

# Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover



# Webinar 8: Non-Required BHC Measures

Presented by the Substance Abuse and  
Mental Health Services Administration  
September 6, 2016



# Speaker

**Peggy O'Brien, PhD, JD**

*Truven Health Analytics, an IBM company*

# Logistics

- **Chat function**
- **Poll questions**
- **Slide and webinar availability**

# Webinar Schedule

- 1: July 12: Introduction and Background – **States and BHCs**
- 2: July 19: State-Reported Measures – **States Only**
- 3: July 26: State-Reported Measures – **States Only**
- 4: August 2: Clinic-Reported Measures – **States and BHCs**
- 5: August 9: Clinic-Reported Measures – **States and BHCs**
- 6: August 16: Special Issues – **States and BHCs**
- 7: August 23: Special Issues – **States and BHCs**
- 8: September 6: Non-Required Measures – **States Only**

All scheduled for Tuesdays 2:00 to 3:30 pm ET

# Focus Today

## Non-required measures:

- **BHC-Lead**
- **State-Lead**

## Outstanding questions

# Non-Required Measures

- **Routine Care Needs (ROUT)**
- **Time to Comprehensive Person and Family-Centered Diagnostic and Treatment Planning Evaluation (TX-EVAL)**
- **Deaths by Suicide (SUIC)**
- **Documentation of Current Medications in the Medical Records (DOC)**
- **Controlling High Blood Pressure (CBP-BH)**
- **Suicide Attempts (SU-A)**
- **Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)**
- **Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)**
- **Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (AMS-BD)**



# BHC-Lead Non-Required

# Age and Stratification (BHC-Lead Measures)

Measure	Age Coverage	Stratification
Routine Care Needs (ROUT)	All ages	Medicaid, Dual Medicare & Medicaid, Other
Time to Comprehensive Person and Family-Centered Diagnostic and Treatment Planning Evaluation (TX-EVAL)	Requirement applies to all ages but stratification and reporting apply to those 12 years and older	Medicaid, Dual Medicare & Medicaid, Other Ages 12 to 17, Ages 18 and older
Deaths by Suicide (SUIC)	Ages 12 years and older	Medicaid, Dual Medicare & Medicaid, Other Ages 12 to 17, Ages 18 to 64, Ages 65+
Documentation of Current Medications in the Medical Records (DOC)	Ages 18 years and older	Medicaid, Dual Medicare & Medicaid, Other
Controlling High Blood Pressure (CBP-BH)	Ages 18 to 85 years	Medicaid, Dual Medicare & Medicaid, Other Ages 18 to 64, Ages 65 to 85

# Routine Care Needs (ROUT) (1)

- **Denominator:** To include all new consumers (not seen in the last 6 months)
- **Denominator Measurement Period (MP):** The MY plus the preceding 6 months
- **Why?** To capture those not seen in the last 6 months
- **Numerator:** All denominator eligible consumers determined to need routine care
- **Numerator MP:** The MY
- **Why?** Within the MY, what percent met criteria for routine care

Year before MY1	MY1
	Numerator MP
	Denominator MP

# Routine Care Needs (ROUT) (2)

- Routine Care Needs:
  - *Based on a preliminary screening and risk assessment*
  - *Determined not to be of an emergency or urgent nature*
  - *Within the commonly accepted meaning of those terms in a behavioral health setting*
- A new consumer: An individual not seen at the clinic in the past 6 months
- Appendix ROUT includes a sample calculation.
- Neither high nor low percentages represent higher quality *per se*.

# Time to Comprehensive Person and Family-Centered Diagnostic and Treatment Planning Evaluation (TX-EVAL) (1)

This metric measures the mean number of days after 1<sup>st</sup> contact until the comprehensive treatment planning evaluation is performed for new consumers.

