Behavioral Health Comparison Rate Development: Phase Three

Engrossed Substitute Senate Bill 5950; Section 215(146); Chapter 376; Laws of 2024

December 31, 2024

Background

The Health Care Authority (HCA), in partnership with Milliman Inc., has been working on a project to develop behavioral health (BH) comparison rates for the last several years. The comparison rates are intended to estimate the costs a provider incurs when delivering specific behavioral health (BH) services. The project consists of multiple phases.

- Phase 1 focused on the initial development of comparison rates for a limited set of services.
- Phase 2 focused on refining the comparison rates developed as part of Phase 1 using a variety of data sources including a provider survey. This phase also looked at the estimated difference between historical Medicaid managed care organization (MCO) provider payments and the comparison rates.

The Legislature provided additional funding as part of the 2024 supplemental budget to continue this work. Phase 3 will span multiple years and focus on several activities including:

- **Developing comparison rates for services** that were not addressed in Phase 1, Phase 2, or other HCA work.
- **Preparing to implement a minimum fee schedule** (MFS) based on the comparison rates.
- **Estimating the cost of implementing MFS** based on the comparison rates.

Engrossed Substitute Senate Bill (ESSB) 5950; Section 215(146), directed HCA to provide a preliminary report to the Legislature and the Office of Financial Management that, amongst other activities,

- Estimates the costs of establishing an MFS based on the comparison rates.
- Identifies implementation challenges and options to address those.
- Provides additional analysis on payment variation between current reimbursement levels and the comparison rates.

The following report fulfills that directive. The final report is due in October 2025. While the proviso requires HCA to prepare to implement an MFS effective January 2026, it falls short of directing HCA to implement an MFS for calendar year 2026.

> **Additional Legislative action** (either funding or direction) **would be required during the 2025 Legislative session in order for HCA to implement an MFS effective January 2026.**

Project purpose

The BH comparison rate project is intended to support a variety of goals including:

- Developing and publishing comparison rates that are consistent with efficiency, economy, quality of care, and access to care.
- Providing an examination and understanding of the provider resources involved in delivering specific BH services.
- Providing a transparent payment-rate benchmark for use by all stakeholders.
- Understanding payment variation across regions, services, and providers.
- Establishing a payment floor (MFS) that helps address historical imbalances.
- Estimating the cost of implementing an MFS based on the comparison rates.

Project approach

This project uses an independent rate model framework to take data and provider feedback to develop rates at the services code level. Rates are built from the ground up based on a variety of assumptions around things like salaries and wages, employee related expenses, transportation expenses and administrative costs and overhead. HCA gathered data through multiple sources including provider workgroups and surveys.

Preparing to implement an MFS is a key part of Phase 3. An MFS establishes a minimum payment amount by services. MCOs and HCA would then be required to pay no less than that amount. MCOs and providers retain flexibility to negotiate rates that are above the MFS depending on a provider's unique circumstances. HCA has discretion on where in relation to the comparison rates to set the MFS for each service. The following report provides a range of options. The high scenario is based on setting the MFS at the BH comparison rates developed in prior phases. For the low scenario, some of the assumptions used for developing the BH comparison rates have been adjusted to reflect a minimum floor. The MFS is then set at this lower threshold. Where the MFS is set will ultimately depend on the amount of funding available from the Legislature.

Key findings

Implementation challenges

HCA and Milliman identified several challenges to implement an MFS for all BH services with a comparison rate developed in prior project phases beginning in calendar year (CY) 2026 including:

- **Encounter data reporting inconsistencies** – utilization reporting, in particular, is inconsistent.
- **Non-fee for services (FFS) payment arrangements** – the encounter data for non-FFS payment arrangements is largely incomplete making it difficult to identify what providers are currently paid at the services level and how that differs from the comparison rate.
- **Provider-type reporting** – BH comparison rates were originally developed to reflect the difference in cost based on rendering provider (i.e., master's-level staff versus B.S. bachelor's-level staff providing care). Current provider-type reporting on encounters is limited.

The following report provides additional details about each of these challenges.

Approach for addressing challenges

HCA is proposing implementing a calendar year (CY) 2026 MFS that is more limited in scope than what was originally contemplated within ESSB 5950; Sec215(146). This will allow HCA additional time to work through some of the challenges highlighted prior with the goal of implementing a more comprehensive MFS beginning in CY 2028. In identifying codes to include in the limited CY 2026 MFS, HCA focused on services:

- With high utilization, making the changes meaningful.
- Provided by a variety of organizations, creating a broad impact.
- With existing payment disparities (regional or provider), increasing payment uniformity and reducing system imbalances.
- Typically reimbursed on a FFS basis, circumventing some of the data challenge.

The services selected for the limited-scope MFS represent approximately one-third of the historical expenditures for services that have a BH comparison rate (see Appendix V for a list of services with and without comparison rates)

Next steps

HCA will:

- Look to the Legislature for additional direction on CY 2026 MFS implementation during the 2025 legislative session.
- Continue to work through the challenges identified in the report.
- Continue to refine the comparison rates developed in prior phase.
- Work to develop comparison rates for services not addressed in prior phases.

The following report provides additional details on the information contained in this summary.

Milliman Client Report

Approach to Implementing a Behavioral Health Minimum Fee Schedule in Washington State

Washington State Health Care Authority

December 2024

Jeremy Cunningham, FSA, MAAA
Annie Hallum, FSA, MAAA
Jacob Epperly, FSA, MAAA
Daniel Gerber, ASA, MAAA
Reagan Olguin, MSBA
Joseph Whitley, MPP

Milliman

Contents

EXECUTIVE SUMMARY 3
I. BACKGROUND 4
II. BH MFS IMPLEMENTATION CHALLENGES 5
LIMITED BH MINIMUM FEE SCHEDULE 5
III. STATEWIDE COST IMPACT OF IMPLEMENTING A LIMITED BH MINIMUM FEE SCHEDULE 7
STATEWIDE COST ESTIMATE OVERVIEW....................7
DATA....................7
METHODOLOGY 8
OTHER IMPACTS 12
IV. BH MINIMUM FEE SCHEDULE IMPLEMENTATION PLAN 14
BH MINIMUM FEE SCHEDULE RATE REVISION APPROACH 14
CY 2028 IMPLEMENTATION ACTIVITIES 15
FISCAL IMPLICATIONS....................15
LIMITATIONS....................16

Appendix I: CY 2024 BH Comparison Rates Modifications

Appendix II: Service-Level Information

Appendix III: Independent Rate Model Buildup – High & Low Estimate

Appendix IV: PTO, Training Time, and Non-Productive Time Factor

Appendix V: MFS Implementation Impact by Service

Appendix VI: Limited Implementation BH MFS Impact by Service and Region

Appendix VII: Comprehensive Implementation BH MFS Impact by Region

Reference Appendix I: Crosswalk of Provider Types to Provider Group

EXECUTIVE SUMMARY

In March of 2024, the Washington State Legislature passed Engrossed Substitute Senate Bill (ESSB) 5950 which directed Washington State Health Care Authority (HCA) to continue the behavioral health (BH) comparison rates project. BH comparison rates have been developed in order to provide transparent payment rate benchmarks for a variety of Medicaid-funded BH services over two previous phases of the work, and HCA is continuing to develop comparison rates for additional BH services in phase three. One of the required activities laid out in ESSB 5950 is a preliminary report exploring the cost of establishing a Medicaid BH minimum fee schedule (MFS) effective January 1, 2026, based on updated comparison rates developed in prior phases of this project. This report provides the impact of implementing a Medicaid BH MFS, including the estimated cost, current limitations, and HCA's plan resulting from ESSB 5950.

A BH MFS would establish minimum payment levels by service, which would require payers to amend established payment levels if they fall below the MFS amounts. This approach results in targeted payment increases to providers with the lowest payment levels, supporting consistency in payment levels across providers.

Comprehensive encounter data is crucial to understanding the impact of a MFS. Currently, Washington BH encounter data frequently lacks reliable utilization, cost, and provider type reporting, and encounters are often under-reported for payment arrangements other than fee-for-service ("non-FFS payment arrangements"). As a result, the cost impact estimate in this report will be different to the extent that complete encounter data reflects differences in payment levels from the current encounter reporting.

In order to move the BH delivery system toward a MFS implementation despite current encounter data limitations, HCA proposes introducing a BH MFS in calendar year (CY) 2026 for only a subset of BH codes (90832, 90834, 90837, H0004, H0038). HCA selected these codes based on factors including historical utilization patterns, known payment disparities across regions, and whether a BH service is typically paid on a fee-for-service basis. Note that these five selected services' historical expenditures are approximately one third of the historical expenditures for BH services with comparison rates. In addition, the BH MFS rate would be the same for any provider of these services regardless of credentialing. While a more limited BH MFS scope is established, HCA proposes to work on addressing the limitations in the encounter data with the aim of implementing a BH MFS on January 1, 2028 which includes all services with BH comparison rates developed as of the second phase of the BH comparison rate initiative.

The potential MFS cost impact has been developed using two separate sets of minimum payment levels in order to develop a range of potential costs. For our low-cost estimate, minimum payment levels reflect median provider wage levels gathered from industry benchmarks, but do not include costs resulting from travel time or time spent completing non-billable activities (i.e., care coordination). For our high-cost estimate, minimum payment levels utilize assumptions consistent with previously developed BH comparison rates including provider wage levels above the median, BH providers spending a significant portion of time completing non-billable activities, and travel costs for services that may require clinical staff to travel to patients' homes or other community settings.

