# Section 223 Waiver Demonstration for Certified Community Behavioral Health Clinics (CCBHC)

## *Provider Type 16*

## Quality Measures Manual

**Version 3.0**

**Developed by the**

**Cabinet for Health and Family Services**

**Department for Medicaid Services**

# Manual Revision History

| Version # | Date | Reviewer | Comments |
|---|---|---|---|
| 2 | 07/07/2023 | V. Smith, A. Adams | This version of the manual is a complete rewrite of all included tables. The updated tables include the calculation workflows that will be followed during the Demonstration. Any edits/corrections to the workflows will be completed at the end of a Measurement Period. |
| 2 | 07/12/2023 | V. Smith | Clarifying language in KY Measure #5 – the KY Modifications section and the Unhealthy Alcohol Screening[1] definition box. |
| 2 | 9/28/23 | V. Smith, J. Lauckner | Clarifying language in KY Measure #9 – the KY Modifications section, Index Date[1] definition box, and Measurement Period[2] box.<br><br>Clarifying language in KY Measure #10 – CMS Workbook boxes for Denominator and Numerator. |
| 2 | 10/23/2023 | J. Lauckner | Changed KY Measure #9 Index Date definition box. |
| 3 | 3/15/2025 | J. Lauckner | Updated for 2025 Clinic-collected Quality Measures Reporting. Updated for new procedures that will be implemented in 2025. |

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# Kentucky CCBHC Demonstration

Section 223 of the Protecting Access to Medicare Act (PAMA) of 2014 outlines the creation of a Demonstration Program to implement Certified Community Behavioral Health Clinics (CCBHCs) and assess their effectiveness. In December 2016, eight states were initially selected to participate in the original Demonstration Program. In August 2020, as a result of the passage of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Kentucky and Michigan were selected as part of a two-state expansion of the Demonstration. CCBHCs were developed to provide comprehensive quality care that is reimbursed through a prospective rate payment system.

As of February 21, 2023, states participating in the Section 223 Protecting Access to Medicare Act of 2014, Certified Community Behavioral Health Clinic (CCBHC) Demonstration, were permitted to add new CCBHCs to their demonstration program. Additionally, Kentucky's demonstration was extended until December 31, 2027

CCBHC providers are required to provide nine core services including: 1) crisis mental health services including 24-hour mobile crisis teams; 2) screening, assessment, and diagnosis services 3) treatment planning; 4) outpatient mental health and substance use disorder services; 5) outpatient primary care screening and monitoring; 6) targeted case management; 7) psychiatric rehabilitation services; 8) peer support services and family support services; and 9) outpatient behavioral health care for veterans.

One of the requirements of the Demonstration is the reporting of Quality Measures as defined by Substance Abuse and Mental Health Services Administration (SAMHSA). These Quality Measures are reported using the SAMHSA Data Reporting Templates for Behavioral Health Clinic Quality Measures February 2024 workbook. There are 8 Clinic-collected and 15 State-collected measures for report. The data collected to calculate and report the measures will assist KY DMS in its continuous quality evaluation and will support the state in monitoring the CCBHCs for compliance with the Demonstration Criteria. Data reported also informs the CCBHC National Evaluation and the U.S. Department of Health and Human Services annual report to Congress. This manual reflects current SAMHSA CCBHC Quality Measures reporting requirements and may be updated as SAMHSA CCBHC guidance directs. Any updates to this manual will be reflected in the Measures Workflow section of this manual.

# Quality Measures Manual Overview

This manual will serve as the primary source document for the collection, calculation and reporting of the required CCBHC quality measures as directed by the Section 223 CCBHC Demonstration in Kentucky. The information contained in this manual includes the quality measures technical specifications, calculation workflows and the data submission process. Also included are timelines for preparation, calculation, and submission of the quality measures data. All data collected, submitted, and calculated should be exclusive to Provider Type 16 CCBHC.

## Clinic-collected & State-collected Measures

Annually, KY DMS is required to submit an Excel workbook containing calculations for Clinic-collected quality measures and State-collected quality measures to SAMSHA. Clinic-collected measures are collected and calculated by CCBHCs and submitted to KY DMS no later than 9-months after the end of a demonstration year. State-collected measures are collected and calculated by KY DMS and results will be shared with CCBHCs prior to submission to SAMHSA.

## CCBHC Demonstration Years

Kentucky's CCBHC Demonstration began on January 1, 2022, and is currently scheduled to end December 31, 2027.For the purposes of the CCBHC Demonstration, Kentucky will use the following dates to define demonstration years (DY).

| KY CCBHC Demonstration Year | Calendar Year |
|---|---|
| DY1 | January 1 to December 31, 2022 |
| DY2 | January 1 to December 31, 2023 |
| DY3 | January 1 to December 31, 2024 |
| DY4 | January 1 to December 31, 2025 |
| DY5 | January 1 to December 31, 2026 |
| DY6 | January 1 to December 31, 2027 |

## SAMHSA Quality Measure Requirements by Demonstration Year

For Demonstration Years (DY) 1 through 3, CCBHC quality measures data collection was informed by the SAMHSA Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications Manual (April 2016).

In February 2024, SAMHSA released updated Quality Measures guidance that will inform the collection and calculation of CCBHC Quality Measures commencing in 2025. (SAMHSA Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual (February 2024).

## Demonstration Years 1 -3 Overview

Kentucky used the SAMSHA's 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual as the guidance for measure calculation unless a measure was listed on one of the three following CMS Core Sets of Health Care Quality Measures for Medicaid: Adult Core Set, Behavioral Health Core Set and Child Core Set. For Dys 1-3, if a required measure was listed on one of these core sets, the 2022 version of the technical specification for each measure was used. For measures included in a 2022 Core Set the NQF# was used to confirm that the correct, most recent, technical specification was used.

While using the 2016 Technical Specifications Manual every effort was made to use corresponding 2016 value sets, however, when a specific 2016 value set was unavailable, the corresponding 2022 edition of that value set was used.

## Demonstration Years 4-6

Kentucky will use the SAMHSA Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual (February 2024) as guidance for measure calculation unless a measure is listed on one of the three following CMS Core Sets of Health Care Quality Measures for Medicaid: Adult Core Set, Behavioral Health Core Set and Child Core Set. If a required measure is listed on one of these core sets, the 2023 version of the technical specification for each measure will be used for DY4 and beyond, unless updated guidance is provided by SAMHSA. For measures included in a 2023 Core Set the NQF# is used to confirm the correct, most recent, technical specification is being used if it is available.

# Section 1: Clinic-Collected Quality Measures

## Kentucky Clinic-Collected CCBHC Quality Measures

The following sections provide all necessary information that a CCBHC needs to collect, calculate, and submit KY CCBHC Clinic-collected quality measures required for participation in the KY CCBHC Demonstration. This includes the data submission process, timelines for collection and submission, and the quality measure workflows. Quality measure reporting for the KY CCBHC demonstration is exclusive to Provider Type 16. All data collected, submitted, and calculated should only be for persons receiving Provider Type 16 services. If a CCBHC has any questions regarding a process or policy, please email CCBHC@ky.gov.

## Clinic-collected Quality Measures

The following measures will be collected and reported to the KY DMS by all Kentucky CCBHCs:

- **TSC** - Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
- **ASC** - Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
- **SRA –CH** - Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
- **SRA – A** - Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
- **CDF-AD** - Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- **I-SERV** - Time to Services
- **DEP-REM-6** - Depression Remission at 6 Months
- **SDOH** - Screening for Social Drivers of Health

## Clinic-collected Measure Calculation.

All CCBHCs are required to calculate all KY Clinic-collected quality measures. Additionally, clinics will use the SAMSHA Reporting Template to report Clinic-collected measures to KY DMS. KY DMS will provide support to CCBHCs for their calculations of Clinic-collected measures by performing quality measure reviews, providing technical assistance, and relaying SAMHSA guidance when available. During a CCBHCs first year in the demonstration, KY DMS will calculate clinic-collected quality measures in tandem with the CCBHC to assist in setting up calculation processes.

## SAMSHA Reporting Template

The reporting template for CCBHC can be found on SAMHSA's CCBHC webpage at the following URL: https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/guidance-and-webinars/data-reporting-templates-disclaimers.

For information on how to use the reporting template, CCBHCs are required to watch the following SAMSHA training at the following URL: https://www.youtube.com/watch?v=M0ALkGRPH6E.

For any additional questions regarding the reporting template, please reach out to KY DMS.

## KY DMS CCBHC Quality Measure Workflows

DMS has created workflows for all clinic-collected measures to assist clinics with measures collection. These workflows may include state specific discretions for CPT codes, value sets, and/or other allowed deviations from the technical specifications. KY CCHBCs are required to use these workflows for quality measure calculation. KY DMS will work directly with each CCBHC IT/data team to ensure workflows are understood and calculations match each step in the workflow.

**Note: To ensure quality measures calculation is uniform for all KY CCBHCs, EHR vendor CCBHC modules for quality measures may not be used in lieu of KY CCBHC Quality Measure workflows.**

The Technical Specification version to be used for calculation of each measure is recorded in the Measure Workflows. These specifications are available in the SAMHSA Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual February 2024, available on the SAMHSA CCBHC webpage at the following URL: https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/guidance-and-webinars/quality-measures-disclaimers.

Addendum D (of this manual) includes workflows for quality measures that have been updated or retired. These workflows are provided for historical calculation purposes, if needed.

## Clinic-collected Value Sets

Each year CCBHCs will be provided value sets for all KY Clinic-collected quality measures. Value sets will provide CCBHCs with the diagnostic and procedure codes necessary to calculate quality measures for a demonstration year.

## CCBHC Case Load Characteristics

As part of the CCBHC Demonstration, CCBHCs will collect "Case Load Characteristics" for all persons who receive CCBHC services. The data categories are as follows:

- Age
- Sex
- Ethnicity
- *Race
- *Insurance Status
- Veteran or Military Status
- Total Clinic Population

***Race:** CCBHCs must have the ability to report more than one race for all persons who receive CCBHC services

***Insurance Status:** CCBHCs must report payer status at the first CCBHC visit of the measurement year. For additional rules on reporting insurance status for Case Load Characteristics, please see Addendum A.

## Health-Related Social Needs (HRSN) Screening Tool

To calculate the quality measure, Screening for Social Drivers of Health (SDOH), each CCBHC must incorporate a HRSN screening tool into their screening processes. CCBHCs may choose any validated HRSN screening tool for use. **The HRSN screening tool must be approved by KY DMS prior to implementation.**

## CCBHC Data Collection

Each Clinic-collected measure requires specific data fields to be calculated. The KY DMS provided CCBHC Data Fields & Data Submission Instructions (2025), available on the KY DMS webpage, defines all the required data fields needed for CCBHC quality measure collection.

Prior to admission to the demonstration, each CCBHC's Electronic Health Record (EHR) will be reviewed by KY DMS to ensure that all required data fields are being captured correctly. These data fields will be transmitted to KY DMS as "raw data" fields. KY DMS defines raw data as data originally generated by a system or device operation, that has not been processed or changed in any way. The transmission and review of raw data will allow KY DMS to provide any needed technical assistance and support to CCBHCs with the calculation of clinic-collected measures.

To allow the transmission of data to KY DMS, each CCBHC will setup a data use agreement (DUA) between their agency, the KY Office of Data Analytics (ODA), and KY DMS. Each clinic will work with KY DMS set up a DUA.

## Data Submission Process

On a quarterly basis each CCBHC will transmit raw data to KY DMS for each of the clinic-collected measures using the MOVEit (https://ftp.ky.gov) platform. Accounts will be setup for authorized CCBHC staff by KY DMS.

The following table outlines the data file submission schedule:

| Quarter | Quarterly Period Definition | File Submission Due |
|---|---|---|
| **Quarter 1 (Q1)** | **January 1 to March 30** | **April 30** |
| **Quarter 2 (Q2)** | **April 1 to June 30** | **July 30** |
| **Quarter 3 (Q3)** | **July 1 to September 30** | **October 30** |
| **Quarter 4 (Q4)** | **October 1 to December 31** | **January 30** |

When submitting raw data, the following naming convention, must be used for Demographic Data (DD) and Measure Data (MD):

**File Naming Convention:**

- With the following naming conventions:
  - CCBHC_QMData_DD_*name*_YYQ#_*YYYYMMDD*.txt (demographic data file)
    **Example:** CCBHC_QMData_DD_NewVista_22Q1_20220430.txt
  - CCBHC_QMData_MD_*name*_YYQ#_*YYYYMMDD*.txt (measures data file)

**Example:** CCBHC_QMData_MD_SevenCounties_22Q1_20220430.txt

The KY DMS Quality Measures team will review submitted files within 5 business days of receipt. The data submission review will result in either an Approved status or a Rejected status. A file may be deemed Approved with an error rate of +/- 10%, depending upon the type of errors. The lines containing any errors will be eliminated and the file will be deemed Approved. If data submission results need to be revised a message will be sent to the CCBHC through the CCBHC SharePoint.

**Approved**: Error rate is within acceptable limits. The data file submitted will be used for calculation purposes for the current reporting period. ODA may provide a report of required corrections to the CCBHC in order for them to continue to improve the accuracy of future submissions. It is the expectation that each subsequent file submission would have a smaller number of unique errors.

**Rejected:** Error rate is outside of acceptable limits. The data file submitted will NOT be used for calculation purposes for the current reporting period. Errors must be corrected and the data file resubmitted.
The KY ODA will provide a report to the CCBHC outlining all corrections to be made prior to data resubmission. This report will be provided through the CCBHC SharePoint. The report will include an expected date for data file resubmission.

**CCBHC Demographic to Measure Files Matching:** The following data fields must match in order for the lines of data to be used in calculation: Date_Birth, SSN and Medical_Record_Number.

**Match between State and CCBHC data:** One of the following **MUST** be true in order for the data to be considered a match:

- SSN, Date_Birth & Medicaid_ID match between State and CCBHC submitted data
- SSN & Date_Birth match between State and CCBHC submitted data, CCBHC submitted blank Medicaid_ID
- SSN & Date_Birth match between State and CCBHC submitted data, CCBHC submitted incorrect Medicaid_ID
- Date_Birth & Medicaid_ID match between State and CCBHC submitted data, CCBHC submitted blank SSN

## Patient Experience of Care Surveys

CCBHCs must distribute Patient Experience of Care (PEC) and Youth/Family Experience of Care Surveys as part of quality measures reporting. CCBHCs will be provided with copies of the Adult and Youth/Family PEC surveys and online fillable survey by KY DMS by May of the current demonstration year. Responses must be entered into online survey by CCBHC staff or CCBHC clients by December 1 of the same demonstration year.

