Public Comment Overview

Agency Overview

The New York State Department of Health (NYSDOH) is responsible for evaluating quality and oversees the collection of health care quality performance data.

Measure Development Process

The Department uses a consensus development process that involves a rigorous review of published guidelines, scientific evidence, and feedback from multi-stakeholder advisory panels, including the Office of Quality and Patient Safety, the Office of Health Insurance Programs, the Office of Alcohol and Substance Abuse and the Office of Mental Health.

Submitting Comments

The Department seeks feedback on the proposed new measures for the 2018 Value-Based Payment (VBP) Quality Measure set and 2018 Quality Assurance Reporting Requirements. Please submit all comments using the spreadsheet provided to vbp@health.ny.gov by September 11, 2017.

Value Set Directory

Any code tables not attached to the measure specifications are from the HEDIS 2018 Value Set Directory.

A **value set** contain the complete set of codes used to identify the service or condition included in the measure.

Item for Public Comment

Proposed New Measures

1. *Continuity of Care from Inpatient Detox to Lower Level of Care*
2. *Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care*
3. *Initiation of Pharmacotherapy upon New Episode of Opioid Dependence*
4. *Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence*
5. *Maintaining/Improving Employment or Higher Education Status*
6. *Maintenance of Stable or Improved Housing Status*
7. *Mental Health Engagement in Care 30 Days*
8. *No or Reduced Criminal Justice Involvement*
9. *Percentage of HARP Enrolled Members Who Received Personalized Recovery Oriented Services (PROS)PROS or Home and Community Based Services (HCBS)*
10. *Potentially Preventable Mental Health Related Readmission Rate 30 Days*
11. *Utilization of Pharmacotherapy for Alcohol Abuse or Dependence*
12. *Utilization of Pharmacotherapy for Opioid Dependence*

Proposed New Measures
Continuity of Care from Inpatient Detox or Inpatient Care to Lower Level of Care

The Department seeks comments on the proposed measures for inclusion in the 2018 Value-Based Payment (VBP) Quality Measure Set and the 2018 Quality Assurance Report Requirements for the HARP Product Line:

1. *Continuity of Care from Inpatient Detox to Lower Level of Care.* The percentage of inpatient detox discharges for members 13 years of age and older with a diagnosis of alcohol and other drug (AOD) dependence, who had a follow-up lower level visit for AOD within 14 days of the discharge date.
2. *Continuity of Care from Inpatient Rehabilitation to Lower Level of Care.* The percentage of inpatient discharges for members 13 years of age and older for alcohol and other drug abuse or dependence treatment (AOD), who had a follow-up lower level AOD visit within 14 days of the discharge date.

These measures focus on individuals engaged in treatment for alcohol and other drug dependence who are discharged to the community. There has been evidence that patients who continue substance use disorder (SUD) treatment after discharge from detoxification services are less likely to experience readmission to another detoxification and are more likely to have improved health and social outcomes.[1] There is also evidence that SUD patients who engage in more continuing outpatient care after intensive inpatient treatment also have better outcomes. A Continuity of Care measure has the potential to be a useful tool to help providers monitor continuation of SUD care and to alert them where improvement of care is needed.

The measures were field-tested with 2016 Medicaid claims and encounters.

Continuity of Care from Inpatient Detox to Lower Level of Care
Average performance was 45 percent with variation across Medicaid Managed Care plans. There was a 18 percent gap in performance which indicates an opportunity for improvement.

Continuity of Care from Inpatient Care to Lower Level of Care
Average performance was 45 percent with variation across Medicaid Managed Care plans. There was a 22 percent gap in performance which indicates an opportunity for improvement.

The Department seeks feedback on this measure, the technical specification, and responses to the following question:

Should follow-up visits (Inpatient excluding detox and outpatient) be restricted to primary AOD diagnosis and/or primary AOD procedures only? We are interested in whether this restriction captures SUD follow-up visits.

[1] Ford, Lucy K., & Zarate, Patrick. (2010). Closing the gaps: The impact of inpatient detoxification and continuity of care on client outcomes. *Journal of Psychoactive Drugs, SARC Supplement 6, September*, 303-314.

Continuity of Care from Inpatient Detox to Lower Level of Care

DRAFT

Description

The percentage of inpatient AOD detox discharges for members 13 years of age and older, who had a follow-up lower level AOD visit within 14 days of the discharge date.

Definitions

Intake Period January 1-December 17 of the measurement year.

Direct Transfer A **direct transfer** is when the discharge date from one inpatient detox setting and the admission date to a second inpatient detox setting are one calendar day apart or less. For example:

- An inpatient detox discharge on June 1, followed by an admission to another inpatient detox setting on June 1, is a direct transfer.
- An inpatient detox discharge on June 1, followed by an admission to an inpatient detox setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient detox setting on June 3, is not a direct transfer; these are two distinct inpatient detox stays.

Use the following method to identify admission to and discharges from inpatient detox settings.

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify if the inpatient stay contains a detox code (Detoxification Value Set).
3. Identify the admission and discharge dates for the stay.

To combine direct transfers, keep the first admission and the last discharge date as one episode.

Eligible Population

Product Lines Medicaid, HARP.

Ages 13 years and older as of December 31, of the measurement year. Report two age stratifications and a total rate.

- 13-17 years.
- 18+ years.
- Total.

Continuous Enrollment Date of discharge through 14 days after discharge.

Allowable Gap No gaps in enrollment.

Anchor date None.

Benefits Medical and chemical dependency (inpatient and outpatient).

