



# **Technical Specifications for the MassHealth Hospital Quality and Equity Incentives Program (CHA-HQEIP)**

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**Performance Year 1**

**Published July 13, 2023**

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## II. Introduction to CHA-HQEIP Technical Specifications

### A. CHA-Specific Adaptations

Cambridge Health Alliance (CHA) will follow the specified measures and technical specifications for the HQEIP for the Medicaid patient population with adaptations described in this document for:

- submission of electronic population-based measures (instead of chart-abstracted/sampled measures) for Stratified Reporting of Quality Data (EOHHS) (described in Section C)
- updates to the aligned measures for Section C. Stratified Reporting of Quality Data (EOHHS)
- ambulatory quality measures for the served uninsured patient population within the CHA HQEIP (Section J); and
- adaptations to other HQEIP deliverables related to the Medicaid and served uninsured patient populations (see CHA-Specific Adaptation tables following Sections A, B, and D - I).

EOHHS has determined that CHA can annually report population-based electronic measures (drawn from the electronic health record) in lieu of chart-abstraction/sampling for measures within Section C. Stratified Reporting of Quality Data (EOHHS) and Section E. Meaningful Access to Healthcare Services for Persons with Limited English Proficiency (*OHA*). This is aligned with EOHHS' goals toward population-based data collection. Measures will be submitted following PY1 utilizing an EOHHS-approved template consistent with the CMS and Joint Commission portal fields used for e-measures.

Related to Stratified Reporting of Quality Data, since CHA is not participating in the Clinical Quality Incentive (CQI) program from which initial hospital-based health equity measures are drawn for PY1, CHA will report a measure set in alignment with HQEIP with adaptation (Section C).

For Section C, CHA will report the same hospital-based quality measures for the Medicaid and served uninsured patient populations with the exception of the perinatal measures (since Medicaid coverage is applicable). The measures will be reported separately for the served uninsured and Medicaid patient populations, unless the measure specification calls for reporting on an all-payer population. For the served uninsured patient population, CHA will report Follow-up After Hospitalization (for medical and surgical discharges), an important indicator for served uninsured patients, in place of perinatal measures.

In the event that a measure is retired by a measure steward for any reason, MassHealth will replace the impacted measure, choosing from a CMS-approved measure that is already widely adopted within Massachusetts (or for which reliable data to establish a valid benchmark and performance changes are readily available) and supported by the findings from analysis and/or needs assessment.

### B. Patient Population Definitions

The served uninsured (or underinsured) patient population and Medicaid population are defined as CHA patient populations for measurement.

The served uninsured population are patients who have the following:

- MassHealth Limited (emergency Medicaid), including those with Health Safety Net (HSN) as a secondary safety net program;
- Health Safety Net including primary, secondary, partial, confidential, or bad debt; or
- Children's Medical Security Plan, with HSN and/MassHealth Limited as secondary programs.

The Medicaid population are MassHealth members who have the following:

- Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).

### III. CHA-HQEIP Technical Specifications

#### A. RELD/SOGI Data Completeness Measures Specifications

##### A.i. Race Data Completeness

###### OVERVIEW

<b>Measure Name</b>	Rate of Race Data Completeness – Acute Hospital
<b>Steward</b>	EOHHS
<b>NQF Number</b>	N/A
<b>Data Source</b>	Numerator source: Center for Health Informatics and Analysis (CHIA) “Enhanced Demographics Data File”  Denominator sources: MassHealth encounter and MMIS claims data
<b>Performance Status</b>	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

<b>Description</b>	The percentage of members with self-reported race data that was collected by an acute hospital in the measurement year.
<b>Numerator</b>	Members with an inpatient stay and/or emergency department (ED) visit at an acute hospital and self-reported race data that was collected by an acute hospital during the measurement year

<b>Denominator</b>	Members with an inpatient stay and/or ED visit at an acute hospital during the measurement year
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## ELIGIBLE POPULATION

<b>Age</b>	Members of any age
<b>Continuous Enrollment</b>	None
<b>Anchor Date</b>	None
<b>Event/Diagnosis</b>	<p>At least one inpatient discharge or ED visit at an acute hospital between January 1 and December 31 of the measurement year.</p> <p>To identify acute inpatient discharges:</p> <ul style="list-style-type: none"> <li>Identify all acute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> </ul> <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> <li>Identify all Emergency Department visits (<u>ED Visit Value Set</u>).</li> </ul>

## DEFINITIONS

<b>Complete Race Data</b>	<p>Complete race data is defined as:</p> <p>At least one (1) valid race value (valid race values are listed in Attachment 1).</p> <ul style="list-style-type: none"> <li>If value is “UNK” it will <u>not</u> count toward the numerator.</li> <li>If value is “ASKU,” it will count toward the numerator.</li> <li>If value is “DONTKNOW,” it will count toward the numerator.</li> <li>Each value must be self-reported.</li> </ul>
<b>Data Collection</b>	<p>Race data may be collected:</p> <ul style="list-style-type: none"> <li>by any member of the hospital care team;</li> <li>over the phone, electronically (e.g. a patient portal), in person, by mail, etc.;</li> <li>from an ACO;</li> <li>must include one or more values in Attachment 1</li> </ul>

<b>Hospital File [“Enhanced Demographics Data File”]</b>	The Center for Information and Analysis (CHIA) will intake race data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.
<b>Measurement Year</b>	Measurement Years 1-5 correspond to Calendar Years 2023-2027
<b>Members</b>	Individuals enrolled in MassHealth including:  Model A ACO, Model B ACO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).
<b>Rate of Race Data Completeness</b>	There will be two rates reported for this measure, defined as. Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100 Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100
<b>Self-Reported data</b>	Race data must be self-reported. Race data that derived using an imputation methodology must not be included. 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).  Self-reported race data that has been rolled-up or transformed for reporting purposes may be included. For example, if a hospital’s data systems include races that are included in <a href="#">HHS’ data collection standards</a> and an individual self-reports their race as “Samoan”, then the hospital can report the value of “Native Hawaiian or Other Pacific Islander” since the value of Samoan is not a valid value in Attachment 1.

## ADMINISTRATIVE SPECIFICATION

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

## ADDITIONAL MEASURE INFORMATION

<b>Required Reporting</b>	<p>The following information is required:</p> <ul style="list-style-type: none"> <li>• A valid MassHealth Member ID Format: Refer to CHIA Submission Guide</li> <li>• At least one (1) race value, as defined under “Complete Race Data” above</li> </ul>
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	Format: Refer to CHIA Submission Guide
<b>Completeness Calculations</b>	Completeness is calculated for: each individual Acute Hospital; and all acute hospitals.

### Attachment 1. Race: Accepted Values

Description	Valid Values	Notes
<b>American Indian/Alaska Native</b>	1002-5	
<b>Asian</b>	2028-9	
<b>Black/African American</b>	2054-5	
<b>Native Hawaiian or other Pacific Islander</b>	2076-8	
<b>White</b>	2106-3	
<b>Other Race</b>	OTH	
<b>Choose not to answer</b>	ASKU	Member was asked to provide their race, and the member actively selected or indicated that they “choose not to answer.”
<b>Don’t know</b>	DONTKNOW	Member was asked to provide their race, and the member actively selected or indicated that they did not know their race.
<b>Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)</b>	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
<b>Unknown</b>	UNK	The race of the member is unknown since either:  (a) the member was not asked to provide their race, or  (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



Description	Valid Values	Notes
		response, and should be assigned the value of ASKU instead of UNK.

