



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

Performance Year 1 (Calendar Year 2024)

Version: July 2024

CCQI Performance Year 1 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 sources: MassHealth claims and encounter data, CBHC Visit and Demographics Data File
PY 1 Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

Description	<p>This measure assesses the percentage of new patients that received an appointment within a specified timeframe.</p> <p>This measure includes six sub-measures defined as follows:</p> <p>Qualifying Visit Type 1 – CBHC Bundle Services for new patients:</p> <ul style="list-style-type: none">• MOUD: MOUD induction appointment within 24 hours of initial contact• Urgent appointment: Urgent appointment within 48 hours of initial contact
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	<ul style="list-style-type: none"> Urgent Psychopharmacology appointment: Urgent psychopharmacology appointment within 72 hours of initial contact Non-Urgent appointment: Non-urgent appointment within 14 calendar days of initial contact <p>The four appointments falling under Qualifying Visit Type 1 are select CBHC Bundle Services appropriate for new patients.</p> <p>Qualifying Visit Type 2 - Mobile Crisis Intervention:</p> <ul style="list-style-type: none"> Adult MCI: Adult Mobile Crisis Intervention within 60 minutes of time of readiness Youth MCI: Youth Mobile Crisis Intervention within 60 minutes of time of readiness <p>The measure also includes overall rate of timely access.</p>
Numerator	The number of “new patients” among MassHealth members who were triaged at initial contact with a given CBHC to billable services (CBHC Bundle services or MCI evaluation) and who received those services within the specified timeframe.
Denominator	<p>The 6 eligible populations (denominators) correspond to the following “qualifying visit” types:</p> <ul style="list-style-type: none"> CBHC Bundled Services <ul style="list-style-type: none"> MOUD Urgent appointment Urgent Psychopharmacology appointment Non-Urgent appointment MCI <ul style="list-style-type: none"> Adult MCI Youth MCI

ELIGIBLE POPULATION

Age	MassHealth members of any age
Continuous Enrollment Date	None
Allowable Gap	None

Anchor Date	None
Event/Diagnosis	<ul style="list-style-type: none"> At least one CBHC Bundle services visit or MCI evaluation through the CBHC between January 1 and December 31 of the measurement year. See Attachment 1 describing EHR time stamps to be utilized for identifying CBHC Bundle services 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.
Initial contact	Initial contact is defined as the first time the patient (or family or guardian if the patient is a child or has a guardian) contacts the CBHC to obtain services. 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.) Initial contact is equivalent to time at which the appointment was scheduled.
Time of readiness	Time of readiness refers to client time of readiness; the 60-min timeframe for MCI evaluation begins when the client is ready to be seen by the MCI team. For MCI only, time of readiness is equivalent to time at which the appointment was scheduled.
Data Elements for Reporting	<p>File Name: CBHC Visit and Demographics Data Description: Encounter or visit-level file sent by the CBHC to MassHealth.</p> <p>EOHHS will provide a separate Submission Guide detailing the submission process and the elements that will be used to calculate the measure.</p>

Measurement Year	Performance (or Measurement) Years 1-5 correspond to Calendar Years 2024-2028
Members	<p>Individuals enrolled in MassHealth including:</p> <p>ACPP ACO, PC ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited)</p>
Rate of Timely Access	<p>There will be seven rates reported for this measure.</p> <p>MOUD: $\text{Numerator 1 Population} / \text{Denominator 1 Population} * 100$</p> <p>Urgent Appointment: $(\text{Numerator 2 Population} / \text{Denominator 2 Population}) * 100$</p> <p>Urgent Psychopharmacology Appointment: $(\text{Numerator 3 Population} / \text{Denominator 3 Population}) * 100$</p> <p>Non-Urgent Appointment: $(\text{Numerator 4 Population} / \text{Denominator 4 Population}) * 100$</p> <p>Adult MCI: $(\text{Numerator 5 Population} / \text{Denominator 5 Population}) * 100$</p> <p>Youth MCI: $(\text{Numerator 6 Population} / \text{Denominator 6 Population}) * 100$</p> <p>Overall Rate of Timely Access:</p> <p>$(\text{All Numerator Populations} / \text{All Denominator Populations}) * 100$</p> <p>The aggregate measure combines the four CBHC Bundle Services and two MCI populations to calculate the overall rate of timely access.</p>
MCI and CBHC Bundle Services Definitions	<p>Mobile Crisis Intervention (MCI) services are a diversionary level of care falling under outpatient services defined by the following service/encounter codes:</p> <ul style="list-style-type: none"> MCI (per diem): S9485 with any combination of HA, HE, or U1 <p>The following modifiers are for MCI per diem codes:</p>

	<ul style="list-style-type: none"> • 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 <p>CBHC Bundle services are behavioral health outpatient services and are defined as follows:</p> <ul style="list-style-type: none"> • CBHC Bundle services: T1040 HA or HB <p>The modifier codes attached to the T1040 code are required and defined as follows:</p> <ul style="list-style-type: none"> • HA = Youth modifier (youth client seen), or • HB = Adult modifier (adult client seen)
New patient	<p>A new patient is defined as a MassHealth member that did not receive care at the CBHC within the previous 90 days. Care at another, different CBHC within the previous 90 days is allowable.</p> <p>If a patient was previously triaged at initial contact to billable CBHC services but declined or did not receive said CBHC services, they are still considered a “New Patient.”</p> <p>Each denominator population is limited to those patients that were triaged at initial contact by a given CBHC to a billable service (that falls under the “qualifying visit” type) offered by that CBHC.</p> <p>CBHCs should only offer the following billable (“bundle”) services to new patients: an MCI occurrence, a MOUD Induction, and Urgent Appointment, and Urgent Psychopharmacology Appointment, or a Non-urgent Appointment.</p> <p>Please note, non-billable encounters (such as phone calls or conversations or brief notes not attached to a billable encounter) can occur in the previous 90 days before a new patient is triaged at initial contact to billable CBHC services.</p>

ADMINISTRATIVE SPECIFICATION

Denominator	<p>There are seven denominators for this measure:</p> <p>Denominator 1 (MOUD):</p>
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	<p>The number of “new patients” among MassHealth members who were triaged at initial contact to CBHC Bundle services for MOUD induction appointments through the CBHC.</p> <p>Denominator 2 (Urgent appointment):</p> <p>The number of “new patients” among MassHealth members who were triaged at initial contact to CBHC Bundle services for urgent appointments through the CBHC.</p> <p>Denominator 3 (Urgent Psychopharmacology appointment):</p> <p>The number of “new patients” among MassHealth members who were triaged at initial contact to CBHC Bundle services for urgent psychopharmacology appointments through the CBHC.</p> <p>Denominator 4 (Non-Urgent appointment):</p> <p>The number of “new patients” among MassHealth members who were triaged at initial contact to CBHC Bundle services for non-urgent appointments through the CBHC.</p> <p>Denominator 5 (Adult MCI):</p> <p>The number of “new patients” among MassHealth members who were triaged at initial contact to adult MCI evaluation through the CBHC.</p> <p>Denominator 6 (Youth MCI):</p> <p>The number of “new patients” among MassHealth members who were triaged at initial contact to youth MCI evaluation through the CBHC.</p> <p>Denominator 7 (Aggregate):</p> <p>The number of “new patients” among MassHealth members who were triaged at initial contact to CBHC Bundle services or MCI evaluation through the CBHC.</p>
Numerator	<p>There are seven numerators for this measure:</p> <p>Numerator 1 (MOUD):</p> <p>The number of “new patients” among MassHealth members who were triaged at initial contact to CBHC Bundle services for</p>

MOUD induction appointments through the CBHC and received those services within the specified timeframe.

Numerator 2 (Urgent appointment):

The number of “new patients” among MassHealth members who were triaged at initial contact to CBHC Bundle services for urgent appointments through the CBHC and received those services within the specified timeframe.

Numerator 3 (Urgent Psychopharmacology appointment):

The number of “new patients” among MassHealth members who were triaged at initial contact to CBHC Bundle services for urgent psychopharmacology appointments through the CBHC and received those services within the specified timeframe.

Numerator 4 (Non-Urgent appointment):

The number of “new patients” among MassHealth members who were triaged at initial contact to CBHC Bundle services for non-urgent appointments through the CBHC and received those services within the specified timeframe.

Numerator 5 (Adult MCI):

The number of “new patients” among MassHealth members who were triaged at initial contact to adult MCI evaluation through the CBHC and received those services within the specified timeframe.

Numerator 6 (Youth MCI):

The number of “new patients” among MassHealth members who were triaged at initial contact to youth MCI evaluation through the CBHC and received those services within the specified timeframe.

Numerator 7 (Aggregate):

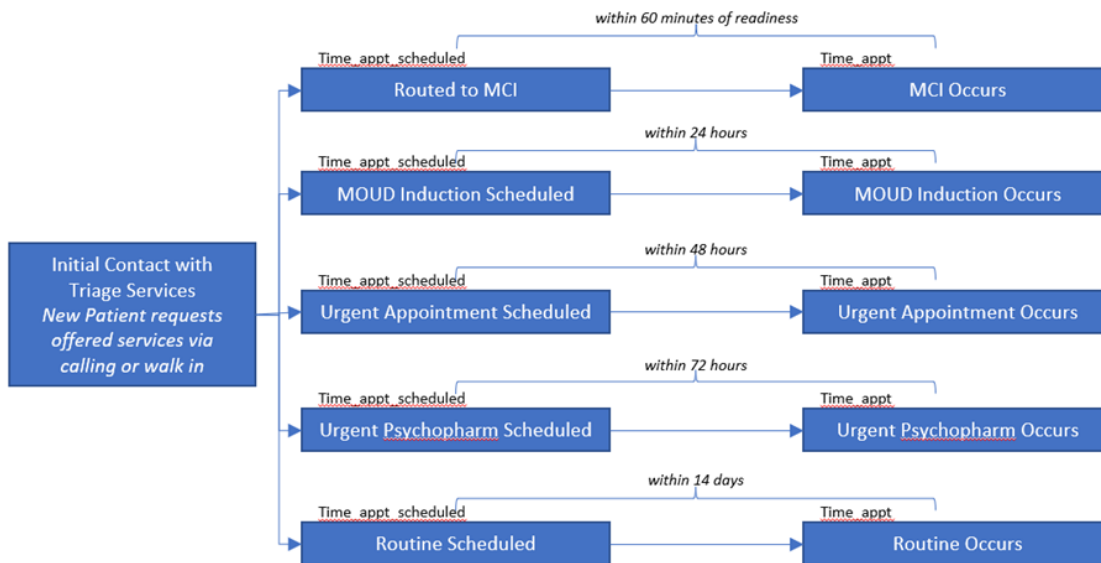
The number of “new patients” among MassHealth members who were triaged at initial contact to CBHC Bundle services or MCI evaluation through the CBHC and received those services within the specified timeframe.

Exclusions	<p>New patients who are referred to a different CBHC or to non-CBHC services (ex: routine outpatient, inpatient level of care, partial hospital program, etc.) at initial contact are excluded from the denominator.</p> <p>New patients triaged at initial contact to an MCI evaluation that cancel, reschedule, or do not show for the scheduled evaluation are excluded from the denominator.</p>
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SUBMISSION REQUIREMENTS FOR PY1

Performance Requirements	<p>For the Access Standards measure in PY1, CBHCs will submit complete, responsive, and timely (anticipated by December 31, 2024) submission to EOHHS of an accurate and successful test file of the MassHealth CBHC Visit and Demographics Data File (VDDF), containing time-stamped, member-level visit data for MassHealth patients, including self-reported demographic data.</p> <p>The test file will minimally contain test data for Access Standards Numerator/Denominator:</p> <ul style="list-style-type: none"> • CBHC Bundled Services <ul style="list-style-type: none"> ○ MOUD ○ Urgent appointment ○ Urgent Psychopharmacology appointment ○ Non-Urgent appointment • MCI <ul style="list-style-type: none"> ○ Adult MCI ○ Youth MCI <p>EOHHS will provide a separate Submission Guide detailing the submission process and the data elements.</p>
Access Standards Calculations	<p>Access Standards is calculated for each individual CBHC TIN-billing entity, all CBHC TIN-billing entities, and for each PID/SL.</p>

Attachment 1



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 source: MassHealth claims and encounter data Denominator sources: MassHealth claims and encounter data
PY 1 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 outcomes for members who have experienced a behavioral health crisis.

