Community Behavioral Health
Pay-for-Performance
Operational Definitions

Reporting Year 2022

Contents

Overview

Introduction

This Operational Definitions Master Document is intended to be used as a guide for understanding the performance evaluation process and performance measures included in the Community Behavioral Health Pay-for-Performance (P4P) program for reporting year 2022. CBH uses P4P as one way to assesses the quality of services our members are receiving and rewards providers that perform above performance targets with a bonus payment, in addition to regular payments for services. In its current form, P4P has been in place since 2007. The performance measures used either align with state and national measures or are developed by CBH and DBHIDS subject matter experts, in conjunction with providers. All measures used for P4P align with the *DBHIDS Practice Guidelines* and are either process or outcome measures that reflect best practices. Unless otherwise indicated, P4P measures utilize claims and CBH eligibility data for processing.

These operational definitions outline the assessment process, the measures, a rationale explaining why each measure is important, and what or who is included or excluded in each element of the measure. The following overview describes how total scores on each P4P report are calculated and eligibility criteria for a P4P award. We hope that you find this document to be useful.

How Scores are Calculated on the Matrix

Weighted Mean	The CBH weighted mean is the average for that measure for all providers. It is calculated by dividing the sum of the numerators by the sum of the denominators for each measure. Using this method to calculate the mean gives each treatment episode or discharge equal "weight" in the calculation. This methodology accounts for differences in provider size and ensures that the contribution each episode or discharge gives to the average is the same, regardless of the size of the provider.
Weighted Standard Deviation	The weighted standard deviation measures the way scores vary around the mean. Using the weighted standard deviation accounts for differences in provider size and ensures that the contribution that each episode or discharge contributes is the same, regardless of the size of the provider.

<table>
<tr><td>Thresholds</td><td>Providers are assessed using performance thresholds based on the most current national or state standards, where available. Where there is no national or state standard for a measurement, CBH calculates performance thresholds based on the distribution, or the weighted mean and standard deviation. When the distribution is used, thresholds for “good” performance (falling within the “green” band) are set by adding ½ of the weighted standard deviation to the weighted mean (or subtracting for reverse measures where a lower rate is better) and, for “poor” performance (falling within the “red” band), by subtracting ½ of the weighted standard deviation from the weighted mean (or adding for reverse measures). “Average” performance is that which falls within the yellow band, or ½ of the weighted standard deviation above and below the weighted mean.</td></tr>
<tr><td>Weight</td><td>Each measure is given a “weight,” meaning a certain number of points. Measures that are new or have significantly changed since the previous reporting year are not given points and are considered “contextual” (performance is considered baseline and provided for context). Weights indicate the relative importance of that measure as compared with other measures for a particular level of care (LOC). A measure that is worth more points contributes more weight to the provider’s total score. The weights are determined by DBH and CBH leadership and are based on CBH priorities and measures that are more within a provider’s control to impact. A provider is given the maximum number of points available for a rate that falls in the green threshold and one-half of the maximum number of points available for a rate that falls in the yellow threshold. A rate in the red range receives zero points.

For example:
Providers with a rate for this measure that is at or above 84% will receive 3 points out of a possible 3 points;
Providers with a rate that is between 73% (inclusive of 73%) to 84% will receive 1.5 points out of a possible 3 points;
Providers with a rate below 73% will receive 0 points out of a possible 3 points.
<table><tr><td>At or Above</td><td>84%</td><td>3</td></tr><tr><td>Between</td><td>73% to 84%</td><td>1.5</td></tr><tr><td>Below</td><td>73%</td><td>0</td></tr></table></td></tr>
<tr><td>Change Measure Calculations</td><td>Providers may also be assessed on change in performance from last measurement period to this measurement period through a change measure. Performance on the change measure will be shown on the matrix next to performance on the corresponding measure.

New measures or measures that have changed significantly do not have a change measure associated with them for the first year after the change is made. If a measure</td></tr>
</table>

number has a letter next to it, that indicates that the measure was significantly changed at some point (for example: MHOP04a).

Change measures receive the same weight (number of points) as the associated measure. Therefore, the total points possible for performance scores and improvement scores are the same. The color band from Year 2 (current measurement period) for a provider is compared to the color band from Year 1 (prior measurement period) for each measure. Therefore, change is determined by performance relative to the performance benchmarks and is not solely based on change in the rate from Year 1 to Year 2.

In 2019, CBH began to award additional points to providers for improvement. Providers no longer have points deducted for deterioration in performance, nor do they receive points for maintaining good performance. This change in methodology was made to acknowledge the efforts of providers over the past year to improve their performance.

To calculate the change score for a measure, the weight (points) achieved on the measure is multiplied by the following base weights, which are the same for every change measure:

		Current Year (Year 2)		
		Green	Yellow	Red
Prior Year (Year 1)	Red	1.00	0.75	0.00
	Yellow	0.75	0.00	0.00
	Green	0.00	0.00	0.00

Using the same example above:

At or Above	84%	3
Between	73% to 84%	1.5
Below	73%	0

- A provider whose rate went from the yellow band last year to green band this year would receive: 0.75 x 3 points = 2.25 points towards their total improvement score.
- A provider whose rate went from the red band last year to the green band this year would receive: 1.00 x 3 points = 3 points towards their total improvement score.

Network Improvement & Accountability Collaborative (NIAC) Score

Definition	In an effort to incorporate additional measures of service quality into P4P provider assessment, the provider's NIAC Score is included in calculation of the provider's total score for a given LOC.
NIAC Score Calculation	The score used in P4P and shown in the matrix is the total score on the Network Inclusion Criteria (NIC) tool for a provider and that LOC in the **calendar year prior to the reporting year**. If a provider received more than one total score on the NIC tool during the calendar year, the most recent score for that program and LOC is used. NIC scores will be carried over a maximum of two (2) years if a provider did not receive a score on the NIC tool for the current reporting year. If a program did not receive a NIC score for the current reporting year, the NIC score received in the prior reporting year will be applied. If a provider did not receive a NIC score in the prior reporting year, the score received in the reporting year 2 years prior to the current year will be applied.
Thresholds (for all populations and all levels of care)	Thresholds for NIAC scores are based on what NIAC considers "good," "fair," and "poor" performance, and are as follows: At or Above 65% Between 50% to 65% Below 50%
Weights	NIAC scores are weighted equivalent to 1/10 (10%) of total available points for the assessed level of care.

Calculating Total Scores

Definition	The Total Score, expressed as a percentage, is your agency's overall performance for that level of care and grouping. Consistent with assessing providers on performance separately from improvement, providers receive two total scores: one for performance on the measures in the current reporting period and a second for improvement on measures from the last to the current reporting period.
Total Score for Performance	The Total Score for performance is calculated by dividing the total number of points a provider has achieved for that level of care by the total number of points available for that level of care, multiplied by 100 and rounded to one decimal place.
Total Score for Improvement	The Total Score for improvement is calculated by dividing the total number of points a provider has achieved for improvement on change measures in that level of care by the total number of points available for change measures in that level of care, multiplied by 100 and rounded to one decimal place.

Eligibility for a P4P Award

A provider must have been **scored on at least half** of the measures for a given LOC and P4P grouping in order to be included in P4P for that LOC. In addition, to be eligible for a P4P award, an agency must be **in-network** for the full measurement period and when awards are made at the end of the reporting year. Providers receive a P4P award for **either performance or improvement** on the measures, not for both. Total score requirements for an award are made by the DBHIDS Commissioner and are communicated to providers in the cover letter that accompanies their report.

A **level II QIP** is a disqualifier for a P4P award. A level II QIP from CBH's Quality Management (QM) Department for a provider for a particular LOC is applied to any measurement year in which the level II QIP was issued and any measurement year in which a level II QIP is extended after review by QM. For example, for reporting year 2022, if a level II QIP is issued in 2021 and resolved after review in 2021, it applies to 2021 and not to 2022. If the level II QIP is issued in 2021 and extended after review in 2022, it applies in 2021 and to 2022 reports for that LOC. If a provider has more than one program within a LOC, the level II QIP for any program will apply to all programs within that LOC for P4P.

A provider will also be disqualified for an award if their **Compliance Error Rate** is at an egregious level, as determined by the CBH Compliance Department, or if they are on a **Directed Corrective Action Plan**, as determined by CBH. If a provider has **confirmed fraud** in either the reporting or measurement year, the provider will be ineligible for a P4P award. Fraud that is actively under investigation at the time when awards are made will result in the withholding of the award until fraud charges have been dismissed.

It is always at the discretion of the DBHIDS Commissioner to deny an award if an agency is in bad standing related to OMHSAS or DDAP licensing, federal investigations or violations etc., or for other serious quality concerns.

Children's Acute Psychiatric Inpatient and Adult Extended Acute Care

Measurement Period for Both LOCs

P4P Measurement Period	The Measurement Period for Children's Psychiatric Acute Inpatient and Adult Extended Acute Care (EAC) is January 1, 2021 – December 31, 2021.

Children's Acute Inpatient (IP) Levels of Care

Levels of Care Included	Includes CBH Levels of Care: 100.001,100.002, 100.004-100.008,100.010-100.012,100.032,100.037

Children's IP Episode

Episode	• An episode of Inpatient treatment begins on the service date of the first claim received for an Inpatient level of care and ends on the service date of the final claim for Inpatient care, as determined by the lack of a subsequent Inpatient claim lasting 1 or more days. • Subsequent Inpatient claims within 1 day shall be counted as a *continuous episode* if the claim is made by the same provider and a *transfer* if the claim is made by a different provider. • Subsequent claims outside 1 day shall be counted as a readmission, and therefore the start of a new episode of treatment.

Extended Acute Care (EAC) Levels of Care

Levels of Care Included	Includes CBH Levels of Care 140.001-140.002, 140.022, 140.023

EAC Episode

Episode	• An episode of EAC treatment begins on the service date of the first claim received for an EAC level of care and ends on the service date of the final claim for EAC care, as determined by the lack of a subsequent EAC claim lasting 1 or more days. • Subsequent EAC claims within 1 day shall be counted as a continuous episode, if the claim is made by the same provider and a transfer if the claim is made by a different provider. • Subsequent claims outside 1 day shall be counted as a readmission, and therefore the start of a new episode of treatment.

Child vs. Adult Populations

Definition	A "child" is considered a member who is less than 18 years old on the episode start date. An episode of treatment for a member who is less than 18 years of age appears in the Child Inpatient report.

Measurements Included

Measure Labels		**Practice Guidelines Domain**	**Measure Description**
Child Inpatient (CIP) Measures	**Extended Acute Care (EAC) Measures**		
CIP01		Continuing Support and Early Re-Intervention	7-Day Follow-Up After Discharge
CIP02	**EAC01**	Continuing Support and Early Re-Intervention	30-Day Follow-Up After Discharge
CIP16	**EAC05**	Continuing Support and Early Re-Intervention	30 Day Readmission Outcomes

CIP01: 7-Day Follow-Up After Discharge

<table>
<tr><td>Rationale</td><td colspan="2">We include measurements of follow-up as an assessment of whether care is continued in a timely fashion after discharge following an Inpatient Psychiatric stay, since continuing support and early re-intervention are important components of continued wellness and recovery.</td></tr>
<tr><td>Definition</td><td colspan="2">Percent of Inpatient discharges for which the member received at least one follow-up service within 7 days of discharge.</td></tr>
<tr><td></td><td>Eligible Population (Inclusion Criteria)</td><td>• Philadelphia County HealthChoices members who were discharged from a Psychiatric Inpatient program during the measurement year.
• Member must be continually eligible for Philadelphia County HealthChoices for at least 30 days post Inpatient discharge.
• Members must be at least 6 years of age.</td></tr>
<tr><td></td><td>Do not include</td><td>• Members who have insurance coverage other than HealthChoices (i.e. Medicare or Commercial)
• Members who do not maintain HealthChoices eligibility continuously for 30 days.
• Members that have EAC claims within 1 day post Inpatient discharge.
• If the member is transferred to another Psychiatric Inpatient or Extended Acute Care facility
• Members that have another IP episode within 7 days of discharge.
• If the IP discharge uses any of the discharge status codes listed in Reference Table 1.</td></tr>
<tr><td></td><td>If a member has multiple IP discharges during the measurement period</td><td>The member is considered to have multiple episodes. Therefore, although a member may be included in the discharge count of more than one provider or of one provider multiple times, each discharge will be counted once.</td></tr>
<tr><td>Denominator</td><td colspan="2">Qualifying Discharges: Discharges of the Eligible Population listed above during the measurement period.</td></tr>
<tr><td>Numerator</td><td colspan="2">Discharges with Follow-Up: Of the Eligible Population, those discharges for which CBH received a claim for a follow-up service within 7 days from the date of discharge from a Psychiatric Inpatient hospital.</td></tr>
</table>

CIP01 THRESHOLDS AND POINTS

At or Above	63.00%	3
Between	53.18% to 63.00%	1.5
Below	53.18%	0

CIP02 and EAC01: 30-Day Follow-Up After Discharge

<table>
<tr><td>Rationale</td><td colspan="2">We include measurements of follow-up rate as an assessment of whether care is continued in a timely fashion after discharge following an Inpatient Psychiatric stay, since continuing support and early re-intervention are important components of continued wellness and recovery.</td></tr>
<tr><td>Definition</td><td colspan="2">Percent of IP discharges for which the member received at least one follow-up service within 30 days of discharge.</td></tr>
<tr><td></td><td>Eligible Population (Inclusion Criteria)</td><td>• Philadelphia County HealthChoices members who were discharged from a Psychiatric Inpatient/EAC program during the measurement year.
• Member must be continually eligible for Philadelphia County HealthChoices for at least 30 days post Inpatient/EAC discharge.
• Members must be at least 6 years of age.</td></tr>
<tr><td></td><td>Do not include</td><td>• Members who have insurance coverage other than HealthChoices (i.e. Medicare or Commercial)
• Members who do not maintain HealthChoices eligibility continuously for 30 days.
• Members that have EAC claims within 1 day post Inpatient discharge.
• If the member is transferred to another Psychiatric Inpatient or Extended Acute Care facility
• Members that have another IP episode within 7 days of discharge.
• If the IP discharge uses any of the discharge status codes listed in Reference Table 1.</td></tr>
<tr><td></td><td>If a member has multiple IP discharges during the measurement period…</td><td>• The member is considered to have multiple episodes. Therefore, although a member may be included in the discharge count of more than one provider or of one provider multiple times, each discharge will be counted once.</td></tr>
<tr><td>Denominator</td><td colspan="2">Qualifying Discharges: Discharges of the Eligible Population listed above during the measurement period.</td></tr>
<tr><td>Numerator</td><td colspan="2">Discharges with Follow-Up: Of the Eligible Population, those discharges for which CBH received a claim for a follow-up service within 30 days from the date of discharge from a Psychiatric Inpatient hospital or Extended Acute Care.</td></tr>
</table>