The below table illustrates the **total state and federal** cost impact estimate of implementing a BH MFS in Washington, both with and without a limited code set in CY 2026, for both the low and high minimum payment levels. Note that these cost impact estimates reflect only FFS payment arrangements and exclude MCO non-FFS payment arrangements due to the aforementioned data limitations. Although MCO non-FFS payment arrangements comprise approximately 50% of projected CY 2026 BH payments covered under managed care capitation rates, we did not identify a significant number of providers reimbursed through non-FFS payment arrangements that would be impacted by the MFS based on the data available.

IMPLEMENTATION TYPE	PROJECTED CY 2026 FFS PAYMENTS	BH MFS CY 2026 COST IMPACT (LOW)	BH MFS CY 2026 COST IMPACT (HIGH)
Limited MFS	$ 104.3	$ 2.9	$ 29.9
Comprehensive MFS	334.1	27.7	104.4

Note that the state would only be responsible for approximately one-third of the incremental Medicaid costs resulting from MFS implementation due to federal matching. In addition, the cost estimate above is specific to benefit cost and does not include other potential sources of additional costs (i.e., administrative payments to MCOs). Potential areas of additional costs are further described within the body of this report.

I.BACKGROUND

WORK ESTABLISHED IN ESSB 5950, SECTION 215 (PROVISO 146)

In March of 2024, the Washington State Legislature passed Engrossed Substitute Senate Bill (ESSB) 5950 which directed Washington State Health Care Authority (HCA) to continue the behavioral health (BH) comparison rates project. BH comparison rates have been developed in order to provide transparent payment rate benchmarks for a variety of Medicaid-funded BH services over two previous phases of the work, and HCA is continuing to develop comparison rates for additional BH services in phase three. One of the required activities laid out in ESSB 5950 is a preliminary report exploring the cost of establishing a Medicaid BH minimum fee schedule (MFS) effective January 1, 2026, based on updated comparison rates developed in prior phases of this project.

This report has been developed to support the request within ESSB 5950 for a preliminary report to the Office of Financial Management by December 31, 2024, which must include the following:

- An estimation of the cost impact for implementing a BH MFS pertaining to both fee-for-service (FFS) and other managed care programs.
- An assessment of BH MFS impacts on the state's Medicaid behavioral health environment other than the aforementioned cost impact.
- Identification of data and other limitations needing to be resolved to implement the BH MFS by January 1, 2026. This includes clarifying any additional funding needs.
- Additional analysis of the variation between the comparison rates and current payment levels at a service and regional level.
- HCA's plans on proposing to the legislature implementation of a BH MFS by January 1, 2026.
- An outline of options to periodically update the BH MFS.

DEFINITIONS

Throughout this report, we will refer to several types of payment arrangement:

- "Non-MCO FFS" references fee-for-service payments directly to providers from the state (i.e., outside of managed care).
- "MCO FFS" references managed care contract arrangements in which MCOs pay providers on a fee-for-service basis.
- "MCO non-FFS" includes all contract arrangements in which MCO payments to providers are not based directly on the services provided. This includes sub-capitated payments, payments based on a provider's budget, case rate payments, and other non-FFS arrangements.

II. BH MFS IMPLEMENTATION CHALLENGES

HCA and Milliman identified several challenges with regards to full implementation of a MFS for BH services by the beginning of CY 2026, including the following:

- **Encounter data reporting inconsistencies.** Some fields on Managed Care Organization (MCO) encounters are reported inconsistently by different providers for many BH services. Utilization reporting in particular is inconsistent and requires significant internal adjustment.
- **MCO non-FFS arrangements.** Many behavioral health providers contract under MCO non-FFS arrangements, as described in the previous section. The encounter data for these payment arrangements is incomplete for many providers and does not include service-level payment information. Without service-level reporting, it is difficult to identify whether providers paid through MCO non-FFS arrangements should receive additional funding because of the BH MFS. This report assumes there are no cost increases for MCO non-FFS arrangements resulting from the implementation of a BH MFS.
- **Provider type reporting.** Lack of robust provider type reporting on encounters (e.g., differentiating between a master's level and bachelor's level staff providing care) leads to an inability to develop separate BH MFS rates for a single service based on the credentialing of the rendering provider.
- **Cost impact uncertainty.** The above challenges lead to increased uncertainty regarding the cost impact of a comprehensive BH MFS. Addressing these challenges is likely to be a multi-year process not completed by January 1, 2026.
- **Lag between data and implementation.** Additional funding provided due to a MFS will be mainly distributed through managed care capitation rates. For example, capitation rates effective in CY 2026 will rely on base data from CY 2024; therefore, implementation of the BH MFS into managed care is two years following the year of improved encounter data.

LIMITED BH MINIMUM FEE SCHEDULE

To account for these challenges, HCA proposes introducing a BH MFS in CY 2026 with a more limited scope than what is requested within ESSB 5950. While a more limited BH MFS scope is established, HCA would work on addressing the above challenges with the aim of implementing a BH MFS in alignment with legislative direction (referred throughout this report as the ***comprehensive BH MFS***) beginning on January 1, 2028.

The CY 2026 BH MFS is proposed to be limited in scope in the following ways:

- **Reduced covered services.** The CY 2026 BH MFS will apply to select BH services rather than all services with associated BH comparison rates developed to date.

  Figure 1 provides the codes proposed for the limited BH MFS and their associated non-MCO FFS and MCO FFS costs in CY 2023. These codes were selected based on the following criteria developed in collaboration with HCA:

  - Services with high utilization. Prioritizing these services allows for the MFS to have a significant effect on provider payments prior to comprehensive implementation.
  - Services provided by a variety of organizations (as opposed to specialty services). Prioritizing these services incentivizes more providers to report encounters prior to comprehensive implementation.
  - Services with existing payment disparities in provider payments across regions or other factors (e.g., Mental Health (MH) versus Substance Use Disorder (SUD) provision payment gaps). Prioritizing these services leads to greater improvements in payment consistency.
  - Services typically compensated on a fee-for-service basis (versus those typically paid through other arrangements). Without comprehensive encounter data it is difficult to identify whether providers under other payment arrangements should receive MFS payments.

- Services not expected to have substantial revisions to BH comparison rates during phase three of HCA's BH comparison rate initiative. For example, we did not consider SUD services with significant expected impacts from the movement to ASAM 4th edition. Prioritizing these services reduces the uncertainty regarding the cost impact resulting from MFS implementation.

FIGURE 1 - SELECTED LIMITED BH MFS SERVICE CODES ($ IN MILLIONS)

HCPCS	SERVICE DESCRIPTION	CY 2023 BH NON-MCO FFS & MCO FFS PAYMENTS
90832	Psychotherapy, 30 minutes with patient and-or family member	$ 4.9
90834	Psychotherapy, 45 minutes with patient and-or family member	12.5
90837	Psychotherapy 60 minutes with patient and/or family member	32.4
H0004	Behavioral health counseling and therapy, per 15 minutes	39.1
H0038	Self-help/peer services, per 15 minutes	5.3
Total Across Selected Codes	**N/A**	**$ 94.3**
Total Across Codes with BH Comparison Rates	**N/A**	**$ 286.2**

- **Singular rate levels.** Services with BH comparison rates tend to have several comparison rate levels due to the credentialing of the rendering provider and setting (rural vs urban). Rather than develop multiple payment levels per service to account for these factors, a single BH MFS rate will be established per service.

These temporary limitations in scope will give HCA additional time to address challenges described above prior to comprehensive implementation. Given the primary challenge is encounter data quality, HCA may propose an encounter data improvement initiative to begin in 2025. An encounter data initiative would support the following:

- Improved utilization reporting for non-MCO FFS arrangements.
- Increased reporting of provider credentialing, location, and populations served.
- Improvements to MCO non-FFS encounter data quality, which would allow HCA to identify impacts of a BH MFS for providers paid through these arrangements.

An encounter data initiative would ensure that there are steps taken to reduce BH MFS cost impact uncertainty prior to implementing a more comprehensive BH MFS.

III. STATEWIDE COST IMPACT OF IMPLEMENTING A LIMITED BH MINIMUM FEE SCHEDULE

STATEWIDE COST ESTIMATE OVERVIEW

ESSB 5950 required that this report include a cost impact estimate for implementing a BH MFS in CY 2026, pertaining to both Medicaid fee-for-service and other managed care programs.

As described in the previous section, HCA is proposing to limit the initial implementation of the BH MFS to a subset of BH services to allow for more time to address challenges prior to a more comprehensive BH MFS implementation. Under this approach, it is proposed that the comprehensive BH MFS including all BH services with comparison rates will be implemented on January 1, 2028.

Figure 2A outlines the range of total cost impacts, from low-cost and high-cost scenarios, of implementing a BH MFS starting in CY 2026 for the service codes identified in Figure 1. Note that projected CY 2026 MCO non-FFS payments have been excluded from the below figures as encounter data limitations lead to challenges when trying to attribute a portion of MCO non-FFS payment to specific codes. Likewise, the cost impact estimates assume that there will not be any BH MFS impact for MCO non-FFS payment arrangements in CY 2026

FIGURE 2A - CY 2026 BH PAYMENTS, FEDERAL + STATE SHARE ($MILLIONS)

BH PAYMENT ARRANGEMENTS	PROJECTED CY 2026 BH PAYMENTS (STATUS QUO)	LIMITED BH MFS INCREASE – LOW ESTIMATE	LIMITED BH MFS INCREASE – HIGH ESTIMATE
Non-MCO FFS	$ 2.7	$ 0.6	$ 2.8
MCO FFS	107.4	2.3	27.1
Total Impact	**$ 110.1**	**$ 2.9**	**$ 29.9**

Figure 2B is limited to the state share of the associated costs for the implementation of the BH MFS shown in Figure 2A.