Event/diagnosis An inpatient detox discharge during the Intake Period.

Follow the steps below to identify the eligible population.

Step 1

An acute or nonacute inpatient detox discharge with a primary diagnosis of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient detox discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify if the inpatient stay contains a detox code (Detoxification Value Set).
3. Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on members. If a member has more than one inpatient detox discharge, identify all inpatient detox discharges between January 1 and December 17 of the measurement year with a clean period (see next step).

Direct transfers: See above definition.

Step 2 Exclusions

Exclude members who are deceased. Use the patient status code (value=20) to determine deceased members.

Exclude inpatient detox discharges followed by admission to a non-AOD acute or nonacute inpatient care setting on the date of the inpatient detox discharge or within 14 days of the inpatient detox discharge, regardless of principal diagnosis for the admission. To identify admission to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

Step 3 Multiple Inpatient Detox Discharges in a 15-day Period

If a member has more than one inpatient detox discharge in a 15-day period, include only the first inpatient detox discharge.

For example, if a member has an inpatient discharge date of January 1, then include the January 1 discharge date and do not include inpatient detox discharges with an admission date that occur on or between January 2 and January 15; then, if applicable, include the next inpatient detox discharge with an admission date on or after January 16. Identify discharges chronologically including only one per 15-day period.

Step 4

Calculate continuous enrollment. Members must be continuously enrolled on the date of discharge through 14 days after the discharge date.

Administrative Specification

Denominator

The eligible population.

Numerator

A follow-up inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization, with a primary diagnosis of AOD within 14 days after the inpatient detox discharge. Include visits that occur on the date of the inpatient detox discharge. Any of the following code combinations meet criteria:

- An inpatient admission ***with*** a primary diagnosis using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Stand Alone Visits Set ***with*** a primary diagnosis using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***and*** with a primary diagnosis using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***and*** with a primary diagnosis using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

Do not count events that include detoxification or detoxification codes (Detoxification Value Set).

Continuity of Care from Inpatient Rehabilitation to Lower Level of Care

DRAFT

Description

The percentage of inpatient discharges for members 13 years of age and older for alcohol and other drug abuse or dependence treatment (AOD), who had a follow-up lower level AOD visit within 14 days of the discharge date.

Definitions

Intake Period January 1-December 17 of the measurement year.

Direct Transfer A **direct transfer** is when the discharge date from one inpatient AOD setting and the admission date to a second inpatient detox setting are one calendar day apart or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient detox setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient detox setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient detox setting on June 3, is not a direct transfer; these are two distinct inpatient detox stays.

Use the following method to identify admission to and discharges from inpatient detox settings.

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission and discharge dates for the stay.

To combine direct transfers, keep the first admission and the last discharge date as one episode.

Eligible Population

Product lines Medicaid, HARP.

Ages 13 years and older as of December 31, of the measurement year. Report two age stratifications and a total rate.

- 13-17 years.
- 18+ years.
- Total.

Continuous Enrollment Date of discharge through 14 days after discharge.

Allowable Gap No gaps in enrollment.

Anchor Date None.

Benefits Medical and chemical dependency (inpatient and outpatient).

Event/diagnosis An inpatient discharge for AOD during the Intake Period.

Follow the steps below to identify the eligible population.

Step 1

An acute or nonacute inpatient AOD discharge with a primary diagnosis of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient detox discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on members. If a member has more than one inpatient discharge, identify all inpatient AOD discharges between January 1 and December 17 of the measurement year.

Do not include inpatient stays that contain detoxification or detoxification codes (Detoxification Value Set).

Direct transfers: See above definition.

Step 2 Exclusions

Exclude members who are deceased. Use the patient status code (value=20) to determine deceased members.

Exclude inpatient discharges followed by admission to a non-AOD acute or nonacute inpatient care setting on the date of the inpatient discharge or within 14 days of the inpatient discharge, regardless of principal diagnosis for the admission. To identify admission to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

Step 3 Multiple inpatient discharges in a 15-day period

If a member has more than one inpatient discharge in a 15-day period, include only the first inpatient discharge.

For example, if a member has an inpatient discharge date of January 1, then include the January 1 discharge date and do not include inpatient detox discharges with an admission date that occur on or between January 2 and January 15; then, if applicable, include the next inpatient discharge with an admission date on or after January 16. Identify discharges chronologically including only one per 15-day period.

Step 4

Calculate continuous enrollment. Members must be continuously enrolled on the date of discharge through 14 days after the discharge date.

Administrative Specification

Denominator

The eligible population.

Numerator

A follow-up outpatient visit, intensive outpatient encounter or partial hospitalization, with a primary diagnosis of AOD within 14 days after the inpatient detox discharge. Include visits that occur on the date of the inpatient detox discharge. Any of the following code combinations meet criteria:

- IET Stand Alone Visits Set ***with*** a primary diagnosis using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***and*** with a primary diagnosis using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***and*** with a primary diagnosis using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

Do not count events that include detoxification or detoxification codes (Detoxification Value Set).

