

Regional Accountable Entity

Behavioral Health Incentive Specification Document
SFY 2020-2021



This document includes the details for calculations of the Regional Accountable Entity Behavioral Health Incentive Measures for the seven Regional Accountable Entities. All measures are calculated using paid claims/encounters data.

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Revision History		
Document Date	Version	Change Description
10/12/2020	V1	

PARTICIPATION MEASURES

To qualify for participation in the BHIP Program, RAEs must meet the following:

- 1) The Contractor must manage the program such that the weighted average per-member-per-month trend is 4% or less from FY 2019-20 to FY 2020-21. The Department may, at its discretion, and with contractor consent, modify the target trend to account for underlying changes in the program's risk structure or population.

To qualify for incentive payments, RAEs must meet the following minimum performance requirements during the contract year:

- 1) Timely submission and completion of a corrective action plan submissions and activities
- 2) Timely and accurate submission of monthly encounter data

Qualifier 1: Monthly Data Submission

Description: The number of successful months of monthly data submissions to the department.

Successful monthly data submission is defined as:

Submission of flat files that are submitted on time in accordance with the contract and meets the following flat file specifications:

- The flat file contains no lines that duplicate other lines within the submission, nor lines that duplicate lines from previous submissions
- The flat file has no missing key fields or incorrect formats.

Each monthly submission that contains only files meeting the above criteria will count towards this qualifying measure. Monthly submissions containing additional files to correct for the errors listed above, or containing additional supplemental files, will not count towards the qualifying measure.

Data Source: Encounter Submission through RAE flat files, using dates August 2019 through July 2020.

Benchmark: To receive 100% of the qualifying measure, the plan must have at least 10 months of successful monthly data submissions. For each month below the 10 months of successful submissions, the plan will lose a portion of the qualifying measure. For 8-9 months of successful submissions, the plan will lose 10% of the measure for each month below 10. For months below 8, the plan will lose the remainder of the qualifying measure. Thus, the schedule for this measure is as follows:

- 10-12 successful months of data submissions – 100%

- 9 successful months of data submissions – 90%
- 8 successful months of data submissions – 80%
- 7 or less successful months of data submissions – 0%

Qualifier 2: Corrective Action Plan Compliance

Description: All corrective action plan submissions and activities shall be in accordance with the provisions of the Contract, for the duration of the Contract term.

To qualify for the portion of the overall incentive funds allocated for this participation measure, the Contractor shall demonstrate 100% compliance.

According to the corrective action plan (CAP) process, there are specific steps to ensure plans are a 100% compliant that are coordinated by the Departments EQRO, they are:

- The plan must submit the CAP within the timeframe given (30 days)
- The CAP must be approved by the Department -
- The CAP must be completed within the allowed timeframe outlined in the CAP

INCENTIVE MEASURES

Regional Baselines and Department Goals for Incentive Measures*:

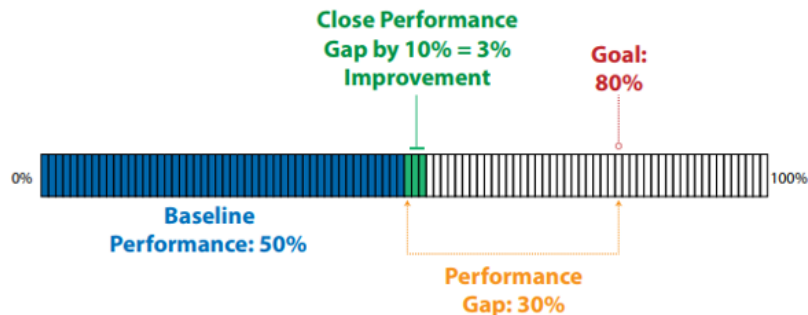
FY2018-2019 Performance								
Indicator	R1	R2	R3	R4	R5	R6	R7	HCPF Performance
1	41.31%	39.95%	38.88%	41.53%	32.87%	35.79%	46.35%	38.90%
2	58.18%	64.31%	58.76%	74.36%	63.56%	69.45%	72.90%	65.43%
3	27.75%	38.33%	27.83%	46.03%	37.22%	35.25%	37.01%	34.93%
4	45.32%	50.00%	43.48%	43.64%	33.82%	52.70%	58.99%	50.19%
5	13.29%	15.76%	12.05%	24.93%	17.20%	13.59%	19.47%	16.86%
FY2019-2020 Goals								
Indicator	R1	R2	R3	R4	R5	R6	R7	HCPF Goal
1	42.27%	40.51%	40.09%	42.47%	34.68%	37.31%	46.82%	50.99%
2	60.54%	66.05%	61.06%	75.10%	65.38%	70.68%	73.79%	81.79%
3	30.03%	39.56%	30.11%	46.49%	38.56%	36.79%	38.37%	50.63%
4	46.89%	51.51%	45.67%	45.20%	35.49%	53.81%	59.77%	65.10%
5	14.71%	16.93%	13.59%	25.18%	18.23%	14.98%	20.26%	27.42%

*Goals will be updated when final data for FY 19-20 is available and validated.

HCPF Goals were developed using the top performer (identified in green in the table above) using this equation:

$$(\text{top performer}) + (10\% \text{ of top performer}) = \text{HCPF Goal}$$

Each RAE will be responsible for closing their performance gap (between SFY 18-19 performance and the identified HCPF Goal) by 10% during the performance year (SFY 19-20). Please see the example below.



Indicator 1: Engagement in Outpatient Substance Use Disorder (SUD) Treatment

Measure Description

The percentage of members who had two or more outpatient services for a primary diagnosis of SUD on or within 30 days of their first episode of substance use disorder treatment.

Measurement Period

Triggering event: July 1, 2020 to June 1, 2021

Full measurement period: July 1, 2020 to June 30, 2021

Denominator

Members will be included in the denominator if they are enrolled in the ACC and received an intake service for a primary covered SUD diagnosis (see Appendix A). For an outpatient visit, or intensive outpatient visit use the first date of service to determine the intake date. For an episode of detoxification use the last date of the first detox episode to determine the intake date.

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Enrolled in the ACC	1		and	During evaluation period
Initiated treatment for a primary Covered SUD diagnosis (see Appendix A)	1	Codes to Identify Detoxification		During the evaluation period
		S3005, T1007, T1019, T1023	or	
		Codes to Identify Outpatient or Intensive Outpatient Visit		
		HCPCS		
		G0176, G0177, H0001, H0002, H0004, H0005, H0007, H0015, H0020, H0022, H0031, H0033, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2035, H2036, S9480, S9485, T1006, T1012	or	
		CPT		
		99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238,		

		99239, 99251, 99252, 99253, 99254, 99255, 99242, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90847, 90849, 90853, 90875, 90876		
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Population Exclusions

Members are excluded if there is previous substance use treatment history in the past 60 days.

Numerator

Members in the denominator who have had at least two or more outpatient visits or intensive outpatient encounters with any primary SUD diagnosis (see Appendix A) on or within 30 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day.

Notes:

1. Do not count events that include inpatient detoxification or detoxification codes (see table below) when identifying engagement of SUD treatment.
2. Billing provider type is only used on FFS data for the calculation of this metric.