For CCBHCs that are also CMHCs, CCBHC PEC survey dissemination is separate from other experience of care survey reporting done for Block Grant reporting. CCBHCs that must report for CMHC Block Grant reporting must work directly with KY DMS to ensure they are satisfying all CCBHC PEC requirements. The CCBHCs plan for survey dissemination must be provided to KY DMS for approval prior to survey distribution.

CCBHCs must distribute at least 300 surveys for both the Adult and Youth/Family survey types. Additionally, CCBHCs must track and report how many surveys they distribute for each survey type. At the end of the survey collection period, KY DMS will contact each CCBHC for distribution numbers of each survey type.

## Quality Measures Timeline of Activities

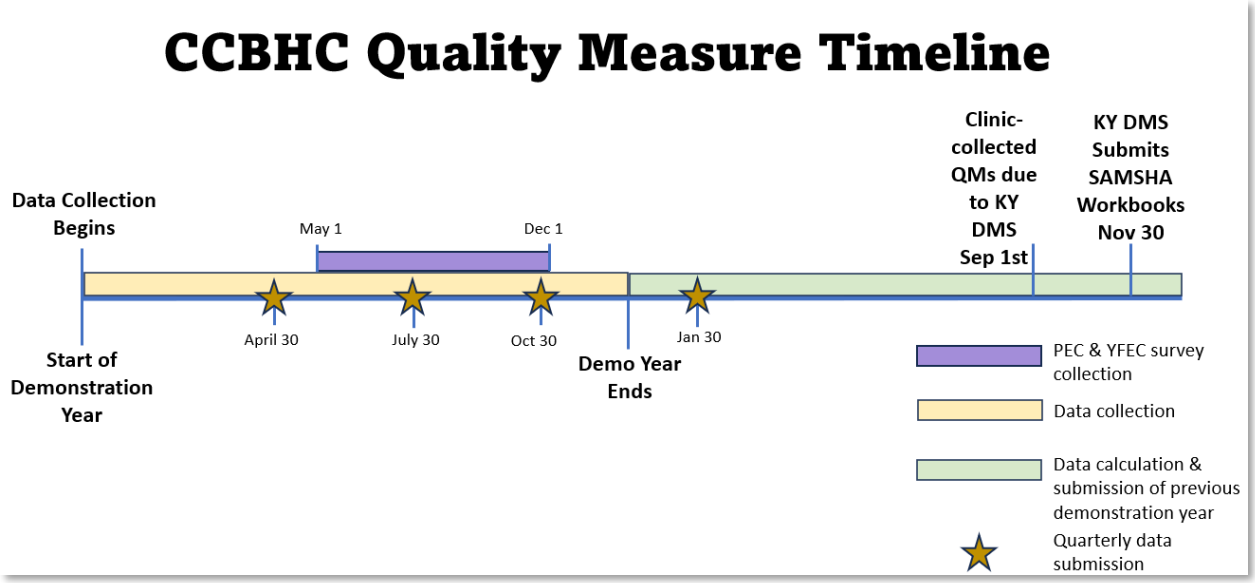


*Figure 1 CCBHC Data Collection and Submission Timeline Example*

KY DMS will schedule regular meetings with each clinic throughout this process. Dates and intervals for these meetings will be determined by KY DMS.

Quality measures data collection and calculation activities will occur based on the following timelines:

- **January 1**: Demonstration year & data collection begins
- **April 30**: First quarterly data submission due to KY DMS
- **May 1**: Patient Experience of Care & Youth/Family Experience of Care Survey collection begins
- **July 30**: Second quarterly data submission due to KY DMS
- **October 30**: Third quarterly data submission due to KY DMS
- **December 1**: Patient Experience of Care & Youth/Family Experience of Care Survey responses due
- **January 30 (of the following demonstration year):** Fourth quarterly data submission due to KY DMS

- **September 1 (of the following demonstration year):** Clinic-collected quality measure workbooks due to KY DMS
- **November 30 (of the following demonstration year):** – KY DMS submits SAMSHA workbooks

# Clinic-collected Measures

## Time to Services (I-SERV)

**Steward:** SAMHSA-Developed Metric
**Abbreviation:** I-SERV
**Version Year:** 2023
**Technical Specifications:** 2023 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
**Value Sets:** N/A
**Reporting Changes:**
**CCBHC Demonstration Modifications:** N/A
**Kentucky CCBHC Modifications:**

- Kentucky will assess those who are 6 years old and greater presenting with Urgent and Emergent care needs in addition to the CMS reported Routine care needs.
- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications.

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- Date_Time_Initial_Contact
- Type_of_Initial_Contact
- Date_Time_of_Service
- Date_Time_Crisis

**Measure Workflow**

| | |
|---|---|
| | **Measure #1: Time to Services (I-SERV)**<br>Based on a measure stewarded by the Substance Abuse and Mental Health Services.<br><br>**DESCRIPTION**<br><br>***Three-part measure calculating for CMS reporting:***<br>The I-SERV measure calculates the Average time for clients to access three different types of services at Behavioral Health Clinics (BHCs) reporting the measure.<br><br>The I-SERV measure is comprised of three sub-measures of time until provision of: (1) initial evaluation, (2) initial clinical services, and (3) crisis services.<br><br>**Metric #1**: The Average number of days from Initial Contact[1] until the provision of an Initial Evaluation[2] for New Clients.[3]<br>AND<br>**Metric #2**: The Average number of days from Initial Contact until the provision of Initial Clinical Services[4] for New Clients.<br>AND<br>**Metric #3** The Average number of hours from first Crisis Episode[5] contact until the provision of Crisis Services[6] for New Clients. |
| | |
| | **Metric #1 Denominator Calculation** |
| **Step Number** | |

| | |
|---|---|
| **Metric #1<br>D1** | Client age ≥ 6 yrs. at the end of the Measurement Year<br><br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |
| **Metric #1<br>D2** | Client contacted clinic for services between July 1 of the prior Measurement Year and November 30 of the current Measurement Year<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |
| | |
| **Metric #1<br>D3** | Client initial screening and risk assessment determined need for routine care<br><br>=YES: Proceed to D4<br>=NO: Do not include in Denominator/Stop |
| | |
| **Metric #1<br>D4** | Client seen by the clinic during the six (6) months prior to the date of Initial Contact[1]<br><br>=YES: Do not include in Denominator/Stop<br>=NO: Include in the Denominator |
| | |
| **Metric #1<br>Denominator** | **Total Unique Clients** |
| | |
| **Metric #1<br>Denominator<br>CMS Workbook** | Report by age groups:<br><br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity |
| | |
| **Metric #1<br>Denominator<br>KY DMS Reporting** | Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| | **Metric #1 Numerator Calculation:** |
| | |
| **Metric #1** | Begin Calculation with Denominator |

| | |
|---|---|
| **N1** | |
| | |
| **Metric #1**<br>**N2** | Consumer received Initial Evaluation[3] between January 1 of the prior Measurement year and December 31 of the current Measurement Year<br><br>=YES: Include number of days from initial contact to initial evaluation in Numerator<br>=NO: Do not include in Numerator/Include client in Additional Note on CMS Workbook/Stop |
| | |
| **Metric #1**<br>**Numerator** | **Total Number of Business Days[7] between Initial Contact[1] and Initial Evaluation[2] for all unique clients in the denominator** |
| | |
| **Metric #1**<br>**Numerator**<br>**CMS Workbook** | Report by age groups:<br><br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br><br>***Note: Indicate in Additional Notes in the data reporting template the number all eligible New Clients who never received an Initial Evaluation.*** |
| | |
| **Metric #1**<br>**Numerator**<br>**KY DMS Workbook** | Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| | **Metric #2 Denominator Calculation**<br>*The Denominator calculation for Metric #2 is the same for Metric #1 except for the exclusion criteria (Metric #2 D5) for Initial Clinical Services[4]* |
| **Step Number** | |
| **Metric #2**<br>**D2** | Client age ≥ 6 yrs. at the end of the Measurement Year<br><br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |

| | |
|---|---|
| **Metric #2<br>D2** | Client contacted clinic for services between January 1 to November 30 of the current Measurement Year<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |
| | |
| **Metric #2<br>D3** | Client initial screening and risk assessment determined need for routine care<br><br>=YES: Proceed to D4<br>=NO: Do not include in Denominator/Stop |
| | |
| **Metric #2<br>D4** | Client seen by the clinic during the six (6) months prior to the date of Initial Contact[1]<br><br>=YES: Do not include in Denominator/Stop<br>=NO: Proceed to D5 |
| | |
| **Metric #2<br>Denominator<br>CMS Workbook** | Report by age groups:<br><br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity |
| | |
| **Metric #2<br>Denominator<br>KY DMS Workbook** | Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| | **Metric #2 Numerator Calculation:** |
| | |
| **Metric #2<br>N1** | Begin Calculation with Denominator |
| | |
| **Metric #2<br>N2** | Client received Initial Clinical Services[4] between January 1 of the prior Measurement year and December 31 of the current Measurement Year<br><br>=YES: Include number of days from Initial Contact to Initial Clinical Services in the |

| | |
|---|---|
| | Numerator<br>=NO: Do not include in Numerator/Include client in Additional Note on CMS Workbook/Stop |
| | |
| **Metric #2 Numerator** | **Total Number of Business Days[7] between Initial Contact[1] and Initial Clinical Services[4] for all unique clients in the denominator** |
| | |
| **Metric #2 Numerator CMS Workbook** | Report by age groups:<br><br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br><br>***Note: Indicate in Additional Notes in the data reporting template the number all eligible New Clients who never received any Initial Clinical Services.*** |
| | |
| **Metric #2 Numerator KY DMS Workbook** | Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| | **Metric #3 Denominator Calculation** |
| **Step Number** | |
| **Metric #3 D1** | Consumer age ≥ 6 yrs. at the end of the Measurement Year<br><br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |
| **Metric #3 D2** | Client initial screening and risk assessment determined need for crisis care as defined by Crisis Episode[5] between January 1 to December 30 of the current Measurement Year<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |
| | |
| **Metric #3 Denominator** | **Total Unique Clients** |
| | |

| | |
|---|---|
| **Metric #3 Denominator CMS Workbook** | Report by age groups:<br><br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity |
| | |
| **Metric #3 Denominator KY DMS Reporting** | Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| | **Metric #3 Numerator Calculation:** |
| | |
| **Metric #3 N1** | Begin Calculation with Denominator |
| | |
| **Metric #3 N2** | Client received Crisis Services[6] between January 1 to December 31 of the current Measurement Year<br>=YES: Include number of hours from Initial Contact to Crisis Services in the Numerator<br>=NO: Do not include in Numerator/Include client in Additional Note on CMS Workbook/Stop |
| | |
| **Metric #3 Numerator** | **The Total Number of Hours between Crisis Episode[5] and related Crisis Services[6] for all unique clients in the denominator.** |
| | |
| **Metric #3 Numerator CMS Workbook** | Report by age groups:<br><br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity |

| | |
|---|---|
| | ***Note: Indicate in Additional Notes in the data reporting template the number of all eligible Clients who never received any Crisis Services*** |
| | |
| **Metric #3 Numerator KY DMS Workbook** | Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| **Initial Contact[1]** | Initial Contact represents the first time that an individual or guardian contacts a CCBHC to obtain services for the individual in a six-month period. Initial Contact may be by telephone. Initial Contact for a CCBHC should include the required preliminary screening and risk assessment and collection of basic data about the person that incudes insurance information. A referral from a primary care physician is NOT an Initial Contact. Only one contact in a six-month period will count (with six months being used to determine if the person is a New Client[2]. |
| | |
| **Initial Evaluation[2]** | KY Modification: The following CPT/HCPCS codes will be used to determine if Consumer received the Initial Evaluation during:<br><br>• **Routine Visit:** 90792, 90791, 96110, 96112, 97151, 96116, 96125, 96127, 96130, 96132, 96136, H0002, H0001, H0031<br><br>Some certification standards, such as the CCBHC certification criteria, require that an Initial Evaluation be carried out for New Clients within a specified time frame based on the acuity of needs. In the case of a CCBHC, the Initial Evaluation is due within 10 Business Days[8] of Initial Contact[1] for those who present with "routine" non-emergency or non-urgent needs. That standard is used in this specification. |
| | |
| **New Client[3]** | An individual not been provided services at the clinic for the 180 days (6 months) prior to the date of contact. |
| | |
| **Initial Clinical Services[4]** | KY Modification: The following CPT/HCPCS codes will be used to determine if Consumer received the Initial Clinical Services:<br><br>• **Clinical Services:** 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90865, 90875, 90887, 97153, 97155, 97156, T1007, 99202, 99203, 99204, 99205, H0015, H0032, H0035, S9480, 99211, 99212, 99213, 99214, 99215, 90846, 90847, 90853<br><br>Some certification standards, such as the CCBHC certification criteria, require that Initial Clinical Services be carried out for New Clients within a specified time frame based on the acuity of needs. In the case of a CCBHC, Initial Clinical Services occur after a preliminary screening and risk assessment to determine acuity of needs and after or at the time of an |

| | |
|---|---|
| | Initial Evaluation. CCBHC criteria require the Initial Clinical Services to occur within 10 Business Days of First Contact for those who present with "routine" non-emergency or non-urgent needs. That standard is used in this specification. Other standards may exist for other entities and this specification can be adapted accordingly. |
| | |
| **Crisis Episode**[5] | A Crisis Service Episode begins when an individual or someone acting on their behalf contacts the Crisis Service provider (whether a CCBHC or its crisis Designated Collaborating Organization (DCO)) requesting Crisis Services for the first time in a 24-hour period. |
| | |
| **Crisis Service(s)**[6] | Crisis Services such as those provided by CCBHCs in accordance with CCBHC certification criteria 2.C.<br><br>KY Modification: The following CPT/HCPCS codes will be used to determine if Consumer received the Crisis Services:<br><br>• **Urgent and Emergent Visit:** 90839, 90840, H2011, S9484, 90792, 90791, 96127, H0002, H0001, H0031, 90832, 90834, 90837, 90846, 90847 |
| | |
| **Business Days**[7] | Monday through Friday, excluding state and federal holidays (regardless of days of operation). |
| | |

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

**Steward:** Minnesota Community Measurement
**Abbreviation:** DEP-REM-6
**Version Year:** 2023
**NQF#**: 0711
**PQRS#:** 370
**Technical Specifications:**

- 2023 Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual Preliminary Version
- 2023 Electronic Clinical Quality Improvement (eCQI)

**Value Sets:**

- 2023 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.

