As outlined in CBH Provider Bulletins 25-17 and 25-26, CBH is required to implement the statewide OMHSAS *Performance Improvement Project (PIP) to Improve Suicide Prevention and Community Resilience*. As outlined in the CBH HL7 Submission Guide and explained in the August 18, 2025, provider training, providers will be submitting responses to various screening tools using an HL7 messaging standard related to the following HEDIS® measures:

- Social Needs Screening and Intervention (SNS-E)
- Depression Screening and Follow-up (DSF-E)
- Depression Remission or Response (DRR-E)
- Postpartum Depression Screening and Follow-up (PDS-E)

Additional suicide screening results will be submitted via claims data, as outlined in CBH Provider Bulletin 25-23. Suicide screening results will be utilized for the MIPS Clinical Quality Measure #504: Initiation, Review, and/or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, or Suicide Risk.

The following Frequently Asked Questions (FAQ) were pulled from the HL7 Provider Training and follow-up emails:

1. PROVIDER PARTICIPATION

1. **Can a provider "opt out" if implementation is prohibitively expensive (to get their electronic health record (EHR) to accommodate the need for vendor development) or if the provider does not have an EHR?**

   Providers are not able to opt out. Providers should submit their compliance plan, including a timeline, to CBH.PIP@phila.gov.

2. **Is CBH offering a financial incentive to ensure the current EHR has the required screenings and HL7 capabilities? Can we bill to administer the screening tools and data input into the EHR?**

   At this time, CBH is not offering any financial incentives for this requirement, and billing for administration and data input is not allowed. Completion of the screening is not a standalone billing service. As the tools are meant to be hardcoded into the electronic health record and mapped on the backend to the appropriate codes, providers should work with vendors and internally to develop workflows to complete the tools with members as part of the clinical appointment.

3. **ICWC already submits HEDIS and SDOH data to the state. Will they be expected to comply with this duplicative reporting requirement? Just FYI, OMHSAS told ICWCs and CCBHCs at a provider meeting that SNOMED/LOINC/HL7 wouldn't be implemented sooner than 2026.**

   The state processes for ICWCs, CCBHCs, and the PIP have different requirements. CBH does not receive the data submitted to the state by ICWCs. This data will need to be reported to CBH via the requirements outlined in the HL7 Submission Guide.

2. HL7 DATA SUBMISSION REQUIREMENTS

1. **For some agencies, staffing challenges are real. Was this taken into consideration for this requirement? If so, what are the measures by CBH and the State to address current staffing issues that may prevent agencies from completing this requirement?**

   While we understand some agencies continue to have staffing challenges, completing screening tools is a standard part of behavioral health treatment delivery and should be completed as part of the treatment session.

2. **Has there been an effort by CBH to connect with providers of all types, service levels, etc., to find out what EHRs and systems are used throughout the network to assess this from a technical and billing perspective, and how certain LOCs are already reporting on these metrics? Many are not set up with LOINC codes, SNOMED, or, at the least, ways to automatically pull correct ones into visit types, F codes, CPT, or E&M codes (for those to which that's relevant). What was that assessment process like, beyond the survey sent out via Provider News Blasts?**

   As outlined in CBH Bulletins 25-17 and 25-26, the HEDIS measures are required by OMHSAS for the statewide PIP. CBH has been sharing information about the PIP with stakeholder groups such as the Provider Advisory Committee (PAC) and executive directors, and at individual provider meetings. Published on April 28, 2025, CBH Bulletin 25-17 offered opportunities to complete a root cause analysis around barriers related to the screening tools and a provider readiness survey around HL7 requirements and capabilities. Survey results from the provider readiness survey indicated that some providers already utilize the LOINC and SNOMED codes and share this information with other payors. CBH has compared the survey results to all EHR types. A majority of providers indicated they would be able to comply within a few months.

3. **For providers operating in multiple counties, have the BH-MCOs made any efforts to align their approach to meeting the PIP requirements?**

   CBH has been working with other BH-MCOs in the state to share information and work to align the approach when possible.

4. **If you are looking for readiness, then why the expectation of dates for completing this?**

   CBH is required to submit the PIP proposal on September 30, 2025. It is also required to include baseline data for the previously discussed HEDIS measures, which is why the start date is set for

September 2, 2025. Some providers completed the readiness survey, indicating they already have the capacity and/or have already submitted this information for other payers. If you don't have the capacity, see the comment below around provider participation expectations.

