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Event Name: State-Lead Behavioral Health Clinic Measures – Part 1 of 2

Peggy O'Brien: Welcome to the second webinar in the Behavioral Health Clinic Data Collection and Quality Reporting Webinar Series, presented by the Substance Abuse and Mental Health Services Administration. Today's topic is State-Lead Behavioral Health Clinic Measures, and this is Part 1 of 2. I'm Peggy O'Brien, a Senior Research Leader at Truven Health Analytics, presenting on behalf of SAMHSA. Today we also have representatives of SAMHSA available.

There is a chat function where you can ask questions, and we encourage you to do so. I will pause for questions at several points in the webinar to respond to questions people have asked about things that I've covered that may be confusing or about related matters that I have not addressed.

Most webinars will also have at least one poll question, which listeners will have time to answer and which we can discuss. There are two poll questions in this webinar.

A PDF of the slides for each webinar is posted as a resource on the webinar site, and the webinars themselves will be downloadable for a year after the event on the webinar site as well as available on the SAMHSA website once it is posted.

This is the webinar schedule, with the intended audience identified in red. All are on Tuesday from 2:00 to 3:30 Eastern Time. These webinars will be available to you as a resource, and this slide and others are provided so you can refer to them later as you wish. The next webinar, to be held next week, also relates to state-reported measures that are required for CCBHCs as part of the demonstration program, and the webinar is generally intended for states to help with their reporting of those state-reported measures, although clinics are welcome to attend if they are interested.

I will begin today by answering a few questions that came into the mailbox after the last webinar. I also will pause for questions several times during the webinar. Feel free to ask questions by chat.

The main focus today will be the six state-lead measures that use administrative data.

To begin with, there were a number of people last time who wanted to know where to find the specs and templates, so the address that you see on your screen is the address where you can access those documents.

After the webinar last week, four questions came in, and I am going to address them. The first one was from Nevada, and it asked, "It appears through the template and upcoming webinar schedule there are 13, not 12, state-lead measures. Is this correct?" The answer to that is that the two Patient Experience of Care Surveys are counted as one measure but I will cover them separately. They're very closely related.

There was a second question from Nevada. "Is it correct that all information for measures, BHC or state, will be collected at the BHC level by each individual BHC under the demonstration

grant?" The question goes on to say, "The state-lead measures will then be an aggregate of all the BHCs in the demonstration grant but won't be general state population data. This is very unclear to us, but when reviewing the measures many seem difficult if information is not being collected at the BHC and client level, where services are being provided."

The answer to that, and this is a very important question, is that the state will calculate the state-lead measures at the individual BHC level for each BHC separately. The individual BHCs will calculate the BHC lead measures for their BHC and send the results on to the state. For states that are participating in the demonstration program, the state will then send on to SAMHSA a separate data reporting template for each CCBHC containing both the state-calculated and the CCBHC-calculated measures in that template. This means that SAMHSA will receive a separate template for each CCBHC. There is no aggregation at the state level.

The third question came from Alaska, and I'm going to paraphrase it. The criteria for the demonstration program include 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, and then it goes on to list a total of nine different types of information. 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 those data elements?

The answer to this is that the criteria expect that the CCBHCs will be capable of collecting data that addresses those elements. However, the quality measures and the caseload characteristics in the data reporting template are the primary reporting that will be required. Consumer characteristics are covered in the caseload template as well as in, in part, 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 do 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 nine items enumerated in 5(a)(1). But that is separate. We're not really talking about the evaluation in these webinars, but I wanted to point that out.

The final question, also from Alaska, I will paraphrase. Volume 1 of the BHC quality measures includes two tables with 21 CCBHC quality measures. Table 1 lists clinic-lead measures, including the WCC measure, which is the children and adolescent BMI measure, and the SRA measure, which is the children and adolescent major depressive disorder suicide risk assessment measure.

Alaska wanted to know if the states already submit the child core measure for these two measures, can they satisfy the CCBHC report template using results from the same child core measure. We consulted with CMS on this, and the answer is the data collection methods for all CCBHC measures that are also 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're submitting for the CCBHC demonstration should only include data on the CCBHC patients and services and not for the state as a whole, though that will be different from what you submit into MACPro for CMS, which is data on the entire state.

All right, those are the four questions that we received after the last webinar.

I'm going to start talking about six of the state-lead measures. These are the measures that we're discussing today: diabetes screening, and I'll shorten the titles; adherence to antipsychotic medications; follow-up care for children prescribed ADHD medication; antidepressant medication management; initiation and engagement of alcohol and other drug dependence treatment; and the plan all-cause readmission rate.

I start each measure-specific webinar by discussing the age covered by the measures and the stratification for each measure. These slides can be a handy guide for that information, which also is found in the individual specifications. As you will see, each measure has its own age coverage. The three on this slide include ages 18 to 64, 19 to 64 and 6 to 12. This variety is a legacy of the source measures to which we adhered as closely as possible.

The individual measure specifications each also provide information on when you measure the age to determine if an individual is part of the eligible population. You will see more about that when I walk through specific measures.