**Reporting Changes:** Starting 2025 CCBHCs will begin using KY Measure #9-M. This measure differs from the previous measure, DEP-REM-12, which looked at remission at 12 months. This measure only requires measurement of remission at six months.
**CCBHC Demonstration Modifications:**
**Kentucky CCBHC Modifications:**

- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications.

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- Depression_Screening_Date Index
- Depression_PHQ9_Score
- Depression_Exclusion_Codes
- PHQ9_Score_Date_Index

**Measure Workflow**

| | |
|---|---|
| | **Measure #9: Depression Remission at Six Months (DEP-REM-6)**<br>Based on CMS MIPS CQMS #370 (2023), stewarded by MN Community Measurement (CBE #0710), modified for Depression Remission at Six Months (CBE #0711)<br><br>**DESCRIPTION**<br>The DEP-REM-6 measure calculates the Percentage of clients (12 years of age or older) with Major Depression or Dysthymia who reach Remission Six Months (+/- 60 days) after an Index Event Date. |
| | |
| | **Denominator Calculation:** |
| **Step Number** | |
| **D1** | Client had an outpatient encounter during the Measurement Year<br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |
| **D2** | Client had an Active Diagnosis[4] of Major Depression or Dysthymia during the outpatient encounter in Step D1, listed in the CCBHC Quality Measures Value Set List (Measure 9) as INCLUDED during the Measurement Year<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |

| | |
|---|---|
| **D3** | Consumer had an Index Visit[1] encounter listed in the CCBHC Quality Measures Value Set List (Measure 9) as INCLUDED within the Measurement Period[2]:<br><br>=YES: Proceed to D5<br>=NO: Do not include in Denominator/Stop |
| | |
| **D4** | Client Age is ≥ 12 years of age on the Index Date[1]<br><br>=YES: Proceed to D5<br>=NO: Do not include in Denominator/Stop |
| | |
| **D5** | **EXCLUDE**: Clients with a diagnosis of bipolar disorder**<br><br>**EXCLUDE**: Clients with a diagnosis of personality disorder**<br><br>**EXCLUDE:** Clients with a diagnosis of schizophrenia or psychotic disorder**<br><br>**EXCLUDE:** Clients with a diagnosis of pervasive developmental disorder**<br><br>**EXCLUDE:** Clients who died prior to the end of the Measurement Year.<br><br>**EXCLUDE:** Clients in Hospice (Refer to General Guideline 17: Members in Hospice.)<br><br>**EXCLUDE**: Clients who were permanent nursing home residents<br><br>**ICD-10 Code Exclusions: See CCBHC Quality Measures Value Set List (Measure 9) as EXCLUDED. |
| | |
| **Denominator** | **Total Unique Clients** |
| | |
| **CMS Workbook** | Report by age groups:<br><br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity |
| | |
| | **Numerator Calculation:** |
| | |
| **N1** | Begin Calculation with Denominator |
| | |

| | |
|---|---|
| **N2** | PHQ-9 Score < 5 documented at Six Months (+/-60 days) after the Index Date[1]<br><br>=YES: Include in Numerator/Stop<br>=NO: Do not include in Numerator/Stop |
| | |
| **Numerator** | **Total Unique Clients** |
| | |
| **CMS Workbook** | Report by age groups:<br><br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity |
| | |
| **Index Date** [1] | The first date the Index Visit occurs.<br><br>An Index Visit occurs when ALL of the following criteria are met:<br><br>• A PHQ-9 result greater than nine<br>• An active diagnosis of Major Depression or Dysthymia** (Major Depression or Dysthymia Value Set)<br><br>**Note**: To be considered denominator eligible for this measure, the client must have both the diagnosis of Depression or Dysthymia and a PHQ-9 or PHQ-9M score greater than nine (9) documented on the same date or up to seven (7) days prior to encounter (Index Event) and this date occurs during denominator Measurement Period[2]. |
| | |
| **Measurement Period[2]** | **Denominator**: The Measurement Period for the Denominator is the Measurement Year.<br><br>**Numerator**: The Measurement Period for the Numerator begins four months after the beginning of the Measurement Year and extends eight (8) months past the end of the Measurement Year; this allows capture of Remission in the period 4 to 8 months after an Index Date[1] that may occur at any point during the Measurement Year (6 months (+/- 60 days)). This equates to a four-month window around the six-month calendar date from the Index Event Date (+/- 60 days). |
| | |
| **Measure Assessment Period[3]** | The Index Date[1] marks the start of the Measure Assessment Period for each client, which is 14 months (12 months +/- 60 days). This period is fixed and does not "start over" with a higher PHQ-9 or PHQ-9M that may occur after the Index Event Date. The Measure Assessment Period is held constant to accommodate both the six- and twelve-month depression outcome measures, if both are being used, so that the client does not re-index after the Six-Month assessment. **The window for assessing the Six-Month measure, however, is at 6 months (+/- 60 days) or 4 to 8 months after Index Event Date.** |
| | |

| | |
|---|---|
| **Active Diagnosis**[4] | The diagnosis of Major Depression or Dysthymia may be in any diagnostic field and need not be the primary diagnosis. |

# Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)

**Steward:** Physician Performance Measure, NCQA
**Abbreviation:** ASF
**Version Year:** 2023
**NQF#**: 2152
**PQRS#:** 431
**Technical Specifications:**

- 2023 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
- 2023 Physician Quality Reporting System (PQRS)

**Value Sets:**

- 2023 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.

**CCBHC Demonstration Modifications:** N/A
**Kentucky CCBHC Modifications:**

- The screener for alcohol use to be used during the CCBHC Demonstration is listed on the Kentucky approved Evidenced Based Practice List.
- For purposes of the Demonstration KY will use the **NIAAA Single Alcohol Screening Question (SASQ) and its recommended response for follow-up/brief counseling being ≥ 1.**
- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- Alcohol_Screener_Date_Index
- Alcohol_Screener_Results_Positive
- Alcohol_Brief_Counseling_Date
- Alcohol_Use_Exclusion_Code

**Measure Workflow**

| | |
|---|---|
| | **Measure #5: Preventive care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASF)**<br>Based on a measure stewarded by the American Medical Association (AMA) and PCPI (NQF #2152; PQRS #431)<br><br>**DESCRIPTION**<br>Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months AND who received Brief Counseling[2] if identified as an unhealthy alcohol user.<br><br>**THERE ARE THREE SUBMISSION CRITERIA FOR THIS MEASURE:**<br>1) All patients who were screened for unhealthy alcohol use using a systematic screening method<br>**AND**<br>2) All patients who were identified as unhealthy alcohol users who received brief counseling<br>**AND**<br>3) All patients who were screened for unhealthy alcohol use using a systematic screening method and, if identified as unhealthy alcohol users received brief counseling, or were not identified as unhealthy alcohol users |
| | |

| | |
|---|---|
| | **Denominator Calculation:** |
| **Step Number** | |
| **D1** | Client Age is ≥ 18 years of age on date of service during the Measurement Year<br><br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/ Stop |
| | |
| **D2** | Client had at least two outpatient encounters listed in the CCBHC Quality Measures Value Set List as INCLUDED (Measure 5) during the Measurement Year OR had one Preventive Care Visit[4]<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |
| | |
| **D3** | **EXCLUDE:** Clients in Hospice (Refer to General Guideline 17: Members in Hospice.)<br><br>**EXCLUDE:** Clients with dementia at any time during the patient's history through the end of the Measurement Year (M1164 or equivalent information source) |
| | |
| **Denominator** | **Total Unique Consumers** |
| | |
| **CMS Workbook** | Report by groups:<br><br>Payer (Medicaid, Non-Medicaid [including dually eligible for Medicare and Medicaid)<br><br>AND<br><br>Ethnicity<br><br>AND<br>Race |
| | |
| | **Submeasure #1 Numerator Calculation:** |
| | |
| **Submeasure #1 N1** | Begin Calculation with Denominator |
| | |
| **N2** | Client had Unhealthy Alcohol Screening[1] Documented within the Measurement Period[3]<br><br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |
| **Numerator** | **Total Unique Clients** |
| | |
| **Submeasure #1 CMS Workbook** | Report by groups:<br><br>Payer (Medicaid, Non-Medicaid [including dually eligible for Medicare and Medicaid)<br><br>AND<br>Ethnicity<br>AND |

| | |
|---|---|
| | Race |
| | |
| | **Submeasure #2 Numerator Calculation:** |
| | |
| **Submeasure #2 N1** | Begin Calculation with Denominator |
| | |
| **Submeasure #2 N2** | Client had Unhealthy Alcohol Screening[1] Documented as Positive, And Brief Counseling[2] Documented<br><br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |
| **Numerator** | **Total Unique Clients** |
| | |
| **Submeasure #2 CMS Workbook** | Report by groups:<br><br>Payer (Medicaid, Non-Medicaid [including dually eligible for Medicare and Medicaid)<br><br>AND<br>Ethnicity<br>AND<br>Race |
| | **Submeasure #3 Numerator Calculation:** |
| | |
| **Submeasure #3 N1** | Begin Calculation with Denominator |
| | |
| **Submeasure #3 N2** | Unhealthy Alcohol Screening[1] Documented within the Measurement Period[3]<br><br>=YES: Proceed to N3<br>=NO: Do not include in Numerator/Stop |
| | |
| **Submeasure #3 N3** | Client had Unhealthy Alcohol Screening[1] Documented as Positive, And Brief Counseling[2] Documented<br><br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |
| **Numerator** | **Total Unique Clients** |
| | |
| **Submeasure #3 CMS Workbook** | Report by groups:<br><br>Payer (Medicaid, Non-Medicaid [including dually eligible for Medicare and Medicaid)<br><br>AND<br>Ethnicity<br><br>AND |

| | |
|---|---|
| | Race |
| | |
| **Unhealthy Alcohol Screening**[1] | The SAMHSA Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual contains the following notation relative to screening tools, however, please note the KY Modification for this measure:<br><br>For purposes of this measure, according to the measure steward, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include:<br>• AUDIT Screening Instrument (score ≥ 8)<br>• AUDIT-C Screening Instrument (score ≥4 for men; score ≥3 for women)<br>• Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response ≥ 1) – See KY Modifications above. |
| | |
| **Brief Counseling**[2] | Brief Counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5–15 minutes, which may include feedback on alcohol use and harms, identification of high-risk situations for drinking and coping strategies, increased motivation, and the development of a personal plan to reduce drinking. |
| | |
| **Measurement Period**[3] | The Measurement Period for the Numerator is the Measurement Year and the prior year. |
| | |
| **Preventive Care Visit**[4] | Relevant codes (Current Procedural Terminology [CPT®] or Healthcare Common Procedure Coding System [HCPCS]) include: 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439 |

# Preventive Care and Screening: Unhealthy Tobacco Use: Screening and Cessation Intervention (TSC)

**Steward:** National Committee for Quality Assurance (NCQA)
**Abbreviation:** TSC
**Version Year:** 2023
**NQF#**: 0028
**PQRS#:** 226
**Technical Specifications:**

- 2024 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
- 2023 Physician Quality Reporting System (PQRS)
- 2023 Electronic Clinical Quality Improvement (eCQI)

**Value Sets:**

- 2023 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.

**Reporting Changes:**
**CCBHC Demonstration Modifications:** N/A
**Kentucky CCBHC Modifications:**

- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- Tobacco_Screener_Index_Date
- Tobacco_Screener_Results_Positive
- Tobacco_Intervention_Date_Index
- Tobacco_Exclusion_Code

