NATIONAL COUNCIL for Mental Wellbeing

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

Monthly State Meeting

January 18, 2024

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NATIONAL COUNCIL *for* Mental Wellbeing

In-Person State Meetings

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Agenda
Topic: State-Collected Measures

- **3:30 PM:** Welcome & Housekeeping
- **3:35 PM:** State-Collected-Required Measures (#1): AMM, SAA, ADD, OUD, HBD, PEC & YFEC
- **4:30 PM**: Discussion
- **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.*

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State-Collected-Required Measures (#1): AMM, SAA, ADD, OUD, HBD, PEC & YFEC

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Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

January 18, 2024
3:30-5:00 PM ET

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Question #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).

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

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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***."

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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.

Antidepressant Medication Management (AMM-AD)

Who?
Clients aged 18 years and older

Why?
Retention in medication treatment

AMM-AD Measure: Description and Source

- Percentage of clients age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported:
  - Effective Acute Phase Treatment. Percentage of clients who remained on an antidepressant medication for at least 84 days (12 weeks)
  - Effective Continuation Phase Treatment. Percentage of clients who remained on an antidepressant medication for at least 180 days (6 months)
- 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*.

AMM-AD Measure: Data Source and Measurement Period

- Data source: Administrative or EHR
- Measurement Period (aka, the time period data must cover):
  - The AMM-AD measure ***denominator*** includes two Measurement Periods:
    - ***Index prescription start date (IPSD)***: The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.
      - ***Intake Period:*** The 12-month window starting on May 1 of the year prior to the Measurement Year and ending on April 30 of the Measurement Year.
    - ***Negative medication history review***: A period of 105 days prior to the IPSD when the client had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
  - The Measurement Period for the AMM-AD ***numerator*** differs for the two submeasures:
    - ***Effective Acute Phase Treatment***: IPSD through 114 days following IPSD
    - ***Effective Continuation Phase Treatment***: IPSD through 231 days following IPSD

AMM-AD: Calculation of Denominator

Denominator is all clients in the Eligible Population:

1. Age 18 or older as of April 30 of MY and seen at least once at the CCBHC during the MY.
2. Determine the IPSD: Identify the date of the earliest dispensing event for an **antidepressant medication** during the **Intake Period**.
3. Exclude clients who did not have an encounter with a **diagnosis of major depression** during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD.
4. Test for Negative Medication History: Exclude clients who filled a prescription for an **antidepressant medication** 105 days prior to the IPSD.
5. Calculate continuous enrollment in Medicaid: 105 days prior to the IPSD through 231 days after the IPSD (with medical and pharmacy benefits), **with one allowable gap in enrollment** of up to 45 days, which may not include the IPSD.

Stratification: payer, race, ethnicity

NOTE: Bold means the specs contain much more detail!

MY: Measurement Year

AMM-AD: Calculation of Numerators

Out of those in the denominator:

Effective Acute Phase Treatment: At least 84 days (12 weeks) of treatment with **antidepressant medication,** beginning on the IPSD through 114 days after the IPSD (115 total days). This allows **gaps** in medication treatment up to a total of 31 days during the 115-day period.

Effective Continuation Phase Treatment: At least 180 days (6 months) of treatment with **antidepressant medication,** beginning on the IPSD through 231 days after the IPSD (232 total days). This allows **gaps** in medication treatment up to a total of 52 days during the 232-day period.

NOTE: Bold means the specs contain much more detail!

AMM-AD: Practice Example (MY=2025): Denominator

Number receiving CCBHC service during Intake Period (May 1, 2024- April 30, 2025).	2,500
Of those, 18 or older as of April 30, 2025.	2,500 -50 = 2,450
For each of those, identify IPSD (earliest prescription dispensing date within the Intake Period).	
From those, exclude those who filled a prescription for an antidepressant medication 105 days prior to their IPSD.	2,450 - 700 = 1,750
From those remaining, exclude any who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD.	1,750 - 200 = 1,550
From those remaining, exclude any w/o continuous enrollment (per spec) in Medicaid.	1,550 – 575 = 975
Denominator	**975**

AMM-AD: Practice Example

Numerator: *Effective Acute Phase Treatment*

Number in Denominator	975
At least 84 days (12 weeks) of treatment with antidepressant medication, beginning on the IPSD through 114 days after the IPSD (115 total days).	975-125 = 850
Numerator	**850**

AMM-AD rate #1 = 850/975 = .87 or 87%

Numerator: *Effective Continuation Phase Treatment*

Number in Denominator	975
Of those, did not have at least 180 days (6 months) of treatment with **antidepressant medication,** beginning on the IPSD through 231 days after the IPSD (232 total days).	975-499 = 476
Numerator	**476**

AMM-AD rate #2 = 476/975 = .49 or 49%

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)

Who?
Clients aged 18 years and older

Why?
Retention in medication treatment

SAA-AD Measure: Description and Source

- Percentage of clients ages 18 and older during the Measurement Year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.
- 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*.

