Technical Specifications for the MassHealth Community Behavioral Health Center (CBHC) Clinical Quality Incentive (CCQI) Program

Performance Year 2 (Calendar Year 2025)

Version: March 2025

CCQI Performance Year 2 Technical Specifications

A. Access Standards

OVERVIEW	
Measure Name	Access Standards – CBHC
Steward	EOHHS
NQF Number	N/A
Data Source	Numerator source: CBHC Visit and Demographics Data File Denominator source: CBHC Visit and Demographics Data File
PY 2 Performance Status	Pay-for-Performance

POPULATION HEALTH IMPACT

Timely access to behavioral health care is essential to improving behavioral health outcomes, especially among vulnerable populations.

MEASURE SUMMARY

Description	This measure assesses timely access to behavioral health services for members experiencing a behavioral health crisis with an urgent or immediate care need by looking at the percentage of new patients (new to qualifying visits) that received an appointment for a qualifying CBHC visit within a specified timeframe.
	This measure includes six sub-measures for each qualifying CBHC visit type, defined as follows:
	Qualifying Visit Type 1 – CBHC Bundle Services: - MOUD: MOUD induction appointment within 24 hours of a qualifying triage - Urgent appointment: Urgent appointment within 48 hours of a qualifying triage - Urgent Psychopharmacology appointment: Urgent psychopharmacology appointment within 72 hours of a qualifying triage

	• Non-Urgent appointment: Non-urgent appointment within 14 calendar days of a qualifying triage The four appointments falling under Qualifying Visit Type 1 are select CBHC Bundle Services appropriate for new patients. **Qualifying Visit Type 2 - Mobile Crisis Intervention:** • Adult MCI: Adult Mobile Crisis Intervention within 60 minutes from MCI time of readiness. • Youth MCI: Youth Mobile Crisis Intervention within 60 minutes of MCI time of readiness.
Numerator	The number of new patients that have a qualifying triage to a CBHC Bundle service or an MCI evaluation at a given CBHC and completed the qualifying visit within the specified timeframe.

Denominator	The eligible population for each denominator are members who had a qualifying triage to the 6 Qualifying CBHC Visit Types:
	
	• CBHC Bundled Services
	    ○ MOUD
	    ○ Urgent appointment
	    ○ Urgent Psychopharmacology appointment
	    ○ Non-Urgent appointment
	
	• MCI
	    ○ Adult MCI
	    ○ Youth MCI

ELIGIBLE POPULATION

Age	MassHealth members of any age
Continuous Enrollment Date	None
Allowable Gap	None
Anchor Date	None
Event/Diagnosis	• A qualifying triage for a patient through the CBHC between January 1 and on or before December 17 of the measurement year. Note: The initial 90-day lookback period to identify eligible patients should begin 90 days prior to the first day of the measurement year between October 3 to December 31 of the previous year.

	PY2 Initial 90-Day Lookback Reporting Exemption: While this will be required for subsequent performance years, CBHCs are exempt from reporting for the initial 90-day lookback period in PY2 2025. • See Attachment 1 describing EHR time stamps to be utilized for identifying CBHC Bundle Service visits and MCI evaluations.

DEFINITIONS

CBHC TIN	CBHC Tax ID Number (TIN)
CBHC TIN-Billing Entity	The entity representing the overall CBHC organization encompassed under a CBHC TIN as reported in claims. In the case of multiple CBHC sites, all respective sites fall under a single TIN-billing entity.
CBHC PID/SL	MassHealth Provider ID/ Service Location (PID/SL). Each provider's NPI is stored in MassHealth's Medicaid Management Information System (MMIS) with a corresponding MassHealth provider ID and service location (PID/SL). This PID/ SL is 10 characters, made up of a 9-digit base number and an alpha service location letter (e.g., 123456789A). For the Access Standards measure only, CBHCs are required to report at the PID/SL level for each CBHC site.
New Patients	Defined as a MassHealth member **that did not receive** any of the 6 qualifying visits (a billable MCI or Bundle Service) at the CBHC within the previous 90 days of the appointment scheduled on the qualifying triage date. Members who have had one of the 6 qualifying services in the previous 90 days of the appointment scheduled are not considered new. (See below for definition of a "Qualifying CBHC Visit"). *Notes:* • *The Qualifying CBHC visit must be at the CBHC performing the triage. Patients who only had any of the 6 qualifying CBHC visits within the previous 90 days at a different CBHC site (at the PIDSL level) may be considered new.* • *A patient is still considered new to qualifying CBHC visits if they only had non-qualifying services (e.g. peer support services) in the last 90 days.* • *If a patient was previously triaged at initial contact to a billable CBHC Bundle Service but declined or did not receive said CBHC Bundle Service, they are still considered a new patient.* • *A patient is considered a new patient if they have only non-billable encounters (such as phone calls or conversations or brief notes not attached to a billable encounter) in the previous 90 days.*