- **Denominator:** The number of new consumers who contacted the BHC seeking services during the measurement year (MY)
- **Denominator Measurement Period (MP):** The MY excluding the last 90 days of the MY and including the 6 months preceding the MY
- **Why?** To only include those who are new and to leave 90 days for completion
- **Numerator:** The total number of days between first contact and completion of the comprehensive evaluation for all members of the eligible population seen at the provider entity during the MY
- **Numerator MP:** The MY
- **Why?** To capture the total number of days it took for all eligible treatment evaluations

<b>Year before MY1</b>	<b>MY1</b>
	<b>Numerator MP</b>
	<b>Denominator MP</b>

# Time to Comprehensive Person and Family-Centered Diagnostic and Treatment Planning Evaluation (TX-EVAL) (2)

## Key Definitions:

- **Comprehensive Person-Centered and Family-Centered Diagnostic and Treatment Planning Evaluation:**
  - *Based on CCBHC certification criteria, establishes time requirements for completion of comprehensive treatment planning evaluations.*
  - *For a CCBHC, the certification criteria require that all new consumers receive a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation to be completed within 60 calendar days of the first request for services.*
  - *Other standards may exist for other entities and this specification can be adapted.*
- **New Consumer:** An individual not seen at the clinic in the past 6 months

## Appendix TX-EVAL: Example calculation

# Deaths by Suicide (SUIC) (1)

- **Denominator:** The number of consumers ages 12 and older seen at the BHC during the Measurement Year (MY)
- **Denominator Measurement Period (MP):** The MY
- **Why? Only want to capture those seen during the MY**
- **Numerator:** Denominator-eligible consumers who died by suicide in MY
- **Numerator MP:** The MY
- **Why?** Only want to capture suicide deaths for those seen during the MY

Year before MY1	MY1
	<b>Numerator MP</b>
	<b>Denominator MP</b>

# Deaths by Suicide (SUIC) (2)

- **Exclude from denominator and numerator:** If cause of death is unknown.
- **Appendix SUIC:** Example calculation
- **Limitations:** Complete accuracy depends on knowledge of consumer intent and cause of death for all consumers seen in the measurement year. We acknowledge that coroner's data will be more accurate and states should feel free to compare the results of this metric to those data. The data reported for this metric, however, should follow the specifications.

# Documentation of Current Medications in the Medical Records (DOC) (1)

- **Denominator:** The number of eligible encounters during the Measurement Year (MY) by consumers age 18 and older
- **Denominator Measurement Period (MP):** The MY
- **Why?** To capture all seen during the MY
- **Numerator:** The number of consumers for whom an eligible professional attests to documenting, updating, or reviewing consumer's current medications using all immediate resources available on the date of the encounter. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency, and route.
- **Numerator MP:** The MY
- **Why?** To capture documentation for all seen during the MY

Year before MY1	MY1
	<b>Numerator MP</b>
	<b>Denominator MP</b>

# Documentation of Current Medications in the Medical Records (DOC) (2)

- Uses medical records data (including billing records)
- Report for every eligible encounter during the MY (encounter codes and age)
- Requires an “eligible provider” perform the documentation, defined as “a licensed professional eligible to prescribe medication as defined by the respective state in which the provider entity is located”

# Documentation of Current Medications in the Medical Records (DOC) (3)

- Denominator exclusion: Urgent or emergent medical situation where time is of the essence and delay would jeopardize health status (must be documented (**CODE G8430**))
- Numerator compliance:
  - *Eligible professional documented obtained, updated, or reviewed medications* → Numerator met (**CODE G8427**)
  - *List of medications not documented as obtained, updated, or reviewed, no reason given* → Numerator NOT met (**CODE G8428**)
- If documentation is not available for numerator or exclusion data elements, the consumer does not meet the criteria for the numerator or exclusion, respectively.
- Higher rate of documented review equates to higher quality

# Controlling High Blood Pressure (CBP-BH) (1)

- **Denominator:** Consumers ages 18 to 85 seen during the Measurement Year (MY) who are hypertensive
- **Denominator Measurement Period (MP):** The first 6 months of the MY
- **Why?** To provide time to attain control of BP
- **Numerator:** Denominator-eligible consumers whose BP is adequately controlled during the MY
- **Numerator MP:** The MY
- **Why?** To measure adequacy of BP control for those diagnosed early in the year