FIGURE 2B - CY 2026 BH PAYMENTS, STATE SHARE ($MILLIONS)

BH PAYMENT ARRANGEMENTS	PROJECTED CY 2026 BH PAYMENTS (STATUS QUO)	STATE COST INCREASE - LOW ESTIMATE	STATE COST INCREASE - HIGH ESTIMATE
Non-MCO FFS	$ 0.9	$ 0.2	$ 1.0
MCO FFS	36.5	0.8	9.2
Total Impact	**$ 37.4**	**$ 1.0**	**$ 10.2**

DATA

As required by Actuarial Standard of Practice (ASOP) No. 23, Data Quality, we disclose that Milliman has relied upon certain data and information included within Washington's behavioral health encounter data. Our assessment of costs resulting from implementing a BH MFS in Washington are dependent upon this reliance.

Some limitations related to encounter data quality identified throughout the scope of this work include the following:

- Reported MCO FFS payments were appropriate for determining the high-level cost impact of a BH MFS. However, MCO FFS utilization data may not be comprehensively reported within the state. To the extent that there are missing encounters, the cost impact may be understated.

- There are certain known issues with MCO FFS encounters reported to the state, including inconsistent utilization reporting, incomplete and inconsistent taxonomy coding, and inconsistent shadow encounter flagging. We have included adjustments to account for these deficits to the extent that we feel comfortable relying on MCO FFS data, but it was not possible to completely correct them.
- MCO non-FFS payments are reported outside of encounter data in total for each provider by MCOs, but this reporting does not include individual service-level detail. Shadow encounters underlying these MCO non-FFS arrangements are included in the state's data warehouse to support the payments, but they do not contain payment information and are not fully reported for many providers and services. Since actual payments include a variety of services and are not allocated by procedure code, it is challenging to develop a cost impact specific to each procedure code included within these MCO non-FFS payment arrangements.

With these limitations in mind, we used Washington's Medicaid non-MCO FFS claims data and MCO FFS encounter data to estimate the potential cost impact of HCA implementing a BH MFS. We did not include an estimate for MCO non-FFS payment arrangements given the encounter data limitations.

Our analysis also relied upon BH comparison rates developed in phase two of Washington's behavioral health comparison rate initiative, documented in the report published on June 30, 2023.[1] Some data limitations regarding these previously developed BH comparison rates are as follows:

- Wage levels were developed based on industry benchmarks (i.e., Bureau of Labor Statistics (BLS) data), as there were limited survey responses during the previous phase of this work. HCA is currently administering another BH provider survey that will collect wage and expense information, and it is anticipated that the BH comparison rates developed in phase three will be refined to account for survey responses prior to CY 2026 BH MFS implementation.
- Phase three BH comparison rates, which will be finalized by June 30, 2025, will include BH comparison rates for additional services as well as refinements to the BH comparison rates developed in phase two. For example, SUD comparison rates developed previously will be reassessed when reflecting changes in costs that may result from the transition to the American Society of Addiction Medicine (ASAM), 4th edition.

We have found the phase two BH comparison rates, with minor updates, to be suitable for the development of this initial cost impact estimate resulting from the implementation of a BH MFS. The BH comparison rate report, to be submitted by June 30th, 2025, will include a refined cost impact that will reflect comparison rate updates including a provider survey which is currently active and due in January 2025.

METHODOLOGY

We have followed the steps below to estimate the MCO and non-MCO BH payment increases in CY 2026 if a state-directed BH MFS is adopted based on the phase 2 comparison rates.

Step 1: Identify and prepare BH payment data to be used as a representation of CY 2026 BH payment levels.

We identified BH non-MCO FFS claims and MCO encounters incurred in CY 2023 and reported to ProviderOne (P1) through March 2024. A cost trend factor of 16.7% was applied to estimate CY 2026 payment levels absent a BH MFS. This cost trend factor is the product of the following two components:

- An adjustment to account for ESSB 5693 (Section 215, proviso #58) mandating a 15% rate increase for all Medicaid behavioral health provider rates effective January 1, 2024.
- An annual trend of 0.5% was applied on top of the behavioral health benefit increase, resulting in a cumulative 1.6% increase in unit cost over three years.

Step 2: Develop low- and high-cost BH MFS scenarios using the Phase Two BH Comparison Rates framework

The purpose of the BH MFS is to establish a ***minimum payment level*** that a MCO can pay a provider for a given BH service. Phase two BH comparison rates were used as a starting point to determine appropriate minimum payment levels.

[1] https://www.hca.wa.gov/assets/program/BH-Comparison-Rate-Development-Phase-Two-202309.pdf

Phase two BH comparison rates were developed using an independent rate model approach, which builds rates from the "ground up" and considers what the costs may be to provide the service based on a set of assumptions. These assumptions were informed by several data sources including provider workgroups for each service, provider survey data, publicly available data, state and federal guidance, and discussions with HCA. Appendix I outlines the updates made to assumptions that underly the phase two BH comparison rates to reflect the timing of limited BH MFS implementation (CY 2026).

An appropriate minimum payment level should depend on the standard methods used to provide BH services within the state. For example, if the typical approach to providing BH services is to support individuals through non-billable activities (e.g., care coordination) in addition to the service itself, then the minimum payment levels should reflect this additional source of provider costs. However, if serving individuals through non-billable activities is not common practice, then minimum payment levels should not include them.

To account for the potential difference in standard practice across services, two sets of minimum payment levels have been developed to assess the potential range of impacts resulting from implementing a BH MFS. One of these two sets of minimum payment levels is consistent with the previously developed phase two BH comparison rates trended forward to CY 2026. The other set of minimum payment levels uses separate assumptions for a few key areas. The following assumptions vary between the two sets of minimum payment levels:

- **Provider wages.** BH comparison rates assume BH clinical direct care professionals are paid, on average, the 62.5th percentile wage estimate developed using information from the Bureau of Labor Statistics.

  A separate set of minimum payment levels have been developed assuming median (i.e., the 50th percentile) wage levels for BH providers. It is important to note that a provider survey is currently active for BH providers and the wages underlying a CY 2026 BH MFS will be updated to consider actual provider wages prior to completion.
- **Transportation adjustments.** BH comparison rates assume travel costs are included for services where clinical staff may be required to travel to patients' homes or other community settings. In practice, this may overestimate the minimum cost of providing a BH service, particularly in office settings. The adjusted set of minimum payment rates assume the provider would not need to travel to the individual being served.
- **Additional non-productive time factor.** Phase two BH comparison rates incorporate a non-productive time factor, which reflects additional time spent on non-billable activities supporting the individual served (i.e., care coordination). In practice, the amount of care coordination provided may vary across behavioral health providers in the state. The adjusted set of minimum payment rates do not include costs related to certain non-billable activities.

The state may wish to assess the status quo of BH service provision across the state to determine what set of minimum payment levels are most appropriate prior to implementation. Minimum payment level assumptions could be adjusted from those in this report if the state decides it is appropriate. For example, a minimum payment level structure could be developed that accounts for non-billable time but not to the extent currently assumed within BH comparison rates.

Figure 3 summarizes the differences in assumptions between minimum payment levels developed using BH comparison rates and those with revised assumptions:

FIGURE 3: BH MINIMUM PAYMENT LEVEL ASSUMPTIONS

COMPONENT	BH MFS PAYMENT LEVELS - BH COMPARISON RATES	BH MFS PAYMENT LEVELS – ALTERNATIVE OPTION
Provider wage levels	62.5th percentile wages	50th percentile wages
Transportation activities	Included for all initial BH MFS services	Excluded for initial BH MFS services
Non-productive time factor	Included for all initial BH MFS services	Excluded for initial BH MFS services

Note that phase two BH comparison rates account for different wage levels depending on the provider type delivering a service. This level of information is not consistently provided in the BH encounter data. To account for this, Milliman and HCA identified the most common provider type for each BH service with comparison rates. The BH MFS rates developed reflect the staffing cost of the most common provider for each service. The chosen provider type for each BH service included in phase two BH comparison rate development along with low and high scenario BH MFS rates are detailed in Appendix II. Reference Appendix I shares the crosswalk from DOH license/credential, Medicaid state plan provider type, SERI provider type, and SERI taxonomy code to the provider grouping included in this appendix.

Note that, as BH MFS rates are intended to establish a minimum payment level for BH services, it is assumed that MCOs will give BH providers a rate increase for any service compensated below the BH MFS rate. ***These rates are not suitable for any other purpose.*** In addition:

- MCOs and providers can still negotiate higher rates than the BH MFS rates based on provider or member needs, and MCOs are not required to change their payment methodologies if providers are not paid less than the BH MFS rate.
- HCA will not require or expect that MCOs reduce rates to other providers to offset the cost of implementing the BH MFS.

Appendix III documents the independent rate model buildup for HCPCS 90837, the procedure code for one of the BH services selected under the limited BH MFS approach, under both the low- and high-cost scenarios. Differences between the two buildups have been highlighted in yellow for increased visibility. More information on the independent rate model approach can be found in the phase two BH comparison rate report.

Appendix IV documents the buildup of the PTO/training/conference time adjustment factor both with and without the additional non-productive time factor that accounts for non-billable activities.