Condition Description	# Event	Detailed Criteria			Criteria Connector	Timeframe
Members included in the denominator	1				and	During evaluation period
Two or more outpatient visits with a PCMP	1	90791, 90832, 90834, 90837, 90846, 90847			or	Within 30 days after initiation encounter
Two or more outpatient visits or intensive outpatient encounters with a primary covered SUD diagnosis (see Appendix A).	1	Codes to Identify Outpatient or Intensive Outpatient Visit				Within 30 days after initiation encounter
		HCPC	with	Billing Provider Type	or	
		G0176, G0177, H0001, H0002, H0004, H0005, H0007, H0015, H0020, H0022, H0031, H0033, H0034, H0035,		63, 64, 37, 35, 38, 25		

		H0036, H0037, H0038, H0039, H0040, H2000, H2001, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2035, H2036, S9480, S9485, T1006, T1012				
		CPT		Billing Provider Type		
		99202-99205, 99211-99215, 99217-99220, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99242-99245, 99341-99345, 99347-99350, 90791, 90792, 90832-90834, 90836-90840, 90847, 90849, 90853, 90875, 90876	With	63, 64, 37, 35, 38, 25	or	
		UB Revenue Codes				
		The organization does not need to determine practitioner type for follow-up visits identified by the following UB Revenue codes. Visits identified by the following Revenue codes must be used in conjunction with any primary covered Substance Use diagnosis code (see Appendix A).				
		Revenue Code		Billing Provider Type		
		0529, 0900, 0914, 0915	with	01	or	Within 30 days after initiation encounter
		UB Revenue Code 0900 with the following				Within 30 days after

		CPT/HCPC		Billing Provider Type		initiation encounter
		G0176, G0177, H0001, H0002, H0004, H0005, H0007, H0015, H0020, H0022, H0031, H0033, H0034, H0035, H0036, H0037, H0038, H0039, H0040, H2000, H2001, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2035, H2036, S9480, S9485, T1006, T1012 99202-99205, 99211- 99215, 99217-99220, 99221-99223, 99231- 99233, 99238, 99239, 99251-99255, 99242-99245, 99341- 99345, 99347-99350, 90791, 90792, 90832-90834, 90836- 90840, 90847, 90849, 90853, 90875, 90876	with	32, 45	or	

Continuous Enrollment Criteria

Members must be continuously enrolled in the ACC on the date of intake through 30 days after the intake date, with no gaps.

Data Source

RAE claims/encounter systems

FFS Claims

Calculation of Measure

This measure will be calculated by the Department.

Indicator 2: Follow-up appointment within 7 days of an Inpatient Hospital discharge for a mental health condition

Measure Description

The percentage of member discharges from an inpatient hospital episode for treatment of a primary covered mental health diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a mental health provider on or within 7 days of discharge.

Measurement Period

Triggering event: July 1, 2020 to June 24, 2021

Full measurement period: July 1, 2020 to June 30, 2021

Denominator

Members will be included in the denominator if they are enrolled in the ACC and received a discharge from an inpatient hospital episode for treatment of a primary covered mental health diagnosis (See Appendix A) to the community or a non-24-hour treatment facility.

Notes:

1. The Department will not exclude state hospital stays not paid under Medicaid due to lack of data.
2. Billing provider type is only used on FFS data for the calculation of this metric.

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Enrolled in the ACC	1		and	During evaluation period
Member discharge from an inpatient hospital episode for a primary covered mental health diagnosis (see Appendix A).	1	UB Revenue Code		
		100-219 or 0100-0219		

Population Exclusions

Members with a non-acute care discharge will be excluded from the denominator based on the chart below.

Codes to Identify Non-Acute Care

Condition Description	Billing Provider Type	HCPCS	UB Revenue	UB Type of Bill	POS
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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			655		
Intermediate care facility					54
Residential substance abuse treatment facility			1002		55
Psychiatric residential treatment center		H0017-H0019	1001		56
Psychiatric residential treatment center (when services are paid for by Fee For Service)	30		0911		
Residential Child Care Facility (when services are paid for by Fee For Service)	52	90791, 90792, 90785, 90832, 90834, 90837, 90846, 90847, 90853, 96101, 96102, 90833, 90836, 90839, 90840, 90863			11, 14
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)					

The following are exclusions from the denominator:

- If the discharge is followed by readmission or direct transfer to an emergency department for a primary diagnosis of mental health- within the 7-day follow-up period, count only the readmission discharge or the discharge from the emergency department to which the patient was transferred.
- Exclude discharges followed by admission or direct transfer to an acute or nonacute facility within the 7-day follow-up period, regardless of primary diagnosis for the admission.

