

**Non-Required BHC Measures**  
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Peggy O'Brien: Good afternoon, and welcome to the eighth 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 "Non-Required BHC Measures." This means I will provide an overview of the BHC measures that are no longer required for the CCBHC demonstration program. I also will spend time addressing some unanswered questions from previous webinars and questions of general interest that have been raised in the office hours over the past month. Some of the questions and answers are very important, so I hope you'll hang on through the non-required measures to get to that point.

I'm Peggy O'Brien, a senior research leader at Truven Health Analytics, presenting on behalf of SAMHSA.

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 give people a chance to ask about parts of what I have covered that may be confusing or ask about related matters that I have not addressed. Each webinar will have at least one poll question, which listeners will have time to answer and which we can discuss.

A PDF of the slides for each webinar is posted as a resource on the webinar site, and the webinars themselves will be available on demand for a year after the event on the webinar site where you are listening to this presentation. All you need to do to access the on-demand webinar on this webinar site is to be registered. So if you know someone who has not done so who would benefit from accessing the webinar or previous webinars, encourage them to register.

The webinar also will be posted on the SAMHSA website probably within a week or two after it is presented.

This is the eight-webinar schedule, and this webinar is the last in the series. These are our topics for today.

These are the measures that I will be discussing today. They're the measures that are part of the BHC set but which are no longer required of CCBHCs as part of the demonstration program. We do expect, however, that some CCBHCs may wish to use some of these for extra quality bonus measures or for other purposes.

The first measures in brown are designated as BHC-reported measures. The second set in blue are designed as state-reported measures but are specified to report at the BHC level. I'm not going to be going into as much detail on these measures as I have on earlier webinars for other measures. I plan to only address the parts of the specs that are somehow distinctive.

I'll start with the five non-required BHC lead measures.

This slide shows the age coverage and stratification for the five BHC lead measures. Each covers a different age group. All are stratified by payer, and three are stratified by age as well. As necessary, I'll cover this in more detail in the specific measure. These measures are of routine care needs; time to comprehensive person- and family-centered diagnostic and treatment planning evaluation; deaths by suicide; documentation of current medications in the medical records, and controlling high blood pressure.

Routine care needs looks at the percentage of new consumers requesting services who were determined to need routine care. The denominator is all new consumers defined as not having been seen in the past six months, as we saw with the initial evaluation measure that is required. The numerator is those denominator eligible consumers determined to need routine care.

The measurement period for the denominator is the measurement year and six months prior, meaning that you need data that looks back six months before the measurement year for anyone who seeks services on January 1. It looks back six months from when that first contact is made.

The measurement period for the numerator is the measurement year.

The origin of the routine care needs measure is the CCBHC criteria. In light of that, the definition of "routine care needs" is care needs that, based on a preliminary screening and risk assessment, are determined not to be of an emergency or urgent nature within the commonly accepted meaning of those terms in a behavioral health setting.

The criteria leave much of this undefined, including the meaning of "routine," "emergency" and "urgent," leaving it up to the states or clinics to determine how best to define this based on their existing best practices.

A "new consumer" is defined as an individual not seen at the clinic in the past six months, as with the I-EVAL measure, and the appendix includes a sample calculation. This is really a straightforward percentage.

Unlike most measures, this percentage cannot be viewed as representing either high or low quality. Rather, it provides a snapshot of new consumer acuity. It can be useful, however, to see if there are outliers in terms of clinics or age groups with an unusually large or small number of new consumers defined as in routine need.

The second measure is the time to comprehensive person- and family-centered diagnostic and treatment planning evaluation measure, which also derives from the requirements of the CCBHC criteria. It measures the mean or average number of days after first contact until comprehensive person-centered and family-centered diagnostic and treatment planning evaluation is performed for new consumers. It's calculated by dividing the total number of days until completion of the comprehensive evaluation for all new consumers by the number of new consumers.

The measurement period for the denominator does, like routine care, have a six-month lookback, but it excludes the last 90 days of the measurement year. This allows you the last 90 days of the measurement year to see timeliness of initial treatment planning evaluations.

Key definitions in this measure include "comprehensive person-centered and family-centered diagnostic and treatment planning evaluation." Some certification standards such as the CCBHC certification criteria establish time requirements for completion of comprehensive treatment planning evaluation. In the case of the CCBHC, the certification criteria require that all new consumers receive the comprehensive evaluation to be completed within 60 calendar days of the first request for services. That standard is used in the specification. Other standards may exist for other entities, and this specification can be adapted accordingly.