**Measure Workflow**

| | |
|---|---|
| | **Measure #4: Tobacco Use: Screening and Cessation Intervention (TSC)**<br>Based on a measure stewarded by the American Medical Association (AMA) and (PCPI) Foundation (NQF #0028e; PQRS #226)<br><br>**DESCRIPTION**<br>Percentage of consumers aged 18 years and older who were screened for tobacco use one or more times during the Measurement Period[3] AND who received Tobacco Cessation Intervention[2] during the Measurement Year or in the six months prior to the Measurement Year if identified as a tobacco user.<br><br>**THERE ARE THREE SUMISSION CRITERIA FOR THIS MEASURE:**<br>1) Percentage of clients aged 18 years and older who were screened for Tobacco Use one or more times within the Measurement Year<br>**AND**<br><br>2) Percentage of clients aged 18 years and older who were identified as a tobacco user during the Measurement Year in submeasure 1 and who received a Tobacco Cessation Intervention during the Measurement Year or in the six months prior to the Measurement Year<br><br>**AND** |

| | |
|---|---|
| | 3) Percentage of clients aged 18 years and older who were screened for Tobacco Use one or more times within the Measurement Year and, if identified as a tobacco user, received a Tobacco Cessation Intervention during the Measurement Year or in the six months prior to the Measurement Year, or identified as a tobacco non-user |
| | |
| | **Denominator Calculation:** |
| **Step Number** | |
| **D1** | Client Age is ≥ 18 years of age on date of service during the Measurement Year<br><br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |
| **D2** | Client had at least two eligible outpatient encounters listed in the CCBHC Quality Measures Value Set List as INCLUDED (Measure 4) during the Measurement Year OR had one Preventive Care Visit[4]<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/ Stop |
| **D3** | **EXCLUDE:** Clients in Hospice (Refer to General Guideline 17: Members in Hospice.) |
| | |
| **Denominator** | **Total Unique Consumers** |
| | |
| **CMS Workbook** | Report by groups:<br><br>Payer (Medicaid, Non-Medicaid [including dually eligible for Medicare and Medicaid)<br><br>AND<br><br>Ethnicity<br><br>AND<br>Race |
| | |
| | **Submeasure #1 Numerator Calculation:** |
| | |
| **Submeasure #1 N1** | Begin Calculation with Denominator |
| | |
| **Submeasure #1 N2** | Tobacco Screening[1] Documented within the Measurement Period[3]<br><br>=YES: Include in the Numerator/Stop<br>=NO: Do not include in Numerator |
| **Submeasure #1 Numerator** | **Total Unique Clients** |
| | |
| **CMS Workbook** | Report by groups:<br><br>Payer (Medicaid, Non-Medicaid [including dually eligible for Medicare and Medicaid)<br><br>**AND**<br><br>Ethnicity |

| | |
|---|---|
| | **AND**<br>Race |
| | |
| | **Submeasure #2 Numerator Calculation:** |
| | |
| **Submeasure #2 N1** | Begin Calculation with Submeasure #1 Numerator |
| | |
| **Submeasure #2 N2** | Tobacco Screening[1] documented as Positive, And Tobacco Cessation Intervention[2] documented<br><br>=YES: Include in Numerator/Stop<br>=NO: Do not include in Numerator |
| | |
| **Submeasure #2 Numerator** | **Total Unique Clients** |
| | |
| **CMS Workbook** | Report by groups:<br><br>Payer (Medicaid, Non-Medicaid [including dually eligible for Medicare and Medicaid)<br><br>**AND**<br><br>Ethnicity<br><br>**AND**<br>Race |
| | |
| | **Submeasure #3 Numerator Calculation:** |
| | |
| **Submeasure #3 N1** | Begin Calculation with Denominator |
| | |
| **Submeasure #3 N2** | Tobacco Screening[1] Documented within the Measurement Period[3]<br><br>=YES: Proceed to N3<br>=NO: Do not include in Numerator |
| **Submeasure #3 N3** | Tobacco Screening[1] documented as Positive, And Tobacco Cessation Intervention[2] documented<br><br>=YES: Include in Numerator/Stop<br>=NO: Do not include in Numerator |
| | |
| **Numerator** | **Total Unique Clients** |
| | |
| **CMS Workbook** | Report by groups: |

| | |
|---|---|
| | Payer (Medicaid, Non-Medicaid [including dually eligible for Medicare and Medicaid)<br><br>**AND**<br><br>Ethnicity<br><br>**AND**<br>Race |
| | |
| **Tobacco Screening**[1] | Tobacco Screening will include screening for any type of tobacco. |
| | |
| **Tobacco Cessation Intervention**[2] | Includes cessation intervention (3 minutes or less) and/or pharmacotherapy. |
| | |
| **Measurement Period**[3] | The Measurement Period for the denominator for all TSC submeasures is the Measurement Year. The Measurement Period for the Numerator, for submeasure 1, is the Measurement Year and, for submeasures 2 and 3, the Measurement Year and July 1 prior to the Measurement Year. |
| **Preventive Care Visit**[4] | Relevant codes (Current Procedural Terminology [CPT®] or Healthcare Common Procedure Coding System [HCPCS]) include: 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439 |

# Screening for Social Drivers of Health (SDOH)

**Steward:** Centers for Medicare & Medicaid Services
**Abbreviation:** SDOH
**Version Year:** 2023
**PQRS#:** 487
**Technical Specifications:**

- 2023 Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual Preliminary Version
- 2023 Physician Quality Reporting System (PQRS)

**Value Sets:**

- 2023 Physician Quality Reporting System (PQRS)

**Reporting Changes:**
**CCBHC Demonstration Modifications:**
**Kentucky CCBHC Modifications:**

- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications.

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- SDOH_Screener_Date

**Measure Workflow**

| | |
|---|---|
| | **Measure #24 Screening for Social Drivers of Health (SDOH)**<br><br>**DESCRIPTION**<br>The SDOH measure calculates the Percentage of clients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.<br><br>Note: This measure is to be reported once per Measurement Year for clients seen during the Measurement Year. |
| | |
| | **Denominator Calculation:** |
| **Step Number** | |
| **D1** | Client had at had a qualifying encounter, listed in the CCBHC Quality Measures Value Set List (Measure 25), as INCLUDED during the Measurement Year[2]<br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |
| **D2** | Client Age is ≥ 18 years of age on the date of service<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |
| | |
| **Denominator** | **Total Unique Clients** |
| | |
| **CMS Workbook** | Report by age groups:<br><br>18+ yrs.; separated into payor groups (Medicaid and Non-Medicaid ) Race, Ethnicity |
| | |

| | |
|---|---|
| | **Numerator Calculation:** |
| | |
| **N1** | Begin Calculation with Denominator |
| | |
| **N2** | Client was screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during using Standardized Health-Related Social Needs Screening Tool[1] the Measurement Year<br><br>=YES: Include in Numerator/Stop<br>=NO: Do not include in Numerator/Stop |
| | |
| **Numerator** | **Total Unique Clients** |
| | |
| **CMS Workbook** | Report by age groups:<br><br>18+ yrs.; separated into payor groups (Medicaid and Non-Medicaid) Race, Ethnicity |
| | |
| **Standardized Health-Related Social Needs (HRSN) Screening Tool** [1] | HRSN is the term used by HHS to refer to an individual's unmet, adverse social conditions that contribute to poor health as a result of the community's underlying SDOH (2018). **CCBHCs can pick any HRSN screening tool that is standardized and validated. The HRSN must be approved by KY DMS prior to implementation.** |
| | |
| **Measurement Year[2]** | The standard 12-month reporting period common to all measures being reported by the Provider. |
| | |

# Screening for Clinical Depression and Follow-Up Plan (CDF-AD & CDF-C)

**Steward:** Medicare & Medicaid Services
**Abbreviation:** CDF-BH
**Version Year:** 2022
**NQF#**: 0418
**PQRS#:** 134
**Technical Specifications DY1, DY2, DY3:**

- 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
- 2022 Electronic Clinical Quality Improvement (eCQI)

**Technical Specifications DY4, DY5, DY6:**

- 2023 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
- 2023 Electronic Clinical Quality Improvement (eCQI)

**Value Sets DY1, DY2, DY3:**

- 2022 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.

**Value Sets DY4, DY5, DY6:**

- 2023 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.

**Reporting Changes:** Beginning DY4 Measure abbreviation changed to CDF-BH-A and CDF-BH-CH in SAMHSA Quality Measures Behavioral Health Clinics Technical Specifications and Resource Manual. CMS Workbook changed to report this measure on two separate tabs: CDF-BH-A and CDF-BH-CH. Reporting changes noted in CMS Workbook box.
**Reporting Years:** DY1, DY2, DY3, DY4
**CCBHC Demonstration Modifications:** N/A
**Kentucky CCBHC Modifications:**

- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications.

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- Depression_Screening_Date_Index
- Depression_PHQ-9_Score
- Depression_Exclusion_Code
- Depression_Screening_FollowUp_Date
- PHQ9_Score_Date_Index

**Measure Workflow**

| | |
|---|---|
| | **Measure #8: Screening for Clinical Depression and Follow-Up Plan (CDF-BH)**<br>Based on a measure stewarded by the Centers for Medicare & Medicaid Services (NQF #0418; PQRS #134)<br><br>NOTE: This measure is recorded as 2 separate measures (CDF-BH-A & CDF-BH-C) in the Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual and reported on 2 separate sheets on the CMS Workbook. Only one workflow has been developed as the workflows are the same for both measures.<br><br>**DESCRIPTION**<br>Percentage of clients ages 12 to 17 screened for depression on the date of the encounter |

| | |
|---|---|
| | or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a Follow-up Plan[1] is documented on the date of the eligible encounter. |
| | |
| | **Denominator Calculation:** |
| **Step Number** | |
| | |
| **D1** | Consumer Age is ≥ to 12 years of age at start of Measurement Year<br><br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |
| **D2** | Consumer had an encounter Listed in the CCBHC Quality Measures Value Set List (Measure 8) as INCLUDED during the Measurement Year<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |
| | |
| **D3** | **EXCLUDE:** Refuses to participate<br><br>~~**EXCLUDE:** Consumer has an active diagnosis of Depression**~~ See Addendum B<br><br>**EXCLUDE:** Consumer has a diagnosed Bipolar Disorder**<br><br>**EXCLUDE:** Consumer when clinician has determined to be in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the consumer's health status<br><br>**EXCLUDE:** Consumer when clinician has determined the consumer's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium<br><br>**ICD-10 Code Exclusions: See CCBHC Quality Measures Value Set List (Measure 8) as EXCLUDED. |
| | |
| **Denominator** | **Total Unique Consumers** |
| | |
| **CMS Workbook** | *Report on sheet CDF-BH-CH:*<br>For ages 12-17 years by payor group: separated into payor groups (Medicaid and Non-Medicaid) Race, Ethnicity<br>*Report on sheet CDF-BH-A:*<br>18+ yrs.; separated into payor groups (Medicaid and Non-Medicaid) Race, Ethnicity |
| | |
| | **Numerator Calculation:** |
| | |

| | |
|---|---|
| **N1** | Begin Calculation with Denominator |
| | |
| **N2** | Consumer Screened for clinical depression using a standardized tool- (PHQ-9)<br><br>=YES: Proceed to N3<br>=NO: Do not include in Numerator/Stop |
| | |
| **N3** | Depression Screen Score: Positive for Depression – (Example; PHQ-9 screening greater than 9)<br><br>=YES: Proceed to N4<br>=NO: Negative for Depression - Include in Numerator/Stop |
| | |
| **N4** | Follow-Up Plan[1] Provided<br><br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |
| **Numerator** | **Total Unique Consumers** |
| | |
| **CMS Workbook** | Report by age groups:<br><br>12-17 yrs.; separated into payor groups: Medicaid and Non-Medicaid<br>AND<br>18-64 yrs.; separated into payor groups: Medicaid and Non-Medicaid<br>AND<br>65+ yrs.; separated into payor groups: Medicaid and Non-Medicaid |
| | |
| **Follow-up Plan[1]** | Documented follow-up for a positive depression screening must include one or more of the following:<br>• Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen.<br>• Pharmacological interventions.<br>• Other interventions or follow-up for the diagnosis or treatment of depression.<br><br>Examples of a follow-up plan include but are not limited to:<br>• Referral to a provider or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression.<br>• Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options.<br><br>The documented follow-up plan must be related to positive depression screening, for example: " Client referred for psychiatric evaluation due to positive depression screening." |

# Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-CH)

**Steward:** American Medical Association (AMA) & CPI Foundation (PCPI)
**Abbreviation:** SRA-CH
**Version Year:** 2016 & 2023
**NQF#:** 1365e
**PQRS#:** 382
**eCQI:** CMS177v11 (2023)
**Technical Specifications DY1, DY2, DY3:**

- 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
- 2016 Electronic Clinical Quality Improvement (eCQI)

**Technical Specifications DY4:**

- 2024 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
- 2023 Electronic Clinical Quality Improvement (eCQI)

**Value Set DY1, DY2, DY3:** 2016 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.
**Value Set DY4:** 2023 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.
**Reporting Years:** DY1, DY2, DY3, DY4
**CCBHC Demonstration Modifications:** N/A
**Kentucky CCBHC Modifications:**

- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications.

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- Suicidal_Risk_Assessment_Date_Index

**Measure Workflow**

| | |
|---|---|
| | **Measure #6: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-CH)**<br>Based on a measure stewarded Mathematica and developed by Mathematica, the American Medical Association (AMA) and (PCPI) (NQF #1365e; PQRS #382)<br><br>**DESCRIPTION**<br>Percentage of client visits for those clients aged 6 through 17 years with a diagnosis of major depressive disorder (MDD) with an assessment for suicide risk. |
| | |
| | **Denominator Calculation:** |
| **Step Number** | |
| **D1** | Client Age is 6 to 17 years of age at the start of the Measurement Year<br><br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |
| **D2** | Client had visit(s) during the Measurement Year listed in the CCBHC Quality Measures Value Set List (Measure 6)<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |

| | |
|---|---|
| **D3** | Client had a new diagnosis of Major Depressive Disorder listed in the CCBHC Quality Measure Set List (Measure 6) during the Measurement Year<br><br>=YES: Include in the Denominator<br>=NO: Do not include in Denominator/Stop |
| | |
| **Denominator** | **Total Number of Client Visits** |
| | |
| **CMS Workbook** | Report by payor group:<br><br>Medicaid, Medicare-Medicaid, Other and Total |
| | |
| | **Numerator Calculation:** |
| | |
| **N1** | Begin Calculation with Denominator |
| | |
| **N2** | Documentation of Suicide Risk Assessment[1] Performed[2]<br><br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |
| **Numerator** | **Total Number of Client Visits with an Assessment for Suicide Risk** |
| | |
| **CMS Workbook** | Report by payor group:<br><br>Medicaid, Medicare-Medicaid, Other and Total |
| | |
| **Suicide Risk Assessment[1]** | Numerator Definition: The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. At a minimum, suicide risk assessment should evaluate:<br><br>1. Risk (e.g., age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (e.g., religious belief, concern not to hurt family) that may influence the desire to attempt suicide.<br>2. Current severity of suicidality.<br>3. Most severe point of suicidality in episode and lifetime.<br><br>Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can also be used. Because no validated assessment tool or instrument fully meets the aforementioned requirements for the suicide risk assessment, individual tools or instruments have not been explicitly included in coding.<br><br>Suicide risk assessments completed via telehealth services can also meet numerator performance. |
| | |
| **Assessment Performed[2]** | A Suicide Risk Assessment[1] should be performed at every visit for Major Depressive Disorder during the Measurement Year. |

# Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)

**Steward:** Mathematica; Developed by Mathematic, American Medical Association (AMA), PCPI® Foundation
**Abbreviation:** SRA-A
**Version Year:** 2016 & 2023
**NQF#**: 0104e
**PQRS#:** 107
**eCQI:** CMS161v20 (2023)
**Technical Specifications DY1, DY2, DY3:**

- 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
- 2016 Electronic Clinical Quality Improvement (eCQI)

**Technical Specifications DY4:**

- 2024 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
- 2023 Electronic Clinical Quality Improvement (eCQI)

**Value Set DY1, DY2, DY3:** 2016 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.
**Value Set DY4:** 2023 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.
**Reporting Years:** DY1, DY2, DY3, DY4
**CCBHC Demonstration Modifications:** N/A
**Kentucky CCBHC Modifications:**

- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications.

