BHO-HCPF Annual Performance Measures Scope Document

Fiscal Year 2015 (FY15)

This document includes the details for calculations of the BHO-HCPF Annual Performance Measures for the five Colorado Behavioral Health Organizations (BHOs) according to the Behavioral Health Services Program Contract. Some of the measures are calculated by HCPF using eligibility data and encounter data submitted by the BHOs, other measures are calculated by the BHOs. With the exception of Penetration Rates, all measures are calculated using paid claims/encounters data.

Created: March 5, 2015 *Last Revised: September 23, 2015*

Table of Contents

Definitions

24 Hour Treatment Facility: A residential facility that has 24-hr professional staffing and a program of treatment services and includes PRTF and TRCCFs. Does not include Nursing Facilities or Alternative Care Facilities (ACF) defined as an assisted living residence licensed by the State to provide alternative care services and protective oversight to Medicaid clients.

Age Category: Unless otherwise specified, aged categories are based on HEDIS age categories: 0-12 (Child), 13-17 (Adolescent), 18-64 (Adult), and 65+ (Older Adult). Age category determination will be based upon the client's age on the date of service for all performance indicators except for inpatient hospitalization and penetration rates. For inpatient hospitalization, age category determination will be based upon the client's age on the date of discharge. For penetration rates, age category determination will be based upon the age of the client on the last day of the fiscal year.

Covered Mental Health Diagnoses: The BHO Colorado Medicaid Community Mental Health Services Program contract specifies that certain mental health diagnoses are covered. These specific diagnoses can be found below or in the BHO Medicaid BHO contract Exhibit D, Part 1. Only those services that cover mental health, with the exception of services related to Assessment, Prevention, and Crisis procedure coding as a diagnosis may have yet to be ascribed, will be included in the calculations of performance measures.

Covered Mental Health Diagnoses Codes			
295.00-298.99	**300.00-301.99**	**307.10-309.99**	**311-314.99**

Covered Substance Use Disorder Diagnosis: Starting January 1, 2014, the BHO Colorado Medicaid Community Mental Health Services Program contract specifies that certain substance use disorder diagnoses be covered. These diagnoses can be found below or in the Medicaid BHO Contract in Exhibit D Part 2. For purposes of the performance measures calculations, the following diagnosis codes are acceptable.

Substance Use Disorder Covered Diagnoses
291; 291.1; 291.3; 291.5; 291.81; 291.89; 291.9; 292; 292.11-.12; 292.81; 292.83-.85; 292.89; 292.9
303; 304; 305; 303.0; 303.9; 304.0-304.6; 305.0; 305.1; 305.2;305.3; 305.4; 305.5; 305.7; 305.9
303.00-303.03; 303.90; 304.00-.03; 304.10-.13; 304.20-.23; 304.30-.33; 304.40-.43; 304.50-.53;304.60-.63
305.00-03; 305.10-.13; 305.20-.23; 305.30-.33; 305.40-.43; 305.50-.53; 305.60-.63; 305.70-.73; 305.90-.93

Fiscal Year (FY) or State Fiscal Year (SFY): Based on the state fiscal year July 1-June 30 of the measurement year

HCPF: The Department of Health Care Policy and Financing for the State of Colorado.

HEDIS: Healthcare Effectiveness Data and Information Set

Hospital Admit: An admission to a hospital (non-residential) for an episode of treatment for a covered mental health diagnosis. There can be multiple admits during the specified fiscal year period. The admission must result in a paid claim for the hospital episode, except where the admission is from a State Hospital for ages 21-64.

Hospital Discharge: A discharge from a hospital (non-residential) for an episode of treatment for a covered mental health diagnosis that does not result in a re-hospitalization within 24 hrs (transfer). There can be multiple discharges during the specified fiscal year period. The discharge must result in a paid claim for the hospital episode, except where the discharge is from a State Hospital for ages 21-64. Adult members on the list of discharges from the State hospital who are not eligible at the time of hospital admission should be included in the measure if eligibility is discontinued 1 day before the admission date. Adult members on the list of discharges from the State hospital who are eligible at the time of hospital admission, but who lose eligibility during the hospital stay should also remain on the hospital discharge list.

Hospitalization: Revenue codes for hospitalization are 100-219 or 0100-0219

Members: Individuals eligible for Medicaid assigned to a specific BHO. Membership is calculated by the number of member months during a 12-month period divided by 12, which gives equivalent members or the average health plan enrollment during the 12-month reporting period.

Member Months: Member months are determined by counting number of clients with an enrollment span covering at least one day in the month, i.e., total member months per month as: enrollment begin date <= last day of the month AND enrollment end date >= first day of the month. Thus, if the client is enrolled for the full month the member month is equal to one and if enrolled for less than the full month the member month is a fraction between 0 and 1.

Penetration Rate: The number of members who received at least one service (paid or denied claim) divided by the number of FTE enrolled in the Medicaid mental health managed care program.

Per 1000 members: A measure based on total eligible members per 1000.

Quarter: Based on fiscal year quarters (Jul-Sep, Oct-Dec, Jan-Mar, Apr-Jun)

Indicator 1: Hospital Readmissions

Indicator 1a: Hospital Readmissions, 7, 30 and 90 Days

Description: Proportion of BHO member discharges from a hospital episode for treatment of a covered mental health diagnosis and readmitted for another hospital episode for treatment of a covered mental health diagnosis within 7, 30, 90 days by age group and overall (recidivism rates). Age for this indicator is determined at first hospital discharge. Two indicators are submitted:

- ***Non-State Hospital:*** Recidivism rates for member discharges from a non-State hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30.
- ***All hospital:*** Recidivism rates for member discharges from all hospital episodes for a covered mental health disorder during the specific fiscal year, July 1 through June 30.

Denominator: Total number of BHO member discharges during the reporting period. The population is based on discharges (e.g., one member can have multiple discharges).

- ***Non-State Hospital:*** Total number of member discharges from a non-State hospital during the specified fiscal year, July 1 through June 30
- ***All Hospitals:*** Total number of member discharges from all hospitals during the specified fiscal year, July 1 through June 30

Numerator: Number of BHO member discharges with an admission within 7, 30, and 90 days of the discharge, reported cumulatively.

- ***Non-State Hospital:*** Total number of member discharges from a non-State hospital, during the specified fiscal year, July 1 through June 30, and then admitted to any hospital (non-state or state) 7, 30, and 90 days after the discharge.
- ***All Hospitals:*** Total number of Member discharges from all hospitals, during the specified fiscal year, July 1 through June 30, and then admitted to all hospitals 7, 30, and 90 days after the discharge.

Data Source: *Denominator:* Number of member discharges, from private hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, is provided by HCPF. *Numerator:* Admissions from non-state hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Admissions from the State hospital system, ages 21 through 64 years, are provided by the HCPF.

