Behavioral Health Clinics

Clarifications to Guidance about Quality Measures and Reporting – Questions Related to Data Reporting and Quality Measurement for CCBHCs

SAMHSA, CMS, and ASPE have provided the following clarifications to questions from states and clinics regarding the 32 quality measures published by HHS.

The Demonstration Year:

Question 1: Is there an "official" start date to the demonstration year (DY)?
Clarification: Each state establishes its DY start or launch date. It may begin as early as January 1, 2017, or as late as July 1, 2017.

Question 2: Are DY1 and DY2 defined as calendar year 2017 and 2018, regardless of when a state launches the CCBHC program? For example, states have until July 1, 2017, to launch the program. Does that mean that DY1 data may actually be less than 1 year?
Clarification: No. DY1 will be the first full year for the state. If the state launches on February 1, its first full year will begin on February 1, 2017, and will end on January 31, 2018. Each state will always have 12 months of data. However, the 12-month time frame will differ across states, depending on when the program launches in the state.

Question 3: If the state begins a demonstration year on January 1 and allows individual CCBHCs to begin services anytime between January 1 and June 30, would the demonstration year begin on January 1 or when the CCBHC begins services?
Clarification: Each state should select a demonstration program launch date between January 1st and July 1st, 2017. The start date should be the first day of one of the months between those dates. All CCBHCs within that state should launch on that state's chosen launch date.

Readiness:

Question 4: Will those CCBHCs that are selected by states to participate in the demonstration program be expected to have systems that are fully capable of complying with the quality measure data collection and reporting expectations upon launch date?
Clarification: The general expectation is that CCBHCs will be ready at day 1 when the demonstration begins. We understand that there could be hiccups and evolution, but we want the CCBHCs to use the planning period to structure those systems. Also note that, in the criteria, the electronic care coordination aspect of the program is not necessarily expected to be ready on day 1 [See Program Requirement 3]. But a plan should be in place that develops over the course of the demonstration.

Question 5: Will the CCBHCs be required to have health information technology (IT) certified by the Office of the National Coordinator (ONC)? If so, does it need to meet 2014 or 2015 standards?
Clarification: The certification criteria at 3.b.1 require the CCBHCs establish or maintain a health IT system that includes EHRs with certain capabilities specified in 3.b.1 and 3.b.2. Criterion 3.b.3 states the following: "If the CCBHC is establishing a health IT system, the system will have the capability to capture structured information in the health IT system (including demographic information, problem lists, and medication lists). CCBHCs establishing a health IT system will adopt a product certified to meet requirements in 3.b.1, to send and receive the full common data set for all summary of care records and be certified to support capabilities including transitions of care and privacy and security. CCBHCs establishing health IT systems will adopt a health IT system that is certified to meet the "Patient List Creation" criterion (45 CFR §170.314(a)(14)) established by the Office of the National Coordinator (ONC) for ONC's

Health IT Certification Program." This criterion seems to suggest that the CCBHCs that are establishing a new health IT system need to meet these requirements, but that the CCBHCs that already have systems in place may not be able to do so. For those establishing a system, the certification requirements are noted above and do not indicate a particular year's standards unless the Patient List criterion bears a certain date.

Question 6: Is the expectation still that all 21 measures will be ready to collect by the beginning of the DY, or just the measures for the Quality Bonus Payments?
Clarification: All 21 measures, not just the measures for Quality Bonus Payments, should be ready to collect by the beginning of the DY. We know there will be fine tuning that goes on through the year, but all 21 should be ready to go at the beginning.

Number of Measures:

Question 7: It appears through the template and upcoming webinar schedule there are 13, not 12, state lead measures required for the CCBHC demonstration. Is this correct?
Clarification: The two patient experience of care surveys are contained in one measure.

Relationship to Other Measures:

Question 8: For participants in the CCBHC demonstration program, will the BHC measures replace reporting required for MHBG and SAPT Block Grant such as Uniform Reporting System Tables, mental health client-level data reporting, and the Treatment Episode Data Set?
Clarification: No. The BHC measures that are required for the CCBHC demonstration program are in addition to what you are already required to report.