These three measures only have payer stratification. Because they are state reported and not BHC reported, only the Medicaid and dual stratifications are really necessary as part of the CCBHC demonstration program. We know the states do not have access to the other data.

These are the age coverages and stratifications for the other three measures we will discuss today. Unlike the three measures on the previous slide, there are age stratifications here. They come from the source measures. They should be the same. Again, as these are state reported, only Medicaid and dual payer stratifications are required as part of the CCBHC demonstration program.

The diabetes screening measure is the first that we will discuss. For those who may be interested, it begins on Page 130 of the specs, Volume 1. I will go through it in detail. After this, I will selectively go through other measures in detail that vary in important ways from this one. And some measures will be addressed in much less detail. And if it appears I am oversimplifying some of this for the audience I apologize. I anticipate that these slides will be provided to and used by people with a wide range of experiences.

For each measure I will explain both the denominator and numerator as well as the measurement periods. For those who are new to quality measurement, the denominator is the entire eligible population you are measuring. In this case, simply put, it is consumers at the BHC who are aged 18 to 64 who have schizophrenia or bipolar disorder and who were dispensed an antipsychotic medication. The numerator is the number within the entire eligible population, so a subset of the denominator, who received the service being measured or somehow otherwise satisfied whatever

is being measured. Here the numerator is the number of consumers in the denominator who had one or more diabetes screenings performed during the measurement year.

As you can see here, the measurement period, or the period of time when data are collected, differ for the numerator and denominator for this measure. For the denominator it is the measurement year plus the year before. This allows a one-year lookback period to see if there is a diabetes diagnosis in the past year, because having diabetes is one of the exclusions for the denominator. For the numerator the measurement period is the measurement year. Again, for the CCBHCs the measurement year is either demonstration year one or demonstration year two.

This is a screenshot of the first part of the diabetes measure. You will note at the top that this is a HEDIS measure. The description section of the specification covers much of what I discussed on the previous few slides, a simple description of the measure and the measurement period as well as information about data source -- the measures today are all administrative -- and stratification requirements.

As you can see, Section A also provides a link to the appropriate value set, which is the 2016 HEDIS at the NCQA website, and references to the templates and appendices. So Section A is a general section.

Section B contains definitions for terms used in the measure. Most are taken directly from the source measure, but we added provider entity to make it clear that the BHC is the unit of measurement. The other definitions for this measure include antipsychotic prescribing events, glucose test and HbA1c test. If you look at the definition of antipsychotic medication dispensing events, for example, you will see how they're identified and where you can access the list of relevant medications. This definition is important, just as one example, because the denominator requires the person have been dispensed an antipsychotic medication during the measurement year.

Section C of the specs defines the eligible population, or, in other words, the denominator, although exclusions may apply, and I will discuss the exclusion in a little bit. Section C begins with age. It tells you the age group covered and when to measure age. Here you measure it at the end of the measurement year. So the person has to fall into the age grouping for the measure at the end of the measurement year.

Continuous enrollment explains when the person must be covered by Medicaid or as a dually eligible person to be considered eligible for inclusion in those groups for stratification purposes. For this measure, the continuous enrollment period is the measurement year.

The allowable gap permits a gap in this case of up to 45 days during the measurement year when the person does not have to be continuously enrolled. However, if the person in this particular measure has eligibility that is determined monthly, this makes clear in that case you can only have a month gap, not two.

The anchor date here is the last day of the measurement year, meaning that the last day of the measurement year cannot be included in the allowable gap or the person is not considered part of the eligible population for purposes of stratification as a Medicaid enrollee or a dually eligible enrollee.

The section on benefits defines the benefit claims needed to complete the measure. Here pharmacy is included, along with medical, in order to capture the antipsychotic dispensing event. And Section C continues on the next slide.

Section C then goes on step by step through the determination of who is in the eligible population or denominator. So Step 1, the person has to be seen at the provider entity at least once in the measurement year. Step 2, out of those who were seen the person has to be 18 to 64 years old as of the last day of the measurement year. Step 3, out of those, the person has to have schizophrenia or bipolar disorder. And this section of the spec very specifically identifies those who had one of those diagnoses, and provides the value sets which include the necessary codes for the administrative claims to be calculated.

So the way you determine whether somebody had schizophrenia or bipolar disorder is that they either had at least one acute inpatient encounter with a diagnosis of schizophrenia or bipolar disorder during the measurement year, or they had at least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting on different dates with a diagnosis of schizophrenia, or two similar encounters on different dates with a diagnosis of bipolar disorder. So you can either be considered eligible because of diagnosis because you have one acute inpatient setting with a diagnosis or two of the other settings with a diagnosis.

Step 4 lays out exclusions and continues on the next slide. You exclude from the denominator those who have diabetes. Those with diabetes are excluded because this measure is about screening for diabetes, and you don't want to include those who already have been diagnosed with diabetes. And the measure goes on to tell you how you determine whether somebody has diabetes, and that can be done with either claims and encounter data or pharmacy data. And this step tells you how to do each.