Proposed New Measures
Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence and Opioid Dependence

The Department seeks comments on the proposed measures for inclusion in the 2018 Value-Based Payment (VBP) Quality Measure Set and the 2018 Quality Assurance Report Requirements for the HARP Product Line:

1. *Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence.* The percentage of individuals who initiate pharmacotherapy with at least 1 prescription for alcohol treatment medication within 30 days following an index visit with a diagnosis of alcohol abuse or dependence.
2. *Initiation of Pharmacotherapy upon New Episode of Opioid Dependence.* The percentage of individuals who initiate pharmacotherapy with at least 1 prescription or visit for opioid treatment medication within 30 days following an index visit with a diagnosis of opioid abuse or dependence.
3. *Utilization of Pharmacotherapy for Opioid Dependence.* The percentage of individuals with any encounter associated with opioid dependence, with at least 1 prescription or visit for appropriate pharmacotherapy at any time during the measurement year.
4. *Utilization of Pharmacotherapy for Alcohol Abuse or Dependence.* The percentage of individuals with any encounter associated with alcohol use or dependence, with at least 1 prescription for appropriate pharmacotherapy at any time during the measurement year.

These measures focus on individuals who may benefit from medication-assisted treatment (MAT) to reduce opioid and alcohol use, or dependence. Medication assisted treatment is the use of FDA-approved medications in combination with evidence-based behavioral therapies to provide a whole-patient approach to treating SUDs. There is strong evidence that use of MAT in managing SUDs provides substantial cost savings. For individuals with alcohol dependence, MAT was associated with fewer inpatient admissions and total healthcare costs were 30 percent less for individuals receiving MAT than for individuals not receiving MAT.[2] Medications treating SUDs in pregnant women resulted in significantly shorter hospital stays for SUD treatment than drug addicted pregnant women not receiving MAT.[3]

The measures were field-tested with 2016 Medicaid claims and encounters.

Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence.
Average performance was 2.5 percent statewide. The low rates indicate opportunity for improvement.
Initiation of Pharmacotherapy upon New Episode of Opioid Dependence.
Average performance was 30 percent with variation across Medicaid Managed Care plans. There was a 50 percent gap in performance which indicates an opportunity for improvement.
Utilization of Pharmacotherapy for Opioid Dependence. Average performance for adolescents ages 13-17 years was 3.9% and average performance for adults was 57%.
Utilization of Pharmacotherapy for Alcohol Abuse or Dependence. Average performance for adolescents ages 13-17 years was 0.5% and average performance for adults was 5.7%.

[2] Baser, o., Chalk, M. Rawson, R. et al. (2001) Alcohol treatment dependence: comprehensive healthcare costs, utilization outcomes, and pharmacotherapy persistence*. The American Journal of Managed Care*, 178(8), S222-234.
[3] Jones HE, Kaltenbach K, Heil SH, et al: Neonatal abstinence syndrome after methadone or buprenorphine exposure. *New England Journal of Medicine* 363:2320–2331, 2010.

Proposed New Measure
Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence
DRAFT

Description

The percentage of individuals who initiate pharmacotherapy with at least 1 prescription for alcohol treatment medication within 30 days following an index visit with a diagnosis of alcohol abuse or dependence.

Definitions

Intake Period	January 1 - December 1 of the measurement year.
Index Episode	The earliest visit with an alcohol dependence disorder diagnosis.
IESD	Index Episode Start Date. The earliest date of service during the Intake Period with a diagnosis of alcohol dependence disorder.
Negative Diagnosis History	A period of 60 days before the IESD when the member had no claims/encounters with a diagnosis of alcohol dependence use disorder. For inpatient stays use the date of admission to determine Negative Diagnosis History.

Eligible Population

Product lines	Medicaid, HARP.
Ages	13 years and older as of December 31, of the measurement year. Report two age stratifications and a total rate. • 13-17 years. • 18+ years. • Total.
Continuous Enrollment	60 days prior to the IESD through 29 days (inclusive) after the IESD.
Allowable Gap	No gaps in enrollment.
Anchor Date	None.
Benefits	Medical, Chemical Dependency, and Pharmacy
Event/diagnosis	The earliest alcohol abuse and dependence diagnosis during Intake Period. Follow the steps below to identify the eligible population.
Step 1	Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following: • An outpatient visit, intensive outpatient visit or partial hospitalization with a diagnosis of alcohol abuse or dependence (Alcohol Abuse or Dependence Value Set), Any of the following code combinations meet the criteria: – IET Stand Alone Visits Set ***with*** a diagnosis of alcohol abuse or dependence (Alcohol Abuse or Dependence Value Set),

- IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***and*** with a diagnosis of alcohol abuse or dependence (Alcohol Abuse or Dependence Value Set),
- IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***and*** with a with a diagnosis of alcohol abuse or dependence (Alcohol Abuse or Dependence Value Set),

- An ED visit (ED Value Set) ***with*** a diagnosis of alcohol abuse or dependence (Alcohol Abuse or Dependence Value Set),
- A detoxification visit (Detoxification Value Set) ***with*** a diagnosis of alcohol abuse or dependence (Alcohol Abuse or Dependence Value Set),
- An acute or nonacute inpatient discharge with a diagnosis of alcohol abuse or dependence (Alcohol Abuse or Dependence Value Set), To identify acute and nonacute inpatient discharges:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Identify the discharge date for the stay.

For members with more than one episode of alcohol abuse or dependence, use the first episode.

For members, whose index episode was an ED visit that resulted in an inpatient stay, or other inpatient stay use the inpatient discharge as the IESD.

Step 2 Exclusions

Test for Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of alcohol abuse or dependence (Alcohol Abuse or Dependence Value Set) during the 60 days (2 months) before the IESD.

Step 3

Calculate continuous enrollment. Members must be continuously enrolled without any gaps, 60 days (2 months) before the IESD through 29 days after the IESD.

Administrative Specification

Denominator

The eligible population.

Numerator

Initiation of pharmacotherapy treatment within 30 days of the Index Episode.