These discharges are excluded from the measure because hospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Numerator

Members in the denominator who were seen on an outpatient basis (this excludes case management) with a mental health provider on or within 7 days of discharge.

Notes:

1. Billing provider type is only used on FFS data for the calculation of this metric.

Condition Description	# Event	Detailed Criteria			Criteria Connector	Timeframe
Member included in the denominator	1	and				Within 7 days of the discharge
Outpatient visit with a PCMP	1	90791, 90832, 90834, 90837, 90846, 90847			or	Within 7 days of the discharge
Mental health (outpatient) follow-up visit with a mental health provider	1	Codes to Identify Mental Health Visits				Within 7 days of the discharge
		HCPCS	with	Billing Provider Type	or	
		G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2011, H2012, H2014-H2018, H2022, M0064, S9480, S9485		37, 35, 38, 28		
		CPT	with	Billing Provider Type	or	

		98960-98962, 99201-99205, 99211-99215, 99217-99220, 99242-99245, 99341-99345, 99347-99350		37, 35, 38, 28		
		CPT		Billing Provider Type		
		90791, 90792, 90832, 90834, 90837, 90839, 90847, 90849, 90853, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	with	37, 35, 38, 28	or	
		UB Revenue Codes				
		<i>The organization does not need to determine practitioner type for follow-up visits identified by the following UB Revenue codes. Visits identified by the following Revenue codes must be used in conjunction with any primary covered Mental Health diagnosis code (see Appendix A).</i>				Within 7 days of the discharge
		Revenue Code		Billing Provider Type		
		0900, 0914, 0915, 0529	with	01	or	
		UB Revenue Code 0900 with the following				
		CPT/HCPC		Billing Provider Type		
		G0176, G0177, H0002, H0004, H0031, H0034- H0037, H0039, H0040, H2000, H2001, H2011, H2012, H2014- H2018, H2022, M0064, S9480,	with	32, 45	or	Within 7 days of the discharge

		S9485, 98960-98962, 99201-99205, 99211-99215, 99217-99220, 99242-99245, 99341-99345, 99347-99350, 90791, 90792, 90832, 90834, 90837, 90839, 90847, 90849, 90853, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255				
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* 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.

Continuous Enrollment Criteria

Members must be continuously enrolled in the ACC from date of discharge for 7 days, with no gaps.

Data Source

RAE claims/encounter systems

FFS Claims

Calculation of Measure

This measure will be calculated by the Department.

Indicator 3: Follow-up Appointment within 7 days of an Emergency Department (ED) visit for a Substance Use Disorder

Measure Description

The percentage of member discharges from an emergency department episode for treatment of a covered substance use disorder (SUD) to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a behavioral health provider on or within 7 days of discharge.

Measurement Period

Triggering event: July 1, 2020 to June 24, 2021

Full measurement period: July 1, 2020 to June 30, 2021

Denominator

Members will be included in the denominator if they are enrolled in the ACC and received a discharge from an emergency department episode for treatment of a primary covered substance use disorder diagnosis (see Appendix A) to the community or a non-24-hour treatment facility.

Notes:

1. The Department will not exclude state hospital stays not paid under Medicaid due to lack of data.
2. Billing provider type is only used on FFS data for the calculation of this metric.

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Enrolled in the ACC	1		and	During evaluation period
Member discharge from an emergency department episode for a primary substance use disorder diagnosis (see Appendix A).	1	UB Revenue Code		
		45x or 045x	or	
		CPT		
		99281-99285	or	

Population Exclusions

Members with a non-acute care discharge will be excluded from the measure.