Qualifying Triage	The event that enters the Member into the measure population. Defined as a triage with a scheduled appointment or open access referral to one of the 6 Qualifying CBHC Visit types. A triage includes the following steps: The patient (or family or guardian if the patient is a child or has a guardian) is: 1.) Experiencing a behavioral health crisis or has an acute care need; 2.) Contacts the CBHC to obtain services; 3.) Is triaged to **a Qualifying CBHC service** with a scheduled appointment (note: the appointment may be scheduled through Open Access). Please note, the service the patient is triaged to **must be one of the 6 Qualifying CBHC Visit types** *(see definitions below for Qualifying CBHC Visit)*. Contact is defined as a phone call to a CBHC, a walk-in or a crisis service provided by the CBHC. (This definition is consistent with that used for SAMHSA's CCBHC quality measures.) Note: Triage refers to a collaborative process in which the patient and provider work together to identify the most clinically appropriate appointment by factoring in the patient's preference.

Qualifying CBHC Visit	Any of the 4 CBHC Bundled Service types or the 2 MCI visits that the patient is triaged to:
	
	• CBHC Bundled Services
	    o MOUD
	    o Urgent appointment
	    o Urgent Psychopharmacology appointment
	    o Non-Urgent appointment
	
	• MCI
	    o Adult MCI
	    o Youth MCI
	
	Please refer to the "MCI and CBHC Bundle Services Definitions" for further details on the service and modifier codes for billable bundled service and MCI visits.

MCI and CBHC Bundle Services Definitions	Mobile Crisis Intervention (MCI) services are a diversionary level of care defined by the following service/encounter codes: • MCI S code per diem only (Note: Do NOT use H code for MCI 15 min):

	• Adult MCI per diem at CBHC site: S9485 with HE modifier only • Youth MCI per diem at CBHC site: S9485 with HA, HE modifiers The following modifiers are for MCI per diem S code: • HA = Youth modifier (youth client seen); may occur in combination with HE or U1 • HE = Services provided at CBHC site • U1 = Services provided at community-based sites of service outside of the CBHC site • ET is not relevant for this service CBHC Bundle services are behavioral health outpatient services and are defined as follows: • CBHC Bundle services: T1040 HA or HB The modifier codes attached to the T1040 code are required and defined as follows: • HA = Youth modifier (youth client seen), or • HB = Adult modifier (adult client seen)
MCI Time of Readiness	For patients who are triaged to an MCI Evaluation only, the time when the patient is determined "ready" to enter treatment after a qualifying triage. For MCI evaluation, timely access is determined by the "time of readiness" indicated by the patient after a qualifying triage.
Data Elements for Reporting	File Name: CBHC Visit and Demographics Data File (VDDF) Description: Encounter or visit-level file sent by the CBHC to MassHealth. EOHHS will provide a separate Submission Guide detailing the submission process and the elements that will be used to calculate the measure.
Measurement Year	Performance (or Measurement) Years 1-5 correspond to Calendar Years 2024-2028
Members	Individuals enrolled in MassHealth including: ACPP ACO, PC ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited)
Rate of Timely Access	There will be seven rates reported for this measure. MOUD: Numerator 1 Population / Denominator 1 Population * 100 Urgent Appointment: (Numerator 2 Population / Denominator 2 Population) * 100

	Urgent Psychopharmacology Appointment:
	(Numerator 3 Population / Denominator 3 Population) * 100
	Non-Urgent Appointment: (Numerator 4 Population / Denominator 4 Population) * 100
	Adult MCI: (Numerator 5 Population / Denominator 5 Population) * 100
	Youth MCI: (Numerator 6 Population / Denominator 6 Population) * 100
	Overall Rate of Timely Access (Aggregate):
	(All Numerator Populations / All Denominator Populations) * 100 The aggregate measure combines the four CBHC Bundle Services and two MCI populations to calculate the overall rate of timely access.

ADMINISTRATIVE SPECIFICATION

Denominator	There are seven denominators for this measure: **Denominator 1 (MOUD):** The number of new patients among MassHealth members who had a qualifying triage with a CBHC to Bundle services for MOUD induction appointments through the CBHC. **Denominator 2 (Urgent appointment):** The number of new patients among MassHealth members who had a qualifying triage with a CBHC to Bundle services for urgent appointments through the CBHC. **Denominator 3 (Urgent Psychopharmacology appointment):** The number of new patients among MassHealth members who had a qualifying triage with a CBHC to Bundle services for urgent psychopharmacology appointments through the CBHC. **Denominator 4 (Non-Urgent appointment):** The number of new patients among MassHealth members who had a qualifying triage with a CBHC to Bundle services for non-urgent appointments through the CBHC. **Denominator 5 (Adult MCI):** The number of new patients among MassHealth members who had a qualifying triage with