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- Suicidal_Risk_Assessment_Date_Index

**Measure Workflow**

| | |
|---|---|
| | **Measure #7: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment**<br>Based on a measure stewarded by the American Medical Association and the PCPI(R) Foundation (NQF #0104e) (PQRS #107)<br><br>**DESCRIPTION**<br>Percentage of all client visits for those clients that turn 18 or older during the measurement period in which a new or recurrent[3] diagnosis of major depressive disorder (MDD) was identified and a Suicide Risk Assessment[1] was completed during the visit. |
| | |
| | **Denominator Calculation:** |
| **Step Number** | |
| **D1** | Client Age is ≥ 18 years during the Measurement Year<br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |
| **D2** | Client had visit(s) during the Measurement Year listed in the CCBHC Quality Measures Value Set List (Measure 6)<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |

| | |
|---|---|
| **D3** | Client had a new diagnosis of Major Depressive Disorder listed in the CCBHC Quality Measure Set List (Measure 6) during the Measurement Year<br>=YES: Include in the Denominator<br>=NO: Do not include in Denominator/Stop |
| | |
| **Denominator** | **Total Number of Client Visits** |
| | |
| **CMS Workbook** | Report by payor group:<br><br>Medicaid, Medicare-Medicaid, Other and Total |
| | |
| | **Numerator Calculation:** |
| | |
| **N1** | Begin Calculation with Denominator |
| | |
| **N2** | Documentation of Suicide Risk Assessment[1] Performed[2]<br><br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |
| **Numerator** | **Total Number of Client Visits** |
| | |
| **CMS Workbook** | Report by payor group:<br><br>Medicaid, Medicare-Medicaid, Other and Total |
| | |
| **Suicide Risk Assessment[1]** | The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. At a minimum, suicide risk assessment should evaluate:<br>1) Suicidal ideation<br>2) Client's intent of initiating a suicide attempt<br><br>AND, if either is present,<br><br>3) Client plans for a suicide attempt<br>4) Whether the client has means for completing suicide<br><br>Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicide Severity Rating Scale (C-SSRS) and the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) can also be used. Because no validated assessment tool or instrument fully meets the aforementioned requirements for the suicide risk assessment, individual tools or instruments have not been explicitly included in coding. |
| | |
| **Assessment Performed[2]** | A Suicide Risk Assessment[1] should be performed at every visit for Major Depressive Disorder during the Measurement Year. |
| | |
| **Recurrent Episode[3]** | For the purposes of this measure, an episode of major depressive disorder (MDD) would be considered to be recurrent if a patient has not had an MDD-related encounter in the past 105 days. If there is a gap of 105 or more days between visits for major depressive disorder (MDD), that would imply a recurrent episode. The 105-day look-back period is an operational provision and not a clinical recommendation, or definition of relapse, remission, or recurrence. |

# Section 2: State-collected Quality Measures

KY DMS is required to report on standardized quality measures as part of the Demonstration. These measures are referred to as the State-collected measures, as they rely on claims data for calculating and reporting during the Demonstration. For State-collected measures, KY DMS will only report data for payor types of Medicaid and Medicaid-Medicare (dual eligible). The state will not report on any payor populations listed in the "Other" category. The following measures will be collected and reported by the KY DMS:

- Patient Experience of Care Survey (PEC)
- Youth/Family Experience of Care Survey (YFEC)
- Antidepressant Medication Management (AMM-AD)
- Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)
- Plan All-Cause Readmissions Rate (PCR-AD)
- Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder Medication (ADD-CH)
- Hemoglobin A1C Control for Patients with Diabetes (HBD-AD)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)
- Follow-up After Hospitalization for Mental Illness Adult & Children (FUH-AD & FUH CH)
- Follow-up After Emergency Department Visit for Mental Illness Adult & Children (FUM-AD & FUM-CH)
- Follow-up After emergency Department Visit for Alcohol and Other Drug Dependence Adult & Children (FUA-AD & FUA-CH)

To calculate the above measures, KY DMS uses "Quality Measures for Behavioral health Clinics Technical Specifications and Resource Manual February 2024," which is available on the Certified Community Behavioral Health Clinics webpage. All State-collected calculations will be shared with clinics prior to submission to SAMSHA.

# Addendum A: Payor Stratification Information for Case Load Characteristics

When completing the Case Load Characteristics section of the SAMHSA reporting template, each CCBHC must provide a breakdown of persons who use CCBHC services by payor type. When reporting payor type, the CCBHC reports the payor type for the consumer for the first CCBHC visit. Additionally, only when payor type should be reporter per consumer. To provide the most accurate reporting, KY DMS has provided the following logic to used when reporting payor type for each CCBHC consumer.

The logic below references the following data fields: Commercial_Insurance; Uninsured; VHA_Tricare; Medicare; Medicaid; Other; CHIP_Insurance. Each field uses "Y" to indicate Yes, "N" to indicate No, and "U" to indicate Unknown.

General filter rules:

- Each consumer can only go in on category.
- Insurance status from the first available quarter without an error is what applies throughout the measurement year.
- If "Y" = 1, put into category with the associated "Y"
- If "Y" = 0, error is present, remove consumer from caseload characteristics
- If "Y" = great than 1, place the consumer in "Other"

Exceptions:

- **If Medicaid "Y" and Medicare "Y" the consumer is placed in Dually-Eligible category**
- **If Medicaid "Y" and if only one additional "Y" is found, put into the Medicaid category** (e.g., Medicaid = "Y"' Commercial Insurance = "Y"; put consumer into Medicaid category)
- **If Medicaid = "Y," Medicare is "Y," and one additional "Y" is found, put into Dually-Eligible** (e.g., Medicare = "Y"; Medicaid ="Y"; Commercial Insurance ="Y"; put consumer into Dually-Eligible)
- **If Uninsured = "Y" and if more than one "Y" is found, put into the additional "Y" category** (e.g., Uninsured = "Y"; and Medicaid "Y"; put into Medicaid)
- **If Other = "Y" and if more than one "Y" is found, put into the additional "Y" category** (e.g., Other = "Y"; and Commercial Insurance "Y"; put into Commercial Insurance)

# Addendum B: Additional SAMHSA Guidance on Quality Measure Technical Specifications

**State-collected Measures**

HBD-AD: Effective Measurement Year (MY) 2025, the Glycemic Status Assessment for Patients with Diabetes (GSD-AD) is substituted for the Hemoglobin A1c Control for Patients with Diabetes (HBD-AD) measure, as the HVD-AD measure is being retired and will not be maintained. For data submission, please modify the HBD-AD worksheet to the GSD-AD and use the notes section as needed.

IET-AD: For the Initiation and Engagement of Substance Use Disorder Treatment (IET-AD) measure, for the two rates reported, please report by SUD diagnosis cohort; specifically, alcohol use disorder, opioid use disorder, other substance use disorder, and total SUD. Please report by cohort, either by modifying the existing worksheet for IET or by attaching the cohort reporting to your submission. The template will be revised at the next opportunity.

**Clinic-collected Measures**

CDF-AD & CDF-CH: Effective MY 2025, adhere to changes to the denominator calculation for the Screening for Clinical Depression and Follow-Up Plan (CDF-AD and CDF-CH) measure. Only clients with diagnosis with bipolar disorder are excluded from the denominator. Clients with history or current depress are not excluded from the denominator.

# Addendum C: Definitions

**Behavioral health:** Behavioral health is a general term "used to refer to both mental health and substance use" (SAMHSA-HRSA [2015]

**Certified Community Behavioral Health Clinic (CCBHC):** A Certified Community Behavioral Health Clinic (CCBHC) is a clinic certified by the state to participate in Demonstration programs to improve community mental health services authorized by Section 223 of the federal Protecting Access to Medicare Act. See the Certification Criteria for more information.

**CCBHC Demonstration Modification:** Any deviations from the technical specifications as written by the Measure Steward directed by SAMHSA for purposes of reporting within the Demonstration will be noted as a CCBHC Demonstration Modification throughout the Measure Workflows and recorded as a deviation on the CMS Workbook.

**Clinic-collected Measure:** The Clinic-collected measures are calculated from data collected from the CCBHCs Electronic Health Record (EHR) and reported using the CMS Workbook.

**SAMSHA Data Reporting Template:** This is the instrument KY DMS will use throughout the Demonstration Period to report required quality measures. Stated reporting requirements include stratification by payor and/or age particular to the measure. It is required, as noted in the instructions, that any deviations from the technical specifications or SAMHSA guidance in calculation or purporting be noted within the SAMSHA Data Reporting Template. All CCBHC Demonstration Modifications and Kentucky CCBHC Modifications listed within the Workflows will be noted as deviations.

**Consumer:** Starting in 2025, the term "consumer" will be replaced with "person receiving services." For quality measures that have been retired, the term "consumer" may still be present. When present, the term "consumer" refers to clients, persons being treated for or in recovery from mental and/or substance use disorders, persons with lived experience, service recipients and patients, all used interchangeably to refer to persons of all ages (i.e., children, adolescents, transition aged youth, adults, and geriatric populations) for whom health care services, including behavioral health services, are provided by CCBHCs. Use of the term "patient" is restricted to areas where the statutory or other language is being quoted. Elsewhere, the word "consumer" is used.[1]

**Description:** The Description section in each workflow includes a narrative description of the measure taken from the technical specification for each measure.

**Denominator:** This is specific for each measure. The Denominator will represent the Initial eligible population in the measure, this could be consumers, visits, events, or discharges.

**Diagnosis**: The terms "principal" and "primary" are often used interchangeably to define the diagnosis that is sequenced first. The term "first-listed diagnosis/condition" is used in the outpatient setting in lieu of principal diagnosis. The condition established after study to be chiefly responsible for the patient's

[1] Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics Section 2.b.1

admission to the hospital is the Principal Diagnosis. The Primary Diagnosis is used to indicate the reason for the continued stay in the facility.

**Eligible Encounter:** Outpatient visit with CCBHC provider (Provider Type 16) that is included in the Value Set specified in the technical specification for each measurement.

**Eligible Population:** In the broadest sense, the eligible population for these measures includes all CCBHC consumers served by a CCBHC provider (Provider Type 16).

**Exclusions:** Criteria listed in the technical specifications requiring exclusion from the Denominator or Numerator.

**Kentucky (KY) CCBHC Specific Modification: A** modification to a workflow calculation that is state-specific.

**KY DMS reporting:** Internal DMS data reports to inform CCBHC monitoring activities.

**Metric:** The word "metric," as used in this manual, refers to statistics designed to allow the collection of data distinct from a quality or performance measure. Unless the context makes it necessary to distinguish them, metrics in this manual are referred to as "measures", or each part of a measure where two-part reporting is required.

**Measure Steward:** An individual or organization that owns a measure and is responsible for maintaining the measure.

**Measurement Period:** A period specific to each measure where data will be collected and calculated. Measurement Period refers to a measure calculation period. A Measurement Period may be different than the Measurement Year. Some Measurement Periods are indexed to a specific date or event or may require some other modification to measure collection that corresponds with the measurement year.

**Measurement Year:** Identifies the year to which the report corresponds (e.g., Demonstration Year (DY) 1, Calendar Year 2022).

**Numerator:** The Numerator is specific for each measure and is the total number of the initial eligible population (Denominator) that meets performance in the measure.

**Payor stratification:** is the process of grouping consumers within a measurement based on their payor type, including Medicaid, Medicare-Medicaid (dually eligible) and Other (Medicare, commercially insured, VHA/TRICARE, uninsured, other etc.).

**Person Receiving Services:** Persons of all ages (i.e., children, adolescents, transition aged youth, adults, and geriatric populations) for whom health care services, including behavioral health services, are provided by CCBHCs.

**Practitioner:** Refers to the professional providing services.

**Provider:** Refers to Provider Type 16 only for the purposes of the CCBHC Demonstration and throughout the technical specifications. Whenever "provider" is used, it is understood that only data relative to participating CCBHCs will be used in calculating each measure.

**Routine Visit:** A visit where a person presents with a non-emergency or non-urgent need.

**Screening** : a brief process for evaluating the possible presence of a particular problem.

**Assessment:** a process for defining the nature of a problem, determining a diagnosis and developing specific treatment recommendations.

**State-collected Measure**: a measure where the data is collected and calculated by the state.

**Value Set**: A defined set of codes specific to a certain Diagnosis, Place of Service, or Service code.

# Addendum D: Retired Quality Measures

This manual is meant to provide the details for quality measure calculation for all years of the demonstration. As new guidance is provided from SAMHSA, and as updated criteria is provided, measures will be updated. In 2025 with the updated criteria, some quality measures were added, removed, updated, or modified. To keep track of how measures were historically calculated and how current measures are calculated, measures that have been updated, modified, or no longer used are included in this section of the manual.

## Time to Initial Evaluation (I-EVAL) – Retired 2025

**Steward:** SAMHSA-Developed Metric
**Abbreviation:** I-EVAL
**Version Year:** 2016
**Technical Specifications:** 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
**Value Sets:** N/A
**Reporting Changes:**
**CCBHC Demonstration Modifications:** N/A
**Kentucky CCBHC Modifications:**

- Kentucky will assess those who are 6 years old and greater presenting with Urgent and Emergent care needs in addition to the CMS reported Routine care needs.
- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications.