Codes to Identify Non-Acute Care

Condition Description	Billing Provider Type	HCPCS	UB Revenue	UB Type of Bill	POS
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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			655		
Intermediate care facility					54
Residential substance abuse treatment facility			1002		55
Psychiatric residential treatment center		H0017-H0019	1001		56
Psychiatric residential treatment center (when services are paid for by Fee For Service)	30		0911		
Residential Child Care Facility (when services are paid for by Fee For Service)	52	90791, 90792, 90785, 90832, 90834, 90837, 90846, 90847, 90853, 96101, 96102, 90833, 90836, 90839, 90840, 90863			11, 14
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)					

The following are exclusions from the denominator:

- If the discharge is followed by readmission or direct transfer to an emergency department for a primary diagnosis of substance use disorder (SUD) within the 7-day follow-up

period, count only the readmission discharge or the discharge from the emergency department to which the patient was transferred.

- Exclude discharges followed by admission or direct transfer to an acute or nonacute facility within the 7-day follow-up period, regardless of primary diagnosis for the admission.

These discharges are excluded from the measure because hospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Numerator

Members in the denominator who were seen on an outpatient basis (this excludes case management) with a behavioral health provider on or within 7 days of discharge.

Condition Description	# Event	Detailed Criteria			Criteria Connector	Timeframe
Member included in the denominator	1				and	Within 7 days of the discharge
Outpatient visit with a PCMP	1	90791, 90832, 90834, 90837, 90846, 90847			or	Within 7 days of the discharge
Substance Use Disorder (outpatient) follow-up visit with a behavioral health provider	1	Codes to Identify Detoxification				
		HCPCS	with	Billing Provider Type	or	
		S3005, T1007, T1019, T1023		63, 64, 37, 35, 38, 25		
		Codes to Identify Behavioral Health Visits				Within 7 days of the discharge
		HCPC	with	Billing Provider Type	or	
		G0176, G0177, H0001, H0002, H0004, H0005, H0007, H0015, H0020, H0022, H0031, H0033, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2011, H2012, H2013, H2014,		63, 64, 37, 35, 38, 25		

		H2015, H2016, H2017, H2018, H2035, H2036, S9480, S9485, T1006, T1012				
		CPT		Billing Provider Type		
		99202-99205, 99211-99215, 99217-99220, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99242-99245, 99341-99345, 99347-99350, 90791, 90792, 90832-90834, 90836-90840, 90847, 90849, 90853, 90875, 90876	with	63, 64, 37, 35, 38, 25	or	Within 7 days of the discharge
		UB Revenue Codes				
		<i>The organization does not need to determine practitioner type for follow-up visits identified by the following UB Revenue codes. Visits identified by the following Revenue codes must be used in conjunction with any primary covered Substance Use diagnosis code (see Appendix A).</i>				Within 7 days of the discharge
		Revenue Code		Billing Provider Type		
		0529, 0900, 0914, 0915	with	01	or	
		UB Revenue Code 0900 with the following				
		CPT/HCPC		Billing Provider Type		
		S3005, T1007, T1019, T1023, G0176, G0177, H0001, H0002, H0004, H0005,	with	32, 45	or	Within 7 days of the discharge

		H0007, H0015, H0020, H0022, H0031, H0033, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2035, H2036, S9480, S9485, T1006, T1012 99202-99205, 99211-99215, 99217-99220, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99242-99245, 99341-99345, 99347-99350, 90791, 90792, 90832-90834, 90836-90840, 90847, 90849, 90853, 90875, 90876				
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Continuous Enrollment Criteria

Members must be continuously enrolled in the ACC from date of discharge for 7 days, with no gaps.

Data Source

RAE claims/encounter systems

FFS Claims

Calculation of Measure

This measure will be calculated by the Department.