Step 3: Develop a cost impact for implementing a BH MFS under low- and high-cost scenarios.

The cost impact of implementing a BH MFS varies for FFS payments and MCO non-FFS payments as outlined below.

- For ***FFS payment arrangements*** (non-MCO FFS and MCO FFS), the cost impact of implementing a BH MFS was calculated at a claim/encounter line level. For claims where the BH MFS rate is greater than the historical payment repriced to CY 2026, a cost impact equal to the difference was assumed. For claims where the historical payment rate is greater than the BH MFS rate, no impact was assumed. This calculation was performed for all FFS claim & MCO encounter lines reflecting services included in the phase two BH comparison rates.
- For ***MCO non-FFS payments***, calculating the impact of implementing a BH MFS would require having complete historical service-level shadow encounter data (both utilization and unit cost information) underlying the aggregate payments a given MCO pays to a given provider. These service-level shadow encounters would then be repriced in cases where the BH MFS rate is greater than the proxy-priced shadow payment.

  Under both the limited and future comprehensive (i.e., including all BH services with existing comparison rates) BH MFS approaches, we found minimal instances of BH MFS priced service-level shadow encounters costing more than historical aggregate MCO non-FFS payment levels for a given provider. **For the sake of this analysis, it is assumed that the BH MFS will <u>not</u> result in a cost impact for MCO non-FFS payment arrangements.**

Figure 4A shares projected low- and high-cost impacts for implementing a BH MFS as a percentage of projected CY 2026 BH FFS payments. Note that these cost impacts are specific to benefit costs and do not account for any increases to administrative payments to MCOs. The limited implementation selected services are the five BH services (90382, 90834, 90837, H0004, H0018) recommended previously in this report. The comprehensive implementation selected services are all BH services with existing comparison rates. MCO non-FFS payments are not illustrated for selected services due to encounter data limitations.

FIGURE 4A – PROJECTED CY 2026 BH MFS COST IMPACTS AS A PERCENTAGE OF CY 2026 BH PAYMENTS FOR SELECTED SERVICES – BY IMPLEMENTATION OPTION ($ IN MILLIONS)

INDEX	COMPONENT	NON-MCO FFS & MCO FFS LOW ESTIMATE	NON-MCO FFS & MCO FFS HIGH ESTIMATE
Limited Implementation Impact Across Selected Services	Projected CY 2026 BH Payments (Status Quo)	$110.1	$110.1
	Projected BH MFS Impact	**2.9**	**29.9**
	Total	112.9	139.9
	Percentage Impact	2.60%	27.10%
Comprehensive Implementation Impact Across Selected Services	Projected CY 2026 BH Payments (Status Quo)	$334.1	$334.1
	Projected BH MFS Impact	**27.7**	**104.4**
	Total	361.9	438.5
	Percentage Impact	8.30%	31.20%

Figure 4B illustrates the projected low- and high-cost impacts of implementing a BH MFS as a percentage of all projected CY 2026 BH service payments (Non-MCO FFS, MCO FFS, and MCO non-FFS).

FIGURE 4B – PROJECTED CY 2026 BH MFS COST IMPACTS AS A PERCENTAGE OF CY 2026 BH PAYMENTS ACROSS ALL BH SERVICES – BY IMPLEMENTATION OPTION ($ IN MILLIONS)

INDEX	COMPONENT	NON-MCO FFS & MCO FFS LOW ESTIMATE	NON-MCO FFS & MCO FFS HIGH ESTIMATE	MCO NON-FFS	TOTAL LOW ESTIMATE	TOTAL HIGH ESTIMATE
Limited Implementation Impact Across All BH Services	Projected CY 2026 BH Payments (Status Quo)	$763.2	$763.2	$715.3	$1,478.6	$1,478.6
	Projected BH MFS Impact	**2.9**	**29.9**	**0**	**2.9**	**29.9**
	Total	766.1	793.1	715.3	1,481.4	1,508.4
	Percentage Impact	0.40%	3.90%	0.00%	0.20%	2.00%
Comprehensive Implementation Impact Across All BH Services	Projected CY 2026 BH Payments (Status Quo)	$763.2	$763.2	$715.3	$1,478.6	$1,478.6
	Projected BH MFS Impact	**27.7**	**104.4**	**0**	**27.7**	**104.4**
	Total	791	867.6	715.3	1,506.3	1,583.0
	Percentage Impact	3.60%	13.70%	0.00%	1.90%	7.10%

Appendix V shares the projected CY 2026 low- and high-cost impacts of implementing a BH MFS by service.

Appendix VI shares the projected CY 2026 low- and high-cost impacts of implementing a BH MFS by service and region, for services included in the limited BH MFS.

Appendix VII shares the projected CY 2026 low- and high-cost impacts of implementing a BH MFS by region for all services with existing BH comparison rates.

Step 4: Identify the portion of the cost impact for which the state would be responsible.

The state will only be responsible for the state share of additional Medicaid costs resulting from BH MFS implementation rather than the entire cost impact shared in Step 3. The distribution of statewide projected CY 2026 BH outpatient costs by Medicaid population was used to approximate the federal share of costs as 66% of total costs.

Figure 5 below shows the approach used to determine this percentage:

FIGURE 5: BLENDED FMAP ADJUSTMENT FACTOR BUILDUP

INDEX	COMPONENT	PERCENTAGE
A	Apple Health Medicaid Expansion FMAP	90.0%
B	State Children's Health Insurance Program (SCHIP) FMAP	65.0%
C	Other Medicaid populations' FMAP	50.0%
D	% of BH outpatient services provided to Apple Health Medicaid Expansion	40.0%
E	% of BH outpatient services provided to State Children's Health Insurance Program (SCHIP)	2.0%
F	% of BH outpatient services provided to other Medicaid populations	58.0%
G	Blended FMAP Adjustment Factor (A * D + B * E + C * F)	66.0%

Figure 6 shares the projected **state share** of additional costs resulting from implementing a BH MFS under both the limited and comprehensive implementation approaches.

FIGURE 6: STATE SHARE OF BH MFS IMPACTS ($ IN MILLIONS)

INDEX	COMPONENT	NON-MCO FFS & MCO FFS LOW ESTIMATE	NON-MCO FFS & MCO FFS HIGH ESTIMATE
Limited Implementation Impact Across Selected Codes	Projected State Share CY 2026 BH Payments (Status Quo)	$ 37.4	$ 37.4
	Projected State BH MFS Payments	**1.0**	**10.2**
	Total State Share	38.4	47.6
	Percent Impact	2.6%	27.1%
Comprehensive Implementation Impact Across Selected Codes	Projected State Share CY 2026 BH Payments (Status Quo)	$ 113.6	$ 113.6
	Projected State BH MFS Payments	**9.4**	**35.5**
	Total State Share	123.0	149.1
	Percent Impact	8.3%	31.2%

OTHER IMPACTS

In addition to the fiscal impacts described above, we anticipate several other potential impacts on Washington's Medicaid behavioral health environment as a result of the BH MFS implementation:

- **Improved encounter reporting** – A BH MFS based on reported utilization is an incentive for BH providers to ensure that they are accurately reporting encounters, especially when they are currently paid at a rate level below BH MFS rates. Under a future BH MFS system that differentiates payments based on provider type, providers would also need to improve their provider type reporting to support increased payments for higher credentialed staff. Improved encounter reporting would broadly support the behavioral health delivery system across all initiatives, enabling the state to have better transparency and accountability of the services being provided to the state's most vulnerable populations.

- **Payment consistency –** The implementation of a statewide BH MFS would target payment increases to providers with the lowest payment levels, supporting consistency in payment levels across providers.

- **Improved understanding of cost differences by provider –** For providers that are paid using a MCO non-FFS contracting arrangement especially, it can be difficult to understand how well payments align with actual costs. The implementation of a BH MFS and the associated improvement in encounter reporting could lead to a better understanding of the relative costs and utilization between providers.

- **Increased administrative burden –** The BH MFS is likely to lead to increased administrative burden on BH providers to the extent that they are not currently reporting all encounter data. It is important to note that encounter data reporting is not a new contract requirement; encounter data reporting has been included within MCO-provider contracts for several years. Additionally, HCA and the MCOs may have an increased administrative burden to both support improved encounter data reporting for the behavioral health delivery system and to operationalize the BH MFS payments to BH providers, as appropriate.

  It should be noted that HCA is not prescribing an approach for MCOs to adjust MCO non-FFS arrangements to ensure that providers are compensated at BH MFS rate levels in future year (i.e., a complete restructuring of MCO payment arrangements is not being required to proactively account for the MFS).

IV. BH MINIMUM FEE SCHEDULE IMPLEMENTATION PLAN

BH MINIMUM FEE SCHEDULE RATE REVISION APPROACH

HCA proposes revising BH MFS rates in a manner consistent with how BH comparison rates are updated on an annual basis. Activities would include the following:

- **New services.** Service-specific assumptions will be determined for services with comparison rates being developed for the first time. Service-specific assumptions would be supported by provider workgroups consistent with prior phases of the comparison rate initiative.
- **Updates to existing services.** Rate model assumptions, such as wages and benefits, will be adjusted on an annual basis for services with existing comparison rates. Common sources for these assumptions include BLS data, which is a publicly available data source that is updated annually, and provider survey data, which is commonly collected by state Medicaid agencies on an annually recurring basis.

In addition to the above items, the approach to modifying BH comparison rates to develop BH MFS rates will continue to be assessed to ensure cost outcomes reflect Washington's vision behind the directive.