CIP02 THRESHOLDS AND POINTS **EAC01 THRESHOLDS AND POINTS**

At or Above	75.00%	3
Between	67.29% to 75.00%	1.5
Below	67.29%	0

At or Above	92.0%	4
Between	82.0% to 92.0%	2
Below	82.0%	0

CIP16 and EAC05: 30 Day Readmission Outcomes Aggregate

Rationale	Effective service planning and coordination/continuity of care are key components to preventing readmissions especially for those with case management. To measure the effectiveness of service planning and continuity of care, particularly discharge planning and coordination, we will examine the rate of members who are readmitted to inpatient treatment within a short time following discharge.
Definition	Percent of discharges from IP that are readmitted to Inpatient treatment within 30 days.
	Eligible Population (Inclusion Criteria): • Philadelphia County HealthChoices members who were discharged from a Psychiatric Inpatient/EAC program during the measurement year. • Member must be continually eligible for Philadelphia County HealthChoices for at least 30 days post Psychiatric Inpatient/EAC discharge. • Member must be older than 6 years of age.
	Do not include: • If the member is ineligible for HealthChoices at the time of discharge. • Members who have insurance coverage other than HealthChoices (i.e. Medicare or Commercial) • If the IP discharge uses any of the discharge status codes listed in Reference **Table 1.**
	If a member has multiple IP readmissions during the measurement period… The member is considered to have multiple episodes. Therefore, although a member may be included in the readmission count of more than one provider or of one provider multiple times, each readmission will be counted once.
Denominator	**Qualifying Discharges:** Discharges from Acute Inpatient or EAC during the measurement period.
Numerator	**Discharges with Readmission:** Those discharges for which CBH received a claim for a new Psychiatric Inpatient or EAC admission within 30 days from the member's initial Psychiatric Inpatient or EAC discharge.

CIP16 THRESHOLDS AND POINTS

Above	16.54%	0
Between	11.75% to 16.54%	1
Below	11.75%	2

EAC05 THRESHOLDS AND POINTS

Above	43.5%	0.0
Between	38.7% to 43.5%	1.5
At or Below	38.7%	3

Reference Table 1: Disqualifying Discharge Status Codes

Discharge Code	Discharge Status Label
2	Discharged/Transferred to another hospital for inpatient care
3	Discharged/Transferred to a skilled nursing facility (SNF)
4	Discharged/Transferred to an Intermediate Care Facility
5	Discharge/Transferred to another type of institution for inpatient care
20	Expired
43	Discharged/Transferred to a Federal Hospital
50	Discharged to Hospice—Home
51	Discharged/Transferred to a Hospice medical facility
61	Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed
62	Discharged/Transferred to an Inpatient Rehabilitation Facility Including Distinct Part Units of a Hospital
63	Discharged/Transferred to Long Term Care Hospitals
64	Discharged/Transferred to a Nursing Facility Certified Under Medicaid but not Certified Under Medicare
65	Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
66	Discharged/Transferred to a Critical Access Hospital (CAH)
70	Discharged/Transferred to Another Type of Health Care Institution not Defined Elsewhere in this Code List

Journey of Hope (JoH)

Levels of Care

Levels of Care included	Includes CBH Levels of Care 200.007, 200.009 ; DBHIDS provides the JoH discharges

Measurement Period

P4P Measurement Period	The measurement period for Journey of Hope discharges is January 1, 2021 – December 31, 2021 (CY 2021).

JOH00: Episode

Rationale	Episodes are created in order to enumerate the lengths of stay, courses of treatment and readmissions received by a member in a level of care, provided by a single grouped provider.	
Definition	An episode is a length of time spent receiving services in a level of care, distinct from other lengths of stay or courses of treatment. Episodes are distinguished from one another by a discharge.	
	Definition: Discharge	If the episode is defined by discharge, the episode is considered ended at the treatment end date provided to the Journey of Hope program manager.
	Multiple Episodes	For some levels of care, members may have multiple episodes during the course of the measurement year. In most cases, episodes shall be counted once per measure. In some cases, the measure specifies a count of unique clients, in which case each member shall be counted once regardless of the number of episodes that member has.
Mean Length of Stay	The average length of stay expresses the average length of episodes of care provided by the reporting provider. This is by the number of days elapsed from the admission date to the treatment end date reported to the JoH program manager.	

Measures Included

Measure Label	Practice Guidelines Domain	Measure Description
JoH11-Stable	Screening, Assessment, Service Planning and Delivery	Percent Not Readmitted to Acute Levels of Care within 90 Days of Discharge (Recovery Initiation); Excluding Discharge Dispositions to Jail or Higher Acuity Levels of Care
JoH03a-Stable	Screening, Assessment, Service Planning and Delivery	Percent Having Length of Stay Greater than or Equal to Three (3) Months, Excluding Discharge Dispositions to Jail or Higher Acuity Levels of Care
JoH14-Stable	Continuing Support & Early Re-Intervention	7-Day Follow-Up Rate, Excluding Discharge Dispositions to Jail or Higher Acuity Levels of Care
JoH06b-Stable	Continuing Support & Early Re-Intervention	14-Day Follow-Up Rate, Excluding Discharge Dispositions to Jail or Higher Acuity Levels of Care

JoH11 *(Stable Discharges)*: Percent Not Readmitted to Acute Levels of Care within 90 Days of Discharge (Recovery Initiation); Excluding Discharge Dispositions to Jail or Higher Acuity Levels of Care

Rationale	Recovery initiation, or not returning to the same or higher level of care within a critical window following discharge from at Journey of Hope program, is an indicator of sustained wellness post-discharge and is associated with long-term recovery.	
Definition	Percent of discharges for which the member is not readmitted to the same or higher Level of Care (i.e.: Inpatient, EAC, Detox or Rehab) within 90 days of discharge.	
	Eligible Population (Inclusion Criteria)	Individuals who were discharged from Journey of Hope within the measurement period.
	Exclude	Excluded discharges are those transferred to other Levels of Care/treatment (i.e.: Inpatient, Detox, Rehab, or Medical/Nursing Care) or who went directly to jail.
	If a member has multiple JoH discharges during the measurement period	The member is considered to have multiple episodes. Therefore, although a member may be included in the discharge count of more than one provider or of one provider multiple times, each discharge will be counted once.
	Measurement note	All qualifying episodes will be counted for this measure even in instances when individuals return to a Journey of Hope program within 30 days from discharge.
Denominator	**Qualifying Discharges:** Based on discharge disposition**,** qualifying discharges from Journey of Hope include Halfway House, Independent Living, MH Residential Program, Recovery House, Living with Friends/Family/Spouse, Other, PSH, Safe Haven, Shelter, or Whereabouts Unknown. Discharges of members older than 6 years of age who do not have Medicare coverage or insurance other than DBHIDS funding and who are continuously eligible for CBH Medicaid funding for the 90 consecutive days following discharge.	
Numerator	**Discharges:** Those JoH discharges for which CBH/BHSI did not receive a claim for the same or higher Level of Care within 90 days from date of discharge.	

JOH11 THRESHOLDS AND POINTS

Current Yr	Rate Range	Points
At or Above	90.0%	2
Between	80.0% to 90.0%	1
Below	80.0%	0

JoH03a *(Stable Discharges)*: Percent Having Length of Stay Greater than or Equal to Three (3) Months; Excluding Discharge Dispositions to Jail or Higher Acuity Levels of Care

<table>
<tr><td>Rationale</td><td>As JoH serves chronically homeless individuals, it is expected that this population would require longer time to engage and longer time in the program to address living situation issues (i.e.: issuance of a form of identification, housing, etc.) related to homelessness. Hence a stay greater than or equal to three (3) months is expected to be a minimally sufficient time to address living situation issues as well as for individuals to be engaged in their D&A treatment.</td></tr>
<tr><td>Definition</td><td>Percent of Journey of Hope members who were discharged from the JoH program greater than or equal to three (3) months of admittance.</td></tr>
<tr><td></td><td><table>
<tr><td>Eligible Population (Inclusion Criteria)</td><td>Individuals who were discharged from Journey of Hope within the measurement period.</td></tr>
<tr><td>Exclude</td><td>Excluded discharges are those transferred to other Levels of Care/treatment (i.e.: Inpatient, Detox, Rehab, or Medical/Nursing Care) or who went directly to jail.</td></tr>
<tr><td>If a member has multiple JoH discharges during the measurement period</td><td>The member is considered to have multiple episodes. Therefore, although a member may be included in the discharge count of more than one provider or of one provider multiple times, each discharge will be counted once.</td></tr>
<tr><td>Measurement note</td><td>All qualifying episodes will be counted for this measure even in instances when individuals return to a Journey of Hope program within 30 days from discharge.</td></tr>
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<tr><td>Denominator</td><td>Qualifying Discharges: Based on discharge disposition, qualifying discharges from Journey of Hope include Halfway House, Independent Living, MH Residential Program, Recovery House, Living with Friends/Family/Spouse, Other, PSH, Safe Haven, Shelter, or Whereabouts Unknown. Discharges of members older than 6 years of age who do not have Medicare coverage or insurance other than DBHIDS funding and who are continuously eligible for CBH Medicaid funding for the 90 consecutive days following discharge.</td></tr>
<tr><td>Numerator</td><td>Discharges: Percent of Journey of Hope individuals who were discharged greater than or equal to three (3) months from admission to a JoH program.</td></tr>
</table>

JOH03a THRESHOLDS AND POINTS

Current Yr	Rate Range	Points
At or Above	86.4%	2
Between	66.8% to 86.4%	1
Below	66.8%	0

JoH14 (*Stable Discharges*): 7-Day Follow-Up Rate, Excluding Discharge Dispositions to Jail or Higher Acuity Levels of Care

<table>
<tr><td>Rationale</td><td colspan="2">We include a measurement of follow-up rate as an assessment of how care is continued in a timely fashion after discharge following a Journey of Hope stay since continuing support and early re-intervention are essential to sustaining wellness and enhancing long term recovery and are important components of the Practice Guidelines.</td></tr>
<tr><td>Definition</td><td colspan="2">Percent of JoH discharges for which the member received at least one follow-up Level of Care within seven (7) days of discharge.</td></tr>
<tr><td></td><td>Eligible Population (Inclusion Criteria)</td><td>Individuals who were discharged from Journey of Hope within the measurement period.</td></tr>
<tr><td></td><td>Exclude</td><td>Excluded discharges are those transferred to other Levels of Care/treatment (i.e.: Inpatient, Detox, Rehab, or Medical/Nursing Care) or who went directly to jail.</td></tr>
<tr><td></td><td>If a member has multiple JoH discharges during the measurement period</td><td>The member is considered to have multiple episodes. Therefore, although a member may be included in the discharge count of more than one provider or of one provider multiple times, each discharge will be counted once.</td></tr>
<tr><td></td><td>Measurement note</td><td>In instances when individuals return to a Journey of Hope program within 30 days from discharge, the first qualifying episode will be excluded from this measure.</td></tr>
<tr><td>Denominator</td><td colspan="2">Qualifying Discharges: Based on discharge disposition, qualifying discharges from Journey of Hope include Halfway House, Independent Living, MH Residential Program, Recovery House, Living with Friends/Family/Spouse, Other, PSH, Safe Haven, Shelter, or Whereabouts Unknown. Discharges of members older than 6 years of age who do not have Medicare coverage or insurance other than DBHIDS funding and who are continuously eligible for CBH Medicaid funding for the 90 consecutive days following discharge.</td></tr>
<tr><td>Numerator</td><td colspan="2">Discharges with Follow-Up: Those qualifying discharges for which CBH/BHSI received a claim for a follow-up Level of Care within seven (7) days from the member's date of discharge from Journey of Hope.</td></tr>
</table>

JOH14 THRESHOLDS AND POINTS

Current Yr	Rate Range	Points
At or Above	91.3%	2
Between	81.1% to 91.3%	1
Below	81.1%	0

JoH06b *(Stable Discharges)*: 14-Day Follow-Up Rate, Excluding Discharge Dispositions to Jail or Higher Acuity Levels of Care

<table>
<tr><td>Rationale</td><td>We include a measurement of follow-up rate as an assessment of how care is continued in a timely fashion after discharge following a Journey of Hope stay since continuing support and early re-intervention are essential to sustaining wellness and enhancing long term recovery and are important components of the Practice Guidelines.</td></tr>
<tr><td>Definition</td><td>Percent of JoH discharges for which the member received at least one follow-up Level of Care within 14 days of discharge.</td></tr>
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<tr><td>Eligible Population (Inclusion Criteria)</td><td>Individuals who were discharged from Journey of Hope within the measurement period.</td></tr>
<tr><td>Exclude</td><td>Excluded discharges are those transferred to other Levels of Care/treatment (i.e.: Inpatient, Detox, Rehab, or Medical/Nursing Care) or who went directly to jail.</td></tr>
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<tr><td>Numerator</td><td>Discharges with Follow-Up: Those qualifying discharges for which CBH/BHSI received a claim for a follow-up Level of Care within 14 days from the member's date of discharge from Journey of Hope.</td></tr>
</table>

JOH06b THRESHOLDS AND POINTS

Current Yr	Rate Range	Points
At or Above	90.0%	2
Between	80.0% to 90.0%	1
Below	80.0%	0

JoH01b (Recovery Initiation); JoH02a (Length of Stay); JoH13 (7-Day Follow-Up); JoH05b (14-Day Follow-Up); JoH08b (30-Day Follow-Up)-All Discharges	
All Discharges	**Exclusion Criteria for All Discharges**
• HALFWAY HOUSE	• CORRECTIONAL INSTIT.
• LIVING ALONE/INDEPENDENT	• COMM.INPATIENT
• MH RES. PROGRAM	• D/A RES. PROGRAM
• RECOVERY HOUSE	• D/A TREATMENT/DETOX.
• WITH PARENT/GUARDIAN	• MEDICAL/NURSING CARE
• WITH OTHER FRIENDS/FAMILY	• CONSUMER DIED
• WITH SPOUSE/SIG.OTHER	• WENT TO BOARDING HOME
• PERMANENT SUPPORTIVE HOUSING	• NURSING HOME
• SAFE HAVEN	
• SHELTER	
• WHERABOUTS UNKNOWN	
• AWOL/AMA	
• STREET	
• DUAL DIAGNOSIS RES.	