Year before MY1	MY1
	<b>Numerator MP</b>
	<b>Denominator MP</b>

# Controlling High Blood Pressure (CBP-BH) (2)

## Controlling High Blood Pressure (CBP-BH)

Based on a measure stewarded by the  
National Committee for Quality Assurance (NQF #0018, HEDIS 2016)

### A. DESCRIPTION

Percentage of consumers ages 18 to 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year based on the following criteria:

- Consumers ages 18 to 59 whose BP was <140/90 mm Hg
- Consumers ages 60 to 85 with a diagnosis of diabetes whose BP was <140/90 mm Hg
- Consumers ages 60 to 85 without a diagnosis of diabetes whose BP was <150/90 mm Hg

A single rate is reported and is the sum of all three groups.

**Data Collection Method:** Hybrid

#### Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. It also is stratified by age as discussed immediately below. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- This measure applies to consumers 18 to 85 years of age. BHCs should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 85. The numerator for consumers ages 18 to 64 will include consumers 18 to 59 years of age who meet the first criterion added to consumers 60 to 64 years of age who meet the second or third criteria. The rate for consumers 65 to 85 years of age will include all consumers in that age group who meet the second or third criteria: diagnosis of diabetes with BP < 140/90 mm Hg or no diagnosis of diabetes with BP of <150/90 mm Hg.

- Different BP levels used as criteria for “controlled” based on age (18-59, 60-85) and diabetes status
- Stratified by payer and age (18-64, 65-85)

Stratify	Include
18-64	18-59 meet 1 <sup>st</sup> criterion
18-64	60-64 meet 2 <sup>nd</sup> or 3 <sup>rd</sup> criterion
65-85	65-85 who meet 2 <sup>nd</sup> or 3 <sup>rd</sup> criterion

# Controlling High Blood Pressure (CBP-BH) (3)

## C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 18 to 85 years as of the last day of the measurement year
Continuous Enrollment	The measurement year
Allowable Gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a consumer for whom enrollment is verified monthly, the consumer may not have more than a 1-month gap in coverage (i.e., a consumer whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	The last day of the measurement year
Benefit	Medical

CRITERIA	REQUIREMENTS
Event/diagnosis	<p>Follow the steps below to identify the eligible population:</p> <p><i>Step 1</i> Identify consumers flagged as having been seen at the provider entity at least once during the measurement year.</p> <p><i>Step 2</i> Identify consumers from step 1 who were 18 to 85 years of age as of the end of the measurement year.</p> <p><i>Step 3</i> Identify consumers from step 2 who are hypertensive by identifying those with at least one outpatient visit (<u>Outpatient Without UBREV Value Set</u>) with a diagnosis of hypertension (<u>Essential Hypertension Value Set</u>) during the first six months of the measurement year.</p>

- Age
- Continuous enrollment
- Eligible Population
  - *Seen at the provider*
  - *Age 18-85 at end of MY*
  - *Hypertensive during 1<sup>st</sup> 6 months of MY (one outpatient visit with hypertension diagnosis)*