CY 2026 IMPLEMENTATION ACTIVITIES:

HCA proposes a phased approach to implementing a BH MFS. Below is a proposed outline of activities from the initial BH MFS implementation year (CY 2026) to the comprehensive BH MFS implementation year (CY 2028):

- **BH comparison rate development.** HCA's third phase of BH comparison rate development is in progress, and the comparison rates used to develop the initial BH MFS will reflect the comparison rates shared in this project's final report due on June 30, 2025.

  One major aspect of this project is informing existing BH comparison rates through provider surveys requesting information about current wage levels and provider expenses. This will result in the final CY 2026 BH MFS rates considering the provider survey in addition to industry benchmarks (i.e., BLS wage data).

  The alternative approach to base a minimum payment level on adjusted BH comparison rate assumptions has not yet been reviewed by interested parties. The proposed approach will be discussed in engagements planned for CY 2025 should Washington choose to move forward with CY 2026 BH MFS implementation.
- **Initial code decision.** HCA will collaborate with the legislature to finalize the listing of services to be initially included in the BH MFS in the first half of 2025.
- **Non-MCO FFS operationalization.** A state plan amendment would need to be approved in order to adjust FFS rate levels.
- **MCO FFS operationalization.** HCA will collaborate with MCOs to develop an approach to operationalize the BH MFS for FFS payment arrangements to ensure payment levels are at least at the level set forth by the BH MFS. *Increased funding needed to implement the BH MFS for MCO FFS payments would be included within the CY 2026 managed care capitation rates.*
- **MCO non-FFS operationalization.** As described above, incomplete encounter data prevents the appropriate assessment of the impact of a BH MFS on MCO non-FFS arrangements. HCA is considering encounter data improvement initiatives beginning in 2025 to provide greater transparency into provider payment levels within existing MCO non-FFS arrangements. To the extent that providers and/or MCOs have robust service-level utilization and unit cost information underlying MCO non-FFS aggregate payments, HCA may consider this information during the CY 2026 managed care capitation rate setting process.

CY 2027 IMPLEMENTATION ACTIVITIES:

- **BH MFS and BH comparison rate revision.** CY 2026 BH MFS rates will be adjusted to reflect CY 2027 costs in a manner consistent with the BH MFS rate revision approach. In addition, HCA may consider adding services to be included in the BH MFS or adjusting the BH MFS rate development approach.

CY 2028 IMPLEMENTATION ACTIVITIES

- **BH MFS and BH comparison rate revision.** CY 2027 BH MFS rates will be adjusted to reflect CY 2028 costs in a manner consistent with the BH MFS rate revision approach. Most services provided under section 13d of the State Plan will have BH MFS rates developed to establish the “comprehensive” BH MFS by the beginning of 2028.

  The CY 2028 BH MFS may include additional BH services that do not yet have comparison rates developed. These additional comparison rates are being drafted as part of the broader phase three comparison rate initiative and include certain mental health outpatient services, opioid treatment program services, and SUD codes resulting from implementing ASAM, 4th edition.

FISCAL IMPLICATIONS

The fiscal implications of implementing a BH MFS are as follows:

Capitation rate increases. Managed care capitation rates are expected to *increase* as a result of the BH MFS. The increase will depend on the assumptions used to develop BH MFS rates, the services included in the initial BH MFS, and the extent to which actual experience deviates from the projected fiscal impact. As shared previously, the estimated benefit cost impact for CY 2026 under the limited implementation approach is **$2.9M** to **$29.9M**, with the state’s share of costs estimated at **$1.0M** to **$10.2M**. In addition to these benefit costs, additional administrative payments to MCOs may be appropriate.

Encounter data initiative. HCA is considering initiatives to improve encounter data quality alongside BH MFS implementation. Potential administrative costs to support HCA, MCOs, and/or providers will depend on whether an initiative is established and the specifications of the initiative.

Managed care actuarial rate setting. Inclusion of the BH MFS into managed care capitation rates will require additional work from the managed care rate setting actuarial team including further analysis and MCO engagement. Additional funding would be needed to support these efforts.

BH minimum fee schedule updates. Additional funding will be required to update the BH MFS on an annual basis. As discussed in this report, this work will benefit from any further BH comparison rate funding provided. The extent of the funding needed for this work depends on the approach and data sources selected to evaluate annual cost increases (e.g., wages) each year.

LIMITATIONS

The information contained in this report, including the appendices, has been prepared for HCA. To the extent that the information contained in this report is provided to third parties, the report should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

The contents of this report are not intended to represent a legal or professional opinion or interpretation on any matters. Milliman makes no representations or warranties regarding the contents of this report to third parties. Similarly, third parties are instructed that they are to place no reliance upon this information prepared for HCA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

The assumptions documented within this report were developed in conjunction between HCA, Milliman, and interested parties. They build upon the results of previous comparison rate projects. Additionally, Milliman has developed certain models to estimate the values included in this report. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purposes and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The information in this report has relied extensively on data provided by HCA, interested parties, and national data sources. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The responsible actuaries for this report, Jeremy Cunningham, Annie Hallum, Jacob Epperly, and Dan Gerber, are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis within this report.

Appendix I: CY 2024 BH Comparison Rates Modifications

Washington State Health Care Authority
Minimum Fee Schedule Development
Appendix I - CY 2024 BH Comparison Rates Modifications

Components	Updated Assumptions to Reflect CY 2026 Costs	Source
BLS Wages	Wages updated to reflect May 2023 State Occupational Employment and Wage Estimates for the State of Washington. Trended from May 1, 2023, to July 1, 2026, by an annual trend of 3.5%.	May 2023 State Occupational Employment and Wage Estimates. Retrieved from https://www.bls.gov/oes/current/oes_wa.htm
Employee Social Security Withholding	Wage Base Limit: $181,800 projected for 2026 As projected by the Social Security Administration under an intermediate scenario	Social Security Administration. 2024 Old-Age, Survivors, and Disability Insurance (OASDI) Trustee Report. Retrieved from https://www.ssa.gov/oact/tr/2024/V_C_prog.html
State Unemployment Tax Acts (SUTA) Tax	1.35% of provider wage levels	Washington State Employment Security Department. Determining Your Tax Rates. Retrieved from https://esd.wa.gov/employer-taxes/determining-rates.
	Wage Base Limit: $68,500	Washington State Employment Security Department. Taxable Wage Base. Retrieved from https://esd.wa.gov/employer-taxes/taxable-wage-base.
Workers' Compensation	1.31% of provider wage levels	Bureau of Labor Statistics (June 2024). Economic News Release, Table 1. Employer Costs for Employee Compensation by Ownership for Civilian Workers. Retrieved from https://www.bls.gov/news.release/pdf/ecec.pdf
Insurance Benefits	$11,022 per year	2022 Provider Cost and Wage Survey
	Increased by 40% based on phase two BH comparison rate provider survey results to reflect higher insurance costs than those reflected in BLS insurance cost per hours worked data ($3.57 base hourly cost for the healthcare and social assistance industry group multiplied by 2,080 hours, trended from June 1, 2024, to July 1, 2026 by an annual trend of 3%).	U.S. Bureau of Labor Statistics. (June 2024). Economic News Release, Table 2. Employer Costs for Employee Compensation for Civilian Workers by Occupational and Industry Group. Retrieved from https://www.bls.gov/news.release/pdf/ecec.pdf
Retirement Percentage	5.0% of provider wage levels	U.S. Bureau of Labor Statistics. (June 2024). Economic News Release, Table 2. Employer Costs for Employee Compensation for Civilian Workers by Occupational and Industry Group. Retrieved from https://www.bls.gov/news.release/pdf/ecec.pdf

Appendix II: Service-Level Information

Washington State Health Care Authority
Minimum Fee Schedule Development
Appendix II - Service-Level Information

Initial Implementation	Most Common Provider Type	Minimum Fee Schedule Rate - Low Scenario	Projected CY 2026 Comparison Rates
90832	Master's Level Degree Licensed (MHP)	$ 53.79	$ 99.99
90834	Master's Level Degree Licensed (MHP)	80.69	136.59
90837	Master's Level Degree Licensed (MHP)	107.58	173.19
H0004	Mental Health Care Provider (MHCP) (Agency-Affiliated Counselors)	24.95	42.26
H0038	Peer Support	20.15	35.57
Additional Services with Comparison Rates			
90791	Master's Level Degree Licensed (MHP)	$ 161.38	$ 246.39
90792	PAs, NPs, and Pharmacists	383.55	557.41
90846	Master's Level Degree Licensed (MHP)	26.90	50.00
90847	Master's Level Degree Licensed (MHP)	26.90	50.00
90853	Master's Level Degree Licensed (MHP)	4.42	5.37
96164	SUDP Bachelor's and Below	8.39	11.95
96165	SUDP Bachelor's and Below	3.26	3.62
99205	PAs, NPs, and Pharmacists	230.35	325.76
99213	PAs, NPs, and Pharmacists	57.59	124.16
99214	PAs, NPs, and Pharmacists	100.78	180.66
99215	PAs, NPs, and Pharmacists	155.48	252.23
H0001	SUDP Bachelor's and Below	24.86	36.16
H0010	N/A - Team-Based Service	494.01	529.97
H0011	N/A - Team-Based Service	637.70	674.81
H0017	N/A - Team-Based Service	918.43	976.40
H0018	N/A - Team-Based Service	324.31	347.43
H0031	Master's Level Degree Unlicensed (MHP)	25.98	39.27
H0036	Mental Health Care Provider (MHCP) (Agency-Affiliated Counselors)	49.90	75.97
H2014	Mental Health Care Provider (MHCP) (Agency-Affiliated Counselors)	23.70	39.67
H2015	Mental Health Care Provider (MHCP) (Agency-Affiliated Counselors)	23.70	49.93
T1016	SUDP Bachelor's and Below	23.62	35.86

Notes:

1. Reference I shares the crosswalk from DOH license/credential, Medicaid state plan provider type, SERI provider type, and SERI taxonomy code to the provider grouping included in the "Most Common Provider Type" column.
2. The comprehensive minimum fee schedule approach would include both "Initial Implementation" services and "Additional Services with Comparison Rates" in CY 2026.
3. Minimum fee schedule rates under the high-cost scenario would be consistent with Projected CY 2026 BH Comparison Rates.