5. **Why would clinical spaces that do not offer case management services be responsible for interventions for SNS-E?**

   Addressing health-related social needs is a priority of *Healthy People 2030* and of the OMHSAS PIP. As stated in CBH Bulletin 18-15, Social Determinants of Health (SDOH) contribute to overall outcomes of care at a disproportionate rate, and the process for assessing z-codes for SDOH has been a requirement since 2018. Completing the screening tools for the SNS-E measure ensures that members' needs are captured and addressed. Addressing these needs can improve the member's experience, reduce healthcare costs, and help the member achieve better overall health. Providers will be responsible for sharing referral resources related to food, housing, and transportation. This will be documented in the clinical record. The referrals will be mapped to the corresponding SNOMED codes and submitted via the instructions in the HL7 Submission Guide.

6. **Will this requirement be the subject of future audits? If so, what would be the penalty for not reporting this data on time?**

   At this time, we do not plan to conduct formal audits. However, CBH staff will reach out to providers who have not submitted the data and have not submitted their timeline and plan for compliance. As previously shared, the start date begins on September 2, 2025. For those who have barriers, please submit a plan for compliance to **CBH.PIP@phila.gov**.

7. **If a CBH member completes a screening with their medical provider and I can pull those results, will I be required to complete a new screening and submit the results?**

   If a member has a screening completed within the past calendar year as part of a shared record system, the screening results should be documented in the chart. If the provider is able to submit the results and required information in the HL7 format, CBH will accept the screening results. Providers should make a clinical judgment as to whether or not the situation has changed for the member, and a new screening should be completed.

8. **How often do you expect the HL7 files to be uploaded? Weekly, monthly?**

   The frequency of HL7 files can be uploaded at the provider's convenience (e.g., daily, weekly, monthly). All information must be submitted within 90 days of the service date.

3. ELECTRONIC HEALTH RECORD SYSTEMS

1. **Is CBH requiring an update to your EHR system?**

   To meet the requirements of the HL7 Submission Guide and CBH Bulletin 25-26, providers will need to ensure that electronic health record systems contain the required screening tools and can produce an HL7 Version 2.5.1 ORU^R01 message version, in accordance with the HL7

Implementation Guide. Vendor assistance may be necessary to understand what is currently available and/or what changes/updates will be needed for your EHR system.

4. TECHNICAL OPERATIONS

1. **You mention zipping the file and renaming it to an HL7 file. Is that naming the text file inside to HL7 or the zip file itself?**

   A compressed file in zip format (i.e., zip file) must have an extension of ".zip". The uncompressed file (i.e., HL7 file) must have an extension ".HL7". The names of the compressed file and the uncompressed file should be the same as identified by the guide (e.g., par_xxxx_mmddyyyy)

2. **Will a companion guide be released for the HL7?**

   The HL7 Submission guide was shared on 8/1 and is currently available on the CBH website under the Provider Bulletin section.

3. **What happens when the decision points are not 'positive', as in the flow diagram?**

   In the example of the SNS screening tools (AHC_HRSN and PRAPARE), an intervention would not be indicated if the individual does not screen positive for a social need. In this instance, CBH expects you to only send the appropriate LOINC code response to the question. All responses should be submitted using the SNS screening tools, even the questions that do not have a "referral intervention SNOMED code."

4. **Does Find Help automatically map for referral interventions?**

   Our current understanding is that Find Help does not map the SNOMED codes for referral interventions.

5. **If we only use the Converter currently, will we have to get set up and learn Ipswitch?**

   Currently, we are only supporting receiving HL7 files via Ipswitch.

6. **Is there a "backup" way to submit, and how will CBH assist providers in this situation? Is it possible for CBH to put the screenings on their portal so we can complete them with families and have them auto-submit to CBH?**

   CBH is evaluating whether this is possible. However, at this time, there is not a "backup" way to submit this information. Providers should submit their plan for compliance, including a timeline, to **CBH.PIP@phila.gov**.

7. **How do we request tech assistance? Can CBH help providers connect with others who use the same EHR?**

   Please review the bulletins, HL7 Submission Guide, and this FAQ. If providers have additional questions not addressed, they can email **CBH.PIP@phila.gov.** We will hold group sessions with providers utilizing the same EHR as needed.