## CHA-SPECIFIC ADAPTATIONS

<b>Measure Summary</b>	This CHA measure results in 4 rates, involving CHA patients, grouped separately: members enrolled in MassHealth, and served uninsured patients.
<b>Eligible Population</b>	<p>The eligible CHA population included in the measure is grouped as follows:</p> <ul style="list-style-type: none"> <li>• MassHealth members</li> <li>• Served uninsured patients</li> </ul>
<b>Members</b>	See Eligible Population
<b>Data Source</b>	Denominator sources: MassHealth encounter and MMIS claims data for the Medicaid population; Denominator source for served uninsured patient population: Hospital EHR
<b>Definitions: Rate of Data Completeness</b>	<p>There will be four rates reported for this measure:</p> <p>(Numerator 1 Population / Denominator 1 Population) * 100</p> <p>(Numerator 2 Population / Denominator 2 Population) * 100</p> <p>(Numerator 3 Population / Denominator 3 Population) * 100</p> <p>(Numerator 4 Population / Denominator 4 Population) * 100</p>
<b>Administrative Specification: Denominators</b>	There are four denominators for this measure.

	<p><b>Denominator 1:</b> The eligible population for <b>MassHealth members</b> with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b> The eligible population for <b>MassHealth members</b> with <b>emergency department visit</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 3:</b> The eligible population for served uninsured patients with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 4:</b> The eligible population for served uninsured patients with <b>emergency department visit</b> claims/encounters from acute hospitals.</p>
<p><b>Administrative Specification: Numerators</b></p>	<p>There are four numerators for this measure.</p> <p><b>Numerator 1:</b></p> <p>For members in <b>Denominator 1</b>, identify those with complete race data, defined as:</p> <p>At least one (1) valid race value (valid race values are listed in Attachment 1).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul> <p><b>Numerator 2:</b></p> <p>For members in <b>Denominator 2</b>, identify those with complete race data, defined as:</p> <p>At least one (1) valid race value (valid race values are listed in Attachment 1).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul>

	<p><b>Numerator 3:</b></p> <p>For patients in <b>Denominator 3</b>, identify those with complete race data, defined as:</p> <p>At least one (1) valid race value (valid race values are listed in Attachment 1).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul> <p><b>Numerator 4:</b></p> <p>For patients in <b>Denominator 4</b>, identify those with complete race data, defined as:</p> <p>At least one (1) valid race value (valid race values are listed in Attachment 1).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul>
<b>Additional Measure Information: Required Reporting</b>	Valid HSN Member IDs must be submitted for the served uninsured population.
<b>Additional Measure Information: Completeness Calculations</b>	Completeness calculations are for CHA overall.

## A.ii. Hispanic Ethnicity Data Completeness

### OVERVIEW

<b>Measure Name</b>	Rate of Hispanic Ethnicity Data Completeness – Acute Hospital
<b>Steward</b>	EOHHS

<b>NQF Number</b>	N/A
<b>Data Sources</b>	Numerator source: Center for Health Informatics and Analysis (CHIA) “Enhanced Demographics Data File”  Denominator sources: MassHealth encounter and MMIS claims data
<b>Performance Status</b>	Pay-for-Reporting

## POPULATION HEALTH IMPACT

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

## MEASURE SUMMARY

<b>Description</b>	The percentage of members with self-reported Hispanic ethnicity data that was collected by an acute hospital in the measurement year.
<b>Numerator</b>	Members with an inpatient stay and/or emergency department (ED) visit at an acute hospital <u>and</u> self-reported Hispanic ethnicity data that was collected by an acute hospital during the measurement year.
<b>Denominator</b>	Members with an inpatient stay and/or ED visit at an acute hospital during the measurement year.

## ELIGIBLE POPULATION

<b>Age</b>	Members of any age
<b>Continuous Enrollment</b>	None
<b>Anchor Date</b>	None
<b>Event/Diagnosis</b>	<p>At least one inpatient discharge and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year.</p> <p>To identify acute inpatient discharges:</p> <ul style="list-style-type: none"> <li>Identify all acute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> </ul> <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> <li>Identify all Emergency Department visits (<u>ED Visit Value Set</u>).</li> </ul>

## DEFINITIONS

<b>Complete Hispanic ethnicity Data</b>	<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"> <li>• If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>• If value is “ASKU it will count toward the numerator.</li> <li>• If value is “DONTKNOW” it will count toward the numerator.</li> <li>• Each value must be self-reported.</li> </ul>
<b>Data Collection</b>	<p>Hispanic ethnicity data may be collected</p> <ul style="list-style-type: none"> <li>• by any member of the hospital care team;</li> <li>• over the phone, electronically (e.g. a patient portal), in person, by mail, etc.</li> <li>• from an ACO.</li> </ul>
<b>Hospital File [“Enhanced Demographics Data File”]</b>	<p>The Center for Information and Analysis (CHIA) will intake Hispanic ethnicity data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable the inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.</p>
<b>Measurement Year</b>	<p>Measurement Years 1-5 correspond to Calendar Years 2023-2027</p>
<b>Members</b>	<p>Individuals enrolled in MassHealth including:</p> <p>Model A ACO, Model B ACO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).</p>
<b>Rate of Hispanic Ethnicity Data Completeness</b>	<p>There will be two rates reported for this measure.</p> <p>(Numerator 1 Population / Denominator 1 Population) * 100</p> <p>(Numerator 2 Population / Denominator 2 Population) * 100</p>
<b>Self-Reported data</b>	<p>Hispanic ethnicity data must be self-reported. Hispanic ethnicity data that is a result of an imputation methodology must not be included. For the purposes</p>

	<p>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 <a href="#">HHS' data collection standards</a> (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>
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## ADMINISTRATIVE SPECIFICATION

<b>Denominator</b>	<p>There are two denominators for this measure:</p> <p><b>Denominator 1:</b></p> <p>The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b></p> <p>The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals</p>
<b>Numerator</b>	<p>There are two numerators for this measure:</p> <p><b>Numerator 1:</b></p> <p>For members in Denominator 1, identify those with complete Hispanic ethnicity data, 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"> <li>○ If value is "UNK," it will <u>not</u> count toward the numerator.</li> <li>○ If value is "ASKU," it will count toward the numerator.</li> <li>○ If value is "DONTKNOW," it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul> <p><b>Numerator 2:</b></p> <p>For members in Denominator 2, identify those with complete Hispanic ethnicity data, 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"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul>
<b>Exclusions</b>	If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.

## ADDITIONAL MEASURE INFORMATION

<b>Required Reporting</b>	<p>The following information is required:</p> <ul style="list-style-type: none"> <li>• A valid MassHealth Member ID Format: Refer to CHIA Submission Guide</li> <li>• At least one (1) ethnicity value, as defined under “Complete Hispanic Data” above Format: Refer to CHIA Submission Guide</li> </ul>
<b>Completeness Calculations</b>	Completeness is calculated for: each individual acute hospital; and all acute hospitals.