|	a CBHC to adult MCI evaluation through the CBHC.
	Denominator 6 (Youth MCI): The number of new patients among MassHealth members who had a qualifying triage with a CBHC to youth MCI evaluation through the CBHC.
	Denominator 7 (Aggregate): The number of new patients among MassHealth members who had a qualifying triage with a CBHC to at least one of the 6 qualifying visit types.
Numerator	There are seven numerators for this measure: **Numerator 1 (MOUD):** The number of new patients among MassHealth members with a qualifying triage to a CBHC Bundle services for MOUD induction appointments through the CBHC <u>and</u> received those services within the specified timeframe from time of qualifying triage. **Numerator 2 (Urgent appointment):** The number of new patients among MassHealth members with a qualifying triage to a CBHC Bundle services for urgent appointments through the CBHC <u>and</u> received those services within the specified timeframe from time of qualifying triage. **Numerator 3 (Urgent Psychopharmacology appointment):** The number of new patients among MassHealth members with a qualifying triage to a CBHC Bundle services for urgent psychopharmacology appointments through the CBHC <u>and</u> received those services within the specified timeframe from time of qualifying triage. **Numerator 4 (Non-Urgent appointment):** The number of new patients among MassHealth members with a qualifying triage to a CBHC Bundle services for non-urgent appointments through the CBHC <u>and</u> received those services within the specified timeframe from time of qualifying triage. **Numerator 5 (Adult MCI):** The number of new patients among MassHealth members with a qualifying triage to a CBHC for adult MCI evaluation through the CBHC <u>and</u> received those services within the specified timeframe from MCI time of readiness. **Numerator 6 (Youth MCI):** The number of new patients among MassHealth members with a qualifying triage to a CBHC to youth MCI evaluation through

	the CBHC <u>and</u> received those services within the specified timeframe from MCI time of readiness. **Numerator 7 (Aggregate):** The number of new patients among MassHealth members who had a qualifying triage with a CBHC to at least one of the 6 qualifying visits through the CBHC <u>and</u> received those services within the specified timeframe.
Exclusions	• Patients who are referred to a different CBHC, to a non-CBHC service, or to any service that is not a Qualifying CBHC Visit Type (ex: routine outpatient, inpatient level of care, partial hospital program, etc.) at the qualifying triage are excluded from the measure. • Patients who are referred to a CBHC for a qualifying CBHC visit type, but subsequently *receive* a non-qualifying service are excluded from measure. Note: If a non-qualifying service occurred before the qualifying visit scheduled at qualifying triage occurred, the qualifying visit would count towards the measure. • Patients who are triaged to a qualifying CBHC visit who subsequently receive a *different* qualifying CBHC visit type are excluded from the measure. (In other words, if the patient was triaged to a qualifying visit and receives another service type than what they were triaged to, the patient would be excluded from the measure.) • Patients who are triaged for an MCI evaluation that do not indicate time of readiness are excluded. • Patients who are triaged to an MCI evaluation that cancel, reschedule, or do not show for the scheduled evaluation indicated at time of readiness are excluded. • Patients who decline the appointment at triage are excluded.

SUBMISSION REQUIREMENTS FOR PY2

Performance Requirements	For the Access Standards measure in PY2, CBHCs are required to submit complete quarterly electronic health record data through the production-level MassHealth CBHC Visit and Demographics Data File (VDDF) to EOHHS on a quarterly

	basis. The production-level VDDF must include time-stamped, encounter and visit-level data for all eligible MassHealth patients.

EOHHS will provide a separate Submission Guide on the production-level VDDF detailing the submission process and data element requirements. |
| **Access Standards Calculations** | Performance rates for Access Standards will be calculated for each PID/SL site, each CBHC TIN-billing entity, and for all CBHC TIN-billing entities. |

Attachment 1: Specified Timeframes for the 6 Qualifying Visit Types
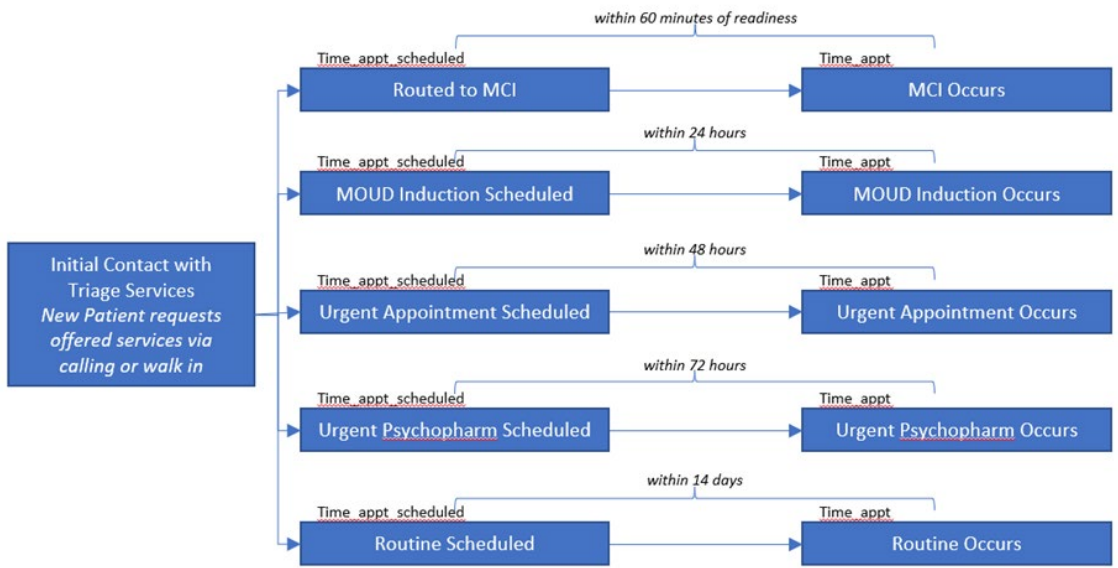
B. Follow-Up After Acute Behavioral Health Episode of Care