MEASURE SUMMARY

Description	The proportion of CBHC follow up visits that occur at a specific CBHC location. This measure includes 4 sub-measures, one per “qualifying encounter” type; inpatient psychiatric or substance use care, or emergency department care, for behavioral health and substance use disorder diagnoses.
Numerator	Members seen by a given CBHC 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 an acute inpatient hospitalization for mental health or substance use disorder, or from an emergency department for a primary diagnosis of mental health or substance use disorder.
Denominator	<p>The 4 eligible populations (denominators) correspond to the following “qualifying encounter” types for ALL MassHealth members who had a CBHC bundled encounter T code, MCI code, or CCS code billed by a CBHC provider encounter within 7 days:</p> <p>Acute Inpatient Psychiatric;</p> <p>Emergency Department – Mental Health;</p> <p>Emergency Department – Substance;</p> <p>Acute Inpatient – Substance Use Disorder</p>

ELIGIBLE POPULATION

Age	MassHealth members of any age
Continuous Enrollment Date	<p>For all sub-measures:</p> <p>Enrolled at the time of the “qualifying encounter” and for 7 days after discharge</p>
Allowable Gap	None
Anchor Date	None

<p>Eligibility Criteria</p>	<p>Members will be included in the denominator only if the discharge comes from a qualifying encounter (an acute inpatient setting with a primary diagnosis of mental health or substance use disorder) and a CBHC bundled encounter was received within 7 days of discharge. Any discharge from a non-qualifying encounter (a non-acute inpatient stay without a primary diagnosis of a mental health or substance use disorder) will NOT be included.</p> <p>If a member has more than one discharge from a qualifying encounter (and a CBHC encounter within 7 days of discharge) on or between January 1 and December 25 of the measurement year, all qualifying discharges for the same member will be included*.</p> <p>Any discharge from a qualifying encounter that occurred AFTER December 25 of the measurement year will be EXCLUDED.</p> <p>Discharges, Readmissions and Direct Transfers:</p> <p>*If a readmission/direct transfer was a qualifying encounter and within 7 days of the initial discharge of a qualifying encounter, only the LAST discharge of a qualifying encounter (and the CBHC bundled encounter within 7 days of that last discharge) will be included in the denominator.</p> <p>Note: In the event of a qualifying encounter with a readmission (within 7 days) or direct transfer to a qualifying encounter, then only the last occurring qualifying encounter in this sequence would count (pending above referenced CBHC service within 7 days of that encounter).</p> <p>In the event of a non-qualifying encounter (i.e., discharge) with a readmission or direct transfer to a qualifying encounter, then only the last occurring qualifying encounter in this sequence would count (pending above referenced CBHC service within 7 days of that encounter).</p> <p>In the event of a qualifying encounter with a readmission (w/in 7 days) or direct transfer to a non-qualifying encounter, then only the qualifying encounter in this sequence would count</p>
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	(pending above referenced CBHC service within 7 days of that encounter).
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DEFINITIONS

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).
Qualifying Encounter Types	<p>The following event/diagnosis with a follow-up visit to a CBHC:</p> <ul style="list-style-type: none"> • Acute Inpatient Psychiatric; • Emergency Department – Mental Health; • Emergency Department – Substance; • Acute Inpatient – Substance Use Disorder • Aggregate denominator of the 4 qualifying encounter types above.
Acute Inpatient Psychiatric Discharges	In-state discharges from acute hospitals with psychiatric units and free-standing Psychiatric Hospitals are included.
Data Type	Administrative data will be used to calculate this quality measure
Measurement Year	Performance (or Measurement) Years 1-5 correspond to Calendar Years 2024-2028
Members	<p>Individuals enrolled in MassHealth including:</p> <p>ACPP ACO, PC ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited)</p>
Access to Timely Follow-up	<p>There will be five rates reported for this measure. Each rate represents the percentage of total timely access to follow-up of MCI, CCS and CBHC Bundle services (denominator) provided by a CBHC (numerator) for each qualifying event and in aggregate.</p> <p>(Numerator 1 Population / Denominator 1 Population)</p> <p>(Numerator 2 Population / Denominator 2 Population)</p> <p>(Numerator 3 Population / Denominator 3 Population)</p>

	<p>(Numerator 4 Population / Denominator 4 Population)</p> <p>Aggregate Measure: (Numerators 1-4 Populations / Denominators 1-4 Populations)</p> <p>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 follow-up CBHC services provided by a CBHC.</p>
MCI, CCS, and CBHC Bundle Services	<p>Mobile Crisis Intervention (MCI) services are a diversionary level of care falling under outpatient services defined by the following service codes: MCI (per diem): S9485 with any combination of HA, HE, or U1MCI (per 15 min): H2011 (HN or HO) and (HA or HB)</p> <p>MCI per diem codes correspond to MCI evaluations.</p> <p>MCI per 15 min codes correspond to MCI follow-up interventions.</p> <p>The following modifiers are for MCI per diem codes:</p> <ul style="list-style-type: none"> • 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 <p>The following modifiers are optional (not required) for MCI per 15 min codes:</p> <ul style="list-style-type: none"> • HN = Paraprofessional seen • HO = Master's level clinician seen • HA = Youth modifier (youth client seen) • HB = Adult modifier (adult client seen) <p>Community Crisis Stabilization (CCS) services are a 24-hour diversionary level of care defined by the following service codes:</p> <ul style="list-style-type: none"> • CCS (per diem): S9485-ET • CCS (per diem): S9485-HA, ET

	<p>The modifier codes attached to CCS codes are defined as follows:</p> <ul style="list-style-type: none"> 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 <p>CBHC Bundle Services are behavioral health outpatient services and are defined as follows:</p> <ul style="list-style-type: none"> CBHC Bundle Services: T1040 HA or HB <p>The modifier codes attached to the T1040 code are required and defined as follows:</p> <ul style="list-style-type: none"> HA = Youth modifier (youth client seen), or HB = Adult modifier (adult client seen)
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ADMINISTRATIVE SPECIFICATION

Denominator	<p>There are five denominators for this measure:</p> <p>Denominator 1:</p> <p>The total eligible population for MassHealth members with a previous Acute Inpatient Psychiatric hospitalization for mental health as the qualifying encounter type and access to a CBHC for a MCI, CCS or CBHC Bundle Service within 7 days of discharge</p> <p>Denominator 2:</p> <p>The total eligible population for MassHealth members with a previous Emergency Department encounter for mental health as the qualifying encounter type and access to a CBHC for a MCI, CCS or CBHC Bundle Service within 7 days of discharge</p> <p>Denominator 3:</p> <p>The total eligible population for MassHealth members with a previous Emergency Department encounter for a substance use disorder as the qualifying encounter type and access to a</p>
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	<p>CBHC for a MCI, CCS or CBHC Bundle Service within 7 days of discharge</p> <p>Denominator 4:</p> <p>The total eligible population for MassHealth members with a previous Acute Inpatient hospitalization for a substance use disorder as the qualifying encounter type and access to a CBHC for a MCI, CCS or CBHC Bundle Service within 7 days of discharge</p> <p>Denominator 5 (Aggregate):</p> <p>The total eligible population for MassHealth members with a previous Acute Inpatient Psychiatric hospitalization for mental health or a substance use disorder or a previous Emergency Department encounter for mental health or a substance use disorder and access to a CBHC for a MCI, CCS or CBHC Bundle Service within 7 days of discharge</p>
Numerator	<p>There are five numerators for this measure for each CBHC:</p> <p>Numerator 1:</p> <p>The eligible population for MassHealth members with a previous Acute Inpatient Psychiatric 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.</p> <p>Numerator 2:</p> <p>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.</p> <p>Numerator 3:</p> <p>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.</p>

	<p>Numerator 4:</p> <p>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.</p> <p>Numerator 5 (Aggregate):</p> <p>The eligible population for MassHealth members with a previous Acute Inpatient Psychiatric 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.</p>
Exclusions	None

ADDITIONAL MEASURE INFORMATION

Completeness Calculations	Completeness is calculated for: each individual encounter type (total of 4 types); each individual CBHC TIN-billing entity (a total of 20 entities); and all CBHC TIN-billing entities (1 aggregate calculation).
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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 source: MassHealth claims and encounter data Denominator sources: MassHealth claims and encounter data
PY 1 Performance Status	Reporting-only

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 readmission rate for patients 30 days after a discharge from an encounter with inpatient psychiatric or substance use care, or emergency department care for behavioral health and/or substance use disorder diagnoses. This measure includes 4 sub-measures, one per “qualifying encounter” type.
Numerator	Patients who had a qualifying visit with a CBHC provider within 7 days of discharge from a qualifying encounter and who subsequently was readmitted for a similar encounter within 30 days of discharge. For example, if a patient was discharged from an Acute Inpatient Psychiatric qualifying encounter, and subsequently had a qualifying visit at a CBHC within 7 days, and then was readmitted within 30 days of their discharge from their first Acute Inpatient Psychiatric qualifying encounter to another Acute Inpatient Psychiatric qualifying encounter, this event would count in the numerator.
Denominator	The 4 eligible populations (denominators) correspond to the following “qualifying encounter” types: <ul style="list-style-type: none"> • Acute Inpatient Psychiatric • Emergency Department – Mental Health • Emergency Department – Substance • Acute Inpatient – 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
Event/Diagnosis	<p>Patients meeting all the following criteria:</p> <ul style="list-style-type: none"> • Patients who have had a “qualifying visit” with a CBHC provider within 7 days of discharge from an Acute Inpatient Psychiatric hospitalization, an Emergency Department Visit with primary diagnosis of mental health or substance use disorder, or an Acute Inpatient – Substance hospitalization • “Qualifying encounters” include: Acute Inpatient Psychiatric, Emergency Department – Mental Health, Emergency Department – Substance, and Acute Inpatient – Substance • “Qualifying visits” with a CBHC provider include: CBHC Bundle services outpatient visit, MCI evaluation or follow-up, or CCS stay • Patients may appear in multiple groups (denominators) if they had qualifying encounters in more than one category. • To identify the eligible population, first identify the populations below: <ul style="list-style-type: none"> ○ Acute Inpatient Psychiatric: 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 Value Set and Intentional Self-Harm Value Set” attached.

	<ul style="list-style-type: none"> ▪ 1. Identify all acute and non-acute inpatient stays (“Inpatient Stay Value Set) ▪ 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). ▪ 3. Identify the discharge date for the stay. ▪ Note: The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year ▪ For Acute readmission or direct transfer: <ul style="list-style-type: none"> ▪ Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period: <ul style="list-style-type: none"> ▪ 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). ▪ 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). ▪ 3. Identify the admission date for the stay. ▪ Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. ▪ If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.
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	<ul style="list-style-type: none"> ▪ If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim) exclude both the original and the readmission/direct transfer discharge. ▪ For Nonacute readmission or direct transfer <ul style="list-style-type: none"> ▪ Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. ▪ To identify readmissions and direct transfers to a nonacute inpatient care setting: <ul style="list-style-type: none"> ▪ 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). ▪ 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. ▪ 3. Identify the admission date for the stay. ▪ These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place. ○ Emergency Department – Mental Health: An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value
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Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.

