SAMHSA

Substance Abuse and Mental Health Services Administration

CCBHC Quality Measurement Frequently Asked Questions

September 10, 2024

Table of Contents

CCBHC Quality Measurement Frequently Asked Questions

Find answers to commonly asked questions about the Quality Measures for the CCBHC program below.

Note: For definitions, acronyms, and other commonly used terms, please visit the *CCBHC Criteria, Appendix B: Behavioral Health Clinic Quality Measures* and *CCBHC Quality Measures Technical Specifications Manual, Appendix A: Glossary of Terms*.

General Questions about Quality Measures

Important Resources for Quality Measurement

Venue for Ongoing Questions about Measure Implementation

How can we get help when we have questions as we implement the quality measures? Should we ask our GPOs?

There are two resources available for additional information. GPOs are the central point of contact and will have general information on these measures. For specific or detailed questions, a second resource is SAMHSA's quality measures email: ccbhcmeasuressubmission@samhsa.hhs.gov. States that submit their measures for the Section 223 Demonstration will also use this email for those submissions. We will make the questions received and the answers given widely available, so everyone has the same information.

Quality Measure Specifications

Where can we access the final version of the CCBHC measures technical specifications?

You can access the final version of the technical specifications manual on the Quality Measures webpage at Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual.

Quality Measure Reporting Templates

Where can we find the newest reporting templates?

You can find the updated Data Reporting Templates for Behavioral Health Clinic Quality Measures February 2024 on the CCBHC Quality Measures webpage. Use this template once you begin reporting the updated measures. To learn more about the 2024 template, watch the recorded webinar, which is also available on the CCBHC Quality Measures webpage in the Webinar Series section.

How does the 2024 Date Reporting Template differ from the 2016 template?

The old and new templates are similar in format although the section in each measure template on Adherence to Measure Specification is greatly reduced. The 2024 template reflects the updated measures and the demographics in the case load summary have expanded a bit. The measure

stratifications are as you will have seen them in the first Fall 2023 webinar and as they are described in the initial sections of the technical specification manual.

Quality Measure Technical Assistance

Where can we find quality measure technical assistance, presentations, and office hours?

You can find quality measure technical assistance relevant to the 2024 technical specifications on the CCBHC Quality Measures webpage. Recent technical assistance includes:

- A 3-part series on quality measures generally
- A 3-part series on clinic-collected measures and an accompanying office hours
- A 2-part series on state-collected measures and an accompanying office hours
- A webinar on the updated reporting template
- A webinar for Section 223 Demonstration clinics related to the state-collected measures

Submitting Quality Measures Data to SAMHSA

How and When to Submit Quality Measure Data

How and when do Section 223 Demonstration states and SAMHSA CCBHC-IA and CCBHC-PDI grantees submit completed data template workbooks?

Section 223 Demonstration CCBHCs will submit quality measures workbooks of clinic-collected measures to the Section 223 Demonstration state CCBHC program, pursuant to any instructions from the state, by September 30 of the year following the Measurement Year being reported. Thus, for Measurement Year (synonymous with Calendar Year) 2025, which will be the first year to which the updated measures apply, Section 223 Demonstration CCBHCs must provide their completed workbooks to the state CCBHC Program by September 30, 2026.

Section 223 Demonstration states will then email the completed quality measures workbooks (including both clinic- and state-collected measure results) to: CCBHCMeasuresSubmission@samhsa.hhs.gov by December 31, 2026.

SAMHSA CCBHC-IA and CCBHC-PDI grantees will submit the completed quality measures workbooks to SAMHSA using a different approach (to be publicized at a later date for grantees only) by December 31 of the year following the Measurement Year being reported. Thus, for Measurement Year (synonymous with Calendar Year) 2025, which will be the first year to which the measures apply to grantees, CCBHCs must provide their completed quality measure workbooks to SAMHSA by December 31, 2026.

If a CCBHC is ***both a Section 223 Demonstration CCBHC and a SAMHSA CCBHC grantee***, identical submission should be made of the year's quality measure workbook in accordance with those deadlines.

Format for Reporting Quality Measure Data

What is the format for CCBHCs to report on the updated quality measures?

CCBHCs should use the quality measures reporting template to report their quality measurement data. The reporting template is posted on the SAMHSA webpage here: Data Reporting Templates for

Behavioral Health Clinic Quality Measures February 2024. More information about using this template can be found in the recorded webinar on the Quality Measures webpage. The webinar includes information about the template's use and where it should be submitted, both for Section 223 Demonstration states and clinics and CCBHC-IAs and CCBHC-PDIs.

Multiple Requirements for Reporting

What must CCBHCs report that are both (1) in the Section 223 Demonstration AND (2) a CCBHC-IA or a CCBHC-PDI SAMHSA grantee?

For CCBHCs who are both Section 223 Demonstration participants and SAMHSA grantees, you must adhere to the requirements of being a Section 223 Demonstration participant and report the required measures through your state as you would even if you were not a SAMHSA grantee. The grant requirements also apply, however, and we are requiring only that you also submit the same reporting template (that you send to your state at the end of September) to SAMHSA by December 31 of the same year. We will provide further instructions on how to submit the measures under the grants to SAMHSA.

When a CCBHC is both a Section 223 Demonstration clinic and a SAMHSA PDI or IA grant recipient, do they also have to submit GPRA data?

Yes, when a CCBHC is both a Section 223 Demonstration CCBHC and a SAMHSA CCBHC-IA or CCBHC-PDI grantee, the Section 223 Demonstration requirements, and the CCBHC-IA or CCBHC-PDI requirements for reporting the five required quality measures apply, as does the standard requirement to report GPRA data to SAMHSA for the CCBHC-IA or CCBHC-PDI grant.

General Information Related to Clinic-Collected Measures

Age Ranges

To what age ranges do each of the clinic-collected required quality measures apply?