8. **How do you submit the date of the referral on this at the same time as submitting the SDOH information and claim data all at the same time?**

   The referral information exists in the OBX segment of the HL7 document. The date and time of the referral will be listed in the OBX.14 field.

9. **Why are you stressing LOINC codes when an LLM can easily run and extract? There are no LOINC ways in systems that do not accommodate. I need authorization for LLM extraction direct into HEDIS HL7. LOINC is an outdated hard code. LLM will get ready immediately and validate data H7.**

   LOINC codes are required for the HEDIS measures. There are currently no other options.

10. **Is patient data going to be deidentified? Or are we submitting patient PHI and clinical data to the state? If we share specific patient data and private health information that will be shared outside of CBH, are we expecting patients to consent to signing a specific release for their information to sit in a database? What if a patient does not consent?**

    Individual patient PHI and clinical data are not being submitted to the state. Patient data will be submitted to CBH as HIPAA allows and utilized to create aggregate HEDIS rates. Aggregate HEDIS rates will be submitted to the state. Patients will not need to consent to share this data.

11. **I anticipate many of my patients will express concern about their protected mental health information being collected by the city or state, due to fear of termination of treatment (related to gender identity and sexuality) or fear of forced hospitalization. What if patients refuse to complete screening tools?**

    The patient has the right to refuse. Completion of the screening tools is not required to receive treatment.

12. **Can a sample submission file with test patient date be provided?**

    Example files can be found throughout the HL7 Submission Guide.

13. **How will the follow-up be submitted to CBH?**

    Follow-up encounters or medication management for depression and postpartum depression screenings will be identified through claims visits. Best practices for follow-up can be found in the depression screening and postpartum depression guides.

Follow-up referrals/interventions for positive social needs screening are submitted via the SNOMED codes outlined in Attachment C of the HL7 Submission Guide. The guide outlines the process for submitting these codes.

5. SCREENING TOOLS

1. **Do we need to use the mentioned screeners, or can we use other alternative screeners that may measure the same construct?**

   The HEDIS measures require the use of certain screeners, so the required screener must be utilized. If a different screener is accepted by HEDIS but not in the bulletin, please contact CBH.PIP@phila.gov for further discussion.

2. **Our EHR uses a screener that gives PHQ-2 first and then expands to PHQ-9 only if the PHQ-2 is positive. Would all the negative PHQ-2s not count as depression screening for the DSF-E measure since only PHQ-9 was listed for it on a previous slide? We are using the PHQ-A for ages 12-17, which is more appropriate for this age range. Is that allowed, or must it be the PHQ-9 even if it's less appropriate?**

   Providers may use a PHQ-2 for the DSF-E screening and LOINC code 56758-7 with a total score. However, positive screenings must use a PHQ-9 in addition. Providers may opt to use a PHQ-9M for adolescents ages 12-17 and LOINC code 89204-2 with the total score. The PHQ-9 or PHQ-9M are the only allowable tools by the DRR-E HEDIS measure.

3. **Any action from the state or CBH for people with depression challenges? Is this just a reporting requirement? If so, with what end?**

   Data collected in this reporting requirement will be utilized to develop system, provider, and member-specific interventions to address depression and other measure requirements. Improving the health of Philadelphians is the priority.

4. **Is this applicable to members who use Modivcare transportation and also meet other requirements?**

   Yes! Even if a member does not have apparent SDOH needs, the purpose is to assess individuals at least annually, as their situations may change.

5. **When can we expect CBH to release a list of referral options we can provide clients for food, housing, transportation needs, etc., that those of us who are not case management can provide?**

   DBHIDS has an extensive webpage with SDOH resource packets.

6. **Are the screeners intended to be used as measurement tools of clinician effectiveness and/or qualification for treatment? Will CBH/OMHSAS indicate/dictate treatment/intervention based on clients' assessment scores?**

   Not at this time.

5.1. Clinical Workflow Questions

7. **Will CBH provide providers with clinical training? When are measures expected to be administered? How frequently? With which services/CPT codes? Will there be a clinical meeting to review the clinical process of care and required follow-up? How would depression screening apply to youth who are non-speaking, non-reading, and not yet able to comprehend the questions being asked (We provide ABA to autistic youth)?**

   The use of screening tools for depression, postpartum depression, and suicide screening must be clinically relevant. CBH will be publishing program guides for depression (ages 12 and over) and postpartum depression screenings, which address resources for training and provide guidance on frequency and modality of screenings.