### Attachment 2. Hispanic Ethnicity: Accepted Values

Description	Valid Values	Notes
<b>Hispanic or Latino</b>	2135-2	
<b>Not Hispanic or Latino</b>	2186-5	
<b>Choose not to answer</b>	ASKU	Member was asked to provide their ethnicity, and the member actively selected or indicated that they “choose not to answer”.
<b>Don’t know</b>	DONTKNOW	Member was asked to provide their ethnicity, and the member actively selected or indicated that they did not know their ethnicity.
<b>Unable to collect this information on member due to lack of clinical capacity</b>	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.

Description	Valid Values	Notes
of member to respond (e.g. clinical condition that alters consciousness).		
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> <p>(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.</p>

## CHA-SPECIFIC ADAPTATIONS

<b>Measure Summary</b>	This CHA measure results in 4 rates, involving CHA patients, grouped separately: members enrolled in MassHealth, and served uninsured patients.
<b>Eligible Population</b>	<p>The eligible CHA population included in the measure is grouped as follows:</p> <ul style="list-style-type: none"> <li>• MassHealth members</li> <li>• Served uninsured patients</li> </ul>
<b>Members</b>	See Eligible Population
<b>Data Source</b>	Denominator sources: MassHealth encounter and MMIS claims data for the Medicaid population; Denominator source for served uninsured patient population: Hospital EHR



<b>Definitions: Rate of Data Completeness</b>	<p>There will be four rates reported for this measure:</p> $(\text{Numerator 1 Population} / \text{Denominator 1 Population}) * 100$ $(\text{Numerator 2 Population} / \text{Denominator 2 Population}) * 100$ $(\text{Numerator 3 Population} / \text{Denominator 3 Population}) * 100$ $(\text{Numerator 4 Population} / \text{Denominator 4 Population}) * 100$
<b>Administrative Specification: Denominators</b>	<p>There are four denominators for this measure.</p> <p><b>Denominator 1:</b> The eligible population for <b>MassHealth members</b> with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b> The eligible population for <b>MassHealth members</b> with <b>emergency department visit</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 3:</b> The eligible population for served uninsured patients with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 4:</b> The eligible population for served uninsured patients with <b>emergency department visit</b> claims/encounters from acute hospitals.</p>
<b>Administrative Specification: Numerators</b>	<p>There are four numerators for this measure.</p> <p><b>Numerator 1:</b></p> <p>For members in <b>Denominator 1</b>, identify those with complete Hispanic ethnicity data, defined as:</p> <p>At least one (1) valid Hispanic ethnicity value (valid Hispanic ethnicity values are listed in Attachment 2).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul>

	<p><b>Numerator 2:</b></p> <p>For members in <b>Denominator 2</b>, identify those with complete Hispanic ethnicity data, defined as:</p> <p>At least one (1) valid Hispanic ethnicity value (valid Hispanic ethnicity values are listed in Attachment 2).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul> <p><b>Numerator 3:</b></p> <p>For patients in <b>Denominator 3</b>, identify those with complete Hispanic ethnicity data, defined as:</p> <p>At least one (1) valid Hispanic ethnicity value (valid Hispanic ethnicity values are listed in Attachment 2).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul> <p><b>Numerator 4:</b></p> <p>For patients in <b>Denominator 4</b>, identify those with complete Hispanic ethnicity data, defined as:</p> <p>At least one (1) valid Hispanic ethnicity value (valid Hispanic ethnicity values are listed in Attachment 2).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul>
<p><b>Additional Measure Information: Required Reporting</b></p>	<p>Valid HSN Member IDs must be submitted for the served uninsured population.</p>
<p><b>Additional Measure Information:</b></p>	<p>Completeness calculations are for CHA overall.</p>

<b>Completeness Calculations</b>	
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### A.iii. English Proficiency Data Completeness

#### OVERVIEW

<b>Measure Name</b>	Rate of English Proficiency Data Completeness – Acute Hospital
<b>Steward</b>	EOHHS
<b>NQF Number</b>	N/A
<b>Data Source</b>	Numerator source: Center for Health Information and Analysis (CHIA) “Enhanced Demographics Data File”  Denominator sources: MassHealth encounter and MMIS claims data

#### POPULATION HEALTH IMPACT

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

#### MEASURE SUMMARY

<b>Description</b>	The percentage of members with self-reported English Proficiency data that was collected by an acute hospital in the measurement year.
<b>Numerator</b>	Members with an inpatient stay and/or emergency department (ED) visit at an acute hospital and self-reported English Proficiency data that was collected by an acute hospital in the measurement year.
<b>Denominator</b>	Members with an inpatient stay and/or ED visit at an acute hospital during the measurement year.

#### ELIGIBLE POPULATION

<b>Age</b>	Members age 5 and older as of December 31st of the measurement year
<b>Continuous Enrollment</b>	None

<b>Anchor Date</b>	None
<b>Event/Diagnosis</b>	<p>At least one inpatient discharge and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year.</p> <p>To identify acute inpatient discharges:</p> <ul style="list-style-type: none"> <li>Identify all acute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> </ul> <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> <li>Identify all Emergency Department visits (<u>ED Visit Value Set</u>).</li> </ul>

## DEFINITIONS

<b>Complete English Proficiency Data</b>	<p>Complete English Proficiency data is defined as:</p> <p>One (1) valid English Proficiency Value (valid English Proficiency values are listed in Attachment 3).</p> <ul style="list-style-type: none"> <li>If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>If value is “ASKU,” it will count toward the numerator.</li> <li>If value is “DONTKNOW,” it will count toward the numerator.</li> <li>Each value must be self-reported.</li> </ul>
<b>Data Collection</b>	<p>English Proficiency data may be collected</p> <ul style="list-style-type: none"> <li>by any member of the hospital care team;</li> <li>over the phone, electronically (e.g. a patient portal), in person, by mail, etc.</li> <li>from an ACO;</li> <li>must include one value in Attachment 3.</li> </ul>
<b>Hospital File [“Enhanced Demographics Data File”]</b>	<p>The Center for Information and Analysis (CHIA) will intake English Proficiency data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.</p>

<b>Measurement Year</b>	Measurement Years 1-5 correspond to Calendar Years 2023-2027
<b>Members</b>	Individuals enrolled in MassHealth including:  Model A ACO, Model B ACO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).
<b>Rate of English Proficiency Data Completeness</b>	There will be two rates reported for this measure.  $(\text{Numerator 1 Population} / \text{Denominator 1 Population}) * 100$  $(\text{Numerator 2 Population} / \text{Denominator 2 Population}) * 100$
<b>Self-Reported data</b>	English Proficiency data must be self-reported. 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).

## ADMINISTRATIVE SPECIFICATION

<b>Denominator</b>	<p>There are two denominators for this measure:</p> <p>Denominator 1:</p> <p>The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals.</p> <p>Denominator 2:</p> <p>The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals</p>
<b>Numerator</b>	<p>There are two numerators for this measure:</p> <p><b>Numerator 1:</b></p> <p>For members in Denominator 1, identify those with complete English Proficiency data, defined as:</p>

	<p>One (1) valid English Proficiency value (valid English Proficiency values are listed in Attachment 3).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul> <p><b>Numerator 2:</b></p> <p>For members in Denominator 2, identify those with complete English Proficiency data, defined as:</p> <p>One (1) valid English Proficiency value (valid English Proficiency values are listed in Attachment 3).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul>
<b>Exclusions</b>	If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.