- Multiple visits in a 31-day period:
 - If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.
 - Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.
- ED visits followed by inpatient admission:
 - Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:
 - 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

- 2. Identify the admission date for the stay. These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.
- 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. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period, as described below.
 - Multiple visits in a 31-day period:
 - If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.
 - Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.
 - ED visits followed by inpatient admission
 - Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission. To identify admissions to an

	<p>acute or nonacute inpatient care setting:</p> <ul style="list-style-type: none"> ▪ 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). ▪ 2. Identify the admission date for the stay. These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place. <p>○ Acute Inpatient – Substance Use Disorder: An acute inpatient discharge, residential treatment or detoxification 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:</p> <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> ▪ 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. ▪ A detoxification visit (Detoxification Value Set) with a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set). The denominator for this measure is
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	<p>based on episodes, not on members. If members have more than episode, include all that fall on or between January 1 and December 1 of the measurement year.</p> <ul style="list-style-type: none">▪ Direct transfers: Identify direct transfers to an acute inpatient care or residential setting. If the direct transfer to the acute inpatient or residential care setting was for a principal diagnosis of substance use disorder (AOD Abuse and Dependence Value Set), use the date of last discharge.<ul style="list-style-type: none">• A direct transfer is when the discharge date from the first acute inpatient or residential care setting precedes the admission date to a second acute inpatient or residential care setting by one calendar day or less. For example:<ul style="list-style-type: none">○ An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.○ An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
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	<ul style="list-style-type: none">○ 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.● Use the following method to identify direct transfers:<ul style="list-style-type: none">○ 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 admission date for the stay.○ Exclude both the initial discharge and the direct transfer discharge if the last discharge occurs after December 1 of
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	<p>the measurement year.</p> <ul style="list-style-type: none">○ If the direct transfer to the acute inpatient or residential behavioral health care setting was for any other principal diagnosis, exclude both the original and the direct transfer discharge.▪ Multiple discharges, visits or events in a 31-day period: After evaluating for direct transfers, if a member has more than one episode in a 31-day period, include only the first eligible episode. For example, if a member is discharged from a residential treatment stay on January 1, include the January 1 discharge and do not include subsequent episodes that occur on or between January 2 and January 31; then, if applicable, include the next episode that occurs on or after February 1. Identify episodes chronologically, including only the first episode per 31-day period.<ul style="list-style-type: none">• Note: Removal of multiple episodes in a 31-day period is based on eligibility. Assess each episode for eligibility before removing multiple episodes in a 31-day period.
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- **Second, identify if any members in each of the populations above had a qualifying service at a CBHC Provider within 7 days of the date of discharge.** See “Definitions” section of this measure for qualifying CBHC billing codes.
- **Third, identify if any of the populations identified in the second step has had a readmission within 30 days to:**
 - **Acute Inpatient Psychiatric:** An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim within 30 days of the first discharge
 - To identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:
 - 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 - 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
 - 3. Identify the admission date for the stay.
 - **Emergency Department – Mental Health:** 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)
 - **Emergency Department – Substance:** An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
 - **Acute Inpatient – Substance Use Disorder:** An acute inpatient discharge, residential treatment or detoxification event for a

	<p>principal diagnosis of substance use disorder</p> <ul style="list-style-type: none"> • Fourth, identify if any of the population had a readmission (per third step above) prior to, or on the same day, as the qualifying service at a CBHC (per second step above). If readmission is prior to, or on the same day, as the qualifying service then exclude original event/dx (i.e., discharge) from denominator. In such a case then the readmission would then count as the new event/dx (for which a 30 day follow up period would then apply) and the CBHC service would count as the qualifying service (even if occurring on the same day as the new event dx). <p>Note: any readmission (of the same encounter type) identified within 30 days of the event/dx (i.e., discharge) should not be considered as an event/diagnosis (i.e., not part of a denominator). In other words, the same discharge may not be counted as a readmission and an event/dx within the same measurement year.</p>
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DEFINITIONS

Data Collection	Claims capture by MassHealth
Qualifying Encounter Types	<ul style="list-style-type: none"> • Acute Inpatient Psychiatric; • Emergency Department – Mental Health; • Emergency Department – Substance; • Acute Inpatient – Substance Use Disorder
Acute Inpatient Psychiatric Discharges	In-state discharges from acute hospitals with psychiatric units and free-standing Psychiatric Hospitals are included.
Data Elements for Reporting	<p>Data elements that will be collected from claims data:</p> <ul style="list-style-type: none"> • 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	<p>There will be five rates reported for this measure.</p> <p>$(\text{Numerator 1 Population} / \text{Denominator 1 Population}) * 100$</p> <p>$(\text{Numerator 2 Population} / \text{Denominator 2 Population}) * 100$</p> <p>$(\text{Numerator 3 Population} / \text{Denominator 3 Population}) * 100$</p> <p>$(\text{Numerator 4 Population} / \text{Denominator 4 Population}) * 100$</p> <p>Aggregate Measure: $(\text{Numerators 1-4 Populations} / \text{Denominators 1-4 Populations}) * 100$</p>
MCI, CCS, and CBHC Bundle Services Definitions	<p>Mobile Crisis Intervention (MCI) services are a diversionary level of care falling under outpatient services defined by the following service codes:</p> <ul style="list-style-type: none"> • MCI (per diem): S9485 with any combination of HA, HE, or U1 • MCI (per 15 min): H2011 (HN or HO) and (HA or HB) <p>MCI per diem codes correspond to MCI evaluations.</p> <p>MCI per 15 min codes correspond to MCI follow-up interventions.</p> <p>The following modifiers are for MCI per diem codes:</p> <ul style="list-style-type: none"> • 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 <p>The following modifiers are optional (not required) for MCI per 15 min codes:</p> <ul style="list-style-type: none"> • HN = Paraprofessional seen • HO = Master's level clinician seen • HA = Youth modifier (youth client seen) • HB = Adult modifier (adult client seen)

	<p>Community Crisis Stabilization (CCS) services are a 24-hour diversionary level of care defined by the following service codes:</p> <ul style="list-style-type: none"> • CCS (per diem): S9485-ET • CCS (per diem): S9485-HA, ET <p>The modifier codes attached to CCS codes are defined as follows:</p> <ul style="list-style-type: none"> • 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 <p>CBHC Bundle Services are behavioral health outpatient services and defined as follows:</p> <ul style="list-style-type: none"> • CBHC Bundle Services: T1040 HA or HB <p>The modifier codes attached to the T1040 code are required and defined as follows:</p> <ul style="list-style-type: none"> • HA = Youth modifier (youth client seen), or • HB = Adult modifier (adult client seen)
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ADMINISTRATIVE SPECIFICATION

Denominator	<p>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:</p> <p>Denominator 1:</p> <p>The eligible population for MassHealth members with a previous Acute Inpatient Psychiatric 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.</p> <p>Denominator 2:</p> <p>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</p>
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	<p>provider within a 7-day period of discharge from the specified qualifying encounter type.</p> <p>Denominator 3:</p> <p>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.</p> <p>Denominator 4:</p> <p>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.</p> <p>Denominator 5 (Aggregate):</p> <p>The eligible population for MassHealth members with a previous Acute Inpatient Psychiatric 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.</p>
Numerator	<p>There are five numerators for this measure:</p> <p>Numerator 1:</p> <p>The eligible population for MassHealth members who had a qualifying visit with a CBHC provider within 7 days of discharge from an Acute Inpatient Psychiatric hospitalization for mental health as the qualifying encounter type and with subsequent readmission for a similar encounter within 30 days of discharge.</p> <p>Numerator 2:</p> <p>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</p>

	<p>the qualifying encounter type and with subsequent readmission for a similar encounter within 30 days of discharge.</p> <p>Numerator 3:</p> <p>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 for a similar encounter within 30 days of discharge.</p> <p>Numerator 4:</p> <p>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 for a similar encounter within 30 days of discharge.</p> <p>Numerator 5 (Aggregate):</p> <p>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 Psychiatric 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 for a similar encounter within 30 days of discharge.</p>
Exclusions	None

ADDITIONAL MEASURE INFORMATION

Completeness Calculations	Completeness is calculated for: each individual encounter type (total of 4 types); each individual CBHC TIN-billing entity (a total of 20 entities); and all CBHC TIN-billing entities (1 aggregate calculation).
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CQEIP Performance Year 1 Technical Specifications

A. Race, Ethnicity, Language, Disability, Sexual Orientation, and Gender Identity (RELD SOGI) Completeness

A.i. Race Data Completeness

OVERVIEW

Measure Name	Rate of Race Data Completeness – CBHC
Steward	EOHHS
NQF Number	N/A
Data Source	Numerator source: CBHC Visit and Demographics Data File Denominator sources: MassHealth claims and encounter data, CBHC Visit and Demographics Data File
PY 1 Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

Complete, beneficiary-reported race data are critically important for identifying, analyzing, and addressing disparities in health and health care access and quality.

MEASURE SUMMARY

Description	The percentage of MassHealth members with self-reported race data that was collected by a CBHC in the measurement year.
Numerator	Members with a Bundle Services and/or Mobile Crisis Intervention (MCI) evaluation through a CBHC <u>and</u> self-reported race data that was collected by a CBHC during the measurement year.
Denominator	Members with a Bundle Services and/or Mobile Crisis Intervention (MCI) evaluation through the CBHC during the measurement year.

ELIGIBLE POPULATION

Age	MassHealth members of any age
Continuous Enrollment Date	None
Anchor Date	None
Event/Diagnosis	At least one CBHC Bundle Services and/or MCI evaluation through the CBHC between January 1 and December 31 of the measurement year.

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.
MCI Evaluation and CBHC Bundle Services	<p>Mobile Crisis Intervention (MCI) services are a diversionary level of care falling under outpatient services defined by the following service code:</p> <ul style="list-style-type: none"> MCI Evaluations (per diem): S9485 HA, HB, HE, or U1 <p>The following modifiers are optional (not required) for MCI per diem codes:</p> <ul style="list-style-type: none"> 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 <p>The following modifiers are optional (not required) for MCI per 15 min codes:</p> <ul style="list-style-type: none"> HN = Paraprofessional HO = Master's level clinician HA = Youth modifier (youth client seen) HB = Adult modifier (adult client seen) <p>CBHC Bundle Services are behavioral health outpatient services and are defined as follows:</p>

	<ul style="list-style-type: none"> CBHC Bundle Services: T1040 HA or HB <p>The modifier codes attached to the T1040 code are defined as follows:</p> <ul style="list-style-type: none"> HA = Youth modifier (youth client seen) HB = Adult modifier (adult client seen)
Complete Race Data	<p>Complete race data is defined as: At least one (1) valid race value (valid race values are listed in Attachment 1).</p> <ul style="list-style-type: none"> If value is “UNK” it will <u>not</u> count toward the numerator. If value is “ASKU,” it will count toward the numerator. If value is “DONTKNOW,” it will count toward the numerator. Each value must be self-reported.
Data Elements for Reporting: CBHC Visit and Demographics Data	<p>File Name: CBHC Visit and Demographics Data</p> <p>Description: Encounter or visit-level file sent by the CBHC to MassHealth.</p> <p>EOHHS will provide a separate Submission Guide detailing the submission process and the elements that will be used to calculate the measure.</p>
Measurement Year	Measurement Years 1-5 correspond to Calendar Years 2024-2028
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).
Rate of Race Data Completeness	<p>There will be two rates reported for this measure:</p> <p>Rate 1: (Numerator 1 Population/ Denominator 1 Population) * 100</p> <p>Rate 2: (Numerator 2 Population/ Denominator 2 Population) * 100</p>
Self-Reported data	<p>For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual’s behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).</p> <p>Self-reported race data that has been rolled-up or transformed for reporting purposes may be included. For example, if a CBHC’s data systems include races that are included in HHS’ data collection standards and an individual self-reports their</p>

	race as “Samoan”, then the CBHC can report the value of “Native Hawaiian or Other Pacific Islander” since the value of Samoan is not a valid value in Attachment 1.
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ADMINISTRATIVE SPECIFICATION

Denominator	<p>There are two denominators for this measure:</p> <p>Denominator 1: The eligible population with CBHC Bundle Services encounters from CBHCs.</p> <p>Denominator 2: The eligible population with MCI evaluation encounters through CBHCs.</p>
Numerator	<p>There are two numerators for this measure:</p> <p>Numerator 1: For members in Denominator 1, identify those with complete race data, defined as: At least one (1) valid race value (valid race values are listed in Attachment 1). <ul style="list-style-type: none"> ○ If value is “UNK,” it will <u>not</u> count toward the numerator. ○ If value is “ASKU,” it will count toward the numerator. ○ If value is “DONTKNOW,” it will count toward the numerator. ○ Each value must be self-reported. </p> <p>Numerator 2: For members in Denominator 2, identify those with complete race data, defined as: At least one (1) valid race value (valid race values are listed in Attachment 1). <ul style="list-style-type: none"> ○ If value is “UNK,” it will <u>not</u> count toward the numerator. ○ If value is “ASKU,” it will count toward the numerator. ○ If value is “DONTKNOW,” it will count toward the numerator. ○ Each value must be self-reported. </p>
Exclusions	If value is UTC, the (Bundled Services or MCI) encounter or visit is excluded from the denominator.