# Controlling High Blood Pressure (CBP-BH) (4)

CRITERIA	REQUIREMENTS
Diabetes flag for the numerator (cont'd)	<p>After the Eligible Population is identified, assign each consumer a diabetic or not diabetic flag using only administrative data and the steps below. The flag is used to determine the appropriate BP threshold to use during numerator assessment (the threshold for consumers with diabetes is different than the threshold for consumers without diabetes).</p> <p><i>Step 1</i> Assign a flag of diabetic to consumers who were identified as diabetic using claims/encounter data or pharmacy data. The BHC must use both methods to assign the diabetes flag, but a consumer only needs to be identified by one method. Consumers may be identified as having diabetes during the measurement year or the year prior to the measurement year.</p> <p>1. <b>Claims/encounter data.</b> Consumers who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):</p> <ul style="list-style-type: none"> <li>At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED visits (<u>ED Value Set</u>), or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) on different dates of service, with a diagnosis of diabetes (<u>Diabetes Value Set</u>). Visit type need not be the same for the two visits.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a diagnosis of diabetes (<u>Diabetes Value Set</u>).</li> </ul> <p>2. <b>Pharmacy data.</b> Consumers who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (refer to Table CBP-A in Appendix CBP-BH).</p>
Diabetes flag for the numerator (cont'd)	<p><i>Step 2</i> From consumers identified in Step 1, assign a flag of "not diabetic" to consumers who do not have a diagnosis of diabetes (<u>Diabetes Value Set</u>), in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (<u>Diabetes Exclusions Value Set</u>), in any setting, during the measurement year or the year prior to the measurement year.</p> <p>Note: Consumers classified as diabetic in step 1 based on pharmacy data alone and who had a diagnosis of gestational or steroid-induced diabetes as specified above are re-classified as not diabetic in this step.</p> <p><i>Step 3</i> For consumers who were not assigned a flag in step 1 or step 2, assign a flag of "not diabetic."</p>

## Diabetes flag for numerator

- Determines appropriate BP threshold
- Must look at both claims/encounter data and pharmacy data

# Controlling High Blood Pressure (CBP-BH) (5)

## Hybrid Specification:

- **Denominator:**

- *Sample medical records*
- *Notation of hypertension up to end of first half of MY*
- *Types and location of notation listed*
- *If diagnosis not confirmed, exclude the consumer*

- *Identifying the medical record:*

- **Instructions regarding PCP or other provider records**
- **Use one medical record for diagnosis of hypertension and representative BP**

- **Numerator:**

- *Utilize medical records*

# Controlling High Blood Pressure (CBP-BH) (6)

## Medical Records Specification

- **Step 1: Most recent BP reading during MY after diagnosis was confirmed**
  - *Some readings excluded*
  - *Multiple readings*
- **Step 2: Numerator**
  - *Not compliant if not a complete reading or did not meet threshold*
- **Step 3: Stratification**

## Exclusions:

- *End-stage renal disease or kidney transplant*
- *Diagnosis of pregnancy*
- *Non-acute inpatient admission during the MY*
- **Must use administrative data to assign diabetes flag (with minor exceptions)**

**Questions?**



# State-Lead Non-Required

# Age and Stratification (State-Lead Measures)

<b>Measure</b>	<b>Age Coverage</b>	<b>Stratification</b>
Suicide Attempts (SU-A)	Ages 12 years and older	Medicaid, Dual Medicare & Medicaid, Other Ages 12 to 17, Ages 18 to 64, Ages 65+
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Ages 1 to 17 years	Medicaid, Dual Medicare & Medicaid, Other Ages 1 to 5, Ages 6 to 11, Ages 12 to 17, total
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	Ages 18 to 64 years	Medicaid, Dual Medicare & Medicaid, Other
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (AMS-BD)	Ages 18 years and older	Medicaid, Dual Medicare & Medicaid, Other

# Suicide Attempts (SU-A) (1)

- **Denominator:** Consumers age 12 years and older seen during the first 11 months of the MY
- **Denominator Measurement Period (MP):** First 11 months of Measurement Year (MY)
- **Why?** To allow time for medical services to have occurred if the attempt was near the end of the year
- **Numerator:** The number of consumers in the eligible population who attempted suicide at least once during the MY, where the suicide attempt resulted in injury requiring medical services during the MY
- **Numerator MP:** The MY
- **Why?** To capture all those seen during the MY who made a suicide attempt

Year before MY1	MY1
	Numerator MP
	Denominator MP

# Suicide Attempts (SU-A) (2)

- **Fatal or non-fatal attempts resulting in use of medical services**
- **Uses administrative claims data**
- **Limitations: Complete accuracy depends on knowledge of consumer intent and accurate coding that reflects suicidality. This measure also only captures suicide attempts that result in billing for services and does not include some individuals who die before receiving any medical services.**

# Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) (1)