Any of the following will identify initiation of pharmacotherapy treatment for alcohol abuse or dependence:

- Dispensed a prescription for Alcohol Abuse or Dependence (MAT Alcohol Abuse or Dependence Medications List) during the measurement year.

If the Index Episode was an inpatient admission, the 30-day period for the MAT begins on the day of discharge.

MAT for Alcohol Abuse or Dependence Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2017.

Proposed New Measure
Initiation of Pharmacotherapy upon New Episode of Opioid Dependence

DRAFT

Description

The percentage of individuals who initiate pharmacotherapy with at least 1 prescription or visit for opioid treatment medication within 30 days following an index visit with a diagnosis of opioid dependence.

Definitions

Intake Period	January 1-December 1 of the measurement year.
Index Episode	The earliest visit with an opioid dependence disorder diagnosis.
IESD	Index Episode Start Date. The earliest date of service during the Intake Period with a diagnosis of alcohol dependence disorder.
Negative Diagnosis History	A period of 60 days before the IESD when the member had no claims/encounters with a diagnosis of opioid use disorder. For inpatient stays use the date of admission to determine Negative Diagnosis History.

Eligible Population

Product lines	Medicaid, HARP.
Ages	13 years and older as of December 31, of the measurement year. Report two age stratifications and a total rate. • 13-17 years. • 18+ years. • Total.
Continuous enrollment	60 days prior to the IESD through 29 days (inclusive) after the IESD.
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefits.	Medical, Chemical Dependency, and Pharmacy
Event/diagnosis	The earliest opioid abuse and dependence diagnosis during Intake Period. Follow the steps below to identify the eligible population.
Step 1	Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following: • An outpatient visit, intensive outpatient visit or partial hospitalization with a diagnosis of alcohol abuse or dependence (Opioid Abuse and Dependence Value Set), Any of the following code combinations meet the criteria:

  - IET Stand Alone Visits Set ***with*** a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set),
  - IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***and*** with a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set),
  - IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***and*** with a with a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set),
- An ED visit (ED Value Set) ***with*** a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set),
- A detoxification visit (Detoxification Value Set) ***with*** a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set),
- An acute or nonacute inpatient discharge with a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.

For members with more than one episode of opioid abuse or dependence, use the first episode.

For members, whose index episode was an ED visit that resulted in an inpatient stay, or other inpatient stay use the inpatient discharge as the IESD.

Step 2 Exclusions

Test for Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) during the 60 days (2 months) before the IESD.

Step 3

Calculate continuous enrollment. Members must be continuously enrolled without any gaps, 60 days (2 months) before the IESD through 29 days after the IESD.

Administrative Specification

Denominator

The eligible population.

Numerator

Initiation of pharmacotherapy treatment within 30 days of the Index Episode.

Any of the following will identify initiation of pharmacotherapy treatment for opioid abuse or dependence:

- A Medication Assisted Therapy Dispensing Event (Medication Assisted Treatment) during the measurement year.
- Dispensed a prescription for Opioid Abuse or Dependence (MAT Opioid Abuse or Dependence Medications List) during the measurement year.

If the Index Episode was an inpatient admission, the 30-day period for the MAT begins on the day of discharge.

MAT for Opioid Abuse or Dependence

Description	Prescription
Opioid Dependence	• Buprenorphine HCL • Naloxone HCL
Alcohol/Opioid Dependence	• Naltrexone HCL • Naltrexone Microspheres

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2017.

Proposed New Measure Use of Alcohol Abuse or Dependence Pharmacotherapy

DRAFT

Description

The percentage of individuals with any encounter associated with alcohol use or dependence, with at least 1 prescription for appropriate pharmacotherapy at any time during the measurement year.

Eligible Population

Product lines	Medicaid, HARP.
Ages	13 years and older as of December 31, of the measurement year. Report two age stratifications and a total rate. • 13-17 years. • 18+ years. • Total.
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.
Benefits.	Medical, Chemical Dependency, and Pharmacy
Event/diagnosis	Members with at least one alcohol use or dependence diagnosis (Alcohol Abuse or Dependence Value Set) during the measurement year.

Administrative Specification

Denominator	The eligible population.
Numerator	Number of individuals with at least 1 prescription for appropriate pharmacotherapy at any time during the measurement year. Any of the following will identify initiation of pharmacotherapy treatment for alcohol abuse or dependence: • Dispensed a prescription for Alcohol Abuse or Dependence (MAT Alcohol Abuse or Dependence Medications List) during the measurement year. *If the Index Episode was an inpatient admission,* the 30-day period for the MAT begins on the day of discharge.

MAT for Alcohol Abuse or Dependence Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2017.

Proposed New Measure
Use of Opioid Dependence Pharmacotherapy

DRAFT

Description

The percentage of individuals with any encounter associated with opioid dependence, with at least 1 prescription or visit for appropriate pharmacotherapy at any time during the measurement year.

Eligible Population

Product lines	Medicaid, HARP.
Ages	13 years and older as of December 31, of the measurement year. Report two age stratifications and a total rate. • 13-17 years. • 18+ years. • Total.
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.
Benefits.	Medical, Chemical Dependency, and Pharmacy
Event/diagnosis	Members with at least one opioid diagnosis (Opioid Abuse and Dependence Value Set) during the measurement year.

Administrative Specification

Denominator	The eligible population.
Numerator	Number of individuals with at least 1 prescription for appropriate pharmacotherapy at any time during the measurement year Any of the following will identify initiation of pharmacotherapy treatment for opioid abuse or dependence: • A Medication Assisted Therapy Dispensing Event (Medication Assisted Treatment) during the measurement year. • Dispensed a prescription for Opioid Abuse or Dependence (MAT Opioid Abuse or Dependence Medications List) during the measurement year. *If the Index Episode was an inpatient admission,* the 30-day period for the MAT begins on the day of discharge.