OVERVIEW

Measure Name	Follow-up after Acute BH Episode of Care – CBHC
Steward	EOHHS

NQF Number	N/A
Data Source	Numerator sources: MassHealth paid claims and paid encounter data
	Denominator sources: MassHealth paid claims and paid encounter data
PY 2 Performance Status	Pay-for-Performance

POPULATION HEALTH IMPACT

Members are at increased risk for poor outcomes after discharging from acute levels of behavioral health care. Timely connection to appropriate follow-up service is critically important to achieving better health outcomes for members who have experienced a behavioral health crisis.

MEASURE SUMMARY

Description	This measure assesses the proportion of <u>qualifying hospital encounters</u> that result in <u>a qualifying CBHC visit</u> within 7 days of discharge that occur at each CBHC. Rate is reported as aggregate and stratified by qualifying encounter type: • Acute Inpatient – Principal diagnosis of Mental Health; • Acute Inpatient – Principal diagnosis of Substance Use Disorder; • Emergency Department – Principal diagnosis of Mental Health; • Emergency Department – Principal diagnosis of Substance Use Disorder
Numerator	Members seen by a given CBHC with a qualifying CBHC visit (See definition of Qualifying CBHC Visit below) within a 7-day period of discharge from a qualifying encounter.
Denominator	The denominator includes all patients who meet the eligibility criteria. The denominator will be reported at the aggregate and will be stratified by qualifying encounter type: • Acute Inpatient– Principal diagnosis of Mental Health; • Acute Inpatient – Principal diagnosis of Substance Use Disorder; • Emergency Department – Principal diagnosis of Mental Health;

	• Emergency Department – Principal diagnosis of Substance Use Disorder;

ELIGIBLE POPULATION

Age	MassHealth members of any age
Continuous Enrollment Date	Enrolled at the time of the Qualifying Hospital Encounter and for 7 days after discharge
Allowable Gap	None
Anchor Date	None

Eligibility Criteria	Members will be included in the denominator if they have a qualifying hospital encounter **and** they receive a qualifying CBHC visit within 7 days of discharge. *(See definition of Qualifying Hospital Encounter below.)*
	
	Any qualifying hospital encounter that occurred AFTER December 24 of the measurement year will be EXCLUDED.
	
	Multiple Qualifying Hospital Encounters Prior to the Qualifying CBHC Visit:
	
	• If a patient has a Qualifying Hospital Encounter followed by a direct transfer or one or more discharges from another Qualifying Hospital Encounter within 7 days prior to or on the same day as the Qualifying CBHC Visit, only include the most recent (last) Qualifying Hospital Encounter in the denominator.
	
	Direct Transfers:
	○ A direct transfer is when the discharge date from the first Qualifying Hospital Encounter precedes the admission date to a second Qualifying Hospital Encounter by one calendar day or less. For example:
	  1. An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
	  2. An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
	  3. An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.
	• In the event of a qualifying hospital encounter with a direct transfer to a non-qualifying encounter, exclude both encounters.
	• In the case of a direct transfer, exclude both the initial discharge and the direct transfer if the last discharge occurs after December 24.
	
	Multiple Qualifying CBHC Visits in 7 Days with Same CBHC:

	In the event of multiple qualifying CBHC visits with the same CBHC within 7 days of discharge from a qualifying hospital encounter, only count the first CBHC visit in the numerator. **Multiple Qualifying CBHC Visits in 7 Days with Different CBHC:** In the event of multiple qualifying CBHC visits with different CBHCs within 7 days of discharge from a qualifying hospital encounter, the first qualifying CBHC visit from each CBHC within 7 days of the hospital encounter would count in the numerator.

Qualifying Hospital Encounter	• *Note*: This denominator is based on qualifying hospital encounters, not members. If a member has more than one qualifying hospital encounter, include all discharges that meet eligibility criteria.
	
	• **To identify a qualifying hospital encounter:**
	
	  1. <u>**Acute Inpatient – Mental Health:**</u> Patients who had an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm on the discharge claim on or between January 1 and December 24 of the measurement year. Please refer to "Mental Illness Value Set and Intentional Self-Harm Value Set".
	
	    ▪ Identify all acute and non-acute inpatient stays (Inpatient Stay Value Set)
	
	    ▪ Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
	
	    ▪ Identify the discharge date for the stay.
	
	  2. <u>**Emergency Department – Mental Health:**</u> An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 24 of the measurement year.
	
	  3. <u>**Emergency Department – Substance:**</u> An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 24 of the measurement year.
	