The applicable age ranges for the eligible population of each of the clinic-collected required quality measures are:

- Time to Services (I-SERV)
  - Individuals 12+ years of age, stratified into ages 12-17 years and 18 years and older
- Depression Remission at Six Months (DEP-REM-6)
  - Individuals 12+ years of age, stratified into ages 12-17 years and 18 years and older
- Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC):
  - Individuals 18+ years of age
- Screening for Clinical Depression and Follow-up Plan (CDF-CH)
  - Individuals 12-17 years of age
- Screening for Clinical Depression and Follow-up Plan (CDF-AD)
  - Individuals 18+ years of age
- Screening for Social Drivers of Health (SDOH)
  - Individuals 18+ years of age

CCBHCs are free to collect data on populations of other ages. However, if you elect to report it, please keep it separate from the required age reporting, so we have comparable data across clinics.

Required vs. Optional Measures

What is the difference between required and optional measures?

Section 223 Demonstration CCBHCs and SAMHSA grantee CCBHC-IAs and CCBHC-PDIs are required to report five specific measures identified in the updated Certification Criteria (Appendix B) and in the updated technical specification manual.

Five additional measures are included as optional. For CCBHC-IAs and CCBHC-PDIs that are not part of the Section 223 Demonstration, reporting the optional measures is voluntary. For CCBHCs that are part of the Section 223 Demonstration, existing Section 223 Demonstration states may elect to require submission of one or more of the optional clinic-collected measures, but SAMHSA does not require it.

Section 223 Demonstration states are required to report 13 measures identified in the updated Certification Criteria (Appendix B) and in the updated technical specification manual.

There also are two optional state-collected measures. It is up to individual states to decide if they wish to report either of the two optional measures.

Populations to Whom the Clinic-Collected Measures Apply

We use multiple funding streams. Should we include services funded by all sources in our CCBHC quality measure reporting?

Yes, the required clinic-collected quality measures should include all clients receiving CCBHC services, regardless of payer. Thus, you may have clients receiving services within the CCBHC required scope of services, such as mental health or substance use disorder treatment and recovery services, which may be funded by other grants, by Medicaid, by commercial insurance, by Medicare, by TRICARE, etc. All clients are included in the clinic-collected measures if they are receiving services within the scope of services required to be provided under the CCBHC Certification Criteria, as updated in 2023.

Must SAMHSA CCBHC grantees report on the quality measures for all CCBHC locations or just locations funded by the SAMHSA CCBHC grant?

All locations that are considered part of the CCBHC under your SAMHSA grant and that are providing CCBHC services must be included for quality measure reporting.

Measurement Years, Measurement Periods, and Look-back Periods

What is the difference between the Measurement Year and the Measurement Period?

The Measurement Year is the year being assessed or measured (e.g., January 1-December 31, 2025). The Measurement Period is the time period for which data are needed in order to calculate results for a given quality measure. Measurement Periods may be the same as the Measurement Year or they may differ (e.g., a Measurement Period (the dates for which data are required) may be longer or shorter than the Measurement Year (e.g., for Measurement Year 2025, the Measurement Period might be the last six months of 2024 and all of 2025)).Similarly, Measurement Periods for numerators and denominators may be the same or may vary, depending on the measure. Some may require data: (1) only from the Measurement Year; (2) from prior to the Measurement Year (hence, there is a "look-back" period); or (3) from after the Measurement Year (hence, there is a "look-forward" period).

Is the Measurement Year the same as the Calendar Year?

Beginning with Measurement Year 2025, the Measurement Year will be the same as the Calendar Year (e.g., January 1, 2025-December 31, 2025). See FAQs related to "How and When to Submit Quality Measure Data" for information on timelines for submitting the data.

Can you clarify look-back and look-forward periods for the clinic-collected required measures?

As noted in Table 1 of Guidance for Quality Measure Transition Planning for Existing Section 223 Demonstration States and Clinics – Transition to Calendar Year (DOC | 78 KB), there will be some actual data collection in 2024 for look-back periods required in the new measures. Of the required clinic-collected measures, there is such a look-back period only for I-SERV and for ASC, as further described in that guidance, and only a look-forward period for DEP-REM-6. Below is an example of those look-back and look-forward periods and possible solutions for addressing the lookbacks for Measurement Year 2025:

- I-SERV needs data from the last six months of 2024 to see if a person is a New Client. Simply put, you just need to know who was a CCBHC client during the last half of 2024. By July 1, 2024, CCBHCs will be able to address this look-back period if they have an EHR able to tell them when people have received CCBHC services.
- ASC needs data from all of 2024 to see if clients were screened for problematic alcohol use in the 12 months before a visit in 2025. Simply put, the measure does not want a CCBHC to have to screen twice within a 12-month period, unless otherwise clinically indicated. If your CCBHC does not have that data available, you can make sure to screen each person who is age 18 or older at least once in 2025.
- DEP-REM-6 requires data for eight months after the end of 2025 to capture six-month remission, defined as four to eight months, for those who enter the denominator at the end of 2025.

Requirements Specific to non- Section 223 Demonstration CCBHC-IAs and CCBHC-PDIs

If we are a CCBHC-IA or CCBHC-PDI not in a Section 223 Demonstration state, do we only collect the five clinic-collected measures?

Correct, if you are not in a Section 223 Demonstration state you need only report the five required clinic-collected measures. Additionally, if you are a CCBHC-IA or CCBHC-PDI located in a Section 223 Demonstration state but are not certified by your state as a CCBHC (i.e., you are not part of the Section 223 Demonstration), you need only report those five clinic-collected measures.

Requirements Specific to States or Clinics in the Section 223 Demonstration before 2024

Changing from the Demonstration Year to the Calendar Year for the Measurement Year

When do the existing Section 223 Demonstration states and clinics begin using the Calendar Year as the Measurement Year?

Use of the Calendar Year formally starts in 2025, with the first reporting of the Calendar Year 2025 data occurring in September 2026. The Guidance for Quality Measure Transition Planning for Existing Section 223 Demonstration States and Clinics – Transition to Calendar Year as Measurement Year (DOC | 78 KB), located on the SAMHSA CCBHC website, addresses this question more fully, including the rationale for the change to the Calendar Year, an overview of the transition periods between 2023 and 2025, and the effects of the change on quality measure look-back periods, by measure.