ADDITIONAL MEASURE INFORMATION

Required Reporting	<p>The following information is required:</p> <ul style="list-style-type: none"> A valid MassHealth Member ID Format: Refer to MassHealth CBHC Visit and Demographics Data File Submission Guide At least one (1) race value, as defined under “Complete Race Data” above Format: Refer to MassHealth CBHC Visit and Demographics Data File Submission Guide
Data Collection	<p>For the purposes of this measure, race data must be self-reported. Race data that are derived using an imputation methodology do not contribute to completeness for this measure.</p> <p>Self-reported race data may be collected:</p> <ul style="list-style-type: none"> By any modality that allows the patient (or a person legally authorized to respond on the patient’s behalf, such as a parent or legal guardian) to self-report race (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); By any entity interacting with the member (e.g. health plan, ACO, provider, staff); Must include one or more values in Attachment 1.
Completeness Calculations	Completeness is calculated for: each individual CBHC TIN-billing entity, and all CBHC TIN-billing entities.

Attachment 1. Race: Accepted Values

Description	Valid Values	Notes
American Indian/Alaska Native	1002-5	
Asian	2028-9	
Black/African American	2054-5	
Native Hawaiian or other Pacific Islander	2076-8	
White	2106-3	
Other Race	OTH	

Description	Valid Values	Notes
Choose not to answer	ASKU	Member was asked to provide their race, and the member actively selected or indicated that they “choose not to answer.”
Don’t know	DONTKNOW	Member was asked to provide their race, and the member actively selected or indicated that they did not know their race.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	<p>The race of the member is unknown since either:</p> <p>(a) the member was not asked to provide their race, or</p> <p>(b) the member was asked to provide their race, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.</p>

A.ii. Hispanic Ethnicity Data Completeness

OVERVIEW

Measure Name	Rate of Hispanic Ethnicity Data Completeness – CBHC
Steward	EOHHS
NQF Number	N/A
Data Source	<p>Numerator source: CBHC Visit and Demographics Data File</p> <p>Denominator sources: MassHealth claims and encounter data, CBHC Visit and Demographics Data File</p>

PY 1 Performance Status	Pay-for-Reporting
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POPULATION HEALTH IMPACT

Complete, beneficiary-reported Hispanic ethnicity data are critically important for identifying, analyzing, and addressing disparities in health and health care access and quality.

MEASURE SUMMARY

Description	The percentage of MassHealth members with self-reported Hispanic ethnicity data that was collected by a CBHC in the measurement year.
Numerator	Members with a Bundle Services and/or Mobile Crisis Intervention (MCI) evaluation through a CBHC and self-reported Hispanic ethnicity data that was collected by a CBHC during the measurement year.
Denominator	Members with a Bundle Services and/or Mobile Crisis Intervention (MCI) evaluation through the CBHC during the measurement year.

ELIGIBLE POPULATION

Age	MassHealth members of any age
Continuous Enrollment Date	None
Anchor Date	None
Event/Diagnosis	At least one CBHC Bundle Services and/or MCI evaluation through the CBHC between January 1 and December 31 of the measurement year.

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.

MCI Evaluation and CBHC Bundle Services	<p>Mobile Crisis Intervention (MCI) services are a diversionary level of care falling under outpatient services defined by the following service code:</p> <ul style="list-style-type: none"> • MCI Evaluations (per diem): S9485 HA, HB, HE, or U1 <p>The following modifiers are optional (not required) for MCI per diem codes:</p> <ul style="list-style-type: none"> • 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 <p>The following modifiers are optional (not required) for MCI per 15 min codes:</p> <ul style="list-style-type: none"> • HN = Paraprofessional • HO = Master's level clinician • HA = Youth modifier (youth client seen) • HB = Adult modifier (adult client seen) <p>CBHC Bundle Services are behavioral health outpatient services and are defined as follows:</p> <ul style="list-style-type: none"> • CBHC Bundle Services: T1040 HA or HB <p>The modifier codes attached to the T1040 code are defined as follows:</p> <ul style="list-style-type: none"> • HA = Youth modifier (youth client seen) • HB = Adult modifier (adult client seen)
Complete Hispanic Ethnicity Data	<p>Complete Hispanic ethnicity data is defined as:</p> <p>One (1) valid Hispanic ethnicity value (valid Hispanic ethnicity values are listed in Attachment 2).</p> <ul style="list-style-type: none"> • If value is “UNK,” it will <u>not</u> count toward the numerator. • If value is “ASKU” it will count toward the numerator. • If value is “DONTKNOW” it will count toward the numerator. • Each value must be self-reported.
Data Elements for Reporting: CBHC Visit and Demographics Data	<p>File Name: CBHC Visit and Demographics Data</p> <p>Description: Encounter or visit-level file sent by the CBHC to MassHealth.</p>

	EOHHS will provide a separate Submission Guide detailing the submission process and the elements that will be used to calculate the measure.
Measurement Year	Measurement Years 1-5 correspond to Calendar Years 2024-2028
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).
Rate of Hispanic Ethnicity Data Completeness	<p>There will be two rates reported for this measure.</p> <p>Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100</p> <p>Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100</p>
Self-Reported Data	<p>For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).</p> <p>Self-reported Hispanic ethnicity data that has been rolled-up or transformed for reporting purposes may be included. For example, if a hospital's data systems include ethnicities that are included in HHS' data collection standards (i.e., Mexican; Puerto Rican; Cuban; Another Hispanic, Latino/a, or Spanish origin) and an individual self-reports their ethnicity as "Puerto Rican", then the hospital can report the value of "Hispanic" since the value of Puerto Rican is not a valid value in Attachment 2.</p>

ADMINISTRATIVE SPECIFICATION

Denominator	<p>There are two denominators for this measure:</p> <p>Denominator 1: The eligible population with CBHC Bundle Services encounters from CBHCs.</p> <p>Denominator 2: The eligible population with MCI evaluation encounters through CBHC MCI teams.</p>
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Numerator	<p>There are two numerators for this measure:</p> <p>Numerator 1: For members in Denominator 1, identify those with complete Hispanic ethnicity data, defined as: One (1) valid Hispanic ethnicity value (valid Hispanic ethnicity values are listed in Attachment 2).</p> <ul style="list-style-type: none"> ○ If value is “UNK,” it will <u>not</u> count toward the numerator. ○ If value is “ASKU,” it will count toward the numerator. ○ If value is “DONTKNOW,” it will count toward the numerator. ○ Each value must be self-reported. <p>Numerator 2: For members in Denominator 2, identify those with complete Hispanic ethnicity data, defined as: One (1) valid Hispanic ethnicity value (valid Hispanic ethnicity values are listed in Attachment 2).</p> <ul style="list-style-type: none"> ○ If value is “UNK,” it will <u>not</u> count toward the numerator. ○ If value is “ASKU,” it will count toward the numerator. ○ If value is “DONTKNOW,” it will count toward the numerator. ○ Each value must be self-reported.
Exclusions	If value is UTC, the (Bundled Services or MCI) encounter or visit is excluded from the denominator.

ADDITIONAL MEASURE INFORMATION

Required Reporting	<p>The following information is required:</p> <ul style="list-style-type: none"> • A valid MassHealth Member ID Format: Refer to MassHealth CBHC Visit and Demographics Data File Submission Guide • One (1) Hispanic ethnicity value, as defined under “Complete Hispanic Ethnicity Data” above Format: Refer to MassHealth CBHC Visit and Demographics Data File Submission Guide
Data Collection	For the purposes of this measure, Hispanic ethnicity data must be self-reported. Hispanic ethnicity data that are derived using

	<p>an imputation methodology do not contribute to completeness for this measure.</p> <p>Self-reported Hispanic ethnicity data may be collected:</p> <ul style="list-style-type: none"> • By any modality that allows the patient (or a person legally authorized to respond on the patient's behalf, such as a parent or legal guardian) to self-report Hispanic ethnicity (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 2.
Completeness Calculations	Completeness is calculated for: each individual CBHC TIN-billing entity, and all CBHC TIN-billing entities.

Attachment 2. Hispanic Ethnicity: Accepted Values

Description	Valid Values	Notes
Hispanic or Latino	2135-2	
Not Hispanic or Latino	2186-5	
Choose not to answer	ASKU	Member was asked to provide their ethnicity, and the member actively selected or indicated that they “choose not to answer”.
Don’t know	DONTKNOW	Member was asked to provide their ethnicity, and the member actively selected or indicated that they did not know their ethnicity.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness).	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	<p>The ethnicity of the member is unknown since either:</p> <p>(a) the member was not asked to provide their ethnicity, or</p>

Description	Valid Values	Notes
		(b) the member was asked to provide their ethnicity, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.

A.iii. Preferred Language Data Completeness

OVERVIEW

Measure Name	Rate of Language Data Completeness – CBHC
Steward	EOHHS
NQF Number	N/A
Data Source	Numerator source: CBHC Visit and Demographics Data File Denominator sources: MassHealth claims and encounter data, CBHC Visit and Demographics Data File
PY 1 Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

Complete, beneficiary-reported preferred written and spoken language data are critically important for identifying, analyzing, and addressing disparities in health and health care access and quality.

MEASURE SUMMARY

Description	The percentage of MassHealth members with self-reported language data that was collected by a CBHC in the measurement year.
Numerator	Members with a Bundle Services and/or Mobile Crisis Intervention (MCI) evaluation through a CBHC and self-reported language data that was collected by a CBHC during the measurement year.
Denominator	Members with a Bundle Services and/or Mobile Crisis Intervention (MCI) evaluation through the CBHC during the measurement year.

ELIGIBLE POPULATION

Age	Members age 6 and older as of December 31 st of the measurement year
Continuous Enrollment	None
Anchor Date	None
Event/Diagnosis	At least one CBHC Bundle Services and/or MCI evaluation through the CBHC between January 1 and December 31 of the measurement year.