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- Date_Initial_Contact
- Type_of_Initial_Contact

**Measure Workflow**

| | |
|---|---|
| | **Measure #1: Time to Initial Evaluation (I-EVAL)**<br>Based on a measure stewarded by the Substance Abuse and Mental Health Services.<br><br>**DESCRIPTION**<br><br>***Two-part measure calculating for CMS reporting:***<br><br>**Metric #1**: Percentage of New Consumers[2] (≥ 06 yrs. old as of the end of the Measurement Period) with Initial Evaluation[3] provided within 10 business days[4] of first contact for those who present with "routine" non-emergency or non-urgent needs.<br>AND<br>**Metric #2**: Mean number of days[5] between Initial Contact[1] and Initial Evaluation[3] for New Consumers[2] who present with "routine" non-emergency or non-urgent needs.<br><br>***Additional Four-part measure calculating for KY DMS reporting:***<br><br>**Metric #3**: Percentage of New Consumers[2] (≥ 06 yrs. old as of the end of the Measurement Period) with Initial Evaluation[3] provided within 1 day[4] of first contact for those who present with urgent needs.<br>AND |

| | |
|---|---|
| | **Metric #4**: Mean number of days[5] between Initial Contact[1] and Initial Evaluation[3] for New Consumers[2] who present with urgent needs.<br>AND<br>**Metric #5**: Percentage of New Consumers[2] (≥ 06 yrs. old as of the end of the Measurement Period) with Initial Evaluation[3] provided same day of first contact for those who present with emergent needs.<br>AND<br>**Metric #6**: Mean number of days[5] between Initial Contact[1] and Initial Evaluation[3] for New Consumers[2] who present with emergent needs. |
| | |
| | **Metric #1 Denominator Calculation** |
| **Step Number** | |
| **Metric #1 D1** | Consumer age ≥ 6 yrs. at the end of the Measurement Year<br><br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |
| **Metric #1 D2** | Consumer contacted clinic for services in the first eleven (11) months of the Measurement Year<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |
| | |
| **Metric #1 D3** | Consumer initial screening and risk assessment determined need for routine care<br><br>=YES: Proceed to D4<br>=NO: Do not include in Denominator/Stop |
| | |
| **Metric #1 D4** | Consumer seen by the clinic during the six (6) months prior to the date of Initial Contact[1]<br><br>=YES: Do not include in Denominator/Stop<br>=NO: Include in Denominator |
| | |
| **Metric #1 D5** | Consumer received Initial Evaluation[3]<br><br>=YES: Include in Denominator<br>=NO: Do not include in Denominator/Stop<br><br>Note: Consumers that have an Initial Contact Date but no Initial Evaluation should be noted in Box F of the reporting template. |
| | |
| **Metric #1 Denominator** | **Total Unique Consumers** |
| | |
| **Metric #1 Denominator CMS Workbook** | Report by age groups:<br><br>12-17 yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other<br>AND<br>18+ yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other<br>AND<br>Total (All Age Groups); separated into payor groups: Medicaid, Medicare-Medicaid, Other |

| | |
|---|---|
| **Metric #1 Denominator KY DMS Reporting** | Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| | **Metric #1 Numerator Calculation:** |
| | |
| **Metric #1 N1** | Begin Calculation with Denominator |
| | |
| **Metric #1 N2** | Consumer received Initial Evaluation[3] within 10 business days[4] of contact<br><br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |
| **Metric #1 Numerator** | **Total Unique Consumers** |
| | |
| **Metric #1 Numerator CMS Workbook** | Report by age groups:<br><br>12-17 yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other<br>AND<br>18+ yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other<br>AND<br>Total (All Age Groups); separated into payor groups: Medicaid, Medicare-Medicaid, Other |
| | |
| **Metric #1 Numerator KY DMS Workbook** | Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| | **Metric #2 Denominator – Metric #1 Denominator is used for Metric #2 calculation.** |
| | |

| | |
|---|---|
| **Metric #2 Denominator CMS Workbook** | *There is no Denominator calculation for Metric #2. The Metric #1 Denominator will be reported as Metric #2 Denominator on CMS Workbook.*<br><br>Report by age groups:<br><br>12-17 yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other<br>AND<br>18+ yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other<br>AND<br>Total (All Age Groups); separated into payor groups: Medicaid, Medicare-Medicaid, Other |
| | |
| **Metric #2 Denominator KY DMS Workbook** | *There is no Denominator calculation for Metric #2. The Metric #1 Denominator will be reported as Metric #2 Denominator on KY DMS Workbook.*<br><br>Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| | **Metric #2 Numerator Calculation:** |
| | |
| **Metric #2 N1** | Begin Calculation with Denominator |
| | |
| **Metric #2 N2** | Documented date of consumer Initial Contact[1] during the first 11 months of the Measurement Year<br><br>=YES: Proceed to N3<br>=NO: Do not include in Numerator/Stop |
| | |
| **Metric #2 N3** | Documented date consumer received Initial Evaluation[3]<br><br>=YES: Proceed to N4<br>=NO: Do not include in Numerator/Stop |
| | |
| **Metric #2 N4** | Calculated number of days[4] between Initial Contact[1] and Initial Evaluation[3]<br><br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |
| **Metric #2 Numerator** | **Total Mean Number of Days[5]** |
| | |

| | |
|---|---|
| **Metric #2 Numerator CMS Workbook** | Report by age groups:<br><br>12-17 yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other<br>AND<br>18+ yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other<br>AND<br>Total (All Age Groups); separated into payor groups: Medicaid, Medicare-Medicaid, Other |
| | |
| **Metric #2 Numerator KY DMS Workbook** | Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| | **Metric #3 Denominator Calculation** |
| **Step Number** | |
| **Metric #3 D1** | Consumer age ≥ 6 yrs. at the end of the Measurement Year<br><br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |
| **Metric #3 D2** | Consumer contacted clinic for Services in the first eleven (11) months of the Measurement Year<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |
| | |
| **Metric #3 D3** | Consumer initial screening and risk assessment determined need for Urgent Care<br><br>=YES: Proceed to D4<br>=NO: Do not include in Denominator/Stop |
| | |
| **Metric #3 D4** | Consumer seen by the clinic during the six (6) months prior to the date of Initial Contact[1]<br><br>=YES: Do not include in Denominator/Stop<br>=NO: Include in Denominator |
| | |
| **Metric #3 Denominator** | **Total Unique Consumers** |
| | |

| | |
|---|---|
| **Metric #3 Denominator KY DMS Reporting** | Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| | **Metric #3 Numerator Calculation:** |
| | |
| **Metric #3 N1** | Begin Calculation with Denominator |
| | |
| **Metric #3 N2** | Consumer received Initial Evaluation[3] within 1 business day[4] of contact (date of contact or next business day)<br><br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |
| **Metric #3 Numerator** | **Total Unique Consumers** |
| | |
| **Metric #3 Numerator KY DMS Workbook** | Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| | **Metric #4 Denominator – Metric #3 Denominator is used for Metric #4 calculation.** |
| | |

| | |
|---|---|
| **Metric #4 Denominator KY DMS Reporting** | *There is no Denominator calculation for Metric #4. The Metric #3 Denominator will be reported as Metric #4 Denominator on KY DMS Workbook*<br><br>Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| | **Metric #4 Numerator Calculation:** |
| | |
| **Metric #4 N1** | Begin Calculation with Metric #3 Denominator |
| | |
| **Metric #4 N2** | Documented date of consumer Initial Contact[1] during the first 11 months of the Measurement Year<br><br>=YES: Proceed to N3<br>=NO: Do not include in Numerator/Stop |
| | |
| **Metric #4 N3** | Documented date consumer received Initial Evaluation[3]<br><br>=YES: Proceed to N4<br>=NO: Do not include in Numerator/Stop |
| | |
| **Metric #4 N4** | Calculated number of days[4] between Initial Contact[1] and Initial Evaluation[3]<br><br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |
| **Metric #4 Numerator** | **Total Mean Number of Days[5]** |
| | |
| **Metric #4 Numerator KY DMS Workbook** | Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND |

| | |
|---|---|
| | Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| | **Metric #5 Denominator Calculation** |
| **Step Number** | |
| **Metric #5 D1** | Consumer age ≥ 6 yrs. at the end of the Measurement Year<br><br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |
| **Metric #5 D2** | Consumer contacted clinic for Services in the first eleven (11) months of the Measurement Year<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |
| | |
| **Metric #5 D3** | Consumer initial screening and risk assessment determined need for emergent care<br><br>=YES: Proceed to D4<br>=NO: Do not include in Denominator/Stop |
| | |
| **Metric #5 D4** | Consumer seen by the clinic during the six (6) months prior to the date of Initial Contact[1]<br><br>=YES: Do not include in Denominator/Stop<br>=NO: Include in Denominator/Stop |
| | |
| **Metric #5 Denominator** | **Total Unique Consumers** |
| | |
| **Metric #5 Denominator KY DMS Reporting** | Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| | **Metric #5 Numerator Calculation:** |
| | |
| **Metric #5 N1** | Begin Calculation with Denominator |
| | |
| **Metric #5 N2** | Consumer received Initial Evaluation[3] on same date of contact<br><br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |

| | |
|---|---|
| **Metric #5 Numerator** | **Total Unique Consumers** |
| | |
| **Metric #5 Numerator KY DMS Workbook** | Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| | **Metric #6 Denominator – Metric #5 Denominator is use for Metric #6 calculation.** |
| | |
| **Metric #6 Denominator KY DMS Workbook** | *There is no Denominator calculation for Metric #6. The Metric #5 Denominator will be reported as Metric #6 Denominator on KY DMS Workbook*<br><br>Report by age groups:<br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| | **Metric #6 Numerator Calculation:** |
| | |
| **Metric #6 N1** | Begin Calculation with Denominator |
| | |
| **Metric #6 N2** | Documented date of consumer Initial Contact[1] during the first 11 months of the Measurement Year<br><br>=YES: Proceed to N3<br>=NO: Do not include in Numerator/Stop |
| | |
| **Metric #6 N3** | Documented date consumer received Initial Evaluation[3]<br><br>=YES: Proceed to N4<br>=NO: Do not include in Numerator/Stop |
| | |

| | |
|---|---|
| **Metric #6<br>N4** | Calculated number of days between Initial Contact[1] and Initial Evaluation[3]<br><br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |
| **Metric #6<br>Numerator** | **Total Mean Number of Days[5]** |
| | |
| **Metric #6<br>Numerator<br>KY DMS Workbook** | Report by age groups:<br><br>6-11 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>12-17 yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>18+ yrs.; separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation<br>AND<br>Total (All Age Groups); separated into payor groups (Medicaid, Medicare-Medicaid, Other), Race, Ethnicity, Housing Situation and stratified by clinic location. |
| | |
| **Initial Contact[1]** | To be determined by the date the New Consumer[2] first contacted the CCBHC (referral, called to set up appointment, etc.) for services. The Initial Contact must be accompanied by the preliminary screening and risk assessment and collection of basic data about the person that includes insurance information to be included in this step. |
| | |
| **New Consumers[2]** | New consumers are defined as an individual not been provided services at the clinic for the 180 days (6 months) prior to the date of contact. |
| | |
| **Initial Evaluation[3]** | KY Modification: The following CPT/HCPCS codes will be used to determine if Consumer received the Initial Evaluation during:<br><br>• **Routine Visit:** 90792, 90791, H0002, H0001, H0031<br>• **Urgent and Emergent Visit:** H0001, H0031, S9484, H2011, 90839, 90840<br><br>As defined in Technical Specifications: The Initial Evaluation (including information gathered as part of the preliminary screening and risk assessment), as required in program requirement 2, includes, at a minimum, (1) preliminary diagnoses; (2) the source of referral; (3) the reason for seeking care, as stated by the consumer or other individuals who are significantly involved; (4) identification of the consumer's immediate clinical care needs related to the diagnosis for mental and substance use disorders; (5) a list of current prescriptions and over-the-counter medications, as well as other substances the consumer may be taking; (6) an assessment of whether the consumer is a risk to self or to others, including suicide risk factors; (7) an assessment of whether the consumer has other concerns for their safety; (8) assessment of need for medical care (with referral and follow-up as required); and (9) a determination of whether the person presently is or ever has been a member of the U.S. Armed Services. As needed, releases of information are obtained.<br><br>As used in the context of the Initial Evaluation being "provided" by the clinic, the word "provided" means "received." The clinic is to record the number of business days[4] from |

| | |
|---|---|
| | Initial Contact[1] until the Initial Evaluation was received by or completed for the New Consumer[2]. |
| | |
| **Business Days[4]** | Monday through Friday, excluding state and federal holidays (regardless of days of operation). |
| | |
| **Total Mean Number of Days[5]** | Number of days between Initial Contact[1] and Initial Evaluation[3]. Any New Consumers[2] receiving an Initial Evaluation[3] after the last day of the Measurement Year are treated as having been evaluated 31 days after Initial Contact[1]. |

# Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up (BMI-SF) – Retired 2025

**Steward:** Centers for Medicare & Medicaid Services
**Abbreviation:** BMI-SF
**Version Year:** 2016
**NQF#:** 0421
**PQRS#**: 128
**eCQI:** CMS69v3 (CMS63v4 is the e-Measure number)
**Technical Specifications:**

- 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
- 2016 Physician Quality Reporting System (PQRS)
- 2016 Electronic Clinical Quality Improvement (eCQI)

**Value Sets:**

- 2016 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.