You have to check both, but you only need to find an indication of diabetes in one of those sources to exclude the person. And to do that you look at data from the measurement year and the prior year to determine if there is a diabetes diagnosis. For the pharmacy data that's used in each exclusion the spec refers and links you to the NCQA HEDIS website to the NDC list of diabetes medications and also the antipsychotic medications.

Section D of the specification lays out the administrative specification for the measure. This is actually a specification that tells you how to calculate it. And the denominator is defined as the consumers and the eligible population, which was defined in Section C that we just discussed. The numerator is defined as those included in the denominator who had one or more diabetes screenings during the measurement year determined by claims or laboratory data, and the value sets are also identified here. The measurement period is also restated here.

And exclusions are either included here or in Section C. It really varies depending on the source measure, because we try to adhere to the source measure as much as possible, but the exclusion here refers back to Section C and it's that diabetes exclusion that we discussed.

Section E has additional notes. It explains that the source measure is for the Medicaid population, and here we are applying it also to the dually eligible population. It is also not risk adjusted. The source was designed and tested at the health plan level, and we are applying it here

at the BHC level. The only other modifications are formatting for consistency with the rest of these measures. Otherwise, it is the same. A higher score or rate on this measure is associated with better quality of care, specifically better screening for diabetes among consumers taking antipsychotic medications that may have metabolic side effects leading to diabetes.

So I'm going to pause now and see if there are questions on what I have covered so far, and I promise I will not go into such great detail on all the measures in the rest of the webinar. Ame, do we have any questions?

Ame: Hi, Peggy. The first question is, if a measure is indicated as a state-level reporting measure and is being gathered through claims data, is there still a need for potential CCBHCs to build this into their EHR reporting system?

Peggy O'Brien: I think it's important that the CCBHCs be very involved in the process, even for the state-reported measures. Obviously, when they are billing or when they're recording billing codes, they're recording encounter codes, that is going to hopefully go into the electronic health record, and it will be -- that billing information then goes on to the state, which is how the state calculates the measures.

So, however the clinics integrate that into their EHR, I imagine it's going to vary from CCBHC to CCBHC. But what's really important for calculation of the measures is that the codes that are required for the state to be able to calculate it are captured by the CCBHCs. So, in some cases that may be very straightforward. In other cases it may be less so. And that the diagnoses are properly recorded. So that is where the CCBHC has a large role in this, in making sure that the data that the state has is complete and accurate.

Ame: The next question is from Allen Walsh. The denominator for the calculations is an average or sum of the counts?

Peggy O'Brien: The denominator is always the sum of the counts.

Ame: The next question is from Justin Harding. Has SAMHSA, ASPI or CMS done any modeling or other investigation to see if current state encounter data is sufficient to calculate the CCBHC responsibility data measures?

Peggy O'Brien: Not to my knowledge. These are, with a few exceptions, these are existing measures. And for the administrative measures that I'm talking about today, the data should be available. There may be some instances and some measures that we'll talk about later where there's going to have to be attention paid to specific codes. But in terms of a direct answer to your question, as far as I know there has been no modeling.

Ame: The next question is from Jim Banks. Will the answers to the questions from all of these webinars be aggregated into an FAQ document available to the CCBHCs?

Peggy O'Brien: That is a good question, and I was thinking about this as I was reading those four questions to you, that it always helps to actually have the words written down. And what I'm going to do for those four questions is I'm going to put them at the end of the webinar that we

have next week, along with the answers, so that you have it in the webinar certainly on the slides. But I believe that they will be aggregated into FAQs.

Ame: The next question is from Tracy Lieber. If the state uses the HCPCS codes rather than CPT codes, can these be cross-walked to a CPT code for inclusion in the measures?

Peggy O'Brien: Yes. Some of the measures, measures that don't really have value sets have either hex text codes or CPT codes. And I'm pretty sure that the value sets that are referred to in these measures include both.

Ame: The next question is from Jerry Storks. Does the CCBHC have to do the screening?

Peggy O'Brien: Have to do -- the diabetes screening?

Ame: Yes.

Peggy O'Brien: No, not necessarily. Because these are state reported and they use claims data, the state should be able to link the individual who was a CCBHC consumer with other data that come in from other sources such as, for example, primary care clinicians in the administrative claims data. So if there is screening that's provided elsewhere and it's reported in the claims data, then the state should have access to it.

Ame: The next question is from Patricia Hirsch. What about schizoaffective disorder for diabetic screening? Is it just schizophrenia and bipolar disorder?

Peggy O'Brien: I believe it is just schizophrenia. However, the value sets, which are the HEDIS value sets, list all of the ICD-9 or ICD-10 codes. And so if schizoaffective disorder were included it would be included in those codes. But it is -- every code is listed in the value sets.

Ame: The last question is from Allen Walsh. This is just a clarification. To be clear, the given measure numerator is just a single year, but the denominator is across two years, one of which is trailing.

Peggy O'Brien: Yes, the numerator is one year, it's the measurement year, say demonstration year one, and then the denominator you will need data that goes back a year prior, because you want to be able to capture diabetes diagnoses going back a year.