MAT for Opioid Abuse or Dependence

Description	Prescription
Opioid Dependence	• Buprenorphine HCL • Naloxone HCL
Alcohol/Opioid Dependence	• Naltrexone HCL • Naltrexone Microspheres

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2017.

Proposed New Measures

The Department seeks comments on the proposed measures for inclusion in the 2018 Value-Based Payment (VBP) Quality Measure Set and the 2018 Quality Assurance Report Requirements for the HARP Product Line:

1. *Maintaining/Improving Employment or Higher Education Status.* The percentage of Community Mental Health (CMH) assessed members who were employed or enrolled in formal education at the second assessment point.
2. *Maintenance of Stable or Improved Housing Status.* The percentage of Community Mental Health (CMH) assessed members with maintenance of stable or improved housing status.
3. *No or Reduced Criminal Justice Involvement.* The percentage of Community Mental Health (CMH) assessed members with no or reduced criminal justice involvement.

These measures describe individuals' status over time for several outcome measures used in mental health and substance use treatment. A recovery model of care emphasizes and supports a person's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance use disorders through empowerment, choice, treatment, educational, employment, housing, and health and well-being goals. The specific outcomes used in these measures include employment and educational status, housing, and criminal justice activity.

Health plans will not be responsible for the calculation of these measures. These measures will be calculated and reported by New York State using the NYS Community Mental Health Eligibility Assessment. HARP members are required to be assessed for Behavioral Health Home and Community Based Services (BH HCBS) eligibility using the NYS Community Mental Health Eligibility Assessment at the time of enrollment and at least annually thereafter.

The measures were field-tested with 2015-2017 Community Mental Health (CMH) assessed members enrolled in a HARP health plan. If an individual had 3 or more screenings that were at least 180 days apart from the most recent screening, then priority was given to the most recent screening (Screen Two) and the screening (Screen One) that was in the previous year.

Maintaining/Improving Employment or Higher Education Status.
Average performance was 10% percent with variation across Community Mental Health (CMH) assessed members.

Maintenance of Stable or Improved Housing Status.
Average performance was 95% percent with variation across Community Mental Health (CMH) assessed members.

No or Reduced Criminal Justice Involvement.
Average performance was 97% percent with variation across Community Mental Health (CMH) assessed members.

NYSDOH seeks feedback on these measures, the technical specifications, and responses to the following question:
Should there be an upper limit placed on the time between screen one and screen two? We have stated that the screens must be at least 180 days apart and continuous enrollment is based on eligibility and enrollment between screen one and screen two.

Proposed New Measure
Maintaining/Improving Employment or Higher Education Status

DRAFT

Description

The percentage of Community Mental Health (CMH) assessed members who were employed or enrolled in formal education at the second assessment point.

Definitions

Intake Period The 12-month window starting on January 1 of the year prior to the measurement year and ending on December 31 of the year prior to the measurement year.

Screen One The first valid Community Mental Health Behavioral Health Home and Community Based Services (BH HCBS) Eligibility Screen in the intake period.

Screen Two The most recent valid Community Mental Health BH HCBS Eligibility Screen in the measurement year.

Valid Screen The screen is complete (neither signed date nor completed assessment date are missing), not a test record, and not a duplicate screen.

CMH BH HCBS Eligibility Screen Items used in measure:

Employment Status

1. Employed
2. Unemployed, seeking employment
3. Unemployed, not seeking employment

Enrolled in formal education program

1. No
2. Part-time
3. Full-time

Eligible Population

Product lines Medicaid HARP.

Ages 21 – 64 years old as of January 1, of the measurement year.

Continuous Enrollment Enrolled on the date of Screen One through the date of Screen Two.

Allowable Gap No more than one gap in enrollment of up to 30 days during the measurement year.

Anchor Date The date of Screen Two.

Benefits Medical, Mental Health, and Chemical Dependency.

Event/diagnosis Follow the steps below to identify the eligible population.

Step 1	• Identify members with at least one valid Community Mental Health BH HCBS Eligibility Screen during the measurement year and at least one valid Community Mental Health BH HCBS Eligibility Screen in the year prior to the measurement year. The screens must be at least 180 days apart. A valid Community Mental Health BH HCBS Eligibility Screen must meet the following criteria: – Signed date is not missing AND – Completed assessment date is not missing AND – The screen is not a duplicate screen. Duplicate screens occur within 30 days of one another, have the same assessment reason, and are done by the same health home. When duplicate screens are found, the screen that has the more recent completed assessment date or signed date, and/or is more complete, and/or has few demographic item errors should be kept.
Step 2 Exclusions	Exclude members where employment status and enrolled in formal education program are missing on Screen Two.

Administrative Specification

Denominator	The eligible population.
Numerator	The number of Community Mental Health (CMH) assessed members who were employed or enrolled in formal education on Screen Two. Members with the following answers to the questions listed below on Screen Two: **Employment Status**: 1. Employed **Formal education program:** 2. Part-time 3. Full-time

Proposed New Measure
Maintenance of Stable or Improved Housing Status

DRAFT

Description

The percentage of Community Mental Health (CMH) assessed members with maintenance of stable or improved housing status.

Definitions

Intake Period The 12-month window starting on January 1 of the year prior to the measurement year and ending on December 31 of the year prior to the measurement year.