## ADDITIONAL MEASURE INFORMATION

<b>Required Reporting</b>	<p>The following information is required:</p> <ul style="list-style-type: none"> <li>• A valid MassHealth Member ID Format: Refer to CHIA Submission Guide</li> <li>• One (1) English Proficiency value, as defined under “Complete English Proficiency Data” above Format: Refer to CHIA Submission Guide</li> </ul>
<b>Completeness Calculations</b>	Completeness is calculated for: each individual acute hospital and all acute hospitals.

### Attachment 3. English Proficiency: Accepted Values

Description	Valid Values	Notes
Very well	VERWELL	

Description	Valid Values	Notes
Well	WELL	
Not well	NOTWELL	
Not at all	NOTALL	
Choose not to answer	ASKU	Member was asked to provide their English Proficiency, and the member actively selected or indicated that they “choose not to answer.”
Don’t know	DONTKNOW	Member was asked to provide their English proficiency, and the member actively selected or indicated that they did not know their English proficiency.
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 English Proficiency of the member is unknown since either:</p> <p>(a) the member was not asked to provide their English Proficiency, or</p> <p>(b) the member was asked to provide their English Proficiency, 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>

## CHA-SPECIFIC ADAPTATIONS

<b>Measure Summary</b>	This CHA measure results in 4 rates, involving CHA patients, grouped separately: members enrolled in MassHealth, and served uninsured patients.
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<b>Eligible Population</b>	<p>The eligible CHA population included in the measure is grouped as follows:</p> <ul style="list-style-type: none"> <li>• MassHealth members</li> <li>• Served uninsured patients</li> </ul>
<b>Members</b>	See Eligible Population
<b>Data Source</b>	Denominator sources: MassHealth encounter and MMIS claims data for the Medicaid population; Denominator source for served uninsured patient population: Hospital EHR
<b>Definitions: Rate of Data Completeness</b>	<p>There will be four rates reported for this measure:</p> <p>(Numerator 1 Population / Denominator 1 Population) * 100</p> <p>(Numerator 2 Population / Denominator 2 Population) * 100</p> <p>(Numerator 3 Population / Denominator 3 Population) * 100</p> <p>(Numerator 4 Population / Denominator 4 Population) * 100</p>
<b>Administrative Specification: Denominators</b>	<p>There are four denominators for this measure.</p> <p><b>Denominator 1:</b> The eligible population for <b>MassHealth members</b> with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b> The eligible population for <b>MassHealth members</b> with <b>emergency department visit</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 3:</b> The eligible population for served uninsured patients with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 4:</b> The eligible population for served uninsured patients with <b>emergency department visit</b> claims/encounters from acute hospitals.</p>



**Administrative  
Specification:  
Numerators**

There are four numerators for this measure.

**Numerator 1:**

For members in **Denominator 1**, identify those with complete English Proficiency data, defined as:

At least one (1) valid English Proficiency value (valid English Proficiency values are listed in Attachment 3).

- 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 English Proficiency data, defined as:

At least one (1) valid English Proficiency value (valid English Proficiency values are listed in Attachment 3).

- 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 3:**

For patients in **Denominator 3**, identify those with complete English Proficiency data, defined as:

At least one (1) valid English Proficiency value (valid English Proficiency values are listed in Attachment 3).

- 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 4:**

	<p>For patients in <b>Denominator 4</b>, identify those with complete English Proficiency data, defined as:</p> <p>At least one (1) valid English Proficiency value (valid English Proficiency values are listed in Attachment 3).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> </ul> <p>Each value must be self-reported.</p>
<b>Additional Measure Information: Required Reporting</b>	Valid HSN Member IDs must be submitted for the served uninsured population.
<b>Additional Measure Information: Completeness Calculations</b>	Completeness calculations are for CHA overall.

#### A.iv. Disability Data Completeness

##### OVERVIEW

<b>Measure Name</b>	Rate of Disability Data Completeness – Acute Hospital
<b>Steward</b>	EOHHS
<b>NQF Number</b>	N/A
<b>Data Source</b>	<p>Numerator source: Center for Health Informatics and Analysis (CHIA) “Enhanced Demographics Data File”</p> <p>Denominator sources: MassHealth encounter and MMIS claims data</p>

##### 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

<b>Description</b>	The percentage of members with self-reported disability data that was collected by an acute hospital in the measurement year. Rates are calculated separately for 6 disability questions.
<b>Numerator</b>	Members with an inpatient stay or emergency department (ED) visit at an acute hospital and self-reported disability data that was collected by an acute hospital in the measurement year.
<b>Denominator</b>	Members with an inpatient stay or ED visit at an acute hospital during the measurement year

## ELIGIBLE POPULATION

<b>Age</b>	<p>Age varies by disability question:</p> <ul style="list-style-type: none"><li>• Disability Questions 1 and 2: no age specified;</li><li>• Disability Questions 3 – 5: age 5 or older as of December 31st of the measurement year;</li><li>• Disability Question 6: age 15 or older as of December 31st of the measurement year.</li></ul>
<b>Continuous Enrollment</b>	None
<b>Anchor Date</b>	None
<b>Event/Diagnosis</b>	<p>At least one inpatient discharge and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year.</p> <p>To identify inpatient discharges:</p> <ul style="list-style-type: none"><li>• Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>).</li></ul> <p>To identify emergency department visits:</p> <ul style="list-style-type: none"><li>• Identify all Emergency Department visits (<u>ED Value Set</u>).</li></ul>

## DEFINITIONS

<b>Complete Disability Data</b>	Complete Disability data is defined as:
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	<p>One (1) valid disability value for each Disability Question (listed in Attachment 4).</p> <ul style="list-style-type: none"> <li>• If value is “UNK,” it will not count toward the numerator.</li> <li>• If value is “ASKU,” it will count toward the numerator.</li> <li>• If value is “DONTKNOW,” it will count toward the numerator.</li> <li>• Each value must be self-reported.</li> </ul>
<b>Data Collection</b>	<p>Disability data may be collected</p> <ul style="list-style-type: none"> <li>• by any member of the ACO care team;</li> <li>• over the phone, electronically (e.g. a patient portal), in person, by mail, etc.</li> <li>• from an ACO;</li> <li>• must include one value in Attachment 4 for each question.</li> </ul>
<b>Hospital File [“Enhanced Demographics Data File”]</b>	<p>The Center for Information and Analysis (CHIA) will intake disability data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.</p>
<b>Measurement Year</b>	<p>Measurement Years 1-5 correspond to Calendar Years 2023-2027</p>
<b>Members</b>	<p>Individuals enrolled in MassHealth including:</p> <p>Model A ACO, Model B ACO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).</p>
<b>Rate of Disability Data Completeness</b>	<p>There will be two rates reported for this measure.</p> <p><math>(\text{Numerator 1 Population} / \text{Denominator 1 Population}) * 100</math></p> <p><math>(\text{Numerator 2 Population} / \text{Denominator 2 Population}) * 100</math></p>
<b>Self-Reported data</b>	<p>Disability data must be self-reported. 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>