Calculation of Measure: BHOs, with some data provided by HCPF

Ratios: Child 7 day readmit/Non-state Child discharges; Child 30 day readmit/Non-state Child discharges; Child 90 day readmit/Non-state Child discharges; Child 7 day readmit/All Hospital Child discharges; Child 30 day readmit/All Hospital Child Discharges; Child 90 day readmit/All Hospital Child discharges; Adolescent 7 day readmit/Non-state Adolescent discharges; Adolescent 30 day readmit/Non-state Adolescent discharges; Adolescent 90 day readmit/Non-state Adolescent discharges; Adolescent 7 day readmit/All Hospital Adolescent discharges; Adolescent 30 day readmit/All Hospital Adolescent

Discharges; Adolescent 90 day readmit/All Hospital Adolescent discharges; Adult 7 day readmit/Non-state Adult discharges; Adult 30 day readmit/Non-state Adult discharges; Adult 90 day readmit/Non-state Adult discharges; Adult 7 day readmit/All Hospital Adult discharges; Adult 30 day readmit/All Hospital Adult Discharges; Adult 90 day readmit/All Hospital Adult discharges; Older Adult 7 day readmit/Non-state Older Adult discharges; Older Adult 30 day readmit/Non-state Older Adult discharges; Older Adult 90 day readmit/Non-state Older Adult discharges; Older Adult 7 day readmit/All Hospital Older Adult discharges; Older Adult 30 day readmit/All Hospital Older Adult Discharges; Older Adult 90 day readmit/All Hospital Older Adult discharges; All ages 7 day readmits/All ages All hospital discharges; All 30 day readmits/All ages all hospital discharges; All 90 day readmits/All ages hospital discharges; All 7 day readmits/Non-state hospital discharges; All 30 day readmits/Non-state hospital discharges; All 90 day discharges/Non-state hospital discharges

Benchmark: Weighted average of all BHOs.

Indicator 1b: Hospital Readmissions, 180 days

Description: Proportion of BHO member admitted from a hospital episode for treatment of a covered mental health diagnosis with a previous discharge for another hospital episode for treatment of a covered mental health diagnosis in the past 180 days by age group and overall (recidivism rates). Age for this indicator is determined at last hospital admission. One indicator is submitted: (note: non-state hospital is not calculated for 1b)

- ***All hospital:*** Recidivism rates for member discharges from all hospital episodes for a covered mental health disorder during the specific fiscal year, July 1 through June 30.

Denominator: Total number of BHO member admissions during the reporting period. The population is based on admissions (e.g., one member can have multiple admissions).

- ***All Hospitals:*** Total number of member admissions from all hospitals during the specified fiscal year, July 1 through June 30

Numerator: Number of BHO member admissions with a discharge within 180 days prior to the admission.

- ***All Hospitals:*** Total number of Member discharges from all hospitals, during the specified fiscal year, July 1 through June 30, with a discharge within 180 days prior to the admission.

Data Source: *Denominator:* Number of member admissions, from private hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of admissions from the State hospital system, ages 21 through 64 years, is provided by HCPF. *Numerator:* Admissions from non-state hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Admissions from the State hospital system, ages 21 through 64 years, are provided by the HCPF.

Calculation of Measure: BHOs, with some data provided by HCPF

Ratios: Child 180 day readmit/All Hospital; Adolescent 180 day readmit/All Hospital; Adult 180 day readmit/All Hospital; Older Adult 180 day readmit/All Hospital

Benchmark: Weighted average of all BHOs.

Indicator 2: Percent of Members prescribed redundant or duplicated atypical antipsychotic medication

Description: The proportion of members, with one or more atypical antipsychotics prescribed, that have, for 120 days or more, two or more different atypical antipsychotic medications prescribed

Denominator: Number of unduplicated members with one or more net value paid pharmacy claims for an atypical antipsychotic medication during the first nine months of the fiscal year studied. The date used to determine whether the claim is within the first nine months is the service date.

Numerator: Number of unduplicated members in the denominator with two concurrent pharmacy claims for an atypical antipsychotic for each month of 120 days or more during the study period. The field for determining the prescribed date is the fill date. A member is only counted once in the numerator even though they may have more than one 120 day periods with two concurrent fill dates for an atypical antipsychotic. The study period is the fiscal year. Each 120-day period is broken into four 30-day parts. Each member must have 2 or more different atypical antipsychotics in each 30 day part to be included for the whole period. Working from the first medication fill, search 0-30 days for a second medication, if true, search for the continuation of two concurrent medications in 30-60 days, 60-90 days and 90-120 days from the initial fill date.

Data Source: Pharmacy claims

Calculation of Measure: BHOs. HCPF will provide the specified pharmacy claim files to each BHO for calculation, Scott Marmulstein (Beacon) will provide HCPF with a list of the most recent (as of July 2015) atypical antipsychotic drug list by July 25, 2015 from First Data Bank. HCPF will then forward this list to the other BHOs.

Benchmark: Overall BHO percentage

Issues:

1. Assumption that the claims are for a 30 day supply
2. Discuss alignment with new CMS Polytherapy with Oral Antipsychotics measure: more specific methodology (p 36-39) and developed using expert panel
    a. Ages 18+ (p. 1); Continuously enrolled 1 year (ability to improve outcomes) (p.2); All oral antipsychotics (excluding clozapine), not just atypicals (p 35); Excludes clozapine (p. 9, 17);
    b. Uses days' supply instead of spans; Denominator (p 3); "routinely" scheduled: at least 2 "consecutive" dispensing of at least 25 day supply "consecutive" dispensing: days' supply for first dispensing divided by difference in days between first and next dispensing is (MPR) >=.8 (example consecutive: 25/25=1, not consecutive 25/36=.7); Caveat as to completeness of data – Medicare Part B does not share their data; as a result any data on Medicare Dual-Eligible individuals should be considered incomplete. This issue may be revisited once changes to this process are made.

Indicator 3: Psychotropic utilization in children

Description: Identifying the children (beneficiaries < 18 years of age) receiving a psychotropic medication stratified by age (< 5 years, 6-11 years, 12-17 years of age), type of psychotropic medication (an antipsychotic, antidepressant, mood stabilizer, stimulant, or antianxiety medication), and overlapping use within and outside the same therapeutic class. Specifically, drugs can be within the same therapeutic class; as long as they are different drugs. The same drug entity with different doses should probably not be counted as separate medications.

Denominator: Number of unduplicated members with one or more net value paid pharmacy claims for a unique psychotropic medication (may be in the same class) during the time period analyzed.

Numerator:

1. Number of unduplicated members in the denominator taking two (2) or more psychotropic medications in the same class. Claims with 30 days or more overlap; stratified by age and therapeutic class.
2. Number of unduplicated children receiving antipsychotic medications and also being tested for metabolic monitoring (i.e. lipid panel, blood glucose) at least once a year.

Data Source: Pharmacy claims and medical claims. CPT codes for metabolic monitoring.

Calculation of Measure:

1. Therapeutic classes of medications are listed in the table under denominator. These will be accessible in pharmacy claims.
2. HCPF has pharmacy claims and medical codes billed. CPT codes should be done annually for any child (<18 years) taking an antipsychotic medication.

Codes to Identify Psychotropic Medications	
Therapeutic Class	**Medicaid Therapeutic Code**
Antipsychotics	*All Drugs in* H2G, H7O, H7P, H7R, H7T, H7U, H7X
Antidepressants	*All Drugs in* H2S, H2H, H2U, H7B, H7C, H7D, H7E, H7J, H8P
Mood Stabilizers	*All Drugs in* H2M, H4B
Stimulants	*All Drugs in* H2V, J5B
Antianxiety Medications	*All Drugs in* H2F
Codes to Identify Metabolic Monitoring	
Monitoring	**CPT Codes**
General health panel (for blood glucose testing)	80048, 80050, 80053
Glucose-specific serum testing (for blood glucose testing)	82947, 82948, 82950, 82951
Lipid testing	80061, 82465, 84478, 83721, 83715, 83700, 83716, 83701

Indicator 4: Mental Health Engagement

Description: The percentage of new members diagnosed with a covered mental health diagnosis (see "definitions", page 2) who were engaged by the behavioral health organization, as defined below:

- New members who received at least four engagement services within 45 days of the initial visit or episode. The initial visit may be counted as the first engagement service.