JoH11 (Recovery Initiation); JoH03a (Length of Stay); JoH14 (7-Day Follow-Up); JoH05b (14 Day Follow-Up); JoH08b (30 Day Follow-Up)-Stable Discharges	
Stable Discharges	**Exclusion Criteria for Stable Discharges**
• HALFWAY HOUSE	• CORRECTIONAL INSTIT.
• LIVING ALONE/INDEPENDENT	• COMM.INPATIENT
• MH RES. PROGRAM	• D/A RES. PROGRAM
• RECOVERY HOUSE	• D/A TREATMENT/DETOX.
• WITH PARENT/GUARDIAN	• MEDICAL/NURSING CARE
• WITH OTHER FRIENDS/FAMILY	• WENT TO BOARDING HOME
• WITH SPOUSE/SIG.OTHER	• NURSING HOME
• PERMANENT SUPPORTIVE HOUSING	• AWOL/AMA

JoH11 (Recovery Initiation); JoH03a (Length of Stay); JoH14 (7-Day Follow-Up); JoH05b (14 Day Follow-Up); JoH08b (30 Day Follow-Up)-Stable Discharges

Stable Discharges	Exclusion Criteria for Stable Discharges
• DUAL DIAGNOSIS RES.	• SAFE HAVEN
	• SHELTER
	• WHEREABOUTS UNKNOWN
	• STREET
	• CONSUMER DIED

JoH12, (Recovery Initiation); JoH04a (Length of Stay); JoH15 (7-Day Follow-Up); JoH06b (14-Day Follow-Up); JoH010b (30-Day Follow-Up)-Vulnerable Discharges

Vulnerable Discharges	Exclusion Criteria for Vulnerable Discharges
• SAFE HAVEN	• CORRECTIONAL INSTIT.
• SHELTER	• COMM.INPATIENT
• WHERABOUTS UNKNOWN	• D/A RES. PROGRAM
• AWOL/AMA	• D/A TREATMENT/DETOX.
• STREET	• MEDICAL/NURSING CARE
	• WENT TO BOARDING HOME
	• NURSING HOME
	• HALFWAY HOUSE
	• LIVING ALONE/INDEPENDENT
	• MH RES. PROGRAM
	• RECOVERY HOUSE
	• WITH PARENT/GUARDIAN
	• WITH OTHER FRIENDS/FAMILY
	• WITH SPOUSE/SIG.OTHER
	• PERMANENT SUPPORTIVE HOUSING
	• CONSUMER DIED
	• DUAL DIAGNOSIS RES.

Mental Health Outpatient (MHOP)

Levels of Care

Levels of Care Included	Includes CBH Levels of Care as listed in Reference **Table 1** and **Table 4**.

Measurement Period

P4P Measurement Period	The Measurement Period for Mental Health Outpatient is January 1, 2021 – December 31, 2021.

Child vs. Adult Populations

Rationale	We assess providers separately on their services to children with a DSM diagnosis of Autism Spectrum Disorder (ASD) and without ASD because these two groups of children may have very different service utilization patterns. This distinction is made at the member level, *not the provider level,* so if a provider served both children with and without an ASD diagnosis during the measurement period, the data for those children will appear in the respective performance reports, according to their diagnoses.
Definition	A “child" is considered a member who is less than 18 years old on the episode start date. An episode of treatment for a member who is less than 18 years of age appears in either the Child ASD or Child Non-ASD report. Conversely, an episode of treatment for a member who is 18 years or older is considered an “adult” and will appear in the Adult report. An episode of treatment for child with a DSM diagnosis of Autism Spectrum Disorder appears in the Child ASD report.

MHOP00: Episode – Therapeutic vs. MHOP Episode

Rationale	Episodes are created to enumerate the lengths of stay, courses of treatment and readmissions received by a member in a level of care, provided by a single grouped provider.	
Definition	An episode is a length of time spent receiving services in a level of care, distinct from other lengths of stay or courses of treatment.	
	Definition: MHOP and Therapeutic Episodes	• Certain measures distinguish between mental health outpatient and therapeutic services. A therapeutic service is defined as all level of care codes included in **Table 1**; an assessment service is defined as all level of care codes included in **Table 3**. • For MHOP01, a treatment episode begins on the date of the first assessment service, as defined in **Table 3**. • For MHOP04a and MHOP05, the therapeutic episode begins on the date of the first therapeutic service, as defined in **Table 1.**
	Definition: Episode End	The episode is considered ended when there is a gap of **120 days or more** between services in this level of care.
	Definition: Multiple Episodes	For some levels of care, members may have multiple episodes during the course of the measurement year. In most cases, episodes shall be counted once per measure. In some cases, the measure specifies a count of unique clients, in which case each member shall be counted once regardless of the number of episodes that member has.

Measures Included for Adult, Child ASD and Child Non-ASD

Adult	Child Non-ASD	Child ASD	Measure Description
MHOP01	**MHOP01**	**Children with an ASD diagnosis are not assessed on this measure**	Percent Discharged from Higher LOCs Having MHOP Follow-Up Within 30 Days (Not measured for Child ASD/ID)
MHOP04a	**MHOP04a**	**MHOP04a**	Percent of Episodes Having At Least 2 Therapeutic Services within 30 Days of Episode Start
MHOP05	**MHOP05**	**MHOP05**	Percent of Episodes Having Two or Fewer Therapeutic Services

Bonus (not a scored measure) for all groupings:

- Community Connection and Mobilization: Participation in Behavioral Health Screening Events

MHOP01: Percent Discharged from Higher LOCs Having MHOP Follow-Up Within 30 Days

Rationale	Timely access to outpatient services ensures continuity of care, an essential tool in sustaining wellness and enhancing long term recovery. Thus, this measure examines whether outpatient providers offer members timely outpatient follow-up after discharge from a higher level of care (e.g. Inpatient, Acute Partial, Residential Rehabilitation, etc.).	
Definition	Percent of outpatient mental health services, as defined in **Reference Tables 1 and 5**, received within 90 days of a higher-level-of-care discharge that occur within 30 days of discharge from a higher level of care, as defined in **Reference Table 7.** RTF services apply to children only.	
	Eligible Population (Inclusion Criteria)	• Philadelphia County HealthChoices members between ages 18-64 years of age (adults) or 17 years of age and younger (children) who do not have other insurance coverage • Member must be continuously eligible for HealthChoices for at least 30 days post discharge from their higher LOC. • Members must have at least one paid claim for a mental health outpatient service preceded by a discharge from a higher level of care within 90 days, as defined in **Reference Table 7.** • The MHOP service must occur within the measurement year • The MHOP service must be the first service received following the discharge from a higher LOC • The Higher LOC discharge was no more than 90 days prior to the first MHOP service • The higher LOC discharges may fall within the last 90 days of the previous calendar year.
	Exclude	• This measure is not used for children who have a diagnosis of Autism Spectrum Disorder. • Members who have insurance coverage other than HealthChoices. • Members who lose HealthChoices eligibility for 15 days or more during the 30 days following discharge from the higher level of care. • Any qualifying outpatient service that is not the first in sequence following a higher-level-of-care discharge. • Individuals discharged from higher level of care services defined in Table 2. • Individuals who receive IBHS, CIRC, long-term partial, ACT, Targeted Case Management, or ASAM Outpatient/IOP (as defined in **Reference Table 3**). • Providers that perform assessments only, as individuals assessed by those providers necessarily receive additional services from other providers and not by the assessing provider (the Outpatient portion of each episode ends when the individual begins service with a different provider).

	Linking outpatient services to discharges from higher levels of care	A qualifying outpatient service will be linked to only one and the most recent higher-level-of-care discharge in the episode. **To be included in this measure, the outpatient service must occur within the reporting calendar year and must be the first service following a higher-level-of-care discharge**. Some discharges from higher levels of care may occur in the previous calendar year. When this occurs, it is important to make sure that the outpatient service is directly preceded by a higher-level-of-care discharge. For instance, in linking a consumer's outpatient service date of January 20, 2022 to a higher-level-of-care discharge, we find that the consumer was released from inpatient on December 5, 2021 (previous calendar year). However, we also find that the consumer received an outpatient service on December 22, 2021 (previous calendar year as well). In this scenario, the outpatient service on January 20th will be excluded from the measure because it is not directly preceded by a higher-level-of-care discharge. Although it represents the consumer's first outpatient service within the reporting calendar year, it is not the first outpatient service in the episode. In contrast, a person with an outpatient service on January 20, 2022, who was discharged from inpatient on December 5, 2021, and who did not receive any outpatient service in between the inpatient discharge and the outpatient service, will be kept in the measure. In this second scenario, the outpatient service occurs within the reporting calendar year, and it represents the first qualifying outpatient service in the episode.
	If a member has multiple Outpatient episodes during the measurement period	…the individual may have multiple episodes with the same provider or with multiple providers within the reporting calendar year. A qualifying episode consists of a service that begins an episode followed by at least one MH outpatient service with the same provider. The member may be counted multiple times if that individual is determined to have multiple new episodes within the measurement year.
Denominator	**Qualifying outpatient services:** From the Eligible Population, number of qualifying mental health outpatient services that are directly preceded by a discharge from a higher level of care (as defined above) within 90 days.	

Numerator	**30-day Outpatient Follow-up:** From the qualifying outpatient services, number of outpatient services occurring within 30 days of a qualifying discharge from a higher level of care.

THRESHOLDS AND POINTS

MHOP01 ADULTS

At or Above	84.40%	3
Between	73.40% to 84.39%	1.5
Below	73.4%	0

MHOP01 CHILDREN NON-ASD

At or Above	80.00%	3
Between	67.10% to 80.00%	1.5
Below	67.1%	0

MHOP04a: Percent of Episodes with At Least Two Therapeutic Services within 30 Days of Episode Start

Rationale	Engagement in treatment early in the therapeutic relationship is critical to promoting long-term recovery. Because early engagement is an important element of care, measures of engagement/retention focus on the first 90 days of Outpatient service.	
Definition	Percent of individuals who receive 2 or more therapeutic Mental Health Outpatient services (as defined in **Reference Table 1**) with the same provider on separate days within 30 days following the episode start date. Episode start date is the date of the first therapeutic service claim.	
	Eligible Population (Inclusion Criteria)	• Philadelphia County HealthChoices members between 18-64 years of age (adults), or 17 years of age or younger (children) who do not have other insurance coverage. • Member must be continuously eligible for HealthChoices for at least 30 days following the episode start date. • Episode start dates must occur within the measurement calendar year. • Children who have a diagnosis of Autism Spectrum Disorder are measured separately from those who do not.
	Exclude	• Members 65 and older • Members who have insurance coverage other than HealthChoices. • Individuals whose outpatient episodes began prior to the reporting year. • All levels of care coded as assessment or evaluation. • Individuals who use Inpatient, Detox, Rehab, RTFA, or RTF within 30 days of the episode start date. • Mental Health Outpatient services received during an acute episode or concurrent with a higher level of care. • Mental Health Outpatient services received concurrent with ASAM OP, IOP, CIRC, IBHS, Acute Partial, or ACT services (**Reference Table 13**). • Assessments and evaluations, as defined in **Reference Table 5**, and providers who perform these services only, as these are not therapeutic services, and individuals assessed by those providers necessarily receive additional services from other providers and not by the assessing provider.
	If a member has multiple qualifying episodes with the same or multiple providers during	A qualifying episode consists of a service that begins an episode followed by at least one mental health outpatient service with the same provider. The individual may have multiple episodes with the same provider or with multiple providers within the reporting calendar year. The member may be counted multiple times if that individual is

	the measurement period	determined to have multiple new episodes within the measurement year.
Denominator	**Qualifying episodes:** Discharges of the Eligible Population listed above during the measurement period.	
Numerator	**Episodes with two or more visits:** From the qualifying episodes, number of episodes that have two or more Therapeutic Outpatient services with the same provider and within 30 days of the therapeutic episode start date. The therapeutic services must have occurred on separate dates.	

THRESHOLDS AND POINTS

MHOP04a ADULTS

At or Above	68.50%	3
Between	52.70% to 68.50%	1.5
Below	52.7%	0

MHOP04a CHILDREN NON-ASD

At or Above	75.38%	2
Between	60.37% to 75.38%	1
Below	60.4%	0

MHOP04a CHILDREN w/ASD

At or Above	48.15%	3
Between	19.06% to 48.15%	1.5
Below	19.06%	0

MHOP05: Percent of Episodes Having Two or Fewer Services (*Retention*)

Rationale	Engagement in treatment early in the therapeutic relationship is critical to promoting long-term recovery. Because early engagement is an important element of care, this retention measure supplements the other early engagement measures in examining clients' levels of engagement with an outpatient provider. It does this by counting the percentage of new clients who fail to engage with the provider by having an episode break of 120 days or more following the first or second therapeutic outpatient day of service.	
Definition	Lack of retention is measured as the percent of clients who have 2 or fewer therapeutic services (as defined in **Reference Table 1**) on separate days with the same provider during a therapeutic episode.	
	Eligible Population (Inclusion Criteria)	• Philadelphia County HealthChoices members between 18-64 years of age (adults), or 17 years of age or younger (children) who do not have other insurance coverage, • Members must be continuously eligible for HealthChoices for at least 90 days following the episode start date. • Episode start dates must occur within the measurement calendar year. • Children who have a diagnosis of Autism Spectrum Disorder are measured separately from those who do not.
	Exclude	• Members 65 and older • Members who have insurance coverage other than HealthChoices. • Individuals whose outpatient episodes began prior to the reporting year. • All levels of care coded as assessment or evaluation. • Individuals who use Inpatient, Detox, Rehab, RTFA, or RTF within the first 90 days of the episode start date. • Outpatient services received during an acute episode or concurrent with a higher level of care. • Outpatient services received concurrent with ASAM OP, IOP, CIRC, IBHS, Acute Partial, or ACT services (Table 13). • Assessments and evaluations, as defined in **Reference Table 5**, and providers who perform these services *only*, as these are not therapeutic services, and individuals assessed by those providers necessarily receive additional services from other providers and not by the assessing provider.
	If a member has multiple qualifying episodes during the measurement period	A qualifying therapeutic episode consists of a service included in **Table 1** that begins an episode followed by at least one mental health outpatient service with the same provider. The individual may have multiple episodes with the same provider or with multiple providers within the reporting calendar year. The member may be counted multiple times if that individual is determined to have multiple new therapeutic episodes within the measurement year.