Ame: There are no more questions.

Peggy O'Brien: Okay, thank you, Ame. I'm going to move on. I want to make sure I get through all the slides. I will stop frequently for questions during this webinar.

Now I'm going to kind of briefly walk through the data reporting template for that diabetes screening measure that we just covered, and I will not talk about any other templates today. I promise. This is the only one.

This slide that you see here identifies the primary components. Let me get to the right slide here. There we go. Okay. So this slide identifies the primary components of the template, Sections A

through F. In this screenshot you can see that the measures identified at the top in the tab itself is labeled with the measure abbreviation, which is SSD.

In Section A you will insert either DY1 or DY2 if you're a CCBHC. If you're using it for another entity you'd use the appropriate fiscal or calendar year. In Section B, Row 7, there's a dropdown where you select the data source, which is either administrative, which is what this one should be, or other, and in Row 8, if it is an administrative data source, the dropdown allows you to select the MMIS or other, and if there is some other administrative data source there's space to state what it is. In Row 9, if it is a nonadministrative data source that you're using you will specify what that source is. The expectation is that the data here will be administrative.

In Section C you provide the month, day and year for the beginning and end of the denominator data collection and for the numerator data collection. So for this measure, assuming it's DY1, the dates for the denominator begin one full year before DY1 and end at the end of DY1, and the numerator matches DY1. If you look back to Slide 11, which I'm not going to do, that matches what the figure shows that I had on that slide.

In Section D you can see the measure written out and the required stratifications. And this is followed by a table where you insert the respective numerators and denominators for the Medicaid and duals populations. Because your state is part of the CCBHC demonstration, you can ignore the other category. The numerator and denominator for the rates we'll total at the bottom and calculate at the right, and that will provide the rates for the Medicaid population, the dually eligible population and both together. This then auto-populates to the roll-up sheet at the end of the templates.

This slide shows you most of Section E for the data reporting template, which relates to adherence to the measure specs. First of all, it asks whether the denominator includes a range of different populations -- Medicaid, Title XIX-eligible CHIP, Title XXI-eligible CHIP, Medicare duals, etc. As states reporting as part of the demonstration program you're only required here to include Medicaid, dually eligible and Title XIX-eligible CHIP beneficiaries, which I talked about last time, because they're included in the Medicaid population for purposes of stratification.

The second part of Section E asks you to provide information for each of the stratifications as to whether the numerator differed for the measure population, whether the denominator differed, and did the calculation differ in some other way for the measure population from what the specification said you should be including.

At the bottom of the template is Section F, where you can put additional notes. For example, if there is something in particular that may have impeded reporting of complete duals data, please indicate that there.

Okay, I'm going to stop again and see if there are any other questions so far.

Ame: We had one question from Brad Horman. If an individual was screened and found to have diabetes and had diabetes claims after the screening, would they be excluded from the numerator?

Peggy O'Brien: No. So I think the question is asking the person is eligible as a -- is part of the eligible population for the denominator, and they had no prior diabetes diagnosis. And then during the measurement year they're screened for diabetes and they're founded to have diabetes. They are counted, because what is counted in the number is the screening. They want to make sure that people with these medications are being screened for diabetes. So that is counted as a success. It's yes, there was screening. Whether or not the person had diabetes or not, it's just did they get screened?

Ame: There are no more questions, Peggy.

Peggy O'Brien: Okay, so we have our first poll question here. I'll read it, read the options. What do you think will be the biggest obstacles for you in obtaining claims data for dually eligible -- that is, people who have both Medicaid and Medicare consumers? Select all that apply. 1. We do not have any access to Medicare data. 2. Our access to Medicare data is delayed enough to affect our ability to report quality measures when required. 3. We will have problems matching Medicare data with Medicaid identifiers. 4. We will not be able to obtain substance use claims in Medicare data. 5. Other. 6. I do not predict that this will be a challenge.

So if you could select any of those that you believe apply to you, and then if you have any additional comments, if you have other reasons that you think it will be difficult to obtain the claims data for the dually eligible in your state please put that in the chat box, and I'll wait about a minute.

Okay, I'm going to move on and see what the results of the poll are. So, 37 percent said we do not have any access to Medicare data; 10.9 percent, our access to Medicare data is delayed enough to affect our ability to report quality measures when required; 8.7 percent, we will have problems matching Medicare data with Medicaid identifiers; 6.5 percent, we will not be able to obtain substance use claims on Medicare data; 8.7 percent, other; and 28.3 percent said I do not predict this to be a challenge. Okay, that's very interesting.

Ame, do we have anything in the chat box related to this?

Ame: We have one question from Regina Smith, and that is is one-on-one state TA available to assist with the questions offline?

Peggy O'Brien: That is a very timely question. There is going to be some TA available, and I'm going to talk about it at the end of the webinar.

Are there any other -- any comments in the chat box other than that one?

Ame: Just we have some general comments about the poll question. You're only able to select one item, so I think maybe a few people wanted to select more than one item.