Indicator 4: Follow-up after a Positive Depression Screen

Measure Description

Percentage of members engaged in mental health service on or within 30 days of screening positive for depression within a Primary Care Setting (Primary Care Visit as defined by the RAE ACC Well Visit KPI [Specification](#) and [Value Set](#)).

*In order to qualify for payment, depression screening rates must **increase by a 10% Gap closure between RAE performance and the Department Goal**, as identified by the number of members with an outpatient primary care visit in the evaluation period who received a depression screening (G8431, G8510)

MEASURE YEAR RATES (EXCLUDING MEMBERS UNDER 1 YEAR OLD)

RAE_REGION	MEMBERS WITH A WELL VISIT WITHIN THE MEASUREMENT YEAR	MEMBERS WITH A DEPRESSION SCREEN WITHIN MEASUREMENT YEAR	18-19 Rate	Gap	UPDATED Goal
RAE 01	47,131	6,395	13.57%	53.10%	18.88%
RAE 02	18,809	688	3.66%	63.01%	9.96%
RAE 03	89,932	23,083	25.67%	41.00%	29.77%
RAE 04	28,765	12,083	42.01%	24.66%	44.47%
RAE 05	37,742	3,267	8.66%	58.01%	14.46%
RAE 06	41,140	10,211	24.82%	41.85%	29.00%
RAE 07	44,649	27,060	60.61%	6.06%	61.21%
ACC Overall	308,168	82,787	26.86%		66.67%

Measurement Period

Triggering event: July 1, 2020 to June 1, 2021

Full measurement period: July 1, 2020 to June 30, 2021

Denominator

All members with a positive depression screening as identified by procedure code G8431 in a primary care setting.

Notes:

1. Billing provider type is only used on FFS data for the calculation of this metric.

Exclusions from the Denominator:

1. Exclude members under 1 year old

Numerator

All members with a positive depression screen who also received one of the following services the same day or within 30 days:

Condition Description	# Event	Detailed Criteria			Criteria Connector	Timeframe
Members included in the denominator	1				and	During evaluation period
Outpatient visit with a PCMP	1	90791, 90832, 90834, 90837, 90846, 90847			or	Within 30 days of the positive depression screen
At least one of the following services	1	Codes to identify follow-up Assessment in any setting (Behavioral Health or Primary Care)				Within 30 days of the Positive Depression Screen
		CPT		Billing Provider Type	Or	
		90791, 90792, 90832, 90834, 90837, 90846, 90847		35, 37, 38, 41, 25, 26, 05, 39		
		Codes to identify follow-up Assessment in a Behavioral Health Setting using a Behavioral Health Screen or Evaluation and Management Codes, including Emergency Department E&M Codes and Consultation E&M Codes				
		CPT/HCPC	With	Billing Provider Type	Or	
		H0002, 90833, 90836,		37, 35, 38, 25		

		90838, 99201- 99205, 99211- 99215, 99217- 99226, 99231- 99236, 99238, 99239, 99304- 99310, 99315, 99316, 99318, 99324- 99328, 99334- 99337, 99341- 99345, 99347- 99350, 99366, 99367, 99368, 99441- 99443, 99281- 99285, 99241- 99245, 99251- 99255				
		UB Revenue Code 0529 or 0900 with the following				Within 30 days of the Positive Depression Screen
		CPT/HCPC		Billing Provider Type		
		H0002, 90791, 90792, 90832, 90833, 90834,	with	32, 45	or	

		90836, 90837, 90838, 90846, 90847, 99201- 99205, 99211- 99215, 99217- 99226, 99231- 99236, 99238, 99239, 99304- 99310, 99315, 99316, 99318, 99324- 99328, 99334- 99337, 99341- 99345, 99347- 99350, 99366, 99367, 99368, 99441- 99443, 99281- 99285, 99241- 99245, 99251- 99255				
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Continuous Enrollment Criteria

Members must be continuously enrolled in the ACC on the date of the positive depression screen for 30 days, with no gaps.