Denominator	**Qualifying episodes:** From the eligible population, number of new outpatient therapeutic episodes. Services that begin episodes need to occur within the measurement calendar year.
Numerator	**Members with two or fewer dates of service**: From the qualifying episodes, number of episodes with two (2) or fewer therapeutic services on different days with the same provider.

THRESHOLDS AND POINTS

MHOP05 ADULTS

Above	36.4%	0
Between	24.31% to 36.40%	1.5
At or Below	24.30%	3

MHOP05 CHILDREN NON-ASD THRESHOLDS AND POINTS

Above	40.0%	0
Between	21.11% to 40.00%	1.5
At or Below	21.11%	3

MHOP05 CHILDREN w/ASD THRESHOLDS AND POINTS

Above	61.6%	0
Between	36.30% to 61.60%	1.5
At or Below	36.30%	3

Community Connection and Mobilization: Participation in a Behavioral Health Screening Event

Rationale	Behavioral health screening events are an important way for service providers to increase access to care by working with communities to provide outreach to individuals who may not otherwise seek treatment or those who may not be aware of the services available to them. These screening events also help to reduce stigma around receiving behavioral health services by presenting behavioral health as an essential part of overall wellness.
Definition	Providers are considered to have participated in a behavioral health screening event if the Parent Provider has completed at least one event in conjunction with the community.

Event Criteria	The pay-for-performance cycle for 2021 events is: November 1, 2021 – October 31, 2022.
	
	To receive pay-for-performance credit in 2022, community-based behavioral health screening events hosted by Drug and Alcohol and Mental Health Outpatient providers to must meet the following criteria:
	
	• Providers are required to host the following number of events, based on their 2021 combined Drug & Alcohol and Mental Health Outpatient 2021 census:
	  ○ Small Providers = 2021 combined census of less than 500 CBH members → 1 event
	  ○ Large Providers = 2021 combined census of 500 CBH members or more → 2 events
	• Providers may host their event either in person or on-line.
	• The provider *must* outreach to the community to advertise/market the event, even if the event is hosted on-line.
	• Additional criteria:
	  ○ Event must be registered on the Healthy Minds Philly® calendar.
	  ○ Event must be posted on Healthy Minds Philly calendar.
	  ○ Provider must submit Feedback Form within 2 weeks of event. The provider must include evidence of community outreach in this summary.

The amount of this special award is determined by the DBHIDS Commissioner at the end of the reporting year and may fluctuate each year.

Community Behavioral Health

Level of Care: Mental Health Outpatient

(Note: All new Levels of Care for 2021 services are in red.)

Reference Table 1: Level of Care Codes for Mental Health Outpatient (MHOP) Therapeutic Services Excluding Assessment: These services are included in MHOP04a and MHOP05 and in the definition of a therapeutic episode.

Level of Care Code	Level of Care Label
300.005	(300-5) MEDICATION MANAGEMENT
300.008	(300-8) INDIV.THERAPY w/ PSYCHIATRIST
300.009	(300-9) INDIV.THERAPY NON-PSYCHIATRIST
300.010	(300-10) FAMILY/COUPLES PSYCHIATRIST
300.011	(300-11) FAMILY/COUPLE,NON-PSYCHIATRIST
300.012	(300-12) COLLATERAL FAMILY PSYCHIATRIST
300.013	(300-13) GROUP THERAPY
300.016	(300-16) CONSULTATION FEES-INITIAL
300.017	(300-17) CONSULTATION FEES-FOLLOW UP
300.018	(300-18) NON-ACUTE ECT
300.019	(300-19) ADMIN.MGT.FACE TO FACE W/CONSUMER
300.020	(300-20) ADMIN.MGT.FACE TO FACE W/COLLATERAL
300.021	(300-21) Healing Hurt People-Certified Peer Specialist
300.022	(300-22) COMMUNITY MENTAL HEALTH SERVICES OTHER
300.023	(300-23) FAMILY FOCUSED PSYCHIATRIC ASSESSMENT
300.024	(300-24) COLLATERAL FAMILY,NON-PSYCHIAT RIST
300.026	(300-26) CLOZARIL MONITOR & EVAL
300.027	(300-27) CLOZAPINE SUPP SVCS
300.028	(300-28) RN/LPN HOME VISIT;1-28 DAYS
300.029	(300-29) RN/LPN HOME VISIT >28 DAYS
300.032	(300-32) TRAUMA COUNSELING
300.035	(300-35) THERAPY W/ PSYCHIATRIST
300.036	(300-36) THERAPY NON-PSYCHIATRIST
300.037	(300-37) SPECIALIZED AUTISM SERVICES
300.038	(300-38) OUTPATIENT THERAPY FOR REACTIVE ATTACHMENT
300.039	(300-39) O/P THERAPY FOR DEAF W/DR.
300.040	(300-40) O/P THERAPY FOR DEAF W/MASTER LEVEL
300.041	(300-41) SPECIALIZED OUTPATIENT
300.042	(300-42) COMP. CHILD EVAL MD
300.047	(300-47) MH SERVICES
300.049	(300-49) THERAPEUTIC FLOOR TIME
300.055	(300-55) MEDICATION ADMIN AND EVAL (NON -PSYCHIATRIST)
300.064	(300-64) MEDICATION MANAGEMENT
300.065	(300-65) INDIV. THERAPY PSYCHIATRIST
300.066	(300-66) INDIV.THERAPY NON-PSYCHIATRIST

Level of Care Code	Level of Care Label
300.067	(300-67) FAMILY/COUPLES PSYCHIATRIST
300.068	(300-68) FAMILY/COUPLE NON-PSYCHIATRIST
300.069	(300-69) GROUP
300.070	(300-70) COLLATERAL FAMILY PSYCHIATRIST
300.071	(300-71) COLLATERAL FAMILY NON-PSYCHIAT RIST
300.073	(300-73) INDIVIDUAL THERAPY W/MED MGMT PSYCHIATRIST
300.075	(300-75) CANS CYD
300.077	(300-77) MH SERVICES (INTENSIVE)
300.084	(300-84) ADOLESCENT COURT PROGRAM
300.087	(300-87) COLLATERAL FAMILY - ENHANCED NON-PSYCH
300.088	(300-88) FAMILY/COUPLE - ENHANCED, NON-PSYCH
300.089	(300-89) FUNCTIONAL FAMILY THERAPY
300.090	(300-90) O/P FAMILY/COUPLE THERAPY FOR DEAF WITH MASTER LEVEL
300.091	(300-91) COLLATERAL GROUP THERAPY
300.092	(300-92) BEHAVIORAL HEALTH OCCUPATIONAL THERAPY
300.093	(300-93) MUSIC THERAPY
300.094	(300-94) ENHANCED GROUP THERAPY
300.095	(300-95) OUTPATIENT PSYCHIATRIC-RN/LPN SHORT VISIT
300.096	(300-96) MOBILE MENTAL HEALTH TREATMENT
300.097	(300-97) ART THERAPY
300.098	(300-98) SPECIALIZED MMHT GROUP THERAPY
300.099	(300-99) SPECIALIZED MMHT FAMILY THERAPY
300.100	(300-100) SPECIALIZED OUTPATIENT FAMILY THERAPY
300.101	(300-101) SPECIALIZED OUTPATIENT INDIVIDUAL THERAPY
300.102	(300-102) SPECIALIZED GROUP THERAPY
300.103	(300-103) SPECIALIZED MMHT INDIVIDUAL THERAPY
300.104	(300-104) SPECIALIZED MEDICATION MANAGEMENT
300.106	(300-106) MH SERVICES (COMMUNITY)
300.108	(300-108) GROUP MUSIC THERAPY
300.109	(300-109) GROUP ART THERAPY
300.110	(300-110) MMHT-COLLATERAL FAMILY-NON PSYCHIATRIST
300.111	(300-111) MMHT-FAMILY/COUPLES-NON PSYCHIATRIST
300.120	(300-120) OUTPATIENT PSYCHIATRIC-DEAF GROUP THERAPY
300.121	(300-121) OUTPATIENT PSYCHIATRIC-DEAF MEDICATION MANAGEMENT
300.123	(300-123) MEDICATION MANAGEMENT-CRNP
300.124	(300-124) INDIVIDUAL THERAPY W/MED MGMT-CRNP
300.126	(300-126) CRISIS INTERVENTION-MOBILE INDIVIDUAL
300.136	(300-136) CRISIS INTERVENTION -HOTLINE SVC/TELEPHONE CRISIS
300.156	(300-156) INDIVIDUAL THERAPY - CFTSI
300.142	(300-142) INDIVIDUAL THERAPY- NON - PSYCHIATRIST-MODERATE
300.143	(300-143) INDIVIDUAL THERAPY - NON - PSYCHIATRIC-COMPLEX

Level of Care Code	Level of Care Label
300.153	(300-153) OUTPATIENT PSYCHIATRIC- INDIVIDUAL THERAPY(OTHER)
300.155	(300-155) INDIVIDUAL THERAPY NON-PSYCH 60 MIN.
300.156	(300-156) INDIVIDUAL THERAPY - CFTSI
300.157	(300-157) INDIVIDUAL THERAPY - TFCBT
300.158	(300-158) FAMILY THERAPY - CFTSI
300.159	(300-159) FAMILY THERAPY - TFCBT
300.161	(300-161) MMH MEDICATION MANAGEMENT
300.162	(300-162) INDIV. THERAPY W/PSYCHIATRIST- MODERATE
300.163	(300-163) INDIV. THERAPY W/PSYCHIATRIST COMPLEX
300.164	(300-164) Outpatient Psychiatric-individual Therapy Non Psychiatrist
300.166	(300-166) Group Therapy-DBT Skills Comprehensive
300.170	(300-170) Initial Autism Assessment
300.171	(300-171) OP Psychiatric-Ind'l Therapy Non-Psych Trauma Counseling
300.173	(300-173) OP Psychiatric-Ind'l Therapy Non-Psych-Complex-Trauma Couns
300.182	(300-182) Family Therapy - PCIT
300.183	(300-183) Group Therapy - DBT
300.184	(300-184) Individual Therapy-PE
300.185	(300-185) Individual Therapy - DBT
300.186	(300-186) Family Collateral - PCIT
300.187	(300-187) Family Collateral - TF-CBT
300.188	(300-188) Group Therapy - Family DBT Group
300.189	(300-189) Group Therapy - Family Collateral DBT Group
300.191	(300-191) PriCARE-Family Collateral Group
300.192	(300-192) BHC-Psychologist
300.193	(300-193) BHC-Licensed Clinician
300.200	(300-200) MAT-Medication Management Opioid Tx-Non Methadone
300.202	(300-202) PEACE-Case Rate Payment (1-7 days)
300.203	(300-203) PEACE-Case Rate Payment (8-14 days)
200.204	(300-204) PEACE-Case Rate Payment (15-21 days)
300.205	(300-205) PEACE-Case Rate Payment(22days or greater)
300.206	(300-206) Individual Therapy-ESFT
300.207	(300-207) Family Therapy-ESFT
300.208	(300-208) Family Collateral Therapy- ESFT
300.210	(300-210) Individual Therapy-EMDR
300.211	(300-211) Individual Therapy-CBT
300.212	(300-212) Group Therapy-CBT
300.213	(300-213) Family Therapy-CBT
300.220	(300-220) Individual Therapy-TARGET
300.221	(300-221) Group Therapy-TARGET
300.222	(300-222) Individual Therapy-Exposure Based CBT
300.223	(300-223) Family Therapy-Exposure Based CBT

Level of Care Code	Level of Care Label
300.224	(300-224) Family Collateral Therapy- Exposure Based CBT

Reference Table 2: Individuals Discharged from These Services Are Excluded From Follow-Up Measures

Level of Care Code	Level of Care Label
325.001	(325-1) LICENSED ADULT PSY.PART.-ADULT ADULT
325.002	(325-2) LICENSED ADULT PSY.PART.-CHILD CHILD
325.003	(325-3) PSYCH.PART.ADULT-NONCOVERED NONCOVERED MEDICARE
325.004	(325-4) PSYCH.PART.CHILD-NONCOVERED NONCOVERED MEDICARE
325.005	(325-5) LICENSED CHILD PSY.PART.ADULT ADULT
325.006	(325-6) LICENSED CHILD PSY.PART.CHILD CHILD
325.007	(325-7) PARTIAL AFTER SCHOOL
325.008	(325-8) ACUTE PARTIAL
325.009	(325-9) INTERMEDIATE PARTIAL
325.010	(325-10) CHILD TRANSITION PROGRAM
325.011	(325-11) CHILD PRESCHOOL PROGRAM
325.012	(325-12) SUBACUTE PARTIAL - PCHD ONLY
325.013	(325-13) INTERMEDIATE PARTIAL-PCHD ONLY
325.014	(325-14) ACUTE PARTIAL - PCHD ONLY
325.016	(325-16) ACUTE PARTIAL/INTENS/NEW VITAE ONLY
325.017	(325-17) ACUTE PARTIAL SPECIFIC AUTH
325.018	(325-18) SCHOOL BASED
325.019	(325-19) PARTIAL PSYCHIATRIC: LTSR
325.020	(325-20) EVALUATION NON-MD
325.022	(325-022) Partial Psychiatric – New Sub-acute Partial PCHD Only
325.023	(325-023) Partial Psychiatric – New Intermediate Partial PCHD Only
325.024	(325-024) Partial Psychiatric – New Acute Partial PCHD Only
400.001	(400-1) BEHAV.SPECIALIST RETRAINING RETRAINING
400.002	(400-2) BEHAVIORAL SPECIALIST PhD.
400.003	(400-3) BEHAV.SPECIALIST MASTER LEVEL LEVEL
400.004	(400-4) CASE MANAGEMENT SERVICES
400.005	(400-5) DIAGNOSIS INTELLECT EVALUATION
400.006	(400-6) DIAGNOSIS PERSONALITY EVAL.
400.007	(400-7) MOBILE THERAPY
400.008	(400-8) THERAPEUTIC SUPPORT
400.009	(400-9) COMPREHENS DIAGNOSTIC PSY.EVAL EVALUATION
400.010	(400-10) COMPREHENSIVE NEURO.EVALUATION EVALUATION
400.011	(400-11) COMPREHENS.NEURO.PERSONAL.EVAL PERSONALITY EVALUATION
400.012	(400-12) PSYCHOLOGICAL EVALUATION
400.013	(400-13) OTHER