   The HEDIS measures do not require that the screenings be completed during specific health encounters. Follow-up care will be submitted via claims, and a list of CPT codes that meet follow-up care will be attached to the depression and postpartum depression screening guides. Additional information around suicide screening will be forthcoming in clinical practice guidelines.

8. **We currently use the MFQ. Will this fit? Several of our units currently utilize the BASIS-24 as an Evidence-Based Assessment EBA. This tool provides additional insights and subscores beyond what the PHQ-9 offers. Could you please confirm whether the BASIS-24 will be accepted in lieu of the PHQ-9?**

   Currently, the MFQ and BASIS-24 tools for the DSF-E HEDIS measure are not allowed.

5.2. Social Determinants of Health (SDOH) Workflow Questions

9. **Why are we switching to a new SDOH? We were using the Arizona before, and it's working fine.**

   Currently, Arizona is not an allowed tool for the SNS-E HEDIS measure.

10. **We treat youth in placement and often don't have contact with their parents or guardians. How are we supposed to use the social determinants tool?**

    The tools should be completed as part of your treatment sessions.

11. **Does the HRSN need to be the longer version (26 questions) or can we use the shorter version (10 questions)?**

    The PRAPARE or AHC HRSN should be completed annually and is required for all CBH members. For youth under 18, the AHRC HRSN can be used for children under 18 by a parent or caregiver, and we are not collecting the supplemental questions. The 10 questions are sufficient and are outlined in Attachment B of the HL7 submission guide. HealthCenters has modified the PRAPARE tool to engage family members. See the **PRAPARE Frequently Asked Questions page** and **Compass Community Health's implementation explainer** to learn more about how to modify the PRAPARE tool for youth.

    Utilize the resources in Bulletin 25-26 to train staff on administering the SDOH screening tool.

12. **Additionally, our facility has integrated the HealthLeads SDOH screening tool into our EMR. Can you confirm if this tool meets the requirements outlined in the bulletin?**

    The HealthLeads SDOH tool is acceptable for the SNS-E HEDIS measure. Appropriate LOINC codes will be added to the HL7 Submission Guide.

6. SUICIDE SCREENINGS AND SUBMISSION OF M CODES

1. **Would we be expected to submit multiple codes within the same encounter (e.g., screening for suicide AND individual reports SI)?**

    Yes. It is possible to submit more than one code at a time. For example, code M1352 for suicidal ideation may be submitted at the same time as M1350 for completion of a suicide safety plan within 24 hours of the index clinical encounter.

2. **In light of the HL7 submission requirement and since there is overlap between G and M code reporting and some HL7 data reporting, should we move forward with submitting G and M codes? While we have built a process to report the codes, we would like clear guidance so we don't take time away from service provision to build and implement a system that will soon be replaced.**

    Yes, they are two separate processes and are required for different purposes. The G Code submission is required for the Core Data Set. Providers should continue to submit the G codes in their claims submissions with encounter data. The HL7 data requires the "total score" for the depression screening, which cannot be obtained via G codes. The M codes do not overlap with HL7. All M codes should be submitted with the claims submission and are not to be submitted via HL7.

3. **If we have to use the C-SSRS, which one should we use? The screener, recent since last visit, or full version?**

    The Suicide Safety Plan Codes (M Codes M1350-56) will be used to run MIPS #504 measure (Initiation, Review, and/or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, or Suicide Risk) as part of the OMHSAS-required PIP.

MIPS specifications indicate that the C-SSRS "Screen Version" can be used to screen for suicidal ideation and/or behavior symptoms. C-SSRS "Lifetime/Recent" can be used to assess for risk level. MIPS also allows for the use of other standardized assessment tools to assess suicidal ideation/behavior/risk level (e.g., PHQ-9 item 9, SAFE-T Protocol), as well as clinician clinical judgement.

CBH is open to providers choosing the version most clinically appropriate for the population served. Various versions of the C-SSRS are available for different levels of care or different care transitions. Providers can also use other structured, evidence-based tools such as the ASQ.