Question 9: Volume 1 of the BHC Quality Measures includes two tables with the 21 BHC quality measures. Table 1 lists clinic-lead measures, including WCC- BH and SRA-BH-C. Both of these measures are identified as Child Core measures; however, the data collection method for WCC-BH is identified as administrative or hybrid; for SRA-BH-C, the data collection method is identified as electronic health records. If states already submit the child core measure for these two measures, can they satisfy the BHC report template using results from the same Child Core measure?
Clarification: The data collection methods for all BHC measures that are also a part of the Medicaid Adult or Child Core Sets are the same as those in the CMS Technical Specifications; however, the BHC Technical Specifications are specified to be reported at the BHC level and not at the state level which is how the Medicaid Core Sets are specified. The data/results that you are submitting for the CCBHC demonstration should only include data on the CCBHC (patients and services) and not for the state as a whole and therefore should be different than what you submit into MACPro for CMS (which is data on the entire state).

Question 10: Can states report some BHC-lead measures instead of requiring the BHCs to do it?
Clarification: When creating the quality measure tables and Technical Specifications, we divided the measures into two groups based on who we thought would have the information and on the level of effort that we felt it would take for them to report it. However, the state is permitted to report data on behalf of CCBHCs, including data for the BHC-lead measures.

Question 11: If the state elects to report BHC-lead measures rather than having the BHCs do it, can the state use administrative data rather than EHR or hybrid data like the BHC Technical Specifications require for three Medicaid Core Set measures (WCC-BH, SRA-BH-C, and CDF-BH)?

Clarification: States (or BHCs) should source data from the EHR or utilize hybrid data from medical chart and claims as required by the BHC Technical Specifications. If this is not possible, then administrative data derived from claims may be used. If a state is not able to report a measure as shown in the Technical Specifications, then it should provide a detailed plan in its demonstration application that outlines how it will move toward reporting the measure as specified.

Question 12: If HEDIS measures are used, how does the plan deal with CCBHC demonstration years that begin in July, whereas HEDIS data are for a calendar year?

Clarification: This question was asked in reference to a suggestion that, for the measures that are both BHC measures and HEDIS measures, data from earlier periods might be used to obtain baseline rates for Quality Bonus Measures (QBMs). This has to be distinguished from reporting the BHC measures for the CCBHC demonstration. With regard to reporting for the demonstration, the demonstration year is the measurement year, unlike for standard HEDIS measures, and you use the demonstration year to report the BHC version of the HEDIS measures during each of the demonstration years. In contrast, when we are talking about using the HEDIS data to provide information on a baseline or a threshold for a QBM, you could use a full year's data or a shorter duration (e.g., the previous quarter). That is just one of several possibilities we discussed in Webinar 7 related to obtaining baselines or setting thresholds for demonstration year 1.

Data Reporting:

Question 13: For the CCBHC demonstration program, are the BHCs reporting directly to the state?

Clarification: The BHC-lead measures are calculated by the BHCs, and those measures are reported on the data reporting template to the state. The state also is reporting the state-lead measures. The state is responsible for submitting both the BHC-lead measures (which were sent to them by the BHC) and the state-lead measures (which the state has calculated) to SAMHSA.

Question 14: Under the Section 223 demonstration program, does the state aggregate the BHC measures before submitting to SAMHSA?

Clarification: No, all measures, whether state-lead or BHC-lead remain at the individual BHC level and the state submits a separate data reporting template to SAMHSA for each BHC in the state. There will be no aggregation at the state level.

Question 15: How frequently is reporting required under the CCBHC demonstration program--annually or quarterly?

Clarification: The criteria require that reporting to SAMHSA be annual. The reporting has to be submitted within a certain amount of time after the DY ends. However, states have certain leeway as to whether they would like to examine the data more frequently. Sometimes it is a good idea to review data more frequently so that you can identify potential problems and can respond to the data, and make adjustments to services if needed. But the criteria only require annual reporting.

Question 16: On page 21 of the Technical Specifications Manual, it is mentioned that data from the CCBHC BHC-lead measures must be submitted within 9 months after the end of the DY. However, in an earlier presentation from SAMHSA (Orientation Presentation given 6/1/2016, slide 41) it is mentioned that the BHC-lead measurements are due 6 months after the end of the DY. May we have clarification as to which deadline is correct?