	  4. <u>**Acute Inpatient – Substance Use Disorder**</u>: An acute inpatient discharge, residential treatment (Residential Behavioral Health Treatment value set) or detoxification (Detoxification value set) event for a principal diagnosis of substance use disorder on or between January 1 and

December 24 of the measurement year. Any of the following code combinations meet criteria:

- An acute inpatient discharge or a residential behavioral health stay (Residential Behavioral Health Treatment value set) with a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set) on the discharge claim. To identify acute inpatient discharges:

    a. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    b. Exclude nonacute inpatient stays other than behavioral health (Nonacute Inpatient Stay Other Than Behavioral Health Accommodations Value Set).
    c. Identify the discharge date for the stay.

DEFINITIONS

Qualifying Hospital Encounter	An encounter with an acute inpatient psychiatric facility, emergency department, or acute inpatient hospital with the required Principal diagnosis. Qualifying encounter types include: • Acute Inpatient – Principal diagnosis of Mental Health, • Acute Inpatient – Principal diagnosis of Substance Use, • Emergency Department – Principal diagnosis of Mental Health, • Emergency Department – Principal diagnosis of Substance Use

MCI, CCS, and CBHC Bundle Services	Mobile Crisis Intervention (MCI) services are a diversionary level of care defined by the following service codes:
	
	1.) MCI Evaluations (per diem) S code:
	    • MCI per diem for adult by CBHC: S9485 HE or U1
	    • MCI per diem for youth by CBHC: S9485, HA and HE or U1
	
	2.) MCI Follow-up Interventions (per 15 min) H code:
	    • MCI per 15 min for adult by CBHC: H2011 HB with either HN or HO required.
	    • MCI per 15 min for youth by CBHC: H2011 HA with either HN or HO required.
	
	MCI per diem codes correspond to MCI evaluations.

	MCI per 15 min codes correspond to MCI follow-up interventions. The following modifiers are for MCI Evaluations per diem S-code S9485: • HE = Services provided at CBHC site • U1 = Services provided at community-based sites of service outside of the CBHC site • HA = Youth modifier (youth client seen); may occur in combination with HE or U1 • ET is not relevant for this service The following modifiers are required for MCI Follow-up Interventions per 15 min H-code H2011: • HN = Paraprofessional seen • HO = Master's level clinician seen • HA = Youth modifier (youth client seen) • HB = Adult modifier (adult client seen) Community Crisis Stabilization (CCS) services are a 24-hour diversionary level of care defined by the following service codes: **CCS services (per diem) S code:** • CCS (per diem) for adult: S9485-ET • CCS (per diem) for youth: S9485-HA, ET The modifier codes attached to CCS codes are defined as follows: • ET = modifier indicating CCS service in conjunction with S9485 code; required for this service • HA = youth modifier (youth client seen); if not present, an adult client was seen CBHC Bundle Services are behavioral health outpatient services and are defined as follows: • CBHC Bundle Services: T1040 HA or HB The modifier codes attached to the T1040 code are required and defined as follows: • HA = Youth modifier (youth client seen), or • HB = Adult modifier (adult client seen)
Qualifying CBHC Visit	A visit with a CBHC provider with a CBHC Bundle, MCI Service, or CCS Service within 7 days of the qualifying encounter discharge. (See Definition of MCI, CCS, and CBHC Bundle Services)
Acute Inpatient Discharges	Discharges for a primary mental health or SUD diagnosis from any in-state acute inpatient hospital including those with psychiatric units and freestanding psychiatric hospitals.

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Data Elements for Reporting	Data elements that will be collected from claims data: • Measurement Period: Calendar Year • Eligible Population by each population. • Numerator events by each population. • Measure rate by each population.
Measurement Years	Performance (or Measurement) Years 1-5 correspond to Calendar Years 2024-2028
Members	Individuals enrolled in MassHealth including: ACPP ACO, PC ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited)
Access to Timely Follow-up	The proportion of qualifying encounters with a qualifying CBHC visit within 7 days of discharge that occur at each CBHC. There will be five proportions reported for this measure for each CBHC. Each proportion represents the percentage of the denominator who had a qualifying CBHC visit at each CBHC. (Numerator 1 Population / Denominator 1 Population) (Numerator 2 Population / Denominator 2 Population) (Numerator 3 Population / Denominator 3 Population) (Numerator 4 Population / Denominator 4 Population) Aggregate Measure: (Numerators 1-4 Populations / Denominators 1-4 Populations) The aggregate measure combines the populations for Numerators 1-4, and separately the populations for Denominators 1-4, to calculate the aggregate percentage of total timely qualifying CBHC follow-up visits provided by a CBHC for all qualifying encounter types.
Data Collection	CBHCs will not report data for this claims-based measure. The numerator and denominator will be calculated by MassHealth's comprehensive quality measure vendor (CQMV).