"New consumer," again, looks back six months from the request for services.

The third of the non-required BHC lead BHC measures is death by suicide, which looks at the percentage of consumers ages 12 or older seen at the BHC during the measurement year who died by suicide during that time. The measurement periods are both the measurement year for the numerator and denominator.

Individuals are excluded in this measure if the cause of death is unknown. This measure has some acknowledged limitations, including that complete accuracy depends on knowledge of consumer intent and knowledge of cause of death for all consumers seen in the measurement year. It has been suggested that coroners' data be used rather than relying on BHC knowledge, and states should feel free to compare the results of the measure as specified with coroners' data. If this measure is reported, however, as part of the CCBHC demonstration, it should be reported as specified.

Unlike the three measures just discussed, this and the one following are based on existing measures. Documentation of current medications in the medical records looks at the percent of eligible encounters in the measurement year by those 18 and older for whom an eligible professional attests to documenting, updating or reviewing current medications on the date of the encounter. The measurement period is the measurement year.

This measure uses medical records data, including billing records. The report is encounter- rather than person-based, so it counts eligible encounters. It also requires that the provider documenting be a defined eligible provider, and that is someone eligible to prescribe medication as defined by the state in which they are operating.

This is another measure that uses G codes or quality codes to document the exclusion, which is urgent or emergent medical situation where time is of the essence and delay would jeopardize health status, and document numerator compliance, either that the review of medications did or did not occur. If documentation is not available for those aspects of the measure, the encounter does not meet the criteria for the numerator or exclusion, respectively. For this measure, a higher rate of documented review equates to higher quality.

Controlling high blood pressure is one of the few measures I will go through in detail today because it's very complicated. If you decide to use it, however, you must review the specs carefully, as I cannot do it justice here. Also, before I forget, there is a resource document for this that is included on the website, which includes a flow diagram of the measure calculation process as we prepared for the two earlier hybrid measures. This is the last of the three hybrid measures in the BHC set.

This measure covers those ages 18 to 85 seen at the BHC during the measurement year who were hypertensive. The numerator counts those out of the denominator-eligible population whose blood pressure is adequately controlled during the measurement year. The denominator only looks at those seen during the first six months of the measurement year in order to allow time to capture whether the blood pressure is controlled during the measurement year.

This measure has a complicated interaction between age stratification, diabetes status and what is considered controlled blood pressure. Different blood pressure levels are used as criteria for "controlled" based on age, with it different for those who are ages 18 to 59 and 60 to 85, and by diabetes status. Layered on top of that are age stratifications for reporting of those 18 to 64 and 65 to 85.

The eligible population for this measure requires that they be seen at the BHC, be age 18 to 85 at the end of the measurement year and be hypertensive during the first six months of the measurement year, which requires one outpatient visit with a hypertension diagnosis.

The specs require that you establish a flag in the data to indicate diabetes status. This status determines what the appropriate blood pressure will be, and to determine diabetes status you must look at both claims and counter data and pharmacy data, although the person need only have evidence of diabetes in one of those places. The requirement to use pharmacy data makes this, as a practical matter, very difficult for a BHC to calculate.

This measure has a hybrid and a medical records specification that work together. The first step in calculating the denominator is to use administrative data to select all consumers with a hypertension diagnosis during the first six months of the measurement year. As stated in the hybrid spec, you then use a sample, or all, if you wish, of the medical records, looking for a notation of hypertension during the first half of the measurement year, and this is done to confirm the hypertension diagnosis that you found in the administrative data.

The spec identifies how that notation might be recorded. If there is no confirmation of the hypertension diagnosis in the medical record by such a notation, the person is simply excluded from the denominator. There is a lot more detail in the spec, including instructions regarding the sample and identifying the medical record and requiring that the same medical record be used to identify the hypertension diagnosis and the representative blood pressure for the numerator, but that the diagnosis precede the representative blood pressure rating.

For this hybrid spec, the numerator utilizes medical records from the denominator sample to determine blood pressure control, as discussed on the next slide.

The medical records spec is for the numerator. For this, you will identify the most recent blood pressure reading during the measurement year after the hypertension diagnosis is confirmed. This is a complicated measure, and I do not have the ability in this webinar to discuss it in enough detail, so please read the specs carefully if you intend to use it. The specs do include information on some readings that are to be excluded, what to do with multiple readings, what happens if you have incomplete readings or readings below the threshold for controlled blood pressure. They talk about stratification and exclusions as well as more on how to establish the diabetes flag.

