BHNNY PHASE THREE CONTRACTING Q&A

UPDATED APRIL 27, 2018

General:

G-1 Q: Does the letter of intent due April 30, 2018 need to include any specific information/ elements?
A: The letter of intent should be on company letter head, include an intent to participate and sign the Phase Three contract, and be signed by an authorized individual. It should also contain a date by which your organization expects the contract to be signed.

G-2 Q: Is there any flexibility on 5/11 date for baseline data reports?
A: 5/11/18 baseline report is a hard deadline. We need the data by this date to have performance contracts available by the end of June.

G-3 Q: My understanding is that the various PfAs are completely separable - if there's one that we determine is just going to be too much trouble, we can simply not do that one and get paid for the ones that are done. Is that correct?
A: You should not edit your contract to remove assigned PfAs. That said, each PfA is a stand-alone activity. You will be paid for those PfAs completed accurately and on time; you will not be paid for activities reported insufficiently or not on time. The activities assigned to your organization within your Phase Three contract is work we need done to advance our goals and is work we need to report to the State to earn the monies to pay our partner organizations.

G-4 Q: Please define which partner types are included in partner type "Adult Health."
A: Please see the Applicable Provider Types section of the BHNNY Measure Specification & Improvement Resource Guide. It includes and defines the different provider types eligible for each metric.

G-5 Q: The reporting requirements are difficult to meet due to the EMR limitations, staff resources/capabilities, and lack of access to other types of reporting tools. Is there any assistance available to help us address the reporting challenges?
A: We would be open to working with individual partners to better understand your reporting abilities and if there are any existing reports that may be used for theses proxy measures. Our goal is to have these measures incorporated into your Electronic Health Record. We would prefer you not create a report manually. Please email the DSRIP@amc.edu with your specific challenges.

PfAs:

P-1 Q: PfA 2 & PfA3- Are we able to partner with any Tier 1 CBO who meets the criteria, or do we have to partner with a BHNNY CBO as per the attached list?
A: Yes, you may partner with any Tier 1 CBO. This partnership is not exclusive to BHNNY CBO partners. CBO partner should provide services which address closing the gap to Social Determinants of Health. Please see the NYSDOH SDH Intervention Menu. BHNNY will also be facilitating networking events later this spring through DY4Q4.

P-2 Q: PfA9- With the workforce impact analysis, does this continue to relate only to DSRIP-related positions? Does this apply to all DSRIP work (for example, if we hired a team to with AHI funding), or to BHHNY work?
A: Yes, the impact analysis continues to pertain only to DSRIP-related positions. Organizations who report to more than one PPS should report to BHNNY only those staffing impacts related to BHNNY DSRIP activities.

P-3 Q: Pfa14- What would implementation require for this metric?
BHNNY and CDPHP are collaborating to provide ED Utilization trainings this spring through Q4. We are asking that front line staff attend and bring back strategies and tools to their organizations. An example of implementation may be establishing a policy to review Ask Me 3 and BHNNY ED Utilization Stoplight tool with patients/community.

Data & Reporting:

DR-1 Q: What happens if I submit a zero value?
A: The contract language states:
To be eligible for payment, a value must be generated for all assigned metrics. Values of zero are acceptable only if accompanied by appropriate documentation and rationale (see BHNNY Measure Specification and Improvement Resource Guide). Acceptable justifications are provided for your selection

The intent is to pay for work that you did when that resulted in a zero numerator or denominator. We understand that effort went into the determination of the result. This work will help us both understand what population you are serving.

BHNNY will evaluate the responses, and reach out for additional details if needed, to determine the payment. If your explanation of the work suffices, you should receive payment.

How to report the Zero is also important to this process.

In Clinical Proxy Measures Templates:
Please refer to the drop-downs on the Contracted Measures tab on the Phase Three proxy measure reporting template when providing justification. When reporting zero we would need:

- "Yes" in the Column "Numerator Zero?" on the Contracted Measure Tab,
- Select a reason from the dropdown list in column "Justification for Numerator Zero" on the Contracted Measure Tab
- For the specific measure, please report zero in the numerator tab in the column "Medicaid Number/CIN"

DR-2 Q: Why are some baseline denominator timeframes different?
A: The PxMs include metrics for activities where it is necessary for the denominator to differ from other baseline measures. For example, PxMs that are tied to DOH reporting of actively engaged patients, and follow-up for prescriptions need to be reported with a different timeframe based on the measure requirements. Please see the Baseline Denominator section of the BHNNY Measure Specification & Improvement Resource Guide for further clarification.