ADMINISTRATIVE SPECIFICATION

Denominator	The denominator for this measure is the total eligible MassHealth population with a qualifying hospital encounter and who had a qualifying CBHC visit within 7 days of discharge. The measure is reported at the aggregate and also stratified by qualifying encounter type for each CBHC: 1. Acute Inpatient hospitalization with a principal diagnosis of mental health. 2. Acute Inpatient hospitalization with a principal diagnosis of substance use disorder. 3. Emergency Department visit with a principal diagnosis of mental health

	4. Emergency Department visit with a principal diagnosis of substance use disorder 5. Aggregate of all qualifying encounters. There will be a total of 5 denominators for each CBHC in this measure.
Numerator	The numerator for the measure is the proportion of the denominator who had a qualifying CBHC visit with a specific CBHC. There will be a total of 5 numerators for each CBHC in this measure. **Numerator 1:** The eligible population for MassHealth members with an Acute Inpatient hospitalization for mental health as the qualifying hospital encounter type <u>and</u> a qualifying CBHC visit within 7-days of discharge. **Numerator 2:** The eligible population for MassHealth members with a previous Emergency Department encounter for mental health as the qualifying hospital encounter type <u>and</u> a qualifying CBHC visit within 7-days of discharge. **Numerator 3:** The eligible population for MassHealth members with a previous Emergency Department encounter for a substance use disorder as the qualifying encounter type <u>and</u> a qualifying CBHC visit within 7-days of discharge. **Numerator 4:** The eligible population for MassHealth members with a previous Acute Inpatient hospitalization for a substance use disorder as the qualifying encounter type <u>and</u> a qualifying CBHC visit within 7-days of discharge. **Numerator 5 (Aggregate):** The eligible population for MassHealth members with any of the 4 qualifying hospital encounters <u>and</u> who had a qualifying CBHC visit within 7-days of discharge.
Exclusions	None

ADDITIONAL MEASURE INFORMATION

Measure Calculations	The rates will be calculated as follows: • Follow-up visits at CBHCs will be calculated for each individual CBHC TIN-billing entity (a total of 20 entities) by each individual qualifying encounter type (total of 4

| | types), and for all qualifying encounter types (1 aggregate calculation). |
| | • Each sub-measure will be reported for each of the 20 CBHC TIN billing entities, NOT for each CBHC (PIDSL) level for CBHCs with more than one site that have a shared Tax ID Number (TIN). |

C. Readmission to Acute Behavioral Health Care

OVERVIEW

Measure Name	Readmission to Acute BH Care – CBHC
Steward	EOHHS
NQF Number	N/A
Data Source	Numerator sources: MassHealth paid claims and paid encounter data Denominator sources: MassHealth paid claims and paid encounter data
PY 2 Performance Status	Pay-for-Performance

POPULATION HEALTH IMPACT

Members are at increased risk for poor outcomes after being discharged from acute levels of behavioral health care. Timely provision of follow-up care is critically important to achieving better outcomes including reducing readmission to acute levels of care for members who have experienced a behavioral health crisis.

MEASURE SUMMARY

Description	This measure assesses the percentage of patients who have a qualifying encounter **and** who have a qualifying CBHC visit within 7 days of discharge from the qualifying encounter who subsequently readmit within 30 days of discharge from the qualifying encounter. This measure is stratified by the 4 qualifying encounter types: • Acute Inpatient – Principal diagnosis of Mental Health; • Acute Inpatient – Principal diagnosis of Substance Use Disorder; • Emergency Department – Principal diagnosis of Mental Health; • Emergency Department – Principal diagnosis of Substance

Numerator	Patients who had a qualifying CBHC visit within 7 days of discharge from a qualifying encounter who were subsequently readmitted to any qualifying encounter within 30 days of discharge. For example, if a patient was discharged from an Acute Inpatient qualifying encounter, and subsequently had a qualifying CBHC visit within 7 days, and then was readmitted within 30 days of their discharge from their first Acute Inpatient qualifying encounter to another Acute Inpatient qualifying encounter (or similar encounter), this event would count in the numerator.
Denominator	Patients who had a qualifying CBHC visit within 7 days of discharge from a qualifying encounter. The denominator is stratified by each qualifying encounter type: • Acute Inpatient – Mental Health • Acute Inpatient – Substance • Emergency Department – Mental Health • Emergency Department – Substance

ELIGIBLE POPULATION

Age	MassHealth members of any age
Continuous Enrollment Date	Enrolled at time of the "qualifying encounter" and for 30 days after discharge
Allowable Gap	None
Anchor Date	None
Eligibility Criteria	Members will be included in the denominator if they have a qualifying hospital encounter and they receive a qualifying CBHC visit within 7 days of discharge. (See definition of Qualifying Hospital Encounter below) Any qualifying hospital encounter that occurred AFTER December 1of the measurement year will be EXCLUDED. Direct Transfers: • In the event of a qualifying hospital encounter with a direct transfer to a qualifying hospital encounter, then only the last occurring event in this sequence would count as the qualifying hospital encounter. o A direct transfer is when the discharge date from the first qualifying hospital encounter precedes the admission date to a second qualifying hospital encounter by one calendar day or less. For example:

	o An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer. o An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer. o An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays. • In the event of a qualifying hospital encounter with a direct transfer to a non-qualifying encounter, exclude both encounters. • Exclude both the initial discharge and the direct transfer if the last discharge occurs after December 1. • If a patient has a Qualifying Hospital Encounter followed by one or more discharges from another Qualifying Hospital Encounter within 7 days prior to or on the same day as the Qualifying CBHC Visit, only include the most recent (last) Qualifying Hospital Encounter in the denominator. **Multiple Qualifying CBHC Visits within 7 Days of the Qualifying Encounter with Same CBHC:** In the event of multiple qualifying CBHC visits with the same CBHC within 7 days of discharge from a qualifying hospital encounter, only count the first CBHC visit in the denominator. **Multiple Qualifying CBHC Visits within 7 Days of the Qualifying Encounter with Different CBHC:** In the event of multiple qualifying CBHC visits with different CBHCs within 7 days of discharge from a qualifying hospital encounter, the first qualifying CBHC visit from each CBHC within 7 days of the hospital encounter would count in the denominator (for each CBHC rate). *Note: Only one CBHC visit from each CBHC would count in the aggregate rate.*
Eligible Qualifying Encounters	• *Note: This denominator is based on qualifying hospital encounters, not members. If a member has more than one qualifying hospital encounter, include all discharges that meet eligibility criteria.* **To identify a qualifying hospital encounter:** 1. **Acute Inpatient – Mental Health:** Patients who had an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm on the discharge claim on or between January 1 and December 1 of the measurement year. Please refer to "Mental Illness and Intentional Self-Harm Value Set".

	a. Identify all acute and non-acute inpatient stays (Inpatient Stay Value Set)
	b. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
	c. Identify the discharge date for the stay.

2. **Emergency Department – Mental Health:** An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness and Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year.
3. **Emergency Department – Substance:** An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the measurement year.
4. **Acute Inpatient – Substance Use Disorder**: An acute inpatient discharge, residential treatment (Residential Behavioral Health Treatment value set) or detoxification (Detoxification value set) event for a principal diagnosis of substance use disorder on or between January 1 and December 1 of the measurement year. Any of the following code combinations meet criteria:
    1. An acute inpatient discharge or a residential behavioral health stay with a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set) on the discharge claim. To identify acute inpatient discharges:
        1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
        2. Exclude nonacute inpatient stays other than behavioral health (Nonacute Inpatient Stay Other Than Behavioral Health Accommodations value set).
        3. Identify the discharge date for the stay.

DEFINITIONS

Data Collection	Claims capture by MassHealth
Qualifying Encounter	An encounter with an acute inpatient psychiatric facility, emergency department, or acute inpatient hospital with the required Principal diagnosis. Qualifying encounter types include:

	• Acute Inpatient – with Principal diagnosis of Mental Health, • Acute Inpatient – Principal diagnosis of Substance Use • Emergency Department – with Principal diagnosis of Mental Health, • Emergency Department – with Principal diagnosis of Substance Use
Qualifying CBHC Visit	A "Qualifying Visit" with a CBHC provider within 7 days of the qualifying encounter discharge. CBHC qualifying visits can be one of the following: CBHC Bundle services outpatient visit, MCI evaluation or follow-up, or CCS stay. (See Definition of MCI, CCS, and CBHC Bundle Services)
Acute Inpatient Discharges	Discharges for a primary mental health or SUD diagnosis from any in-state acute inpatient hospital including those with psychiatric units and freestanding psychiatric hospitals are included.

MCI, CCS, and CBHC Bundle Services Definitions	Mobile Crisis Intervention (MCI) services are a diversionary level of care falling under outpatient services defined by the following service codes:
	    1.) MCI Evaluations (per diem) S code:
	       • MCI per diem for adult by CBHC: S9485 HE or U1
	       • MCI per diem for youth by CBHC: S9485, HA and HE or U1
	
	    2.) MCI Follow-up Interventions (per 15 min) H code:
	       • MCI per 15 min for adult by CBHC: H2011 HB with either HN or HO required.
	       • MCI per 15 min for youth by CBHC: H2011 HA with either HN or HO required.
	
	MCI per diem codes correspond to MCI evaluations.
	MCI per 15 min codes correspond to MCI follow-up interventions.
	
	The following modifiers are for MCI per diem codes:
	• HA = Youth modifier (youth client seen); may occur in combination with HE or U1
	• HE = Services provided at CBHC site
	• U1 = Services provided at community-based sites of service outside of the CBHC site
	• ET is not relevant for this service
	
	The following modifiers are required for MCI per 15 min codes:
	• HN = Paraprofessional seen
	• HO = Master's level clinician seen
	• HA = Youth modifier (youth client seen)
	• HB = Adult modifier (adult client seen)