How do Section 223 Demonstration states manage their 2024 Quality Bonus Payment programs, given the transition to the Calendar Year?

A second memo, the Guidance for Quality Measure Transition Planning for Existing Section 223 Demonstration States and Clinics – Effect of Transition to Calendar Year as Measurement Year on Existing Quality Bonus Payment (QBP) Programs (PDF | 157 KB), provides options for existing Section 223 Demonstration states based on input from those states. Because effects on the existing Section 223 Demonstration states will vary depending on the timing of their Demonstration Year and on their circumstances, the memo provides two options regarding QBP programs, one excusing a portion of the 2024 data and placing the QBP on hiatus for that period, and the second requiring overlapping reporting that permits continuous participation in the state QBP program. Existing Section 223 Demonstration states were allowed to select either option, both of which are described in detail in the posted memo.

Effects of Measure Updates on Older Resources

What measures that were included in 2016 are being removed in 2024?

Measures that were included in the 2016 technical specification resource manual that are being removed from the updated Behavioral Health Clinic (BHC) measures are listed below:

BHC-Lead (formerly required):

- Time to Initial Evaluation (I-EVAL): This measure is incorporated in limited fashion into the new I-SERV measure.
- Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-up (BMI-SF)
- Depression Remission at Twelve Months (DEP-REM-12): This measure is replaced with the Six-Month version.

BHC-Lead (formerly not required by SAMHSA):

- Routine Care Needs (ROUT)
- Time to Comprehensive Person- and Family-Centered Diagnostic and Treatment Planning Evaluation (TX-EVAL)
- Deaths by Suicide (SUIC)
- Documentation of Current Medications in the Medical Record (DOC)

State-Lead (formerly required):

- Housing Status (HOU): Housing need is one of the questions in the SDOH measure.
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD): A more general diabetes measure is being introduced instead.

State-Lead (formerly not required by SAMHSA):

- Suicide Attempts (SU-A)
- Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (Hba1c) Poor Control (>9.0%): A more general diabetes measure is being introduced.
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)
- Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (AMS-BD)

Can existing Section 223 Demonstration states continue collecting the old Suicide Attempts (SU-A) measure?

If states are already collecting that or other older measures, you are welcome to continue; however, reporting was not and is not required by SAMHSA, and we will not be maintaining measure specifications or providing templates for reporting those measures.

We get an error message when we try to enter dates in the old Quality Measures data reporting workbook. Is there a solution?

The old workbook was designed for a two-year demonstration that has lasted much longer. SAMHSA has updated the template to address this problem once the updated measures are in use. That template can be found here. For previous submissions with the older version, however, when you run into the problem you encountered, please indicate the date in the section titled *Additional Notes*. If you have any other similar problems, please add the information there and indicate to which section of the worksheet it relates. You should not encounter this with the updated template as the data validation requirements for dates is now more lenient. However, if you do encounter problems of this nature with the new data reporting template, please email CCBHCMeasuresSubmission@samhsa.hhs.gov.

State-Collected Measures

Where do states get data to calculate measures of follow-up after hospitalization or emergency department use?

Except for two client and family experience of care measures based on surveys (PEC and Y/FEC), all state-collected quality measure data come from Medicaid claims and encounter data. The measures were divided into state-collected vs. clinic-collected based on data availability. For example, with a follow-up measure, a state would have claims data from both the Emergency Department (ED) or inpatient setting and the CCBHC providing the follow-up care for Medicaid-enrolled CCBHC clients. The CCBHC would not have access to the claims data from the ED or inpatient setting; therefore, the state reports those measures using its Medicaid claims or encounter data.

Use of the Data Submitted to SAMHSA

When will SAMHSA report on aggregate data for comparison?

There is an ongoing national evaluation of the Section 223 Demonstration being conducted by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) that has produced several reports that include aggregated quality measure results for Section 223 Demonstration participants. All the ASPE reports are publicly available on the ASPE website resource page. The longer the evaluation

goes, the greater the information available. If you bookmark the link to Certified Community Behavioral Health Clinics (CCBHC) Demonstration Program | ASPE (hhs.gov), you can obtain a list of all reports that have been published. There also will be a national evaluation of the CCBHC-IAs and CCBHC-PDIs, but a timeline has not yet been developed for when aggregated data will be available. This data will first be reported in 2026, so 2027 is the earliest aggregate data might be available.

How is data privacy preserved?

The national evaluator uses the data aggregated by a state for its work. Nothing is reported out by clinic. Additionally, if aggregation at the state level yields denominators that are less than 30, the data will not be reported at the state level.

Quality Bonus Program (QBP) Measures

Payment for QBP Quality Measures with Submeasures

For QBP quality measures with submeasures, must the threshold be met for all submeasures to receive a payout for the parent measure?

Yes. States must establish a threshold for each submeasure and the clinics must meet that threshold for each submeasure in order to receive payment. The following measures include multiple rates: FUA, FUM, FUH, IET, HBD, ADD, ASC, and I-SERV.

Measure Specific Questions: Required Clinic Collected Measures

Time to Services (I-SERV)

I-SERV Time Periods

What are the Measurement Year and Measurement Period for I-SERV submeasures 1 and 2?

As with all other measures used by the CCBHCs, the ***Measurement Year*** for I-SERV is the calendar year. Hence, Measurement Year 2025 will cover January 1, 2025-December 31, 2025.

The ***Measurement Period*** is the time period that the data must cover to allow calculation of the measure.

- For I-SERV submeasures 1 and 2, the Measurement Period for the ***denominator*** is the first 11 months of the Measurement Year plus six months prior to the Measurement Year. Therefore, the denominator for I-SERV submeasures 1 and 2 in Measurement Year 2025 will use data from July 1, 2024 (6 months prior to the MY) to November 30, 2025 (first 11 months of the Measurement Year).
- The Measurement Period for the ***numerator*** for I-SERV submeasures 1 and 2 is the Measurement Year. The time period for the numerator data for Measurement Year 2025 would be January 1, 2025-December 31, 2025.