Peggy O'Brien: Okay. All right. That's good to know, and the other poll will probably be the same way that's on this webinar. We'll make sure that we find a way to allow multiple selections for future webinars. Thanks for letting us know.

And then I did want to say that this is very valuable information. One of the special issues webinars will touch on duals data, so the information that you provided here today will be useful just to know that there are all of these concerns. So thank you for that.

So I'm going to move on to the next measure. This is adherence to antipsychotic medications for individuals with schizophrenia. And this also uses administrative data, and for those of you who have the specs it starts on Page 158.

The denominator for this measure includes consumers between the ages of 19 and 64 who have schizophrenia and who were dispensed an antipsychotic medication during the measurement year. The numerator is those who had a proportion of days covered, which is also called PDC, and which really means adherence to medication of 90 percent during the measurement year. Both the numerator and the denominator have a measurement year for the measurement period, which means the data is only one measurement year, which would be either DY1 or DY2 for the CCBHCs.

And I'm not going to go through this measure in detail but do want to note a few things. It's also a HEDIS measure, and value sets are available on the NCQA HEDIS website. This measure has a fairly extensive set of definitions for terms used in the measure, including PDC, or proportion of days covered. There also are instructions for how to calculate the measure if the antipsychotic is a long-acting injection, and there is an exclusion for individuals with dementia. Because the objective of this measure is to have increased adherence to prescribed antipsychotic medications, a higher rate on this measure is taken as higher quality of care.

And I know I can't go into detail on all of these measures, but I'm going to stop for just a second and see if anybody has a specific question about this measure.

Ame: There are no specific questions about this measure, Peggy.

Peggy O'Brien: Okay, great. Thank you.

Okay, the next measure has to do with follow-up care for children prescribed ADHD medication, and I'm going through this one in detail, but this will be the last one that I examine in detail today. It is different from the two measures before because it has two rates and four different measurement periods, and this is one of the more complicated ones. And for those of you looking at the specs, this is on Page 179.

The eligible population or denominator for this measure is consumers age 6 through 12 with newly prescribed ADHD medication. The numerator has two parts. The first is follow up with a prescribing provider during the 30-day initiation phase after the index prescription start date, that is, after the first prescription that's included here. And second is for those that had follow-up in the initiation phase, was there follow-up with at least two visits within the nine months after that prescription start date. This means that there are two different rates for the measure.

And there are, as you can see from the chart at the bottom, four different measurement periods. And I've numbered them 1 through 4, and that's the order I'm going to talk about them in just to try and make it a little simpler. Number 1 is the index prescription start date, the IPSD, and that

goes back up to 10 months before the measurement year begins and stops 2 months after the measurement year begins. So that is the time during which the new prescriptions can occur.

And then Number 2 is how you determine whether it's a new prescription, and that's the negative medication history review. And that looks back 120 days before the index prescription start date. And this allows a clean period of 120 days before the first prescription. So you're capturing people who didn't have prescriptions for ADHD in the recent past.

The measurement periods for the numerator are -- the first one is -- Number 3 is initiation, and that's the 30 days after the index prescription, and then Number 4 is continuation and maintenance phase, and that's the nine months after the index prescription. I apologize for the chart, which was very difficult to create for a measure that's as complex as this one. It's really just an approximation to try and give you some sense of where the data lies.

And, as a reminder for CCBHCs and states with CCBHCs, the templates, the data reporting templates at the very back include measurement periods that are key to when the demonstration year starts, assuming it starts at the beginning of a month, which would be best in terms of calculating these -- in terms of calculating the measures.

Section A of this measure lays out the two rates in narrative form, as well as the usual data collection and stratification information. It also explains what to do when children switch between Medicaid and CHIP and can't be identified as continuously enrolled throughout the entire period.

So even though I go through these measures in some detail, there's a lot of detail that I'm not capturing in this webinar, which means that you have to read them, so a word of warning.

The Section A description continues with guidance related to narcolepsy, which is an optional exclusion because ADHD medication is often used for treatment of narcolepsy. There is provision for the location of the value sets, the medications list for the ADHD medication, the importance of trying to incorporate all paid, suspended, pending and denied claims. There's a reference to Appendix D in Volume 2 where types of prescribing providers are listed and more information about the templates and the four measurement periods.

Section B contains multiple definitions of terms that are used in the spec. Any time that you are looking at one of the specs and you have a question about what something means, look at the definitions, because the hope is that they are included in that section of the specification.

The definition of the eligible population is provided for Rate 1 and Rate 2 separately. I'll walk you through the first rate, which is initiation, and spare you some of Rate 2.

The Rate 1 eligible population directions define age and when the person must meet the age criteria. It's very detailed and essentially covers the index prescription start date period. The person must be at least age 6 as of 10 months before the measurement year begins and no more than 12 as of 2 months after it begins.

Continuous enrollment is required for a five-month period starting four months before the index prescription start date and going through the initiation phase. And, remember, I'm only covering

Rate 1 here. So that's not the same for Rate 2. It's different. There's no allowable cap and no anchor date for the initiation rate. The benefits are medical and pharmacy.

