Certified Community Behavioral Health Clinic State Technical Assistance Center (CCBHC S-TAC)

February 15, 2024

CCBHC S-TAC

CCBHC State Technical Assistance Center

This presentation was made possible through funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views, opinions or policies of SAMHSA, or the U.S. Department of Health and Human Services (HHS).

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NATIONAL COUNCIL *for* Mental Wellbeing

Agenda
Topic: State-Collected Measures

- **3:30 PM:** Welcome & Housekeeping
- **3:35 PM:** State-Collected-Required Measures (#2): FUH-AD/CH, FUA-AD/CH, FUM-AD/CH, IET-AD, PCR-AD
- **4:35 PM**: Building a Quality Measurement Program
- **4:55 PM:** Closing

Reminder: *All 56 states and territories are invited to these meetings. They may invite any state-contracted consultants who are currently supporting their CCBHC efforts.*

State-Collected-Required Measures (#2): FUH, FUM, FUA, IET, and PCR

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U.S. Department of Health and Human Services

February 15, 2024
3:30-5:00 PM ET

SAMHSA
Substance Abuse and Mental Health Services Administration

Poll #1

I am representing (please select **no more than two** best answers and respond in the poll):

1. An existing Section 223 demonstration state
2. A current Section 223 planning grant state or a former Section 223 planning grant state not selected in 2016
3. An independent state CCBHC initiative under an approved Medicaid waiver or SPA
4. Any other interested state, territory, or tribal entity
5. None of the above

Intended audience for this webinar

1. Existing and prospective CCBHC Section 223 Demonstration state staff
2. Independent state CCBHC initiative personnel
3. Other interested states

Schedule for Discussion of Required State-Collected Measures

January 18, 2024

- Antidepressant Medication Management (AMM-AD)*●x
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)* ● x
- Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH) *● x
- Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)*●
- Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)* x
- Patient Experience of Care Survey (PEC)
- Youth/Family Experience of Care Survey (YFEC)

February 15, 2024

- Follow-Up After Hospitalization for Mental Illness (FUH-CH and FUH-AD)*● x
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-AD and FUA-CH)*● x
- Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD and FUM-CH)*● x
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)*● x
- Plan All-Cause Readmissions Rate (PCR-AD)* x
- Two optional measures (if there is time and interest) * ● x

* Derived directly from CMS Medicaid Adult and/or Child Core Sets

● Required reporting statewide for Medicaid programs as of 2024

x Measures subject to copyright by National Committee for Quality Assurance (NCQA).

Background on Treatment of CMS Medicaid Core Sets

Approach to Measures in the CMS Medicaid/CHIP Core Sets

1. All BHC state-collected measures except the two experience of care survey "measures" are derived directly from the CMS Adult or Child Medicaid/CHIP Core Sets.
2. States reporting these for CCBHC will already be reporting them on the Calendar Year for the state in aggregate and most will be required of all states beginning in 2024 (all behavioral health and child measures).
3. The specs contain the 2023 versions with instructions to use the updated versions (including the updated value sets) as the Core Set may revise measure specifications annually.
4. Changes from the Medicaid Core Sets take three forms:
   a. ~~Strikethroughs for language removed~~
   b. [brackets for added language]
   c. Supplemental materials directly before each measure or set of measures (see next slide for screenshot example)

Screenshot of Approach to Materials Supplementing Core Set Specs

Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (OUD-AD)

These supplemental materials are necessary for implementation of the State-Collected Required BHC Measures that are derived from the CMS Medicaid Adult and/or Child Core Set Measures. This volume includes the exact specifications that are on the CMS website for the 2023 Medicaid Core Set, with simple modifications noted in the text. Limited additional needed modifications are included below, as well as supplemental useful materials.

Changes directly in the specifications: For all Core Set-derived measures, the changes in the specification from the CMS Medicaid Adult or Child Core Set reflect: (1) substitution of the

Types of Changes from the CMS Core Set Versions

- Use of “client” rather than “patient” or “beneficiary”
- Removal of age stratifications (e.g., children and older adults) due to clinic level reporting and small numbers
- Removal of most references directly to the Core Set
- Addition of stratifications by payer, race, and ethnicity
- Addition of FAQs where we have them
- Most importantly, the requirement that the measure be reported at the CCBHC level for the Section 223 Demonstration.

Key Points from the Specification Introductory Materials

- Attribution requires only one visit for CCBHC services during the MY.
- For states, you will only have access to Medicaid data but still must stratify by payer:
  - Medicaid beneficiaries, including Title 19-eligible CHIP beneficiaries,
  - Others, including those dually enrolled under Medicare and Medicaid and Title 21-eligible CHIP beneficiaries.

Clinic Site Identifiers

Section 5.a.3 of the CCBHC certification criteria updated in 2023 require that "Medicaid claims and encounter data provided by the state to the national evaluation team, and to CMS through TMSIS, should include a unique identifier for each person receiving services, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. ***Clinic site identifiers are very strongly preferred***."

Other Core Set-Related Tips

- Some measures have optional exclusions (e.g., SAA and HBD). In deciding whether to use the optional exclusions, follow your state's practice in reporting for the Core Set generally.
- For purposes of Section 223 Demonstration quality measure reporting, all required measures must be reported to SAMHSA regardless of the size of the specified eligible population for a given measure in a CCBHC.
  - Our evaluators will aggregate at the state level for all reporting and, even then, if the denominators are too small, the results will not be publicly reported.

Follow-Up After Hospitalization for Mental Illness (FUH-AD and FUH-CH)

Who? Clients ages 18 years and older Clients ages 6 - 17

Why? Measure of care coordination and follow-up

FUH-AD and FUH-CH Measures: Description and Source

- Percentage of discharges for clients ages 18 and older [6-17] who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:
  - Percentage of discharges for which the client received follow-up within 30 days after discharge
  - Percentage of discharges for which the client received follow-up within 7 days after discharge
- Source: CMS Medicaid Adult Core Set Measure (2023), derived from a measure stewarded by NCQA

NCQA: National Committee for Quality Assurance

The NCQA HEDIS measure specification has been adjusted pursuant to NCQA's *Rules for Allowable Adjustments of HEDIS*.