Clarification: The Technical Specifications are correct—BHCs have 9 months and states have 12 months to submit those data. The BHC-lead measures that are reported to the state at 9 months will, in turn, be provided to SAMHSA with the remainder of the measures at 12 months. The certification criteria do mention that the cost report must be submitted within 6 months.

Question 17: Providers have up to one year to file a Medicaid claim. What does this mean for CCBHC reporting deadlines? We know that the states have up to a year after the demonstration year ends to submit the quality measures. What do we do if we get claims after that point?

Clarification: As part of Medicaid rules, states have up to 2 years to make claim adjustments under the 2-year timely filing rule. Although the states might have additional time to seek reimbursement after the year in which data must be reported for the demonstration, evaluation time constraints mean that, for the measures, the data available by the one-year deadline for submission are what will be used for the evaluation.

Question 18: Under the CCBHC demonstration program, how often does SAMHSA want data to be transmitted from the sites to the state? Is the cadence up to the sites?

Clarification: This is up to the states to work out with their BHCs. The only explicit requirement is that the BHCs report to the states by 9 months after the end of the DY and that the states submit all data to SAMHSA within 12 months of the end of the DY.

Question 19: We use HEDIS measurement for reporting, and HEDIS measurements use calendar years. If the state DY begins at any time other than January 1, how should the state report this year? HEDIS is generally from January to December. If the DY is July to June, should the state be reporting 2017 or 2018 data?

Clarification: You need to follow the DY, not the calendar year, in reporting the BHC quality measure rates for the CCBHC demonstration program. Data would be from July to June if your state's DY starts at the beginning of July. We did include in the data reporting template tables of measurement periods (MPs) for all the measures that take into account all the different dates between January 1 and July 1, assuming you launch on the 1st of a month.

Question 20: For the CCBHC demonstration program, will SAMHSA be designing a reporting format and methodology for states to use, or will the states be designing their own processes to report the measure data?

Clarification: Please use the data reporting template. That is how the measures will be reported.

Question 21: For the CCBHC demonstration program, will a portal be available for data input reporting, or will electronic forms be made available to fill out?

Clarification: No, there is no portal, and there is no electronic form. The data reporting template is an Excel worksheet, and this worksheet is submitted via email. You send the data reporting template to SAMHSA. The email address, which can be found in the front matter to the Technical Specifications Manual, is CCBHCMeasuresSubmission@samhsa.hhs.gov.

Data Sources:

Question 22: Are all of the CCBHCs in a state required to have the same data source, or could some CCBHC data sources be from EHRs and some from registries?

Clarification: All the CCBHCs in a state do not have to have the same data source. It is very likely that CCBHCs will have different EHRs and different capabilities.

Question 23: For the BHC-lead measures, is it correct that the BHCs will only use data from their system? For example, is it correct that if one client had a visit with his or her PCP, those data would not show up in the data sent for the measures reported for the CCBHC demonstration program?

Clarification: No, that is not correct. There are data-sharing requirements with Designated Collaborating Organizations (DCOs). If the PCP is a DCO for purposes of physical health screening, the data would be shared. If the PCP is merely a care coordination partner, efforts should be made to obtain data on elements such as BMI that the PCP might be collecting, unless the BHC plans to conduct that screen itself. The certification criteria at 3.b.5 state that "Whether a CCBHC has an existing health IT system or is establishing a new health IT system, the CCBHC will develop a plan to be produced within the two-year demonstration program time frame to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan shall include information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care."

Data Collection:

Question 24: Our state has many decisions to make about quality assurance of the data collected by clinics as part of the CCBHC demonstration program. One of these decisions is whether the clinic should complete the reporting templates and submit them to the state or whether the clinic should submit raw data to the state and then the state completes the templates. Do you have any guidance?

Clarification: This is a question that will need to be considered by each state. Here are some points to consider:

- BHCs may be more capable than states realize.
- The data reporting templates were designed to be as simple as possible, and they contain data validation messages and formats that can help prevent many errors.
- The raw data that the state gets may or may not be difficult to use in completing the templates.
- The state may want to examine the BHC-lead measures and determine if some BHCs are more suited for this than others, if having the state fill out the template is the path you take.
- If the state opts to complete the templates, it should make sure that its systems can accept the BHC data. The state also should consider the BHCs' capacity to collect, clean, analyze, and transfer the data.