SAA-AD Measure: Data Source and Measurement Period

- Data source: Administrative
- Measurement Period (aka, the time period data must cover):
  - The Measurement Period for both the SAA-AD measure ***denominator*** and ***numerator*** is the Measurement Year.

SAA-AD: Calculation of Denominator

Denominator is all clients in the Eligible Population:

1. Age 18 years or older as of January 1 of MY and seen at least once at the CCBHC during the MY.
2. Who have continuous enrollment in Medicaid (medical and pharmacy benefits) through the entire MY, **with one allowable gap in enrollment** of up to 45 days during the MY, which gap may not include December 31 of the MY.
3. Of those, clients with **schizophrenia or schizoaffective disorder** who met **encounter criteria** during the MY.
4. Of those, exclude any who, during the MY, had a **dementia diagnosis**, did not have at least two **antipsychotic medication dispensing events**, or who received **hospice services**.
5. Optionally exclude any who were ages 66 to 80 as of December 31 of the MY and had both **frailty and advanced illness or who were** age 81 and older as of December 31 of the MY with **frailty.**

Stratification: payer, race, ethnicity

NOTE: Bold means the specs contain much more detail!

MY: Measurement Year

SAA-AD: Calculation of Numerators

Out of those in the denominator:

- The number who achieved a **Proportion of Days Covered** (**PDC)** of at least 80 percent for their **antipsychotic medications** during the MY.
  - For each client, identify the IPSD (the earliest dispensing event for any antipsychotic medication during the MY).
  - For each client, calculate the **treatment period**.
  - For each client, count the **days covered** by at least one **antipsychotic medication** during the **treatment period**.
  - For each client, **calculate their PDC**.
  - Sum the number of clients whose **PDC** is ≥ 80 percent for their **treatment period**.

NOTE: Bold means the specs contain much more detail!

SAA-AD: Practice Example

Denominator

Number of people receiving CCBHC service in Measurement Year (MY)	2,500
Of those, age 18 years or older	2,500 - 500= 2,000
Of those, remove any w/o continuous enrollment (per spec) in Medicaid	2,000 – 475 = 1,525
Of those, remove any who did not have a schizophrenia or schizoaffective disorder and who did not meet specified encounter criteria during the MY	1,525 – 930 = 595
Of those, exclude any who, during the MY, had a dementia diagnosis, did not have at least two antipsychotic medication dispensing events, or who received hospice services.	595 – 125 = 470
Of those, determine whether to use the optional exclusions (frailty/advanced illness) [assume not used]	
Denominator	**470**

Numerator

Number in Denominator	470
For each of those clients: 1) Identify IPSD 2) Calculate their treatment period 3) Count the days covered by at least one antipsychotic medication during the treatment period 4) Calculate their PDC	
Remove the clients in the denominator whose PDC was not ≥ 80 percent for their treatment period	470 – 290 = 180
Numerator	**180**

SAA-AD rate = 180/470 = .38 or 38%

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)

Who?
Clients aged 6-12 years

Why?
Follow-up and retention in treatment

ADD-CH Measure: Description and Source

- Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.
  - Initiation Phase: Percentage of children ages 6 to 12 with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.
  - Continuation and Maintenance (C&M) Phase: Percentage of children ages 6 to 12 with a prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.
- 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*.

