioid intoxication
292.0	Drug withdrawal	292.0	Opioid withdrawal
292.81	Drug induced delirium	292.81	Opioid intoxication delirium
292.11	Drug induced psychotic disorder with delusions	292.11	Opioid induced psychotic disorder with delusions
292.12	Drug induced psychotic disorder with hallucinations	292.12	Opioid induced psychotic disorder with hallucinations
292.84	Drug induced mood disorder	292.84	Opioid induced mood disorder
292.89	Drug induced sexual dysfunction	292.89	Opioid induced sexual dysfunction
292.85	Drug induced sleep disorder	292.85	Opioid induced sleep disorder
292.9	Unspecified drug induced mental disorder	292.9	Opioid related disorders not otherwise specified
Phencyclidine Use Disorders			
304.6 [0-3]	Other specified drug dependence	304.60	Phencyclidine dependence
305.9 [0-3]	Other, mixed, or unspecified drug use	305.90	Phencyclidine abuse
Phencyclidine Induced Disorders			
292.89	Other specified drug induced mental disorders	292.89	Phencyclidine intoxication

292.81	Drug intoxication delirium	292.81	Phencyclidine intoxication delirium
292.11	Drug induced psychotic disorder with delusions	292.11	Phencyclidine induced psychotic disorder with delusions
292.12	Drug induced psychotic Disorder with hallucinations	292.12	Phencyclidine induced psychotic Disorder with hallucinations
292.84	Drug induced mood disorder	292.84	Phencyclidine induced mood disorder
292.89	Drug induced anxiety disorder	292.89	Phencyclidine induced anxiety disorder
292.9	Unspecified drug induced mental disorder	292.9	Phencyclidine related disorders not otherwise specified (NOS)
Sedative-,Hypnotic-,or Anxiolytic Use Disorders			
304.1 [0-3]	Sedative-,hypnotic-,or anxiolytic dependence	304.10	Sedative-,hypnotic-,or anxiolytic dependence
305.4 [0-3]	Sedative-,hypnotic-,or anxiolytic abuse	305.40	Sedative-,hypnotic-,or anxiolytic abuse
Sedative-,Hypnotic-,or Anxiolytic-Induced Disorders			
292.89	Other specified drug induced mental disorders	292.89	Sedative-,hypnotic-,or anxiolytic intoxication
292.0	Drug withdrawal	292.0	Sedative-,hypnotic-,or anxiolytic withdrawal
292.81	Drug induced delirium	292.81	Sedative-,hypnotic-,or anxiolytic intoxication delirium
292.83	Drug induced persisting amnestic disorder	292.83	Sedative-,hypnotic-,or anxiolytic induced persisting amnestic disorder
292.11	Drug induced psychotic disorder with delusions	292.11	Sedative-,hypnotic-,or anxiolytic induced psychotic disorder with delusions
292.12	Drug induced psychotic disorder with hallucinations	292.12	Sedative-,hypnotic-,or anxiolytic induced psychotic disorder with hallucinations
292.84	Drug induced mood disorder	292.84	Sedative-,hypnotic-,or anxiolytic induced mood disorder
292.89	Drug induced anxiety disorder	292.89	Sedative-,hypnotic-,or anxiolytic induced anxiety disorder
292.89	Drug induced sexual dysfunction	292.89	Sedative-,hypnotic-,or anxiolytic induced sexual dysfunction
292.85	Drug induced sleep disorder	292.85	Sedative-,hypnotic-,or anxiolytic induced sleep disorder

292.9	Unspecified drug induced mental disorder	292.9	Sedative-,hypnotic-,or anxiolytic-related disorder not otherwise specified
304.7 [0-3]	Combinations of opioid type drug with any other	*	Polysubstance dependence
304.8 [0-3]	Combinations of drug dependence excluding opioid type drug	304.80	Polysubstance dependence
Tobacco Use Disorder			
305.1	Tobacco use disorder	305.1	Nicotine Dependence

--No equivalent DSM IV code

*Fifth digit sub-classification Subcategories:

[0 unspecified; 1 continuous; 2 episodic; 3 in remission]

Please note: The Department and its Contractors will continue to refine and update the covered procedures and diagnoses list on an ongoing basis.