Question 25: The Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics includes the following text under Program Requirement 5.a.1: "The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including but not limited to data capturing: (1) consumer characteristics; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) consumer outcomes. Data collection and reporting requirements are elaborated below and in Appendix A." Does SAMHSA intend that the 21 reported quality measures will address each of the data elements identified in 5.a.1? In particular, are "consumer characteristics", "staffing" and "care coordination" reported through the 21 quality measures? If not, are there additional reporting requirements related to these data elements?

Clarification: The certification criteria expect that the CCBHCs will be capable of collecting data that address those elements. The quality measures and case load characteristics in the data reporting template are the primary reporting that will be required. Consumer characteristics are covered in the case load template, as well as, in part, in the measure stratifications. Care coordination is captured in a number of measures, most explicitly the follow-up measures. Staffing is not addressed in the measures but the cost reports contain elements of staffing reporting. While the quality measures do not directly address staffing, it is possible that the national evaluation will seek information that encompasses any of the 9 items enumerated in 5.a.1.

Payers:

Question 26: What is the rationale for stratifying by Medicaid, dually eligible, and other populations in reporting quality measures during the CCBHC demonstration program?

Clarification: For purposes of evaluation, we need information on the population served to the greatest extent possible. Additionally, CMS uses this information to determine the population to which the Quality Bonus Payments may apply.

Question 27: For clarification, will BHCs be reporting across all insurers and not just Medicaid for the CCBHC demonstration program?

Clarification: For the BHC-lead measures, BHCs will report on the entire consumer population (every insurer) at the BHC for which you are reporting. The way that the measures are stratified means that you will provide rates (1) for individuals who are Medicaid only, which will probably be a large portion of the population you serve; (2) for individuals who are dually eligible for both Medicare and Medicaid; and then (3) for all remaining individuals without regard to what kind of insurance they have ("other"). These three mutually exclusive and comprehensive insurance categories cover everyone—Medicaid only, dual Medicare and Medicaid, and then all remaining individuals.

Question 28: For the CCBHC demonstration, how are states to report on measures requiring stratification by Medicaid, dually eligible, and other populations when the state does not have access to data for the commercially insured and Medicare population?

Clarification: For state-lead measures, we recognize that states will not have access to information on the "other" population and that some states will have more or less access to information on Medicare beneficiaries. States must separate Medicaid from all the others. If a state cannot access the dually eligible data, it should indicate in the data reporting templates that it is excluding some or all of that group. For BHC-lead measures, the BHCs will have access to all payers and should include and stratify all individuals into the three categories.

Question 29: For the CCBHC demonstration program, does the "other" category for stratification include the uninsured?

Clarification: The "other" category does include anyone who is uninsured as well as anyone who does not fall into the (1) Medicaid only or the (2) dually eligible for Medicare and Medicaid categories. Individuals in the "other" category also might include those who are commercially insured, those with only Medicare, or those with TRICARE benefits.

Question 30: For insurance stratifications, some states have expanded Medicaid. Are these expanded Medicaid programs considered part of the Medicaid only category or are they considered part of the "other" category?

Clarification: Expanded Medicaid is Medicaid. So yes, the people who are included in the expanded Medicaid coverage are counted as Medicaid, as long as the expansion is part of the state's approved Medicaid plan and the Medicaid insurance pays for services that are within the CCBHC scope of services (Criteria, Program Requirement 4).

Question 31: Into which group should we place individuals who do not receive full Medicaid but who are receiving some type of Medicaid services (e.g., those receiving only Family Planning services)?

Clarification: This will depend on the type of services covered by Medicaid. In general, the Medicaid group includes any Medicaid beneficiary (who is not a dually eligible enrollee) and any Title 19 eligible Children's Health Insurance Program (CHIP) enrollee (who is not a Title 21 eligible enrollee). However, if individuals

are only receiving Medicaid for family planning, they fall into the "other" category because the services paid by Medicaid are not within the CCBHC scope of services. If, on the other hand, Medicaid pays for a Medicare premium only or a Medicare premium as well as family planning but nothing else, CMS has indicated that these individuals should be treated as dually eligible.