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.
MCI Evaluation and CBHC Bundle Services	<p>Mobile Crisis Intervention (MCI) services are a diversionary level of care falling under outpatient services defined by the following service code:</p> <ul style="list-style-type: none"> • MCI Evaluations (per diem): S9485 HA, HB, HE, or U1 <p>The following modifiers are optional (not required) for MCI per diem codes:</p> <ul style="list-style-type: none"> • 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 <p>The following modifiers are optional (not required) for MCI per 15 min codes:</p> <ul style="list-style-type: none"> • HN = Paraprofessional • HO = Master's level clinician • HA = Youth modifier (youth client seen) • HB = Adult modifier (adult client seen)

	<p>CBHC Bundle Services are behavioral health outpatient services and are defined as follows:</p> <ul style="list-style-type: none"> • CBHC Bundle Services: T1040 HA or HB <p>The modifier codes attached to the T1040 code are defined as follows:</p> <ul style="list-style-type: none"> • HA = Youth modifier (youth client seen) • HB = Adult modifier (adult client seen)
Complete Preferred Written Language Data	<p>Complete Preferred Written Language (PWL) data is defined as:</p> <p>One (1) valid Preferred Written Language value (valid Preferred Written Language values are listed in Attachment 3).</p> <ul style="list-style-type: none"> • If value is “UNK,” it will <u>not</u> count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. • Each value must be self-reported.
Complete Preferred Spoken Language Data	<p>Complete Preferred Spoken Language (PSL) data is defined as:</p> <p>One (1) valid Preferred Spoken Language value (valid Preferred Spoken Language values are listed in Attachment 3).</p> <ul style="list-style-type: none"> • If value is “UNK,” it will <u>not</u> count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. • Each value must be self-reported.
Data Elements for Reporting: CBHC Visit and Demographics Data	<p>File Name: CBHC Visit and Demographics Data</p> <p>Description: Encounter or visit-level file sent by the CBHC to MassHealth.</p> <p>EOHHS will provide a separate Submission Guide detailing the submission process and the elements that will be used to calculate the measure.</p>
Measurement Year	Measurement Years 1-5 correspond to Calendar Years 2024-2028
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).

Rate of Preferred Written and Spoken Language Data Completeness	<p>There will be four rates reported for this measure, defined as:</p> <p>Rate 1: (Numerator 1 (PWL) Population / Denominator 1 (BS) Population) * 100</p> <p>Rate 2: (Numerator 1 (PSL) Population / Denominator 1 (BS) Population) * 100</p> <p>Rate 3: (Numerator 2 (PWL) Population / Denominator 2 (MCI) Population) * 100</p> <p>Rate 4: (Numerator 2 (PSL) Population / Denominator 2 (MCI) Population) * 100</p>
Self-Reported data	<p>For the purposes of this measure specification, data are defined as self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).</p>

ADMINISTRATIVE SPECIFICATION

Denominator	<p>There are two denominators for this measure:</p> <p>Denominator 1: The eligible population with CBHC Bundle Services encounters from CBHCs.</p> <p>Denominator 2: The eligible population for MassHealth members with MCI evaluation encounters through CBHCs.</p>
Numerator	<p>Numerator 1:</p> <p>For members in Denominator 1, identify those with complete language data, (defined above under “Complete Language Data”) for each question below:</p> <ul style="list-style-type: none"> • QMAT Language Q1: In which language would you feel most comfortable reading medical or health care instructions? (or similar phrasing to elicit written language preference). • QMAT Language Q2: What language do you feel most comfortable speaking with your doctor or nurse? (or similar phrasing to elicit spoken language preference). <p>Numerator 2:</p>

	<p>For members in Denominator 2, identify those with complete language data, (defined above under “Complete Language Data”) for each question below:</p> <ul style="list-style-type: none"> • QMAT Language Q1: In which language would you feel most comfortable reading medical or health care instructions? (or similar phrasing to elicit written language preference). • QMAT Language Q2: What language do you feel most comfortable speaking with your doctor or nurse? (or similar phrasing to elicit spoken language preference).
Exclusions	If value is UTC, the (Bundled Services or MCI) encounter or visit is excluded from the denominator.

ADDITIONAL MEASURE INFORMATION

Required Reporting	<p>The following information is required:</p> <ul style="list-style-type: none"> • A valid MassHealth Member ID Format: Refer to MassHealth CBHC Visit and Demographics Data File Submission Guide • At least one (1) Preferred Written and Spoken Language value per question, as defined under “Complete Preferred Written Language Data” and “Complete Preferred Spoken Language Data” above Format: Refer to MassHealth CBHC Visit and Demographics Data File Submission Guide
Data Collection	<p>For the purposes of this measure, Preferred Written and Spoken Language data must be self-reported. Preferred Written and Spoken Language data that are derived using an imputation methodology do not contribute to completeness for this measure.</p> <p>Self-reported Preferred Written and Spoken Language data may be collected:</p> <ul style="list-style-type: none"> • By any modality that allows the patient (or a person legally authorized to respond on the patient’s behalf, such as a parent or legal guardian) to self-report preferred written and spoken languages (e.g. over

	<p>the phone, electronically (e.g. a patient portal), in person, by mail, etc.);</p> <ul style="list-style-type: none"> • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 3; <ul style="list-style-type: none"> ○ If a CBHC submits a value that is not included in Attachment 3 but allowable per the CBHC Visit and Demographics Data File, the value will be mapped to Other Preferred Written Language (OTH).
Completeness Calculations	<p>Completeness is calculated per language question per denominator population each individual CBHC TIN-billing entity, and all CBHC TIN-billing entities.</p> <p>For each individual CBHC (<i>Bundle Services Denominator only</i>):</p> <p>For CBHC x, the percentage of members with self-reported preferred written language data for question 1 that was collected by CBHC x in the measurement year.</p> <p>For CBHC x, the percentage of members with self-reported preferred spoken language data for question 2 that was collected by CBHC x in the measurement year.</p> <p>For each individual CBHC (<i>MCI evaluation Denominator only</i>):</p> <p>For CBHC x, the percentage of members with self-reported preferred written language data for question 1 that was collected by CBHC x in the measurement year.</p> <p>For CBH x, the percentage of members with self-reported preferred spoken language data for question 2 that was collected by CBHC x in the measurement year.</p>

Attachment 3. Preferred Written and Spoken Language: Accepted Values

Preferred Written Language

Description	Valid Values	Notes
English	en	
Spanish	es	
Portuguese	pt	

Description	Valid Values	Notes
Chinese – Traditional	zh-Hant	
Chinese Simplified	zh-Hans	
Haitian Creole	ht	
French	fr	
Vietnamese	vi	
Russian	ru	
Arabic	ar	
Other Preferred Written Language	OTH	If a CBHC submits a value that is not included in Attachment 3 but allowable per CBHC Visit and Demographics Data Submission Guide, the value will be mapped to Other Preferred Written Language (OTH).
Choose not to answer	ASKU	Member was asked to provide their Preferred Written Language, and the member actively selected or indicated that they “choose not to answer.”
Don’t know	DONTKNOW	Member was asked to provide their Preferred Written Language, and the member actively selected or indicated that they did not know their Preferred Written Language.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	The Preferred Written Language of the member is unknown since either: (a) the member was not asked to provide their Preferred Written Language, or

Description	Valid Values	Notes
		(b) the member was asked to provide their Preferred Written Language, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.

Preferred Spoken Language

Description	Valid Values	Notes
English	en	-
Spanish	es	-
Portuguese	pt	-
Chinese	zh	If a CBHC submits Cantonese (yue), Mandarin (cmn), or Min Nan Chinese (nan) it will be mapped to Chinese for the purposes of data completeness.
Haitian Creole	ht	
Sign Languages	sgn	If a CBHC submits American Sign Language (ase) or Sign Languages (sgn), it will be mapped to Sign Languages for the purpose of data completeness.
French	fr	-
Vietnamese	vi	-
Russian	ru	-
Arabic	ar	-
Other Preferred Spoken Language	OTH	If a CBHC submits a value that is not included in Attachment 3 but allowable per CBHC Visit and Demographics Data Submission Guide, the value will be

		mapped to Other Preferred Spoken Language (OTH).
Choose not to answer	ASKU	Member was asked to provide their Preferred Spoken Language, and the member actively selected or indicated that they “choose not to answer.”
Don’t know	DONTKNOW	Member was asked to provide their Preferred Spoken Language, and the member actively selected or indicated that they did not know their Preferred Spoken Language.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	The Preferred Spoken Language of the member is unknown since either: (a) the member was not asked to provide their Preferred Spoken Language, or (b) the member was asked to provide their Preferred Spoken Language, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.

A.iv. Disability Data Completeness

OVERVIEW

Measure Name	Rate of Disability Data Completeness – CBHC
Steward	EOHHS
NQF Number	N/A

Data Source	Numerator source: CBHC Visit and Demographics Data File Denominator sources: MassHealth claims and encounter data, CBHC Visit and Demographics Data File
PY 1 Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

Complete, beneficiary-reported disability data are critically important for identifying, analyzing, and addressing disparities in health and health care access and quality.

MEASURE SUMMARY

Description	The percentage of MassHealth members with self-reported disability data that was collected by a CBHC in the measurement year.
Numerator	Members with a Bundle Services and/or Mobile Crisis Intervention (MCI) evaluation through a CBHC and self-reported disability data that was collected by a CBHC during the measurement year.
Denominator	Members with a Bundle Services and/or Mobile Crisis Intervention (MCI) evaluation through the CBHC during the measurement year.

ELIGIBLE POPULATION

Age	Age varies by disability question: <ul style="list-style-type: none"> Disability Questions 1 and 2: no age specified; Disability Questions 3 – 5: age 6 or older as of December 31st of the measurement year; Disability Question 6: age 16 or older as of December 31st of the measurement year.
Continuous Enrollment Date	None
Anchor Date	None
Event/Diagnosis	At least one CBHC Bundle Services and/or MCI evaluation through the CBHC between January 1 and December 31 of the measurement year.

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.
MCI Evaluation and CBHC Bundle Services	<p>Mobile Crisis Intervention (MCI) services are a diversionary level of care falling under outpatient services defined by the following service code:</p> <ul style="list-style-type: none"> • MCI Evaluations (per diem): S9485 HA, HB, HE, or U1 <p>The following modifiers are optional (not required) for MCI per diem codes:</p> <ul style="list-style-type: none"> • 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 <p>The following modifiers are optional (not required) for MCI per 15 min codes:</p> <ul style="list-style-type: none"> • HN = Paraprofessional • HO = Master's level clinician • HA = Youth modifier (youth client seen) • HB = Adult modifier (adult client seen) <p>CBHC Bundle Services are behavioral health outpatient services and are defined as follows:</p> <ul style="list-style-type: none"> • CBHC Bundle Services: T1040 HA or HB <p>The modifier codes attached to the T1040 code are defined as follows:</p> <ul style="list-style-type: none"> • HA = Youth modifier (youth client seen) • HB = Adult modifier (adult client seen)
Complete Disability Data	<p>Complete Disability data is defined as:</p> <p>One (1) valid disability value for each Disability Question (listed in Attachment 4).</p> <ul style="list-style-type: none"> • If value is "UNK," it will <u>not</u> count toward the numerator.

	<ul style="list-style-type: none"> • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. • Each value must be self-reported.
Measurement Year	Measurement Years 1-5 correspond to Calendar Years 2024-2028
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).
Rate of Disability Data Completeness	<p>There will be two rates reported for this measure.</p> <p>Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100</p> <p>Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100</p>
Data Elements for Reporting: CBHC Visit and Demographics Data	<p>File Name: CBHC Visit and Demographics Data</p> <p>Description: Encounter or visit-level file sent by the CBHC to MassHealth.</p> <p>EOHHS will provide a separate Submission Guide detailing the submission process and the elements that will be used to calculate the measure.</p>
Self-Reported data	For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual’s behalf

ADMINISTRATIVE SPECIFICATION

Denominator	<p>There are two denominators for this measure:</p> <p>Denominator 1: The eligible population for MassHealth members Bundle Services encounters from CBHCs.</p> <p>Denominator 2: The eligible population for MassHealth members with MCI evaluation encounters through CBHC MCI teams.</p>
Numerator Set	<p>There are two numerators for this measure:</p> <p>Numerator 1:</p>

For members in Denominator 1, identify those with complete disability data, (defined above under “Complete Disability Data”) for each question below:

Disability Q1 (all ages): Are you deaf or do you have serious difficulty hearing? Disability

Q2 (all ages): Are you blind or do you have serious difficulty seeing, even when wearing glasses?

Disability Q3 (age 5 or older): Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

Disability Q4 (age 5 or older): Do you have serious difficulty walking or climbing stairs?

Disability Q5 (age 5 or older): Do you have difficulty dressing or bathing?

Disability Q6 (age 15 or older): Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor’s office or shopping?