FUH-AD and FUH-CH Measures: Data Source and Measurement Period

- Data source: Administrative
- Measurement Period (aka, the time period data must cover):
  - The FUH-AD and FUH-CH measure ***denominators*** include all discharges between January 1 and December 1, if the Measurement Year (MY) is the calendar year.
- The Measurement Period for both the FUH-AD and FUH-CH ***numerators*** are as follows:

  (a) ***7-Day Follow-up:*** January 1 through December 8

  (b) ***30-Day Follow-up:*** January 1 through December 31

FUH-AD and FUH-CH: Calculation of Denominator

Denominator is all discharges in the Eligible Population:

1. **Age 18 or older** [6-17] and received CCBHC services at least once during the MY.
2. Include only clients with continuous enrollment in Medicaid (medical and mental health + inpatient and outpatient) from discharge through 30 days after discharge with no allowable gaps.
3. Identify both **acute** and **nonacute inpatient discharges** with a principal diagnosis of **mental illness** or **intentional self-harm** on the discharge claim on or between January 1 and December 1 of the MY. Identify discharge date(s) for each client. Flag **acute** vs **nonacute inpatient** discharges for separate attention below.
4. Identify **readmissions and direct transfers** to an **acute inpatient** care setting with an admission date during the 30-day follow-up period.
   a. Exclude both the initial discharge and the **readmission/direct transfer** discharge if the last discharge occurs after December 1 of the MY.
   b. Include only the last discharge during the 30-day period, if both the initial and subsequent **readmission/direct transfer** discharges in the 30-day period have a principal diagnosis of **mental illness or intentional self-harm** on the discharge claim.
   c. Exclude both the initial discharge and subsequent **readmission/direct transfer** discharges during the 30-day period, if the principal diagnosis on the discharge from the readmission/direct transfer was other than one for **mental illness or intentional self-harm.**
5. Exclude discharges followed by readmission or direct transfer to a **nonacute inpatient** care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission.
6. Exclude discharges if the clients were in **hospice** or using hospice services anytime during the MY.

Stratification: payer, race, ethnicity

NOTE: Bold means the specs contain much more detail!

ADDITIONAL NOTE: The denominator for this measure is based on discharges, not on clients. A client may have more than one discharge in the MY.

MY: Measurement Year

FUH-AD and FUH-CH: Calculation of Numerators

Out of those in the denominator:

- The FUH-AD and FUH-CH measure numerator include:
  - **30-Day Follow-Up**: A follow-up **outpatient visit** with a mental health provider within 30 days after discharge.
  - **7-Day Follow-Up**: A follow-up **outpatient visit** with a mental health provider within 7 days after discharge.

  For numerator, exclude visits that occur on the date of discharge.

NOTE: Bold means the specs contain much more detail!

FUH-AD 7-Day Follow-up: Practice Example

Denominator

Clients (C) receiving CCBHC services during MY	2,500 clients (C)
Of those exclude Cs not age 18 or older (per spec)	2,500–100 = 2,400 (C)
Of those, remove Cs without continuous enrollment (per spec) in Medicaid	2,400-300 = 2,100 (C)
For remaining Cs, identify all acute inpatient discharges (D) with a principal diagnosis of mental illness or intentional self-harm between January 1 and December 1 of the MY	2,100 C had a total of 2,775 such discharges (D)
Of those, identify Ds with readmissions or direct transfers (RDTs) to acute inpatient setting during the 30-day period after initial D	Out of 2,775 D: with RDT: 1,000 w/o RDT: 1,775
Of those, exclude Ds and RDTs with last D after December 1	Ds with RDT: 1,000 - 100 = 900 Ds w/o RDT: 1,775
Of those, exclude all Ds (w/RDT) except the last D from RDT during the 30-day period with principal diagnosis of mental illness or intentional self-harm	Ds with RDT: 900-250 = 650 Ds w/o RDT: 1,775
Exclude Ds with RDTs to nonacute inpatient care setting during the 30-day follow-up period	Ds with RDT: 650-33 = 617 Ds w/o RDT: 1,775

Denominator (cont'd)

Of those, exclude Ds of clients in hospice or using hospice services anytime during the MY	617+1,775-250 = 2,142
Denominator	**2,142 discharges**

Numerator for 7-Day Follow-up

Number of discharges (D) in Denominator	2,142 (D)
Of those, remove any discharges without follow-up outpatient visit with a mental health provider within 7 days after discharge	2,142-1,700= 442
Of those, remove discharges with a 7-day follow-up visit that occurs on the discharge date	442-25 = 417
Numerator	**417 discharges**

FUH-AD 7-day follow-up rate = 417/2,142 = .19 or 19%

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Substance Abuse and Mental Health Services Administration

Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD and FUM-CH)

Who? Clients ages 18 years and older Clients ages 6 to 17

Why? Measure of care coordination and follow-up

SAMHSA
Substance Abuse and Mental Health Services Administration

FUM-AD and FUM-CH Measures: Description and Source

- Percentage of emergency department (ED) visits for clients ages 18 and older [6-17] with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness.
- Two rates are reported:
  - Percentage of ED visits for mental illness for which the client received follow-up within 30 days of the ED visit (31 total days)
  - Percentage of ED visits for mental illness for which the client received follow-up within 7 days of the ED visit (8 total days)

Source: CMS Medicaid Adult Core Set Measure (2023), derived from a measure stewarded by NCQA

NCQA: National Committee for Quality Assurance

The NCQA HEDIS measure specification has been adjusted pursuant to NCQA's *Rules for Allowable Adjustments of HEDIS*.