- **Denominator:** Consumers aged 1–17 years with diabetes who had two or more antipsychotic prescriptions during the Measurement Year (MY)
- **Denominator Measurement Period (MP):** The MY and the year before
- **Why?** To identify those with diabetes or certain exclusions
- **Numerator:** Denominator-eligible consumers who had metabolic monitoring during the MY
- **Numerator MP:** The MY
- **Why?** To identify those with monitoring during the MY

Year before MY1	MY1
	Numerator MP
Denominator MP	

# Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) (2)

## Administrative Data Source

### Eligible Population/

### Denominator:

- *Seen at the provider during MY*
- *Ages 1-17 at end of MY*
- *At least 2 antipsychotic dispensing events on two or more dates during MY*
- *See definitions and sources*

### Numerator:

- *At least one blood glucose or HbA1c test*
- AND*
- *At least one test for LDL-C or cholesterol*

# Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)(1)

- **Denominator:** Consumers 18–64 years of age with schizophrenia and cardiovascular disease
- **Denominator Measurement Period (MP):** The MY and the year before
- **Why?** To identify those with cardiovascular disease
- **Numerator:** Denominator-eligible consumers with LDL-C test during the MY
- **Numerator MP:** The MY
- **Why?** To identify those with LDL-C test during the MY

Year before MY1	MY1
	Numerator MP
Denominator MP	

# Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)(2)

- **Administrative data source**
- **Eligible Population/ Denominator:**
  - *Seen at the BHC*
  - *Age 18-64 at end of MY*
  - *Schizophrenia based on encounter and diagnoses requirements*
  - *Cardiovascular disease based on encounter, procedure, and/or diagnoses*
- **Numerator:**
  - *LDL-C test during MY (claim or laboratory data)*

# Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (AMS-BD) (1)

- **Denominator:** Consumers at least 18 years of age with Bipolar I Disorder who had at least 2 prescription drug claims for mood stabilizer medications
- **Denominator Measurement Period (MP):** The Measurement Year (MY)
- **Why?** To identify those with claims during the MY
- **Numerator:** Denominator-eligible consumers with a Proportion of Days Covered (PDC) of at least 0.8 for mood stabilizer medications
- **Numerator MP:** The MY
- **Why?** To assess adherence during the MY

Year before MY1	MY1
	Numerator MP
	Denominator MP

# Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (AMS-BD) (2)

- **Administrative data source**
- **Eligible Population/ Denominator:**
  - *Seen at provider during MY*
  - *18 or older at beginning of MY*
  - *Diagnosis of Bipolar I Disorder in inpatient or outpatient claims data (criteria differ by setting) during the MY*
  - *At least 2 prescription drug claims for mood stabilizers on different dates during the MY*
- **Numerator:**
  - *With a Proportion of Days Covered (PDC) of at least 0.8 for mood stabilizer medications*
  - *PDC calculation in definitions*



# Questions?

# Poll Question

**Question is for states only:**

**Do you plan to use any of the non-required BHC measures?**

*(Please select all applicable answers)*

- 1. Yes, as part of the CCBHC demonstration as an optional Quality Bonus Measure**
- 2. Yes, as part of the CCBHC demonstration but not as an optional Quality Bonus Measure**
- 3. Yes, including outside the CCBHC demonstration**
- 4. Not sure yet, possibly**
- 5. No**

# Outstanding Questions

# When is Someone a CCBHC Consumer – DCO Visits

**Question: Identification of CCBHC consumers who are established patients at the CCBHC: What data source should be used to establish whether or not DCO care was coordinated by the CCBHC for a patient who receives care at a DCO after the initiation of the demonstration year, but before receiving service from the CCBHC?**

- **For BHC-reported measures, this will be information the BHC has. For state-reported measures, unless there is a care coordination code that the BHC uses which is submitted with other Medicaid (and in the case of dually eligible, Medicare) data to the state, there will be no way to determine this. You should look at codes governing post-discharge transitional care coordination and codes governing complex care coordination, evaluation, and management. Some require face to face interaction with the patient and will be less useful in this situation, while others allow interaction between providers without the patient being present.**