Screen One The first valid Community Mental Health Behavioral Health Home and Community Based Services (BH HCBS) Eligibility Screen in the intake period.

Screen Two The most recent valid Community Mental Health BH HCBS Eligibility Screen in the measurement year.

Valid Screen The screen is complete (neither signed date nor completed assessment date are missing), not a test record, and not a duplicate screen.

CMH BH HCBS Eligibility Screen Items used in measure:

Residential/Living status at time of assessment

1. Private home / apartment / rented room
2. DOH Adult Home
3. Homeless – shelter
4. Homeless - street
5. Mental Health supported/supportive housing (all types)
6. OASAS/SUD community residence
7. OCFS/ACS/DSS Community Residential Program (Family Foster Care Group Home, Therapeutic Foster Care)
8. OPWDD community residence
9. Long-term care facility (nursing home)
10. Rehabilitation hospital/unit
11. Hospice facility/palliative care unit
12. Acute care hospital
13. Correctional facility

Eligible Population

Product lines Medicaid HARP.

Ages 21 – 64 years old as of January 1, of the year prior to the measurement year.

Continuous enrollment Enrolled on the date of Screen One through the date of Screen Two.

Allowable gap No more than one gap in enrollment of up to 30 days during the measurement year.

Anchor date	The date of Screen Two.
Benefits	Medical, Mental Health, and Chemical Dependency.
Event/diagnosis	Follow the steps below to identify the eligible population.
Step 1	• Identify members with at least one valid Community Mental Health BH HCBS Eligibility Screen during the measurement year and at least one valid Community Mental Health BH HCBS Eligibility Screen in the year prior to the measurement year. The screens must be at least 180 days apart. A valid Community Mental Health BH HCBS Eligibility Screen must meet the following criteria: – Signed date is not missing AND – Completed assessment date is not missing AND – The screen is not a duplicate screen. Duplicate screens occur within 30 days of one another, have the same assessment reason, and are done by the same health home. When duplicate screens are found, the screen that has the more recent completed assessment date or signed date, and/or is more complete, and/or has few demographic item errors should be kept.
Step 2 Exclusions	Exclude members where Residential/Living status at time of assessment is Missing or Other on Screen Two.

Administrative Specification

Denominator	The eligible population.
Numerator	The number of members with maintenance of stable or improved housing status. The number of Community Mental Health (CMH) assessed members with any of the answers specified in the numerator inclusion on Screen Two. Members with any of the following answers to the Residential/Living status at time of assessment question on Screen Two: 1. Private home / apartment / rented room 2. DOH Adult Home 3. Mental Health supported/supportive housing (all types) 4. OASAS/SUD community residence 5. OCFS/ACS/DSS Community Residential Program (Family Foster Care Group Home, Therapeutic Foster Care) 6. OPWDD community residence

Proposed New Measure
No or Reduced Criminal Justice Involvement

DRAFT

Description

The percentage of Community Mental Health (CMH) assessed members with No or Reduced Criminal Justice Involvement.

Definitions

Intake Period The 12-month window starting on January 1 of the year prior to the measurement year and ending on December 31 of the year prior to the measurement year.

Screen One The first valid Community Mental Health Behavioral Health Home and Community Based Services (BH HCBS) Eligibility Screen in the intake period.

Screen Two The most recent valid Community Mental Health BH HCBS Eligibility Screen in the measurement year.

Valid Screen The screen is complete (neither signed date nor completed assessment date are missing), not a test record, and not a duplicate screen.

CMH BH HCBS Eligibility Screen Items used in measure:

Police Intervention – Arrested with charges

1. Never
2. More than 1 year ago
3. 31 days - 1 year ago
4. 8 - 30 days ago
5. 4 - 7 days ago
6. In last 3 days

Eligible Population

Product lines Medicaid HARP.

Ages 21 – 64 years old as of January 1, of the year prior to the measurement year.

Continuous enrollment Enrolled on the date of Screen One through the date of Screen Two.

Allowable gap No more than one gap in enrollment of up to 30 days during the measurement year.

Anchor date The date of Screen Two.

Benefits Medical, Mental Health, and Chemical Dependency.

Event/diagnosis Follow the steps below to identify the eligible population.

Step 1	• Identify members with at least one valid Community Mental Health BH HCBS Eligibility Screen during the measurement year and at least one valid Community Mental Health BH HCBS Eligibility Screen in the year prior to the measurement year. The screens must be at least 180 days apart. A valid Community Mental Health BH HCBS Eligibility Screen must meet the following criteria: – Signed date is not missing AND – Completed assessment date is not missing AND – The screen is not a duplicate screen. Duplicate screens occur within 30 days of one another, have the same assessment reason, and are done by the same health home. When duplicate screens are found, the screen that has the more recent completed assessment date or signed date, and/or is more complete, and/or has few demographic item errors should be kept.
Step 2 Exclusions	Exclude members where Police Intervention – Arrested with charges is Missing on Screen Two.

Administrative Specification

Denominator	The eligible population.
Numerator	The number of Community Mental Health (CMH) assessed members who were never arrested with charges or were arrested with charges more than 1 year ago on Screen Two. Members with any of the following answers to the Police Intervention – Arrested with charges question on Screen Two. 1. Never 2. More than 1 year ago

Proposed New Measure

Percentage of HARP Enrolled Members Who Received Personalized Recovery Oriented Services (PROS) PROS or Home and Community Based Services (HCBS)

The Department seeks comments on the proposed measure for inclusion in the 2018 Value-Based Payment (VBP) Quality Measure Set and the Quality Assurance Report Requirements for the HARP Product Line:

1. *Percentage of HARP Enrolled Members Who Received Personalized Recovery Oriented Services (PROS) PROS or Home and Community Based Services (HCBS).* The percentage of HARP enrolled members who received either Personalized Recovery Oriented Services (PROS) or Home and Community Based Services (HCBS) PROS or HCBS for at least 3 months in the measurement year.