FUM-AD and FUM-CH: Data Source and Measurement Period

- Data source: Administrative
- Measurement Period (aka, the time period data must cover):
  - The Measurement Period for both the FUM-AD and FUM-CH ***denominators*** are January 1 through December 1, if the Measurement Year is the calendar year.
  - The Measurement Period for both the FUM-AD and FUM-CH ***numerators*** are as follows:

    (a) ***7-Day Follow-up:*** January 1 through December 8

    (b) ***30-Day Follow-up:*** January 1 through December 31

FUM-AD and FUM-CH: Calculation of Denominator

Denominator is all ED visits in the Eligible Population:

- Age 18 years [6-17] as of the date of the **ED visit** and received CCBHC services at least once during the MY.
- Include only clients with continuous enrollment in Medicaid (medical + mental health benefits) from the date of the **ED visit** through 30 days after the **ED visit** (31 days) with no allowable gaps
- Exclude clients in **hospice** or using **hospice services** anytime during the MY.
- Identify **ED visits** with a principal diagnosis of **mental illness or intention self-harm** on or between January 1 and December 1 of the MY where the client was 18 years or older at the day of the **ED visit**
- **Exclude ED visits** that result in an **inpatient stay** and **ED visits** followed by admission to an **acute or nonacute inpatient care setting** on the date of the **ED visit** or within the 30 days after the **ED visit** (31 total days), regardless of the principal diagnosis for the admission. An **ED or observation visit** that **billed on the same claim as an inpatient stay** is considered a visit that resulted in an inpatient stay and are excluded from the measure. You now have your **eligible ED visits**.
- If a client has more than one **ED visit**, identify all **eligible ED visits** between January 1 and December 1 of the MY and do not include more than one visit per 31-day period.
    - Include only **first eligible ED visit** in a 31-day period, if more than one visit occurred in the 31-day period**.** Identify **eligible ED visits** chronologically, including only one per 31-day period.

Stratification: payer, race, ethnicity

NOTE: Bold means the specs contain much more detail!

ADDITIONAL NOTE: The denominator for this measure is based on ED visits, not on clients.

MY: Measurement Year

FUM-AD and FUM-CH: Calculation of Numerators

Out of all ED visits in the denominator:

- **30-Day Follow-Up**
  - A **follow-up visit** with any practitioner, either with (1) a principal diagnosis of a **mental health disorder** or (2) a principal diagnosis of **intentional self-harm** and any diagnosis of **mental health disorder,** within 30 days after the ED visit (31 total days).
- **7-Day Follow-Up**
  - A **follow-up visit** with any practitioner, either with (1) a principal diagnosis of a **mental health disorder** or (2) a principal diagnosis of **intentional self-harm** and any diagnosis of **mental health disorder,** within 7 days after the ED visit (8 total days).

For numerator, include **follow-up visits** that occur on the date of the **ED visit**.

ADDITIONAL NOTE: Bold means the specs contain much more detail!

FUM-AD 7-Day Follow-up: Practice Example

Denominator

Clients (C) receiving CCBHC services during MY	2,800 (C)
Of those, exclude Cs not age 18 or older (per specs)	2,800-200=2600 (C)
Of those, remove Cs without continuous enrollment (per spec) in Medicaid from date of the ED visit through 30 days after the ED visit (31 days)	2,600-300=2300 (C)
Of those, remove Cs in hospice or using hospice services anytime during the MY	2,300-300 = 2,000 (C)
Of the remaining clients, identify ED visits (EV) with a principal diagnosis of mental illness or intention self-harm on or between January 1 and December 1 of the MY where the client was age 18 and older at the day of the EV	2,000 C has a total of 2,800 such EVs
Of those, exclude EVs that resulted in inpatient stay and EVs followed by admission to an acute or nonacute inpatient care setting on the day of the EV or within the 30 days after the EV	2,800-300=2,500 (EVs)
Of those EVs remaining (eligible EVs), count only the first EV during any 31-day period (if C had more than one EV during a 31-day period)	2,500-500=2,000 (EVs)
Denominator	**2,000 EVs**

Numerator for 7-Day Follow-up

Number of EVs in Denominator	2,000 (EV)
Out of the denominator, remove any EVs without a follow-up for appropriate diagnosis within 7 days after EV.	2,000-300=1,700 (EV)
Numerator	**1,700 EVs**

FUM-AD 7-day follow-up rate = 1,700/2,000 = 0.85 or 85%

Follow-Up After Emergency Department Visit For Substance Use (FUA-AD and FUA-CH)

Who? Clients ages 18 years and older Clients ages 13 to 17

Why? Measure of care coordination and follow-up

FUA-AD and FUA-CH Measures: Description and Source

- Percentage of emergency department (ED) visits for clients age 18 and older [13-17] with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:
  - Percentage of ED visits for which the client received follow-up within 30 days of the ED visit (31 total days)
  - Percentage of ED visits for which the client received follow-up within 7 days of the ED visit (8 total days)

Source: CMS Medicaid Adult Core Set Measure (2023), derived from a measure stewarded by NCQA

NCQA: National Committee for Quality Assurance

The NCQA HEDIS measure specification has been adjusted pursuant to NCQA's *Rules for Allowable Adjustments of HEDIS*.

FUA-AD and FUA-CH: Data Source and Measurement Period

- Data source: Administrative
- Measurement Period (aka, the time period data must cover):
  - The Measurement Period for both the FUA-AD and FUA-CH ***denominators*** are January 1 through December 1, if the Measurement Year is the calendar year.
  - The Measurement Period for both the FUA-AD and FUA-CH ***numerators*** are as follows:

    (a) ***7-Day Follow-up:*** January 1 through December 8

    (b) ***30-Day Follow-up:*** January 1 through December 31

FUA-AD and FUA-CH: Calculation of Denominator

Denominator is all ED visits in the Eligible Population:

- Age 18 years [13-17] as of the date of the **ED visit** and received CCBHC services at least once during the MY.
- Include only clients with continuous enrollment in Medicaid (medical + chemical dependency + pharmacy benefits) from the date of the **ED visit** through 30 days after the **ED visit** (31 days) with no allowable gaps.
- Exclude clients in **hospice** or using **hospice services** anytime during the MY.
- Identify **ED visits** with a principal diagnosis of **substance use disorder or any diagnosis of drug overdose** on or between January 1 and December 1 of the MY where the client was 18 years or older at the day of the **ED visit.**
- **Exclude ED visits** that result in an **inpatient stay** and **ED visits** followed by admission to an **acute or nonacute inpatient care setting** on the date of the **ED visit** or within the 30 days after the **ED visit** (31 total days), regardless of the principal diagnosis for the admission. An **ED or observation visit** that **billed on the same claim as an inpatient stay** is considered a visit that resulted in an inpatient stay and are excluded from the measure. You now have your **eligible ED visits**.
- If a client has more than one **ED visit**, identify all **eligible ED visits** between January 1 and December 1 of the MY and do not include more than one visit per 31-day period.
    - Include only **first eligible ED visit** in a 31-day period, if more than one visit occurred in the 31-day period**.** Identify **eligible ED visits** chronologically, including only one per 31-day period.