What is the purpose of the six-month look-back period for I-SERV submeasures 1 and 2?

The six-month look-back period is only used to see if the person is a New Client. A New Client is a person who was not seen at the CCBHC in the past six months. For example, for Measurement Year 2025, if a person has an encounter at the CCBHC on March 1, 2025, the CCBHC staff will look back six months to see if they are a New Client. Submeasures 1 and 2 only apply to New Clients.

Questions related to First Contact for I-SERV Submeasures 1 and 2

What constitutes First Contact for I-SERV submeasures 1 and 2?

First Contact represents the first time that a person, guardian, or family member contacts a CCBHC to obtain services for the person in a six-month period.

- First Contact may be in-person, by telephone, or by using audiovisual means.
- First Contact with a CCBHC should include the required preliminary screening and risk assessment and collection of basic data about the person that includes insurance information.
- Referral from a primary care physician or other provider is not a First Contact (contact must be between the prospective client and the CCBHC).
- Only one contact in a six-month period will count (with six months being used to determine if the person is a New Client).
- The idea of First Contact does not apply to I-SERV submeasure 3 on time to crisis services.

What is required for the preliminary screening and risk assessment that must be included in the First Contact?

A preliminary screening and risk assessment involves gathering information at the time of a request for services that is, in effect, a triage that determines whether a person is presenting with an emergent, urgent, or more routine need. This helps the CCBHC determine how quickly the person needs access to CCBHC services. In addition, the First Contact must include the inclusion of other basic information about the person, including insurance.

For I-SERV submeasures 1 and 2, is there any time requirement for CCBHCs to follow-up on a referral from an outside source?

Referrals do not count as the First Contact for I-SERV submeasures 1 and 2, and there is no specific requirement in the CCBHC Certification Criteria related to time of response to referrals. Despite that, CCBHCs should respond to referrals promptly. Additionally, individual states or payers may have their own requirements regarding timing of response to referrals.

For I-SERV submeasures 1 and 2, would a referral from a higher level of care or another setting such as a prison be First Contact?

No, with one exception.

Referrals are not treated as starting the clock on First Contact, whether from primary care, a higher level of care, or some other source. This also is true if the ED or hospital, for instance, is part of a larger integrated health system that also includes the CCBHC. Rather, it is the actual contact between the prospective/new client and the CCBHC that is First Contact. In part, this is to ensure that client choice is respected.

However, if the CCBHC has a presence in the other facility (e.g., an ED, hospital, prison, school) and there is contact between the CCBHC staff and the new client via outreach in that facility designed to

get the person into outpatient care in the CCBHC, that contact would be sufficient to start the clock for I-SERV submeasures 1 and 2.

If a CCBHC is part of an organization with a global intake department, is contact with global intake the First Contact?

If the global intake department is either part of the CCBHC or a formal DCO and if the global intake department conducts the preliminary screening, risk assessment, and collects basic data about the person, including insurance information, that can be First Contact. Otherwise, First Contact will be when the person and the CCBHC staff make contact (by phone or in-person) and that information is collected.

Is it First Contact if a person calls to ask about open access and staff conducts intake instead of only providing hours of service?

If a person calls the CCBHC seeking services and is directed to open access or is given an appointment, that is a telephonic request for services that is First Contact, provided a qualified CCBHC staff conducts the preliminary screening and risk assessment, and collects basic data about the person, including insurance information.

If a person calls and simply asks when open access hours are, that is not First Contact unless the preliminary information gathering occurs at that time.

If a preliminary screening and risk assessment determines a caller does not need services, is that still First Contact?

During that call (or in-person encounter), if the call taker determines that the person does not need evaluation or other behavioral health services, the person is not included in the I-SERV measure.

For I-SERV submeasures 1 and 2, do clients need to be scheduled for a follow-up appointment after First Contact?

If a decision is made on the First Contact by both parties (the CCBHC and the caller/potential new client) to pursue behavioral health services at the CCBHC, then it would be prudent to schedule an appointment with the person at that time so the necessary follow-up activities, including Initial Evaluation and Initial Clinical Services, can be provided to the person in a timely manner.

As the submeasure 1 and 2 denominator Measurement Periods end November 30, how do you compute time to initial services received later?

Because the *numerator* Measurement Period is the entire Measurement Year, you count the actual number of Business Days until the Initial Evaluation or Initial Clinical Service occurs. If it occurs after the end of the Measurement Year, as indicated in the I-SERV specification, they should be treated as having been evaluated or as receiving the services 31 days after First Contact.

If a mobile crisis recipient is admitted to the hospital, is First Contact later at the time of a post-crisis follow-up?

Yes. The First Contact for submeasures 1 and 2 would be the follow-up contact post-crisis resolution. For example, if someone is hospitalized as part of the crisis, First Contact is established after the crisis is resolved. The visit/encounter that stems from that outreach from the First Contact becomes Initial Evaluation and/or Initial Clinic Services, depending on the nature of the visit.

Submeasure 1, Time to Initial Evaluation

What is the difference between a Comprehensive Evaluation and an Initial Evaluation for I-SERV submeasure 1?

The CCBHC Certification Criteria (Criteria 2.B "General Requirements for Timely Access to Services and Initial and Comprehensive Evaluation") require all people receiving CCBHC services to receive both an Initial Evaluation and a Comprehensive Evaluation. The Initial Evaluation is due within 10 business days of first contact for those who present with "routine," non-emergency, or non-urgent needs. Comprehensive Evaluation, on the other hand, is conducted with CCBHC clients within 60 calendar days of when the client requests CCBHC services. I-SERV submeasure 1 only requires reporting regarding the time to Initial Evaluation. Further information regarding differences between the required initial evaluation and comprehensive evaluation are included in CCBHC Certification Criteria 4.D "Screening, Assessment, and Diagnosis."

How is "First Contact" defined for I-SERV submeasure 1?

Please refer to the subsection of these FAQs that are under I-SERV General Questions.

Submeasure 2, Time to Initial Clinical Services

What is included in Initial Clinical Services for I-SERV submeasure 2?