Definitions:
Intake Period: July 1, 2014 to May 16, 2015

Intake Date: Used to capture new episodes the intake date is the earliest visit during the intake period with one of the selected covered diagnosis, identified by the following codes:

- CPT – 90791 & 90792

Denominator:
Step 1: Identify all members with an intake date

Step 2: Calculate continuous enrollment. Members must be continuously enrolled without any enrollment gaps from the intake date through 45 days after the intake date.

Numerator: Four or more engagements (see table below for engagement codes) within 45 days after the intake date. The initial visit on the date of intake may count as one engagement service. Services can occur on the same day.

The intent of this measure is to ensure members receive ongoing engagement within the first 45 days of an initial visit. Therefore, engagement services for monthly supported housing (H0044) may only count as one service during the 45-day period, however, the "per day" supported housing (H0043) can be counted multiple times within the 45 day period.

Examples:

- A member receiving two monthly supported housing services (H0044) in the 45-day period should count as one service.
- A member receiving two supported housing services (H0043) in the 45-day period may count as two services.

Data Source: BHO claims/encounter systems

Calculation of Measure: BHOs

Ratios: Reporting is the percentage of members who received four or more services within the 45 days from the intake period. Rates are reported by age category.

Benchmark: Weighted average of all BHOs

Numerator Codes to Identify Engagement Services	
CPT	**HCPCS**
90791-90792; 90832-90834; 90836-90840 90846-90847; 90849; 90853; 90875-90876 90887; 96101-96103; 96116; 96118-96120 96372; 97535; 97537; 99201-99205; 99212-99215; 99211; 99304-99310; 99324-99328 99334-99337; 99341-99345; 99347-99350 99441-99443	G0176-G0177; H0001-H0002; H0004-H0006; H0020; H0031-H0034 H0036-H0040; H0043; H0044; H2000-H2001; H2011-H2012; H2014-H2018; H2021-H2027; H2030-H2033; M0064; S5150-S5151;S9445; S9453-S9454; S9480; S9485; T1016-T1017

Indicator 5: Adherence to antipsychotics for individuals with schizophrenia

Description: The percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Definitions:
IPSD: Index prescription start date; the earliest prescription dispensing date for any antipsychotic medication between January 1 and September 30 of the measurement year
Treatment Period: The period of time beginning on the IPSD through the last day of the measurement year
PDC: Proportion of days covered. The number of days a member is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.
Oral Medication dispensing event: One prescription of an amount lasting 30 days or less.

- To calculate dispensing events for prescriptions longer than 30 days, divide the days' supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events
- Multiple prescriptions for different medications dispensed on the same day are counted as separate dispending events. If multiple prescriptions for the same medication are dispensed on the same day, use the prescription with the longest days' supply. Use the Drug ID to determine if the prescription are the same or different.

Long-acting injections dispending event: Injections count as one dispensing event.

- Multiple J codes or NDCs for the same or different medication on the same day are counted as a single dispensing event.

Calculating number of days covered for oral medications:

- If multiple prescriptions for the same or different oral medications are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days' supply.
- If multiple prescriptions for different oral medications are dispensed on different days, count each day within the treatment period only once toward the numerator
- If multiple prescriptions for the same oral medication are dispensed on different days, sum the days' supply and use the total to calculate the number of days covered by an antipsychotic medication (for the numerator). For example, if three antipsychotic prescriptions for the same oral medication are dispensed on different days, each with a 30-day supply; sum the days' supply for a total of 90 days covered by an oral antipsychotic (even if there is overlap).
- Use the drug ID provided on the NDC list to determine if the prescription are the same or different

Calculating number of days covered for long-acting injections:

- Calculate number of days covered (for the numerator) for long-acting injections using the days-supply specified for the medication in Table SAA-A.
- For multiple J codes or NDCs for the same or different medications on the same day, use the medication with the longest days' supply.
- For multiple J codes or NDCs for the same or different medications on different days with overlapping days' supply, count each day within the treatment period only once toward the numerator.

Denominator: The eligible population

Numerator: The number of members who achieved a PDC of at least 80% for their antipsychotic medications (Table SAA-A) during the measurement year.

Data Source: HCPF quarterly pharmacy file; BHO encounter data

Calculation of Measure: HCPF

Benchmark: HEDIS

Indicator 6: ECHO Survey

Description: The Colorado Department of Health Care Policy & Financing conducted a baseline assessment of adult and child client satisfaction with mental health services provided by participating Colorado Behavioral Health Organizations (BHOs) and/or BHO-contracted community mental health centers (CMHCs). The survey instrument selected for adult clients was a modified version of the standard Adult Experience of Care and Health Outcomes (ECHO™) Survey, Managed Behavioral Healthcare Organization (MBHO), Version 3.0 ("Adult ECHO Survey") which incorporated items from the Mental Health Statistics Improvement Program (MHSIP) survey. The survey instrument selected for child clients was a modified version of the standard Child/Parent ECHO Survey, MBHO, Version 3.0 ("Child/Parent ECHO Survey"), which incorporated items from the Youth Services Survey for Families (YSS-F) survey and the YSS.

The surveys include a global rating, composite measures, and individual items from the standard ECHO Surveys, as well as MHSIP/YSS-F domains.* Specifically, the modified Colorado Adult and Child/Parent ECHO surveys assessed one global rating, Rating of All Counseling or Treatment; four composite measures: Getting Treatment Quickly, How Well Clinicians Communicate, Perceived Improvement, and Information About Treatment Options; nine individual item measures: Office Wait, Told About Medication Side Effects, Including Family and Friends (adult survey only), Information to Manage Condition, Patient Rights Information, Patient Feels He or She Could Refuse Treatment, Privacy, Cultural Competency, and Amount Helped; and two MHSIP/YSS-F domains: Improved Functioning and Social Connectedness.

Denominator: Number of surveys where respondents: (1) Indicated that they meet the survey age criteria and (2) Did not indicate that they had not received counseling, treatment or medicine for a specified list of behavioral health reasons. Additionally, valid responses for each ECHO survey measurement were required and at least two-thirds of the questions for each MHSIP/YSS-F domain were required.

Numerator: For the ECHO global rating, composite measures, and individual item measures, the numerator is the number of respondents that have a positive satisfaction rating for the topic (i.e., "top-box" response). A "top-box" response was defined as follows for the ECHO survey measures:

- "9" or "10" for the Rating of All Counseling or Treatment global rating
- "Usually" or "Always" for the Getting Treatment Quickly, How Well Clinicians Communicate composites
- "Much better" or "A little better" for the Perceived Improvement composite
- "Yes" for the Information About Treatment Options composite
- "Usually" or "Always" for the Office Wait individual item
- "A lot" or "Somewhat" for the Amount Helped individual item
- "Yes" for the Told About Medication Side Effects, Including Family and Friends, Information to Manage Condition, Patient Rights Information, Patient Feels He or She Could Refuse Treatment, and Cultural Competency individual items,
- "No" for the Privacy individual item

For the MHSIP/YSS-F domains, response options were based on a 5-point Likert scale from 1=Strongly Agree to 5=Strongly Disagree. For a given domain, each respondent's average score was taken from all questions comprising the domain. Respondents with an average score less than or equal to 2.5 were defined as the qualifying numerator.