Stratification: payer, race, ethnicity

NOTE: Bold means the specs contain much more detail!

ADDITIONAL NOTE: The denominator for this measure is based on ED visits, not on clients.

MY: Measurement Year

FUA-AD and FUA-CH: Calculation of Numerators

Out of all **ED visits** in the denominator:

- **30-Day Follow-Up**
  - A **follow-up visit or pharmacotherapy dispensing event** within 30 days after the **ED visit** (31 total days).
- **7-Day Follow-Up**
  - A **follow-up visit or pharmacotherapy dispensing event** within 7 days after the **ED visit** (8 total days).

Include **follow-up visits and pharmacotherapy events** that occur on the date of the **ED visit.**

NOTE: Bold means the specs contain much more detail!

FUA-AD 7-Day Follow-up: Practice Example

Denominator

Clients (C) receiving CCBHC services during MY	3,000 (C)
Of those, exclude Cs not age 18 or older (per specs)	3,000-200=2,800 (C)
Of those, remove Cs without continuous enrollment (per spec) in Medicaid benefits from date of the ED visit through 30 days after the ED visit (31 days)	2,800-400=2,400 (C)
Of those, remove Cs in hospice or using hospice services anytime during the MY	2,400-350=2,050 (C)
Of the remaining clients, identify ED visits (EV) with a principal diagnosis of substance use disorder or any diagnosis of drug overdose on or between January 1 and December 1 of the measurement year where the client was age 18 and older at the day of the EV	2,050 C has a total of 3,000 such ED visits (EVs)
Of those, exclude EVs that resulted in inpatient stay and EVs followed by admission to an acute or nonacute inpatient care setting on the day of the EV or within the 30 days after the EV	3,000-400=2,600 EVs
Of those EVs remaining (eligible EVs), count only the first EV during any 31-day period (if C had more than one EV during a 31-day period)	2,600-200=2,400 (EVs)
Denominator	**2,400 EVs**

Numerator for 7-Day Follow-up

Number of EVs in Denominator	2,400 (EVs)
Out of the denominator, remove any EV without follow-up visit or pharmacotherapy dispensing event within 7 days after ED visit	2,400-400=2,000 (EVs)
Numerator	**2,000 EVs**

FUA-AD 7-day follow-up rate = 2,000/2,400 = 0.83 or 83%

Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)

Who? Clients aged 18 and older

Why? Initiation and engagement of SUD treatment

IET-AD Measure: Description and Source

- Percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:
  - **Initiation of SUD Treatment:** The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.
  - **Engagement of SUD Treatment:** The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Source: CMS Medicaid Child Core Set Measure (2023), derived from a measure stewarded by NCQA

NCQA: National Committee for Quality Assurance

The NCQA HEDIS measure specification has been adjusted pursuant to NCQA's *Rules for Allowable Adjustments of HEDIS*.

IET-AD Measure: Data Source and Measurement Period

- Data source: Administrative or EHR

- Measurement Period (aka, the time period data must cover):
  - For the IET-AD measure ***denominator,*** two measurement periods are used:
    - The SUD Episode Date Measurement Period is November 15 of the prior year through November 14 of the Measurement Year (also known as the Intake Period).
    - The Negative SUD Diagnosis and Medication History Review Measurement Period begins 194 days prior to the SUD Episode date.
  - For the ***numerator***, two measurement periods are used:
    - The Measurement Period for Initiation is the period within 14 days of the SUD Episode date
    - The Measurement Period for Engagement is the period beginning the day after the Initiation encounter through 34 days after the Initiation event (inclusive).

IET-AD: Calculation of Denominator (slide 1 of 2)

Follow the steps below to identify the denominator for both rates:

- Clients who receive at least one CCBHC service during the MY
- Of those, include clients who experience a **SUD Episode** during the **Intake** Period and who were age 18 years or older as of the **SUD Episode Date.**
- Of those, determine whether it was a new **SUD Episode:**
  - First, test for **Negative SUD Diagnosis History**:
    - Exclude **SUD Episodes** if there was an encounter in any setting other than an **ED visit** or a **medically managed withdrawal)** event with a **diagnosis of SUD** during the 194 days prior to the **SUD Episode Date**.
      - If the **SUD Episode** was an **inpatient stay**, use the admission date to determine **Negative SUD History.**
      - For visits with an **SUD diagnosis** that resulted in an **inpatient stay** (where the **inpatient stay** becomes the **SUD Episode**), use the earliest date of service to determine the **Negative SUD Diagnosis History** (so that the visit that resulted in the **inpatient stay** is not considered a positive diagnosis history).
      - For **direct transfers**, use the first admission date to determine the **Negative SUD Diagnosis History.**
  - Second, of those, test for **Negative SUD Medication History**:
    - Exclude **SUD Episodes** if either of the following occurred during the 194 days prior to the **SUD Episode Date:**
      - An **SUD medication treatment dispensing event**
      - An **SUD medication administration event** (denominator continues next slide)

NOTE: Bold means the specs contain much more detail!

IET-AD: Calculation of Denominator (slide 2 of 2)

- Of those, exclude **SUD Episodes** where there was not continuous enrollment in Medicaid (medical, pharmacy, and chemical dependency (inpatient and outpatient) benefits) for 194 days prior to the **SUD Episode Date** through 47 days after the **SUD Episode Date** (242 total days). Gaps are not allowed in the continuous enrollment period.