Level of Care Code	Level of Care Label
400.014	(400-14) AFTER SCHOOL PROGRAM
400.015	(400-15) THERAPEUTIC CAMP
400.016	(400-16) TSS AIDE
400.018	(400-18) GROUP TSS
400.019	(400-19) PACT WRAPAROUND
400.020	(400-20) CAP WRAPAROUND 265 E. LEHIGH AVE.
400.021	(400-21) CAP WRAPAROUND 27 E. MOUNT AIRY AVE.
400.022	(400-22) INTENSIVE SUMMER CAMP
400.023	(400-23) ENHANCED SUMMER CAMP
400.024	(400-24) EMERGENCY THERAPEUTIC SUPPORT
400.025	(400-25) EMERGENCY BEHAVIORAL SPECIALIS T CONSULT.
400.026	(400-26) EMERGENCY MOBILE THERAPY
400.027	(400-27) TSS AIDE - INTERPRETER
400.028	(400-28) SPECIALIZED DUAL DIAGNOSIS
400.029	(400-29) PSYCHOLOGICAL EVAL-MODEL COURT
400.030	(400-30) PILOT EVALUATION PROGRAM
400.031	(400-31) TSS SCHOOL
400.032	(400-32) TSS NON-SCHOOL
400.034	(400-34) CTSS MENTAL HEALTH WORKER
400.035	(400-35) CTSS THERAPIST
400.036	(400-36) BSC SPECIALIZED
400.041	(400-41) SBBH (BACHE-MARTIN)
400.042	(400-42) SBBH (FERGUSON)
400.043	(400-43) SBBH (COOK-WISSAHICKON)
400.044	(400-44) SBBH (KELLY)
400.045	(400-45) SBBH (A.D. HARRINGTON)
400.046	(400-46) SBBH (TURNER)
400.047	(400-47) CARE
400.050	(400-50) BIOPSYCHOSOCIAL EVAL MD
400.051	(400-51) BIOPSYCHOSOCIAL EVAL NON-MD
400.052	(400-52) COURT EVALUATION MD
400.053	(400-53) COURT EVALUATION NON-MD
400.054	(400-54) RE-EVALUATION MD
400.057	(400-57) RE-EVALUATION NON-MD
400.060	(400-60) PRESCHOOL FAMILY INTERVENTION
400.061	(400-61) SBBH (CLEMENTE)
400.062	(400-62) SBBH (DOUGLASS, F.)
400.063	(400-63) SBBH (HARDING)
400.064	(400-64) SBBH (JONES)
400.065	(400-65) SBBH (WEBSTER)
400.066	(400-66) SBBH (MITCHELL, S.W.)
400.067	(400-67) MOBILE THERAPY DEAF SERVICES
400.068	(400-68) TSS SCHOOL WITH AUTISM
400.069	(400-69) TSS NON-SCHOOL WITH AUTISM

Level of Care Code	Level of Care Label
400.070	(400-70) SBBH
400.072	(400-72) TESC
400.075	(400-75) CANS JJS
400.076	(400-76) SVC FOR DEAF CHILDREN BEHAVIOR SPECIALIST
400.077	(400-77) SVC FOR DEAF CHILDREN TSS SCHO OL
400.078	(400-78) SVC FOR DEAF CHILDREN TSS NON- SCHOOL
400.079	(400-79) SVC DEAF CHILD TSS AIDE SCHOOL
400.080	(400-80) SVC DEAF CHILD TSS AIDE NON-SC HOOL
400.081	(400-81) GROUP TSS - SPECIALIZED
400.083	(400-83) LEAD CLINICIAN
400.084	(400-84) SBBH - MOBILE THERAPY
400.085	(400-85) SBBH - GROUP MOBILE THERAPY
400.086	(400-86) NURTURE
400.087	(400-87) SBBH - SCHOOL BASED SEVICES ASSESSMENT
400.088	(400-88) SCHOOLTHERAPEUTIC SERVICES
400.089	(400-89) IBHS - TRAUMA COUNSELING
400.090	(400-90) PSYCHOSEXUAL EVALUATION
400.091	(400-91) PCIT-LEAD CLINICIAN
400.092	(400-92) MULTI-SYSTEMIC THERAPY
400.094	(400-94) MOBILE THERAPY WITH AUTISM
400.095	(400-95) BSC WITH AUTISM
400.096	(400-96) ABA SERVICES
400.097	(400-97) AFTER SCHOOL TRAUMA TREATMENT PROGRAM
400.098	(400-98) AFTER SCHOOL WELLNESS PROGRAM
400.099	(400-99) FUNCTIONAL FAMILY THERAPY
400.100	(400-100) FFT ASSESSMENT
400.101	(400-101) DEAF CBE-PSYCHOLOGIST
400.102	(400-102) DEAF CBR-PYCHOLOGIST
400.103	(400-103) IBHS School Therapeutic Services II
400.104	(400-104) FACT-MT
425.010	(425-10) Behavior Consultation- Specialized
425.013	(425-13) Mobile Therapy-Specialized
425.015	(425-15) IBHS Group Service (9 to 12 group members)
425.018	(425-18) Behavioral Health Technician-Specialized
425.020	(425-20) Functional Family Therapy
425.021	(425-21) Multi Systemic Therapy
425.022	(425-22) Multi Systemic Therapy-PSB
425.023	(425-23) CTSS
425.025	(425-25) Early Childhood Intensive Treatment
425.026	(425-26) Therapeutic Afterschool Program
425.027	(425-27) Summer Therapeutic Activities Program
425.030	(425-30) Assistant Behavior Consultation-ABA Services

Level of Care Code	Level of Care Label
425.035	(425-35) Family Peer Support
425.049	(425-49) IBHS ABA Services LOC Assessment by Licensed Prof.
425.050	(425-50) IBHS ABA Services Psychological Evaluation
425.051	(425-51) IBHS ABA Services Mobile Therapy
425.052	(425-52) IBHS ABA Services Mobile Therapy-Licensed
425.053	(425-53) ABA Group (2-3 Group Members)
700.003	(700-3) DAY PROGRAM ITEMIZED
700.004	(700-4) DAY PROGRAM ITEMIZED
700.007	(700-7) CIRC-Psychiatric Rehab-Site Based
700.009	(700-9) CIRC-Psychiatric Rehab-Mobile
700.011	(700-11) WHOQOL-BREF Assessment
700.024	(700-24) CIRC-Common Ground-Medication Training
700.025	(700-25) CIRC-Individual Therapy PE
700.026	(700-26) CIRC-Group Therapy DBT
700.027	(700-27) CIRC-Individual Therapy DBT
700.028	(700-28) CIRC-Group Therapy-Family DBT Group
700.029	(700-29) CIRC-Group Therapy-Family Collateral DBT Group
700.030	(700-30) CIRC-Evaluation-CRNP
700.031	(700-31) CIRC-Medication Management CRNP
800.019	(800-19) ACT (ASSERTIVE COMMUNITY OUTREACH)
800.022	(800-22) Community Support Psychiatric- Assertive Community Trt CTT II

Reference Table 3: Alternative Services That May Meet Follow-Up Needs. Individuals receiving these services concurrently with MHOP following discharge from a higher LOC are excluded from follow-up measures.

Level of Care Code	Level of Care Label
325.001	(325-1) LICENSED ADULT PSY.PART.-ADULT ADULT
325.002	(325-2) LICENSED ADULT PSY.PART.-CHILD CHILD
325.003	(325-3) PSYCH.PART.ADULT-NONCOVERED NONCOVERED MEDICARE
325.004	(325-4) PSYCH.PART.CHILD-NONCOVERED NONCOVERED MEDICARE
325.005	(325-5) LICENSED CHILD PSY.PART.ADULT ADULT
325.006	(325-6) LICENSED CHILD PSY.PART.CHILD CHILD
325.007	(325-7) PARTIAL AFTER SCHOOL
325.008	(325-8) ACUTE PARTIAL
325.009	(325-9) INTERMEDIATE PARTIAL
325.010	(325-10) CHILD TRANSITION PROGRAM
325.011	(325-11) CHILD PRESCHOOL PROGRAM
325.012	(325-12) SUBACUTE PARTIAL - PCHD ONLY
325.013	(325-13) INTERMEDIATE PARTIAL-PCHD ONLY
325.014	(325-14) ACUTE PARTIAL - PCHD ONLY

Level of Care Code	Level of Care Label
325.016	(325-16) ACUTE PARTIAL/INTENS/NEW VITAE ONLY
325.017	(325-17) ACUTE PARTIAL SPECIFIC AUTH
325.018	(325-18) SCHOOL BASED
325.019	(325-19) PARTIAL PSYCHIATRIC: LTSR
325.020	(325-20) EVALUATION NON-MD
325.022	(325-022) Partial Psychiatric – New Sub-acute Partial PCHD Only
325.023	(325-023) Partial Psychiatric – New Intermediate Partial PCHD Only
325.024	(325-024) Partial Psychiatric – New Acute Partial PCHD Only
350.001	(350-1) PSYCH. EVALUATION
350.002	(350-2) PHYSICAL EXAM BY A PHYSICIAN
350.003	(350-3) ASSESSMENT
350.005	(350-5) MEDICATION MANAGEMENT
350.007	(350-7) PSYCHOLOGICAL TESTING
350.008	(350-8) INDIV.THERAPY-PSYCHIATRIST PSYCHIATRIST
350.009	(350-9) INDIV.THERAPY-NON-PSYCHIATRIST NON-PSYCHIATRIST
350.010	(350-10) FAMILY/COUPLES-PSYCHIATRIST
350.011	(350-11) FAM./COUPLES NON-PSYCHIATRIST NON-PSYCHIATRIST
350.012	(350-12) COLLATERAL FAMILY PSYCHIATRIST
350.013	(350-013) GROUP SESSIONS
350.015	(350-15) Evaluation-Physician Assistant
350.025	(350-25) COLLATER.FAM.NON-PSYCHIATRIST NON-PSYCHIATRIST
350.035	(350-35) THERAPY W/ PSYCHIATRIST
350.036	(350-36) THERAPY NON-PSYCHIATRIST
350.037	(350-37) SPECILAIZED OP PRE-ENGAGEMENT 30 DAYS
350.038	(350-38) IND.THERAPY NON-PSYCH INTERPRE TER
350.040	(350-40) BIOPSYCHOSOCIAL EVAL. MD
350.041	(350-41) BIOPSYCHOSOCIAL EVAL. NON-MD
350.042	(350-42) RE-EVALUATION MD
350.043	(350-43) RE-EVALUATION NON-MD
350.055	(350-55) MEDICATION ADMIN AND EVAL (NON -PSYCHIATRIST)
350.056	(350-56) FAM/COUPLES NON-PSYCH INTERPRE TER
350.057	(350-57) BEHAVIORAL HEALTH COUNSELING & THERAPY
350.058	(350-58) COLLATERAL GROUP THERAPY
350.059	(350-59) MEDICATION MANAGEMENT INTERPRETER
350.060	(350-60) GROUP THERAPY INTERPRETER
350.061	(350-61) BIOPSYCHOSOCIAL EVAL, MD. INTERPRETER
350.123	(350-123) MEDICATION MANAGEMENT-CRNP
350.124	(350-124) FAMILY THERAPY - TFCBT
350.127	(350-127) INDIVIDUAL THERAPY - TFCBT
350.152	(350-152) CRNP EVALUATION
350.154	(350-154) MAT-Medication Admin and Eval -Opioid Tx-Non-Methadone
350.155	(350-155) MAT-Medication Management -Opioid Tx-Non-Methadone
350.156	(350-156) MAT-Physical Exam-Opioid Tx-Non Methadone

Level of Care Code	Level of Care Label
350.157	(350-157) Individual Therapy Psychiatrist
350.163	(350-163) Individual Therapy-PE
350.164	(350-164) Individual Therapy-CBT
350.165	(350-165) Group Therapy-CBT
350.166	(350-166) Family Therapy-CBT
350.170	(350-170) ASAM 2.1 IOP
350.695	(350.695) ASSESSMENT/SERVICE PLANNING
350.696	UNKNOWN MEMBER
350.697	(350.697) INDIVIDUAL COUNSELING
350.698	(350.698) FAMILY COUNSELING
350.699	(350.699) SERVICE CONSULATIONS
350.700	(350.700) RECOVERY ORENTIED ASSESSMENT/PLANNING
350.700	(350.700) RECOVERY RESOURCE COORDINATION
350.956	(350.956) PYSCHOEDUCATIONAL GROUP
350.957	(350.957) FAMILY COUNSELING
350.958	(350.958) RECOVERY RESOURCE/REFERRAL ASSISTANCE
350.959	(350.959) PYSCHOEDUCATIONAL GROUP
350.960	(350.960) RECOVERY HOUSE
350.961	(350.961) SCREENING
350.962	(350.962) SERVICE CONSULATIONS
350.963	(350.963) INDIVIDUAL COUNSELING
350.964	(350.964) ASSESSMENT/SERVICE PLANNING
350.975	(350-975) URINE ANALYSIS
350.976	(350-976) PHYSICAL EXAM
350.982	(350-982) TRANSLATION SERVICE FOR HEARING IMPAIRED-
350.983	(350-983) ASSESSMENT ONLY
350.984	(350-984) PSYCHIATRIC EVALUATIONS
350.985	(350-985) INDIVIDUAL SESSIONS
350.988	(350-988) PSYCHIATRIC EVALUATIONS
350.990	(350-990) MED CHECK
350.991	(350-991) INDIVIDUAL SESSIONS
350.995	(350-995) FAMILY THERAPY
350.996	(350-996) FAMILY SESSIONS
350.997	(350-997) ENHANCED OUTPATIENT
350.998	(350-998) DRUG EVALUATION VISIT
350.999	(350-999) COMPREHENSIVE PYSCHOLOGICAL
375.009	(375-009) LAAM
375.002	(375-2) PARTIAL D&A - METHADONE MAINTENANCE DAILY
375.011	(375-11) IOP (15 min)
400.001	(400-1) BEHAV.SPECIALIST RETRAINING RETRAINING
400.002	(400-2) BEHAVIORAL SPECIALIST PhD.
400.003	(400-3) BEHAV.SPECIALIST MASTER LEVEL

