2024 Clinic-Led Metrics FAQs

Use this document as a supplement to the Technical Specifications Manual.

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General Questions

Q. Where do we report commercially insured individuals with Medicaid in the caseload characteristics?

Per SAMHSA guidance, “the key determinant for actual stratifications will be if the Medicaid coverage includes the service for which a given measure is being calculated. For example, does the person’s Medicaid coverage encompass screening for depression or for alcohol use disorders? If so, stratify them as Medicaid (or CHIP, as appropriate)

for the CDF, DEP-REM-6, and ASC measures. For SDOH and I-SERV, if the person's Medicaid coverage includes any CCBHC behavioral health services, stratification as Medicaid makes sense. For the case load characteristics, we suggest using the same rule as for the SDOH and I-SERV measures, that, if the person's Medicaid coverage includes any CCBHC behavioral health services, include them as Medicaid (unless, of course, they are dully eligible for Medicare and Medicaid as well, in which case they should be included as dully eligible for Medicare and Medicaid)".

An example of limited Medicaid coverage would be those who receive it only for family planning purposes. Because CCBHC services are not covered, those individuals are stratified as "others."

Q. At what point does an individual become eligible for inclusion in metrics?

Individuals are included once they receive a CCBHC service- regardless of whether they received an intake. This includes crisis services. Any individual who received a service on the CCBHC Services Billing Matrix should be included in the caseload characteristics and the metrics.

Please review SAMHSA clarification on when an individual is included within the metrics.

Questions Regarding Time to Services (I-SERV)

Time to Initial Clinical Service

Q: What constitutes a clinical service?

Services listed on the CCBHC services billing matrix as eligible for a prospective payment system (PPS) rate are clinical services that count towards this metric. Please refer to the services billing matrix on the CCBHC website. This excludes crisis services, initial evaluation services, and comprehensive evaluation services.

Q: Does evaluation or treatment planning count as initial clinical service?

Evaluation and treatment planning do not count as an initial clinical service.

Q: Do crisis services count as initial clinical service?

Crisis services do not count as an initial clinical service. Crisis services are captured in Submeasure 1 of the I-SERV metric.

Q: Does a clinical service count if it occurs before the initial evaluation?

Yes. This Submeasure is counted from first contact and counts towards this metric even if it occurs before initial evaluation. If first contact is a clinical service, it is counted as 0 days since first contact.

Time to Initial Clinical Service

Q: If someone does not have a follow-up within 24 hours, does it get counted in the metric?

Yes. If there is a request for crisis services and a service is not provided within the 24 hours, it is still counted in the metric at whatever time it was provided. For example, if a service was not provided until 32 hours after the request, it shall be reported at 32 hours.

The only except is if the individual makes an additional request after 24 hours has passed and before services were provided for the initial call. The initial call is reported in the "Additional Notes" as having been unmet and a new crisis episode starts.

Q: If there is an additional call within the 24-hour period, is it considered a new crisis episode?

If the second request for crisis services comes within a 24-hour period regardless of whether services have already been provided or not, it counts as one crisis episode. For example, if an individual requests crisis services at 10:00am, a service is provided at 11:00am, and the individual calls again at 1:00pm, it is all counted as one crisis episode. The clinic reports time from initial request to the initial provision of service.

If a second request for crisis services comes in after 24 hours have passed from the first request, it is counted as a second crisis episode regardless of whether a service had previously been provided. For example, an individual requests crisis services at 10:00am, a service is provided at 11:00am, and an additional request comes in at 11:00am the following day. The second call is a second crisis episode. In the event a service was not provided for the first request before the second request came in, the first

request is reported in "Additional Notes" as not completed and the second request begins the new timeframe.

If a call comes in before the end of the period, January 31, but the service is not provided until after the period (January 31), it is reported as 24 hours.

Q: Is this metric for individuals currently served by CCBHCs or all crisis services?

This metric is for all individuals receiving crisis services including individuals receiving services at the CCBHC and individuals not enrolled in the CCBHC.

Questions Regarding Preventative Care and Screening: Unhealth Alcohol Use (ASC)

Q: If an individual declines to complete the screening, does it still count towards the metric?

If an individual declines to complete the screening, it is reported as unmet.

Q: The codes provided in the ASC requirements are primary care codes. How are CCBHCs supposed to track the metric?

Clinics have flexibility to use "equivalent information" in places of the G-Codes used to note whether an individual has been screened and whether they were provided brief counseling. Clinics will need to create their own documentation practices that appropriately captures:

1. Whether the individual was screened using the appropriate screener and:
    a. If the individual screened positive
        i. Whether they were provided brief counseling
            1. If not, the reason brief counseling was not provided
    b. If the individual screened negative

To calculate the eligible population based on eligible visits, the following codes are part of the CCHBC Services Billing Matrix : 90832, 90834, 90837, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350.

CCBHCs are NOT limited to these codes. Any service provided meeting listed in the eligible codes list in the technical specifications counts towards the eligible population whether the service is eligible for PPS encounter or not.

Questions Regarding Screening for Clinical Depression and Follow-Up Plan

Q. Who should we be screening?

Screening should be done for children 12-17 and adults 18+ who do NOT have a diagnosis of depression or bipolar.

Q. Do we screen at every visit?

Per the technical specifications manual, “the electronic version of this measure, however, has been modified to indicate that “[t]his eCQM is a patient-based measure. Depression screening is required once per measurement period, not at all encounters." This reflects an upcoming change to the Core Set measure for 2024 which will parallel the electronic measure. For that reason, we will treat this as a once a Measurement Year requirement for those in the Eligible Population.”

For individuals 12 and older who do NOT have a diagnosis of depression or bipolar, a depression screening should be done once per measurement year.

Q. What level of screen is required?

Clinical discretion may be used to determine the appropriate and clinically indicated level of screening. The screening must be a normalized, validated tool.

Q. What is considered follow-up?

Follow-up includes but is not limited to: referral for higher level of evaluation if clinically indicated, updating treatment plan as appropriate to include services to address depression, and other interventions.

A risk assessment should be completed if clinically indicated and appropriate; however, it is not counted as follow-up.

Q. When can we stop screening?

Screening should continue until the individual has completed treatment or if they receive a diagnosis of depression or bipolar. On the date a diagnosis is made you must document a follow-up plan and count the visit as part of the measure. On the next visit after the diagnosis these individuals would be excluded from the measure due to the now active diagnosis of bipolar disorder or depression.

Questions Regarding Screening for Social Drivers of Health (SDOH)

Q: What screening tools are allowable?

Any standardized SDOH screening tool is allowable so long as it assesses the required domains. SAMHSA has provided a list of standardized tools in the technical specifications. This is not an exhaustive list. If the screening tool you are looking into is on the SAMHSA provided list, it meets the requirements of this metric. If there is a tool not listed, please reach out to OHA staff for approval.

Q: If another provider completes the screening within the reporting timeline, does this count towards the metric?

If another provider has already completed the screening within the allowed timeframe, the CCBHC does not have to collect the information again. While the CCBHC does not have to gather the information again, they must ensure the individual's responses are readily available for clinicians to review.

Q: What if we ask questions that are on the SDOH screening tool in other areas of the intake or screening process?

SAMHSA requires the use of a standardized tool; however, acknowledge that clinics may already gather this information in other parts of their screening and intake processes. Clinicians may use the responses from other screening and intake questions to complete the SDOH screening so long as the answers were provided within a clinically appropriate window to do so and no later than within the metric reporting period (current calendar year).

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