  NOTE: The denominator is based on **SUD Episodes**, not clients.
- Exclude **SUD Episodes** if clients were in **hospice or using hospice services at** anytime during the MY.
- For purposes of your state's Medicaid Core Reporting, you will identify the SUD diagnosis cohort for each **SUD Episode** and may elect to do so by CCBHC if you wish:
  - **Alcohol use disorder**
  - **Opioid use disorder**
  - **Other substance use disorder**
  - **Total (the sum of the SUD Episodes in the separate cohort stratifications)**

  NOTE: Include **SUD Episodes** in all SUD diagnosis cohorts for which they meet criteria. For example, if the **SUD Episode** has a diagnosis of **alcohol use disorder** and **opioid use disorder**, include the episode in both the alcohol use disorder and opioid use disorder cohorts.

Stratification: payer, race, ethnicity

NOTE: Bold means the specs contain much more detail!

IET-AD: Numerator 1: Initiation of SUD Treatment

Out of the **SUD Episodes** remaining in the denominator:

- **Step 1:** If the SUD Episode was an **inpatient** discharge, the inpatient stay is considered initiation of treatment and the **SUD Episode** is compliant.
- **Step 2:** If the **SUD Episode** was an **opioid treatment service** that bills monthly, the **opioid treatment service** is considered initiation of treatment, and the **SUD Episode** is compliant.
- **Step 3:** For remaining **SUD Episodes** (those not compliant after steps 1–2), identify episodes with at least one of the **specified encounters** on the **SUD Episode Date** or during the 13 days after the **SUD Episode Date** (14 total days).
  - For all initiation events except medication treatment dispensing events and medication administration events, initiation on the same day as the **SUD Episode Date** must be with different providers in order to count.
  - Exclude client from denominator if the initiation of treatment event is an **inpatient stay** with a discharge date after November 27 of the measurement year.

NOTE: Bold means the specs contain much more detail!

IET-AD: Numerator 2: Engagement of SUD Treatment

Out of the **SUD Episodes** remaining in the denominator:

- **Step 1:** Identify all **SUD Episodes** compliant for the **Initiation of SUD Treatment numerator**. **SUD Episodes** that are not compliant for **Initiation of SUD Treatment** are not compliant for **Engagement of SUD Treatment.**
- **Step 2:** Identify **SUD Episodes** that had at least **one weekly or monthly opioid treatment service** with **medication administration** on the day after the **initiation encounter** through 34 days after the initiation event. For these, the numerator is compliant.
- **Step 3:** Identify **SUD Episodes** with **long-acting SUD medication** administration events on the day after the **initiation encounter** through 34 days after the initiation event. For these, the numerator is compliant.
- **Step 4:** For remaining **SUD Episodes**, identify episodes with at least two of the following (any combination) on the day after the **initiation encounter** through 34 days after the initiation event:
  - **Engagement visit**
  - **Engagement medication treatment event**

Note: If **Initiation of SUD Treatment** was an **inpatient admission,** the 34-day period for engagement begins the day after discharge.

Note: Exclude client from **Engagement of Treatment** denominator if the initiation of treatment event is an **inpatient stay** with a discharge date after November 27 of the measurement year.

NOTE: Bold means the specs contain much more detail

IET-AD: Practice Example

Denominator

Include all clients (C) who receive at least one CCBHC service during the MY	2,500 (C)
Exclude clients who do not experience a SUD Episode (E) during the Intake Period. Identify the number of SUD Episodes.	2,500-500=2,000 (C) with 2,800 (E)
Exclude SUD Episode where clients were under age 18 as of their SUD Episode Date.	2,800-300=2,500 (E)
Include only SUD Episodes if there was a Negative SUD Diagnosis History (per the specs) during the 194 days prior to the SUD Episode Date.	2,500-200=2,300 (E)
Of those, exclude SUD Episodes without a Negative SUD Medication History (per the specs) during 194 days prior to the SUD episode date.	2,300-500=1,800 (E)
Remove any SUD Episodes w/o continuous enrollment (per the specs) in Medicaid.	1,800-800=1,000 (E)
Exclude episodes if clients were in hospice or using hospice services anytime during the MY.	1,000-100=900 (E)
Break down episodes by diagnosis cohort (AUD: 600, OUD: 500, Other: 400) (if you elect to do so)	
Denominator (OUD Cohort)	**500 (E)**

Numerator 1: Initiation of SUD Treatment (OUD Cohort)

Number of SUD Episodes (E) in Denominator (D)	500
Out of the Denominator, include OUD episodes with inpatient discharges	50
Out of the Denominator, include OUD episodes where opioid treatment service was delivered and billing is monthly	100
Out of the Denominator, include OUD episodes with at least one of the other specified numerator encounters on the SUD Episode Date or during the 13 days after the SUD Episode Date	125
Numerator (OUD Cohort)	**275**

IET-AD Initiation rate (OUD cohort) = 275/500 = .55 or 55%

Plan All-Cause Readmissions (PCR-AD)

Who? Clients aged 18 – 64 years

Why? Minimize unnecessary acute readmission

PCR-AD Measure: Description and Source

- For clients ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:
  - Count of Index Hospital Stays (IHS)
  - Count of Observed 30-Day Readmissions
  - Count of Expected 30-Day Readmissions

Source: CMS Medicaid Adult Core Set Measure (2023), National Committee for Quality Assurance (NCQA)

NCQA: National Committee for Quality Assurance

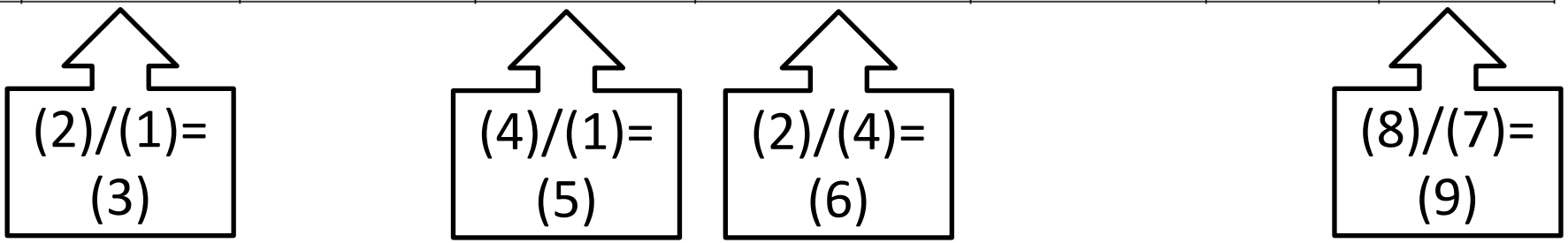
The NCQA HEDIS measure specification has been adjusted pursuant to NCQA's *Rules for Allowable Adjustments of HEDIS*.