Question 32: For stratification purposes in the BHC-lead measures, if the consumer has both private insurance and Medicaid, will we consider this consumer as Medicaid or as other?

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

Question 33: If a consumer changes from Medicaid at the beginning of the measurement year (MY) to dually eligible for both Medicare and Medicaid in the middle of the year, into what group should we place this consumer?

Clarification: For the measures that do not have continuous enrollment requirements (which is mainly applicable for state-lead measures), the front matter to the Technical Specifications Manual and Webinar 1 provide guidance on this question. The consumers are counted as they were at the earliest point in the MY, which in this case would be Medicaid. If it is a continuous enrollment measure you are calculating, however, you should follow the directions for that measure.

Question 34: The manual requires stratification by payer, but the template requires indicating which Medicaid program groups are included. Do we need to verify that a member of each program type is in the measure or indicate that they are in the population served as a whole?

Clarification: Section E of each template provides cells that indicate whether different types of individuals are in the denominator (e.g., Medicaid, Title XIX-eligible CHIP population, commercially insured). That is just to identify who is in the denominator as a general matter; there does not need to be some of each insurance type. Further down in Section E of each template, there is a section that identifies who is in the groups stratified by payer, and there is a relatively simple distinction between the different payer groups; it is either Medicaid, dually eligible, or other.

Codes and Services:

Question 35: The HCPCS G codes used in a number of metrics are not reimbursable under Medicaid in our state for behavioral health providers. Is the expectation that clinics use the code and simply accept denial? Or are clinics expected to add this code to claims in addition to other codes that are used for reimbursement? Do you have any other recommendations?

Clarification: For BHC-lead measures, most of the Healthcare Common Procedure Coding System (HCPCS) Level II G codes are included to allow measurement and may indicate exclusions to measures or represent status on certain screenings involved in measures. We recommend that the clinics use these codes in conjunction with reimbursable codes. Another acceptable approach is to use alternate ways that EHRs have for accurately ascertaining what the G codes are designed to do, *if* this approach makes measure reporting possible. But we encourage use of the G codes.

Question 36: There is a potential issue with some of the metrics such as TSC, BMI-SF, and WCC-BH in that they are limited to certain CPT and HCPCS codes. These limited codes would exclude several codes commonly used for services provided to individuals with serious mental illness and substance use disorders, such as skills training, peer support, community-based wraparound, and case management. These limited codes also would exclude all the services provided in our state's Assertive Community Treatment programs (which are widely used to serve individuals with high needs), because all such

services are coded with HCPCS code H0039, even if the service would otherwise meet the criteria for Psychotherapy or E&M Medication Management, in order to capture the cost of these team-based programs accurately. In our state, substance use disorder counseling can be provided by a certified alcohol and drug counseling, an individual without a master's degree, and that counseling service is then coded with HCPCS code H0004 rather than the Psychotherapy CPT codes (e.g., 90832, 90834, 90837). So these services also would be excluded if the measurement is based on the limited set of codes. Are clinics limited to measuring only the eligible encounter codes provided, even if this approach will potentially cut out large portions of patients toward whom this program is targeted?

Clarification: The codes identified in the measures are those from the source measures, many of which were originally targeted at primary care settings more than behavioral health settings. The purpose of having the measures, however, is to determine the quality of care that was actually provided with as much accuracy as possible. Because of differences in licensing or certification requirements, the certification criteria recognize the need for state flexibility. Of the 3 measures you mention, only WCC-BH is a Medicaid Core Measure and our discussion indicates that you currently report it only for physical health providers so this has not been an issue. For the demonstration, you should use the codes that you think are most appropriate, but you should indicate on the data reporting worksheet that you are deviating and provide information about why and how. There should be a single source where these codes can be found that is available to all providers, used uniformly across CCBHCs and preferably other providers, and indicated in the data template. This will permit uniformity and transparency for the evaluation.