Level of Care Code	Level of Care Label
400.004	(400-4) CASE MANAGEMENT SERVICES
400.005	(400-5) DIAGNOSIS INTELLECT EVALUATION
400.006	(400-6) DIAGNOSIS PERSONALITY EVAL.
400.007	(400-7) MOBILE THERAPY
400.008	(400-8) THERAPEUTIC SUPPORT
400.009	(400-9) COMPREHENS DIAGNOSTIC PSY.EVAL EVALUATION
400.010	(400-10) COMPREHENSIVE NEURO.EVALUATION EVALUATION
400.011	(400-11) COMPREHENS.NEURO.PERSONAL.EVAL PERSONALITY EVALUATION
400.012	(400-12) PSYCHOLOGICAL EVALUATION
400.013	(400-13) OTHER
400.014	(400-14) AFTER SCHOOL PROGRAM
400.015	(400-15) THERAPEUTIC CAMP
400.016	(400-16) TSS AIDE
400.018	(400-18) GROUP TSS
400.019	(400-19) PACT WRAPAROUND
400.020	(400-20) CAP WRAPAROUND 265 E. LEHIGH AVE.
400.021	(400-21) CAP WRAPAROUND 27 E. MOUNT AIRY AVE.
400.022	(400-22) INTENSIVE SUMMER CAMP
400.023	(400-23) ENHANCED SUMMER CAMP
400.024	(400-24) EMERGENCY THERAPEUTIC SUPPORT
400.025	(400-25) EMERGENCY BEHAVIORAL SPECIALIS T CONSULT.
400.026	(400-26) EMERGENCY MOBILE THERAPY
400.027	(400-27) TSS AIDE - INTERPRETER
400.028	(400-28) SPECIALIZED DUAL DIAGNOSIS
400.029	(400-29) PSYCHOLOGICAL EVAL-MODEL COURT
400.030	(400-30) PILOT EVALUATION PROGRAM
400.031	(400-31) TSS SCHOOL
400.032	(400-32) TSS NON-SCHOOL
400.034	(400-34) CTSS MENTAL HEALTH WORKER
400.035	(400-35) CTSS THERAPIST
400.036	(400-36) BSC SPECIALIZED
400.041	(400-41) SBBH (BACHE-MARTIN)
400.042	(400-42) SBBH (FERGUSON)
400.043	(400-43) SBBH (COOK-WISSAHICKON)
400.044	(400-44) SBBH (KELLY)
400.045	(400-45) SBBH (A.D. HARRINGTON)
400.046	(400-46) SBBH (TURNER)
400.047	(400-47) CARE
400.050	(400-50) BIOPSYCHOSOCIAL EVAL MD
400.051	(400-51) BIOPSYCHOSOCIAL EVAL NON-MD
400.052	(400-52) COURT EVALUATION MD
400.053	(400-53) COURT EVALUATION NON-MD
400.054	(400-54) RE-EVALUATION MD

Level of Care Code	Level of Care Label
400.057	(400-57) RE-EVALUATION NON-MD
400.060	(400-60) PRESCHOOL FAMILY INTERVENTION
400.061	(400-61) SBBH (CLEMENTE)
400.062	(400-62) SBBH (DOUGLASS, F.)
400.063	(400-63) SBBH (HARDING)
400.064	(400-64) SBBH (JONES)
400.065	(400-65) SBBH (WEBSTER)
400.066	(400-66) SBBH (MITCHELL, S.W.)
400.067	(400-67) MOBILE THERAPY DEAF SERVICES
400.068	(400-68) TSS SCHOOL WITH AUTISM
400.069	(400-69) TSS NON-SCHOOL WITH AUTISM
400.070	(400-70) SBBH
400.072	(400-72) TESC
400.075	(400-75) CANS JJS
400.076	(400-76) SVC FOR DEAF CHILDREN BEHAVIOR SPECIALIST
400.077	(400-77) SVC FOR DEAF CHILDREN TSS SCHO OL
400.078	(400-78) SVC FOR DEAF CHILDREN TSS NON- SCHOOL
400.079	(400-79) SVC DEAF CHILD TSS AIDE SCHOOL
400.080	(400-80) SVC DEAF CHILD TSS AIDE NON-SC HOOL
400.081	(400-81) GROUP TSS - SPECIALIZED
400.083	(400-83) LEAD CLINICIAN
400.084	(400-84) SBBH - MOBILE THERAPY
400.085	(400-85) SBBH - GROUP MOBILE THERAPY
400.086	(400-86) NURTURE
400.087	(400-87) SBBH - SCHOOL BASED SEVICES ASSESSMENT
400.088	(400-88) SCHOOLTHERAPEUTIC SERVICES
400.089	(400-89) IBHS - TRAUMA COUNSELING
400.090	(400-90) PSYCHOSEXUAL EVALUATION
400.091	(400-91) PCIT-LEAD CLINICIAN
400.092	(400-92) MULTI-SYSTEMIC THERAPY
400.094	(400-94) MOBILE THERAPY WITH AUTISM
400.095	(400-95) BSC WITH AUTISM
400.096	(400-96) ABA SERVICES
400.097	(400-97) AFTER SCHOOL TRAUMA TREATMENT PROGRAM
400.098	(400-98) AFTER SCHOOL WELLNESS PROGRAM
400.099	(400-99) FUNCTIONAL FAMILY THERAPY
400.100	(400-100) FFT ASSESSMENT
400.101	(400-101) DEAF CBE-PSYCHOLOGIST
400.102	(400-102) DEAF CBR-PYCHOLOGIST
400.103	(400-103) IBHS School Therapeutic Services II
400.104	(400-104) FACT-MT
425.010	(425-10) Behavior Consultation- Specialized
425.013	(425-13) Mobile Therapy-Specialized

Community Behavioral Health

Level of Care: Mental Health Outpatient

Level of Care Code	Level of Care Label
425.015	(425-15) IBHS Group Service (9 to 12 group members)
425.018	(425-18) Behavioral Health Technician-Specialized
425.020	(425-20) Functional Family Therapy
425.021	(425-21) Multi Systemic Therapy
425.022	(425-22) Multi Systemic Therapy-PSB
425.023	(425-23) CTSS
425.025	(425-25) Early Childhood Intensive Treatment
425.026	(425-26) Therapeutic Afterschool Program
425.027	(425-27) Summer Therapeutic Activities Program
425.030	(425-30) Assistant Behavior Consultation-ABA Services
425.035	(425-35) Family Peer Support
425.049	(425-49) IBHS ABA Services LOC Assessment by Licensed Prof.
425.050	(425-50) IBHS ABA Services Psychological Evaluation
425.051	(425-51) IBHS ABA Services Mobile Therapy
425.052	(425-52) IBHS ABA Services Mobile Therapy-Licensed
425.053	(425-53) ABA Group (2-3 Group Members)
700.003	(700-3) DAY PROGRAM ITEMIZED
700.004	(700-4) DAY PROGRAM ITEMIZED
700.007	(700-7) CIRC-Psychiatric Rehab-Site Based
700.009	(700-9) CIRC-Psychiatric Rehab-Mobile
700.011	(700-11) WHOQOL-BREF Assessment
700.024	(700-24) CIRC-Common Ground-Medication Training
700.025	(700-25) CIRC-Individual Therapy PE
700.026	(700-26) CIRC-Group Therapy DBT
700.027	(700-27) CIRC-Individual Therapy DBT
700.028	(700-28) CIRC-Group Therapy-Family DBT Group
700.029	(700-29) CIRC-Group Therapy-Family Collateral DBT Group
700.030	(700-30) CIRC-Evaluation-CRNP
700.031	(700-31) CIRC-Medication Management CRNP
800.003	(800-3) NON FIDELITY ACT
800.009	(800-9) ICM:OFFICE/HOME/OTHER
800.012	(800-12) RES COOR:OFFICE/HOME/OTHER
800.018	(800-18) COMMUNITY SUPPORT PSYCHIATRIC TARGET MH CASE MGMT-BLENDED CM
800.019	(800-19) ACT (ASSERTIVE COMMUNITY OUTREACH)
800.022	(800-22) Community Support Psychiatric- Assertive Community Trt CTT II
800.024	(800-024) BHID Non-Fidelity ACT
800.026	(800-026) Community Support Psychiatric – D&A Treatment Court Case Mgmt.
800.033	(800-33) Blended Case Management-SBPP
800.036	(800-36) D&A Case Management Non- Billable
800.037	(800-37) D&A Certified Recovery Specialist Non-Billable

Reference Table 4: Levels of Care Indicating Methadone Maintenance. Individuals receiving these services are excluded from all continuity of care and early engagement/retention measures.

Level of Care Code	Level of Care Label
350.168	(350-168) D&A-Methadone Daily
350.169	(350-169) D&A-Methadone Take Home Services
375.002	(375-002) METHADONE MAINTENANCE
375.002	(375-2) METHADONE MAINTENANCE DAILY
375.012	(375-12) METHADONE TAKE HOME SERVICE

Reference Table 5: Assessment/Evaluation LOCs

These services are *included* in MHOP01, but excluded from MHOP04a and MHOP05.

Outpatient providers who provide *only* these services are not evaluated for Pay-for-Performance.

Level of Care Code	Level of Care Label
100.031	(100-31) NEUROBEHAVIORAL INTAKE AND ASSESSMENT
300.001	(300-1) EVALUATION MD
300.002	(300-2) EVALUATION NON-MD
300.003	(300-3) ASSESSMENT
300.015	(300-15) ASSESSMENT-OTHER
300.026	(300-26) CLOZARIL MONITOR & EVAL
300.043	(300-43) Initial IP Consult
300.048	(300-48) SPECIALIZED ASSESSMENT
300.050	(300-50) BIOPSYCHOSOCIAL EVAL MD
300.051	(300-51) BIOPSYCHOSOCIAL EVAL NON-MD
300.053	(300-53) COURT EVALUATION NON-MD
300.054	(300-54) RE-EVALUATION MD
300.055	(300-55) MEDICATION ADMIN AND EVAL (NON -PSYCHIATRIST)
300.057	(300-57) RE-EVALUATION NON-MD
300.063	(300-63) ASSESSMENT
300.074	(300-74) CRC EVALUATION
300.13	(300-130) IP FOLLOW-UP CONSULTATION,LOW
300.131	(300-131) IP FOLLOW-UP CONSULTATION, MODERATE
300.132	(300-132) IP FOLLOW-UP CONSULTATION,HIGH
300.136	(300-136) CRISIS INTERVENTION -HOTLINE SVC/TELEPHONE CRISIS
300.137	(300-137) INITIAL INPATIENT CONSULT, MINOR
300.138	(300-138) INITIAL INPATIENT CONSULT, PROBLEM LOW
300.139	(300-139) INITIALINPATIENT CONSULT, MODERATE
300.140	(300-140) INITIAL INPATIENTCONSULT, MODERATE TO HIGH
300.144	(300-144) BEHAVIORAL HEALTH FORENSIC EVALUATION-MDI-TIER I
300.145	(300-145) BEHAVIORAL HEALTH FORENSIC EVALUATION-MD-TIER II
300.146	(300-146) BEHAVIORAL HEALTH FORENSIC EVALUATION-MD-TIER III
300.147	(300-147) BEHAVIORAL HEALTH FORENSIC EVALUATION-MD-ADDENDUM
300.148	(300-148) BEHAVIORAL HEALTH FORENSIC EVAL-PSYCHOLOGIST TIER I
300.149	(300-149) BEHAVIORAL HEALTH FORENSIC EVAL-PSYCHOLOGIST-TIER II
300.150	(300-150) BEHAVIORAL HEALTH FORESNIC EVAL-PSYCHOLOGIST-TIER III
300.151	(300-151) BEHAVIORAL HEALTH FORENSIC EVAL-PSYCHOLOGIST ADDENDUM
300.152	(300-152) CRNP EVALUATION
300.154	(300-154) CRISIS INTERVENTION SVS-WALKIN CRISIS
300.169	(300-169) Autism Extended Assessment
300.170	(300-170) Initial Autism Assessment
300.179	(300-179) Office Consult New or Established PT-Problem Mod

Level of Care Code	Level of Care Label
300.197	(300-197) Biopsychosocial Evaluation Psychologist-Adults
300.198	(300-198) Biopsychosocial Re Evaluation Psychologist-Adults
300.199	(300-199) MAT-Physical Exam-Opioid Tx-Non Methadone
300.201	(300-201) MAT-Medication Admin and Eval Opioid Tx-Non Methadone
300.206	(300-206) Individual Therapy-ESFT
300.207	(300-207) Family Therapy-ESFT
300.208	(300-208) Family Collateral Therapy- ESFT
300.211	(300-211) Individual Therapy-CBT
300.212	(300-212) Group Therapy-CBT
300.213	(300-213) Family Therapy-CBT
300.216	(300-216) Neuropsychology Consult-First Hour
300.217	(300-217) Neuropsychology Consult- Additional Hours
300.218	(300-218) Neuropsychological Testing First Hour
300.219	(300-219) Neuropsychological Testing Additional Hours
325.021	(325-21) ACUTE PARTIAL 60-MINUTES

Reference Table 6: Services Delivered by an MD or CRNP

Level of Care Code	Level of Care Label
300.001	(300-1) EVALUATION MD
300.042	(300-42) COMP. CHILD EVAL MD
300.050	(300-50) BIOPSYCHOSOCIAL EVAL MD
300.052	(300-52) COURT EVALUATION MD
300.054	(300-54) RE-EVALUATION MD
300.123	(300-123) MEDICATION MANAGEMENT-CRNP
300.124	(300-124) INDIVIDUAL THERAPY W/MED MGMT-CRNP
300.144	(300-144) BEHAVIORAL HEALTH FORENSIC EVALUATION-MDI-TIER I
300.145	(300-145) BEHAVIORAL HEALTH FORENSIC EVALUATION-MD-TIER II
300.146	(300-146) BEHAVIORAL HEALTH FORENSIC EVALUATION-MD-TIER III
300.147	(300-147) BEHAVIORAL HEALTH FORENSIC EVALUATION-MD-ADDENDUM
300.152	(300-152) CRNP EVALUATION

Reference Table 7: Higher Levels of Care
Discharges from these services are included in follow-up measures; Individuals who use these LOCs within 30 days of the episode start date are excluded from MHOP04a.