Data Source: BHO encounter data, Medicaid member enrollment data, and CMHC client/patient lists identified clients eligible for the survey (i.e., eligible population). HSAG subcontracted with a survey vendor to conduct the survey administration and data collection.

Calculation of Measure: Health Services Advisory Group, Inc. (HSAG)

Benchmark: Overall BHOs

*Please note that the standard Adult and Child/Parent ECHO Surveys 3.0 include one global rating, five composite measures, and 10 individual item measures. However, the Colorado Department of Health Care Policy & Financing elected to use modified versions of the ECHO Surveys 3.0; therefore, not all composite measures and individual item measures were included in the survey administered to the adult and child populations.

Indicator 7: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Description: The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following.

- ***7a) Initiation of AOD Treatment.*** The percentage of members who initiate treatment through an outpatient visit or intensive outpatient encounter within 14 days of the diagnosis.
- ***7b) Engagement of AOD Treatment.*** The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Definitions:
Intake Period: July 1, 2014 to May 16, 2015

Intake Date: Used to capture new episodes, the intake date is the earliest date of service during the intake period for one of the following:

- An outpatient visit or intensive outpatient visit with a diagnosis of AOD *(use date of service to determine the intake date)*
- A detoxification visit *(see below for intake date)*

Detoxification Notes: An episode of detoxification is determined by consecutive days of detox codes from the same provider. For a detoxification visit, use the last date of the detox episode to determine the intake date.

General Notes: For members with more than one episode of AOD, use the first episode.

Negative Diagnosis History: A period of 60 days (2 months) before the intake date when the member had no claims/ encounters with a diagnosis of AOD dependence. For detoxification count 60 days back from the first date of the detox episode.

Denominator:
Step 1: Identify all members with an intake date

Step 2: Exclude members with a negative diagnosis history

Step 3: Calculate continuous enrollment. Members must be continuously enrolled for 60 days (2 months) before the intake date through 44 days after the intake date, with no gaps.

Numerator:
7a) Initiation of AOD Treatment: Initiation of AOD treatment through an outpatient visit or intensive outpatient encounter within 14 days of diagnosis.

- If the initial service was an outpatient, intensive outpatient, or detoxification visit the member must have an outpatient visit or intensive outpatient encounter with a diagnosis of AOD, within 14 days of the intake date (inclusive).

Notes: Do not count events that include inpatient detoxification or detoxification codes (see table below) when identifying initiation of treatment.

7b) Engagement of AOD Treatment: Initiation of AOD treatment and two or more outpatient visits or intensive outpatient encounters with any AOD diagnosis within 30 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day.

Notes: Do not count events that include inpatient detoxification or detoxification codes (see table below) when identifying engagement of AOD treatment.

Data Source: BHO claims/encounter systems

Calculation of Measure: BHOs

Ratios: Report two age groups (13-17 years & 18+ years), and a total rate

Benchmark: HEDIS and all BHOs

*Note: The specification presented here for the Initiation & Engagement of AOD Treatment performance indicator is closely based upon HEDIS specifications.

Codes to Identify an Outpatient or Intensive Outpatient Visit				
HCPCS				**ICD9PCS**
G0155, G0176, G0177, G0396, G0397, G0409, G0410, G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012, T1015			**WITH**	Diagnosis of AOD (see below)
CPT				**ICD9PCS**
98960-98962, 99078, 99202-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408-99412, 99510			**WITH**	Diagnosis of AOD (see below)
UBREV				**ICD9PCS**
0510, 0513, 0515-1517, 0519-0523, 0526-0529, 0900, 0902-0907, 0911-0919, 0944, 0945, 0982, 0983			**WITH**	Diagnosis of AOD (see below)
CPT		**POS**		**ICD9PCS**
90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876	**WITH**	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72	**AND**	Diagnosis of AOD (see below)
CPT		**POS**		**ICD9PCS**
99221-99223, 99231-99233, 99238, 99239, 99251-99255	**WITH**	52, 53	**AND**	Diagnosis of AOD (see below)

Codes to Identify Detoxification
HCPCS
S3005,T1007,T1019, T1023

Codes to Identify AOD	
ICD9PCS	
Diagnosis of AOD	291.00, 291.10, 291.20, 291.30, 291.40, 291.50, 291.81, 291.82, 291.89, 291.90, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.30, 535.31, 571.1
AOD Procedure	94.61, 94.63, 94.64, 94.66, 94.67, 94.69

Indicator 8: Penetration Rates

Description: Percent BHO Members with one contact (paid or denied) in a specified fiscal year (12-month period) by HEDIS age group, Medicaid eligibility category **(refer to the table below),** race **(refer to the table below),** and service category **(refer to the table below for HEDIS specs and additional place of service (POS) and service codes.)**

- Medicaid eligibility category is the eligibility category on the member's most recent Medicaid eligibility span during the fiscal year.
- Race/ethnic group is the race category on the member's most recent Medicaid eligibility span during the fiscal year.
- Service category is defined any paid or denied MH service grouped as inpatient, intensive outpatient/partial hospital, and ambulatory care in a specified fiscal year 12-month period. POS category 53 will be excluded for the intensive outpatient and partial hospitalization service category.
- Mental health managed care enrollment spans with at least one day of enrollment during the fiscal year are analyzed.
- All enrollment spans identified as: enrollment begin date <= the last date of the fiscal year (6/30) AND enrollment end date >= the first date of the fiscal year (7/1).
- Member months are determined by counting number of clients with an enrollment span covering at least one day in the month, i.e., total member months per month as: enrollment begin date <= last day of the month AND enrollment end date >= first day of the month. Thus, if the client is enrolled for the full month the member month is equal to one and if enrolled for less than the full month the member month is a fraction between 0 and 1.

Notes: The Data Analysis Section tailors data to specific internal and external customer needs that are not met through existing reporting. Thus, calculations may differ from existing published figures due to several factors that may include, but are not limited to: the specificity of the request, retroactivity in eligibility determination, claims processing and dollar allocation differences between MMIS and COFRS.

Denominator: Number of FTE Enrollees

Numerator: Members with any MH service in the specified fiscal year (12-month period) in each age group, Medicaid eligibility category, race/ethnic group, and by service category grouped as inpatient, intensive outpatient/partial hospitalization, and ambulatory care.

Data Source: BHO claims/encounter file (both paid and denied claims/encounters will be used).