- If value is “UNK,” it will not count toward the numerator.
- If value is “ASKU,” it will count toward the numerator.
- If value is “DONTKNOW,” it will count toward the numerator.
- Each value must be self-reported.

Numerator 2:

For members in Denominator 2, identify those with complete disability data, (defined above under “Complete Disability Data”) for each question below:

Disability Q1 (all ages): Are you deaf or do you have serious difficulty hearing?

Disability Q2 (all ages): Are you blind or do you have serious difficulty seeing, even when wearing glasses?

Disability Q3 (age 5 or older): Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

	<p>Disability Q4 (age 5 or older): Do you have serious difficulty walking or climbing stairs?</p> <p>Disability Q5 (age 5 or older): Do you have difficulty dressing or bathing? Disability Q6 (age 15 or older): Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?</p> <ul style="list-style-type: none"> • If value is "UNK" it will <u>not</u> count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported. <p>Disability Q6 (age 15 or older): Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?</p> <ul style="list-style-type: none"> • If value is "UNK," it will <u>not</u> count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported.
Exclusions	If value is UTC, the (Bundled Services or MCI) encounter or visit is excluded from the denominator.

ADDITIONAL MEASURE INFORMATION

Required Reporting	<p>For a given disability question, the following information is required:</p> <ul style="list-style-type: none"> • A valid MassHealth Member ID Format: Refer to MassHealth CBHC Visit and Demographics Data File Submission Guide • One (1) valid disability value per question, as defined under "Complete Disability Data" above Format: Refer to MassHealth CBHC Visit and Demographics Data File Submission Guide
Data Collection	For the purposes of this measure, disability data must be self-reported. Disability data that are derived using an

	<p>imputation methodology do not contribute to completeness for this measure.</p> <p>Self-reported disability data may be collected:</p> <ul style="list-style-type: none"> • By any modality that allows the patient (or a person legally authorized to respond on the patient's behalf, such as a parent or legal guardian) to self-report disability (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc); • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 4.
Completeness Calculations	<p>Completeness is calculated per disability question per CBHC and overall, as described below for questions 1 and 2, as an example:</p> <p>For each individual CBHC:</p> <p>Example 1: For CBHC x, the percentage of MassHealth members with self-reported disability data for question 1 that was collected by CBHC x in the measurement year.</p> <p>Example 2: For CBHC x, the percentage of MassHealth members with self-reported disability data for question 2 that was collected by CBHC x in the measurement year.</p> <p>For all CBHCs</p> <p>Example 1: For all CBHCs, the percentage of MassHealth members with self-reported disability data for question 1 that was collected by all CBHCs in the measurement year.</p> <p>Example 2: For all CBHCs, the percentage of MassHealth members with self-reported disability data for question 2 that was collected by all CBHCs in the measurement year.</p>

Attachment 4. Disability: Accepted Values

Disability Q1: Are you deaf or do you have serious difficulty hearing?

Description	Valid Values	Notes
Yes	LA33-6	

Description	Valid Values	Notes
No	LA32-8	
Choose not to Answer	ASKU	Member was asked whether they are deaf or have difficulty hearing, and the member actively selected or indicated that they “choose not to answer.”
Don’t know	DONTKNOW	Member was asked whether they are deaf or have difficulty hearing, and the member actively selected or indicated that they did not know if they are deaf or have difficulty hearing.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	Whether the member is deaf or has difficulty hearing is unknown since either: (a) the member was not asked whether they are deaf or have difficulty hearing, or (b) the member was asked whether they are deaf or have difficulty hearing, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.

Disability Q2: Are you blind or do you have serious difficulty seeing, even when wearing glasses?

Description	Valid Values	Notes
Yes	LA33-6	
No	LA32-8	
Choose not to Answer	ASKU	Member was asked whether they are blind or have difficulty seeing, and the member actively selected or indicated that they “choose not to answer.”
Don’t know	DONTKNOW	Member was asked whether they are blind or have difficulty seeing, and the member actively selected or

Description	Valid Values	Notes
		indicated that they did not know whether they are blind or have difficulty seeing.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	<p>Whether the member is blind or has difficulty seeing is unknown since either:</p> <p>(a) the member was not asked whether they are blind or have difficulty seeing, or</p> <p>(b) the member was asked whether they are blind or have difficulty seeing, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.</p>

Disability Q3: Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

Description	Valid Values	Notes
Yes	LA33-6	
No	LA32-8	
Choose not to Answer	ASKU	Member was asked whether they have serious difficulty concentrating, remembering or making decisions, and the member actively selected or indicated that they “choose not to answer”.
Don’t know	DONTKNOW	Member was asked whether they have serious difficulty concentrating, remembering or making decisions, and the member actively selected or indicated that they did not know

Description	Valid Values	Notes
		whether they have serious difficulty concentrating, remembering or making decisions.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	<p>Whether the member has difficulty concentrating, remembering or making decisions is unknown since either:</p> <p>(a) the member was not asked whether they have difficulty concentrating, remembering or making decisions, or</p> <p>(b) the member was asked whether they have difficulty concentrating, remembering or making decisions, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.</p>

Disability Q4: Do you have serious difficulty walking or climbing stairs?

Description	Valid Values	Notes
Yes	LA33-6	
No	LA32-8	
Choose not to Answer	ASKU	Member was asked whether they have difficulty walking or climbing stairs, and the member actively selected or indicated that they “choose not to answer.”
Don’t know	DONTKNOW	Member was asked whether they have difficulty walking or climbing stairs, and the member actively selected or indicated

Description	Valid Values	Notes
		that they did not know whether they have difficulty walking or climbing stairs.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	<p>Whether the member has difficulty walking or climbing stairs is unknown since either:</p> <p>(a) the member was not asked whether they have difficulty walking or climbing stairs, or</p> <p>(b) the member was asked whether they have difficulty walking or climbing stairs, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.</p>

Disability Q5: Do you have difficulty dressing or bathing?

Description	Valid Values	Notes
Yes	LA33-6	
No	LA32-8	
Choose not to Answer	ASKU	Member was asked whether they have difficulty dressing or bathing, and the member actively selected or indicated that they “choose not to answer.”
Don’t know	DONTKNOW	Member was asked whether they have difficulty dressing or bathing, and the member actively selected or indicated that they did not know whether they have difficulty dressing or bathing.

Description	Valid Values	Notes
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	<p>Whether the member has difficulty dressing or bathing is unknown since either:</p> <p>(a) the member was not asked whether they have difficulty dressing or bathing, or</p> <p>(b) the member was asked whether they have difficulty dressing or bathing, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.</p>

Disability Q6: Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

Description	Valid Value	Notes
Yes	LA33-6	
No	LA32-8	
Choose not to Answer	ASKU	Member was asked if they have difficulty doing errands, and the member actively selected or indicated that they “choose not to answer”.
Don't know	DONTKNOW	Member was asked if they have difficulty doing errands, and the member actively selected or indicated that they did not know whether they have difficulty doing errands.
Unable to collect this information on member due to	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.

Description	Valid Value	Notes
lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)		
Unknown	UNK	<p>Whether a member has difficulty doing errands is unknown since either:</p> <p>(a) the member was not asked whether they have difficulty doing errands, or</p> <p>(b) the member was asked whether they have difficulty doing errands, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.</p>

A.v. Sexual Orientation Data Completeness

OVERVIEW

Measure Name	Rate of Sexual Orientation Data Completeness – CBHC
Steward	EOHHS
NQF Number	N/A
Data Source	<p>Numerator source: CBHC Visit and Demographics Data File</p> <p>Denominator sources: MassHealth claims and encounter data, CBHC Visit and Demographics Data File</p>
PY 1 Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

Complete, beneficiary-reported sexual orientation data are critically important for identifying, analyzing, and addressing disparities in health and health care access and quality.

MEASURE SUMMARY

Description	The percentage of MassHealth members with self-reported sexual orientation data that was collected by a CBHC in the measurement year.
Numerator	Members with a Bundle Services and/or Mobile Crisis Intervention (MCI) evaluation through a CBHC and self-reported sexual orientation data that was collected by a CBHC during the measurement year.
Denominator	Members with a Bundle Services and/or Mobile Crisis Intervention (MCI) evaluation through the CBHC during the measurement year.

ELIGIBLE POPULATION

Age	MassHealth members age 19 and older as of December 31 of the measurement year
Continuous Enrollment Date	None
Anchor Date	None
Event/Diagnosis	At least one CBHC Bundle Services and/or MCI evaluation through the CBHC between January 1 and December 31 of the measurement year.

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.
MCI Evaluation and CBHC Bundle Services	<p>Mobile Crisis Intervention (MCI) services are a diversionary level of care falling under outpatient services defined by the following service code:</p> <ul style="list-style-type: none"> MCI Evaluations (per diem): S9485 HA, HB, HE, or U1 <p>The following modifiers are optional (not required) for MCI per diem codes:</p> <ul style="list-style-type: none"> HA = Youth modifier (youth client seen); may occur in combination with HE or U1

	<ul style="list-style-type: none"> • HE = Services provided at CBHC site • U1 = Services provided at community-based sites of service outside of the CBHC site <p>The following modifiers are optional (not required) for MCI per 15 min codes:</p> <ul style="list-style-type: none"> • HN = Paraprofessional • HO = Master's level clinician • HA = Youth modifier (youth client seen) • HB = Adult modifier (adult client seen) <p>CBHC Bundle Services are behavioral health outpatient services and are defined as follows:</p> <ul style="list-style-type: none"> • CBHC Bundle Services: T1040 HA or HB <p>The modifier codes attached to the T1040 code are defined as follows:</p> <ul style="list-style-type: none"> • HA = Youth modifier (youth client seen) • HB = Adult modifier (adult client seen)
Complete Sexual Orientation Data	<p>Complete sexual orientation data is defined as:</p> <p>At least one (1) valid sexual orientation value (listed in Attachment 5).</p> <ul style="list-style-type: none"> • If value is "UNK," it will <u>not</u> count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. <p>Each value must be self-reported.</p>
Data Elements for Reporting: CBHC Visit and Demographics Data	<p>File Name: CBHC Visit and Demographics Data</p> <p>Description: Encounter or visit-level file sent by the CBHC to MassHealth.</p> <p>EOHHS will provide a separate Submission Guide detailing the submission process and the elements that will be used to calculate the measure.</p>
Measurement Year	Measurement Years 1-5 correspond to Calendar Years 2024-2028
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).

Rate of Sexual Orientation Data Completeness	<p>There will be two rates reported for this measure.</p> <p>Rate1: (Numerator 1 Population / Denominator 1 Population) * 100</p> <p>Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100</p>
Self-Reported data	<p>For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either:</p> <p>(a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).</p>

ADMINISTRATIVE SPECIFICATION

Denominator	<p>There are two denominators for this measure:</p> <p>Denominator 1: The eligible population with CBHC Bundle Services visit encounters from CBHCs.</p> <p>Denominator 2: The eligible population with MCI evaluation encounters through CBHC MCI teams.</p>
Numerator	<p>There are two numerators for this measure:</p> <p>Numerator 1: For members in Denominator 1, identify those with complete sexual orientation data, defined as:</p> <p>At least one (1) valid sexual orientation value (valid sexual orientation values are listed in Attachment 5).</p> <ul style="list-style-type: none"> • If value is "UNK," it will <u>not</u> count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported. <p>Numerator 2: For members in Denominator 2, identify those with complete</p>

	<p>Hispanic ethnicity data, defined as: At least one (1) valid sexual orientation value (valid sexual orientation values are listed in Attachment 5).</p> <ul style="list-style-type: none"> • If value is “UNK,” it will <u>not</u> count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. <p>Each value must be self-reported.</p>
Exclusions	If value is UTC, the (Bundled Services or MCI) encounter or visit is excluded from the denominator.

