Behavioral Health Clinics
Clarifications to Guidance about Quality Measures and Reporting – Questions Related to Data Reporting and Quality Measurement for all BHCs

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

Critical Links:
Question 1: Where can the BHC Technical Specification manual and the data reporting template be accessed?
Clarification: The Technical Specification manual and the data reporting template are available on the SAMHSA website at the following site: http://www.samhsa.gov/section-223/quality-measures To access the templates, click on the link. Next, to access the Technical Specification manual, you click the following link on the Quality Measures webpage: (two-volume technical specifications manual – 2016 (ZIP | 2.99 MB) You will see a page with a Notice of Copyright that you must accept. Once you accept it, you will get a small message, usually located at the bottom of your screen, asking whether you want to open or save the document. (Although the main screen will look as though the Acceptance button did not work, it did. So you should look for that small message that gives you the option to open or save.) If you select open, a zip folder will open with both volumes of the specifications inside. You can extract and save them if you wish.

Question 2: How can I access the slides to the BHC Data Quality Collection and Quality Reporting Webinars?
Clarification: The webinars are on the SAMHSA website at: http://www.samhsa.gov/section-223/webinars

Relationship to Other Measures:
Question 3: Are the BHC measures, except the payer mix, aligned with the Patient Quality Reporting System (PQRS) measures? Can the PQRS specification sheet be used as a resource for this work?
Clarification: Aside from payer mix and minor formatting differences, the following measures do align with the 2016 measures (TSC, ASC, CDF-BH, BMI-SF, Dep-Rem-12, DOC). The two SRA measures align with the 2014 PQRS quality measures (and their Technical Specifications indicate that in Section A).

Question 4: Are all the state-lead measures using administrative data the same as the standard measures (aside from the reporting level)?
Clarification: Many of these measures have been developed in different formats for different programs or initiatives. One BHC measure may be related to a HEDIS measure, a Medicaid Core Measure, and a PQRS measure. There are three potential differences between the state-lead measures using administrative data and the source measure: 1) the reporting level which the question acknowledges (the BHC measures are reported at the BHC level and not the state or plan level); 2) format (the measures are formatted for general consistency); and 3) other changes. Formatting changes include things such as: a) general additional information included in section A of the Technical Specification such as links to value sets, information on the measurement period, etc.; b) additional definitions in section B, such as the definition of "provider entity"; c) an additional step in the eligible population definition in section C to bring the Technical Specification to the BHC level as well as an attempt to more clearly provide the steps in determining the eligible population; d) reminders about measurement periods in section D; e) additional general information in section E such as information about the source measure and interpretation of the score (for some measures this is added); and f) the appendices for some measures in volume 2. Other, non-level, non-formatting changes should be limited to measurement year/measurement period, stratification, and age requirements:

- Because measurement years for different uses of the BHC measures may begin at different points, the measurement year and periods identified in the source measures, which are linked to a measurement year that is the calendar year, will differ.
- Each of the BHC state-lead measures require stratification by payer (for the states, into Medicaid and dually eligible beneficiaries). The BHC state-lead measures, by requiring reporting for both Medicaid and dually-eligible, also may cover different populations than those for which you presently report a measure.
- Some of the BHC state-lead administrative measures require stratification by age (by abbreviation, these are PCR-BH, APM, FUH-BH-A, AMM-BH, and IET-BH, of which APM is not a required CCBHC demonstration program measure). You should check the age coverage and stratifications for these against what you report now because there may have been modifications. The PCR HEDIS measure may be reported for commercial consumers (ages 18-64) or for Medicaid consumers (18 and older) while the PCR-BH reports for those 18 and older, stratifying by 18-64 and 65+. APM-BH does not differ on age from the HEDIS source measure. FUH-BH-C and FUH-BH-A separate a HEDIS measure that covers all ages 6 and older into 6-20 (FUH-BH- C) and 21 and older, stratified into 21-64 and 65+ (FUH-BH-A).) AMM-BH is stratified (18-64, 65 and older) differently from the HEDIS measure (not stratified). IET-BH is stratified (13-17, 18-64, 65 and older) differently from the HEDIS measure (13-17, 18+). Most of these differences reflect the fact that many of the measures also are Medicaid Child or Adult Core Measures and, if you are reporting those, the stratifications and age coverage may differ in other ways (for example the Medicaid Core IET measure only covers those ages 18 and older, with stratification into 18-64 and 65+). We would also encourage you to check the age coverage for the state-lead BHC measures that are not stratified by age against those that you currently report.

Data Reporting:

Question 5: What ultimately is the difference between a state-lead versus a BHC-lead measure? It has been our understanding from the webinars that all measures would eventually be collected on a BHC level and rolled up from there.

Clarification: A state-lead measure is calculated by the state for each BHC, usually relying on administrative data. A BHC-lead measure is calculated by the BHC and sent to the state. The measures are not aggregated by the state and the real distinction is who is designated to perform the data analysis and calculation.