Question 37: It was stated that states did not have to limit the denominator to physician visits on a measure. To which measures does this rule apply? If we do not use physician visits, how do we know which services to include in the denominator? Would we only include psychotherapy services (i.e., individual, family, groups)?

Clarification: Specifically, it may be that this applied to the WCC measure of child/adolescent BMI that was a BHC-lead measure. It is a measure-by-measure consideration. For example, physician assistants or medical assistants might be able to do the work in some measures; in other measures, it will need to be a behavioral health provider. The issue has to do with what the provider can do within state licensing laws. A large number of these measures and their designated codes came from primary care. We have consulted with CMS about this issue, and there is a regulation in 42 CFR which indicates that codes that focus on physician-provided services can be used by others who are supervised by a physician. There also will be instances where you use other codes; in these instances, we ask the state to compile those codes to assure transparency and that the information be provided to and used by all CCBHCs consistently. You should indicate a deviation in the data reporting templates in Section E or F, and the evaluators will want to know how these measures are calculated.

Question 38: Many of the code sets use ICD-10 codes, whereas we use HCPCS codes. Can we substitute these HCPCS codes or do we have to add them to the MMIS for the CCBHC demonstration sites? If we do change codes, our comparison sites will not be using them, so we are not sure how a fair comparison can be made.

Clarification: Ideally the same set of codes will be used across sites for the measures that use administrative claims data. You should identify these codes clearly and ensure that information is shared with all CCBHCs and that the evaluators also have access to it.

Question 39: Some measures use SNOMED codes only for face-to-face intervention and suicide risk assessment (SRA-BH-C), but we do not use SNOMED codes for behavioral health services. It will be difficult to ask comparison clinics to change the way they are doing things to allow us to compare between CCBHCs and comparison clinics.

Clarification: Most likely, only claims data measures will be compared in the evaluation.

Question 40: Where can we find the list of Current Procedural Terminology (CPT) or of Healthcare Common Procedure Coding System (HCPCS) PPS codes that will be covered as part of the PPS?

Clarification: The CCBHC and the PPS are designed to include the nine overarching CCBHC services, such as physical health screening and monitoring, psychiatric rehabilitation, targeted case management, and outpatient psychotherapy. Much discretion is left to the states in terms of how they define those services. What each state determines should be included in the scope of services determines the CPT and HCPCS codes that will be covered by the PPS.

Baseline, Targets, Quality Bonus Measures, Quality Improvement:

Question 41: The Technical Specifications Manual does not stipulate a baseline MP for the Quality Bonus Measures (QBMs). Can baselines be obtained in the 6 months prior to MY1?

Clarification: Yes, baselines could be the 6 months prior. CMS provided some other ideas as well in a discussion of QBMs in Webinar 7.

Question 42: Does a QBM baseline year have to be for the entire year?

Clarification: No, the baseline for DY1 does not have to be a full year. If you have January through June data for 2017 and you launch your demonstration on July 1, the first half of 2017 could be DY1 baseline data for you. The baseline for DY2 will be DY1.

Question 43: What are the compliance targets for the QBMs?

Clarification: There are no set compliance targets for these measures. The states are to determine what they think is an appropriate rate for the QBMs. SAMHSA does not set the targets for this. Instead, it is a state-by-state decision.

Question 44: Will the CCBHCs have quarterly targets for the quality measures that they would have to report? Will this be a federal requirement for participation?

Clarification: No, there is no such federal requirement. Continuous Quality Improvement principles, however, suggest that earlier access to data will be beneficial for determining where improvement is needed and how to make desired changes in a timely fashion. Earlier access to data also means that CCBHCs and states will have more opportunities to correct data problems before it is too late.

Question 45: In general, what will be defined as success related to the performance measures? How will SAMHSA and CMS know a state is successful as part of the demonstration?

Clarification: Each state will set its own baselines and targets for purposes of QBMs. CMS spoke some about that in Webinar 7. For purposes of the evaluation, the CCBHCs hopefully will demonstrate meaningful improvement from baseline to DY1 to DY2 (or from DY1 to DY2 if baselines are not available for some measures) when compared with the comparison sites. The evaluation will examine factors beyond quality measures, however, focusing on improved access, scope of services, quality, utilization patterns, and cost. Success in general is broader than the performance measures. It is up to the states to define success within the QBMs.