DR-3 Q: Which patients should be included in reporting?
A: Medicaid, Medicaid-Managed, Uninsured patients. **Per DOH, dual-eligibles are not to be included**. Medicaid, or Medicaid-Managed must be the primary insurance. Patients who are back-and-forth with coverage may be included in reports, but this will ultimately be deferred to partner judgement.

DR-4 Q: Are reports patient lists or numbers?
A: Patient lists.
FYI: For reporting CIN, most often a managed care number will be available, and this is fine. Uninsured patients may have an identification number assigned internally, this is also fine.

DR-5 Q: Which DOS should be reported when patients have several visits within a timeframe? Most recent?
A: Yes, most recent visit.

DR-6 Q: Meaningful Use data will require a lot of manual input. Doesn't the state have this?
A: After the April 3, 2018 Partner meeting, it was decided to remove the majority of the "Meaningful Use" data elements due to the comments on compiling this information. Thus, RACE, ETHNICITY and LANGUAGE data elements were removed from the templates. You still need to report GENDER. The reason we were collecting the Meaningful Use Data Elements was to further our focus on needed populations to provide services. We still value this type of information for our DSRIP projects and may need to collect this in the future.

The State does have RACE on Member Roster File (they do not provide Ethnicity or Preferred Language), however, this would not be available to your system. Thus, going forward, the goal was to have you use your own Meaningful Use data for evaluating the patients you serve.

DR-7 Q: What is meant by "COB"?
A: COB (Close of Business) means 11:59pm, unless otherwise specified. Please set your own internal deadline to account for lag in MoveIT, which could be up to 24 hours. Take and save screenshots of your successful submission and include a time stamp.

DR-8 Q: Many of the proxy measures specify particular CPT and ICD codes. Is the use of these specific codes necessary for demonstrating compliance with the relevant measures?
A: Yes. We require this to achieve reporting consistency across all participating partners.

DR-9 Q: Please provide an example to clarify the phrase, "during the previous 12 months ending on the last day of the month that was 2 months prior to the reporting month."
A: Please refer to examples in the BHNNY Measure Specification & Improvement Resource Guide, pages 4-5.

DR-10 Q: Please confirm that when age ranges are specified, they are inclusive (e.g., "ages 20-44" means greater than or equal to 20 and less than or equal to 44 and that "44" means up to 44 years, 11 months, 29 days).
A: Correct.

DR-11 Q: Can you tell me what quarterly reporting will still need to be completed? Will it be the registries and patient engagement?
A: All of the activities you are assigned to complete are within your contract. All but one of the patient engagement measures are included within the partner-specific clinical reporting templates and are indicated as red tabs within the document. The remaining patient engagement metric is listed as PfA 24.

DR-12 Q: What do the red tabs in the PxM templates indicate?
A: The red tabs indicate patient engagement metrics.

DR-13 Q: Would a nurse-only visit (say, for immunizations) count in the denominator for PxM 1-7?
A: Nurse-only visits for immunization **should not** be counted for the visit unless a 99211 is used for additional services.

DR-14 Q: I'm having a bit of trouble understanding the numerator for PxM 1-7. If I were reporting, say, August 2018, would the numerator consist of all patients in the denominator seen between July 1, 2017 and June 30, 2018?
A: For monthly reporting, using your example of the report *due* August 2018: The monthly numerator is patients seen July 1, 2017 to June 30, 2018.
The monthly denominator is patients seen July 1, 2016 – June 30, 2018. The report for August 2018 would be due to BHNNY by August 10, 2018 and cover patients seen through June 2018. This gives you approximately a 40 day window to gather the data.
Q2: What then should I do for the baseline data for these measures, in which we are reporting two years' worth of visits?
A2: For the baseline data BHNNY is requesting all patients seen between April 1, 2016 and March 31, 2018. The baseline numerator is April 1, 2017 to March 31, 2018.

DR-15 Q: For PxM 1-7, how should I handle patients whose age crosses one of the boundaries during the measurement period? In particular, what about a patient who is seen at age 19 and at age 20, since these ages are on different spreadsheets?
A: For reporting, please include the most recent visit for a patient on the appropriate template. The patient will either be on the template for 0-19 years (pediatrics) or 20 years and older (adults), based on their age at the most recent visit.