PCR-AD Measure: Data Source and Measurement Period

- Data source: Administrative
- Measurement Period (aka, the time period data must cover):
  - The Measurement Period for the PCR-AD ***denominator*** covers the allowable period for Index Hospital Stay (IHS) discharges to be included and is January 1 – December 1 when the Measurement Year is the Calendar Year. The Measurement Period for the PCR-AD ***numerator*** *(*or the allowable period for readmissions to be included) is the Measurement Year, excluding the first two days of that Measurement Year (January 3 – December 31), covering the 2nd through 30th days after the IHS discharge date.

Table PCR-A. Plan All-Cause Readmissions Rates

	Count of Index Hospital Stays (1)	Count of Observed 30-Day Readmissions (2)	Observed Readmission Rate (3)	Count of Expected 30-Day Readmissions (4)	Expected Readmission Rate (5)	O/E Ratio (Count of Observed 30-Day Readmissions/ Count of Expected 30-Day Readmissions) (6)	Count of Beneficiaries in Medicaid Population (7)	Number of Outliers (8)	Outlier Rate (9)
Total			Calculated		Calculated	Calculated			Calculated



SAMHSA
Substance Abuse and Mental Health Services Administration

PCR-AD: Count of Index Hospital Stays (IHS)

Count of **index hospital stays (IHS):**

- Identify all clients who receive a CCBHC service during the MY.
- For those clients, identify all **acute inpatient and observation stay discharges** on or between January 1 and December 1 of the MY. For each, identify the **discharge date**.
- Exclude clients who were not ages 18 to 64 as of the **Index Discharge Date**.
- Exclude clients who did not have continuous Medicaid enrollment (medical benefits) from 365 days prior to the **Index Discharge Date** through 30 days after the **Index Discharge Date** (with allowable gaps per the specs, excluding the **Index Discharge Date**).
- Exclude clients who were in **hospice** or using **hospice services** at any point in the MY.
- For discharges with one or more **direct transfers**, use the last discharge.
  - Exclude the hospital stay if the direct transfer's discharge date occurs after December 1 of the MY.
- Exclude hospital stays where the **Index Admission Date** is the same as the **Index Discharge Date**.
- Exclude hospital stays if the client died during the stay, or if client had a **principal diagnosis of pregnancy** or a **principal diagnosis originated in the perinatal period.**
- Remove hospital stays for **outlier** clients and report such clients as outliers.
- The IHS is based on discharges, not clients.

Reporting for Table PCR-A: Count of Index Hospital Stays (IHS): Count the number of IHS among nonoutlier clients and enter this value into the reporting table under Count of Index Stays (Table PCR-A, **column 1**).

Stratification: Payer only

NOTE: Bold means the specs contain much more detail!

MY: Measurement Year

PCR-AD: Count of Observed 30-Day Readmissions/ Calculation of Observed Readmission Rate

- Identify all **acute inpatient and observation stays** with an admission date on or between January 3 and December 31 of the MY. For each, identify the admission date.
- For discharges with one or more **direct transfers**, use the last discharge.
- **Exclude acute hospitalizations** meeting **criteria listed in the specification.**
- For each IHS identified in the denominator (count of IHS's), determine if any of the acute inpatient and observation stays identified in the numerator (observed readmissions) have an admission date within **30 days after the Index Discharge Data**

Reporting for Table PCR-A: Count of Observed 30-Day Readmissions: Count the number of observed IHS among nonoutlier clients with a readmission within 30 days of discharge and enter this value into the reporting table under Count of Observed 30-Day Readmissions (Table PCR-A, **column 2**).

Calculation of Observed Readmission Rate: Count of Observed 30-Day Readmissions/ Count of Index Hospital Stays (Table PCR-A, **column 3**).

NOTE: Bold means the specs contain much more detail!

PCR-AD: Count of Expected 30-Day Readmissions/ Calculation of Expected Readmission Rates and Observed-to-Expected Ratio

- For each IHS among **nonoutlier** clients, **identify risk adjustment categories** based on presence of **observation stay status** at discharge, **surgeries**, **discharge condition**, **comorbidity**, age, and gender.
- For each IHS among **nonoutlier** clients, **identify risk adjustment weights** based on the **risk adjustment categories**. Ensure that **weights are linked appropriately** for each nonoutlier IHS.
- **Calculate** the **Estimated Readmission Risk** for each IHS.

Reporting for Table PCR-A: Count of Expected 30-Day Readmissions: Sum the Expected Readmission Risk for each IHS among nonoutlier clients to calculate the Count of Expected Readmissions. Round to four decimal places using the .5 rule and enter the Count of Expected Readmissions into the reporting table (Table PCR-A, **column 4**).

Calculation of Expected Readmission Rate: Count of Expected 30-Day Readmissions/ Count of Index Hospital Stays (Table PCR-A, **column 5**).
Calculation of Observed-to-Expected Ratio (O/E): Count of Observed 30-Day Readmissions/ Count of Expected 30-Day Readmissions (Table PCR-A, **column 6**).

NOTE: Bold means the specs contain much more detail!

PCR-AD: Count of Clients in Medicaid Population, Count of Outlier Clients, and Calculation of Outlier Rate

- **Count of Clients in Medicaid Population:** Determine the count of clients in the Medicaid population who were ages 18 to 64 as of their earliest Index Discharge Date.

  Reporting for Table PCR-A: Enter this count into the reporting table under Count of Clients in Medicaid Population (Table PCR-A, **column 7).**

- **Count of Outlier Clients:** Determine the count of outlier clients in the Medicaid population who were ages 18 to 64 as of their earliest Index Discharge Date.