# Basics -- Timing for Reporting

- **Cost report: 6 months** after end of demonstration year
- **BHC-lead measures: 9 months** after end of demonstration year
- **State-lead measures: 12 months** after end of demonstration year

**Example: For a demonstration year from 1/1/2017-12/31/2017:**

- *Cost report due June 30, 2018*
- *BHC-lead measures due September 30, 2018*
- *State-lead measures due December 31, 2018*

# Basics – State-Lead Data & Stratification

For state-lead measures, the state is only expected to report:

- Medicaid only beneficiaries
- Dually eligible Medicare/Medicaid beneficiaries

The state is **not** expected to report “Others” for state-lead measures

# Basics -- Medicaid and Commercially Insureds

**Question: For stratification purposes, if the consumer has both private insurance and Medicaid, will we consider this consumer as Medicaid or as other?**

- *If the Medicaid insurance covers the services that are part of the demonstration, they should be considered Medicaid. If the Medicaid does not, they are stratified as “other.” An example of limited Medicaid coverage would be those who receive it only for family planning purposes. Because demonstration services are not covered, those individuals are stratified as “others.”*

# Basics – Measurement Year

- **For CCBHCs, the measurement year (MY) is the state's demonstration year (DY)**
  - *If the state's DY1 is January 1-December 31, 2017, that is also the MY*
  - *If the state's DY1 is July 1-June 30, 2017, that is also the MY*

# Basics --Data Reporting Templates

- **Data reporting templates are what you must use to submit the quality measures**

# Case Load Characteristics (1)

Case Load Characteristics		
Characteristic	Number	Percent
<b>Age</b>		
0-11 years		
12-17 years		
18-64 years		
65+ years		
<b>Gender</b>		
Women		
Men		
Other		
Unknown		
<b>Ethnicity</b>		
Not Hispanic or Latino		
Hispanic or Latino		
Unknown		
<b>Race</b>		
White		
Black or African American		
American Indian or Alaskan Native		
Asian		
Native Hawaiian or Pacific Islander		
More than one Race		
Unknown		
<b>Insurance Status</b>		
Medicaid		
CHIP		
Medicare		
Medicare and Medicaid Dually-Eligible		
VHA/TRICARE		
Commercially insured		
Uninsured		
Other		
<b>Veteran or Military Status</b>		
Active Duty Military		
Prior Military Service/Veteran		
Neither		

# Case Load Characteristics (2)

## Questions related to Case Load Characteristics:

- Applies to **entire** CCBHC consumer population
- **Veteran** or military status rows: Type of discharge does not matter
- To determine **age**, use age at time of first visit in measurement year
- To determine **payer**, use payer status at time of first visit in measurement year

# Basics -- Code Issues -- Who Can Deliver Services

**States have identified problems because they would like to have a non-physician provide services using codes normally applied to a physician (e.g., medical assistant screening for BMI).**

- Will the person be working within their scope of practice as credentialed within the state (per state licensing laws, etc)?**
- Are they providing the services under the personal supervision of a person licensed to practice medicine (42 CFR §440.50(a)(2))?**

# Basics -- Code Issues – Codes Not Available

States have identified problems because they may not have activated certain codes required to establish an eligible encounter in the specification or value sets.

- Preferred: See if the codes can be activated
- If not and you are using other codes: The state may identify those codes and CCBHCs may use them **AS LONG AS:**
  - *It is completely transparent: States provides and maintains list of codes*
  - *It is consistent: All CCBHCs and similar BHCs in the state are using those codes in that way*
- If not that (e.g., some G codes) and the measure is a BHC-lead measure: The BHC can capture the information in a clear way in their EHR and provide documentation of how they are doing it for the evaluation team.