Level of Care Code	Level of Care Label
100.001	(100-1) ACUTE HOSPITAL SERVICES
100.002	(100-2) SUBACUTE HOSPITAL SERVICES

Level of Care Code	Level of Care Label
100.004	(100-4) ACUTE 302
100.005	(100-5) ACUTE HOSPITAL SERVICES (B)
100.006	(100-6) ACUTE HOSPITAL SERVICES (C)
100.007	(100-7) ACUTE SVCS-CHILD/ADOLESCENT
100.008	(100-8) SUBACUTE SVCS-CHILD/ADOLESCENT
100.010	(100-10) INPATIENT PSYCHIATRIC-2:1 STAFFING
100.011	(100-11) ACUTE MH/D&A CO-OCCURING
100.012	(100-12) SUBACUTE MH/D&A CO-OCCURING
100.014	(100-14) 302 -1:1 STAFFING
100.022	(100-22) ONE:ONE STAFFING
100.028	(100-28) 1-1 INPATIENT ADD-ON
100.030	(100-30) SPECIALIZED CHILDREN/ ADOLESCENT
100.034	(100-34) Acute Stabilization-Child/ Adolescent
100.037	(100-37) Inpatient Psychiatric-High Acuity
140.001	(140-1) EXTENDED ACUTE HOSPITAL BASED SERVICES
140.002	(140-2) EAC SPECIALIZED
200.001	(200-1) DETOXIFICATION
200.002	(200-2) SHORT TERM REHAB
200.003	(200-3) OTHER CHEMOTHERAPY
200.005	(200-5) HALFWAY HOUSE
200.007	(200-7) LONG TERM REHAB
200.008	(200-8) SHORT-TERM SPECIALIZED
200.009	(200-9) SPECIALIZED REHAB
200.010	(200-10) CO-OCCURING
200.011	(200-11) CO-OCCURRING, WOMEN'S PROGRAM
200.012	(200-12) HIV - TOGETHER HOUSE
200.022	(200-22) ONE:ONE STAFFING
200.023	(200-23) TRANSITIONAL REHAB
300.154	(300-154) CRISIS INTERVENTION SVS-WALKIN CRISIS
500.002	(500-2) R&B AND TREATMENT
500.005	(500-5) R&B & (SPECIALIZED) TREATMENT
500.007	(500-7) R&B &TREATMENT (ENHANCED RATE)
500.008	(500-8) RCTF LEVEL 2
500.022	(500-22) ONE:ONE STAFFING
550.001	(550-1) TREATMENT ONLY
550.002	(550-2) R&B AND TREATMENT
550.007	(550-7) BIOPSYCHOSOCIAL R&B+TREATMENT
550.012	(550-12) FOSTER CARE R&B+TREATMENT LEVEL B
550.022	(550-22) ONE:ONE STAFFING
550.025	(550-25) RCTF LEVEL 2 TREATMENT ONLY
550.026	(550-26) RCTF LEVEL 3 TREATMENT ONLY
550.027	(550-27) RCTF LEVEL 2-SPECIALIZED - TREATMENT ONLY

Level of Care Code	Level of Care Label
550.028	(550-28) RTCF LEVEL 2 - SPECIALIZED - R&B AND TREATMENT

Non-Hospital Residential Rehabilitation (NHRR) and Residential Independent Non-Hospital Treatment (RINT)

Measurement Period

P4P Measurement Period	The Measurement Period for Non-Hospital Residential Rehabilitation and Residential Independent Non-Hospital Treatment is January 1, 2021 – December 31, 2021.

Measurements Included for All Levels of Care

Measure Labels	Practice Guidelines Domain	Measure Description
NHRR01	Continuing Support and Early Re-Intervention	Percent of Discharges Having Follow-Up within 7 Days
NHRR03	Continuing Support and Early Re-Intervention	Percent of Discharges Having Follow-Up within 30 Days
NHRR04	Continuing Support and Early Re-Intervention	Percent of Discharges Not Readmitted Within 90 Days
NHRR05 ***(New; Contextual)***	Continuing Support and Early Re-Intervention	Percent of Discharges Receiving Methadone or Buprenorphine within 7 Days or Vivitrol or Sublocade within 35 Days

Populations Included

These following program categories apply to the 2022 reporting/2021 measurement years but will no longer apply in 2023, as these categories changed in 2022 consistent with ASAM standards.

- Short Term
- Long Term (includes Adolescent programs)
- Women with Children
- RINT

Population Note: Each population or program assessed for Pay-for-Performance is defined below. Please note that Journey of Hope programs for Chronically Homeless members are assessed as their own P4P grouping.

Short-Term Non-Hospital Residential Rehabilitation

Levels of Care

Levels of Care Included	Includes CBH Level of Care 200.002, 200.008, 200.009

NHRR00 Episode

Definition	Episodes are distinguished from one another either by a *discharge* or a *gap*. Depending on the category gaps vary in length and for different reasons.	
	Definition: Discharge	If the episode is defined by discharge, the episode is considered ended at the treatment end date provided to the CBH Care Manager at the time of discharge review. Discharge of episodes generally applies only to authorized levels of care.
	Definition: Gap	• If the episode Is defined by gap, the episode is considered ended on the specified service date of the final claim for that level of care and provider if that claim is followed by a specified number of days where the member remains eligible for Health Choices (or BHSI or OMH funding, as defined in the operational definitions for the specific level of care) but does not receive services in that level of care or with that provider. • The gaps in care for Short Term Rehabilitation is a 5 Day Gap. Short-term Rehabilitation programs tend to be short (<30 days) so the PIR leaving longer than five days is believed to impact upon treatment. • A member shall be considered transferred if the service date on the final claim with a provider is within one (1) day of a claim in the same level of care but with a different provider.
Mean Length of Stay	The mean length of stay expresses the average length of episodes of care provided by the reporting provider. This shall usually be defined either by number of contacts (with each claim counted as a contact for that level of care), or by the number of days elapsed from the first claim to the final claim.	

Long-Term Non-Hospital Residential Rehabilitation

Levels of Care

Levels of Care Included	Includes CBH Level of Care 200.002, 200.007, 200.009, 200.011, 200.012

NHRR00 Episode

Definition	Episodes are distinguished from one another either by a *discharge* or a *gap*. Depending on the category gaps vary in length and for different reasons.
	Definition: Discharge: If the episode is defined by discharge, the episode is considered ended at the treatment end date provided to the CBH care manager at the time of discharge review. Discharge of episodes generally applies only to authorized levels of care. **Definition: Gap**: • If the episode Is defined by gap, the episode is considered ended on the specified service date of the final claim for that level of care and provider as long as that claim is followed by a specified number of days where the member remains eligible for Health Choices (or BHSI or OMH funding, as defined in the operational definitions for the specific level of care) but does not receive services in that level of care or with that provider. • The gaps in care for Long Term Rehabilitation is a 15 Day Gap. For those in long-term treatment to account for hospital stays and other activities that give the PIR time to return to treatment without interrupting the treatment and not penalizing the agency for the person absconding for a period. • A member shall be considered transferred if the service date on the final claim with a provider is within one (1) day of a claim in the same level of care but with a different provider.
Mean Length of Stay	The mean length of stay expresses the average length of episodes of care provided by the reporting provider. This shall usually be defined either by number of contacts (with each claim counted as a contact for that level of care), or by the number of days elapsed from the first claim to the final claim.

Women with Children Non-Hospital Residential Rehabilitation

Levels of Care

Levels of Care included	Includes CBH Levels of Care 200.002, 200.007

NHRR00: Episode

Definition	Episodes are distinguished from one another either by a *discharge* or a *gap*. Depending on the category gaps vary in length and for different reasons.	
	Definition: Discharge	If the episode is defined by discharge, the episode is considered ended at the treatment end date provided to the CBH care manager at the time of discharge review. Discharge of episodes generally applies only to authorized levels of care.
	Definition: Gap	• If the episode Is defined by gap, the episode is considered ended on the specified service date of the final claim for that level of care and provider as long as that claim is followed by a specified number of days where the member remains eligible for Health Choices (or BHSI or OMH funding, as defined in the operational definitions for the specific level of care) but does not receive services in that level of care or with that provider. • The gaps in care for Women with Children Rehabilitation is a 15 Day Gap. We used the 15-day gap for those in woman and child treatment to account for hospital stays and other activities that give the PIR time to return to treatment without interrupting the treatment and not penalizing the agency for the person absconding for a period of time. That is even more common in women with children, because they have hospital stays for childbirth. • A member shall be considered transferred if the service date on the final claim with a provider is within one (1) day of a claim in the same level of care but with a different provider.
Mean Length of Stay	The mean length of stay expresses the average length of episodes of care provided by the reporting provider. This shall usually be defined either by number of contacts (with each claim counted as a contact for that level of care), or by the number of days elapsed from the first claim to the final claim.	

Residential Independent Non-Hospital Treatment (RINT)

Levels of Care

Levels of Care included	Includes CBH Levels of Care 200.002, 200.007, 900.015

NHRR00: Episode

Definition	An episode is a length of time spent receiving services in a level of care, distinct from other lengths of stay or courses of treatment. Episodes are distinguished from one another either by a *discharge* or a *gap*. Depending on the category gaps vary in length and for different reasons.	
	Definition: Discharge	If the episode is defined by discharge, the episode is considered ended at the treatment end date provided to the CBH care manager at the time of discharge review. Discharge of episodes generally applies only to authorized levels of care.
	Definition: Gap	• If the episode Is defined by gap, the episode is considered ended on the specified service date of the final claim for that level of care and provider as long as that claim is followed by a specified number of days where the member remains eligible for Health Choices (or BHSI or OMH funding, as defined in the operational definitions for the specific level of care) but does not receive services in that level of care or with that provider. • The gaps in care for RINT Rehabilitation is a 5 Day Gap We use the 5-day gap for those in residential non-hospital inpatient treatment to account for hospital stays and other activities that give the PIR time to return to treatment without interrupting the treatment and not penalizing the agency for the person absconding for a period. • A member shall be considered transferred if the service date on the final claim with a provider is within one (1) day of a claim in the same level of care but with a different provider.
Mean Length of Stay	The mean length of stay expresses the average length of episodes of care provided by the reporting provider. This shall usually be defined either by number of contacts (with each claim counted as a contact for that level of care) or by the number of days elapsed from the first claim to the final claim.	

NHRR01: Percent of Discharges Having Follow-Up within 7 Days
NHRR03: Percent of Discharges Having Follow-Up within 30 Days

<table>
<tr><td>Rationale</td><td colspan="2">We include a measurement of follow-up rate as an assessment of how care is continued in a timely fashion after discharge from a drug & alcohol residential rehabilitation facility since continuing support and early re-intervention are essential to sustaining wellness and enhancing long term recovery and are important components of the DBHIDS Practice Guidelines.</td></tr>
<tr><td>Definition</td><td colspan="2">Percent of discharges from Non-Hospital Residential Rehabilitation (or Residential Independent Non-Hospital Treatment, when applicable) with a follow-up service within 7 and 30 days of the discharge.</td></tr>
<tr><td></td><td>Eligible Population (Inclusion Criteria)</td><td>• Philadelphia County HealthChoices (CBH) funded members that were discharged from a Non-Hospital Residential Rehabilitation center during the measurement year.
• Philadelphia County HealthChoices (CBH) members that do not have commercial or other insurance coverage (i.e. Medicare)
• Member must be continuously eligible for Philadelphia County HealthChoices funding for at least 30 days following their discharge from Non-Hospital Residential Rehabilitation.
• Members must be older than 6 years of age but younger than 64 years of age</td></tr>
<tr><td></td><td>Do Not Include</td><td>• Members who have insurance coverage other than HealthChoices
• Members who do not maintain CBH HealthChoices eligibility continuously for 30 days
• If the member is transferred to another Residential Rehabilitation Center, Psychiatric Inpatient, Extended Acute Care or Detoxification Center
• If the member has a Discharge Status Code of 20 (deceased)</td></tr>
<tr><td></td><td>If a member has multiple discharges during the measurement period</td><td>The member is considered to have multiple episodes. Therefore, although a member may be included in the discharge count of more than one provider or of one provider multiple times during the reporting year, each discharge will be counted once.</td></tr>
<tr><td>Denominator</td><td colspan="2">Qualifying Discharges: The discharges of the Eligible Population listed above during the measurement period.</td></tr>
</table>

Numerator	**Discharges with Follow-Up:** Of the Eligible Population, those discharges for which CBH received a claim for a follow-up service within 7 and 30 days from the date of discharge from a Non-Hospital Residential Rehabilitation LOC or RINT program.