Appendix III: Independent Rate Model Buildup – High & Low Estimate

Washington State Health Care Authority
Minimum Fee Schedule Development
Appendix III - Independent Rate Model Buildup - High Estimate (Consistent with BH Comparison Rate Assumptions)

Service Information

Service Code:	90837 - Master's Level Degree Licensed (MHP)
Region:	Statewide Wage, Statewide Travel
Service Category:	Mental Health Outpatient
Service Description:	Psychother. approx. 60 mins w/ PT and/or fam. mem.
Reporting Units:	SUD Outpatient

Ref.	Description	62.5th Percentile Clinician: Master's Level Degree Licensed (MHP)	75th Percentile Supervisor: Master's Level Degree Licensed (MHP)	Total	Notes
A	Average minutes of direct time per unit	60.00			
B	Average minutes of indirect time per unit	20.00			
C	Average minutes of transportation time per unit	11.37			Based on separate travel build
D	**Total minutes per unit**	**91.37**			D = A + B + C
E	Staffing Ratio	1.00			
F	Supervisor span of control		10.00		10 employees assumed to be managed by 1 supervisor
G	Supervisor time per unit		9.14		G = D / E / F
H	PTO/training/conference time adjustment factor	51.2%	51.2%		Based on separate PTO build (includes 20.0% unproductive time adjustment)
I	**Adjusted Total minutes per unit**	**138.16**	**13.82**		I = D / E * (1 + H) || I = G * (1 + H)
J	Hourly wage	$ 37.88	$ 41.77		Based on separate wage build
K	**Total wages expense per unit**	**$ 87.23**	**$ 9.62**	**$ 96.85**	K = J * I / 60
L	Employee related expense (ERE) percentage	29.6%	28.2%		Based on separate ERE build
M	**Total ERE expense per unit**	**$ 25.85**	**$ 2.71**	**$ 28.56**	M = K * L
N	Estimated average MPH			35.34	Based on estimated % of in-home services, and the following MPH: Statewide 35.3, Urban 30, Rural 45 MPH, Frontier 55
O	Estimated miles driven per unit			6.70	O = C * N / 60
P	Federal reimbursement rate			$ 0.670	
Q	**Transportation fleet costs per unit**			**$ 4.49**	Q = O * P
R	Administration / program support / overhead			25.0%	Portion of total rate
S	**Administration Expenses**			**$ 43.30**	S = R * (K + M + Q) / (1 - R)
T	**Rate Per SUD Outpatient**			**$173.19**	**T = K + M + Q + S**

Ref.	Summary of Rate Model Components			Total	Notes
U	Direct Service Employee Salaries & Wages			$ 63.59	
V	Indirect Service Employee Salaries & Wages			$ 21.20	
W	Transportation Service Employee Salaries & Wages			$ 12.06	
X	Employee Related Expenses			$ 28.56	
Y	Transportation & Fleet Vehicle Expenses			$ 4.49	
Z	Administration, Program Support & Overhead			$ 43.30	
AA	**Total Rate**			**$173.19**	

Washington State Health Care Authority
Minimum Fee Schedule Development
Appendix III - Independent Rate Model Buildup - Low Estimate

Service Information

Service Code:	90837 - Master's Level Degree Licensed (MHP)
Region:	Statewide Wage, Statewide Travel
Service Category:	Mental Health Outpatient
Service Description:	Psychother. approx. 60 mins w/ PT and/or fam. mem.
Reporting Units:	SUD Outpatient

Ref.	Description	50th Percentile Clinician: Master's Level Degree Licensed (MHP)	75th Percentile Supervisor: Master's Level Degree Licensed (MHP)	Total	Notes
A	Average minutes of direct time per unit	60.00			
B	Average minutes of indirect time per unit	20.00			
C	Average minutes of transportation time per unit	-			Transportation time has been excluded.
D	**Total minutes per unit**	**80.00**			D = A + B + C
E	Staffing Ratio	1.00			
F	Supervisor span of control		10.00		10 employees assumed to be managed by 1 supervisor
G	Supervisor time per unit		8.00		G = D / E / F
H	PTO/training/conference time adjustment factor	21.0%	21.0%		This factor excludes the non-productive time factor accounting for non-billable activities. See Appendix IV for more information.
I	**Adjusted Total minutes per unit**	**96.77**	**9.68**		I = D / E * (1 + H) || I = G * (1 + H)
J	Hourly wage	$ 33.99	$ 41.77		The clinician's wage levels have been reduced from the 62.5th percentile to the 50th percentile.
K	**Total wages expense per unit**	**$ 54.82**	**$ 6.74**	**$ 61.56**	K = J * I / 60
L	Employee related expense (ERE) percentage	31.4%	28.2%		Based on separate ERE build
M	**Total ERE expense per unit**	**$ 17.23**	**$ 1.90**	**$ 19.13**	M = K * L
N	Estimated average MPH			35.34	Based on estimated % of in-home services, and the following MPH: Statewide 35.3, Urban 30, Rural 45 MPH, Frontier 55
O	Estimated miles driven per unit			-	Mileage has been excluded.
P	Federal reimbursement rate			$ 0.670	
Q	**Transportation fleet costs per unit**			**$ 0.00**	Q = O * P
R	Administration / program support / overhead			25.0%	Portion of total rate
S	**Administration Expenses**			**$ 26.90**	S = R * (K + M + Q) / (1 - R)
T	**Rate Per SUD Outpatient**			**$107.58**	**T = K + M + Q + S**

Ref.	Summary of Rate Model Components			Total	Notes
U	Direct Service Employee Salaries & Wages			$ 46.17	
V	Indirect Service Employee Salaries & Wages			$ 15.39	
W	Transportation Service Employee Salaries & Wages			$ 0.00	
X	Employee Related Expenses			$ 19.13	
Y	Transportation & Fleet Vehicle Expenses			$ 0.00	
Z	Administration, Program Support & Overhead			$ 26.90	
AA	**Total Rate**			**$107.58**	

Appendix IV: PTO, Training Time, and Non-Productive Time Factor

Washington State Health Care Authority
Minimum Fee Schedule Development
Appendix IV - PTO, Training Time, and Non-Productive Time Factor

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Provider group	Total hours	Paid holidays and PTO per year	On-going training / conference time hours per year	Total B + C	Training hours / inefficient time for each new hire	Turnover percentage	New hire training hours per year E * F	Hours of replacement for non-productive time D + G	Annual productive time prior to non-productive adjustment A - H	PTO / training / conference time adjustment factor A / I - 1	Additional non-productive time	Adjustment factor using additional non-productive time A / (I * (1 - K)) - 1	Total Annual non-productive time I * K + H	Total Annual Productive/Service time A - M
Minimum Fee Schedule Low Estimate	2,080	268	40	308	150	35%	53	361	1,720	**21.0%**	0.0%	**21.0%**	361	1,720
Minimum Fee Schedule High Estimate	2,080	268	40	308	150	35%	53	361	1,720	**21.0%**	20.0%	**51.2%**	704	1,376