Calculation of Measure: HCPF (by Overall, HEDIS age, eligibility category, cultural/ethnic [% total missing])

Benchmark: Overall BHO

Medicaid Eligibility Categories	
Medicaid Eligibility Category is determined by the member's most recent Medicaid eligibility span during the fiscal year.	
Eligibility Type Code	**Description**
001	OAP-A
002	OAP-B-SSI
003	AND/AB-SSI
004	AFDC/CWP Adults
005	AFDC/CWP CHILDREN
006	FOSTER CARE
007	BC WOMEN
008	BC CHILDREN
020	BCCP-WOMEN BREAST&CERVICAL CAN
030	MAGI ADULTS
031	BUYIN: WORKING ADULT DISABLED
032	BUYIN: CHILDREN W/ DISABILITIES
Race / Ethnicity Categories	
Medicaid Race Category is determined by the member's most recent Medicaid eligibility span during the fiscal year.	
Race Code	**Description**
1	SPANISH AMERICAN
2	OTHER – WHITE
3	BLACK
4	AMERICAN INDIAN
5	ASIAN
6	OTHER
7	UNKNOWN
8	NATV HAWAIIAN OTH PACIFIC ISL
Penetration Rates by Service Category	
Description: The number and percentage of members receiving the following mental health services during July 1 and June 30 of the fiscal year. • *Any service* • *Inpatient* • *Intensive outpatient or partial hospitalization* • *Outpatient or ED* • *Substance Use Disorder*	
Calculations	
Counts	Members who received inpatient, intensive outpatient, partial hospitalization, and outpatient and ED mental health services in each column. Count members only once in each column, regardless of number of visits Count members in the Any Services column for any service during the measurement year is defined any paid or denied MH service grouped as inpatient, intensive outpatient/partial hospital, and ambulatory care in a specified fiscal year 12-month period. POS category 53 will be excluded for the intensive outpatient and partial hospitalization service category

Age	Members should be reported in the respective age category as of the last date of the fiscal year
Denominator	1. Mental health managed care enrollment spans with at least one day of enrollment during the fiscal year are pulled from the DSS. The data are pulled after the end of the prior fiscal year thus allowing for retroactive enrollment to be captured 2. The enrollment spans are converted to a number of days enrolled by taking the enrollment end date minus the enrollment begin date plus one. The days are then summed and divided by 365 (366 in leap years). This creates a member year or FTE calculation 3. Each client's age group, race, and eligibility type are determined using the most recent data stored in MMIS client demographic and eligibility records
Numerator	1. Encounter data submitted by the BHOs are analyzed in the Colorado Medicaid decision support system (DSS) 2. The encounters are grouped by Medicaid managed care mental health provider (BHO) number, and the number of unique client IDs are summed to obtain the number of clients served 3. For unique client IDs by age, race, and eligibility type the client's demographic information is pulled and then joined to the encounter information, by Medicaid client ID, so that each BHO encounter is associated with an age group, race code and eligibility type
Member Months	Report all member months during the measurement year for members with the benefit. Refer to Specific Instructions for Use of Services Tables. Because some organizations may offer different benefits for inpatient and outpatient mental health services, denominators in the columns of the member months table may vary. The denominator in the Any column should include all members with any mental health benefit. Member months are determined by counting number of clients with an enrollment span covering at least one day in the month, i.e., total member months per month as: enrollment begin date <= last day of the month AND enrollment end date >= first day of the month. Thus, if the client is enrolled for the full month the member month is equal to one and if enrolled for less than the full month the member month is a fraction between 0 and 1.
Substance Use Disorder	Client receiving SUD treatment will be counted in the overall BHO Penetration rate. In addition, Clients receiving SUD treatment will be shown separately in the breakout by service category. • Include all encounters with an approved SUD diagnosis • **291.XX, 292.XX, 303.XX, 304.XX, 305.XX** Also include encounters with covered SUD procedure code • **H0001, H0004, H0005, H0006, H0020, H0038** • **S3005, S9445, T1007, T1019, T1023**

Inpatient	Includes inpatient care at either a hospital or treatment facility with a covered mental health diagnosis as the principal diagnosis: • **295.00-298.99** • **300.00-301.99** • **307.00-309.99** • **311.00-314.99** One of the following criteria should be used to identify inpatient services: • An Inpatient Facility code in conjunction with a covered mental health diagnosis o***r*** • DRGs (Table MPT-B) Includes discharges associated with residential care and rehabilitation
Codes to Identify Inpatient Service	
Inpatient Facility Codes	100, 101, 110, 114, 124, 134, 144, 154, 204
Sub-Acute Codes	0919
ATU Codes	190, H2013, H0018AT, H0017
RTC Codes	0191, 0192, 0193, H0018, H0019,
Table MPT-B Codes to Identify Inpatient Services	
MS-DRG	876, 880-887

Codes to Identify Intensive Outpatient and Partial Hospitalization Services:		
HCPCS	**UB Revenue**	
Visits identified by the following HCPCS, UB Revenue, and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).		
H0035, H2001, H2012, S9480	0905, 0907, 0912, 0913, 0906	
CPT	**POS**	
90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90840, 90847, 90849, 90853, 90870, 90875, 90876	**WITH**	52
Visits identified by the following CPT/POS codes must be with a mental health practitioner.		
99221-99223, 99231-99233, 99234-99236, 99238, 99239, 99251-99255, 99201-99205, 99211-99215, 99217-99219, 99242-99245, 99304-99310, 99315-99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99366-99368, 99441-99443	**WITH**	52

Codes to Identify Outpatient and ED Services: Additional BHO codes & POS		
CPT	**HCPCS**	**UB Revenue**
Visits identified by the following CPT, HCPCS, UB Revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).		
90832, 90834, 90837, 90839, 90887, 96101-96103, , 96116, 96118-20,	G0176, G0177, H0002, H0004, H0023, H0025, H0031- H0034, H0036- H0040, H0043, H0044, H0045, H1011, H2000, H2011, H2012, H2014-H2018, H2021-H2026, H2027, H2030-H2032, H2033, M0064, S5150, S5151, S9453, S9454, S9485, T1005, T1016, T1017	0513, 0900-0904, 0911, 0914-0919, 0762, 0769, 045x

CPT	**POS**	
90791, 90792, 90785, 90846, 90847, 90849, 90853, 90870, 90875, 90876	**WITH**	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 23, 33, 49, 50, 53*, 71, 72, 19, 26, 32, 34, 41, 99

CPT	**UB Revenue**
Visits identified by the following CPT and UB Revenue codes must be with a mental health practitioner.	
96372, 97535, 97537, 98966-98968, 99201-99205, 99211-99215, 99217-99220, 99224-99226, 99241-99245, 99281-99285, 99341-99345, 99347-99350,	045x, 0510, 0515-0517, 0519,-0523, 0526-0529, 0762, 0981-0983

*****POS 53 identifies visits that occur in an outpatient, intensive outpatient, or partial hospitalization setting. If the organization elects to use POS 53 for reporting, it must have a system to confirm the visit was in an outpatient setting.

Note: The specifications presented here for the Penetration Rates by Service Category performance indicator is closely based upon HEDIS specifications.

Indicator 9: Diabetes screening for individuals with schizophrenia or bipolar disorder who are using antipsychotic medication

Description: The percentage of members 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year

Definitions:
Product lines: Medicaid

Ages: 18-64 years as of December 31 of the measurement year.

Continuous enrollment: The measurement year.

Allowable gap: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date: June 30 of the measurement year.

Benefits: Medical and pharmacy.

Denominator:
Step 1:Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year.