Community Behavioral Health
Levels of Care: NHRR and RINT

NHRR01 THRESHOLDS

LONG-TERM THRESHOLDS AND POINTS

At or Above	64.4%	4
Between	48.8% to 64.4%	2
Below	48.8%	0

SHORT-TERM THRESHOLDS AND POINTS

At or Above	47.0%	4
Between	33.3% to 47.0%	2
Below	33.3%	0

WOMEN WITH CHILDREN THRESHOLDS AND POINTS

At or Above	62.0%	4
Between	38.9% to 62.0%	2
Below	38.9%	0

RINT THRESHOLDS AND POINTS

At or Above	48.8%	4
Between	40.4% to 48.8%	2
Below	40.4%	0

NHRR03 THRESHOLDS

At or Above	76.2%	2
Between	61.5% to 76.2%	1
Below	61.5%	0

At or Above	53.9%	2
Between	52.8% to 53.9%	1
Below	52.8%	0

At or Above	74.8%	2
Between	52.3% to 74.8%	1
Below	52.3%	0

At or Above	60.9%	2
Between	54.5% to 60.9%	1
Below	54.5%	0

NHRR04: Percent of Discharges Not Readmitted within 90 Days

<table>
<tr><td>Rationale</td><td colspan="2">Recovery initiation, or not returning to the same or higher level of care within a critical window following discharge from a Residential Rehabilitation program, is an indicator of sustained wellness post-discharge and is associated with long-term recovery.</td></tr>
<tr><td>Definition</td><td colspan="2">Percent of discharges for which the member has not readmitted to Non-Hospital Residential Rehabilitation (or Residential Independent Non-Hospital Treatment when applicable) or an equal LOC (i.e. Psychiatric Inpatient, Extended Acute Care or Detoxification) within 90 days from initial discharge date.</td></tr>
<tr><td></td><td>Eligible Population (Inclusion Criteria)</td><td>• Philadelphia County HealthChoices (CBH) funded members that were admitted into a Non-Hospital Residential Rehabilitation center during the measurement year.
• CBH funded members that do not have commercial or other insurance coverage (i.e. Medicare)
• Member must be continuously eligible for Philadelphia County HealthChoices funding for at least 90 days following their discharge from Non-Hospital Residential Rehabilitation.
• Members must be older than 6 years of age but younger than 64 years of age</td></tr>
<tr><td></td><td>Do Not Include</td><td>• Members who have insurance coverage other than HealthChoices
• If the member is transferred to another Residential Rehabilitation Center, Psychiatric Inpatient, Extended Acute Care or Detoxification Center
• If the member has a Discharge Status Code of 20 (deceased)</td></tr>
<tr><td></td><td>If a member has multiple discharges during the measurement period</td><td>The member is considered to have multiple episodes. Therefore, although a member may be included in the discharge count of more than one provider or of one provider multiple times during the reporting year, each discharge will be counted once.</td></tr>
<tr><td>Denominator</td><td colspan="2">Qualifying Discharges: Discharges of the Eligible Population listed above during the measurement period.</td></tr>
<tr><td>Numerator</td><td colspan="2">Discharges not Readmitted within 90 Days: Those discharges for which CBH did not receive a claim for Non-Hospital Residential Rehabilitation, Residential Independent Non-Hospital Treatment, or Psychiatric Inpatient (including Extended Acute Care) or Detoxification/Withdrawal Management levels of care within 90 days from the date of discharge of their initial Non-Hospital Residential Rehabilitation LOC or RINT Treatment.</td></tr>
</table>

NHRR05 THRESHOLDS

LONG-TERM THRESHOLDS

At or Above	79.0%	3
Between	71.6% to 79.0%	1.5
Below	71.6%	0

SHORT-TERM THRESHOLDS

At or Above	72.7%	3
Between	56.7% to 72.7%	1.5
Below	56.7%	0

WOMEN WITH CHILDREN THRESHOLDS

At or Above	73.5%	3
Between	65.5% to 73.5%	1.5
Below	65.5%	0

RINT THRESHOLDS

At or Above	66.4%	3
Between	64.4% to 66.4%	1.5
Below	64.4%	0

NHRR05 *(New, Contextual)*: Percent of Discharges Receiving Methadone or Buprenorphine within 7 Days or Vivitrol or Sublocade within 35 Days

<table>
<tr><td>Rationale</td><td colspan="2">Compared to non-pharmacological therapies, people receiving medications for opioid use disorder OUD (MOUD), which are evidence-based pharmacological treatments for OUD, remain in treatment longer, have reduced illicit opioid use or prescription opioid misuse, and are at lower risk of opioid-related harms, including overdose and death. Therefore, we measure the extent to which members being discharged from ASAM Residential are receiving MOUD soon after discharge as a proxy indicator of MOUD induction during residential treatment.</td></tr>
<tr><td>Definition</td><td colspan="2">Percent of discharges with a Methadone or Buprenorphine claim within 7 days, or a Vivitrol or Sublocade claim within 35 days</td></tr>
<tr><td></td><td>Eligible Population (Inclusion Criteria)</td><td>• Philadelphia County HealthChoices (CBH) funded members that were discharged from a Non-Hospital Residential Rehabilitation center during the measurement year.
• CBH funded members that do not have commercial or other insurance coverage (i.e. Medicare)
• Member must be continuously eligible for Philadelphia County HealthChoices funding for at least 90 days following their discharge from Non-Hospital Residential Rehabilitation.
• Members must be at least 6 years of age and younger than 65 years of age.</td></tr>
<tr><td></td><td>Do Not Include</td><td>• Members who have insurance coverage other than HealthChoices
• If the member is transferred to another Residential Rehabilitation Center, Psychiatric Inpatient, Extended Acute Care or Detoxification Center
• If the member has a Discharge Status Code of 20 (deceased)</td></tr>
<tr><td></td><td>If a member has multiple discharges during the measurement period</td><td>…the member is considered to have multiple episodes. Therefore, although a member may be included in the discharge count of more than one provider or of one provider multiple times during the reporting year, each discharge will be counted once.</td></tr>
<tr><td>Denominator</td><td colspan="2">Qualifying Discharges: Of the eligible population listed above, discharges during the measurement period with a primary or non-primary OUD diagnosis:
<table><tr><td>F11.1XX (excluding F11.11, in remission) – Opioid abuse</td></tr><tr><td>F11.2XX (excluding F11.21, in remission) – Opioid dependence</td></tr></table></td></tr>
</table>

Numerator	**Discharges receiving MOUD:** Of the qualifying discharges, those that meet one of the following conditions: Methadone claim within 7 days, or Buprenorphine claim within 7 days, or Vivitrol claim within 35 days, or Sublocade claim within 35 days.

Children's Blended Generic Targeted Case Management (TCM)

Levels of Care

Levels of Care included	Includes CBH Level of Care 800.009, 800.018 and 800.033

Measurement Period

P4P Measurement Period	The Measurement Period is July 1, 2021 – June 30, 2022

Episode

Definition	A new TCM episode is defined as one where the person has not had a TCM visit within that level of care and that provider for a 31-day period prior to that claim.

Definition of Age

Age	In TCM a "child" can be up to 21 years of age, while within CBH "child" refers to individual's younger than 18. • For providers with child-specific services, age was disregarded • For providers of adult TCM or ACT services only, age was disregarded • Otherwise persons are divided based on age following CBH's definition.

Measures Included for Children's Blended Generic Case Management

Measure Label	Practice Guidelines Domain	Measure Description
TCM01	Screening, Assessing, Service Planning and Delivery	Percent of Authorizations Having At Least One 31-Day Gap Between Services
TCM03	Screening, Assessing, Service Planning and Delivery	Percent of Individuals Having At Least One Inpatient Admission
TCM04	Screening, Assessing, Service Planning and Delivery	Percent of TCM-Authorized Individuals Having TCM Contact Within 2 Days of Inpatient Admission
TCM05	Continuing Support and Early Re-Intervention	Percent of TCM-Authorized Individuals Having TCM Contact Within 7 Days of Inpatient Discharge

TCM01: Percent of Authorizations Having At Least One 31-Day Gap Between Services

Rationale	To measure the continuity of service provided to CBH-funded TCM members. Continuity of care is an important measure as we believe that the likelihood of recovery is improved when services are consistent and continuous.	
Definition	Percentage of CBH members with one or more 31-day gaps in service observed among all members receiving services from the reporting provider in the measurement period.	
	Eligible Population (Inclusion Criteria)	• Philadelphia County HealthChoices (CBH) members who at any point during the measurement period had a TCM authorization. • Member must have multiple claims spanning at least 31 days during the measurement period.
	Exclude	• The time between the authorization open date and the date of the first claim and the time between the date of the last claim and the authorization close date. Therefore, if either of these time periods lasts 31 days, that period is not counted as a gap in service • Members that have insurance coverage other than Philadelphia County HealthChoices • Authorizations in which the member lost CBH eligibility for 15 days or more • Any 31-day gaps in service that occur before the date the authorization was generated
	Count the event when	…at any time during the measurement period after the authorization date, the member has had a period of 31 days since the last paid CBH claim on the authorization, unless that claim is the last claim billed to that authorization in the measurement period.
	If a client is authorized for TCM services with multiple providers during the same time period	…the member is considered to have multiple episodes with overlapping time periods. Therefore, a member may be included in the denominator of more than one provider.
	If there are multiple gaps during an authorization	…a member is only counted in the numerator once, regardless of the number of 31-day gaps in service.
Denominator	**Members Served:** The total number of members with multiple CBH paid claims for a specific authorization with the given provider and level of care in the measurement period. These paid claims must span at least 31 days in the measurement period.	

Numerator	**Members with Observed Gaps in Service:** Of the members served, the number of members for whom at least one 31-day gap in TCM service is observed for the provider in question.

TCM01 THRESHOLDS AND POINTS

Above	20.0%	0
Between	10.0% to 20.0%	0.5
At or Below	10.0%	1

TCM03: Percent of Individuals Having At Least One Inpatient Admission

Rationale	As it is expected that successful TCM engagement will in most cases foster connections to services that will over time, reduce the need for inpatient admissions. It is also expected that better engaged individuals will have lower hospital utilization rates.	
Definition	Percentage of TCM members who have one or more inpatient episodes during the measurement period while they are receiving CBH-funded TCM services.	
	Eligible Population (Inclusion Criteria)	• Philadelphia County HealthChoices (CBH) members who at any point during the measurement period had a TCM authorization. • Member must have a TCM treatment dosage of at least 90 days
	Exclude	• Members that have insurance coverage other than Philadelphia County HealthChoices • Members that do not have a TCM treatment dosage of at least 90 days • Members that are authorized for TCM during the measurement period that were not admitted to Psychiatric Inpatient or Extended Acute Services
	When there is a gap in service	…of 60 days without a CBH TCM claim for a given provider and level of care combination, a break in the episode is indicated. The episode end date is the last day the member received TCM services before this gap.
	If a client is authorized for TCM services with multiple providers	…the member is considered to have multiple episodes with overlapping time periods. Therefore, a member may be included in the denominator of more than one provider.
Denominator	**Qualifying Members:** During the measurement year, members that are authorized for TCM with at least a 90 Day TCM Treatment Dosage	
Numerator	**Members Admitted to IP:** Of the Qualifying Members, those that were admitted to a CBH-funded Psychiatric Inpatient facility during that episode. The admission can take place at any point during or after the 90-day required "dose" of TCM services.	

TCM03 THRESHOLDS AND POINTS

Above	15.0%	0
Between	10.0% to 15.0%	1
At or Below	10.0%	2

TCM04: Percent of TCM Authorized Individuals Having a TCM Contact Within 2 Days of Inpatient Admission

Rationale	To measure provider compliance with TCM standards and consistency with practice guidelines. Continuity of care is an important measure, as we believe that the likelihood of recovery is improved when services are consistent and continuous.	
Definition	Percentage of inpatient episodes for which a CBH TCM claim is made within two days following the date of admission to an Inpatient Psychiatric Facility.	
	Eligible Population (Inclusion Criteria)	• Philadelphia County HealthChoices (CBH) members who at any point during the measurement period had a TCM authorization • Must have at least one paid TCM claim associated with the authorization • Member must have been admitted to a Psychiatric Inpatient Facility during the measurement year and during the TCM Authorization • Member must be authorized for TCM services at the time of their Psychiatric Inpatient admission
	Exclude	• Members that have insurance coverage other than Philadelphia County HealthChoices • Member was not authorized for TCM services at the time of admission to the Psychiatric Inpatient • Member's Psychiatric Inpatient episode did not occur during the measurement year or during the members TCM authorization
	When there are multiple authorizations	…include all CBH authorizations (TCM and Psychiatric Inpatient) for members who have more than one authorization in the measurement period.
Denominator	**Qualifying Authorizations:** During the measurement year, members that are authorized for TCM with at least one paid claim associated to their authorization and have been admitted to a Psychiatric Inpatient facility during the TCM authorization.	
Numerator	**Episodes Receiving TCM Services Within Two Days of Admission:** Of the Qualifying Authorizations, any inpatient episode for which the client has a TCM claim with the specified provider and level of care within two days of the inpatient admission date.	

TCM04 THRESHOLDS AND POINTS

At or Above	90.0%	1
Between	80.0% to 90.0%	0.5
Below	80.0%	0

Please note, there has been a change in scoring for TCM04: Providers that had **zero acute inpatient admissions**

within the reporting period (a rate of 0% for TCM03) will also receive **one (1) point** on this measure, to acknowledge the work that the provider has done in successfully keeping members in the community.

TCM05: Percent of TCM Authorized Individuals Having a TCM Contact Within 7 Days of Inpatient Discharge

Rationale	To measure provider compliance with TCM standards and consistency with practice guidelines. Continuity of care is an important measure as we believe that the likelihood of recovery is improved when services are consistent and continuous.	
Definition	Percentage of inpatient episodes for which a CBH TCM claim is made within seven days following the date of discharge from an Inpatient Psychiatric Facility.	
	Eligible Population (Inclusion Criteria)	• Philadelphia County HealthChoices (CBH) members who at any point during the measurement period had a TCM authorization • Must have at least one paid TCM claim associated with the authorization • Member must have been admitted to a Psychiatric Inpatient Facility during the measurement year and during the TCM Authorization • Member must be authorized for TCM services at the time of their Psychiatric Inpatient discharge
	Exclude	• Members that have insurance coverage other than Philadelphia County HealthChoices • Member was not authorized for TCM services at the time of discharge from the Psychiatric Inpatient • Member's Psychiatric Inpatient episode did not occur during the measurement year or during the members TCM authorization
	When there are multiple authorizations	…include all CBH authorizations (TCM and Psychiatric Inpatient) for members who have more than one authorization in the measurement period.
Denominator	**Qualifying authorizations:** During the measurement year, members that are authorized for TCM with at least one paid claim associated to their authorization and have been discharged from a Psychiatric Inpatient facility that occurred during the TCM authorization.	
Numerator	**Members Receiving TCM Services Within Seven Days of Discharge:** Of the Qualifying Authorizations, any inpatient episode for which the client has a TCM claim with the specified provider and level of care within seven days of the inpatient discharge date.	

TCM05 THRESHOLDS AND POINTS

At or Above	90.0%	1
Between	80.0% to 90.0%	0.5
Below	80.0%	0

Please note, there has been a change in scoring for TCM05: Providers that had **zero acute inpatient admissions** within the reporting period (a rate of 0% for TCM03) will also receive **one (1) point** on this measure, to acknowledge the work that the provider has done in successfully keeping members in the community.