Frequently Asked Questions: Data Collection and Analysis

Questions are in bold. Answers in regular text

Please send any additional questions to CCBHC.Grant@dhsoha.state.or.us

General Questions

Is Medicaid QMB counted as Medicaid or as Dually Eligible Medicaid/Medicare?

For the purposes of the CCBHC program, SAMHSA has directed that Medicaid QMB is going to be treated as Dually Eligible Medicaid/Medicare

PERC codes for Dual Eligible Medicaid Medicare consumers: NG, NH, NI, NJ, NK, NL, QB, QS

How do we break apart Title 19 CHIP and Title 21 CHIP for the purposes of reporting?

Title 19 CHIP and Title 21 CHIP are differentiated by PERC codes as follows:

Title 19: U3, U6, U9, Z1, Z5, ZA, ZK, ZE, U1, U4, U7

Title 21: HF, HG, H5, 19, 62, KA, MF, C5, MC, GA

How do we count consumers who have both private insurance and Medicaid?

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

When are the clinic-lead measures due to SAMHSA and to whom do we report the data?

Clinic-lead measures are required to be reported to SAMHSA 9 months after the end of Demonstration Year 1. Once Oregon has finalized an initial start date, OHA will provide a deadline by which clinics must report the clinic-lead measures to the State, which will then be forwarded to SAMHSA.

For measures that have Hybrid data sources (WCC-BH and CDF-BH), are clinics required to use the sampling methodology if they are more easily able to report on all consumers?

No, if clinics can more easily track all consumers instead of picking a sample it is preferred that clinics report on all consumers. Please make a note in the reporting template on these measures whether you are using your entire consumer population or a sample (including size of sample).

Some measures utilize HCPCS G-codes, which are not reimbursable for behavioral health providers in Oregon. How do we report on these measures?

It is requested that clinics add the G-codes for these measures into their EHR for reporting purposes and use the billing codes they would normally use for reimbursement when submitting claims.

Some measures (such as TSC and BMI-SF) are limited to certain CPT and HCPCS codes, which would exclude codes commonly used by behavioral health providers for services. This would potentially exclude many services done by these clinics from being counted.

SAMHSA has permitted OHA to provide a list of additional codes allowed to be used for the affected measures. This list is forthcoming.

Case Load Characteristics

Do we use the consumer's age and insurance information at the first encounter or the last encounter of the measurement year?

Report the consumer's age and insurance status at the first encounter of the measurement year.

I-EVAL: Time to Initial Evaluation

What counts as "first contact"?

First contact is usually a call looking for an appointment or a walk-in looking for an appointment. A crisis service provided by the CCBHC also can count. Criteria 2.b.1 requires that at first contact a preliminary screening and risk assessment occurs to determine acuity of needs. Referrals are not considered first contact, as contact must be done either by the person seeking services or a family member of the person who would be served so that a preliminary screening can be done to determine acuity of needs.

If a person contacts a clinic more than once prior to the initial evaluation, do both contacts count?

The first time a new consumer contacts a clinic requesting services is the only contact that counts for the purposes of I-EVAL, and a preliminary screening and risk assessment should be done at that time.

If someone makes first contact but never receives an initial evaluation (e.g., moves away, no show), are they still counted as part of the measure?

Someone who makes contact but does not receive an initial evaluation is counted for Metric #1 in I-EVAL (% of new consumers with initial evaluation provided within 10 business days of first contact). However, SAMHSA has directed that these consumers would be excluded from Metric #2 (Mean # of days until initial evaluation). If clinics so desire, they may report the number of consumers who made first contact but never received an initial evaluation in the "additional notes" section on the reporting template.

BMI-SF: Adult Body Mass Index Screening and Follow Up

If a BMI measure is documented after the last CCBHC encounter of the measurement year, can it still count toward the numerator?

No. The BMI must be recorded within the 6 months prior to the last CCBHC encounter of the measurement year. Any BMI recorded after the last CCBHC encounter would not count.