DR-16 Q: For PxM 40, How do you report children seen in our ED but transferred to another hospital for admission?
A: You would not report on these patients as the key for this requirement is patients that are discharged with that diagnosis.

DR-17 Q: For PxM9 and similar measures, do you want one entry per new prescription? Or is it just one entry per patient, and they are included in the numerator if ANY of these prescriptions had a follow-up in the appropriate timeframe?
A: For PxM 9, we are requesting one entry per new prescription.

DR-18 **Q: Say I have a patient who was seen in May 2016 and then not again until December 2017. Clearly, they are included in the denominator. Should they be in the numerator?**
A: For the baseline data BHNNY is requesting all patients seen between April 1, 2016 and March 31, 2018. The baseline numerator is April 1, 2017 to March 31, 2018. The patient in the example you provided would be included in both the numerator and the denominator. Because the patient had visits in May and December 2016 that is in the timeframe of the denominator April 1, 2016 – March 31, 2018.The most recent visit in December 2017 is in the timeframe of the numerator April 1, 2017 – March 2018.

Primary Care

Primary Care Metric Specific:

Define "Preventive or ambulatory care visit"

- PCP-1 **Q: Many of the descriptions of the proxy measures include the expression, "ambulatory care visit." Please define the expression and explain how it differs from "preventive" visits and the other visit types. For example, for proxy measure #1, it appears that the goal of the measure is to find out how many adult patients are receiving annual preventive exams but the measure definition is not clearly asking for that result.**
    - A: Please refer to CPT codes for Measures 1-7 as listed in the Measure Specification & Improvement Resource Guide.

Metric 26: Controlling Blood Pressure

- PCP-2 **Q: For quality measures, the encounter has to be associated with BP, a nurse visit won't meet the measure and currently quality scores are not great because it is only counted when billable (provider).**
    - A: This metric is based on the DOH medical record audit criteria. The BHNNY Measure Specification & Improvement Resource Guide includes applicable CPT codes for this metric. Any visit, including a nurse visit, with the listed CPT codes can be counted for this metric.

Metric ID 29: Prescription of asthma controller medications.

- PCP-3 **Q: Should the goal of the measure be referring to patients with persistent asthma instead of asthma. If the measurement is to look at patients that should be on controller medications, that would be recommended for persistent asthmatics not all asthmatics**
    - A: Agree that the controller medications are recommended for persistent asthmatics and not for all asthmatics. However, given the difficulties faced by majority of partners during Phase II reporting process in reporting patients with persistent asthma consistently, the proxy metric is requiring partners to include all patients with asthma. Additionally, the HEDIS criteria for persistent asthma is broader than the criteria listed in the NHLBI guidelines resulting in increase in number of patients eligible for the controller medications. The target for this metric will be adjusted to align with the BHNNY proxy denominator.

Behavioral Health:

BH-1 Q: If the process of PCP/ BH integration is underway, will those metrics be applicable?
A: Integration as per DSRIP specifications must be complete March 31, 2018 to qualify for submission of data. Please see the BHNNY Measure Specification & Improvement Resource Guide for clarification.

BH-2 Q: Can you clarify under which license (OASAS/ OMH) providers must be to qualify for BH metrics?
A: Please see the Applicable Provider Types section of the BHNNY Measure Specification & Improvement Resource Guide. It includes and defines the different provider types eligible for each metric.

BH-3 Q: For behavioral health outpatient metrics, with integrated primary care and behavioral health sites, who reports this measure?
A: Please see the Applicable Provider Types section of the BHNNY Measure Specification & Improvement Resource Guide. It includes and defines the different provider types eligible for each metric

Behavioral Health Metric Specific:

Metric 9

- **BH-4 Q: Is the reporting period April 1, 2016- February 28, 2018 as indicated on the document, or April 1, 2016-March 31, 2018?**
    - A: The Denominator – Baseline Report period for this metric is April 1, 2016 – February 28, 2018. This metric concerns follow-up appointments after new prescriptions. For this and similar metrics, the period of time covered in the Baseline Denominator ends before the beginning of the contract period (April 1st), so as to allow partners time to complete the follow-up care in the specified time frame.