I know I have raced through these non-required measures that are specified for BHC reporting, but I do want to make sure I have ample time at the end to address outstanding questions. Are there any questions right now about what I have covered so far?

Speaker: Hi, Peggy. The first question is from [Shen Tayget]. If these measures are not required, we are wondering why we would provide them, other than it being a best practice workflow. Or will they be required in the future and are just not required now?

Peggy O'Brien: They were originally included in the CCBHC criteria as to be required, and then when the BHC measures were developed and published, it was determined that these measures would not be required for the demonstration. There is no anticipation that they're going to be required for the demonstration. I believe that there may be a state or two that has considered using one or more of them for a quality bonus measure that is designated by the state. That is one use. It's possible that states may elect to use them because they want to be able to see how these practices are being provided, if they're being provided at the CCBHC or at other BHCs. But in general there is no expectation that they're going to be required by SAMHSA as part of the demonstration program.

Speaker: There are no more questions.

Peggy O'Brien: Okay. Thank you. I'm going to move on to the four state-lead measures that are not required as part of the CCBHC demonstration, and again, I will go through these pretty quickly.

This chart shows the age and stratifications for the four state-lead measures. Each covers a different age range. Two are stratified by age, all by payer. The measures are suicide attempts; metabolic monitoring for children and adolescents on anti-psychotics; cardiovascular monitoring for people with cardiovascular disease and schizophrenia, and adherence to mood stabilizers for individuals with Bipolar I disorder.

The measure of suicide attempts looks at the percentage of those who are 12 and older seen during the first 11 months of the measurement year who attempted suicide at least once during the measurement year, as long as the attempt resulted in injury requiring medical services during the measurement year. The measurement period for the denominator is the first 11 months of the measurement year, and the numerator is the entire measurement year.

The month that is excluded from the denominator allows a month at the end of the measurement year to capture those with attempts in the eleventh month with associated medical attention that may appear in the twelfth month.

The definition of "suicide attempts" includes both fatal and non-fatal attempts that result in use of medical services, and the measure uses administrative claims data, which is how the medical services are captured. It has a recognized limitation because complete accuracy depends on knowledge of consumer intent and it also depends on accurate coding that reflects suicidality, and we know that these are both often difficult to be sure of. This measure also only captures suicide attempts that result in billing for services and will not include individuals who may die before receiving any medical services.

This is the second measure that is a state-lead measure of the non-required. The measure of metabolic monitoring for children and adolescents on anti-psychotics looks at the percent of those who are ages 1 through 17 who have diabetes and have two or more anti-psychotic prescription fills during the measurement year and who have metabolic monitoring during the measurement year. The metabolic monitoring is what is being measured in the numerator.

The measurement period for the denominator is the measurement year and the year before, and for the numerator it's the measurement year. The denominator goes back a year to identify those with diabetes and some exclusions. It uses administrative data, and the starting point is those with a service at the BHC during the measurement year, so linking to past-year administrative data, at least for Medicaid, should be straightforward for the state.

The highlights of the measure are that it includes those seen at the provider during the measurement year who are ages 1 through 17 at the end of the measurement year with at least two anti-psychotic dispensing events on two or more dates during the measurement year.

Terms are defined in Section B of the spec, and the numerator requires at least one blood glucose or HbA1c test and at least one test of LDL-C or cholesterol.

The measure of cardiovascular monitoring for people with cardiovascular disease and schizophrenia includes those who are ages 18 to 64 with a diagnosis of both schizophrenia and cardiovascular disease with a numerator that counts those who had an LDL-C test during the measurement year. Like the previous measure, this has a measurement period for the denominator that looks back a year, in this case to identify those who have cardiovascular disease.

Also like the previous measure, this uses administrative data and ties it to individuals seen during the measurement year at the BHC, allowing the state to link identifiers in data from the measurement year to the prior year.

As I mentioned, it uses administrative data, and for the denominator the diagnosis of schizophrenia is based on combined encounter and diagnoses codes, and the cardiovascular disease determination is based on encounter, procedure and/or diagnoses codes. The numerator relies on claims or automated laboratory data.