WCC-BH: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Though the requirement that BMI is taken by an OB/GYN or PCP has been relaxed for this measure, are the list of codes for the outpatient value set still going to be the same? Could this potentially be limiting to clinics who did not use a PCP or OB/GYN?

SAMHSA has permitted OHA to provide a list of additional codes allowed to be used for this measure. This list is forthcoming.

TSC: Tobacco Use Screening and Cessation Intervention

Does the screening and cessation intervention have to occur during the same encounter?

While not directly stated in the measure, both screening and cessation intervention are intended to occur in the same encounter.

Are there state requirements for tobacco interventions?

Yes. There are state requirements for tobacco interventions.

OAR 410-130-0190

Tobacco Cessation

(1) Tobacco treatment interventions may include one or more of these services: basic, intensive, and telephone calls.

(2) Basic tobacco cessation treatment includes the following services:

(a) Ask — systematically identify all tobacco users — usually done at each visit;

(b) Advise — strongly urge all tobacco users to quit using;

(c) Assess — the tobacco user's willingness to attempt to quit using tobacco within 30 days;

(d) Assist — with brief behavioral counseling, treatment materials and the recommendation/prescription of tobacco cessation therapy products (e.g., nicotine patches, oral medications intended for tobacco cessation treatment and gum);

(e) Arrange — follow-up support and/or referral to more intensive treatments, if needed.

(3) When providing basic treatment, include a brief discussion to address client concerns and provide the support, encouragement, and counseling needed to assist with tobacco cessation efforts. These brief interventions, less than 6 minutes, generally are provided during a visit for other conditions, and additional billing is not appropriate.

Does the question we use for submitting data concerning tobacco use to MOTS count as tobacco screening?

Yes and no. The question that is reported to MOTS does count as screening, but the brief cessation intervention that is also part of the metric must occur and be recorded for a consumer to count as part of the numerator for TSC. Simply reporting tobacco screening to MOTS does not count as compliance with the TSC metric.

ASC: Unhealthy Alcohol Use Screening and Brief Counseling

For clinics who are only now starting to use AUDIT and AUDIT-C to report on the ASC metric, do we need to rescreen all of our consumers using the AUDIT and AUDIT-C at the start of the program? What about consumers who already have an active diagnosis of alcohol use disorder?

Clinics who have not previously used the AUDIT and AUDIT-C are recommended to re-screen all consumers during the measurement year. However, consumers who already have an active diagnosis for alcohol use disorder are considered exempt for documented medical reasons. They do not need to be rescreened and will not be included in the measure.

SRA-BH-C: Child and Adolescent Major Depressive Disorder Suicide Risk Assessment

Will the state have any official recommendations for a suicide assessment tool?

No, the state will not have any official recommendations of suicide screening tools. If the screening you use meets the criteria in the technical manual then it is fine.

There is a discrepancy between Volume 1 and Volume 2 as to whether this measure is calculated using number of visits or the number of consumers, which is correct?

Volume 1 is correct, you calculate the measure using the number of visits.

The measure description says that a minimum two encounters are required for a consumer to be included in the measure. Must both encounters be with the same clinician?

While ideally both encounters would be with the same clinician, this is not required to satisfy the conditions of the measure.

An individual would need a diagnosis of "Active Major Depressive Disorder" to qualify as part of the denominator. Does this active MDD diagnosis need to be the primary diagnosis for that visit, or does the consumer simply have to have a diagnosis of active MDD at that visit to be counted as part of the denominator? E.g., if there was a consumer who had diagnoses and was receiving services for both depression and substance abuse, would any visits with the substance abuse specialist count as part of the denominator since the consumer also has the active MDD diagnosis even though the substance abuse diagnosis would be the primary concern?

No, the active MDD diagnosis does not need to be primary for a consumer to count for this measure. In this situation the substance abuse specialist would also need to provide a suicide risk assessment. However, SAMHSA has stated that there may be further clarification forthcoming for this metric.