  Reporting for Table PCR-A: Enter this count into the reporting table under Number of Outliers (Table PCR-A, **column 8**).

Calculation of Outlier Rate: Number of Outlier clients/ Count of clients in Medicaid Population (Table PCR-A, **column 9**), displayed as a permillage (multiplied by 1,000).

PCR-AD: Practice Example to Calculate Rates

- **Observed Readmission Rate** (Count of Observed 30-Day Readmissions/ Count of Index Hospital Stays)
  - 50/100 = .50
- **Expected Readmission Rate** (Count of Expected 30-Day Readmissions/ Count of Index Hospital Stays)
  - 20/100=.20
- **O/E Ratio** (Count of Observed 30-Day Readmissions/ Count of Expected 30-Day Readmissions)
  - 50/20=2.5
- **Outlier Rate** (Number of Outliers/ Count of Clients in Medicaid Population)
  - 100/50,000 = 0.002
- **Outlier Rate Permillage** (Outlier Rate * 1000): 2.0000

PCR-AD: Additional Technical Assistance Resources

For additional guidance, the Centers for Medicare and Medicaid Services (CMS) webpage on Adult Core Set Reporting Resources, at 2015-2023 Archived Adult Core Set Measure Lists and Reporting Resources (below the 2024 information), contains a PCR Technical Assistance Brief.

Upcoming Quality Measure Technical Assistance

Upcoming Quality Measure Technical Assistance

Additional Quality Measure-Related Technical Assistance

January 18, 2024, State-Collected-Required Measures Part 1

February 15, 2024, State-Collected-Required Part 2 and Optional Measures

February 22, 2024, Office Hours for States
March 8, 2024, Office Hours for Clinics

To be recorded and released in March 2024:

- **State-Collected Measure Overview for Clinics**
- **Reporting Template Use**

Questions and Discussion

Poll #2

In the last 90 minutes, I have learned *(please select the best option)*:

A. A lot of useful new information
B. Some useful new information
C. Very little new information
D. Not sure
E. Other *(please add comments to the chat box)*

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12
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Thank You

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.

Direct **Quality Measure** Questions to:

CCBHCMeasuresSubmission@samhsa.hhs.gov

www.samhsa.gov

1-877-SAMHSA-7 (1-877-726-4727) ● 1-800-487-4889 (TDD)

Building a Quality Measurement Program

CCBHC S-TAC
Monthly State Meeting
February 15, 2024

CCBHC S-TAC
CCBHC State Technical Assistance Center

Quality Measurement in the CCBHC Criteria

5.a.2 Both Section 223 Demonstration CCBHCs, and CCBHC-Es awarded SAMHSA discretionary CCBHC-Expansion grants beginning in 2022, must collect and report the Clinic-Collected quality measures identified as required in Appendix B.

- Reporting is annual and, for Clinic-Collected quality measures, reporting is required for all people receiving CCBHC services.
- Section 223 Demonstration CCBHCs are to report required quality measures to their states nine (9) months after the end of the measurement year as that term is defined in the technical specifications.
- CCBHC-Es that are required to report quality measure data report it directly to SAMHSA nine (9) months after the end of the measurement year as that term is defined in the technical specifications.
- States participating in the Section 223 Demonstration must report State-Collected quality measures identified as required in Appendix B.
- The State-Collected measures are to be reported for all Medicaid enrollees in the CCBHCs, as further defined in the technical specifications.

Quality Measurement in the CCBHC Criteria

5.a.2 (Continued)

- Section 223 Demonstration program states must advise SAMHSA and its CCBHCs which, if any, of the listed optional measures it will require (either State-Collected or Clinic-Collected).
- Whether the measures are State- or Clinic-Collected, all must be reported to SAMHSA annually via a single submission from the state twelve (12) months after the end of the measurement year, as that term is defined in the technical specifications.
- States participating in the Section 223 Demonstration program are expected to share the results from the State-Collected measures with their Section 223 Demonstration program CCBHCs in a timely fashion.

Quality Measurement in the CCBHC Criteria

5.a.2 (Continued)

- For this reason, Section 223 Demonstration program states may elect to calculate their State-Collected measures more frequently to share with their Section 223 Demonstration program CCBHCs, to facilitate quality improvement at the clinic level.
- Quality measures to be reported for the Section 223 Demonstration program may relate to services individuals receive through DCOs.
- It is the responsibility of the CCBHC to arrange for access to such data as legally permissible upon creation of the relationship with DCOs. CCBHCs should ensure that consent is obtained and documented as appropriate, and that releases of information are obtained for each affected person. CCBHCs that are not part of the Section 223 Demonstration are not required to include data from DCOs into the quality measure data that they report.
- Note: CCBHCs may be required to report on quality measures through DCOs as a result of participating in a state CCBHC program separate from the Section 223 Demonstration, such as a program to support the CCBHC model through the state Medicaid plan.

Quality Measurement in the CCBHC Criteria

5.a.3 In addition to the State- and Clinic-Collected quality measures described above, Section 223 Demonstration program states may be requested to provide CCBHC-identifiable Medicaid claims or encounter data to the evaluators of the Section 223 Demonstration program annually for evaluation purposes.

- These data also must be submitted to CMS through T-MSIS in order to support the state's claim for enhanced federal matching funds made available through the Section 223 Demonstration program.
- At a minimum, Medicaid claims and encounter data provided by the state to the national evaluation team, and to CMS through T-MSIS, should include a unique identifier for each person receiving services, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis.

Quality Measurement in the CCBHC Criteria

5.a.3 (Continued)

- Clinic site identifiers are very strongly preferred. In addition to data specified in this program requirement and in Appendix B that the Section 223 Demonstration state is to provide, the state will provide other data as may be required for the evaluation to HHS and the national evaluation contractor annually.
- To the extent CCBHCs participating in the Section 223 Demonstration program are responsible for the provision of data, the data will be provided to the state and, as may be required, to HHS and the evaluator.
- CCBHC states are required to submit cost reports to CMS annually including years where the state's rates are trended only and not rebased.
- CCBHCs participating in the Section 223 Demonstration program will participate in discussions with the national evaluation team and participate in other evaluation-related data collection activities as requested.