## ADMINISTRATIVE SPECIFICATION

<b>Denominator</b>	<p>There are two denominators for this measure:</p> <p><b>Denominator 1:</b></p> <p>The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b></p> <p>The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals</p>
<b>Numerator Set</b>	<p>There are two numerators for this measure:</p> <p><b>Numerator 1:</b></p> <p>For members in Denominator 1, identify those with complete disability data, (defined above under “Complete Disability Data”) for each question below:</p> <p>Disability Q1 (all ages): Are you deaf or do you have difficulty hearing?</p> <p>Disability Q2 (all ages): Are you blind or do you have difficulty seeing?</p> <p>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> <p>Disability Q4 (age 5 or older): Do you have difficulty walking or climbing stairs?</p> <p>Disability Q5 (age 5 or older): Do you have difficulty dressing or bathing?</p> <p>Disability Q6 (age 15 or older): Because of a physical, mental, or emotional condition, do you have difficulty doing errands such as visiting a doctor’s office or shopping?</p> <ul style="list-style-type: none"><li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li><li>○ If value is “ASKU,” it will count toward the numerator.</li></ul>

	<ul style="list-style-type: none"> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul> <p><b>Numerator 2:</b></p> <p>For members in Denominator 2, identify those with complete disability data, (defined above under “Complete Disability Data”) for each question below:</p> <p>Disability Q1 (all ages): Are you deaf or do you have difficulty hearing?</p> <p>Disability Q2 (all ages): Are you blind or do you have difficulty seeing?</p> <p>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> <p>Disability Q4 (age 5 or older): Do you have difficulty walking or climbing stairs?</p> <p>Disability Q5 (age 5 or older): Do you have difficulty dressing or bathing?</p> <p>Disability Q6 (age 15 or older): Because of a physical, mental, or emotional condition, do you have difficulty doing errands such as visiting a doctor's office or shopping?</p> <ul style="list-style-type: none"> <li>○ If value is “UNK” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul>
<b>Exclusions</b>	If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.

## ADDITIONAL MEASURE INFORMATION

<b>Required Reporting</b>	<p>For a given disability question, the following information is required:</p> <ul style="list-style-type: none"> <li>• A valid MassHealth Member ID Format: Refer to CHIA Submission Guide</li> <li>• At least one (1) valid disability value per question, as defined under “Complete Disability Data” above Format: Refer to CHIA Submission Guide</li> </ul>
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<b>Completeness Calculations</b>	<p>Completeness is calculated per disability question per acute hospital and overall, as described below for questions 1 and 2, as an example:</p> <p>For each individual acute hospital:</p> <p>Example 1: For acute hospital x, the percentage of members with self-reported disability data <u>for question 1</u> that was collected by acute hospital x in the measurement year.</p> <p>Example 2: For acute hospital x, the percentage of members with self-reported disability data <u>for question 2</u> that was collected by acute hospital x in the measurement year.</p> <p>For all acute hospitals</p> <p>Example 1: For all acute hospitals, the percentage of members with self-reported disability data <u>for question 1</u> that was collected by all acute hospitals in the measurement year.</p> <p>Example 2: For all acute hospitals, the percentage of members with self-reported disability data <u>for question 2</u> that was collected by all acute hospitals in the measurement year.</p>
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#### Attachment 4. Disability: Accepted Values

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

Description	Valid Values	Notes
<b>Yes</b>	LA33-6	
<b>No</b>	LA32-8	
<b>Choose not to Answer</b>	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.”
<b>Don’t know</b>	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.
<b>Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition)</b>	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.

Description	Valid Values	Notes
that alters consciousness)		
Unknown	UNK	<p>Whether the member is deaf or has difficulty hearing is unknown since either:</p> <p>(a) the member was not asked whether they are deaf or have difficulty hearing, or</p> <p>(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.</p>

**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 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	Whether the member is blind or has difficulty seeing is unknown since either:



Description	Valid Values	Notes
		<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 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	Whether the member has difficulty concentrating, remembering or making decisions is unknown since either:

Description	Valid Values	Notes
		<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 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>

Description	Valid Values	Notes
		(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.

### 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.
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</p>

Description	Valid Values	Notes
		answer” is a valid response, and should be assigned the value of ASKU instead of UNK.

**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
<b>Yes</b>	LA33-6	
<b>No</b>	LA32-8	
<b>Choose not to Answer</b>	ASKU	Member was asked if they have difficulty doing errands, and the member actively selected or indicated that they “choose not to answer”.
<b>Don’t know</b>	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.
<b>Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)</b>	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
<b>Unknown</b>	UNK	Whether a member has difficulty doing errands is unknown since either:  (a) the member was not asked whether they have difficulty doing errands, or  (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.

## CHA-SPECIFIC ADAPTATIONS

<b>Measure Summary</b>	This CHA measure results in 4 rates, involving CHA patients, grouped separately: members enrolled in MassHealth, and served uninsured patients.
<b>Eligible Population</b>	<p>The eligible CHA population included in the measure is grouped as follows:</p> <ul style="list-style-type: none"> <li>• MassHealth members</li> <li>• Served uninsured patients</li> </ul>
<b>Members</b>	See Eligible Population
<b>Data Source</b>	Denominator sources: MassHealth encounter and MMIS claims data for the Medicaid population; Denominator source for served uninsured patient population: Hospital EHR
<b>Definitions: Rate of Data Completeness</b>	<p>There will be four rates reported for this measure:</p> $(\text{Numerator 1 Population} / \text{Denominator 1 Population}) * 100$ $(\text{Numerator 2 Population} / \text{Denominator 2 Population}) * 100$ $(\text{Numerator 3 Population} / \text{Denominator 3 Population}) * 100$ $(\text{Numerator 4 Population} / \text{Denominator 4 Population}) * 100$
<b>Administrative Specification: Denominators</b>	<p>There are four denominators for this measure.</p> <p><b>Denominator 1:</b> The eligible population for <b>MassHealth members</b> with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b> The eligible population for <b>MassHealth members</b> with <b>emergency department visit</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 3:</b> The eligible population for served uninsured patients with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p>

	<p><b>Denominator 4:</b> The eligible population for served uninsured patients with <b>emergency department visit</b> claims/encounters from acute hospitals.</p>
<p><b>Administrative Specification: Numerators</b></p>	<p>There are four numerators for this measure:</p> <p><b>Numerator 1:</b> For members in Denominator 1, identify those with complete disability data (defined above under “Complete Disability Data”) for each question below:</p> <p>Disability Q1 (all ages): Are you deaf or do you have difficulty hearing?</p> <p>Disability Q2 (all ages): Are you blind or do you have difficulty seeing?</p> <p>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> <p>Disability Q4 (age 5 or older): Do you have difficulty walking or climbing stairs?</p> <p>Disability Q5 (age 5 or older): Do you have difficulty dressing or bathing?</p> <p>Disability Q6 (age 15 or older): Because of a physical, mental, or emotional condition, do you have difficulty doing errands such as visiting a doctor’s office or shopping?</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul> <p><b>Numerator 2:</b> For members in Denominator 2, identify those with complete disability data (defined above under “Complete Disability Data”) as for Numerator 1 above.</p>

	<p><b>Numerator 3:</b></p> <p>For patients in Denominator 3, identify those with complete disability data (defined above under “Complete Disability Data”) as for Numerator 1 above.</p> <p><b>Numerator 4:</b></p> <p>For patients in Denominator 4, identify those with complete disability data (defined above under “Complete Disability Data”) as for Numerator 1 above.</p>
<b>Additional Measure Information: Required Reporting</b>	Valid HSN Member IDs must be submitted for the served uninsured population.
<b>Additional Measure Information: Completeness Calculations</b>	Completeness calculations are for CHA overall.