Initial Clinical Services under I-SERV submeasure 2 include services provided by CCBHCs within the 2023 CCBHC Certification Criteria on Scope of Services that include criteria 4.E Person-Centered and Family-Centered Treatment Planning, 4.F Outpatient Mental Health and Substance Use Services, 4.H Targeted Case Management Services, and 4.I Psychiatric Rehabilitation Services, as well as 4.J. Peer Supports, Peer Counseling, and Family/Caregiver Supports, and 4.K. Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans, if those services fall within the general scope of service in criteria 4.E, 4.F, 4.H, or 4.I.

For I-SERV submeasure 2, is the Initial Evaluation counted as an Initial Clinical Service?

No. The Initial Evaluation does not count as a clinical service for purposes of the measurement of time to Initial Clinical Service. It is counted separately in submeasure 1.

For I-SERV submeasure 2, are Crisis Services counted as an Initial Clinical Service?

No. Crisis services do not count as an Initial Clinical Service for purposes of the measurement of time to Initial Clinical Service. They are counted separately in submeasure 3.

For I-SERV submeasure 2, is the Initial Clinical Service the first face-to-face service after the Initial Evaluation?

It is possible that each of the following may occur at the same time or in succession, depending on client need and service availability: First Contact, Initial Evaluation, and Initial Clinical Services:

(1) First Contact/intake, which includes at least preliminary screening, risk assessment, and collection of basic information on the client, specifically including insurance;

(2) Initial Evaluation, all components of the Initial Evaluation must be done before the evaluation is considered complete for purposes of I-SERV submeasure 2; however, some parts of the Initial

Evaluation may be covered in the preliminary screening and risk assessment that is part of First Contact;

(3) Initial Clinical Services. Initial clinical service is the first clinical service after First Contact.

How is "First Contact" defined for I-SERV submeasure 2?

Please refer to the subsection of these FAQs that are under I-SERV General Questions.

Submeasure 3, Time to Crisis Services

Is I-SERV submeasure 3 (time to crisis services) an encounter-based measure?

Yes. Submeasure 3 is a measure of time to service for crisis episodes. This means that, if a person has multiple encounters involving crisis episodes during the Measurement Year, each episode is included in the measure, if there is at least 24 hours between episodes.

Does the I-SERV submeasure 3 requirement for face-to-face service delivery include crisis services delivered by telehealth?

Yes. CCBHC crisis services delivered by telehealth with audiovisual capabilities do count as face-to-face interaction.

Can a 988 or other suicide prevention hotline call ever be used in lieu of a face-to-face interaction for I-SERV submeasure 3?

No. However, it may be, in limited circumstances, the contact that initiates delivery of face-to-face crisis services. If a system is set up by the CCBHC or its crisis Designated Collaborating Organization (DCO), so that a hotline call both identifies a need for face-to-face crisis services and is the mechanism initiating the process for receipt of those services, then the contact begins the time being measured. If, however, the hotline call resolves the issue on the phone or by text and no need for face-to-face crisis services is identified at that time, it does not lead to a face-to-face crisis service and does not begin time to service.

For submeasure 3, should the number of hours between when crisis contact occurs and crisis services are provided be rounded?

You may round using standard rounding procedure (rounding down to the next lowest number of hours if less than half an hour; rounding up to the next higher number of hours if half hour or greater), as long as you are consistent. When numbers are entered into the data reporting template for reporting purposes, the template automatically reports numbers to one decimal point.

For submeasure 3, is there a cutoff time for the denominator exclusion for "clients who never received a Crisis Service"?

You should look no further than 24 hours.

For submeasure 3, do CCBHCs report encounters for all clients who contact the CCBHC or the CCBHC's DCO seeking crisis services?

Yes. For I-SERV submeasure 3, include all crisis episodes of both new clients and existing clients who contact the CCBHC or its Designated Collaborating Organization (DCO) seeking crisis services.

What CPT or other encounter codes are used to identify crisis services for I-SERV submeasure 3?

The measure does not specify CPT or other codes. If necessary, CCBHCs should use those codes which apply to crisis services that are within the scope of crisis services defined at Certification Criteria 4.C.

Do peer support services qualify for I-SERV submeasure 3 crisis services?

If your state allows peer providers to provide crisis services that are included in Certification Criteria 4.C, those services may be included.

Depression Remission at Six Months (DEP-REM-6)

DEP-REM-6 Screening Instruments

Are we limited to use of PHQ-9 or PHQ-9M for evaluating youth? May we use an alternative instrument for clients younger than age 12?

The PHQ-9 or PHQ-9M is required for screening youth ages 12 years and older. To screen clients under the age of 12 years, however, an alternative age-appropriate instrument may be used. Those younger than age 12 are not included in the DEP-REM-6 measure.

Timing of Diagnosis and Elevated PHQ-9 Score for DEP-REM-6 Denominator Eligibility

Must BOTH an elevated PHQ-9 score AND depression diagnosis occurs in the Measurement Year to include a client in the DEP-REM-6 measure?

The Index Event Date must occur during the Measurement Year for inclusion in the DEP-REM-6 denominator. The Index Event Date is the point at which both of the following conditions are met: (1) the first (or first known) PHQ-9 greater than 9, and (2) a documented diagnosis of Major Depression or Dysthymia (MD/D) (not necessarily a new diagnosis, but an active diagnosis). Here are three examples:

- Client A has a PHQ-9 score of 12 on December 27, 2023, and a diagnosis of MD/D is documented on January 2, 2024. The Index Event Date for Client A is January 2, 2024, because it is the date when both conditions were met, since it is possible that the PHQ-9 could be administered up to seven days in advance of an encounter in which a diagnosis is applied/provided. That Index Event Date is when Client A becomes eligible for the denominator.
- Client B may be a new or existing client but has a long-standing diagnosis of MD/D. They are seen on November 20, 2023, and either not administered a PHQ-9 or their PHQ-9 was less than or equal to 9. At that point, they do not have an Index Event Date that makes them eligible for the denominator, but you do decide that the diagnosis of MD/D should be retained. They return on January 25, 2024, are administered a PHQ-9 and the score is greater than 9. January 25, 2024, is the Index Event Date and Client B is now eligible for the denominator.
- Client C is seen on June 3, 2024. Because their symptoms meet the diagnostic criteria for MD/D, they are given a diagnosis of MD/D. They also are administered a PHQ-9 on that date, with a score of 14. Both requirements for an Index Event Date are met on June 3, 2024, for Client C and they are eligible for the denominator.