Data Source

RAE claims/encounter systems

FFS Claims

MCO Encounters as appropriate

Calculation of Measure

This measure will be calculated by the Department.

Indicator 5: Behavioral Health Screening or Assessment for children in the Foster Care system

Measure Description

Percentage of foster care children who received a behavioral screening or assessment on or within 30 days of ACC enrollment.

Measurement Period

Triggering event: July 1, 2020 to June 1, 2021

Full Measurement Period: July 1, 2020 to June 30, 2021

Denominator

Total number of members who became Medicaid eligible on or after July 1, 2020 based on aid code and are assigned to a RAE. Members must be continuously enrolled for 30 days from the date of ACC enrollment.

Notes:

1. Billing provider type is only used on FFS data for the calculation of this metric.
2. If a member moves from one aid category to another, they will not be added to the denominator a second time. Only members new to foster care will count in the denominator.

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Members who became Medicaid eligible based on aid code, are enrolled in a RAE for 30 days from the date of ACC enrollment	1	Aid Codes used to identify members	and	During the evaluation period
		10, 11, 12, 13, 19, 20, 23		

Population Exclusions

Condition Description	Billing Provider Type	HCPCS	UB Revenue	UB Type of Bill	POS
Psychiatric residential treatment center (when	30		0911		

services are paid for by Fee For Service)					
Residential Child Care Facility (when services are paid for by Fee For Service)	52	90791, 90792, 90785, 90832, 90834, 90837, 90846, 90847, 90853, 96101, 96102, 90833, 90836, 90839, 90840, 90863			11, 14

Exclude members with aid code 70 from denominator.

Numerator

Total number of members from the denominator who received one of the following services on or within 30 days of ACC enrollment:

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Members included in the denominator	1		and	During evaluation period
Outpatient visit with a PCMP	1	90791, 90832, 90834, 90837, 90846, 90847	or	Within 30 days from the date of RAE enrollment
At least one of the following services	1	Codes to identify follow-up Assessment in a Behavioral Health Setting using a Behavioral Health Screen or Evaluation and Management Codes, including Emergency Department E&M Codes and Consultation E&M Codes		Within 30 days from the date of RAE enrollment
		CPT/HCPC	with	Billing Provider Type

		H0002, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 99201-99205, 99211-99215, 99217-99226, 99231-99236, 99238, 99239, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99366, 99367, 99368, 99441-99443, 99281-99285, 99241-99245, 99251-99255		37, 35, 38, 25,	
		UB Revenue Code 0529 or 0900 with the following			
		CPT/HCPC		Billing Provider Type	
		H0002, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 99201-99205, 99211-99215, 99217-99226, 99231-99236, 99238, 99239, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99366, 99367,	with	32, 45	Within 30 days from the date of RAE enrollment

		99368, 99441- 99443, 99281- 99285, 99241- 99245, 99251- 99255			
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Continuous Enrollment Criteria

Members must be continuously enrolled in the ACC for 30 days from the time enrollment began.

Data Source

RAE claims/encounter systems

FFS Claims

Calculation of Measure

This measure will be calculated by the Department.

Appendix A

Covered Behavioral Health Diagnosis

Covered Mental Health Diagnosis:

ICD-10-CM Code Ranges	
Start Value	End Value
F20.0	F42.3
F42.8	F48.1
F48.9	F51.03
F51.09	F51.12
F51.19	F51.9
F53.0	F53.1
F60.0	F63.9
F68.10	F69
F90.0	F98.4
F98.8	F99
R45.1	R45.2
R45.5	R45.82

Covered Substance Use Disorder Diagnosis:

ICD-10-CM Code Ranges	
Start Value	End Value
F10.10	F10.26
F10.28	F10.96
F10.98	F13.26
F13.28	F13.96
F13.98	F18.159
F18.18	F18.259
F18.28	F18.959
F18.980	F19.16
F19.18	F19.26
F19.28	F19.99