**Reporting Changes:**
**CCBHC Demonstration Modifications:** N/A
**Kentucky CCBHC Modifications:**

- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- Weight
- Height
- BMI_Score
- BMI_Score_Date_Index
- BMI_FollowUp_Date_Index
- BMI_Exclusion_Code

**Measure Workflow**

| | |
|---|---|
| | **Measure #2: Body Mass Index (BMI) Screening and Follow-Up Plan**<br>Based on a measure stewarded by the Centers for Medicare & Medicaid Services (NQF# 0421; PQRS# 128)<br><br>**DESCRIPTION**<br>Percentage of consumers aged ≥ 18 years with a BMI documented during the current encounter or during the previous 6 months AND when a BMI Measurement[2] outside of normal parameters with a Follow-Up Plan[3] is documented during the encounter or during the previous 6 months of the current encounter. |
| | |
| | **Denominator Calculation:** |
| **Step Number** | |
| **D1** | Consumer Age is ≥ 18 years of age on Date of Service during the Measurement Period<br><br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |

| | |
|---|---|
| **D2** | Consumer had an encounter listed in the CCBHC Quality Measures Value Set List (Measure 2) as INCLUDED<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |
| | |
| **D3** | **EXCLUDE:** Consumers with Active Diagnosis: Pregnancy Dx overlaps Measurement Period.<br><br>**EXCLUDE:** Consumers with an Order for Palliative Care which started before the current encounter.<br><br>**EXCLUDE:** Consumers with documented medical reason why BMI Measurement[2] was not appropriate.<br><br>**EXCLUDE:** Consumers who refused BMI Measurement[2].<br><br>**EXCLUDE:** Consumer is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient's health status. |
| | |
| **Denominator** | **Total Unique Consumers** |
| | |
| **CMS Workbook** | Report by payor group:<br><br>Medicaid, Medicare-Medicaid, Other |
| | |
| | **Numerator Calculation:** |
| | |
| **N1** | Begin Calculation with Denominator |
| | |
| **N2** | BMI Documented (Height/Weight[1]), on the date of or in the 6-month period prior to the eligible encounter<br><br>=YES: Proceed to N3<br>=NO: Do not include in Numerator/Stop |
| | |
| **N3** | BMI Parameters:<br><br>Normal[2]: No Follow-Up Plan[3] Required<br>=YES: Include in Numerator/Stop<br><br>Above Normal:<br>=YES: Proceed to N4<br><br>Below Normal:<br>=YES: Proceed to N4<br>=NO: Do not include in Numerator/Stop |
| | |
| **N4** | Follow-Up Plan[3] Documented<br><br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |

| Numerator | Total Unique Consumers |
|---|---|
| | |
| **CMS Workbook** | Report by payor group:<br><br>Medicaid, Medicare-Medicaid, Other |
| | |
| **Height/Weight[1]** | Height & Weight must both be measured by an eligible professional or their staff on the date of or within 6 months of the current encounter and may be obtained from separate encounters. **Self-reported values cannot be used.** |
| | |
| **BMI Measurement[2]** | BMI - Body mass index (BMI), is a number calculated using the Quetelet index: weight divided by height squared (W/H2) and is commonly used to classify weight categories. BMI can be calculated using:<br><br>Metric Units: BMI = Weight (kg) / (Height (m) x Height (m))<br>OR<br>English Units: BMI = Weight (lbs.) / (Height (in) x Height (in)) x 703<br><br>Normal[2] Parameters:<br><br>• Age 65 years and older BMI > 23 and < 30 kg/m2<br>• Age 18 - 64 years BMI > 18.5 and < 25 kg/m2 |
| | |
| **Follow-Up Plan[3]** | Follow-Up Plan Proposed outline of treatment to be conducted as a result of a BMI Measurement[2] out of normal parameters. A Follow-Up Plan may include, but is not limited to:<br>• Documentation of education<br>• Referral (for example a registered dietitian, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon)<br>• Pharmacological interventions<br>• Dietary supplements<br>• Exercise counseling<br>• Nutrition counseling |

# Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-CH) – Retired 2025

**Steward:** HEDIS
**Abbreviation:** WCC-BH
**Version Year:** 2022
**NQF#:** 0024
**Technical Specifications:**

- 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
- 2022 HEDIS MY 2022 (from Section B: Prevention and Screening, Pg. 73)

**Value Sets:**

- 2022 Child HEDIS Codes available for clinics to review on CCBHC Quality Measures Value Set List.

**Reporting Changes:**
**CCBHC Demonstration Modifications:**

1. Only the BMI percentile component is reported in this measure; the physical activity/nutrition counseling components are not included.
2. Per SAMHSA clarification to Question 13.f.: In the context of the CCBHC Demonstration, the BMI screening (Outpatient Value Set) may be conducted by medical personnel at either the CCBHC or a DCO without regard to whether they are a PCP or OB/GYN for the consumer, as long as they are operating within the scope of practice for their licensure.

**Kentucky CCBHC Modifications:**

- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- Weight
- Height
- BMI_Score
- BMI_Score_Date_Index
- BMI_Percentile
- BMI_Exclusion_Code

**Measure Workflow**

| | |
|---|---|
| | **Measure #3: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)**<br>Based on a measure developed by the National Committee for Quality Assurance (NQF# 0024)<br><br>**DESCRIPTION**<br>The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN (Outpatient Value Set) and who had evidence of the following during the Measurement Year: BMI Percentile[1] documentation.<br><br>**NOTE:** Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI Percentile[1] is assessed rather than an absolute BMI value. |
| | |

| | |
|---|---|
| | **Denominator Calculation:** |
| **Step Number** | |
| **D1** | Consumer Age is 3 to 17 years of age as of December 31 of the Measurement Year<br><br>=YES: for Medicaid Consumer proceed to D2<br>=YES: for Non-Medicaid Consumer proceed to D3<br>=NO: Do not include in Denominator/Stop |
| | |
| **D2** | Medicaid Consumer with continuous enrollment (no more than one gap of up to 45 days) during the Measurement Year<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |
| | |
| **D3** | Consumer had an eligible outpatient encounter listed in the CCBHC Quality Measures Value Set List (Measure 3) with a prescribing practitioner (MD, APRN, Psychiatrist or PA), during the Measurement Year<br><br>=YES: Proceed to D4<br>=NO: Do not include in Denominator/Stop |
| | |
| **D4** | **EXCLUDE:** Consumer in Hospice (Refer to General Guideline 17: Members in Hospice.)<br><br>**EXCLUDE:** Consumers with Active Diagnosis: Pregnancy Dx overlaps Measurement Year. |
| | |
| **Denominator** | **Total Unique Consumers** |
| | |
| **CMS Workbook** | Report by age groups:<br><br>3-11 yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other and Total of all payor groups for this age group<br>AND<br>12-17 yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other and Total of all payor groups for this age group. |
| | |
| | **Numerator Calculation:** |
| | |
| **N1** | Begin Calculation with Denominator |
| | |
| **N2** | BMI Percentile[1] Documented during the Measurement Year<br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |
| **Numerator** | **Total Unique Consumers** |
| | |

| | |
|---|---|
| **CMS Workbook** | Report by age groups:<br><br>3-11 yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other and Total of all payor groups for this age group<br>AND<br>12-17 yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other and Total of all payor groups for this age group |
| | |
| **BMI Percentile**[1] | Documentation must include height, weight and BMI Percentile during the Measurement Year. The height, weight and BMI Percentile must be from the same data source.<br><br>Either of the following meets criteria for BMI Percentile:<br>BMI Percentile documented as a value (e.g., 85th percentile).<br>BMI Percentile plotted on an age-growth chart.<br><br>Only evidence of the BMI Percentile or BMI Percentile plotted on an age-growth chart meets criteria. |

# Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC) – Retired 2025

**Steward:** American Medical Association (AMA) & CPI Foundation (PCPI)
**Abbreviation:** TSC
**Version Year:** 2016
**NQF#**: 0028
**PQRS#:** 226
**Technical Specifications:**

- 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
- 2016 Physician Quality Reporting System (PQRS)
- 2016 Electronic Clinical Quality Improvement (eCQI)

**Value Sets:**

- 2016 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.

**Reporting Changes:**
**CCBHC Demonstration Modifications:** N/A
**Kentucky CCBHC Modifications:**

- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- Tobacco_Screener_Index_Date
- Tobacco_Screener_Results_Positive
- Tobacco_Intervention_Date_Index
- Tobacco_Exclusion_Code

**Measure Workflow**

| | |
|---|---|
| | **Measure #4: Tobacco Use: Screening and Cessation Intervention (TSC)**<br>Based on a measure stewarded by the American Medical Association (AMA) and (PCPI) Foundation (NQF #0028e; PQRS #226)<br><br>**DESCRIPTION**<br>Percentage of consumers aged 18 years and older who were screened for tobacco use one or more times during the Measurement Period[3] AND who received Tobacco Cessation Intervention[2] if identified as a tobacco user. |
| | |
| | **Denominator Calculation:** |
| **Step Number** | |
| **D1** | Consumer Age is ≥ 18 years of age on date of service during the Measurement Year<br><br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |
| **D2** | Consumer had an eligible outpatient encounter listed in the CCBHC Quality Measures Value Set List as INCLUDED (Measure 4) during the Measurement Year<br><br>=YES: Include in Denominator<br>=NO: Do not include in Denominator/ Stop |
| | |
| **Denominator** | **Total Unique Consumers** |

| | |
|---|---|
| **CMS Workbook** | Report by payor group:<br><br>Medicaid, Medicare-Medicaid, Other |
| | |
| | **Numerator Calculation:** |
| | |
| **N1** | Begin Calculation with Denominator |
| | |
| **N2** | Tobacco Screening[1] Documented within the Measurement Period[3]<br><br>=YES: Proceed to N3<br>=NO: Proceed to N5 |
| | |
| **N3** | Tobacco Screening[1] Documented as Negative: No Tobacco Cessation Intervention[2] Required<br><br>=YES: Include in Numerator/Stop<br>=NO: Proceed to N4 |
| | |
| **N4** | Tobacco Screening[1] documented as Positive, And Tobacco Cessation Intervention[2] documented<br><br>=YES: Include in Numerator<br>=NO: Proceed to N5 |
| | |
| **N5** | Consumers has a documented medical reason why screening was not appropriate<br><br>=YES: Remove from both Numerator and Denominator totals<br>=NO: Do not include in Numerator |
| | |
| **Numerator** | **Total Unique Consumers** |
| | |
| **CMS Workbook** | Report by payor group:<br><br>Medicaid, Medicare-Medicaid, Other |
| | |
| **Tobacco Screening[1]** | Tobacco Screening will include screening for any type of tobacco. |
| | |
| **Tobacco Cessation Intervention[2]** | Includes cessation intervention (3 minutes or less) and/or pharmacotherapy. |
| | |
| **Measurement Period[3]** | The Measurement Period for the numerator is the Measurement Year and the prior year.<br>The Measurement Period for the Numerator is the Measurement Year and the prior year. |

# Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASF) - Retired 2025

**Steward:** Physician Performance Measure, NCQA
**Abbreviation:** ASF
**Version Year:** 2016
**NQF#**: 2152
**PQRS#:** 431
**Technical Specifications:**

- 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
- 2016 Physician Quality Reporting System (PQRS)

**Value Sets:**

- 2016 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.

**Reporting Changes:**
**CCBHC Demonstration Modifications:** N/A
**Kentucky CCBHC Modifications:**

- The screener for alcohol use to be used during the CCBHC Demonstration is listed on the Kentucky approved Evidenced Based Practice List.
- For purposes of the Demonstration KY will use the NIAAA Single Alcohol Screening Question (SASQ) and its recommended response for follow-up/brief counseling being ≥ 1.
- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- Alcohol_Screener_Date_Index
- Alcohol_Screener_Results_Positive
- Alcohol_Brief_Counseling_Date
- Alcohol_Use_Exclusion_Code

**Measure Workflow**

| | |
|---|---|
| | **Measure #5: Preventive care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASF)**<br>Based on a measure stewarded by the American Medical Association (AMA) and PCPI (NQF #2152; PQRS #431)<br><br>**DESCRIPTION**<br>Percentage of consumers aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received Brief Counseling[2] if identified as an unhealthy alcohol user. |
| | |
| | **Denominator Calculation:** |
| **Step Number** | |
| **D1** | Consumer Age is ≥ 18 years of age on date of service during the Measurement Year<br><br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/ Stop |
| | |

| | |
|---|---|
| **D2** | Consumer had an eligible outpatient encounter listed in the CCBHC Quality Measures Value Set List as INCLUDED (Measure 5) during the Measurement Year<br><br>=YES: Include in Denominator<br>=NO: Do not include in Denominator/Stop |
| | |
| **Denominator** | **Total Unique Consumers** |
| | |
| **CMS Workbook** | Report by payor group:<br><br>Medicaid, Medicare-Medicaid, Other |
| | |
| | **Numerator Calculation:** |
| | |
| **N1** | Begin Calculation with Denominator |
| | |
| **N2** | Unhealthy Alcohol Screening[1] Documented within the Measurement Period[3]<br><br>=YES: Proceed to N3<br>=NO: Do not include in Numerator/Stop |
| | |
| **N3** | Unhealthy Alcohol Screening[1] Documented as Negative, No Brief Counseling[2] Required<br><br>=YES: Include in Numerator/Stop<br>=NO: Proceed to N5 |
| | |
| **N4** | Unhealthy Alcohol Screening[1] Documented as Positive, And Brief Counseling[2] Documented<br><br>=YES: Include in Numerator<br>=NO: Proceed to N5 |
| | |
| **N5** | Consumer has a documented medical reason why screening was not appropriate<br><br>=YES: Remove from both Numerator and Denominator totals<br>=NO: Do not include in Numerator |
| **Numerator** | **Total Unique Consumers** |
| | |
| **CMS Workbook** | Report by payor group:<br><br>Medicaid, Medicare-Medicaid, Other |
| | |
| **Unhealthy Alcohol Screening[1]** | The SAMHSA Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual contains the following notation relative to screening tools, however, please note the KY Modification for this measure:<br><br>For purposes of this measure, according to the measure steward, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include:<br>• AUDIT Screening Instrument (score ≥ 8)<br>• AUDIT-C Screening Instrument (score ≥4 for men; score ≥3 for women)<br>• Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response ≥ 1) – See KY Modifications above. |
| | |

| | |
|---|---|
| **Brief Counseling[2]** | Brief Counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5–15 minutes, which may include feedback on alcohol use and harms, identification of high-risk situations for drinking and coping strategies, increased motivation, and the development of a personal plan to reduce drinking. |
| | |
| **Measurement Period[3]** | The Measurement Period for the Numerator is the Measurement Year and the prior year. |

# Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-CH) - Retired 2025

**Steward:** American Medical Association (AMA) & CPI Foundation (PCPI)
**Abbreviation:** SRA-BH-C
**Version Year:** 2016
**NQF#**: 1365
**PQRS#:** 382
**Technical Specifications:**

- 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
- 2016 Electronic Clinical Quality Improvement (eCQI)

**Value Sets:**

- 2016 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.

**Reporting Changes:**
**CCBHC Demonstration Modifications:** N/A
**Kentucky CCBHC Modifications:**

- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications.