Quality Measurement in the CCBHC Criteria

5.a.4 CCBHCs participating in the Section 223 Demonstration program annually submit a cost report with supporting data within six months after the end of each Section 223 Demonstration year to the state.

- The Section 223 Demonstration state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each Section 223 Demonstration year to CMS.
- Note: In order for a clinic participating in the Section 223 Demonstration Program to receive payment using the CCBHC PPS, it must be certified by a Section 223 Demonstration state as a CCBHC.

Clinic-Collected Measures

Required

=5

- Time to Services (I-SERV)
- Depression Remission at Six Months (DEP-REM-6)
- Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)
- Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD)
- Screening for Social Drivers of Health (SDOH)

Optional

- Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)
- Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA) (SRA-A)
- Adult Major Depressive Disorder: Suicide Risk Assessment (SRA) (SRA-C)
- Weight Assessment and
- Counseling for Nutrition and Physical Activity for children/Adolescents (WCC-CH)
- Controlling High Blood Pressure (CBP-AD)

State-Collected Measures

Required

- Patient Experience of Care Survey
- Youth/Family Experience of Care Survey
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)
- Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)
- Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD)

Required =13

- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD)
- Plan All-Cause Readmissions Rate (PCR-AD)
- Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)
- Antidepressant Medication Management (AMM-BH)
- Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)
- Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)

Optional

- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)

Establishing a Quality Measurement Program

Two types of Quality Measures require two types of systems

State Collected Measures

- Establish internal state resources and/or identify external evaluator
- Collecting and reporting claims data

Clinic Collected Measures

- Establish Technical Assistance resources (internal and/or external) for clinics
- Collecting, aggregating and reporting clinic data

Planning for State Collected Measures

- ❑ Establish goals for the CCBHC program
  - ✓ Consider baselines for required CCBHC measures
  - ✓ Research potential thresholds for quality bonus measures early
  - ✓ Work backwards from goals to develop evaluation plan
  - ✓ Determine additional measures relative to state's strategic goals
  - ✓ Provide "the why" to clinics and stakeholders for data reporting
- ❑ Establish the resources necessary for data collection, analysis and reporting
  - ✓ Align with or modify current systems for collecting Medicaid Core Set
  - ✓ 90% of QMs are from 2024 new mandated Core Set as SAMHSA looks toward uniform QMs
  - ✓ Identify internal resources in data analysis unit, claims processing unit, managed care liaison
  - ✓ Consider an external evaluator with experience with claims data reporting and clinic EHR reporting

Planning for State Collected Measures

- ❑ Collaboratively determine claiming system architecture with data reporting in mind
  - ✓ Pipeline configuration: Billing code in EHR -> billing module -> clearinghouse -> claims engine (MMIS or MCO)
  - ✓ T1040 and shadow billing
  - ✓ Using billing codes, modifiers, specialty codes, provider IDs, provider types, or NPIs that will help aggregate data efficiently
  - ✓ Wrap payment or paying PPS up-front
  - ✓ Consider claiming and data collection from TPL, Medicare, Medicaid
  - ✓ Determine collaboratively with clinics
  - ✓ Collaborate closely with managed care about payment systems and data collection
- ❑ Reconfigure MMIS
  - ✓ Get in the queue early as this takes considerable time and effort
  - ✓ Coordinate with managed care claims processing and claims data collection systems

Planning for Clinic Collected Measures

- ❑ Establish consistent and collaborative communication systems
  - ✓ Clinics, DCOs, Associations (mental health, substance use, primary care)
  - ✓ Managed Care Organizations
  - ✓ EHR Vendors
  - ✓ Contracted Evaluators
  - ✓ State Data Quality staff
- ❑ Create an inventory of clinic resources used for QM
  - ✓ Electronic Health Records (EHRs) used and capacity to meet CCBHC requirements
  - ✓ Which clinics use external evaluators
  - ✓ Primary points of contact for data discussions
  - ✓ QM experience level at each clinic
- ❑ Plan for clinic dashboards and patient portals
  - ✓ Internal resources to collect, analyze and report close to real-time clinic data
  - ✓ Listed in the CCBHC criteria
  - ✓ Provides opportunities for care coordination and follow-up after crisis and hospital utilization
  - ✓ Assists clinics with measuring progress toward Quality Bonus Measures

Planning for Clinic Collected Measures

- ❑ Determine a data collection process intentionally
  - ✓ Build the collection process collaboratively with clinics/evaluators/MCOs/EHR Vendors
  - ✓ Changing systems for clinics mid-demonstration causes chaos
  - ✓ EHR configurations should be done accurately from the beginning
  - ✓ Collect comparable information between clinic and state collected measures to validate data whenever possible
- ❑ Establish a quarterly data reporting system
  - ✓ Provide to the clinics a toolkit, evaluation manual and the SAMHSA-created reporting template for clinic submissions
  - ✓ Perform data checks to identify any errors or data truncation
  - ✓ Provide immediate Technical Assistance about corrections needed
  - ✓ Allows for more real-time data analysis opportunities
  - ✓ Assures data integrity leading up to annual reporting
- ❑ Provide TA to current and prospective CCBHCs
  - ✓ Assist in building data infrastructure at clinics
  - ✓ Support clinics in building their Health IT infrastructures for population health management

Questions & Discussion

SAMHSA Policy Academy

Please take a moment to answer the question that will appear on your screen:

What is your level of interest in attending the SAMHSA Policy Academy?

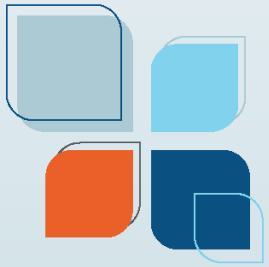
- Will be there - no more information needed.
- Very interested - would like more information.
- Slightly interested- would like more information.
- Uninterested - would like more information.
- Very uninterested - no more information needed.

Questions

Request TA

Resources

The CCBHC State Technical Assistance Center is live and is here to provides accessible, timely and evidence-based technical assistance designed to meet the needs of all states implementing the CCBHC model, as well as individualized consultation to support the needs of specific states. Please request technical assistance by clicking “Request TA” above.



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