Percentage of HARP Enrolled Members Who Received Personalized Recovery Oriented Services (PROS) PROS or Home and Community Based Services (HCBS).

PROS is a recovery program for individuals with severe and persistent mental illness. The program aims to reduce inpatient and emergency room visits while increasing overall functioning, employment, education and security for the individual. HCBS is a service that offers greater accessibility to services by allowing the individual to be served in their home or community.

The measures were field-tested with 2016 Medicaid claims and encounters. Average performance was 3% percent with variation seen by region and plan type.

Proposed New Measure
Percentage of HARP Enrolled Members Who Received Personalized Recovery Oriented Services (PROS) or Home and Community Based Services (HCBS)

DRAFT

Description

The percentage of HARP enrolled members who received either Personalized Recovery Oriented Services (PROS) or Home and Community Based Services (HCBS) for at least 3 months in the measurement year.

Eligible Population

Product lines	Medicaid HARP.
Ages	21 – 64 years old as January 1 of the measurement year.
Time Frame	The measurement year.
Allowable Gap	No more than one gap in enrollment of up to 30 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	None.
Benefits	Medical, Mental Health, and Chemical Dependency.
Event/diagnosis	Claims from the NYS PROS/HCBS Value set for at least 3 months in the measurement year..

Administrative Specifications

Denominator	The eligible population.
Numerator	Three or more claims on different dates of service at any time in the measurement year for any of the PROS or HCBS services listed below: PROS Services: Community Rehabilitation and Support (CRS); Intensive Rehabilitation (IR); Ongoing Rehabilitation and Support (ORS); and Clinical Treatment, an optional component of a PROS program. (PROS Services Value Set) HCBS Services: Rehabilitation; Crisis Intervention; Habilitation; Empowerment Services/Peer Supports; Support Services; Individual Employment Support Services; Educational Support Services. (HCBS Value Set)

Proposed New Measures

Potentially Preventable Mental Health Related Readmission Rate 30 Days

The Department seeks comments on the proposed measures for inclusion in the 2018 Value-Based Payment (VBP) Quality Measure Set and the Quality Assurance Report Requirements for the HARP Product Line:

1. *Potentially Preventable Mental Health Related Readmission Rate 30 Days.* The percentage of at-risk admissions for Mental Health that result in a clinically related readmission within 30 days.

Potentially Preventable Readmissions are return hospitalizations which may have been avoided with a different method of care, discharge plan or follow-up. A reduction in readmissions could improve patient outcomes and lower costs.

The measures were field-tested with 2014 Medicaid claims and encounters. HARP eligible members were used as a proxy for HARP enrolled members due to the October 2015 HARP rollout date. For this measure, lower performance is better. Average performance was 19 percent with variation seen by region and facility. There was a 5 percent gap in performance seen by region and facility.

The Department seeks feedback on these measures, the technical specifications, and responses to the following question:

If the Department calculates this measure for the health plans will it provide useful information for reducing readmissions and improving the quality of care?

What factors should be considered in any risk-adjustment models developed for this measure?

Proposed New Measure
Potentially Preventable Mental Health Related Readmission Rate 30 Days
DRAFT

Description

The percentage of at-risk admissions for Mental Health that result in a clinically related readmission within 30 days.

Definitions

Mental Health (MH) Related Admission	An admission is considered MH Related when the 3M™ All Patient Refined Diagnosis Related Group (APR DRG) service line, derived mainly from the primary diagnosis and the severity of illness, is categorized as mental health. See the attached table for a list of APR DRG that are considered MH Related.
Clinically-related	Clinically-related is defined as a requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following a prior hospital admission. These are not restricted to MH related readmissions. A clinically-related readmission may have resulted from the process of care and treatment during the prior admission (e.g. readmission for a surgical wound infection) or from a lack of post admission follow up (lack of follow-up arrangements with a primary care physician) rather than from unrelated events that occurred after the prior admission (broken leg due to trauma) within a specified readmission time interval.
Initial Admission (IA)	The Initial Admission is a MH related admission that is followed by a clinically related readmission within the readmission time interval. Subsequent readmissions relate back to the care rendered during or following the Initial Admission. The Initial Admission initiates a readmission chain.
Readmission Chain	A readmission chain is a sequence of admissions that are all clinically-related to the MH related Initial Admission and occur within a specified readmission time interval. A readmission chain must contain an Initial Admission and at least one readmission.
Only Admission (OA)	An Only Admission is a MH related admission for which there is neither a prior Initial Admission nor a clinically-related readmission within the readmission time interval and the individual was alive at discharge.
At-Risk Admission	An admission that has the potential for a readmission. Initial Admissions and Only Admissions are considered At Risk Admissions.
Terminating a Readmission Chain	Terminating a Readmission Chain prevents any subsequent readmissions from joining the Readmission Chain. Admissions that do not pass the exclusion criteria or are not clinically-related to the Initial Admission or occur outside of the specified readmission time interval or have a discharge status of transferred to an acute care hospital, left against medical advice or died, terminate a Readmission Chain.

Eligible Population

Product lines	Medicaid HARP.
Ages	21 – 64 years old as of the date of discharge.