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- Suicidal_Risk_Assessment_Date_Index

**Measure Workflow**

| | |
|---|---|
| | **Measure #6: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-CH)**<br>Based on a measure stewarded by the American Medical Association (AMA) and (PCPI) (NQF #1365e; PQRS #382)<br><br>**DESCRIPTION**<br>Percentage of consumer visits for those consumers aged 6 through 17 years with a diagnosis of Major Depressive Disorder with a Suicide Risk Assessment completed during the visit. |
| | |
| | **Denominator Calculation:** |
| **Step Number** | |
| **D1** | Consumer Age is 6 to 17 years of age at the start of the Measurement Year<br><br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |
| **D2** | Consumer had two encounters listed in the CCBHC Quality Measures Value Set List (Measure 6) as INCLUDED during the Measurement Year<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |
| | |

| | |
|---|---|
| **D3** | Consumer had active diagnosis of Major Depressive Disorder listed in the CCBHC Quality Measures Value Set List (Measure 6) as INCLUDED at the time of each Encounter<br><br>=YES: Include in Numerator<br>=NO: Do not include in Denominator/Stop |
| | |
| **Denominator** | **Total Number of Consumers** |
| | |
| **CMS Workbook** | Report by payor group:<br><br>Medicaid, Medicare-Medicaid, Other and Total |
| | |
| | **Numerator Calculation:** |
| | |
| **N1** | Begin Calculation with Denominator |
| | |
| **N2** | Documentation of Suicide Risk Assessment[1] Performed[2]<br><br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |
| **Numerator** | **Total Number of Consumers** |
| | |
| **CMS Workbook** | Report by payor group:<br><br>Medicaid, Medicare-Medicaid, Other and Total |
| | |
| **Suicide Risk Assessment[1]** | Suicide Risk Assessment can include:<br><br>• specific inquiry about suicidal thoughts, intent, plans, means, and behaviors<br>• identification of specific psychiatric symptoms (e.g., psychosis, severe anxiety, substance use) or general medical conditions that may increase the likelihood of acting on suicidal ideas<br>• assessment of past and, particularly, recent suicidal behavior<br>• delineation of current stressors and potential protective factors (e.g., positive reasons for living, strong social support)<br>• identification of any family history of suicide or mental illness |
| | |
| **Assessment Performed[2]** | A Suicide Risk Assessment[1] should be performed at every visit for Major Depressive Disorder during the Measurement Year. |

# Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A) - Retired 2025

**Steward:** Mathematica, CMS Version 10
**Abbreviation:** SRA-A
**Version Year:** 2016
**NQF#**: 0104e
**PQRS#:** 107
**Technical Specifications:**

- 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
- 2016 Electronic Clinical Quality Improvement (eCQI)

**Value Sets:**

- 2016 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.

**Reporting Changes:**
**CCBHC Demonstration Modifications:** N/A
**Kentucky CCBHC Modifications:**

- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications.

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- Suicidal_Risk_Assessment_Date_Index

**Measure Workflow**

| | |
|---|---|
| | **Measure #7: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment**<br>Based on a measure stewarded by the American Medical Association and the PCPI(R) Foundation (NQF #0104e) (PQRS #107)<br><br>**DESCRIPTION**<br>All consumer visits during which a new diagnosis of Major Depressive Disorder (MDD) or a new diagnosis of recurrent MDD was identified for consumers aged 18 years and older with a Suicide Risk Assessment[1] completed during the visit. |
| | |
| | **Denominator Calculation:** |
| **Step Number** | |
| **D1** | Consumer Age is ≥ 18 years of age at the start of the Measurement Year<br><br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |
| **D2** | Consumer had one encounter listed in the CCBHC Quality Measures Value Set List (Measure 7) as INCLUDED<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |
| | |
| **D3** | Consumer had active diagnosis of MDD listed in the CCBHC Quality Measures Value Set List (Measure 7) as INCLUDED at the time of the qualifying Encounter<br><br>=YES: Include in Denominator<br>=NO: Do not include in Denominator/Stop |

| | |
|---|---|
| **Denominator** | **Total Number of Consumers** |
| | |
| **CMS Workbook** | Report by payor group:<br><br>Medicaid, Medicare-Medicaid, Other and Total |
| | |
| | **Numerator Calculation:** |
| | |
| **N1** | Begin Calculation with Denominator |
| | |
| **N2** | Documentation of Suicide Risk Assessment[1] Performed[2]<br><br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |
| **Numerator** | **Total Number of Consumers** |
| | |
| **CMS Workbook** | Report by payor group:<br><br>Medicaid, Medicare-Medicaid, Other and Total |
| | |
| **Suicide Risk Assessment[1]** | Suicide Risk Assessment can include:<br><br>• specific inquiry about suicidal thoughts, intent, plans, means, and behaviors<br>• identification of specific psychiatric symptoms (e.g., psychosis, severe anxiety, substance use) or general medical conditions that may increase the likelihood of acting on suicidal ideas<br>• assessment of past and, particularly, recent suicidal behavior<br>• delineation of current stressors and potential protective factors (e.g., positive reasons for living, strong social support)<br>• identification of any family history of suicide or mental illness |
| | |
| **Assessment Performed[2]** | A Suicide Risk Assessment[1] should be performed at every visit for Major Depressive Disorder during the Measurement Year. |
| | |
| **Assessment Performed[2]** | A Suicide Risk Assessment[1] should be performed at every visit for Major Depressive Disorder during the Measurement Year. |

# Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan (CDF-AD) - Retired 2025

**Steward:** Medicare & Medicaid Services
**Abbreviation:** CDF-BH
**Version Year:** 2022
**NQF#**: 0418
**PQRS#:** 134
**Technical Specifications:**

- 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
- 2022 Electronic Clinical Quality Improvement (eCQI)

**Value Sets:**

- 2022 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.

**Reporting Changes:**
**CCBHC Demonstration Modifications:** N/A
**Kentucky CCBHC Modifications:**

- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications.

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- Depression_Screening_Date_Index
- Depression_PHQ-9_Score
- Depression_Exclusion_Code
- Depression_Screening_FollowUp_Date
- PHQ9_Score_Date_Index

**Measure Workflow**

| | |
|---|---|
| | **Measure #8: Screening for Clinical Depression and Follow-Up Plan (CDF-BH)**<br>Based on a measure stewarded by the Centers for Medicare & Medicaid Services (NQF #0418; PQRS #134)<br><br>**DESCRIPTION**<br>Percentage of consumers aged 12 and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a Follow-up Plan[1] is documented on the date of the positive screen. |
| | |
| | **Denominator Calculation:** |
| **Step Number** | |
| | |
| **D1** | Consumer Age is ≥ to 12 years of age at start of Measurement Year<br><br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |
| **D2** | Consumer had an encounter Listed in the CCBHC Quality Measures Value Set List (Measure 8) as INCLUDED during the Measurement Year<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |
| | |

| | |
|---|---|
| **D3** | **EXCLUDE:** Refuses to participate<br><br>**EXCLUDE:** Consumer has an active diagnosis of Depression**<br><br>**EXCLUDE:** Consumer has a diagnosed Bipolar Disorder**<br><br>**EXCLUDE:** Consumer when clinician has determined to be in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the consumer's health status<br><br>**EXCLUDE:** Consumer when clinician has determined the consumer's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium<br><br>**ICD-10 Code Exclusions: See CCBHC Quality Measures Value Set List (Measure 8) as EXCLUDED. |
| | |
| **Denominator** | **Total Unique Consumers** |
| | |
| **CMS Workbook** | Report by age groups:<br><br>12-17 yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other<br>AND<br>18-64 yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other<br>AND<br>65+ yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other |
| | |
| | **Numerator Calculation:** |
| | |
| **N1** | Begin Calculation with Denominator |
| | |
| **N2** | Consumer Screened for clinical depression using a standardized tool- (PHQ-9)<br><br>=YES: Proceed to N3<br>=NO: Do not include in Numerator/Stop |
| | |
| **N3** | Depression Screen Score: Positive for Depression – (Example; PHQ-9 screening greater than 9)<br><br>=YES: Proceed to N4<br>=NO: Negative for Depression - Include in Numerator/Stop |
| | |
| **N4** | Follow-Up Plan[1] Provided<br><br>=YES: Include in Numerator<br>=NO: Do not include in Numerator/Stop |
| | |
| **Numerator** | **Total Unique Consumers** |
| | |

| | |
|---|---|
| **CMS Workbook** | Report by age groups:<br><br>12-17 yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other<br>AND<br>18-64 yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other<br>AND<br>65+ yrs.; separated into payor groups: Medicaid, Medicare-Medicaid, Other |
| | |
| **Follow-up Plan**[1] | Documented follow-up for a positive depression screening must include one or more of the following:<br><br>• Additional evaluation for depression<br>• Suicide Risk Assessment<br>• Referral to a practitioner who is qualified to diagnose and treat depression<br>• Pharmacological interventions<br>• Other interventions or follow-up for the diagnosis or treatment of depression |

# Depression Remission at 12-Months (DEP-REM-12) - Retired 2025

**Steward:** Minnesota Community Measurement
**Abbreviation:** DEP-REM-12
**Version Year:** 2016
**NQF#**: 0710
**PQRS#:** 370
**Technical Specifications:**

- 2016 Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual
- 2016 Physician Quality Reporting System (PQRS)
- 2016 Electronic Clinical Quality Improvement (eCQI)

**Value Sets:**

- 2016 Electronic Clinical Quality Improvement (eCQI) available for clinics to review on CCBHC Quality Measures Value Set List.

**Reporting Changes:**
**CCBHC Demonstration Modifications:**
**Kentucky CCBHC Modifications:**

- Kentucky has developed an CCBHC Demonstration Services Codes List which will be used throughout the Demonstration and will define any Value Set Lists stated in the technical specifications.

- Per SAMHSA clarification to Question 10.C: KY interpreted the clarification as follows: For purposes of the Demonstration the first possible Index Date would be twelve months (+/- 30 days) prior to January 1 of the Demonstration Year and the last possible date to be included in the Numerator would be 12/31 of the Demonstration Year.

**Measure Data Collection Field List:** The following list is in addition to identifying fields reported for all measures.

- Depression_Screening_Date Index
- Depression_PHQ9_Score
- Deression_Exclusion_Codes
- PHQ9_Score_Date_Index

**Measure Workflow**

| | |
|---|---|
| | **Measure #9: Depression Remission at Twelve Months (DEP-REM-12)**<br>Based on a measure stewarded by the Minnesota Community Measurement (NQF #0710; PQRS #370)<br><br>**DESCRIPTION**<br>Adult consumers 18 years of age or older with Major Depression or Dysthymia who reached remission 12 months (± 30 days) after an Index Visit[1]. This measure applies to consumers with both newly diagnosed and existing Depression who's current PHQ-9 score indicates a need for treatment. |
| | |
| | **Denominator Calculation:** |
| **Step Number** | |
| **D1** | Consumer had an outpatient encounter during the Measurement Year<br>=YES: Proceed to D2<br>=NO: Do not include in Denominator/Stop |
| | |

| | |
|---|---|
| **D2** | Consumer had a Primary Diagnosis[3] of Major Depression or Dysthymia during the outpatient encounter in Step D1, listed in the CCBHC Quality Measures Value Set List (Measure 9) as INCLUDED during the Measurement Year<br><br>=YES: Proceed to D3<br>=NO: Do not include in Denominator/Stop |
| | |
| **D3** | Consumer had an Index Visit[1] encounter listed in the CCBHC Quality Measures Value Set List (Measure 9) as INCLUDED within the Index Period[1]:<br><br>=YES: Proceed to D4<br>=NO: Do not include in Denominator/Stop |
| | |
| **D4** | Consumer Age is ≥ 18 years of age on the Index Date[1]<br><br>=YES: Proceed to D5<br>=NO: Do not include in Denominator/Stop. |
| | |
| **D5** | **EXCLUDE:** Consumers who died prior to the end of the Measurement Year.<br><br>**EXCLUDE:** Consumer in Hospice (Refer to General Guideline 17: Members in Hospice.)<br><br>**EXCLUDE**: consumers who were permanent nursing home residents<br><br>**EXCLUDE**: consumers with a diagnosis of bipolar disorder**<br><br>**EXCLUDE**: consumers with a diagnosis of personality disorder**<br><br>**ICD-10 Code Exclusions: See CCBHC Quality Measures Value Set List (Measure 9) as EXCLUDED. |
| | |
| **Denominator** | **Total Unique Consumers** |
| | |
| **CMS Workbook** | Report by payor group:<br>Medicaid, Medicare-Medicaid, Other and Total |
| | |
| | **Numerator Calculation:** |
| | |
| **N1** | Begin Calculation with Denominator |
| | |
| **N2** | PHQ-9 Score < 5 documented at Twelve Months (+/-30 days) after the Index Date[1]<br><br>=YES: Include in Numerator/Stop<br>=NO: Do not include in Numerator/Stop |
| | |
| **Numerator** | **Total Unique Consumers** |
| | |

| | |
|---|---|
| **CMS Workbook** | Report by payor group:<br>Medicaid, Medicare-Medicaid, Other and Total |
| | |
| **Index Date** [1] | The first date the Index Visit occurs. For purposes of the Demonstration the first possible Index Date would be twelve months (+/- 30 days) prior to January 30 of the Demonstration Year.<br><br>An Index Visit occurs when ALL of the following criteria are met:<br><br>• A PHQ-9 result greater than nine<br>• An active diagnosis of Major Depression or Dysthymia** (Major Depression or Dysthymia Value Set)<br><br>The Index Period begins on the date of the Index Visit and extends twelve months (+/- 30 days). For each consume this period will be unique.<br><br>**Note**: The first Index Visit identified during the time which beings 12 months (+/- 30 days) prior to January 30 of the demonstration year is the only visit to determine inclusion in the denominator. Dates beyond January 30 WILL NOT be included in the denominator as the Index Period will be outside of the Demonstration Year. |
| | |
| **Measurement Period**[2] | **Denominator**: The Measurement Period for the Denominator is the Measurement Year, but it starts for each person at their individual Index Date[1].<br><br>**Numerator**: The Measurement Period for the Numerator runs from the Index Date[1] for the consumer included in the Denominator to the point 12 months after (± 30 days). Scores obtained prior to or after this period are not counted as Numerator compliant (remission). For purposes of the Demonstration, the Measurement Period for the Numerator ends December 31 of the Demonstration Year. Any consumers who achieve remission after this date will NOT be reported in the Numerator.<br><br>**Index Visit Identification Period:** The Index Visit Identification Period begins for each consumer on the date (Index Date[1]) of the Index Visit and extending out twelve months (+/- 30 days). |
| | |
| **Primary Diagnosis**[3] | For behavioral health providers, the Depression or Dysthymia diagnosis codes must be listed as the primary diagnosis. This excludes patients with other psychiatric diagnosis with a secondary component of Depression. |