Do we exclude clients from DEP-REM-6 if they have an Index Event Date, but also a diagnosis from the denominator exclusion list?

Yes, they are excluded from both the denominator and, therefore, the numerator. The exclusions include a diagnosis of Bipolar Disorder, any Personality Disorder, Schizophrenia or Psychotic Disorder, or Pervasive Developmental Disorder, at any point before the end of the numerator period; or if the person dies or is in hospice/palliative care prior to the end of the numerator period. The exclusions take precedence over the MD/D diagnosis and elevated PHQ-9 score because the exclusionary diagnoses are ones that can complicate treatment and reduce the likelihood of depression remission at six months.

Coding for DEP-REM-6 Numerator

The specification for DEP-REM-6 does not list Performance Met/Not Met codes for remission by six months. What should we use?

You are correct that the numerator specification for the six-month measure does not include Performance Met/Not Met reporting codes for remission by six months. CCBHCs may use whatever method works for them to keep track of met or not met status for clients, including but not limited to use of the reporting codes found in the 12-month CMS MIPS measure.

Measure of Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)

Screening Instruments for ASC

For the ASC measure's systematic screening method, are we limited to using the AUDIT, AUDIT-C, or Single Question Screening?

To satisfy the measure, you must use one of those three options. However, in some instances, you may wish to use a more specialized instrument. Although the three are very good options for most people, there are subgroups (e.g., pregnant clients) where, from a clinical perspective, different instruments or cut points may be needed. In those instances, the clinic should use sound clinical judgment. Further, if a clinic routinely uses a different systematic screening tool for certain clients, or a different cut-point, and if they are concerned about implications for the measure, there is a section at the bottom of the reporting template where they can note routine use of another approach for specific subpopulations.

Is it acceptable to include the NIDA self-report version of the AUDIT in an intake packet?

Yes. Clinics should feel free to use the NIDA version of the AUDIT. Y es, it may be sent in an intake packet, but the results should be discussed.

Does the CAGE alcohol screener satisfy the screening requirements of the ASC measure?

Unfortunately, we are unable to allow substitutions for the systematic screening tools identified in the ASC measure. In terms of measure compliance, you must use one of the three enumerated tools. It is not that those tools are “SAMHSA-approved.” Rather, that is how the source measure is written, and it cannot be altered. However, there will be clinical instances that warrant a different cut-point (e.g., alcohol use by pregnant people) or possibly a more comprehensive assessment as follow-up.

Scoring with Approved Screening Instruments

What counts as a positive screen for the three instruments included in the ASC measures?

For purposes of the ASC measure, the definition of a systematic screening instrument is as follows:

"One of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic Screening Methods and thresholds for defining unhealthy alcohol use include:

- AUDIT Screening Instrument (score ≥ 8)
- AUDIT-C Screening Instrument (score ≥4 for men; score ≥3 for women)
- Single Question Screening – How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response ≥1)"

Of course, there will be populations (such as pregnant people) for whom any drinking is unhealthy.

If we use the Single Question Screening, how would we interpret results for a person who is non-binary?

We recommend that you use the 5 or more drinks a day cut point for nonbinary people who are younger than 65 years in age. This recommendation is based on the following study:

Flentje A, Barger BT, Capriotti MR, Lubensky ME, Tierney M, Obedin-Maliver J, Lunn MR. Screening gender minority people for harmful alcohol use. PloS One. 2020 Apr 7;15(4):e0231022. Doi: 10.1371/journal.pone.0231022. PMID: 32255781; PMCID: PMC7138294), which may be accessed online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7138294/.

Timing of Screening for ASC Measure

If we use the Single Question Screening method in our comprehensive assessment, does that satisfy the ASC requirement for screening?

Yes, you will be fine using that single screener question in your comprehensive assessment, as long as it is done at least every 12 months for each person who is not excluded from the measure denominator. However, if the person is pregnant or has other vulnerabilities that would make alcohol consumption risky at those levels, please be sure to use a more appropriate screener and cut point that is suitable, relying on clinical judgment and expertise.

Population to be Included in ASC Denominator

If a person is not enrolled at a CCBHC for the entire look-back period, should they be included in the ASC denominator?

For purposes of ASC, you look back 12 months before the relevant eligible encounter **only** to see if they were already screened at the CCBHC in the 12 months prior to the encounter during the Measurement Year and, if applicable, whether they received a brief counseling intervention. If this is the first encounter with that person, you cannot look-back and should screen (and counsel if relevant) during the 2025 visit (assuming the Measurement Year is 2025). Hence, the lookback period really has no bearing on eligibility for the denominator, nor does enrollment with the organization.

Should clients who were already diagnosed with and being treated for “unhealthy alcohol use” be included in the ASC denominator?

No. Clients with existing active "unhealthy alcohol use" diagnoses should not be counted in the ASC denominator for screening and brief counseling. The brief counseling is intended to support new clients with "unhealthy alcohol use," identified through screening. You should, however, feel free to do continuing screening for such clients as you consider clinically appropriate.

Eligible Encounters for ASC Denominator

Is alcohol screening required for encounters that are not clinical, for example, targeted case management and peer support services?

The ASC measure includes specific CPT and HCPCS encounter codes that determine whether an encounter or visit is eligible to include the person in the measure denominator, subject to age requirements, and certain diagnostic and other exclusions. We recommend that you check with your billing department to determine which of those codes, if any, might be used for the types of visits about which you are concerned. If one of these encounter codes is applicable under the requirements of the respective denominator specification, then the person should be included in the denominator.

Why are CPT codes for medical disciplines included in the technical specifications if those services are not provided by CCBHCs?