- **BH-5 Q: The document states new antidepressant medication- does this include change in dosage? Or change in medication type?**
    - A: This metric is concerned only with new medication or medication type, not with changes in dosage only.
- **BH-6 Q: Are you only looking for those clients with a Depression diagnosis? Or should we include similar diagnoses as well?**
    - A: Please see the BHNNY Measure Specification & Improvement Resource Guide for lists of all diagnostic codes applicable for individual metrics.

- **BH-7 Q: For PxM9 and similar measures, do you want one entry per new prescription? Or is it just one entry per patient, and they are included in the numerator if ANY of these prescriptions had a follow-up in the appropriate timeframe?**
    - A: For PxM 9, we are requesting one entry per new prescription.

Metric 10

- BH-10 **Q: Can you clarify the reporting period dates? Document states April 1, 2016- December 31, 2017**
  - A: The Denominator – Baseline Report period for this metric is April 1, 2016 – December 31, 2017. This metric concerns contacting patients after new prescriptions. For this and similar metrics, the period of time covered in the Baseline Denominator ends before the beginning of the contract period (April 1st), so as to allow for sufficient time to complete the contact.
- BH-9 **Q: Are behavioral health outpatient providers that are part of a clinic, but sitting at a PCP site, eligible for this PxM?**
  - A: Please see the Applicable Provider Types section of the BHNNY Measure Specification & Improvement Resource Guide. It includes and defines the different provider types eligible for each metric.

Metric 12

- BH-10 **Q: Our Excel template includes sheets for PxM12b, but this is listed neither on the Contracted Measures tab nor the contract itself- is it something we need to do?**
  - Metric 12 has two options to choose to complete, and partners can only complete one of these options: 12a or 12b. The primary difference in these two options is that the data is drawn from different data sources: Partner EMR or PSYCKES. However, primary care and pediatric sites, such as your own, do not have access to the PSYCKES database, and so must select 12a (Partner EMR). Behavioral Health sites, on the other hand, might have access to both sources, and so could choose which to use.

Metric 13

- BH-11 **Q: Can you clarify the reporting period? Document states April 1, 2016-February 28, 2018.**
  - A: The Denominator – Baseline Report period for this metric is April 1, 2016 – February 28, 2018. This metric concerns follow-up appointments after new prescriptions. For this and similar metrics, the period of time covered in the Baseline Denominator ends before the beginning of the contract period (April 1st), so as to allow for sufficient time to complete the follow-up care.

Metric 15

- BH-12 **Q: Is there a certain age range required for this data?**
  - A: The related HEDIS quality metric includes patients ages six and older.

- BH-13 **Q: How is a care manager being defined?**
  - A: We defer to partners to define who falls into this category at their organization.

Metric 17

- BH-14 **Q: This is for patients 18+, are pediatricians not eligible?**
  - A: Pediatricians are eligible to report PxM_17.

Metric 20

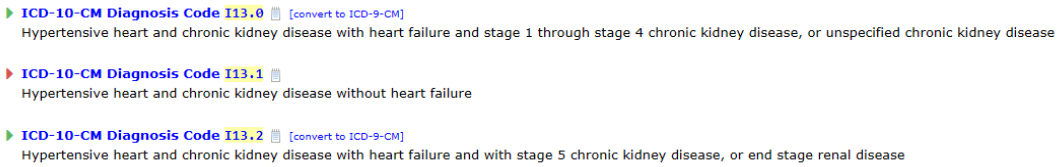
- BH-15 **Q: Can you clarify primary care service?**
  - A: Please see the BHNNY Measure Specification & Improvement Resource Guide for the visit codes that are applicable to individual metrics.

Metric 23

- **BH-16 Q: Would partner be eligible if previously OMH- and OASAS-licensed, but they now provide SUD under OMH?**
    - A: Please see the BHNNY Measure Specification & Improvement Resource Guide for clarification.

Metric 37

- **BH-17 Q: I am not so sure how to interpret the details in the BHNNY Measure Specification & Improvement Resource Guide. For example, I1310 is a requirement. Looking in the government site we have the following:**



    - A: The ICD 10 codes available in the BHNNY Measure Specification & Improvement Resource Guide come directly from the AHRQ Quality Indicators ICD 10-CM/PCS Specification version 7.0. All of the PQI/PDI measures are consistent with the AHRQ measure specifications guide. We have not deleted or added any new ICD10 codes. Please only use what is identified in the BHNNY Measure Specification & Improvement Resource Guide for reporting.