Question 6: There are additional breakouts of payer types in section E of the data reporting templates than are listed in the Technical Specification Manual? Do we need to make sure there is representation for a Medicaid program type in every measure?

Clarification: No, you do not need to make sure there is a representation for each classification listed in Section E of the templates. For example, for BMI-SF in rows 25-33, the template asks if the denominator included each of the populations listed (yes or no). Do not worry if all the populations are not there (e.g., a BHC may not have any TRICARE). Also, as a state, for state-reported measures, you will not have data on the commercially insured, uninsured, and VHA/Tricare.

Coding:

Question 7: Is it true that G codes can only be used for Medicare beneficiaries and that they can only be used in primary health clinics?

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. G codes can be used for non-Medicare beneficiaries and can be used outside primary health clinics. Many of the measures that use G codes originally were developed for primary care settings (e.g., screening for alcohol use, screening for tobacco use, BMI screening), but are now included in this set of BHC quality measures that will be applicable to

behavioral health clinics as well. If your state has not activated the codes and does not do so, or if your state has restricted the use of these codes to certain settings (e.g., non-behavioral health) and does not change that, BHCs will need to have some other mechanism for coding the results (e.g., whether BMI screening results were normal or abnormal, whether follow-up occurred).

Question 8: Our record creates a Quality Reporting Data Architecture-3 (QRDA-3) uploadable file. Is it possible this would be an alternative to using the G codes?
Clarification: If that file permits you to capture the same elements as the G codes, that is acceptable. In all cases, you should maintain a clear record of how you capture the measure elements (in part for purposes of the evaluation) and, if you deviate from the Technical Specifications, so indicate in the data reporting template at the appropriate location.

Case Load Characteristics:
Question 9: Although many measures have specifications as to whether the age of a consumer is measured at the beginning of the measurement year (MY), at the end of the MY, or at the date of service, there have been no guidelines as to when the age should be counted for case load characteristics. Do we use the consumer's age at the beginning or end of the MY when counting case load by age? Similarly, if a consumer switches insurance coverage during the MY, do we use the insurance at first encounter or last encounter during the MY?
Clarification: The front matter to the Technical Specifications Manual (page 18) provides the answer related to payer for purposes of stratification when continuous enrollment is not present. For the case load characteristics, please use the payer status at the time of the first visit during the MY. Please use the same standard for age.

Question 10: In counting veterans for demographics, does this group include any individual who has served, regardless of discharge status and regardless of access to and eligibility for VA services?
Clarification: Yes. With regard to the veteran row in case load characteristics, there is no requirement as to discharge status or eligibility for VA services. Count as veterans all individuals discharged from the military.

Age:
Question 11: Is age determined by the age at date of service or the age at beginning or end of reporting year?
Clarification: Section C of the Technical Specification for each measure provides information about how the age for that measure is determined. For example, for the "Time to Initial Evaluation" measure, age is measured at the end of the MY.

Denied or Suspended Claims:
Question 12: Care is needed in using denied and suspended claims for some BHC measures, as "denied" may only have been erroneously entered. Can we just work with paid claims?
Clarification: In general, the measures that call for use of pending, denied, and suspended claims (i.e., WCC, CDF, AMS, SAA, FUH-A, FUH-C, ADD, AMM, and IET) take that from the source measure. One exception is Suicide Attempts. We are aware that this can be difficult, so we modified the measures to read (in each case) "to the extent possible." If you do not use pending, denied, or suspended claims for measures where their use is included in the instructions, lease so indicate in the Additional Notes in the data reporting template.

Hybrid Measures Generally:

Question 13: How do you prove your sample is a random sample representative of the eligible population?

Clarification: For the BHC measures, only age is singled out as an indicator of representativeness and that is specific to the measures that are stratified by age. Using age as an example, first, determine the eligible population as it is defined in the Technical Specification at Section C. If it is an age-stratified measure, divide that population into age groups that match the stratifications. For example, assume that the eligible population is described as age 18 and older and is required to be stratified into two age groups – aged 18 to 64 years, and 65 years and older. Second, perform random assignment and select a random sample from each age group proportionate to the representation of the age group in the eligible population. One mechanism is to simply assign numbers to everybody in that population and draw a sample from that, using a random number generator. There are free mechanisms available online for doing this. There also are more sophisticated methods to create a random sample, but this is the simplest one.

Question 14: When stratifying by age for purposes of obtaining a representative sample in a hybrid measure, is there a standard or recommended age group to use?

Clarification: The Technical Specification for each measure will tell you if it is required to be stratified by age and what the age stratifications are.

Question 15: As part of the random sampling, do we also have stratification based on payment sources like those for age brackets?

Clarification: Almost all of the measures are stratified by payer. However, there is nothing specific in any of the guidance related to stratification by payer and random sampling.