Measures such as ASC were originally developed for general medical settings but are also used in behavioral health settings. Due to copyright restrictions, we publish the specifications as written. You should disregard CPT codes that do not pertain to your specific setting.

ASC Look-back Period

Why is there a 12-month look-back period for the ASC measure?

The ASC look-back period is solely for the purpose of determining if someone seen in 2025 was already screened for alcohol use in the past 12 months. The first ASC Measurement Year is Calendar Year 2025. That is the year being assessed. For the Measurement Period, the period for which data are required to calculate the measure for 2025, you do need enough information from 2024 to determine if the person who you see in 2025 was already screened in the past 12 months (and if they screened positive, whether they received a brief counseling intervention). For example, if you see someone on March 1, 2025, for the very first time in Measurement Year 2025, you need to look back 12 months prior into 2024, to see if they were already screened in the past 12 months. That way, you do not screen them again until 12 months have passed. However, if you do not have that data from 2024, the simple solution for the first year of measurement is simply to screen everyone at least once during 2025 (and follow through if the screening is positive).

Measure of Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD)

Screening Instruments and Scoring for the CDF-CH (child) and CDF-AD (adult) Measures

For CDF, is a particular screening tool recommended and how would we know if the screening is positive or negative?

We recommend that the PHQ-9 be used because of its use in the companion DEP-REM-6 measure, as noted in the 2nd webinar in the clinic-collected quality measurement webinar series. However, you can use another standardized screening tool, listed or not, in the CDF measure. Each standardized tool will have its own scoring regime specific to the tool. For example, the instructions for the PHQ-9 state that, "Scores of 5, 10, 15, and 20 represent cut-points for mild, moderate, moderately severe and severe depression, respectively." (See https://www.phqscreeners.com/images/sites/g/files/g10016261/f/201412/instructions.pdf). For diagnostic purposes, you also should use the appropriate criteria in the most recent version of the DSM.

The CESD is listed as an acceptable screening tool in the CDF specification. May we use the CES-DC modified version for adolescents?

The CDF-CH measure allows for any age-appropriate assessment tool to be used that has been appropriately normalized and validated for the population in which it is being used. This would include both the original Center for Epidemiologic Studies Depression Scale (CES-D) and the modified version for adolescents. In the medical record, you must document the name of the age-appropriate standardized depression screening tool used.

Frequency of Screening for the CDF-CH and CDF-AD Measures

How often must a client be screened for depression to meet the numerator requirement for the CDF-AD or CDF-CH measure?

Both CDF-AD and CDF-CH are patient-based measures. Depression screening is required once per Measurement Year, not at all encounters.

Inclusion in the CDF Denominator

Who should be included in the CDF-AD and CDF-CH denominators?

This measure is designed to ensure annual depression screening for all who are not already diagnosed with either depression or bipolar disorder. The denominator applies to each client with at least one outpatient visit during the Measurement Year that warrants one of the encounter codes in Table CDF-A, and where the person is 18 or older on the date of the encounter (for the adult measure) or age 12-17 years (for the child measure).

If a person has ever had a diagnosis of depression or bipolar disorder under the criteria in the specification, they are excluded from the denominator, as well as the numerator. There also are two denominator exceptions: (1) the client exception – refusal to participate in screening or follow-up planning, and (2) the medical exceptions – the client is in an urgent or emergent situation where time is of the essence and delaying treatment would jeopardize their health status OR the client's cognitive, functional, or motivational limitations may impact accuracy of screening results.

Does the CDF exclusion of clients diagnosed with depression or bipolar disorder only apply to diagnoses during the Measurement Year?

No. Clients who have ever been diagnosed with depression or bipolar disorder are excluded.

Denominator-Eligible Encounters

At which encounters would screening need to occur?

The types of outpatient encounters that qualify a person for inclusion in the denominator are those identified in Section D of the CDF specifications (*D. Administrative Specification, Denominator, Table CDF-A*), using any of the CPT or HCPCS codes identified in that table. The first FAQ, found in the supplemental materials that immediately precede the two CDF specifications, provide additional information related to encounters and to types of providers, which may vary by state. Screening is not required at all such encounters, just one per Measurement Year.

Is the screening required for encounters such as targeted case management, psychiatric rehabilitation, and peer support services?

The CDF measures (adult and child) include specific CPT and HCPCS encounter codes that determine whether an encounter or visit is eligible to include the person in the measure denominator, subject to age requirements, certain diagnostic, and other exclusions. We recommend that you check with your billing department to determine which of those codes, if any, might be used for the types of visits about which you are concerned. If one of these encounter codes is applicable under the requirements of the respective denominator specification, then the person should be included in the denominator. Again, note that screening is not required at all such encounters, just one per Measurement Year.

Follow-up Planning Requirements in CDF-AD and CDF-CH Measures

For CDF-AD, would completing a suicide risk assessment for someone who screens positive for depression count as a follow-up plan?

No, a suicide risk assessment does not satisfy the requirement for a follow-up plan after a positive depression screen. The Guidance for Reporting in the CDF-AD measure states: “A clinician could opt to complete a suicide risk assessment when appropriate and based on individual beneficiary [client] characteristics. However, for the purposes of this measure, a suicide risk assessment will not qualify as a follow-up plan.” The follow-up plan is intended to guide further treatment for depression identified in the screening.

When should the CDF follow-up plan be documented, and how does it align with the CMS Medicaid Adult Core Set Measures and CMS eCQMs?

The follow-up plan should be documented on the date of the eligible encounter. This requirement is consistent with the 2023 and 2024 Medicaid Core Sets.

How is the CDF follow-up plan handled for people who decline services for depression?

The CDF specifications state that people who decline to participate should be removed from both the denominator and numerator.

Measure of Screening for Social Drivers of Health (SDOH)

Screening Instruments for the SDOH Measure

What screening instrument should we use for the SDOH measure? We use the DLA-20, but want to learn what tools might be used by other CCBHCs?