Time Frame	Discharges on or between January 1 – December 1 of the measurement year.
Allowable gap	No gaps in enrollment.
Anchor date	Date of discharge.
Benefits	Medical, Mental Health (Inpatient and Outpatient).
Event/diagnosis	Identify all acute inpatient Mental Health (MH) related discharges on or between January 1 to December 1 of the measurement year.
Step 2 ***Exclusions***	Exclude direct transfers and admissions where the patient died. Identify and exclude admissions related to complex medical conditions, non-events as listed in the following tables:

Readmission Exclusions (Specific to 3M™ Grouper Version 31)

- Admissions for immunocompromised or metastatic malignancy
- Neonatal or obstetrical admissions
- Multiple Trauma Admissions
- Admissions for burns
- Admissions that have age exclusions (as defined below)
- Transplant admissions
- Planned readmissions
- Patient left against medical advice
- Data errors

Non-events (At Risk Admission Exclusions: Specific to 3M™ Grouper Version 31)

- Admissions to non-acute care facilities
- Admissions to an acute care hospital for patients assigned to the APR DRGs for rehabilitation, aftercare, and convalescence
- Same-day transfers to an acute care hospital for non-acute care (e.g., hospice care)
- Malignancies with a chemotherapy or radiotherapy procedure
- Selected hematological disorders
- Certain blood disorder/procedure combinations
- Certain planned chemotherapy, radiation procedure

Step 3	Restrict to initial admissions and only admissions.

Denominator	At-risk admissions.
Numerator	The number of at-risk admissions for Mental Health that result in a clinically related readmission within 30 days.

PPR Formula*: $\frac{IA}{IA+OA}$

*note: the IA and OA must be MH-related

Table of MH Related APR DRG's

Acute Anxiety & Delirium States
Adjustment Disorders & Neuroses except Depressive Diagnoses
Bipolar Disorders
Childhood Behavioral Disorders
Depression except Major Depressive Disorder
Disorders of Personality & Impulse Control
Eating Disorders
Major Depressive Disorders & Other/unspecified Psychoses
Organic Mental Health Disturbances
Other Mental Health Disorders
Schizophrenia

Proposed New Measures
Mental Health Engagement in Care 30 Days and Continuing Engagement in Alcohol and Other Drug Abuse or Dependence Treatment

The Department seeks comments on the proposed measures for inclusion in the 2018 Value-Based Payment (VBP) Quality Measure Set only:

1. *Mental Health Engagement in Care 30 Days.* The percentage of discharges for members 21-64 years of age who were hospitalized for treatment of selected mental illness diagnosis and who had two or more follow-up visits with a mental health practitioner within 30 days of discharge.

Mental Health Engagement in Care 30 Days
This measure looks at continuity of care for mental illness. It measures the percentage of members 21 years of age and older who were hospitalized for selected mental disorders and who were seen at least two or more times on an outpatient basis by a mental health provider within 30 days after their discharge from the hospital. National data confirm that dropout from outpatient mental health is concentrated during the first visits. Quality metrics that focus only on initiation of treatment (first visit) risk mischaracterizing the proportion of patients who are engaged in clinically meaningful outpatient treatment following hospital discharge. [4]

The measures were field-tested with 2016 Medicaid claims and encounters. Average performance was 32 percent with variation seen by region and type of insurance product (Medicaid Managed Care, Fee-for-service, and HARP). There was a 34 percent gap in performance which indicates an opportunity for improvement.

[4] Olfson M, Mojtabai R, Sampson NA, Hwang I, Druss B, Wang PS, Wells KB, Pincus HA, Kessler RC: Drop out from outpatient mental health care in the United States. *Psych Serv* 2009;60:898-907

Proposed New Measure
Mental Health Engagement in Care 30 Days

DRAFT

Description

The percentage of discharges for members 21-64 years of age who were hospitalized for treatment of selected mental illness diagnosis and who had two or more follow-up visits with a mental health practitioner within 30 days of discharge.

Eligible Population

Product lines	Medicaid HARP.
Ages	21 – 64 years old as of the date of discharge.
Time Frame	January 1 – December 1 of the measurement year.
Allowable Gap	No gaps in enrollment.
Anchor Date	Date of discharge.
Benefits	Medical, Mental Health (Inpatient and Outpatient).
Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness on or between January 1 to December 1 of the measurement year. Refer to HEDIS Volume 2 Follow-up after Hospitalization technical specifications to identify acute inpatient discharges, readmissions or direct transfers. and required exclusions.

Denominator	The eligible population for the Follow-up After Hospitalization (FUH).
Numerator	Two or more follow-up visits on different dates of service with a mental health practitioner within 30 days of discharge. Do not include visits that occur on the date of discharge.

For both indicators, any of the following meet criteria for a follow-up visit:

- A visit (FUH Stand Alone Visits Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set).
- A visit (FUH Visits Group 1 Value Set ***with*** FUH POS Group 1 Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set).

- A visit (FUH Visits Group 2 Value Set ***with*** FUH POS Group 2 Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set).
- A visit in a behavioral healthcare setting (FUH RevCodes Group 1 Value Set).
- A visit in a nonbehavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a mental health practitioner.
- A visit in a nonbehavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set).
- Transitional care management services (TCM 7 Day Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- Assertive Community Treatment (ACT), or Personalized Recovery Oriented Services (PROS) services (NYS ACT/PROS Value Set).

Note: *Refer to HEDIS Volume 2 Appendix 3 for the definition of* mental health practitioner.