SRA-A: Major Depressive Disorder Suicide Risk Assessment

Will the state have any official recommendations for a suicide assessment tool?

No, the state will not have any official recommendations of suicide screening tools. If the screening you use meets the criteria in the technical manual then it is fine.

CDF-BH: Screening for Clinical Depression and Follow-Up Plan

Screening at every session for clients without a depression or bipolar disorder diagnosis seems excessive. Some clients receive intensive services (multiple over a short timeframe). It does not seem necessary to screen at every visit. Additionally, screening for clients attending a group seems inappropriate in some cases.

SAMHSA has indicated that clinics should screen at every appointment for consumers without an active diagnosis for depression or bipolar disorder. However, it is up to the discretion of the clinic in how a clinic chooses to meet the screening requirements. If the clinic feels that it is not appropriate to screen at every visit for clients who receive more intensive services then that is up to the clinic. However, it is possible that a client may not be counted in the numerator if a screening is not performed at the last encounter.

For CDF-BH and SRA-BH-C, screening for MDD/Dysthymia and/or suicidality during group treatment sessions or family therapy sessions may be inappropriate due to the nature of these sessions.

Metric specifications are not requirements for treatment. It is up to the discretion of the clinic as to whether it will provide suicide risk assessments or depression screening in group sessions. However, based on how the measure is calculated if a clinic does not provide suicide assessments at each visit it will be reflected in the numerator of SRA-BH-C, and similarly for CDF-BH. If a clinic decides that it does not wish to regularly screen for depression or suicidality at group or family sessions, please make a note of this in the "additional notes" section of the reporting template.

If the diagnosis of bipolar or depression is made on the date of the encounter, is the consumer still excluded as ineligible?

No. On the date a diagnosis is made you must document a follow-up plan and count the consumer as part of the measure. On the next visit after the diagnosis these consumers would then be excluded from the measure due to the now active diagnosis of bipolar disorder or depression.

DEP-REM-12: Depression Remission at Twelve months

Upon examining the measurement period for the numerator, it appears that not all of the required data will have been collected by the time clinics are supposed to report data to SAMHSA. The numerator measurement period begins at an index visit and goes for 12 months ± 30 days. Let us give the example of a measurement year lasting from Jan 1st to Dec 31st, 2017. If a consumer was seen October 1st, 2017 (and met criteria for an index visit), the numerator measurement period would not end until September 1st - October 30th, 2018. If MY1 ends Dec 31st, 2017 then the clinics would have to report their data to SAMHSA by September 1st, 2018. Thus it would be impossible for clinics to report complete data for any consumers who were seen in the last three months of the measurement year. Should clinics only report on consumers for whom the 12 month (± 30 days) has lapsed?

SAMHSA has directed that any consumers for whom the 12 month ± 30 day period has not lapsed by the time of reporting should be excluded from the measure.

If a client has finished treatment prior to 12 months and is no longer being seen by the clinic because they are in remission, this would currently not count as part of the numerator based on how the measure is set up even though the client is no longer in need of service. How should clinics to handle this issue?

SAMHSA has directed that, if possible, an appointment be scheduled within the 12 month ± 30 days window so that clinics can meet the conditions of the measure. However, both SAMHSA and OHA understand that this may be difficult for clinics to manage. If clinics so desire, they may report the number of consumers who achieved remission prior to 12 months who would not have been counted in the measure in the "additional notes" section of the reporting template.

For existing clients with MDD/Dysthymia who do not have a PHQ-9 on file, do clinics need to screen them with the PHQ-9 at the first index visit of the demonstration year?

Re-screening of current consumers is not required, and these consumers would *not* be included in the measure. However, a clinic may re-screen all of its current consumers should it so desire so they may be included in the measure. Clinics are advised to use the PHQ-9 going forward for all new consumers so that they may be included in the metric.

Last Updated: 8/26/2016

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