The SDOH quality measure is newly added to the quality measures for CCBHCs, so it's not yet known how it relates to screening instruments in the CCBHCs. At this point, clinics and states seem to be varied in whether and how they are capturing SDOH, as well as other aspects of functioning. SAMHSA does not recommend any single tool. The SDOH measure does identify five standardized screeners that are specific to SDOH. However, they are examples and not required to be used to meet the measure. Here is a list of those five screeners:

- Accountable Health Communities Health-Related Social Needs Screening Tool (2017)
- Accountable Health Communities Health-Related Social Needs Screening Tool (2021)
- The Protocol for Responding to and Assessing Patients' Risks and Experiences (PRAPARE) Tool (2016)
- WellRx Questionnaire (2014)
- American Academy of Family Physicians (AAFP) Screening Tool (2018)

We are aware that some states and clinics are already using other instruments such as the DLA-20 or the FARS. These two screening instruments are acceptable, with caveats, given that the SDOH measure requires screening for "food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety."

The DLA-20, although focused on ADLs, taken should enable you to capture the basic information intended by the SDOH measure. We suggest that those using the instrument be attuned to issues such as lack of access to transportation to critical services that may not be covered by public transportation as framed by the "Community Resources" question (e.g., in a rural area) and which might warrant further inquiry or support. Similarly, although utilities may reasonably be covered by the "Managing Money" or "Community Resources" questions, additional probing about utilities would be appropriate if the person indicated trouble in those spheres of their life.

Similarly, the FARS instrument, if implemented properly, clearly addresses four of the five domains included in the SDOH measure (housing, food, interpersonal safety, and transportation) and, less directly, the fifth (utility difficulties). Regarding the latter, the assessment of money management should cover that as well as other critical aspects of money and budget, provided review with the client probes further regarding utilities specifically.

Can additional items be added to the SDOH tool to meet both the reporting requirements for CCBHCs and requirements for other grants?

If your SDOH tool screens for the five SDOH listed in the technical specifications, your clinic may add other items, if needed, as long as there are no copyright restrictions on doing so.

Digital Screeners

The SDOH measure lists the AAFP screener. What is the cost for use of the AAFP screener? Is this screener free to download for CCBHCs?

There is a link in the specifications manual to the AAFP Social Need Screening Tool (https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-form-sdoh.pdf). It is available free on the AAFP website at that link with scoring instructions. We have heard, however, that only the PDF is free and that a license is required for the digital version. We are investigating this further.

The use of SDOH measures and screeners is new, and it is possible that no single electronic version exists. If your concern involves intellectual property and the ability to use the AAFP screener in your electronic system, you might consider the AHC HRSN tool, which is nonproprietary and may be obtained at the link in the measure. We suggest that you work with your vendor to embed whatever screener works for you into your electronic system.

Timing and Provision of Screening for SDOH

Is the screening for SDOH required annually or just once during the period of the SAMHSA grant?

For purposes of CCBHC quality measurement reporting, the screening for SDOH should be done once annually for all CCBHC clients. Quality measures will be reportable for the first time by non- Section 223 Demonstration CCBHCs starting with a Measurement Year of 2025 (calendar year 2025) and include more than the SDOH measure. The actual reporting of quality measures covering Measurement Year 2025 will be due at the end of 2026. There is a reporting template for clinics to use and a recorded webinar on how to do the reporting available on the SAMHSA CCBHC webpage.

Can the SDOH screening occur anytime within the Measurement Year and independent of the denominator encounter?

The SDOH screening may occur at any point within the Measurement Year but should be prior to or at the time of the encounter to permit discussion, if warranted, during the encounter.

Who must provide the SDOH screening and review of the numerator SDOH qualifying screening?

The measure does not specify which staff should do the screening and it is not uncommon for these types of screenings to be handed to people on paper or a tablet by the receptionist, or sent to the client in advance electronically, and then discussed, as appropriate, with the provider involved in the denominator encounter. The denominator does include codes for specific encounter types, which we are treating as encounters for purposes of discussing the results. You should follow any state-specific requirements for licensure and training that would otherwise apply to such encounters.

Is provision of SDOH screening on the day of or before a denominator service sufficient or is review of the screening also required?

The SDOH measure focuses explicitly on screening and assumes that the screening takes place during an encounter that is included in the denominator, at which time a review with the client also would occur. If an earlier screening happened during the same Measurement Year, we expect that some review will occur during the encounter, whether the screening is done on the same day or before the encounter.

Use of Telehealth for SDOH Screening

The SDOH specification mentions the inclusion of telehealth, with allowable modifiers. Does this include audio-only telehealth?

There are encounter codes in the SDOH measure which, until December 31, 2024, can be used with audio-only telehealth services for Medicare patients. The codes that may be used for Medicaid patients will vary by state Medicaid program, as may the extent to which audio-only telehealth

services are reimbursable. The same is true if you have commercial insurers. For people without insurance, you will need to make sure you have some way to indicate that the service has been provided whether it occurs via telehealth (of any sort) or not.

Meeting SDOH Denominator Requirements

Are clinics limited to using the "appropriate encounter codes" for the SDOH measure denominator that are in the specification?

Many of the current measures are designed for primary care settings. However, SAMHSA's goal is to collaborate with measure stewards to incorporate codes relevant to behavioral health. You may use other encounter codes for the SDOH measure but if you do, we ask that you identify them for SAMHSA, so that they can be considered for future iterations of the measure. Please email clinic defined "appropriate encounter codes" that are not included in the SDOH technical specifications to CCBHCMeasuresSubmission@samhsa.hhs.gov.

Measure Specific Questions: Optional Clinic Collected Measures

Measure of Suicide Risk Assessment (SRA-A and SRA-C)

Can you confirm when people fall into the denominator for SRA and when they fall into the numerator?

For the SRA-A measure, people fall into the denominator when they are diagnosed with MDD for the first time, or when they are re-diagnosed after not having an encounter for MDD after 105 days. People fall into the numerator when they are screened for suicide risk on the date the diagnosis or re-diagnosis is made.

You can find more information on this and the other optional clinic-collected measures in the 3rd of the 3-part CCBHC Quality Measure webinar series.