#### A.v. Sexual Orientation Data Completeness

OVERVIEW	
<b>Measure Name</b>	Rate of Sexual Orientation Data Completeness – Acute Hospital
<b>Steward</b>	EOHHS
<b>NQF Number</b>	N/A
<b>Data Source</b>	<p>Numerator source: Center for Health Informatics and Analysis (CHIA) “Enhanced Demographics Data File”</p> <p>Denominator sources: MassHealth encounter and MMIS claims data</p>

#### 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

<b>Description</b>	The percentage of members with self-reported sexual orientation data that was collected by an acute hospital in the measurement year.
<b>Numerator</b>	Members with an inpatient stay and/or emergency department (ED) visit at an acute hospital <u>and</u> self-reported sexual orientation data that was collected by an acute hospital in the measurement year.
<b>Denominator</b>	Members with an inpatient stay and/or ED visit at an acute hospital during the measurement year.

## ELIGIBLE POPULATION

<b>Age</b>	Members age 18 and older as of December 31 of the measurement year
<b>Continuous Enrollment</b>	None
<b>Anchor Date</b>	None
<b>Event/Diagnosis</b>	<p>At least one inpatient discharge and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year.</p> <p>To identify inpatient discharges:</p> <ul style="list-style-type: none"> <li>Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>).</li> </ul> <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> <li>Identify all Emergency Department visits (<u>ED Value Set</u>).</li> </ul>

## DEFINITIONS

<b>Complete Sexual Orientation Data</b>	<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"> <li>If value is "UNK," it will not count toward the numerator.</li> <li>If value is "ASKU," it will count toward the numerator.</li> <li>If value is "DONTKNOW," it will count toward the numerator.</li> </ul> <p>Each value must be self-reported.</p>
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<b>Data Collection</b>	<p>Sexual orientation data may be collected</p> <ul style="list-style-type: none"> <li>• by any member of the hospital care team;</li> <li>• over the phone, electronically (e.g. a patient portal), in person, by mail, etc.</li> <li>• from an ACO;</li> <li>• must include one or more values in Attachment 5</li> </ul>
<b>Hospital File [“Enhanced Demographics Data File”]</b>	<p>The Center for Information and Analysis (CHIA) will intake sexual orientation data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.</p>
<b>Measurement Year</b>	<p>Measurement Years 1-5 correspond to Calendar Years 2023-2027</p>
<b>Members</b>	<p>Individuals enrolled in MassHealth including:</p> <p>Model A ACO, Model B ACO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).</p>
<b>Rate of Sexual Orientation Data Completeness</b>	<p>There will be two rates reported for this measure, defined as.</p> <p>Rate 1: <math>(\text{Numerator 1 Population} / \text{Denominator 1 Population}) * 100</math></p> <p>Rate 2: <math>(\text{Numerator 2 Population} / \text{Denominator 2 Population}) * 100</math></p>
<b>Self-Reported data</b>	<p>Sexual orientation data must be self-reported. 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>

## ADMINISTRATIVE SPECIFICATION

<b>Denominator</b>	<p>There are two denominators for this measure:</p> <p><b>Denominator 1:</b></p> <p>The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals.</p>
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	<p><b>Denominator 2:</b></p> <p>The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.</p>
<b>Numerator</b>	<p>There are two numerators for this measure:</p> <p><b>Numerator 1:</b></p> <p>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"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul> <p><b>Numerator 2:</b></p> <p>For members in Denominator 2, identify those with complete Hispanic ethnicity 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"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul>
<b>Exclusions</b>	<p>If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.</p>

## ADDITIONAL MEASURE INFORMATION

<b>Required Reporting</b>	<p>The following information is required:</p> <ul style="list-style-type: none"> <li>• A valid MassHealth Member ID Format: Refer to CHIA Submission Guide</li> <li>• At least one (1) valid sexual orientation value, as defined under “Complete Sexual Orientation Data” above Format: Refer to CHIA Submission Guide</li> </ul>
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<b>Completeness Calculations</b>	Completeness is calculated for: each individual acute hospital; and all acute hospitals.
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#### Attachment 5. Sexual Orientation: Accepted Values

Description	Valid Values	Notes
<b>Bisexual</b>	42035005	
<b>Straight or heterosexual</b>	20430005	
<b>Lesbian or gay</b>	38628009	
<b>Queer, pansexual, and/or questioning</b>	QUEER	
<b>Something else</b>	OTH	
<b>Choose not to answer</b>	ASKU	Member was asked to provide their sexual orientation, and the member actively selected or indicated that they “choose not to answer”.
<b>Don’t know</b>	DONTKNOW	Member was asked to provide their sexual orientation, and the member actively selected or indicated that they did not know their sexual orientation.
<b>Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)</b>	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
<b>Unknown</b>	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>

## CHA-SPECIFIC ADAPTATIONS

<b>Measure Summary</b>	This CHA measure results in 4 rates, involving CHA patients, grouped separately: members enrolled in MassHealth, and served uninsured patients.
<b>Eligible Population</b>	<p>The eligible CHA population included in the measure is grouped as follows:</p> <ul style="list-style-type: none"> <li>• MassHealth members</li> <li>• Served uninsured patients</li> </ul>
<b>Members</b>	See Eligible Population
<b>Data Source</b>	Denominator sources: MassHealth encounter and MMIS claims data for the Medicaid population; Denominator source for served uninsured patient population: Hospital EHR
<b>Definitions: Rate of Data Completeness</b>	<p>There will be four rates reported for this measure:</p> $(\text{Numerator 1 Population} / \text{Denominator 1 Population}) * 100$ $(\text{Numerator 2 Population} / \text{Denominator 2 Population}) * 100$ $(\text{Numerator 3 Population} / \text{Denominator 3 Population}) * 100$ $(\text{Numerator 4 Population} / \text{Denominator 4 Population}) * 100$
<b>Administrative Specification: Denominators</b>	<p>There are four denominators for this measure.</p> <p><b>Denominator 1:</b> The eligible population for <b>MassHealth members</b> with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b> The eligible population for <b>MassHealth members</b> with <b>emergency department visit</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 3:</b> The eligible population for served uninsured patients with <b>inpatient</b></p>

	<p><b>discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 4:</b> The eligible population for served uninsured patients with <b>emergency department visit</b> claims/encounters from acute hospitals.</p>
<p><b>Administrative Specification: Numerators</b></p>	<p>There are four numerators for this measure:</p> <p><b>Numerator 1:</b></p> <p>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"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul> <p><b>Numerator 2:</b></p> <p>For members in Denominator 2, 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"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported</li> </ul> <p><b>Numerator 3:</b></p> <p>For patients in Denominator 3, 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"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> </ul>

	<ul style="list-style-type: none"> <li>Each value must be self-reported.</li> </ul> <p><b>Numerator 4:</b></p> <p>For patients in Denominator 4, 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"> <li>If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>If value is “ASKU,” it will count toward the numerator.</li> <li>If value is “DONTKNOW,” it will count toward the numerator.</li> <li>Each value must be self-reported.</li> </ul>
<b>Additional Measure Information: Required Reporting</b>	Valid HSN Member IDs must be submitted for the served uninsured population.
<b>Additional Measure Information: Completeness Calculations</b>	Completeness calculations are for CHA overall.