ADD-CH Measure: Data Source and Measurement Period

- Data source: Administrative or EHR
- Measurement Period (aka, the time period data must cover):
  - The ADD-CH measure ***denominator*** includes two Measurement Periods:
    - ***Index prescription start date (IPSD):*** The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.
      - ***Intake Period:*** The 12-month window starting March 1 of the year prior to the measurement year and ending the last calendar day of February of the measurement year.
    - ***Negative medication history review***: 120 days prior to the IPSD.
  - The Measurement Period for the ADD-CH ***numerator*** differs for the two submeasures:
    - ***Initiation Phase:*** 30 days following the IPSD
    - ***Continuation and Maintenance Phase:*** The 300 days following the IPSD (10 Months)

ADD-CH Calculation of Rate 1: Initiation Phase

ADD-CH: Calculation of Denominator Rate 1 Initiation Phase

Denominator is all clients in the Rate 1 Eligible Population:

1. Age 6 as of March 1 of the year prior to the Measurement Year to age 12 as of the last calendar day of February of the Measurement Year and seen at least once at the CCBHC during the MY.
2. Of those, clients dispensed an **ADHD medication** during the **Intake Period**.
3. Determine the IPSD: For each of those, identify the date of the earliest dispensing event for an **ADHD medication** during the **Intake Period**.
4. Test for Negative Medication History: Of those, exclude clients who filled a prescription for an **ADHD medication** (new or refill) 120 days prior to the IPSD.
5. Calculate continuous enrollment in Medicaid/CHIP: Of those, continuous enrollment for 120 days (4 months) prior to the IPSD through 30 days after the IPSD (with medical and pharmacy benefits), with no allowable gaps.
6. Remove clients who had an **acute inpatient encounter** for a mental, behavioral, or neurodevelopmental disorder during the 30 days after the IPSD.
7. Of those remaining, exclude those with a **diagnosis of narcolepsy** or who **received hospice services**.

Stratification: payer, race, ethnicity

NOTE: Bold means the specs contain much more detail!

MY: Measurement Year

ADD-CH: Calculation of Numerator Rate 1 Initiation Phase

Out of those in the Rate 1 denominator:

- A **follow-up visit** with a practitioner with prescribing authority, within 30 days after the **IPSD**.
  - Do not count a visit on the **IPSD** as the Initiation Phase visit.

NOTE: Bold means the specs contain much more detail!

ADD-CH: Rate 1 Initiation Phase Practice Example

Rate 1 Denominator

Number of people receiving CCBHC service in Measurement Year (MY)	2,500
Of those, age 6-12 years	2,500 - 2,000= 500
Of those, received ADHD medication during Intake Period	500 – 112 = 388
For each of those, identify IPSD	
From those, exclude ones who filled a prescription for an ADHD medication 120 days prior to their IPSD	388 – 100 = 288
Of those, exclude any w/o continuous enrollment (per Rate 1 spec) in Medicaid/CHIP	288 – 199 = 89
Of those, remove any with a relevant acute inpatient encounter during the 30 days after the IPSD	89 – 5 = 84
Of those, exclude any with narcolepsy or who received hospice services.	84 - 2 = 82
Rate 1 Denominator	**82**

Rate 1 Numerator

Number in Rate 1 Denominator	82
Of those, remove those who did not have an appropriate follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD	82 – 20 = 62
Rate 1 Numerator	**62**

ADD-CH rate #1 = 62/82 = .76 or 76%

ADD-CH Calculation of Rate 2: C&M Phase

ADD-CH: Calculation of Denominator Rate 2 C&M Phase

Denominator is all clients in the Rate 2 Eligible Population:

1. Identify all children who meet the **eligible population criteria for Rate 1.**
2. Calculate continuous enrollment in Medicaid/CHIP: Of those, continuous enrollment for 120 days (4 months) prior to the **IPSD** through 300 days (10 months) after the IPSD (with medical and pharmacy benefits), with **enrollment gap allowed per spec**.
3. Of those, clients dispensed a sufficient number of **ADHD prescriptions** to provide **continuous treatment** for at least 210 days out of the 301-day period beginning on the **IPSD** through 300 days after the IPSD **(with dispensing gaps allowed per spec).**
4. Remove clients who had an **acute inpatient encounter** for a mental, behavioral, or neurodevelopmental disorder during the 300 days (10 months) after the IPSD.

Stratification: payer, race, ethnicity

NOTE: Bold means the specs contain much more detail!

MY: Measurement Year

ADD-CH: Calculation of Numerator Rate 2 C&M Phase

Out of those in the Rate 2 denominator:

- Who were **numerator compliant** for the Rate 1 Initiation Phase, and
- Had at least two **follow-up visits** with any practitioner, from 31–300 days (9 months) after the **IPSD**.

NOTE: Bold means the specs contain much more detail!