1. At least one acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria:
   - BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set
   - BH Stand Alone Acute Inpatient Value Set with Bipolar Disorder Value Set
   - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and Schizophrenia Value Set
   - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and Bipolar Disorder Value Set

2. At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:
   - BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set
   - BH Outpatient/PH/I OP Value Set with BH Outpatient/PH/I OP POS Value Set and Schizophrenia Value Set
   - ED Value Set with Schizophrenia Value Set
   - BH ED Value Set with BH ED POS Value Set and Schizophrenia Value Set

- BH Stand Alone Non-acute Inpatient Value Set with Schizophrenia Value Set
- BH Non-acute Inpatient Value Set with BH Non-acute Inpatient POS Value Set and Schizophrenia Value Set

3. At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder. Any two of the following code combinations meet criteria:
   - BH Stand Alone Outpatient/PH/IOP Value Set with Bipolar Disorder Value Set
   - BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/I OP POS Value Set and Bipolar Disorder Value Set
   - ED Value Set with Bipolar Disorder Value Set
   - BH ED Value Set with BH ED POS Value Set and Bipolar Disorder Value Set.
   - BH Stand Alone Non-acute Inpatient Value Set with Bipolar Disorder Value Set.
   - BH Non-acute Inpatient Value Set with BH Non-acute Inpatient POS Value Set and Bipolar Disorder Value Set

Step 2: Exclude members who met any of the following criteria:

1. Members with diabetes. There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify members with diabetes, but a member need only be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

   Claim/encounter data: Members who met at any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years)
   - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set) or non-acute inpatient encounters (Non-acute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters
   - At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set)
   - At least one ED encounter (ED Value Set) with a diagnosis of diabetes (Diabetes Value Set)

   Pharmacy data: Members who were dispensed insulin or oral hypoglycemic/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis

2. Members who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted.

   Claim/encounter data: An antipsychotic medication (Long-Acting Injections Value Set).
   Pharmacy data: Dispensed an antipsychotic medication (Table SSD-D) on an ambulatory basis.

Numerator: Members with a glucose test (Glucose Tests Value Set) or an HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

Data Source: Fee for service MMIS encounters, broken out by BHO

Calculation of Measure: The Department

Benchmark: HEDIS

Codes to Identify Antipsychotic Medications	
Description	**Prescription**
Miscellaneous antipsychotics	Aripiprazole, Lurisadone, Quetiapine, Asenapine, Molindone, Clozapine, Olanzapine, Risperidone, Haloperidol, Paliperidone, Ziprasidone, Lloperidone, Pirnozide, Loxapine, Quetiapine Turnarate
Phenothiazine antipsychotics	Chlorprornazine, Perphenazine Arnitriptyline, Thioridazine, Fluphenazine, Trifluoperazine, Perphenazine, Prochlorperazine
Psychotherapeutic combinations	Fluoxetine-Olanzapine
Thioxanthenes	Thiothixene
Long-acting injections	Aripiprazole, Olanzapine, Risperidone, Fluphenazine Decanoate, Paliperidone Palrnitate, Haloperidol Decanoate

Note: The specifications presented here for the Diabetes Screening performance indicator is closely based upon HEDIS specifications.

Indicator 10: Cardiovascular monitoring for people with cardiovascular disease and schizophrenia

Description: The percentage of members 18-64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

Definitions:
Product lines: Medicaid

Ages: 18-64 years as of December 31 of the measurement year.

Continuous enrollment: The measurement year and the year prior to the measurement year.

Allowable gap: No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date: December 31 of the measurement year.

Benefits: Medical.

Denominator:
Step 1: Identify members with schizophrenia as those who met at least one of the following criteria during the measurement year:

1. At least one acute inpatient encounter with any diagnosis of schizophrenia. Either of the following code combinations meets criteria:
   - BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set
   - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and Schizophrenia Value Set

2. At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:
   - BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set
   - BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and Schizophrenia Value Set
   - ED Value Set with Schizophrenia Value Set
   - BH ED Value Set with BH ED POS Value Set and Schizophrenia Value Set
   - BH Non-acute Inpatient Value Set with BH Non-acute Inpatient POS
   - Value Set and Schizophrenia Value Set

Step 2: Identify members from step 1 who also have cardiovascular disease. Members are identified as having cardiovascular disease in two ways: by event or by diagnosis. The organization must use both methods to identify the eligible population, but a member need only be identified by one to be included in the measure.

1. ***Event:*** Any of the following during the year prior to the measurement year meet criteria:
   - AMI. Discharged from an inpatient setting with an AMI (AMI Value Set). Use both facility and professional claims to identify AMI.
   - CABG. Discharged from an inpatient setting with a CABG (CABG Value Set). Use both facility and professional claims to identify CABG.
   - PC /. Members who had PCI (PCI Value Set) in any setting (e.g., inpatient, outpatient, ED).

2. ***Diagnosis:*** Identify members with IVD as those who met at least either of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
   - At least one outpatient visit (Outpatient Value Set) with a diagnosis of IVD (IVD Value Set).
   - At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of IVD (IVD Value Set).

Numerator: Members with an LDL-C test (LDL-C Test Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data. The organization may use a calculated or direct LDL.

Data Source: Fee for service MMIS encounters, broken out by BHO.

Calculation of Measure: HCPF

Benchmark: HEDIS

Note: The specifications presented here for the Cardiovascular Monitoring performance indicator is closely based upon HEDIS specifications.

Indicator 11: Diabetes monitoring for people with diabetes and schizophrenia

Description: The percentage of members 18-64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year (HEDIS Like).

Definitions:
Product lines: Medicaid

Ages: 18-64 years as of December 31 of the measurement year.

Continuous enrollment: The measurement year.

Allowable gap: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date: December 31 of the measurement year.

Benefits: Medical.

Denominator:
Step 1: Identify members with schizophrenia as those who met at least one of the following criteria during the measurement year.

1. At least one acute inpatient encounter, with any diagnosis of schizophrenia. Either of the following code combinations meet criteria:
   - BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set
   - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and Schizophrenia Value Set.

2. At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:
   - BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set
   - BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and Schizophrenia Value Set
   - ED Value Set with Schizophrenia Value Set
   - SH ED Value Set with SH ED POS Value Set and Schizophrenia Value Set
   - SH Stand Alone Non-acute Inpatient Value Set with Schizophrenia Value Set
   - SH Non-acute Inpatient Value Set with SH Non-acute Inpatient POS Value Set and Schizophrenia Value Set

Step 2: Identify members from step 1 who also have diabetes. There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to

identify the eligible population, but a member need only be identified by one to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or non-acute inpatient encounters (Non-acute Inpatient Value Set), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters.
- At least one acute inpatient encounter (Acute Inpatient Value Set), with a diagnosis of diabetes (Diabetes Value Set).

Pharmacy data. Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or year prior to the measurement year.

Numerator: An HbA1c test (HbA1c Tests Value Set) and an LDL-C test (LDL-C Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data. The member must have had both tests to be included in the numerator. The organization may use a calculated or direct LDL.

Exclusions: Identify members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who meet either of the following criteria:

- A diagnosis of polycystic ovaries (Polycystic Ovaries Value Set), in any setting, any time during the member's history through December 31 of the measurement year.
- A diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

Data Source: Fee for service MMIS encounters, broken out by BHO.

Calculation of Measure: HCPF

Benchmark: HEDIS

Codes to Identify Members with Diabetes	
Description	**Prescription**
Alpha-glucosidase inhibitors	Acarbose, Miglitol
Amylin analogs	Pramlinitide
Antidiabetic combinations	Alogliptin-metformin, Glyburide-metformin, Metformin-saxagliptin, Alogliptin-pioglitazone, Linagliptin-metformin, Metformin-sitagliptin, Glimepiride-pioglitazone, Metformin-pioglitazone, Sitagliptin-simvastatin, Glimepiride-rosiglitazone, Metformin-repaglinide, Glipizide-metformin, Metformin-rosiglitazone
Insulin	Insulin aspart, Insulin isophane human, Insulin aspart-insulin aspart protamine, Insulin isophane-insulin regular, Insulin lispro Insulin detemir, Insulin lispro-insulin lispro protamine, Insulin glargine, Insulin regular human, Insulin glulisine
Meglitinides	Nateglinide, Repaglinide
Glucagon-like peptide-1 (GLP1) agonists	Exenatide, Liraglutide, Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	Canagliflozin, Dapagliflozin
Sulfonylureas	Chlorpropamide, Glipizide, Tolazamide, Glimepiride, Glyburide, Tolbutamide
Thiazolidinediones	Pioglitazone, Rosiglitazone
Dipeptidyl peptidase-4 (DDP-4) inhibitors	Alogliptin, Saxagliptin, Linagliptin, Sitaglipin

Note: The specifications presented here for the Diabetes Monitoring performance indicator is closely based upon HEDIS specifications.