The last of these state measures looks at adherence to mood stabilizers for individuals with Bipolar I disorder. The denominator includes consumers who are 18 or older with Bipolar I disorder and at least two prescription drug claims for mood stabilizer medications. The numerator counts those with a proportion of days covered of at least 0.8, meaning 80% adherence to prescribed dosing. The measurement period is, straightforwardly, the measurement year.

The person must have been seen at the BHC during the measurement year, be 18 or older at the beginning of the measurement year, have a Bipolar I diagnosis and inpatient or outpatient claims during the measurement year and at least two prescription drug claims for mood stabilizers on different dates in the measurement year.

The numerator is proportion of days covered, and the calculation for this is in the definitions in Section B of the specification.

Okay, I raced through those also but want to reserve time to answer the outstanding questions. Are there any questions about what I have covered on the non-required BHC measures?

Speaker: Hi, Peggy. There are no questions.

Peggy O'Brien: Okay. Good. We do have a poll, and this is for the states, so if there are BHC representatives or others, please don't answer. Only if you are a representative of the state: Do you plan to use any of the non-required BHC measures? Please select all applicable answers: yes, as part of the CCBHC demonstration as an optional quality bonus measure; yes, as part of the CCBHC demonstration but not as a quality bonus measure; yes, including outside the CCBHC demonstration; not sure, possibly; or, no.

Okay, I will move on to the poll results. Thirteen percent plan to use one of these measures at least as an optional QBM. Almost 9% in some other capacity as part of the demonstration; 4% outside the demonstration; 48% aren't sure yet, and about 35%, no, will not plan on using them. That's helpful. Thank you.

All right. There are a number of outstanding questions. I'm going to start with the general questions that don't apply to particular measures—some of them are very important basics—and then move on to questions about specific measures.

There's a lot of words on here, so I'll try and say it in a way that means you don't have to read it. This is a question that came up during office hours that raised a very important question, specifically what data source should be used to establish whether or not DCO care was coordinated by the CCBHC for a patient who receives care at a DCO after the initiation of the demonstration year but before receiving from the CCBHC?

This stems from the document about when someone is a CCBHC consumer and the requirement for existing clients at a BHC that has just become a CCBHC who were seen first at a DCO after the demonstration starts. So, the BHC becomes a CCBHC and their existing client, the very first visit that has anything to do with the CCBHC is at a DCO instead of at the CCBHC parent, I'll call it.

There is a requirement in that document that SAMHSA disseminated that the initial care at the DCO had been coordinated by the CCBHC.

So, for BHC measures, this should be information that the BHC has. For state-reported measures, however, unless there is a care coordination code that the BHC uses which is submitted with other Medicaid or, in the case of the dually eligible, Medicare data to the state or to CMS, there is no way to determine this. You should look at codes governing post-discharge transitional care coordination and codes governing complex care coordination evaluation in management, and those are CPT codes. Some require face-to-face interaction with the patient and will be less useful in this situation, while others allow interaction between providers without the patient being present.

This slide reiterates the timing for reporting. The cost report is due six months after the end of the demonstration year. The BHC lead measures are due nine months after the end of the demonstration year. And the state-lead measures are due 12 months after the end of the demonstration year.

So, for example, if a state selected a demonstration year that began on January 1 of 2017, the cost report is due June 30 of 2018, the BHC lead measures are due September 30, 2018, and the state-lead measures are due December 31, 2018. I do want to point out to one of the office-hours states that your question assumed that the BHC lead measures would be due August 31. That is one month short of when they are actually due. You have a full nine months.

This slide is also prompting me to think about how the nine-month requirement for the BHC feeds into reporting by the state to SAMHSA, and that is something that when we post the final sets of questions that are going to be posted on the 223 quality measure site, there will be something addressing that.

Another basic that I want to make sure is really clear, for state-lead measures the state is only expected to report Medicaid-only beneficiaries and dually eligible Medicare/Medicaid beneficiaries. The state is not expected to report others for state-lead measures.

This is a question of basic importance, but it doesn't have an intuitively apparent answer. For stratification purposes, if the consumer has both private insurance and Medicaid, will we consider this consumer as Medicaid or as other?

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

On the other hand, if Medicaid insurance covered only a Medicare premium or a Medicare premium plus family planning, those people fall into the dually eligible category because the Medicaid pays for their Medicare premium.

Another basic. For CCBHCs, the measurement year is the state's demonstration year. So if the state's Demonstration 1 year is January 1 through December 31, 2017, that is also the measurement year. If the state's demonstration begins on July 1 and goes through June 30, that also is the measurement year for them.