Question 46: Do we have to identify performance measures for QBM?

Clarification: If you are a PPS2 state, you are required to use QBMs. If you are a PPS1 state, you are not required to use QBMs although you have the option of doing so. CMS identified 11 QBMs—6 are required to be used and met if you do use them and the remaining 5 are optional. In addition, states can designate other QBMs to be approved by CMS, but the 6 QBMs required by CMS must be used and met if payment is to be made on any. This information should be included in the application guidance. The ultimate goal is to see improvement from baseline and from DY1 to DY2.

Question 47: Are there implications if a state opts out of the QBMs?
Clarification: If you are a PPS1 state, it is optional. It is required for PPS2 states. There are not any criteria about selecting states on the basis of their PPS methodology.

Question 48: When will quality bonus payments (QBPs) need to be made?
Clarification: The states have flexibility. QBPs most likely will be made after the first year that data are submitted, but that is up to the states as part of their plan. CMS discussed this in Webinar 7.

Question 49: In regard to the quality improvement piece, should the state be involved?
Clarification: For quality improvement, you want to make sure the data are good data. If at all possible, the data should be reviewed early in the process (e.g., quarterly, semiannually). Looking at the data often is important for quality improvement (1) to reduce the likelihood when reporting is due after each DY that the data will be overwhelming and possibly in need of a large amount of correction and (2) to get a good idea of the work that needs to be done to foster improvement.

Question 50: What validation of quality measure rates submitted will occur?
Clarification: CCBHCs and the states should be engaged in data and measure result validation although there is no specific requirement for such in the certification criteria. Neither SAMHSA nor CMS will be validating the results reported by the CCBHCs or states as part of the demonstration program.

When is someone a CCBHC Consumer?:

Question 51: Individuals become clients when they receive certain services. One of those services is a crisis screening for a new individual. We may never see individuals who receive a crisis screening again for a variety of reasons such as: there is not a true crisis, they are already in treatment elsewhere, or they do not live in our area. How will these individuals influence our measure reporting? They often will not have a diagnosis, BMI, etc. Will they become part of the denominator on our measure reporting or will they be excluded in some way?
Clarification: The source of our answer is the document SAMHSA prepared about "When is a person a CCBHC consumer and their services covered by the Demonstration?" (http://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-consumer-and-payment.pdf). If the crisis screening is provided by the CCBHC crisis service (not a state-sanctioned service acting as a DCO), the person does become a CCBHC consumer and is counted upon receipt of the crisis screening. If the service is provided by a DCO/crisis service, the person also must receive another of the nine services that are within the scope of CCBHC services delivered by the CCBHC. The latter requirement is designed to ensure that simple receipt of a DCO crisis service by an individual does not force the CCBHC to count that person in the quality measures. We understand there will be situations where you will not see these people again, but that is how the distinction is drawn.

Question 52: Identification of CCBHC consumers who are established patients at the CCBHC: What data source is to be used to establish whether or not DCO care was coordinated by the CCBHC for a patient who receives care at a DCO after the initiation of the DY but before receiving service directly from the CCBHC?

Clarification: This question stems from the SAMHSA document about when someone becomes a CCBHC consumer. For existing clients of the BHC to become CCBHC consumers, if their first contact after the demonstration begins is with a DCO rather than with a CCHBC, their care at the DCO must be coordinated by the CCBHC after the demonstration began. For BHC-lead measures, the BHC will have this information. For state-lead measures, there will be no way to determine this unless there is a care coordination code that the BHC uses that is submitted with other Medicaid (and in the case of dually eligible, Medicare) data to the state. There are two CPT codes for post-discharge transitional care coordination and four for complex care coordination, evaluation, and management. Some of these codes require face-to-face interaction with the patient and therefore will be less useful in this situation, whereas others allow interaction between providers without the patient being present.

Question 53: If a non-established/new consumer receives crisis demonstration services provided by a CCBHC, will that person then be considered a CCBHC consumer or will he or she still need an additional service?