Indicator 12: Follow-up appointments within 7 and 30 days after hospital discharge for a mental health condition

Description: The percentage of member discharges from an inpatient hospital episode for treatment of a covered mental health diagnosis to the community or a non-24-hour treatment facility and were seen on an outpatient basis (excludes case management) with a mental health provider by age group and overall within 7 or 30 days (follow-up rates). Two indicators are provided: 1) ***Non-State:*** Follow-up rates for member discharges from a non-State hospital episode for treatment of a covered mental health diagnosis during the specific fiscal year, July 1 through June 30) ***All hospital:*** Follow-up rates for member discharges from all hospital episodes for a covered mental health diagnosis during the specific fiscal year, July 1 through June 30.

Denominator: The population based on discharges during the specified fiscal year July 1 through June 30 (can have multiple discharges for the same individual). Discharges for the whole fiscal year are calculated because the use of 90 day run out data provides the time to collect 30 day follow-up information.

Non-state Hospital: All discharges from a non-state hospital during the specified fiscal year.

All Hospitals: All discharges from any inpatient facility for the specified fiscal year.

Numerator: Total number of discharges with an outpatient service (see table below) within 7 and 30 days (the 30 days includes the 7-day number also). For each denominator event (discharge), the follow-up visit must occur after the applicable discharge. An outpatient visit on the date of discharge should be included in the measure. See codes in table below for follow-up visit codes allowed.

Non-state Hospital: All discharges from a non-state hospital during the specified fiscal year with an outpatient service within 7 and 30 days.

All Hospitals: All discharges from any inpatient facility for a specified fiscal year with an outpatient service within 7 and 30 days.

Data Source: Denominator: Number of Member discharges, from non-State hospitals, ages 6-20 and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, will be provided by the State. Numerator: An outpatient visit, intensive outpatient encounter or partial hospitalization provided by each BHO based on paid claims in the BHO transaction system.

Calculation of Measure: BHO

Benchmark: HEDIS and all BHOS

Description	
The percentage of discharges for members 6-20 years of age and 21-64, and 65+ who were hospitalized for treatment of a covered mental health diagnosis and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates for each age group are reported. 1. The percentage of members who received follow-up within 30 days of discharge 2. The percentage of members who received follow-up within 7 days of discharge	
Eligible Population	
Ages	Two age categories are identified, ages 6-20, 21-64, and 65+
Continuous Enrollment	Date of discharge through 30 days after discharge.
Allowable Gap	No gap in enrollment except for State hospital stays (ages 22-64) which allow gaps at 1 day prior to admission through 1 day after discharge.
Event / Diagnosis	Discharged from an acute inpatient setting (including acute care psychiatric facilities) with a covered mental health diagnosis during July1 and June 30 of the fiscal year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge during July1 and June 30 of the fiscal year.
Mental health readmission or direct transfer	If readmission or direct transfer to an acute facility follows the discharge for any covered mental health diagnosis within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although re-hospitalization might not be for a selected mental health diagnosis, it is probably for a related condition. In some cases, data associated with member transfers from inpatient care to less acute 24-hour care that are initiated by the Department of Youth Corrections, the Department of Human Services, or similar organizations are not available to the BHO. In these cases, an affected member may be included in the denominator, even though the transfer prevents a follow-up visit from occurring. Thus, the lack of available data reflecting these transfers will result in a lower percentage of completed follow-up visits for the BHO. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after June 30 of the fiscal year. Exclude discharges followed by readmission or direct transfer to a *non-acute facility* for any covered mental health diagnosis within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer to the following table for codes to identify non-acute care.
Exclusion	Because residential treatment for Foster Care members is paid under fee-for-service, the BHOs cannot easily determine if a Foster Care member was discharged to residential treatment. Therefore, prior to official rate reporting, the HCPF Business Analysis Section will forward each BHO a list of foster care members who were discharged from an inpatient setting to a residential treatment facility, in order to assist the BHOs in removing these members from this measure.

Codes to Identify Non-Acute Care				
Description	**HCPCS**	**UB Revenue**	**UB Type of Bill**	**POS**
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x, 28x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other non-acute care facilities that do not use the UB Revenue or type of bill codes for billing (e.g. ICF, SNF)				

Administrative Specification	
Denominator	The eligible population.
Numerator: 30-day follow-up	An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Refer to the following table for appropriate codes.
Numerator: 7-day follow-up	An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Refer to the following table for appropriate codes.

Codes to Identify Visits	
CPT	**HCPCS**
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner.	
, 99201-99205, 99211-99215, 99217-99220, 99242-99245, 99341-99345, 99347-99350, 90839	G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2011, H2022, H2014-H2019, M0064, S9480, S9485

CPT	POS	
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner.		
90847, 90849, 90853, , 90870, 90875, 90876, 90791, 90792, 90832, 90834, 90837, 90791, 90792	**WITH**	03, 04, 05, 07, 11, 12, 13, 14, 15, 16, 20, 22, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	**WITH**	52, 53
UB Revenue		
The organization does not need to determine practitioner type for follow-up visits identified by the following UB Revenue codes.		
0513, 0900-0905, 0907, 0911-0917, 0919		
Visits identified by the following Revenue codes must be with a mental health practitioner or in conjunction with any covered diagnosis code.		
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983		

*Note: The specification presented here for the Follow up Post Discharge performance indicator is closely based upon HEDIS specifications.

Indicator 13: Members with physical health well-care visits

Description: The total number of Members who received outpatient mental health treatment during the measurement period and also had a qualifying physical healthcare visit during the measurement period

Denominator: Total number of unduplicated members who had at least one BHO outpatient service claim/encounter during the measurement period. Members must be Medicaid eligible and enrolled at least 10 months with the same BHO during the 12-month measurement period (Outpatient services are defined using the same code criteria as the Penetration Rates performance measure (Indicator 8) Outpatient category excluding ED services).

Numerator: Total number of members in the denominator with at least one preventive or ambulatory medical visit as defined using the service codes in the table below during the measurement period, excluding those services provided by rendering provider type codes identified in the table below.

Data Source: The encounter/claims files (BHO, MCO, Fee for Service) for the fiscal year, including paid claims, provided by HCPF

Calculation of Measure: HCPF

Ratios: Rates are reported by age group (0-17; 18+). Report the percentage of members who received a BHO service and a qualifying physical health visit during the fiscal year.