ADD-CH: Rate 2 C&M Phase Practice Example

Rate 2 Denominator

Number of children who meet the eligible population criteria for Rate 1	82
Of those, exclude any w/o continuous enrollment (per Rate 2 spec) in Medicaid/CHIP	82 – 15 = 67
Of those, remove any who were not dispensed a sufficient number of ADHD prescriptions to provide continuous treatment for at least 210 days out of the 301-day period beginning on the IPSD through 300 days after the IPSD (with dispensing gaps allowed per spec).	67-10 = 57
Of those, remove any with a relevant acute inpatient encounter during the 300 days after the IPSD	57 – 20 = 37
Rate 2 Denominator	**37**

Rate 2 Numerator

Number in Rate 2 Denominator	37
Of those, remove any who were not Rate 1 Initiation Phase numerator compliant	37-20 = 17
Of those, remove any who did not have at least two follow-ups with any practitioner, from 31–300 days (9 months) after the IPSD	17-10 = 7
Rate 2 Numerator	**7**

ADD-CH rate #2 = 7/37 = .19 or 19%

Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)

Who?
Clients aged 18 – 64 years

Why?
Use of medication therapy for OUD

OUD-AD Measure: Description and Source

- Percentage of clients ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the Measurement Year. Five rates are reported:
  - A total (overall) rate capturing any medications used in medication assisted treatment of opioid dependence and addiction (Rate 1)
  - Four separate rates representing the following types of FDA-approved drug products:
    - Buprenorphine (Rate 2)
    - Oral naltrexone (Rate 3)
    - Long-acting, injectable naltrexone (Rate 4)
    - Methadone (Rate 5)
- Source: CMS Medicaid Adult Core Set Measure (2023)

OUD-AD Measure: Data Source and Measurement Period

- Data source: Administrative
- Measurement Period (aka, the time period data must cover):
  - The Measurement Period for both the OUD-AD measure ***denominator*** and ***numerator*** is the Measurement Year.

OUD-AD: Calculation of Denominator

Denominator is all clients in the Eligible Population:

1. Age 18 – 64 years as of January 1 of MY and at least one CCBHC encounter with a **diagnosis of opioid abuse, dependence, or remission** (primary or other) at any time during the MY.
2. Calculate continuous enrollment in Medicaid throughout the MY (with medical and chemical dependency (inpatient, residential, and outpatient) benefits), with no allowable gap in enrollment.

Stratification: payer, race, ethnicity

NOTE: Bold means the specs contain much more detail!

MY: Measurement Year

OUD-AD: Calculation of Numerators for each Rate

Out of those clients in the denominator:

Rate 1 (Total): Clients with **evidence** of at least one prescription filled, or who were administered or dispensed an **FDA-approved medication for OUD** during the Measurement Year.

- Not the sum of the other rates!

Rate 2 (buprenorphine): Clients with evidence of at least one prescription for **buprenorphine** at any point during the Measurement Year.

Rate 3 (oral naltrexone): Clients with evidence of at least one prescription for **oral naltrexone** at any point during the Measurement Year.

Rate 4 (long-acting, injectable naltrexone): Clients with evidence of at least one prescription for **long-acting, injectable naltrexone** at any point during the Measurement Year.

Rate 5 (methadone): Clients with evidence of at least one dose for **methadone** at any point during the Measurement Year.

NOTE: Bold means the specs contain much more detail!

OUD-AD Rate 1 (Total): Practice Example

Rate 1 Denominator

Number of clients ages 18 – 64 years as of January 1 of MY	2,000
Of those, exclude those who did not have at least one CCBHC encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the MY.	2,000 - 1,000 = 1,000
Of those, remove any did not have continuous enrollment in Medicaid throughout the MY (with medical and chemical dependency (inpatient, residential, and outpatient) benefits), with no allowable gap in enrollment.	1,000 – 475 = 525
Rate 1 Denominator	**525**

Rate 1 Numerator

Number in Rate 1 Denominator	525
Of those, remove those clients without evidence of at least one prescription filled, or who were not administered or dispensed an FDA-approved medication for OUD during the MY	525 – 100 = 425
Rate 1 Numerator	**425**

OUD-AD Rate 1 = 425/525 = .81 or 81%

Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)

Who?
Clients aged 18 to 75 years

Why?
Assessment of physical health

HBD-AD Measure: Description and Source

- Percentage of clients ages 18 to 75 with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:
  - HbA1c control (<8.0%)
  - HbA1c poor control (>9.0%)
- 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*.