The steps to determine Rate 1 population eligibility look at age and receipt of ADHD medication. There has to be a negative medication history. There has to be continuous enrollment for the appropriate period. And then you exclude those with an acute inpatient encounter for mental health or chemical dependency during the 30-day period after the index prescription start date. Again, this is just for Rate 1.

And the reason that you exclude people who have an acute inpatient encounter for mental health or chemical dependency during that initiation phase is presumably because this would or could interfere with the initiation phase visit and, probably more importantly, there are likely to be major shifts in diagnosis or treatment if someone is on a medication and then they are hospitalized for a mental health or chemical dependency diagnosis. It's very possible their medication will be changed or that there are other factors that could interfere with follow-up care.

A similar process is followed for Rate 2. For Rate 2 there is provision for an allowable gap in continuous enrollment. And to determine the eligible population for Rate 2 requires some careful reading, but in general you look at did they satisfy Rate 1? They had to first meet the initiation follow-up care before you even look at this. If so, was their continuous enrollment? And if so, was there continuous medication treatment? And there are some provisions for gaps, but you have to read the details on that. And then there is, again, an exclusion for the acute inpatient encounter during that specified period of time.

The administrative specification in Section D refers back to Section C for the denominators for Rates 1 and 2, respectively. There are also separate numerator specifications for Rates 1 and 2, with reference to the applicable HEDIS value sets for the codes.

The narcolepsy exclusion is noted again here, as well as how to determine who might fall into that exclusion. And, again, there is a value set for that.

The additional notes in Section E address things such as how to count overlapping prescriptions, how to count certain units of service that are sometimes coded differently, information on the source measure and score interpretation, and for this measure in general higher rates of follow-up on each rate is considered to be associated with a higher quality of care.

So I'm going to stop again to see if there are any questions so far. If not, there'll be another opportunity to ask them.

Ame: Hi, Peggy. The only question is from Gary Trayvor. "I'm confused about the timeline for collecting the data. For example, the result of a diabetes screening are to be obtained by the state from claims data, but the BHC must submit the measure numerator and denominator in a BHC-specific template?"

Peggy O'Brien: Okay, so going back to the diabetes one, because that's simpler than the ADHD one, first of all, it's a state-reported measure, and it relies on claims data. So the BHC doesn't report on the template or that measure. It is calculated completely by the state based on

administrative claims data that it has in its possession. So when that billing or administrative claims information is fully available to the states, they use that to calculate it, and then they report on the reporting template for that measure.

And for diabetes, the latest that the data is required to cover is the end of the measurement year. So by the end of -- once the state has all the data for the measurement year, it should be in a position to calculate that one.

Ame: That was the only question, Peggy.

Peggy O'Brien: Okay. I'm going to move on, then.

Okay, so this is antidepressant medication management. It begins on Page 187 of the specs, and it looks at the percentage of consumers ages 18 and older who are treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant. And there are two different rates. Did they remain on the medication for at least 12 weeks, is 84 days? And did they remain on the medication for at least six months, which is 180 days?

In large part this measure has similarities to the ADHD measure, so I will not go through it in great detail. I will just touch on some key parts. So the denominator is those who are 18 or older and who are treated with an antidepressant and had a diagnosis of major depressive disorder. Again, there are separate measurement periods. There's an index prescription start date, so it's the first prescription. There is a negative medication history review which allows you to tell it's a new prescription. Then there is the numerator for the 12 weeks and six months rates.

Again, for CCBHCs, the templates include the measurement periods key to whenever your demonstration year starts. And for this measure, medication adherence over the course of time measured is considered to be associated with higher quality.

So are there -- I'm going to pause and just see if there are any questions about this one, because that's the extent of what I was going to cover on this one.

Ame: We have a question by Daniel Collison. "Within the Medicaid dataset we can identify whether a consumer is dually eligible for Medicaid and Medicare. We were not aware that we need to access Medicare claims to report on dually eligible consumers."

Peggy O'Brien: Okay, so it sounds as though the person believes that the data that they have to access is strictly Medicaid data, not Medicare and Medicaid data. So for people who are just Medicaid that would be simple. It would be the Medicaid data. For the dually eligible it would be -- to get comprehensive data would be Medicare and Medicaid. And, as I said before, in one of the special issues webinars, which is Webinars 6 and 7, I'm not sure which one, I will be talking about the data for the dually eligible.

And the question that I asked, the poll question, was asked for a reason, and that was to kind of see what sort of problems people might have and if there are issues, and it also recognizes that there might be. So I encourage anybody who has specific questions about accessing dually eligible data to submit that question to the mailbox that's going to be shown on the last slide.

Ame: There are no more questions.

Peggy O'Brien: Okay, I'll move on.

Okay, so we have one more poll question, and actually this you pick one answer, so it should work right. Do you agree with the following statement? "SSI spend-down requirements will result in consumer use of cash to purchase medication, making it difficult to accurately track medication purchases using claims data." Select the option with which you agree the most: one, I think this will be a big problem with any measure related to medication; the second, it will happen, but it will not have a significant effect on the measures; I will need to confer with providers to see if this is a big problem; I do not predict this to be a challenge.

