Mental Health Service Rate Measure Definition

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Medicaid and Commercial Version 6.3

Description

The percentage of members with a mental health service need who received outpatient mental health services in the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	Separate reporting for age groups 6 – 17, 18 – 64 and 65+
Continuous enrollment	The measurement year
Allowable gap	No more than one gap in continuous 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
Identification window	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months)
Benefit	Full Benefit Medicaid or SCHIP without third-party liability in the measurement year
Event/diagnosis	Members meeting the mental health service need criteria defined below
Claim status	Include only final paid claims or accepted encounters in measure calculation

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Mental Health Service Need

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

1. Receipt of any mental health service encounter meeting the numerator service criteria in the 24-month identification window
2. Any diagnosis of mental illness (not restricted to primary) in the MI-Diagnosis (7MCGs) code set in the 24-month identification window
3. Receipt of any psychotropic medication listed in the Psychotropic-NDC (5MCGs) code set in the 24-month identification window

Denominator

Include in the measure denominator all individuals in the eligible population with a mental health service need in the 24-month identification window.

Numerator

Members receiving at least one outpatient[1] mental health service[2] meeting at least one of the following criteria, applied by claim line, in the 12-month measurement year:

1. Receipt of an outpatient service with a procedure code in the MH-Proc1 value set (MCG 261)
2. Receipt of an outpatient service with:
    a. Servicing provider taxonomy code in the MH-Taxonomy value set (MCG262) AND
    b. Procedure code in MH-Proc2 value set (MCG 4947) OR MH-Proc3 value set (MCG 3117) AND
    c. Primary diagnosis code in the MI-Diagnosis value set
3. Receipt of an outpatient service with:
    a. Procedure code in MH-Proc4 value set (MCG 4491) AND
    b. Any diagnosis code in the MI-Diagnosis value set
4. Receipt of an outpatient service with:
    a. Servicing provider taxonomy code in the MH-Taxonomy value set (MCG262) AND
    b. Procedure code in MH-Proc5 value set (MCG 4948) AND
    c. Any diagnosis code in the MI-Diagnosis value set
5. Receipt of an outpatient service with:
    a. Procedure code in MH-Proc3-MCG3117 AND
    b. Primary diagnosis code in the MI-Diagnosis value set

[1] In the Medicaid MMIS data system context, qualifying outpatient mental health services are restricted to professional, EPSDT, and Medicare Part B crossover claim types, and institutional outpatient claims are excluded. Organizations should implement analogous claim-type inclusion criteria in their measurement context.

[2] This specification has been designed for use in a managed care context (e.g., Medicaid MCO replication of state-reported results). In measurement contexts where available data include fee-for-service claims, numerator criteria should include tribal mental health service enhancement payments.

Numerator Interpretation

The five criteria comprising the numerator definition reflect the following measurement concepts. Note that the criteria are not mutually exclusive by design.

1. The first criterion includes services (procedure codes in MH-Proc1) that are considered by definition to be mental health treatment (e.g., psychotherapy).
2. The second criterion includes services (procedure codes in MH-Proc2 or MH-Proc3) that are considered mental health treatment when they are delivered by a mental health provider (as identified by Taxonomy codes in the MH-Taxonomy value set) in treatment encounters associated with a primary diagnosis of mental illness (as identified by diagnosis codes in the MI-Diagnosis value set). Procedure code examples include office visits with new or established patients. Taxonomy code examples include psychiatrists, psychologists, and social workers.
3. The third criterion includes services (procedure codes in MH-Proc4) that are likely to be behavioral health related, but are required to meet an additional mental illness diagnosis criterion to ensure that the service relates to mental illness (as opposed to treatment for substance use disorder for persons without co-occurring mental illness). Procedure code examples include "behavioral health counseling and therapy."
4. The fourth criterion includes established patient outpatient visits (procedure codes in MH-Proc5) with a mental health provider (as identified by Taxonomy codes in the MH-Taxonomy value set) with a diagnosis of mental illness in any diagnosis field (as identified by diagnosis codes in the MI-Diagnosis value set).
5. The fifth criterion includes services (procedure codes in MH-Proc3) that are considered mental health treatment when the primary diagnosis associated with the encounter is mental illness, regardless of the taxonomy of the servicing provider. Procedure code examples include office visits with new or established patients. This numerator component was designed to capture management of mental health conditions in a primary care setting by non mental health providers.