HBD-AD Measure: Data Source and Measurement Period

- Data source: Administrative or Hybrid or EHR
- Measurement Period (aka, the time period data must cover):
  - The Measurement Period for the HBD-AD measure ***denominator*** is the MY but, data from the entire previous year also is used to identify the diabetes diagnosis. For the HBD-AD ***numerator***, the Measurement Period is the MY.

MY: Measurement Year

HBD-AD: Calculation of Denominator

Denominator is all clients in the Eligible Population:

1. Age 18 – 75 years as of December 31 of MY and at least one CCBHC encounter during the MY.
2. Calculate continuous enrollment in Medicaid throughout the MY (with medical benefits), with no more than one **gap in enrollment** of up to 45 days during the MY, which gap may not include December 31.
3. Identify clients with **diabetes using approaches defined in the specs involving claims/encounter data and pharmacy data**. Diabetes may be evident in either the MY or the year prior.
4. Exclude clients without a diabetes diagnosis who had a diagnosis of **polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes**, in any setting, during the MY or the year prior.
5. Exclude those who used **hospice services** or **palliative care** during the MY or the year prior.
6. Optionally exclude any who were ages 66 and older as of December 31 of the MY and had both **frailty and advanced illness.**

Stratification: payer, race, ethnicity

NOTE: Bold means the specs contain much more detail!

MY: Measurement Year

HBD-AD: Calculation of Numerators for each Rate (Administrative)

Out of those clients in the denominator:

- Numerator 1: HbA1c Control <8%: Numerator compliance exists if **evidence** shows most recent HbA1c was <8%. Noncompliance if ≥8%, result is missing, or HbA1c not performed during MY. (higher measures rates are better)
- Numerator 2: HbA1c Poor Control >9%: Numerator compliance exists if **evidence** shows most recent HbA1c >9%, result is missing, or HbA1c not performed during MY (in other words, this numerator compliance indicates poor control of diabetes). (lower measure rates are better)

NOTE: Bold means the specs contain much more detail!

HBD-AD: Rate 1 (Control) Practice Example

Denominator

Number of clients ages 18 – 75 years as of December 31 of MY	2,300
Of those, remove any did not have continuous enrollment in Medicaid throughout the MY (with medical benefits), with up to one allowable gap (per specs) in enrollment	2,300 - 1,500 = 800
Of those, retain all who had a diabetes diagnosis (determined one of two ways) in MY or in prior year	800 – 350 = 450
Exclude clients without a diabetes diagnosis other than a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes, in any setting, during the MY or the year prior.	450-45 = 405
Exclude those who used hospice services or palliative care during the MY or the year prior	405-30 = 375
Optionally exclude those meeting requirements for frailty and advanced illness [assume not]	
Denominator	**375**

Rate 1 Numerator

Number in Denominator	375
Of those, remove those clients whose most recent HbA1c during the MY was ≥8%, result is missing, or HbA1c not performed during MY.	375 – 100 = 275
Rate 1 Numerator	**275**

HBD-AD Rate 1 = 275/375 = .73 or 73%

Patient Experience of Care Survey (PEC) & Youth/Family Experience of Care Survey (YFEC)

Who?
Adults, Youth & Their Families

Why?
Assessment of client experience of care & services

PEC and YFEC Measures: Description and Source

- The PEC and YFEC measures use states' existing annual completion and submission of the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Experience of Care Survey and the Youth/Family Services Survey for Families (YSS-F) Experience of Care Survey, identifying results separately for CCBHCs and comparison clinics and oversampling those clinics.
- Source: Process for reporting for CCBHCs created by SAMHSA, using existing data collection process that is part of the state Mental Health Block Grants

PEC & YFEC Measures: Additional Information

1. The states continue sampling using the MHSIP and the YSS-F for MHBGs as they do at present, but, for CCBHC reporting purposes, disaggregate to capture each CCBHC individually and a comparison clinic and oversample to include 300 clients per CCBHC and comparison clinic.
2. No stratification requirements relate to this reporting.
3. Report by attaching results to the reporting template.
4. All reporting of results by HHS will be aggregated back to include all CCBHCs in the state.

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

To be scheduled:

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

Questions and Discussion

Question #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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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)

TA Opportunities – Quality Measurement Program

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Questions?

CCBHC@TheNationalCouncil.org