And so if you could select the one you find most agrees with what you believe, and then summarize any additional comments that you have in the chat box, please. I'll wait a minute. Okay, I'm going to reveal the results here. Thirty-eight percent see this as a big problem with any measure related to medication; about 12 percent think it will happen but it won't have a significant effect; 41 percent, I need to confer with providers; and about 9 percent, I do not predict this to be a challenge.

And that was put in there just to raise a question that somebody has asked is how do you rely on claims data to track medication dispensing if people are paying cash or people are getting samples, things like that? It's not going to be captured in the claims data. And I think my answer to that is yes, it will happen. We don't know how much it will happen. The hope is that it will be at a relatively consistent level across providers so that it happens to everyone equally, but that is just food for thought. Ame, are there any comments?

Ame: There's one comment from Timothy Santoni. "Trying to get Part D data could be a major issue. I do not personally know for certain, but I'm reasonably sure that we do not get Part D data."

Peggy O'Brien: Okay, so Medicare medication data. Again, any of these questions or comments that you have about this, I encourage you to send them to the TA box that's on the last slide, because that will go into our thinking about the webinar about duals data.

Okay, so we are down to the fifth of six of here. This is a measure with which you're likely familiar. It's on Page 193 of the specs. "Initiation and engagement of alcohol and other drug dependence treatment is designed to encourage initiation of substance use treatment and continued engagement after a new episode." It has two rates, one for initiation and one for engagement.

The denominator is the number of consumers age 13 and older with a new episode of alcohol or other drug dependence, and the denominator has two measurement periods. It's very similar to the medication ones, but it's not medication. It is the episode. So you have the index episode start date, and then you have a negative diagnosis history review that goes back 60 days from the beginning of the episode to make sure that it's a new episode, that there's a 60-day clean period beforehand, or the person is not included in the denominator.

And then for the numerator the first rate is initiation, and that is to satisfy the numerator it has to be within 14 days of diagnosis. And then to satisfy the numerator for engagement in treatment -- this is after initiation, so you have to initiate first -- but are there two or more additional services within 30 days of initiation. And, as you might expect, higher rates of initiation and engagement are considered to be associated with higher quality of care.

There's a digression I'm going to make here that's important I want to point out. This measure is fairly widely used, and it's traditionally had very low rates. And there may be many reasons for that, but there are at least three that I could think of without thinking too hard about it. And the first is that it's a complicated measure and some calculations may be more accurate than others. I don't think that that necessarily accounts for low rates, though. The second is that actual initiation and engagement in substance use disorder treatment may be far lower than is desired. And the third is that part of what is required for this measure is for someone to be counted -- is to have an alcohol or other drug dependence diagnosis.

I wonder how many people with an alcohol or other drug disorder of any kind don't actually receive that diagnosis or don't receive it consistently, either because of stigma and the desire not to label someone, or in order to avoid the application of 42 CFR Part 2 to the person's medical records. So it's important to note that the index episode might show up in one location. For instance, it could be an ED or a hospital visit. But the potential follow-up visits might be to a CCBHC, for instance. And if neither one puts in a substance use diagnosis, the person just isn't counted, and it doesn't affect your rate, because it doesn't ever go into the denominator.

However, if the first visit, say the hospital or ED, puts in a substance use disorder diagnosis, and the follow-up or initiation or engagement visits do not include that diagnosis, even if the person is seen, the person does not get included in the numerator and the rate goes down, even if the person is actually initiating or engaging in substance use treatment. So this is where it is very important that the coding that goes on at the clinics be accurate, that it include the diagnosis, that it include the appropriate encounter and other codes in order for the states to be able to accurately capture what is happening, whether people are initiating or engaging in alcohol and other drug dependence treatment. So that's something to think about as you move forward related to training for the BHCs that you work with.

And the last measure for today is the plan all-cause readmission rate. This measures unplanned readmissions, and it is on Page 123 of the specs. The denominator here is the number of acute inpatient stays by consumers 18 or older, and the numerator captures any unplanned readmission within 30 days during the measurement year. The measurement period for the denominator is the measurement year minus the last 30 days of the measurement year, which allows capture of 30 days readmissions after a late-in-the-year acute inpatient stay, and a measurement period for the numerator is the measurement year.

There are some unusual things about this measure, which include it is based on acute inpatient admission. So there may be multiple admissions per consumer that are counted. It's not the number of consumers. It's the number of admissions. It requires risk adjustment to be fully accurate, but there is not yet a standardized risk adjustment table for it, and therefore you don't need to worry about it. You just report it as it is.

Unlike some measures, you include paid claims only. All of this is in the specs. And there are some special considerations for dealing with acute-to-acute transfers, hospital stays where the admission and discharge dates are the same, hospital stays related to perinatal conditions, where the consumer is pregnant, where you have a planned readmission, and a lot of other factors that are laid out in the specs. These complicating factors that play into the calculation are there to make sure the measure does not encourage unplanned readmission for things such as pregnancy. You don't want the measures to have undesired results.