We've been asked, Do we have to use the data reporting templates to submit the quality measures? You must use the OMB-approved data reporting templates to submit the quality measures. It's very important that the templates be used in order to allow consistency for the evaluation and for quality bonus payments.

Also related to the data-reporting template, some of you may have noticed the caseload characteristics in the templates near the beginning of the BHC-reported section. This is for the BHC to complete, and I think that states and clinics have finally had enough time to explore the documents to start asking questions about this worksheet.

I think I'm missing a slide here, so I'm going to tell you what it said. This goes to the caseload characteristics, this worksheet that you see on the screen. This applies to the entire CCBHC consumer population, and with regard to the veteran or military status rows, the type of discharge from the service does not matter, and whether they are eligible for VHA benefits does not matter. If they were discharged from the military, they're considered a veteran. If they're still in the military, they are active duty.

To determine age for the caseload characteristics, you will use age at the time of the first visit in the measurement year, and to determine payer, you will use payer status at the time of the first visit in the measurement year.

There have been a series of questions about codes that are included in the measures or that are referred to in the measures, and so, in an effort to respond to those, we have a couple of slides that should be greatly useful to people who are listening. The first is this one, which relates to who can deliver services. States have identified problems because they would like to have non-physicians provide services using codes that are normally applied to a physician. For instance, using a medical assistant to screen for BMI. The first question to ask if you want to do this is, Will the person be working within their scope of practice as credentialed within the state, per the state licensing laws, etc.? And the second question to ask is, Are they providing the services under the personal supervision of a person who is licensed to practice medicine?

Consultation with CMS pointed us in the direction of 42 CFR 440.50(a)(2), which you see written out on the screen, to which we refer you on this matter. I'm going to wait so you can make sure you have that CFR reference.

States also have identified problems because they may not have activated certain codes required to establish an eligible encounter in the specification or value sets. Here is the approach you should take to this. The preferred approach is for the state to see if the codes can be activated, or activated for behavioral health providers, because we have heard there are some states where codes are indeed activated but they are not available for use by behavioral health providers.

That's the preferred choice. If it's not possible and you are using other codes, the state may identify those codes, and CCBHCs may use them as long as it is completely transparent—and that means the states provide and maintain a list of those codes as they relate to specific measures—and it is consistent, all CCBHCs and similar BHCs in the state are using those codes in those ways.

If not that—some of the G codes, for instance—and the measure is a BHC lead measure, the BHC can capture the information in a clear way in their EHR and provide documentation of how they are doing it for the evaluation team. Again, the crosswalk, or a list of codes for these measures where this is an issue, must be available to the evaluation team at the SAMHSA and to all CCBHCs in the state, and it should coincide to the extent possible with existing usage in the state so comparison BHCs will be comparable.

A very important question was asked about the measure of depression remission at 12 months and its problematic measurement period. Specifically, the numerator measurement period spans both measurement Year 1 and measurement Year 2 and one month in what would be

measurement Year 3, while the denominator encompasses measurement Year 1 only. So how do we use this measurement period and still report this BHC lead measure annually within nine months of the end of the demonstration year?

I have a diagram to help you with this on the next slide, but the bottom line is that you will need to stop including people at a certain point. You will exclude from the denominator and numerator those for whom the 12 months, plus or minus 30 days, has not lapsed when the data must be reported. So, for example, if you have a measurement year that begins January 1, 2017, and goes through December 31 of that year, BHC lead measure data must be reported by September 30, 2018. The last index date you can include for a depression diagnosis that gets the whole measure going for a person, given the hypothetical measurement year that begins in January, would be August 31, 2017, counting back 13 months from the reporting date.

So, most CCBHCs will not have a demonstration year that begins on January 1. You will need to calculate from your BHC lead measure reporting date, counting back 13 months, and that's when you cut off index periods for this measure.

This complicated picture shows the process for measurement Year 1 and measurement Year 2. The top chart is for measurement Year 1 where you see the numerator measurement period extends 13 months after measurement Year 1, and the bottom chart is for measurement Year 2 where the numerator measurement period extends 13 months after measurement Year 2.

The vertical black line, the line that's on the right side of the slide, indicates when the BHC lead quality measure report is due, nine months after the measurement year ends. The red line counts back 13 months to indicate the last date you can have a depression index date. This may not be precisely to scale, but it was as close as we could make it.