Clarification: Pursuant to the document "When is a person a CCBHC consumer and their services covered by the Demonstration?" (http://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-consumer-and-payment.pdf), if the crisis service is run by the CCBHC (i.e., if it is not a state-sanctioned crisis system that is acting as a DCO for the CCBHC), the person becomes a CCBHC consumer upon receipt of that crisis service.

Question 54: If a screening and risk assessment occurs at a hospital or ED prior to any contact with the CCBHC but the person is referred to and appears at the CCBHC on the same day, is the crisis service cost reimbursable by the CCBHC covered under the PPS?

Clarification: If a person who has never been to the BHC is seen in an ED or hospital and a screening that fulfills the requirements for a preliminary screening and risk assessment occurs that is undertaken by the ED or hospital, that does not make the person eligible to be considered a CCBHC consumer and the ED or hospital costs are not covered by the PPS. If the person is in the hospital and the CCBHC comes to the hospital to do a prescreen that satisfies the criteria for the preliminary screening and risk assessment and the person subsequently is seen at the CCBHC, the first contact is considered to have occurred at the hospital for purposes of timing for the initial evaluation. The CCBHC screening that is conducted in the hospital by the CCBHC, however is not covered by the PPS.

Question 55: The document "When is a person a CCBHC consumer and their services covered by the Demonstration?" (http://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-consumer-and-payment.pdf) specifies that, if an established consumer receives services that fall within the scope of CCBHC services from a DCO (after the BHC becomes a CCBHC but before receiving any service directly from the CCBHC itself), the service is covered upon receipt of that DCO service only if the DCO service is authorized by and coordinated with the CCBHC once the BHC becomes a CCBHC. Can you provide an example of how this might be applied in practice?

Clarification: This example that we are providing assumes that a BHC becomes a CCBHC on January 1 and that an already established consumer at the BHC receives services at a DCO for that CCBHC on January 5. The organization was not a DCO before January 1 but became one effective January 1. The consumer is an established consumer of the BHC, but has not been to the CCBHC between January 1 and 5. Rather, they are being seen first at a DCO. The only way that visit to the DCO is a CCBHC service that is enumerated for purposes of the PPS is if the DCO visit was authorized and coordinated by the CCBHC sometime between January 1 and 5 (i.e., the time between when the BHC became a CCBHC and when the person went to the DCO). If the person went to the DCO and there was no coordination between the CCBHC and the DCO during that period between January 1 and January 5, then the visit to a DCO is not

an enumerated service. It would be a service that is reimbursable under the Medicaid State Plan (assuming the person is a Medicaid beneficiary), the same way it would have been before the CCBHC came into existence. There must be that preliminary involvement by the CCBHC.

Question 56: Several services can be provided over the phone, such as case management. Will these services count as a CCBHC service?

Clarification: The answer to this has three parts. First, case management (and care coordination), other than targeted case management, is not a service; instead it is an activity that is included in indirect costs. Targeted case management is the only type of case management that is considered a CCBHC service within the nine overarching services. CCBHCs should reference their own state's definition of targeted case management because it differs by state. Second, whether services can be provided over the phone is a question that the state will need to answer. There may be restrictions within states as to what can be included and, because it is left to the states to define the entire scope of the nine overarching CCBHC services, that also is a question for them. Third, within the CCBHC criteria, there is only one explicit restriction related to phone use for services and it relates to the initial evaluation. Please see criterion 2.b.1, which allows the initial evaluation to be conducted telephonically if a person presents with emergency or urgent needs but requires in person evaluation at the next encounter.

Hybrid Measures:

Question 57: Does anyone have to approve the use of a hybrid measure and, if so, who?

Clarification: There are three hybrid BHC measures. Two are required for the CCBHC demonstration program (WCC-BH and CDF-BH), and one is not required as part of the demonstration program (CBP-BH) unless a state decides to make it so. The WCC-BH measure gives you a choice of using either a hybrid or administrative approach; there is no requirement for approval as to which option you use, although your state might have a preference. The CDF-BH and CBP-BH measures are hybrid and that should be the data source. For all three measures, if you are using a hybrid data source, you still have a choice as to whether you sample. It may be simpler to sample than it is to review medical records for an entire eligible population. On the other hand, the EHR may in some situations simplify the process of record review for the entire population.