# Depression Remission at 12 Months (DEP-REM-12) – Measurement Period (1)

**Question: The numerator measurement period (MP) spans MY1 and MY2 and one month into MY3 and the denominator would encompass MY1 only. How do we use this MP and still report this BHC-Lead measure annually within 9 months of the end of the demonstration year?**

- You will need to stop including people at a certain point. Exclude from the denominator and numerator those for whom the 12 months ( $\pm$  30 days) has not lapsed when the data must be reported.**
- E.g.: With a MY from 1/1/2017-12/31/2017, data must be reported by 9/30/2018. The last index date you can include would be 8/31/2017, obtained by counting back 13 months from the reporting date.**

# Depression Remission at 12 Months (DEP-REM-12) – Measurement Period (2)

Year before MY 1	MY1		MY2		Year after MY2
	Numerator MP				
	Denominator MP (post-index)				
MY 1	MY2		Year after MY2		Two years after MY2
	Numerator MP				
	Denominator MP (post-index)				



# Alcohol Screening and Brief Counseling (ASC)—Existing Diagnosis

**Question: Do we have to screen those who already have an active diagnosis of an alcohol use disorder?**

- **Consumers with an active diagnosis of alcohol use disorder can be excluded from the denominator and numerator using the “exception” of:**

*Documentation of medical reason(s) for not screening for unhealthy alcohol use in the measurement year or the year prior (e.g., limited life expectancy, **other medical reasons**) (G9623)*

# I-EVAL Average -- Clarifications

The second metric is the average number of days until initial evaluation.

- Count **actual days** for the average (not business days)
- Do not include in the average (D or N) those who **never received a required initial evaluation**. Exclude and note in the Additional Notes on the data reporting template the number of individuals excluded for this reason.
- I-EVAL resource

# Suicide Risk Assessment Measures

Are these measure person based or **EPISODE BASED?**

- **SRA-BH-C (EHR data):**

- *Percentage of **visits** for those 6-17 with diagnosis of MDD and SRA was performed*

- **SRA-A:**

- *EHR data: Percentage of **visits** for those 18 & older with active diagnosis of MDD and SRA was performed*
- *Medical records: Percentage of **visits** for those 18 & older with new or recurrent diagnosis of MDD and SRA was performed*



# Questions?

# BHC Measures (1)

Measure	State or BHC Lead	CCBHC Required	CCBHC Not Required	Webinar
SSD	State	✓	n/a	2
SAA-BH	State	✓	n/a	2
ADD-BH	State	✓	n/a	2
AMM-BH	State	✓	n/a	2
IET-BH	State	✓	n/a	2
PCR-BH	State	✓	n/a	2
FUM	State	✓	n/a	3
FUA	State	✓	n/a	3
FUH-BH-A	State	✓	n/a	3
FUH-BH-C	State	✓	n/a	3
HOU	State	✓	n/a	3
PEC	State	✓	n/a	3
Y/FEC	State	✓	n/a	3

# BHC Measures (2)

Measure	State or BHC Lead	CCBHC Required	CCBHC Not Required	Webinar
I-EVAL	BHC	✓	n/a	4
BMI-SF	BHC	✓	n/a	4
TSC	BHC	✓	n/a	4
ASC	BHC	✓	n/a	4
CDF-BH	BHC	✓	n/a	5
WCC-BH	BHC	✓	n/a	5
SRA-BH-C	BHC	✓	n/a	5
SRA-A	BHC	✓	n/a	5
DEP-REM-12	BHC	✓	n/a	5

# BHC Measures (3)

Measure	State or BHC Lead	CCBHC Required	CCBHC Not Required	Webinar
ROUT	BHC	n/a	✓	8
TX-EVAL	BHC	n/a	✓	8
SUIC	BHC	n/a	✓	8
DOC	BHC	n/a	✓	8
CBP-BH	BHC	n/a	✓	8
SU-A	State	n/a	✓	8
APM	State	n/a	✓	8
SMC	State	n/a	✓	8
AMS-BD	State	n/a	✓	8

# Contact Information

Please submit additional questions to the mailbox below by September 22, 2016:

[CCBHC\\_Data\\_TA@samhsa.hhs.gov](mailto:CCBHC_Data_TA@samhsa.hhs.gov)

# Behavioral Health is Essential To Health



Prevention Works



Treatment is Effective



People Recover