Okay, I'm going to pause here again and see if there are any questions. I've covered six state-calculated measures that rely on administrative data. Some are more complex than others. I know there's a limit to how much detail anybody can tolerate, so I may have omitted some things that you're dying to know, and if so this is your chance to ask.

Ame: We have one question from Tracy Lieber. What if the person is seen in a residential treatment program which is not paid for by Medicaid in our state?

Peggy O'Brien: Okay, so the person, I'm assuming, would be a Medicaid enrollee but is seen somewhere that is not captured in the data. That is a good question. And that is a question that I think requires some thought. So we will have these questions transcribed. So I will make note of that question and confer with people about that. I don't want to answer off the top of my head.

Okay, I will move on. So, this is our upcoming webinar schedule, again. We meet every Tuesday at 2:00, skipping the last week of August. This is a preview of the next webinar next week on Tuesday, July 26. This is going on its own again. Let me try and get back to it. Okay. So this is next week. And these are the last seven state-lead measures that are required as part of the CCBHC program, demonstration program, and they include the four follow-up measures. Two of those are for emergency department and two are for hospitalization after mental illness, and then there is the housing status measure and the patient experience of care surveys, both of them.

And this is the webinar that follows that one on August 2, and this is the first one that goes into the BHC-lead measures. And I will be covering five measures during that webinar. BHCs are strongly encouraged to attend these webinars. The measures I'll cover in that webinar are time to initial evaluation, the BMI measure, the tobacco use screening and cessation intervention measure, unhealthy alcohol use screening and brief counseling, and depression remission at 12 months.

And I'm not going to go through these in detail. These are the -- this is the list of measures by abbreviation by whether it's state- or BHC-lead, whether it's required for the demonstration program, and the webinar in which I address it.

And this is here for your reference. Like I said, these slides are downloadable as a PDF off of the site where you are watching this right now.

So, again, please submit any additional questions you have to the CCBHC_Data_TA mailbox. The address is up on the screen. And it can be about material that's covered today, questions about the state-lead measures that I'm going to cover next week if you know in advance what those are, about the BHC-lead measures that will be covered in the two weeks after that, ideas for the two special issues webinars and any other questions you have that relate to the data

collection analysis and reporting for these quality measures. And to the extent you know in advance questions that are related to the measures it would be great if you can ask them through the mailbox so I can try and answer them in the webinar where the measure is discussed.

I also would especially appreciate any feedback on the content or pace of this webinar today, as there are four more webinars that cover specific measures, and I want to make sure that we are providing what you need, particularly as we move into Webinars 4 and 5 for the behavioral health clinic, specifically. So that sort of feedback can also go to that Data_TA mailbox.

And so at this point I am finished with the prepared material. And I do want to say one other thing before I stop. I want to let people know that SAMHSA will be offering office hours in 30-minute increments where the states and clinics can sign up to meet and ask questions. We will get you more information on this over the next week, but we expect it probably to begin late in the week of July 25 and go through August.

And somebody asked about one-to-one TA. This may not be one to one. There might be more than one state employee on the phone, or there might be multiple BHCs from the state on the phone. But it will be each 30-minute increment we will limit to a state. There will not be multiple states. At least at that point -- at this point we're not planning on doing that.

The preference will be that you send the questions in advance in writing, because that way we can make maximum use of the 30 minutes. And we also ask that the questions relate only to data and quality measure, collection analysis and reporting, that it not go into things about cost reports and things like that. And, again, we'll be in touch with more information about that.

So we have a few minutes, so I'm going to pause one last time to see if there are any questions right now.

Ame: The first question is from Jerry Stork. When a diagnosis is required as part of the measure, does it have to be a primary diagnosis or one of any on a claim?

Peggy O'Brien: That depends on the measure, and the specification will tell you if it's anything other than any place. There are a few measures that say that in certain circumstances it may have to be a primary diagnosis. But generally if it calls for a diagnosis the diagnosis just has to be there. So I refer you to the measure specification. Unless it says something it can be in any position on the diagnostic list.

Ame: The last question is from Timothy Santoni. Providers have up to one year to file an MA claim. What does this mean for reporting deadlines?

Peggy O'Brien: Well, I think that that is one reason that the states have up to a year after the end of the demonstration year to submit the data reporting templates for their measures and why the BHCs have somewhat less time. That was designed to allow the states time to gather as much data as possible to be able to calculate the measures. It also sounds like that raises the question of what happens if a state doesn't have all of the data at the end of the year or they need additional time, and that's something to think about going forward, us.

Ame: We have one more question from Daniel Collison. Would diagnosis include admitting and the patient's reason for visit?

Peggy O'Brien: Diagnosis would include a diagnosis code, an ICD-10 that conveys a diagnosis. So the person has to have a diagnosis and a code.

Are there any other questions, Ame?

Ame: There are no more questions, Peggy.

Peggy O'Brien: Great. Thank you. Thank you, everybody. We'll be back next week.