	Community Crisis Stabilization (CCS) services are a 24-hour diversionary level of care defined by the following service codes:
	• CCS (per diem): S9485-ET
	• CCS (per diem): S9485-HA, ET
	The modifier codes attached to CCS codes are defined as follows:
	• ET = modifier indicating CCS service in conjunction with S9485 code; required for this service
	• HA = youth modifier (youth client seen); if not present, an adult client was seen
	CBHC Bundle Services are behavioral health outpatient services and defined as follows:
	• CBHC Bundle Services: T1040 HA or HB
	The modifier codes attached to the T1040 code are required and defined as follows:
	• HA = Youth modifier (youth client seen), or
	• HB = Adult modifier (adult client seen)
Acute Inpatient Discharges	In-state discharges from acute inpatient hospitals (including those with psychiatric units) and free-standing Psychiatric Hospitals are included.
Data Elements for Reporting	Data elements that will be collected from claims data:
	• Measurement Period: Calendar Year
	• Eligible Population by each population.
	• Numerator events by each population.
	Measure rate by each population.
Measurement Year	Performance (or Measurement) Years 1-5 correspond to Calendar Years 2024-2028
Members	Individuals enrolled in MassHealth including: ACPP ACO, PC ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited)
Rates of Readmission	There will be five rates reported for this measure. (Numerator 1 Population / Denominator 1 Population) * 100 (Numerator 2 Population / Denominator 2 Population) * 100 (Numerator 3 Population / Denominator 3 Population) * 100 (Numerator 4 Population / Denominator 4 Population) * 100 Aggregate Measure: (Numerators 1-4 Populations / Denominators 1-4 Populations) * 100

ADMINISTRATIVE SPECIFICATION

Denominator	There are five denominators for this measure, which should be equivalent to the respective 5 numerators from measure CCQI-2, Follow-up after Acute BH Episode of Care:

	Denominator 1: The eligible population for MassHealth members with a previous Acute Inpatient hospitalization for mental health as the qualifying encounter type <u>and</u> with a CBHC bundled encounter T code, MCI code, or CCS code billed by a CBHC provider within a 7-day period of discharge from the specified qualifying encounter type. **Denominator 2:** The eligible population for MassHealth members with a previous Emergency Department encounter for mental health as the qualifying encounter type <u>and</u> with a CBHC bundled encounter T code, MCI code, or CCS code billed by a CBHC provider within a 7-day period of discharge from the specified qualifying encounter type. **Denominator 3:** The eligible population for MassHealth members with a previous Emergency Department encounter for a substance use disorder as the qualifying encounter type <u>and</u> with a CBHC bundled encounter T code, MCI code, or CCS code billed by a CBHC provider within a 7-day period of discharge from the specified qualifying encounter type. **Denominator 4:** The eligible population for MassHealth members with a previous Acute Inpatient hospitalization for a substance use disorder as the qualifying encounter type <u>and</u> with a CBHC bundled encounter T code, MCI code, or CCS code billed by a CBHC provider within a 7-day period of discharge from the specified qualifying encounter type. **Denominator 5 (Aggregate):** The eligible population for MassHealth members with a previous Acute Inpatient hospitalization for mental health or a substance use disorder or a previous Emergency Department encounter for mental health or a substance use disorder <u>and</u> with a CBHC bundled encounter T code, MCI code, or CCS code billed by a CBHC provider within a 7-day period of discharge from the specified qualifying encounter type.
Numerator	There are five numerators for this measure: **Numerator 1:** The eligible population for MassHealth members who had a qualifying visit with a CBHC provider within 7 days of discharge from an Acute Inpatient hospitalization for mental health as the qualifying encounter type and with subsequent readmission to any qualifying encounter within 30 days of discharge. **Numerator 2:** The eligible population for MassHealth members who had a qualifying visit with a CBHC provider within 7 days of discharge from an Emergency Department encounter for mental health as the qualifying encounter type and with subsequent readmission to any qualifying encounter within 30 days of discharge.

	Numerator 3: The eligible population for MassHealth members who had a qualifying visit with a CBHC provider within 7 days of discharge from an Emergency Department encounter for a substance use disorder as the qualifying encounter type and with subsequent readmission to any qualifying encounter within 30 days of discharge. **Numerator 4:** The eligible population for MassHealth members who had a qualifying visit with a CBHC provider within 7 days of discharge from an Acute Inpatient hospitalization for a substance use disorder as the qualifying encounter type and with subsequent readmission to any qualifying encounter within 30 days of discharge. **Numerator 5 (Aggregate):** The eligible population for MassHealth members who had a qualifying visit with a CBHC provider within 7 days of discharge from a previous Acute Inpatient hospitalization for mental health or a substance use disorder or a previous Emergency Department encounter for mental health or a substance use disorder as the qualifying encounter type and with subsequent readmission to any qualifying encounter within 30 days of discharge.
Exclusions	None

ADDITIONAL MEASURE INFORMATION

Readmission Rate Calculations	The rates will be calculated as follows: • Follow-up visits at CBHCs will be calculated for each individual CBHC TIN-billing entity (a total of 20 entities) by each individual qualifying encounter type (total of 4 types), and for all qualifying encounter types (1 aggregate calculation). • Each sub-measure will be reported for each of the 20 CBHC TIN billing entities, NOT for each CBHC (PIDSL) level for CBHCs with more than one site that have a shared Tax ID Number (TIN).