#### A.vi. Gender Identity Data Completeness

##### OVERVIEW

<b>Measure Name</b>	Rate of Gender Identity Data Completeness – Acute Hospital
<b>Steward</b>	EOHHS
<b>NQF Number</b>	N/A
<b>Data Source</b>	<p>Numerator source: Center for Health Informatics and Analysis (CHIA) “Enhanced Demographics Data File”</p> <p>Denominator sources: MassHealth encounter and MMIS claims data</p>

##### 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

<b>Description</b>	The percentage of members with self-reported gender identity data that was collected by an acute hospital in the measurement year.
<b>Numerator</b>	Members with an inpatient stay and/or emergency department (ED) visit at an acute hospital <u>and</u> self-reported gender identity data that was collected by an acute hospital in the measurement year.
<b>Denominator</b>	Members with an inpatient stay and/or ED visit at an acute hospital during the measurement year.

## ELIGIBLE POPULATION

<b>Age</b>	Members age 18 and older as of December 31 of the measurement year
<b>Continuous Enrollment</b>	None
<b>Anchor Date</b>	None
<b>Event/Diagnosis</b>	<p>At least one inpatient discharge and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year.</p> <p>To identify inpatient discharges:</p> <ul style="list-style-type: none"> <li>Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>).</li> </ul> <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> <li>Identify all Emergency Department visits (<u>ED Value Set</u>).</li> </ul>

## DEFINITIONS

<b>Complete Gender Identity Data</b>	<p>Complete gender identity data is defined as:</p> <p>At least one (1) valid gender identity value (listed in Attachment 6).</p> <ul style="list-style-type: none"> <li>If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>If value is “ASKU,” it will count toward the numerator.</li> <li>If value is “DONTKNOW,” it will count toward the numerator.</li> </ul>
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	<ul style="list-style-type: none"> <li>Each value must be self-reported.</li> </ul>
<b>Data Collection</b>	<p>Gender Identity data may be collected</p> <ul style="list-style-type: none"> <li>by any member of the hospital care team;</li> <li>over the phone, electronically (e.g. a patient portal), in person, by mail, etc.</li> <li>from an ACO;</li> <li>must include one or more values in Attachment 6</li> </ul>
<b>Hospital File [“Enhanced Demographics Data File”]</b>	<p>The Center for Information and Analysis (CHIA) will intake gender identity data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.</p>
<b>Measurement Year</b>	<p>Measurement Years 1-5 correspond to Calendar Years 2023-2027</p>
<b>Members</b>	<p>Individuals enrolled in MassHealth including:</p> <p>Model A ACO, Model B ACO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).</p>
<b>Rate of Gender Identity Data Completeness</b>	<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>
<b>Self-Reported data</b>	<p>Gender Identity data must be self-reported. 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>

## ADMINISTRATIVE SPECIFICATION

<b>Denominator</b>	<p>There are two denominators for this measure:</p> <p><b>Denominator 1:</b></p>
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	<p>The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b></p> <p>The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals</p>
<b>Numerator</b>	<p>There are two numerators for this measure:</p> <p><b>Numerator 1:</b></p> <p>For members in Denominator 1, identify those with complete sexual orientation data, defined as:</p> <p>At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 6).</p> <ul style="list-style-type: none"> <li>○ If value is "UNK," it will <u>not</u> count toward the numerator.</li> <li>○ If value is "ASKU," it will count toward the numerator.</li> <li>○ If value is "DONTKNOW," it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul> <p><b>Numerator 2:</b></p> <p>For members in Denominator 2, identify those with complete Hispanic ethnicity data, defined as:</p> <p>At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 6).</p> <ul style="list-style-type: none"> <li>○ If value is "UNK," it will <u>not</u> count toward the numerator.</li> <li>○ If value is "ASKU," it will count toward the numerator.</li> <li>○ If value is "DONTKNOW," it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul>
<b>Exclusions</b>	<p>If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.</p>

## ADDITIONAL MEASURE INFORMATION

<b>Required Reporting</b>	<p>The following information is required:</p> <ul style="list-style-type: none"> <li>• A valid MassHealth Member ID</li> </ul> <p>Format: Refer to CHIA Submission Guide</p>
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	<ul style="list-style-type: none"> <li>At least one (1) valid gender identity value, as defined under “Complete Gender Identity Data” above</li> </ul> <p>Format: Refer to CHIA Submission Guide</p>
<b>Completeness Calculations</b>	<p>Completeness is calculated for:</p> <p>each individual acute hospital; and</p> <p>all acute hospitals.</p>

#### Attachment 6. Gender Identity: Accepted Values

Description	Valid Values	Notes
<b>Male</b>	446151000124109	
<b>Female</b>	446141000124107	
<b>Genderqueer/gender nonconforming/non-binary; neither exclusively male nor female</b>	446131000124102	
<b>Transgender man/trans man</b>	407376001	
<b>Transgender woman/trans woman</b>	407377005	
<b>Additional gender category or other</b>	OTH	
<b>Choose not to answer</b>	ASKU	Member was asked to provide their gender identity, and the member actively selected or indicated that they “choose not to answer”.
<b>Don’t know</b>	DONTKNOW	Member was asked to provide their gender identity, and the member actively selected or indicated that they did not know their gender identity.
<b>Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition</b>	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.

Description	Valid Values	Notes
that alters consciousness)		
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>

## CHA-SPECIFIC ADAPTATIONS

<b>Measure Summary</b>	This CHA measure results in 4 rates, involving CHA patients, grouped separately: members enrolled in MassHealth, and served uninsured patients.
<b>Eligible Population</b>	<p>The eligible CHA population included in the measure is grouped as follows:</p> <ul style="list-style-type: none"> <li>• MassHealth members</li> <li>• Served uninsured patients</li> </ul>
<b>Members</b>	See Eligible Population
<b>Data Source</b>	Denominator sources: MassHealth encounter and MMIS claims data for the Medicaid population; Denominator source for served uninsured patient population: Hospital EHR
<b>Definitions: Rate of Data Completeness</b>	There will be four rates reported for this measure:

	<p>(Numerator 1 Population / Denominator 1 Population) * 100</p> <p>(Numerator 2 Population / Denominator 2 Population) * 100</p> <p>(Numerator 3 Population / Denominator 3 Population) * 100</p> <p>(Numerator 4 Population / Denominator 4 Population) * 100</p>
<b>Administrative Specification: Denominators</b>	<p>There are four denominators for this measure.</p> <p><b>Denominator 1:</b> The eligible population for <b>MassHealth members</b> with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b> The eligible population for <b>MassHealth members</b> with <b>emergency department visit</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 3:</b> The eligible population for served uninsured patients with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 4:</b> The eligible population for served uninsured patients with <b>emergency department visit</b> claims/encounters from acute hospitals.</p>
<b>Administrative Specification: Numerators</b>	<p>There are four numerators for this measure:</p> <p><b>Numerator 1:</b></p> <p>For members in Denominator 1, identify those with complete gender identity data, defined as:</p> <p>At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 6).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul> <p><b>Numerator 2:</b></p>

	<p>For members in Denominator 2, identify those with complete gender identity data, defined as:</p> <p>At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 6).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul> <p><b>Numerator 3:</b></p> <p>For patients in Denominator 3, identify those with complete gender identity data, defined as:</p> <p>At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 6).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul> <p><b>Numerator 4:</b></p> <p>For patients in Denominator 4, identify those with complete gender identity data, defined as.</p> <p>At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 6).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported</li> </ul>
<b>Additional Measure Information: Required Reporting</b>	Valid HSN Member IDs must be submitted for the served uninsured population.
<b>Additional Measure Information:</b>	Completeness calculations are for CHA overall.

