

Mental Health Treatment Penetration (Broad Version)

Metric Information

Metric description: The percentage of Medicaid beneficiaries, 6 years of age and older, with a mental health service need identified within the past two years, who received at least one qualifying service during the measurement year.

Metric specification version: Washington State Department of Social and Health Services, Research and Data Analysis Division, Cross-System Outcome Measures for Adults Enrolled in Medicaid – “Mental Health Treatment Penetration (Broad) (April 2018, v 2.0)”.

These specifications are derived from a metric developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 2013 Engrossed House Bill 1519 (Chapter 320, Laws of 2013) and Second Substitute Senate Bill 5732 (Chapter 338, Laws of 2013) performance measure development process.

Data collection method: Administrative only.

Data source: ProviderOne Medicaid claims/encounter and enrollment data.

Claim status: Include only final paid claims or accepted encounters in metric calculation.

Identification window: Measurement year and the year prior to the measurement year.

Direction of quality improvement: Higher is better.

URL of specifications: N/A

DSRIP Program Summary

Metric utility: ACH Project P4P ■ ACH High Performance ■ DSRIP statewide accountability ■

ACH Project P4P – Metric results used for achievement value: Submetric results reported for three age groups: 6 – 17 years; 18 – 64 years; 65+ years. Weighted average of performance for each submetric is used to calculate overall AV; determined by number of Medicaid beneficiaries the ACH has in the denominator of each submetric.

ACH Project P4P – improvement target methodology: improvement over self (1.9% improvement over reference baseline performance).

ACH High Performance – methodology: HCA will use a Quality Improvement (QI) Model to determine relative high performance among ACHs for the set of High Performance metrics. For more information, see Chapter 8: ACH High Performance Incentives.

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DSRIP statewide accountability – methodology: HCA will use a Quality Improvement (QI) Model to determine statewide performance across the quality metric set. For more information, see Chapter 2: Statewide accountability.

ACH regional attribution: Residence in the ACH region for 11 out of 12 months in the measurement year.

Statewide attribution: Residence in the state of Washington for 11 out of 12 months in the measurement year.

DSRIP Metric Details

Eligible Population – ACH Project P4P and DSRIP statewide accountability	
Age	6 years and older. Age is as of the last day of the measurement year.
Gender	N/A
Minimum Medicaid enrollment	Measurement year. Enrollment must be continuous.
Allowable gap in Medicaid enrollment	One gap of one month during the measurement year.
Medicaid enrollment anchor date	Last day of measurement year.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid and beneficiaries with primary insurance other than Medicaid.

Eligible Population – ACH High Performance	
Age	6 years and older. Age is as of the last day of the measurement year.
Gender	N/A
Minimum Medicaid enrollment	Measurement year. Enrollment must be continuous.
Allowable gap in Medicaid enrollment	One gap of one month during the measurement year.
Medicaid enrollment anchor date	Last day of measurement year.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries with primary insurance other than Medicaid. <i>Note: for the ACH High Performance Incentives calculation, Medicaid beneficiaries that are eligible for both Medicaid and</i>

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	<i>Medicare (duals) are included in the eligible population for the metric.</i>
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Denominator:

Data elements required for denominator: Medicaid beneficiaries, aged 6 and older on the last day of the measurement year, with a mental health service need identified in either the measurement year or the year prior to the measurement year.

Mental health service need is identified by the occurrence of any of the following conditions:

- Receipt of any mental health service encounter meeting the numerator service criteria in the 24-month identification window
- Any diagnosis of mental illness (not restricted to primary) in the MI-Diagnosis code set in the 24-month identification window
- Receipt of any psychotropic medication listed in the Psychotropic-NDC code set in the 24-month identification window

Value sets required for denominator.

Name	Value Set
MI-Diagnosis code set	<p>All value sets are available upon request. Please email medicaidtransformation@hca.wa.gov</p> <p>Some value sets are updated frequently. When calculating this metric, check to make sure the most up to date value sets are being used.</p>
Psychotropic-NDC code set	
MH-Proc1 value set	
MH-Taxonomy value set	
MH-Proc2 value set	
MH-Proc3 value set	
MI-Diagnosis	
MH-Proc4	
MH-Proc5	

Required exclusions for denominator.

- Eligible population exclusions are listed in the eligible population table above.
- Metric specific exclusions: None.

Deviations from cited specifications for denominator.

- None.

Numerator:

Beneficiaries must qualify for inclusion in the denominator to be eligible for inclusion in the numerator.

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Data elements required for numerator: Members receiving at least one mental health service meeting at least one of the following criteria, applied by claim line, in the 12-month measurement year:

- Receipt of an outpatient service with a procedure code in the MH-Proc1 value set (MCG 261)
OR
- Receipt of an outpatient service with:
 - o Servicing provider taxonomy code in the MH-Taxonomy value set (MCG262) AND
 - o Procedure code in MH-Proc2 value set (MCG 4947) OR MH-Proc3 value set (MCG 3117) AND
 - o Primary diagnosis code in the MI-Diagnosis value set**OR**
- Receipt of an outpatient service with:
 - o Procedure code in MH-Proc4 value set (MCG 4491) AND
 - o Any diagnosis code in the MI-Diagnosis value set**OR**
- Receipt of an outpatient service with:
 - o Servicing provider taxonomy code in the MH-Taxonomy value set (MCG262) AND
 - o Procedure code in MH-Proc5 value set (MCG 4948) AND
 - o Any diagnosis code in the MI-Diagnosis value set

Value sets required for numerator.

Name	Value Set
MI-Diagnosis code set	All value sets are available upon request. Please email medicaidtransformation@hca.wa.gov Some value sets are updated frequently. When calculating this metric, check to make sure the most up to date value sets are being used.
Psychotropic-NDC code set	
MH-Proc1 value set	
MH-Taxonomy value set	
MH-Proc2 value set	
MH-Proc3 value set	
MI-Diagnosis	
MH-Proc4	
MH-Proc5	

Required exclusions for numerator.

- None

Deviations from cited specifications for numerator.

- None

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Version Control

July 2018 release: The specification was updated to reflect changes in ProviderOne and billing related to the Integration of Managed Care.

January 2019 update: Minor formatting updates were made to the metric specification sheet (updating URL of specification). No substantive changes were made to the specification.

August 2019 update: The specification sheet has been updated to reflect the current version of the technical specification from the measure steward. No substantive changes were made to the DSRIP Metric Details. Note that while the names of the value sets included in the specifications have not changed, the underlying values may have been updated.

August 2020 update: The specification sheet has been updated to reflect the current version of the technical specification from the measure steward. No substantive changes were made to the DSRIP Metric Details. Note that the names of the value sets included in the specifications have changed and the underlying values may have been updated.