Appendix V: MFS Implementation Impact by Service

Washington State Health Care Authority Minimum Fee Schedule Development Appendix V - Minimum Fee Schedule Implementation Impact by Service					
Initial Implementation Services	**SERI Modality**	**Service Description**	**Projected CY 2026 FFS Payments**	**Minimum Fee Schedule Cost Impact - Low**	**Minimum Fee Schedule Cost Impact - High**
90832	Individual Treatment Services	Psychotherapy, 30 minutes with patient and-or family member	$ 5.8	$ 0.19	$ 2.12
90834	Individual Treatment Services	Psychotherapy, 45 minutes with patient and-or family member	14.6	0.52	4.19
90837	Individual Treatment Services	Psychotherapy 60 minutes with patient and/or family member	37.9	0.99	11.90
H0004	Individual Treatment Services	Behavioral health counseling and therapy, per 15 minutes	45.6	0.71	9.60
H0038	Peer Support	Self-help/peer services, per 15 minutes	6.2	0.45	2.06
Total			**$ 110.1**	**$ 2.9**	**$ 29.9**
Additional Services with Comparison Rates					
90791	Intake Evaluation	Psychiatric diagnostic evaluation	$ 6.4	0.07	0.71
90792	Intake Evaluation	Psychiatric diagnostic evaluation with medical services	2.8	0.84	2.28
90846	Family Treatment	Family psychotherapy (without the patient present)	1.0	0.01	0.14
90847	Family Treatment	Family psychotherapy (conjoint psychotherapy) (with patient present)	3.4	0.02	0.21
90853	Group Treatment Services	Group psychotherapy (other than of a multiple-family group)	4.1	0.03	0.07
96164	Outpatient Treatment	Hlth bhv ivntj grp 1st 30	8.4	0.02	0.09
96165	Outpatient Treatment	Hlth bhv ivntj grp ea addl	27.1	0.01	0.05
99205	Intake Evaluation	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	0.8	0.11	0.40
99213	Medication Management	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	4.1	0.17	2.26
99214	Medication Management	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	11.8	0.84	5.43
99215	Medication Management	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	3.0	0.22	1.13
H0001	Assessment	Alcohol and/or drug assessment	6.9	0.32	0.99
H0010	Withdrawal Management (Subacute)	Alcohol/drug services; subacute detox in hospital setting, per diem (inpatient residential addiction program)	2.4	1.39	2.18
H0011	Withdrawal Management (Secure)	Alcohol/drug services; subacute detox in hospital setting, per diem (inpatient residential addiction program)	8.4	2.16	3.94
H0017	Withdrawal Management (Secure)	Withdrawal management facility service in a hospital setting, per diem.	6.2	0.42	1.25
H0018	Mental Health Services Provided in a Residential Setting	BH srvcs; short-term residential (nonhospital residential tx program where stay is typically less than 30 days), w/o R&B, per diem	84.6	9.96	23.03
H0031	Intake Evaluation	Mental health assessment, by non-physician	2.1	0.10	0.27
H0036	Individual Treatment Services	Community psychiatric supportive treatment, face-to-face, per 15 minutes	2.5	0.82	2.65
H2014	Individual Treatment Services	Skills training and development, per 15 minutes	29.4	7.17	24.84
H2015	Individual Treatment Services	Comprehensive community support services, per 15 minutes	8.2	0.16	2.39
T1016	ORCSP	Case management, each 15 minutes	0.6	0.03	0.21
Total for Additional Services with Comparison Rates			**$ 224.1**	**$ 24.9**	**$ 74.5**
Total - Comprehensive Implementation (Additional w/ Initial services)			**$ 334.1**	**$ 27.7**	**$ 104.4**
Services with BH Comparison Rates to be Developed by June 30, 2025					
99202	Intake Evaluation	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	$ 0.0	0.00	0.00
99212	Medication Management	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	0.6	0.00	0.00
H0020	Opioid Treatment Program	Alcohol and/or drug services; methadone administration and/or service	57.5	0.00	0.00
H0033	Medication Monitoring	Oral medication administration, direct observation	0.4	0.00	0.00
H0034	Medication Monitoring	Medication training and support, per 15 minutes	0.2	0.00	0.00
H0035	Partial Hospitalization	Mental health partial hospitalization, treatment, less than 24 hours	3.6	0.00	0.00
H0046	Individual Treatment Services	Mental health services, not otherwise specified	0.9	0.00	0.00
H2012	Day Support	Behavioral health day treatment, per hour	2.9	0.00	0.00
H2027	Therapeutic Psychoeducation	Psycho-educational service, per 15 minutes	0.6	0.00	0.00
T1001	Medication Management	Nursing assessment/evaluation	0.7	0.00	0.00
S9446	Therapeutic Psychoeducation	Patient education, not otherwise classified, non-physician provider, group, per session	0.3	0.00	0.00
S9480	High Intensity Treatment	Intnsv. O/P psychiatric srvcs, per diem	9.7	0.00	0.00
All Other BH Services Covered in State Plan Section 13d					
80305			$ 0.3	0.00	0.00
80306			0.0	0.00	0.00
80307			1.2	0.00	0.00
90785			0.1	0.00	0.00
90833			0.2	0.00	0.00
90836			0.0	0.00	0.00
90838			0.0	0.00	0.00
90839			0.0	0.00	0.00
90849			0.0	0.00	0.00
90870			0.2	0.00	0.00
90899			0.0	0.00	0.00
96110			0.0	0.00	0.00
96112			0.0	0.00	0.00
96113			0.0	0.00	0.00
96116			0.0	0.00	0.00
96121			0.0	0.00	0.00
96125			0.0	0.00	0.00
96127			0.0	0.00	0.00
96130			0.0	0.00	0.00
96131			0.0	0.00	0.00
96132			0.0	0.00	0.00
96133			0.0	0.00	0.00
96136			0.0	0.00	0.00
96137			0.0	0.00	0.00
96138			0.0	0.00	0.00
96139			0.0	0.00	0.00
96156			0.0	0.00	0.00
96158			0.0	0.00	0.00
96159			0.0	0.00	0.00
96160			0.0	0.00	0.00
96167			0.0	0.00	0.00
96168			0.0	0.00	0.00
96170			0.0	0.00	0.00
96171			0.0	0.00	0.00

96372	0.4	0.00	0.00
98968	0.0	0.00	0.00
98971	0.0	0.00	0.00
98972	0.0	0.00	0.00
99050	0.0	0.00	0.00
99051	0.0	0.00	0.00
99075	0.0	0.00	0.00
99195	0.0	0.00	0.00
99203	0.2	0.00	0.00
99204	0.5	0.00	0.00
99211	0.2	0.00	0.00
99304	0.0	0.00	0.00
99305	0.0	0.00	0.00
99306	0.0	0.00	0.00
99307	0.0	0.00	0.00
99308	0.0	0.00	0.00
99309	0.0	0.00	0.00
99310	0.0	0.00	0.00
99342	0.0	0.00	0.00
99344	0.0	0.00	0.00
99345	0.0	0.00	0.00
99347	0.0	0.00	0.00
99348	0.0	0.00	0.00
99349	0.1	0.00	0.00
99350	0.0	0.00	0.00
99406	0.0	0.00	0.00
99421	0.0	0.00	0.00
99422	0.0	0.00	0.00
99423	0.0	0.00	0.00
99439	0.0	0.00	0.00
99441	0.0	0.00	0.00
99442	0.1	0.00	0.00
99443	0.1	0.00	0.00
99483	0.0	0.00	0.00
99490	0.0	0.00	0.00
A0021	0.0	0.00	0.00
C7900	0.0	0.00	0.00
C7901	0.0	0.00	0.00
C7902	0.0	0.00	0.00
G0176	0.0	0.00	0.00
G0317	0.0	0.00	0.00
G0318	0.0	0.00	0.00
G0410	0.0	0.00	0.00
G0411	0.0	0.00	0.00
G0463	0.0	0.00	0.00
G0467	0.0	0.00	0.00
G0469	0.0	0.00	0.00
G0470	0.1	0.00	0.00
G0480	0.2	0.00	0.00
G0481	0.0	0.00	0.00
G0511	0.0	0.00	0.00
G0512	0.0	0.00	0.00
G2025	0.0	0.00	0.00
G2067	0.4	0.00	0.00
G2068	0.0	0.00	0.00
G2074	0.0	0.00	0.00
G2076	0.0	0.00	0.00
G2077	0.0	0.00	0.00
G2078	0.0	0.00	0.00
G2079	0.0	0.00	0.00
G2080	0.0	0.00	0.00
G2212	0.2	0.00	0.00
G2214	0.0	0.00	0.00
G2215	0.0	0.00	0.00
H0015	0.0	0.00	0.00
H0019	29.6	0.00	0.00
H0023	0.3	0.00	0.00
H0025	0.0	0.00	0.00
H0030	0.0	0.00	0.00
H0032	0.0	0.00	0.00
H0040	0.1	0.00	0.00
H0047	0.0	0.00	0.00
H0050	0.1	0.00	0.00
H2011	0.1	0.00	0.00
H2013	10.7	0.00	0.00
H2017	0.0	0.00	0.00
H2019	6.2	0.00	0.00
H2022	0.0	0.00	0.00
S0201	0.5	0.00	0.00
S9484	0.0	0.00	0.00
S9485	8.5	0.00	0.00
S9976	0.7	0.00	0.00
T1017	1.3	0.00	0.00
T1023	0.0	0.00	0.00
T2048	1.3	0.00	0.00

Notes:

1. Dollars shown are in millions
2. Additional BH comparison rates may be developed by June 30, 2025, to account for implementation of ASAM, 4th edition.

Appendix VI: Limited Implementation BH MFS Impact By Service and Region

Washington State Health Care Authority
Minimum Fee Schedule Development
Appendix VI - Limited Minimum Fee Schedule Implementation Impact by Service and Region

Total

Region	Projected CY 2026 FFS Payments	Minimum Fee Schedule Cost Impact - Low	Minimum Fee Schedule Cost Impact - High
Great Rivers	$ 21.9	$ 0.41	$ 2.97
Greater Columbia	7.7	0.32	3.23
King County	4.3	0.24	2.59
North Central	1.0	0.08	0.67
North Sound	22.7	0.32	5.38
Pierce	22.0	0.34	4.36
Salish	1.8	0.05	0.93
Southwest Washington	14.1	0.32	2.93
Spokane	5.7	0.29	3.88
Thurston-Mason	8.9	0.49	2.93
Total	**$ 110.1**	**$ 2.9**	**$ 29.9**

Service Code: 90832

Region	Projected CY 2026 FFS Payments	Minimum Fee Schedule Cost Impact - Low	Minimum Fee Schedule Cost Impact - High
Great Rivers	$ 1.1	$ 0.02	$ 0.20
Greater Columbia	0.3	0.03	0.27
King County	0.2	0.03	0.14
North Central	0.1	0.03	0.13
North Sound	1.5	0.03	0.37
Pierce	1.2	0.01	0.36
Salish	0.1	0.00	0.06
Southwest Washington	0.8	0.01	0.29
Spokane	0.2	0.02	0.19
Thurston-Mason	0.3	0.00	0.11
Total	**$ 5.8**	**$ 0.2**	**$ 2.1**