ADDITIONAL MEASURE INFORMATION

Required Reporting	<p>The following information is required:</p> <ul style="list-style-type: none"> • A valid MassHealth Member ID Format: Refer to MassHealth CBHC Visit and Demographics Data File Submission Guide • At least one (1) valid sexual orientation value, as defined under “Complete Sexual Orientation Data” above Format: Refer to MassHealth CBHC Visit and Demographics Data File Submission Guide
Data Collection	<p>For the purposes of this measure, sexual orientation data must be self-reported. Sexual orientation data that are derived using an imputation methodology do not contribute to completeness for this measure.</p> <p>Self-reported sexual orientation data may be collected:</p> <ul style="list-style-type: none"> • By any modality that allows the patient (or a person legally authorized to respond on the patient’s behalf, such as a parent or legal guardian) to self-report sexual orientation (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 5.
Completeness Calculations	Completeness is calculated for: each individual CBHC TIN-billing entity, and all CBHC TIN-billing entities.

Attachment 5. Sexual Orientation: Accepted Values

Description	Valid Values	Notes
Bisexual	42035005	
Straight or heterosexual	20430005	
Lesbian or gay	38628009	
Queer, pansexual, and/or questioning	QUEER	
Something else	OTH	
Choose not to answer	ASKU	Member was asked to provide their sexual orientation, and the member actively selected or indicated that they “choose not to answer”.
Don’t know	DONTKNOW	Member was asked to provide their sexual orientation, and the member actively selected or indicated that they did not know their sexual orientation.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	<p>The sexual orientation of the member is unknown since either:</p> <p>(a) the member was not asked to provide their sexual orientation, or</p> <p>(b) the member was asked to provide their sexual orientation, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.</p>

A.vi. Gender Identity Data Completeness

OVERVIEW

Measure Name	Rate of Gender Identity Data Completeness – CBHC
Steward	EOHHS
NQF Number	N/A
Data Source	Numerator source: CBHC Visit and Demographics Data File Denominator sources: MassHealth claims and encounter data, CBHC Visit and Demographics Data File
PY 1 Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

Complete, beneficiary-reported gender identity data are critically important for identifying, analyzing, and addressing disparities in health and health care access and quality.

MEASURE SUMMARY

Description	The percentage of MassHealth members with self-reported gender identity data that was collected by a CBHC in the measurement year.
Numerator	Members with a Bundle Services and/or Mobile Crisis Intervention (MCI) evaluation through a CBHC and self-reported gender identity data that was collected by a CBHC during the measurement year.
Denominator	Members with a Bundle Services and/or Mobile Crisis Intervention (MCI) evaluation through the CBHC during the measurement year.

ELIGIBLE POPULATION

Age	MassHealth members age 19 and older as of December 31 of the measurement year
Continuous Enrollment Date	None
Anchor Date	None

Event/Diagnosis	At least one CBHC Bundle Services and/or MCI evaluation through the CBHC between January 1 and December 31 of the measurement year.
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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.
MCI Evaluation and CBHC Bundle Services	<p>Mobile Crisis Intervention (MCI) services are a diversionary level of care falling under outpatient services defined by the following service code:</p> <ul style="list-style-type: none"> MCI Evaluations (per diem): S9485 HA, HB, HE, or U1 <p>The following modifiers are optional (not required) for MCI per diem codes:</p> <ul style="list-style-type: none"> 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 <p>The following modifiers are optional (not required) for MCI per 15 min codes:</p> <ul style="list-style-type: none"> HN = Paraprofessional HO = Master's level clinician HA = Youth modifier (youth client seen) HB = Adult modifier (adult client seen) <p>CBHC Bundle Services are behavioral health outpatient services and are defined as follows:</p> <ul style="list-style-type: none"> CBHC Bundle Services: T1040 HA or HB <p>The modifier codes attached to the T1040 code are defined as follows:</p> <ul style="list-style-type: none"> HA = Youth modifier (youth client seen) HB = Adult modifier (adult client seen)

Complete Gender Identity Data	<p>Complete gender identity data is defined as: At least one (1) valid gender identity value (listed in Attachment 6).</p> <ul style="list-style-type: none"> • If value is “UNK,” it will not count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. <p>Each value must be self-reported.</p>
Data Elements for Reporting: CBHC Visit and Demographics Data	<p>File Name: CBHC Visit and Demographics Data</p> <p>Description: Encounter or visit-level file sent by the CBHC to MassHealth.</p> <p>EOHHS will provide a separate Submission Guide detailing the submission process and the elements that will be used to calculate the measure.</p>
Measurement Year	Measurement Years 1-5 correspond to Calendar Years 2024-2028
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).
Rate of Gender Identity Data Completeness	<p>There will be two rates reported for this measure.</p> <p>Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100</p> <p>Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100</p>
Self-Reported data	<p>For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either:</p> <p>(a) the individual, or (b) a person who can act on the individual’s behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).</p>

ADMINISTRATIVE SPECIFICATION

Denominator	<p>There are two denominators for this measure:</p> <p>Denominator 1: The eligible population with CBHC Bundle Services visit</p>
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	<p>encounters from CBHCs.</p> <p>Denominator 2: The eligible population with MCI evaluation encounters through CBHC MCI teams.</p>
Numerator	<p>There are two numerators for this measure:</p> <p>Numerator 1: For members in Denominator 1, identify those with complete sexual orientation data, defined as: At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 6).</p> <ul style="list-style-type: none"> • If value is “UNK,” it will <u>not</u> count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. • Each value must be self-reported. <p>Numerator 2: For members in Denominator 2, identify those with complete Hispanic ethnicity data, defined as: At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 6).</p> <ul style="list-style-type: none"> • If value is “UNK,” it will <u>not</u> count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. <p>Each value must be self-reported.</p>
Exclusions	<p>If value is UTC, the (Bundled Services or MCI) encounter or visit is excluded from the denominator.</p>

ADDITIONAL MEASURE INFORMATION

Required Reporting	<p>The following information is required:</p> <ul style="list-style-type: none"> • A valid MassHealth Member ID <p>Format: Refer to MassHealth CBHC Visit and Demographics Data File Submission Guide</p> <ul style="list-style-type: none"> • At least one (1) valid gender identity value, as defined under “Complete Gender Identity Data” above
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	Format: Refer to MassHealth CBHC Visit and Demographics Data File Submission Guide
Data Collection	<p>For the purposes of this measure, gender identity data must be self-reported. Gender identity data that are derived using an imputation methodology do not contribute to completeness for this measure.</p> <p>Self-reported gender identity data may be collected:</p> <ul style="list-style-type: none"> • By any modality that allows the patient (or a person legally authorized to respond on the patient's behalf, such as a parent or legal guardian) to self-report gender identity (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 6.
Completeness Calculations	Completeness is calculated for: each individual CBHC TIN-billing entity, and all CBHC TIN-billing entities.

Attachment 6. Gender Identity: Accepted Values

Description	Valid Values	Notes
Male	446151000124109	
Female	446141000124107	
Genderqueer/gender nonconforming/non-binary; neither exclusively male nor female	446131000124102	
Transgender man/trans man	407376001	
Transgender woman/trans woman	407377005	
Additional gender category or other	OTH	
Choose not to answer	ASKU	Member was asked to provide their gender identity, and the member actively selected or indicated that they "choose not to answer".

Description	Valid Values	Notes
Don't know	DONTKNOW	Member was asked to provide their gender identity, and the member actively selected or indicated that they did not know their gender identity.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	<p>The gender identity of the member is unknown since either:</p> <p>(a) the member was not asked to provide their gender identity, or</p> <p>(b) the member was asked to provide their gender identity, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.</p>

A.vii. Performance Requirements and Assessment (Applicable to all subcomponents of the RELDSOGI Data Completeness Measure)

PERFORMANCE REQUIREMENTS AND ASSESSMENT

Performance Requirements	Complete, timely, and responsive, (at a date to be determined by EOHHS) submission to EOHHS of a mapping and verification deliverable which may include descriptions of member-reported demographic data collection efforts as specified by EOHHS.
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B. Health-Related Social Needs Screening: Preparing for Reporting Beginning in PY2

OVERVIEW

Measure Name	Health-Related Social Needs Screening: Preparing for Reporting Beginning in PY2
Steward	EOHHS
NQF Number	N/A
Data Source	Claims Data, Clinical Data
PY 1 Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

Eliminating health care disparities is essential to improve quality of care for all patients. An important step in addressing health care disparities and improving patient outcomes is to screen for social drivers of health, including the immediate daily necessities prioritized by individuals that arise from the inequities caused by social determinants of health.

Identification of such needs provides an opportunity to improve health outcomes through interventions such as referral to appropriate social services.

MEASURE SUMMARY

Description	<p>This metric assesses essential foundational interventions by CBHCs to prepare for accountability under the MassHealth Health-Related Social Needs measure which would be implemented in the CQEIP beginning in PY2 to assess whether a CBHC implements screening for all MassHealth patients for food insecurity, housing instability, transportation needs, and utility difficulties.</p> <p>This measure assesses CBHC performance in conducting necessary precursor activities in preparation for implementation of the finalized Health-Related Social Needs measure in Performance Year 2.</p>
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SUBMISSION REQUIREMENTS: PY1

Performance Requirements

1. Health-Related Social Needs Assessment

Complete, responsive, and timely (anticipated by September 30th, 2024) submission to EOHHS of an initial assessment of:

- a) patient-reported health-related social needs (HRSN) data adequacy and completeness, and
- b) strategies employed to provide information about referrals including to community resources and support services

2. Health-Related Social Needs Tool(s) and Plan

Complete, responsive, and timely (anticipated by December 1, 2024) submission of a report to EOHHS describing:

- a) One or more HRSN screening tool(s) selected by the CBHC for intended use in screening members beginning in PY 2; the selected tool(s) must meet requirements for screening tools for the MassHealth Health-Related Social Needs metric; and
- b) An implementation plan to begin screening for HRSNs in Q1 PY 2 (CY 2025) to have capacity to report on the MassHealth Health-Related Social Needs Screening metric beginning in PY 2.
- c) Strategies to provide information about community resources and support services available to members who screen positive for HRSNs.

CBHC TIN-billing entities shall submit one HRSN assessment and one HRSN Tool(s) and Plan on behalf of its CBHC sites, if there are multiple.

C. Stratified Reporting of Quality Data

OVERVIEW

Measure Name	Stratified Reporting of Quality Data
Steward	EOHHS

NQF Number	N/A
Data Source	CBHC-Submitted File
PY 1 Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

Eliminating health care disparities is essential to improve quality of care for all patients. One step in addressing health care disparities and improving patient outcomes is stratifying patient data by social risk factors. By collecting and stratifying quality measures by social risk factors, providers and care systems can identify where health care disparities exist—and then focus interventions to reduce the disparities. Providers and care systems that understand their patient populations and work to make quality improvements where there are opportunities to reduce disparities in care among their patients, will improve and promote equitable care for the overall population.

MEASURE SUMMARY

Description	<p>This measure outlines CBHC-focused stratified reporting requirements for applicable quality measures as defined by EOHHS for Performance Year 1.</p> <p>These requirements include disaggregated demographic factors (including race and ethnicity).</p>
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APPLICABLE QUALITY MEASURE(S)

Domain	Access Standards
Measure	CCQI-1: Access Standards

STRATIFICATION REQUIREMENTS

Description	Participating CBHCs are required to generate or otherwise report on applicable quality measure rates stratified by self-reported race and ethnicity according to data standard requirements specified by EOHHS and summarized below:
Variable	Race

Standard	MassHealth
Variable	Ethnicity
Standard	MassHealth

SUBMISSION REQUIREMENTS: PY1

Performance Requirements	<p>Complete, responsive, and timely (anticipated by December 31, 2024) submission to EOHHS of an accurate and successful test file of the MassHealth CBHC Visit and Demographics Data File (VDDF), containing time-stamped, member-level visit data for MassHealth patients, including self-reported demographic data.</p> <p>The test file will minimally contain race and ethnicity test data for stratified reporting.</p> <p>EOHHS will provide a separate Submission Guide detailing the submission process and the data elements.</p>
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D. Equity Improvement Interventions

OVERVIEW

Measure Name	Equity Improvement Interventions
Steward	EOHHS
NQF Number	N/A
Data Source	CBHC-submitted data
PY 1 Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

Performance improvement projects (PIP) will lead to demonstrated improvements on access and quality metrics, including associated reductions in disparities leading to overall improved health outcomes.