Benchmark: Overall BHO

Preventative or Ambulatory Medical Visits Table AAP-A: Codes to Identify Preventive/Ambulatory Health Services (HEDIS)				
Description	**CPT**	**HCPCS**	**ICD-9-CM Diagnosis**	**UB Revenue**
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245	T1015		0510-0519, 0520-0529, 0982, 0983
Home Services	99341-99345, 99347-99350			
Nursing Facility Care	99304-99310, 99315, 99316, 99318			
Domiciliary, Rest Home or Custodial Care Services	99324-99328, 99334-99337,			
Preventative Medicine	99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429	G0402, G0438, G0439, G0463		
Ophthalmology and Optometry	92002, 92004, 92012, 92014	S0620, S0621		
General Medical Examination			V20.2,V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Rendering Provider Type Code Exclusions	
Rendering Provider Type Code	**Rendering Provider Type Description**
06	Podiatrist
11	Case Manager
27	Speech Therapist
12	Independent Laboratory

Indicator 14: Inpatient Utilization

Description: The total number of BHO member discharges from a hospital episode for treatment of a covered mental health diagnosis per 1000 members, by age group (see "definitions", page 2) and total population. The discharge must occur in the period of measurement. Two indicators are provided: 1) Number of member discharges from a non-State hospital and 2) Number of member discharges from all hospitals (non-State and State hospitals). Age for this indicator is determined at hospital discharge. Please note: For members transferred from one hospital to another within 24 hours, only one discharge should be counted and it should be attributed to the hospital with the final discharge.

Denominator: Total number of members during the specified fiscal year (12-month period) per HEDIS age group.

Numerator: All discharges from a hospital episode for treatment of a covered mental health diagnosis per HEDIS age group

Non-State Hospitals: All discharges from a non-State hospital episode for treatment of a covered mental health diagnosis during the specific fiscal year, July 1 through June 30.

All Hospitals: All discharges from a hospital episode for treatment of a covered mental health diagnosis during the specific fiscal year, July 1 through June 30.

Data Source: *Denominator*: Members by BHO provided by HCPF. *Numerator*: Discharge dates from non-State hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Discharge dates from the State hospital system, ages 21 through 64 years, will be provided by the State.

Calculation of Measure: BHO; Calculation: Numerator (non-state hospital)/Denominator x 1000; Numerator (all hospital)/Denominator x 1000

See "definitions", page 3 for revenue codes for hospitalization

Benchmark: HEDIS for all hospital and Overall BHOs for all hospital and non-State hospital

Indicator 15: Emergency Department Utilization for mental health condition

Description: Number of BHO Member emergency room visits for a covered behavioral health diagnosis (include mental health and substance use diagnoses found on page 2) per 1,000 Members by age group and overall for the specified fiscal year 12-month period. For this measure, include only paid encounters. Age for this indicator is determined on date of service.

Denominator: Total number of Members during the specified fiscal year (12-month period).

Numerator: ED visits that don't result in an inpatient admission within 24 hours of the day of the ED visit. ED visit codes include CPT 99281-99285 and 99291-99292 and revenue code 45x.

Data Source: Denominator: HCPF; Numerator: BHO encounter claim file.

Calculation of Measure: BHO; Calculation: Numerator/Denominator x 1,000

Benchmark: Overall BHO

Indicator 16: Antidepressant medication management acute and continuation phases

Description: Percent of members 18 years of age and older with a diagnosis of major depression, treated with antidepressant medication and who remained on an antidepressant medication treatment. Two rates are reported:

- *Effective Acute Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
- *Effective Continuation Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Refer to the table below for specific criteria on calculating this measure.

Definitions:
Intake Period: The 12-month window starts on April 1, 2014 and ends on March 31, 2015 with a run out to Sept 30, 2015

Index Prescription Start Date: The earliest prescription dispensing date for an antidepressant medication during the Intake Period.

Negative Medication History: A period of 105 days prior to the IPSD when the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication (Table AMM-C).

Treatment Days:

- *Effective Acute Phase Treatment*: the actual number of days covered with prescriptions within the specified 84-day measurement interval.

- *Effective Continuation Phase Treatment:* the actual number of days covered with prescriptions within the 180-day measurement interval.

Denominator: Members 18 years and older who were diagnosed with major depressive disorder and treated with antidepressant medication.

Numerator: The number of members in the denominator who remained on antidepressant medication treatment for 84 days (12 weeks) for acute phase treatment and 180 days (6 months) for continuation phase treatment.

Data Source: HCPF quarterly pharmacy file; BHO encounter data

Calculation of Measure: BHOs

Benchmark: Weighted average of BHOs and HEDIS

Eligible Population	
Product Lines	Medicaid
Ages	18 years and older as of June 30 of the measurement year.
Continuous Enrollment	105 days prior to the IPSD through 114 days after the IPSD.
Allowable Gap	One gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	IPSD.
Benefits	Medical, pharmacy (HCPF)

Event/diagnosis	The organization should follow the steps below to identify the eligible population, which should be used for both rates.
	
	Step 1: Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the Intake Period.
	
	Step 2: Exclude members who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient, or partial hospitalization setting during the 60 days prior to the IPSD (inclusive) through 60 days after the IPSD (inclusive). Members who meet the following criteria remain in the eligible population:
	
	• An outpatient visit, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria
	  o AMM Stand Alone Visits Value Set with Major Depression Value Set
	  o AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set
	• An ED visit (ED Value Set) with any diagnosis of Major Depression (Major Depression Value Set)
	• An inpatient (acute or non-acute) encounter with any diagnosis of major depression (Major Depression Value Set)
	
	For inpatient (acute or non-acute) encounter, use the date of discharge.
	For direct transfer, use the discharge date from the facility where the member was transferred.
	
	Step 3: Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 105 days prior to the IPSD.
	
	Step 4: Calculate continuous enrollment. Members should be continuously enrolled for 105 days prior to the IPSD to 114 days after the IPSD.

Administrative Specification	
Denominator	The eligible population.
Effective Acute Phase Treatment	At least 84 days (12-weeks) of continuous treatment with antidepressant medication) during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Allowable medication changes or gaps include: • Washout period gaps to change medication • Treatment gaps to refill the same medication Regardless of the number of gaps, there may be no more than 30 gap days. The organization may count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).
Effective Continuation Phase Treatment	At least 180 days (6 months) of continuous treatment with antidepressant medication during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 30 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Allowable medication changes or gaps include: • Washout period gaps to change medication • Treatment gaps to refill the same medication Regardless of the number of gaps, there may be no more than 51 gap days. The organization may count any combination of gaps (e.g., two washout gaps of 25 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

Codes to Identify Antidepressant Medications	
Description	**Prescription**
Miscellaneous antidepressants	Bupropion, Vilazodone
Monoamine oxidase inhibitors	Isocarboxazid, Phenelzine, Seleqiline, Tranylcypromine
Phenylpiperazine antidepressants	Nefazodone, Trazodone
Psychotherapeutic combinations	Amitriptyline-chlordiazepoxide, Amitriptyline-perphenazine, Fluoxetine-olanzapine
SSNRI antidepressants	Desvenlafaxine, Duloxetine, Venlafaxine
SSRI antidepressants	Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline
Tetracyclic antidepressants	Maprotiline, Mirtazapine
Tricyclic antidepressants	Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6 mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine

Major Depression Value Set	
Description	**ICD-9-CM Diagnosis**
Major depression	296.20-296.25, 296.30-296.35, 298.0, 311

Codes to Identify Outpatient, Intensive Outpatient and Partial Hospitalization		
CPT	**HCPCS**	**UB Revenue**
98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510, 90839	G0155, G0176, G0177, G0409-G0411,G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, S0201, S9480, S9484, S9485,T1015	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983

CPT		**POS**
90845, 90847, 90849, 90853, , 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 90791, 90792, 90832, 90834, 90837	**WITH**	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72

*Note: Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the time frame specified (e.g., during the Intake Period).