A question was asked, Do we have to screen those who already have an active diagnosis of alcohol use disorder? This is for the measure of alcohol screening and brief counseling, also known as ASC. The response to this is that consumers with an active diagnosis of alcohol use disorder can be excluded from the denominator and numerator using an exception that's in the measure. That exception, also known as an exclusion, is documentation of medical reasons for not screening for unhealthy alcohol use in the measurement year or the year prior. Examples that are given in the measure include limited life expectancy or other medical reasons, and the code is provided there on the slide. This is considered an "other" medical reason for not screening if somebody has an existing, active alcohol use diagnosis.

For I-EVAL, initial evaluation, the second metric is the average number of days until initial evaluation for new consumers at the BHC. For this measure for the average, please count the actual days rather than business days. Also, do not include in the average either the denominator or the numerator those who never received a required initial evaluation. Exclude them and note in the additional notes on the data-reporting template the number of individuals excluded for this reason.

And lastly, hopefully the last word on this measure, a resource document will be coming out from SAMHSA this month that compiles all the questions we have received on I-EVAL into one

place so everyone has the same information in writing, because there have been a lot of questions about this one.

Suicide risk assessment measures, there are two suicide risk assessment measures, one for children and one for adults. This needed clarification: Are they person based or are they episode based? Because it's not really clear from looking at the specs. They are episode based. So the measure is the percentage of visits for individuals with a diagnosis of major depressive disorder where a suicide risk assessment was performed. It's always the number of visits rather than the number of people. So, one person could have multiple visits.

Okay. I expect there will be questions about this part. Do people have questions about what I've covered so far?

Speaker: Hi, Peggy. The first question is from Roxanne Bly. Is there any possibility that the cost report due date could be extended? We received some feedback from clinics that this would be difficult to meet.

Peggy O'Brien: My guess is no. However, that is something that SAMHSA, CMS and ASPI would all need to confer about and agree upon. I will make sure that they hear the question.

Speaker: There are no more questions.

Peggy O'Brien: Okay. All right. As usual, here are the slides with the chart showing the measures and the webinar in which they were discussed, so you can find them easily if you need to. The AMM measure, which is anti-depressant medication management, had been omitted from earlier versions of this table, and it is now there. It's the fourth measure down. So if you use these tables, I would use this version from this webinar.

There are a few things I want to make sure I cover here. First of all, SAMHSA will be posting questions and clarification that came out of these webinars on the quality measure website. I've tried to answer as many as possible during later webinars but have not gotten to all of them, so please look out for those questions and clarifications. Webinars 1 through 3, which is the general webinar and then the two webinars that dealt with state-lead measures, should be up very shortly. That will be followed by Webinars 4 and 5, which are the BHC-lead measures, and then Webinars 6, 7, and 8, which are the two special issues webinars and this webinar today.

To the extent we can, we will also include questions of general interest that came out of office hours in those questions and clarifications as well.

I also promised that we would do a comparison of the BHC measures that are also PQRS measures to see what discrepancies there might be, and one of the posted questions will address this in detail, but I can briefly summarize the findings.

We looked at the tobacco screening, alcohol screening, the two suicide risk assessment measures, the screening for clinical depression and follow-up, depression remission and documentation of medications, which is one that was discussed today. All of these obviously had a different payer mix than the PQRS measures, and there are superficial formatting differences and clarifications. However, aside from payer mix, the substantive matters that affect calculation do not differ.

Other than the two SRA measures, the suicide risk assessment measures, which are the only ones that are specified for EHR calculation, indicate that you should use the 2014 eCQM spec and the accompanying value sets. That is the only thing that differs from the standard PQRS which you would normally use the most recent, and the payer mix, of course.

Also, there is a survey that is on the website where you are listening to this. It's designed to encompass the entire series. It won't take but a few minutes to complete, and it would be greatly appreciated feedback. If you could take the time to complete it, I would really appreciate it and so would SAMHSA.

And again, if you have any additional questions, please submit them to the SAMHSA Data TA mailbox, and please do so by September 22 of 2016. The address is up there on the slide. That way, I can provide answers by September 29.

If you have questions about things related to CMS, please submit those to the CMS mailbox.

Again, please do fill out the survey. It won't take very long. I will pause and see if there are any further questions from the audience.

Speaker: There are no questions.

Peggy O'Brien: Okay. Great. Thank you, everybody. Good luck.