MEASURE SUMMARY

Description

CBHCs will describe current capacity to conduct performance improvement projects and identify resources and infrastructure to support future equity improvement intervention planning and implementation.

Performance Year 1 planning will support CBHC efforts to develop a PIP Baseline Report in PY2 to identify performance goals and metrics to address disparities reduction in Performance Years 3 through 5.

PERFORMANCE REQUIREMENTS: PY1

Performance Requirements

PIP Assessment and Planning Document

Complete, responsive, and timely (anticipated November 1st, 2024, to be determined by EOHHS) submission to EOHHS of the following report:

1. **Organizational Assessment and Quality Planning Document**, which describes the CBHC's current capacity to conduct performance improvement projects and identifies resources and infrastructure to support future equity improvement intervention planning and implementation. This deliverable may include:
 - a. Identification of key CBHC personnel to support equity improvement interventions. Personnel could include, but are not limited to, an Executive Sponsor, Clinical Lead, and Project Manager as well as other supporting staff.
 - b. Description of CBHC resources, including but not limited to, access to population and health disparities data and ability to regularly use data to measure improvement.
 - c. Identification of potential needs to support quality improvement efforts such as additional staff, trainings, or technical assistance.
 - d. Descriptions of CBHC relationships with external entities, such as those involved in the care or support of a sizeable volume of CBHC patients (i.e., hospitals and community organizations)

	<p>that can be leveraged or expanded to support quality improvement efforts.</p> <p>e. Descriptions of current health equity goals and priorities.</p> <p>CBHC TIN-billing entities shall submit one planning document on behalf of its CBHC sites, if there are multiple.</p>
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E. Meaningful Access to Healthcare Services for Individuals with a Preferred Language Other than English

OVERVIEW

Measure Name	Meaningful Access to Healthcare Services for Individuals with a Preferred Language Other than English
Steward	EOHHS
NQF Number	N/A
Data Source	CBHC-submitted data
PY 1 Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

Access to high quality language services is essential to delivery of accessible, high-quality care for individuals with a preferred language other than English.

MEASURE SUMMARY

Description	<p>This measure assesses access to healthcare services for individuals with a preferred language other than English and has one component for PY 1:</p> <p>Language Services Organizational Self-Assessment</p> <p>This self-assessment evaluates capacity of a CBHC related to providing high quality communication services to patients. The survey will capture information pertinent to providing high quality language services, including related to:</p>
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	<ul style="list-style-type: none"> a. Data collection and identification of communication needs b. Provision of Language Assistance Services c. Providing notice of language assistance services d. Policies, procedures and staff training Monitoring and evaluation
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PERFORMANCE REQUIREMENTS: PY1

Performance Requirements	<p>Language Services Organizational Self-Assessment</p> <p>Complete, responsive, and timely (anticipated by December 31, 2024) reporting of an organizational self-assessment of capacity related to providing access to high quality language services to members. CBHC TIN-billing entities shall submit one self-assessment on behalf of its CBHC sites, if there are multiple.</p>
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F. Disability Competent Care

OVERVIEW

Measure Name	Disability Competent Care
Steward	EOHHS
NQF Number	N/A
Data Source	CBHC-submitted data
PY 1 Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

Despite evidence of health care disparities experienced by people with disabilities, many health care workers lack adequate training to competently meet the health care needs of people with disabilities. This measure will incentivize CBHCs to identify and prepare for addressing unmet needs for healthcare worker education and training to promote core competencies in providing care to members with disabilities.

MEASURE SUMMARY

Background	<p>Two evidence-based competency models may help health care organizations achieve disability competent care: 1) The Disability Competencies,[1] a set of six core competencies developed in 2015 by the Alliance for Disability in Health Care Education (ADHCE) for the future health care workforce [2,3] and 2) The Resources for Integrated Care (RIC) Disability Core Competency (DCC) Model, a set of seven competency ‘pillars’ developed in 2017 for the practicing health care workforce. [3-5] Both models share common elements and an overarching goal to improve health care for persons with disabilities by educating the health care workforce. [3] Healthcare organizations may assess the degree to which they meet disability competencies using the Resources for Integrated Care (RIC) Disability-Competent Care Self-Assessment Tool (DCCAT) and the Disability-Competent Care Self-paced Training Assessment Review Tool (DCC-START). [6,7]</p>
Description	<p>This measure evaluates whether CBHCs have:</p> <ol style="list-style-type: none"> 1. Performed a self-assessment of disability-competent care; 2. Identified at least three areas of competency in need of improvement; and 3. Developed a disability competency training plan for patient-facing CBHC staff.
Additional Measure Information	<p>Patient-facing staff: any employed (part or full-time), non-agency CBHC staff whose role requires engagement with patients (and/or a patient’s caregiver(s)). Patient-facing staff may serve in clinical roles (e.g. provider) or non-clinical roles (e.g., transport staff, diagnostic (lab, radiology) support staff, food services, registration.)</p> <p>Medical needs: the needs related to the medical evaluation, assessment, diagnostic, functional and therapeutic care needs of a patient including patients who may have additional needs for assistance or accommodation due to their disability.</p>
References	<ol style="list-style-type: none"> 1. https://nisonger.osu.edu/wp-content/uploads/2019/08/post-consensus-Core-Competencies-on-Disability_8.5.19.pdf

	<ol style="list-style-type: none"> 2. https://www.adhce.org/ 3. https://doi.org/10.1016/j.dhjo.2020.100941 4. https://www.resourcesforintegratedcare.com/introduction/ 5. https://www.resourcesforintegratedcare.com/disability-competent-care/ 6. https://www.resourcesforintegratedcare.com/disability-competent-care-self-assessment-tool/ 7. The DCCAT Evaluation Results Form was developed by CMS' RIC with the purpose of helping health plans and systems evaluate their ability to meet the needs of adults with functional limitations, and to identify opportunities for improvement. The DCCAT Evaluation Results Form is an Excel document that is available here.
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PERFORMANCE REQUIREMENTS AND ASSESSMENT: PY1

Performance Requirements	<ol style="list-style-type: none"> 1. Disability Competent Care Self-Assessment Report Complete, responsive, and timely (anticipated by November 1st, 2024) submission to EOHHS of the following: The CBHC's DCC Team's completed Disability-Competent Care Self-Assessment Report (DCCSAR) report, or another tool to be specified by EOHHS, that includes the following: <ol style="list-style-type: none"> a. Overview of DCC Team member composition. The members included on the CBHC's Disability Competent Care (DCC) Team can be decided by the CBHC and should represent a reasonable mix of clinical and non-clinical patient-facing staff from different clinical services. In the case of multiple CBHC sites, the DCC team should include staff from each site. Further, we strongly recommend including individuals with disability on the CBHC's DCC Team. b. The summary results from the CBHC DCC Team's DCCAT Evaluation Results Form (DCCAT-ERF) exercise, or another tool to be specified by EOHHS. CBHCs will have freedom to further modify the 'base' DCC-ERF, e.g. add
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	<p>new questions so long as the CBHC submits documentation of (as part of their report) the modifications made along with the reason(s) for the modification(s).</p> <p>Each participating CBHC TIN-billing entity must complete the DCCAT-ERF. This form is not required to be submitted. In the case of multiple CBHC sites, the CBHC TIN-billing entity completes the DCCAT-ERF on behalf of all respective sites.</p> <p>2. Disability Competent Care Training Plan</p> <p>Complete, responsive, and timely (anticipated to be due by a date following December 31, 2024) submission to EOHHS of a plan for improving competency in targeted competency areas during PY 2, including:</p> <ul style="list-style-type: none"> a. selected training tools and/or educational resources, b. which patient-facing staff will be assessed (including self-assessed) for post-educational/training competency, and c. approaches that will be used to assess post-education/training, organizational, and staff competency. <p>This plan must describe how the CBHC will be prepared to begin reporting performance in PY 2 on a process measure (in development by EOHHS) beginning in PY 2 that assesses the percent of patient-facing staff demonstrating competency in targeted competency areas for improvement.</p> <p>CBHC TIN-billing entities shall submit one DCC Training Plan on behalf of its CBHC sites, if there are multiple.</p>
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G. Disability Accommodation Needs

OVERVIEW	
Measure Name	Accommodation Needs: Structural Measure
Steward	EOHHS
NQF Number	N/A
Data Source	CBHC-submitted data

PY 1 Performance Status	Pay-for-Reporting
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POPULATION HEALTH IMPACT

Evidence suggests people who have needs for accommodation when accessing health care due to a disability (e.g. behavioral, physical, intellectual) do not always have those needs met. Lack of necessary accommodation can impact health care access and quality.

MEASURE SUMMARY

Description	<p>This measure evaluates whether CBHCs have:</p> <ol style="list-style-type: none"> 1. Assessed current state of CBHC practice related to screening for accommodation needs at the point of care; and 2. Planned for how they will, beginning in PY2, screen patients for accommodation needs at the point of care.
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PERFORMANCE REQUIREMENTS AND ASSESSMENT: PY1

Performance Requirements	<p>Disability Accommodation Needs Current Practice and Future Plans</p> <p>Complete, responsive, and timely (anticipated by September 30, 2024) submission to EOHHS of a report describing the CBHC's current practice and future plans for the following:</p> <ol style="list-style-type: none"> 1. screening members for accommodation needs* before or at the start of a member encounter, and how the results of this screening are documented, 2. other methods, if any, for documenting accommodation needs. <p>CBHC TIN-billing entities shall submit one report deliverable on behalf of its CBHC sites, if there are multiple.</p> <p><i>* For this report, accommodation needs are regarded to be needs related to a disability, including disabilities as a result of a physical, intellectual or behavioral health condition. For this report, this does not include needs for language interpreters,</i></p>
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but does include accommodation needs for vision impairments (e.g., Braille) or hearing impairments (e.g., ASL interpreters).

H. Patient Experience: Communication, Courtesy, and Respect

OVERVIEW

Measure Name	Patient Experience: Communication, Courtesy, and Respect
Steward	N/A
NQF Number	N/A
Data Source	CBHC-submitted survey
PY 1 Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

Using patient-reported experience, organizations can assess the extent to which patients are receiving culturally competent care that is respectful of and responsive to their individual preferences, needs, and values.

MEASURE SUMMARY

Description	This measure assesses current practices for eliciting patient experience of care with CBHC services, with a focus on equitable experience, to inform survey requirements in future years.
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PERFORMANCE REQUIREMENTS AND ASSESSMENT: PY1

Performance Requirements	1. Patient Experience Report Complete, responsive, and timely (anticipated by September 30th, 2024) submission to EOHHS of an initial assessment of current practices for eliciting patient experience of care with CBHC services, with a focus on equitable experience, to include the following:
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- a) Description of how the CBHC currently evaluates or plans to evaluate patient experience of care,
- b) Instruments currently in use or development, such as a survey or focus group questions, and said survey or group location(s) and method(s) of collection,
- c) How or whether any existing methods assess patient experience with regard to communication, courtesy, and respect, and
- d) Results collected from the instrument, if available, including insights garnered and changes considered or implemented in response to results.

EOHHS may use results from the assessment to inform requirement #2 (e.g. specific questions to address within the survey instrument).

2. Patient Experience Plan

Complete, responsive, and timely (anticipated by a date following December 31, 2024) submission to EOHHS of a report describing the final plan for eliciting patient experience of care in PY2, including specific instrument(s), plans for administration of the instrument(s), and how any such instrument(s) will incorporate concepts of communication, courtesy, respect, and/or other dimensions of equitable patient experience.

CBHC TIN-billing entities shall submit one report and one plan on behalf of its CBHC sites, if there are multiple.