Service Code: 90834

Region	Projected CY 2026 FFS Payments	Minimum Fee Schedule Cost Impact - Low	Minimum Fee Schedule Cost Impact - High
Great Rivers	$ 1.6	$ 0.04	$ 0.29
Greater Columbia	0.6	0.05	0.35
King County	0.5	0.03	0.17
North Central	0.1	0.02	0.11
North Sound	4.2	0.08	0.88
Pierce	1.9	0.04	0.43
Salish	0.3	0.01	0.19
Southwest Washington	3.7	0.18	1.08
Spokane	0.5	0.05	0.38
Thurston-Mason	1.3	0.02	0.31
Total	**$ 14.6**	**$ 0.5**	**$ 4.2**

Service Code: 90837

Region	Projected CY 2026 FFS Payments	Minimum Fee Schedule Cost Impact - Low	Minimum Fee Schedule Cost Impact - High
Great Rivers	$ 5.4	$ 0.05	$ 0.43
Greater Columbia	3.0	0.16	1.59
King County	2.0	0.09	1.18
North Central	0.3	0.03	0.24
North Sound	8.5	0.17	2.25
Pierce	8.5	0.17	2.19
Salish	0.4	0.01	0.20
Southwest Washington	5.1	0.11	0.90
Spokane	3.0	0.14	2.15
Thurston-Mason	1.5	0.05	0.77
Total	**$ 37.9**	**$ 1.0**	**$ 11.9**

Service Code: H0004

Region	Projected CY 2026 FFS Payments	Minimum Fee Schedule Cost Impact - Low	Minimum Fee Schedule Cost Impact - High
Great Rivers	$ 11.2	$ 0.17	$ 1.53
Greater Columbia	3.6	0.05	0.92
King County	1.5	0.02	0.73
North Central	0.4	0.00	0.18
North Sound	8.3	0.01	1.71
Pierce	8.8	0.10	1.28
Salish	1.0	0.00	0.42
Southwest Washington	3.7	0.00	0.55
Spokane	1.7	0.01	0.82
Thurston-Mason	5.5	0.35	1.46
Total	**$ 45.6**	**$ 0.7**	**$ 9.6**

Service Code: H0038

Region	Projected CY 2026 FFS Payments	Minimum Fee Schedule Cost Impact - Low	Minimum Fee Schedule Cost Impact - High
Great Rivers	$ 2.5	$ 0.14	$ 0.51
Greater Columbia	0.2	0.02	0.11
King County	0.2	0.07	0.36
North Central	0.0	0.00	0.01
North Sound	0.2	0.03	0.17
Pierce	1.7	0.02	0.10
Salish	0.1	0.01	0.07
Southwest Washington	0.7	0.02	0.11
Spokane	0.2	0.07	0.34
Thurston-Mason	0.4	0.06	0.28
Total	**$ 6.2**	**$ 0.4**	**$ 2.1**

Note:

1. Dollars shown are in millions.
2. FFS payments include MCO FFS and non-MCO FFS amounts.

Appendix VII: Comprehensive Implementation BH MFS Impact by Region

Washington State Health Care Authority
Minimum Fee Schedule Development
Appendix VII - Comprehensive Implementation Minimum Fee Schedule Impact by Region

Region	Projected CY 2026 FFS Payments	Minimum Fee Schedule Cost Impact - Low	Minimum Fee Schedule Cost Impact - High
Great Rivers	$ 48.4	$ 2.64	$ 9.33
Greater Columbia	34.0	2.91	11.08
King County	20.5	2.96	10.82
North Central	6.7	1.02	3.15
North Sound	62.7	4.09	16.29
Pierce	51.1	3.17	12.65
Salish	14.0	1.22	4.23
Southwest Washington	32.1	1.84	8.87
Spokane	38.9	5.70	19.20
Thurston-Mason	25.6	2.19	8.76
Total	**$ 334.1**	**$ 27.7**	**$ 104.4**

Note:

1. Dollars shown are in millions.
2. FFS payments include MCO FFS and non-MCO FFS amounts.
3. The comprehensive minimum fee schedule approach would include all BH services with existing comparison rates in the CY 2026 minimum fee schedule.

Reference Appendix I: Crosswalk of Provider Types to Provider Group

Washington State Health Care Authority
Minimum Fee Schedule Development
Reference Appendix I - Crosswalk of Provider Types to Provider Group

DOH License/Credential	Medicaid State Plan Provider Type	SERI Provider Type	SERI Taxonomy code	Provider Grouping
Nursing Assistant Registered/Certified	Nursing Assistant Registered/Certified	Nursing Assistant	376K00000X	Certified Medical Assistant
Medical Assistant - Certified	Medical Assistant - Certified	Medical Assistant- Certified	101Y99993L	Certified Medical Assistant
Licensed Psychologist	Psychologist	Licensed Psychologist	103T00000X	Clinical Psychologist
Licensed Practical Nurse	Licensed Practical Nurse	Licensed Practical Nurse	164W00000X	Licensed Practical Nurse
Licensed Social Worker (Advanced or Independent Clinical License)/Associates	Mental Health Professional (MHP)	Licensed Social Worker (Advanced or Independent Clinical License)	104100000X	Master's Level Degree Licensed (MHP)
Licensed Mental Health Counselor/Associates	Mental Health Professional (MHP)	Licensed/Certified Mental Health Counselor	101YM0800	Master's Level Degree Licensed (MHP)
Licensed Marriage and Family Therapist/ Associates	Mental Health Professional (MHP)	Licensed Marriage and Family Therapist	106H00000X	Master's Level Degree Licensed (MHP)
Agency Affiliated Counselor - Licensed	Mental Health Professional (MHP)	Non-Licensed MA/PHD	101Y99996L	Master's Level Degree Unlicensed (MHP)
Agency Affiliated Counselor - Licensed	Mental Health Professional (MHP)	Master Level with Exception/Waiver	101Y99995L	Master's Level Degree Unlicensed (MHP)
Agency Affiliated Counselor - Certified	Mental Health Professional (MHP)	Bachelor Level with exception/waiver	101Y99995L	Master's Level Degree Unlicensed (MHP)
Agency Affiliated Counselor - Registered	Mental Health Care Provider (MHCP)	Other Clinical Staff	101Y99995L	Mental Health Care Provider (MHCP) (Agency-Affiliated Counselors)
Agency Affiliated Counselor Registered	Mental Health Care Provider (MHCP)	Below Master's Degree	101Y99995L	Mental Health Care Provider (MHCP) (Agency-Affiliated Counselors)
Advanced Registered Nurse Practitioner	Advanced Registered Nurse Practitioner, working as a Psychiatric Advance Registered	Psych, Mental Health ARNP	363LP0808X	PAs, NPs, and Pharmacists
Physician Assistant	Physician Assistant, working under the supervision of a psychiatrist	Physician Assistant	363A00000X	PAs, NPs, and Pharmacists
Osteopathic Physician Assistant	Osteopathic Physician Assistant, working under the supervision of a psychiatrist	Physician Assistant	363A00000X	PAs, NPs, and Pharmacists
Pharmacist	Pharmacist	Pharmacist -D	183500000X	PAs, NPs, and Pharmacists
Agency Affiliated Counselor Registered	Certified Peer Counselor	DBHR Credentialed Certified Peer Counselor	175T00000X	Peer Support
Registered Nurse	Registered Nurse, as a Psychiatric Nurse; or Registered Nurse	Registered Nurse	163W00000X	Registered Nurse
NA	NA	Not Listed in SERI	Not Listed in SERI	Resident Assistant in SUD Facility (non-clinical)
Physician	Physician, working as a Psychiatrist or Child Psychiatrist	Psychiatry and Neurology	2084P0800X	Specialty Physician
Physician	Physician	Family Medicine	207Q00000X	Specialty Physician
Osteopathic Physician	Osteopathic Physician, working as a Psychiatrist	Psychiatrist/Osteopathic Physician	2084P0800X	Specialty Physician
Substance Use Disorder Professional (SUDP)	Substance Use Disorder Professional (SUDP)	Substance Use Disorder Professional (SUDP)	101YA0400X	SUDP Bachelor's and Below
Substance Use Disorder Professional (SUDP)	NA	Substance Use Disorder Professional (SUDP)	101YA0400X	SUDP Master's in a Social Services Field
Substance Use Disorder Professional Trainee (SUDPT)	Substance Use Disorder Professional Trainee (SUDPT)	Substance Use Disorder Professional Trainee (SUDPT)	101Y99995L	SUDPT

Solutions for a world at risk™

Milliman leverages deep expertise, actuarial rigor, and advanced technology to develop solutions for a world at risk. We help clients in the public and private sectors navigate urgent, complex challenges—from extreme weather and market volatility to financial insecurity and rising health costs—so they can meet their business, financial, and social objectives. Our solutions encompass insurance, financial services, healthcare, life sciences, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

Jeremy Cunningham
Jeremy.Cunningham@milliman.com

Annie Hallum
Annie.Hallum@milliman.com

Jacob Epperly
Jacob.Epperly@milliman.com

© 2024 Milliman, Inc. All Rights Reserved. The materials in this document represent the opinion of the authors and are not representative of the views of Milliman, Inc. Milliman does not certify the information, nor does it guarantee the accuracy and completeness of such information. Use of such information is voluntary and should not be relied upon unless an independent review of its accuracy and completeness has been performed. Materials may not be reproduced without the express consent of Milliman.