<b>Completeness Calculations</b>	
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## B. Screening for Social Drivers of Health: Preparing for Reporting Beginning in PY2

Reference: CMS “Screening for Social Drivers of Health Measure” Technical Specifications (*pending finalization*)

### OVERVIEW

<b>Measure Name</b>	Screening for Social Drivers of Health: Preparing for Reporting Beginning in PY2
<b>Steward</b>	EOHHS
<b>NQF Number</b>	N/A
<b>Data Source</b>	Claims Data, Clinical Data
<b>Performance Status</b>	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

<b>Description</b>	This metric assesses essential foundational interventions by hospitals to prepare for accountability under the “Screening for Social Drivers of Health” measure (Steward: CMS), <sup>1</sup> which if finalized, would be implemented in the HQEIP beginning in PY2 to assess whether a hospital implements screening for all MassHealth patients that are 0-64 years old at time of admission for
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<sup>1</sup> Centers for Medicare and Medicaid Services. Screening for Social Drivers of Health Measure; Hospital Inpatient Quality Reporting Program Resources. <https://qualitynet.cms.gov/inpatient/iqr/resources>

	<p>food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety.</p> <p>This measure assesses hospital performance in conducting necessary precursor activities in preparation for implementation of the finalized “Screening for Social Drivers of Health” measure in Performance Year 2.</p>
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## SUBMISSION REQUIREMENTS

<b>PY Requirement #1</b>	<p>Complete and timely (anticipated by September 30, 2023) submission of a report to EOHHS describing:</p> <ol style="list-style-type: none"> <li>1) One or more HRSN screening tool(s) selected by the hospital for intended use in screening patients beginning in PY 2; the selected tool(s) must meet requirements for screening tools for the “Screening for Social Drivers of Health” metric; and</li> <li>2) A plan to begin screening for HRSN in inpatient settings in Q1 CY 2024 in order to have capacity to report on the “Screening for Social Drivers of Health” metric beginning in PY 2.</li> </ol>
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## CHA-SPECIFIC ADAPTATIONS

<b>PY Requirement #1</b>	<p>CHA will submit one report covering the Medicaid and served uninsured patient population for this metric, which will include a section discussing served uninsured population aspects.</p>
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## C. Stratified Reporting of Quality Data

### OVERVIEW

<b>Measure Name</b>	Stratified Reporting of Quality Data, CHA HQEIP
<b>Steward</b>	EOHHS
<b>NQF Number</b>	See below
<b>Data Source</b>	Administrative, Clinical. CHA will report population-based electronic measures from the EHR, separately reported for the Medicaid and served uninsured patient populations, unless otherwise specified below.
<b>Performance Status</b>	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, hospitals and care systems can identify where health care disparities exist—and then focus interventions to reduce the disparities. Hospitals 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

<b>Description</b>	This metric outlines hospital focused stratified reporting requirements for applicable quality measures as defined by EOHHS for performance year 1. These requirements include the scope, timing, personnel, dissemination plan and application of disaggregated demographic factors (including race, ethnicity, language, disability, sexual orientation, and gender identity) and health-related social needs (including food insecurity, housing insecurity) on a subset of quality measures including maternal health, care coordination, care for acute & chronic conditions, patient experience, and access to care.
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## APPLICABLE QUALITY MEASURES

Domain	Measure
<b>Perinatal Care</b>	PC-02: Cesarean Birth, NTSV (NQF 0471, Joint Commission)  <i>**Only applicable for the Medicaid population</i>  <i>EHR-based measure</i>
	PC-06: Unexpected Newborn Complications in Term Infants (NQF 0716, Joint Commission)  <i>**Only applicable for the Medicaid population</i>  <i>EHR-based measure</i>
<b>Care Coordination</b>	TOB-1: Tobacco Use Screening (NQF 1651, Joint Commission) (for CHA medical, surgical, and maternity inpatient units)  <i>EHR-based measure</i>



	<p>TOB-2: Tobacco U/se Treatment Provided or Offered (NQF 1654, Joint Commission) (for CHA medical, surgical, and maternity inpatient units)</p> <p><i>EHR-based measure</i></p>
	<p>TOB-3: Tobacco Use Treatment Provided or Offered at Discharge (NQF 1656, Joint Commission) (for CHA medical, surgical, and maternity inpatient units)</p> <p><i>EHR-based measure</i></p>
	<p>NCQA: Follow-up After ED Visit for Mental Illness (NQF 3489) (7-Day)</p> <p><i>*EHS will be calculating and stratifying this claims-based measure for the Medicaid population, however hospitals must demonstrate ability to stratify the measure per specification or a proxy measure.</i></p> <p><i>**CHA will report an EHR-based measure for a) the served uninsured patient population with an index ED visit at CHA and b) for the served uninsured patient population on CHA's primary care panel with an index ED visit at CHA.</i></p>
	<p>NCQA: Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence (NQF 3488) (7-Day) *</p> <p><i>*EHS will be calculating and stratifying this claims-based measure for the Medicaid population, however hospitals must demonstrate ability to stratify the measure per specification or a proxy measure.</i></p> <p><i>**CHA will report an EHR-based measure for a) the served uninsured patient population with an index ED visit at CHA and b) for the served uninsured patient population on CHA's primary care panel with an index ED visit at CHA.</i></p>
<p><b>Care Coordination (Served Uninsured only)</b></p> <p>[Replacement measure since Perinatal Measures do not apply to the served uninsured]</p>	<p>Follow-up After Hospitalization (medical-surgical discharges) for primary care patients in the public hospital's primary care system. NQF 0576 is adapted to medical-surgical admissions (7-Day).</p> <p>Description: The percentage of active primary care patients in the public hospital's primary care system who had a medical-surgical discharge from a CHA hospital and received a follow-up contact or CHA visit (ambulatory or specialty care) within seven calendar days of the discharge.</p> <p>Numerator: Follow-up contact or CHA visit (ambulatory or specialty care) within seven calendar days after the discharge from the denominator.</p>

	<p>Denominator: Medical-surgical discharges for active primary care patients from a CHA Hospital during the measurement period.</p> <p><i>**Since this is a new measure, reporting will be for quarters 3 through 4 of the calendar year.</i></p> <p><i>EHR-based measure</i></p>
<b>Acute &amp; Chronic Conditions</b>	<p>SUB-2: Alcohol Use – Brief Intervention Provided/Offered* (NQF 1663, Joint Commission)</p> <p><i>**Since this is a new measure applied to the acute care setting, reporting will be for quarters 3 through 4 of the calendar year.</i></p> <p><i>EHR-based measure</i></p>
	<p>SUB-3: Alcohol &amp; Other Drug Use d/o – treatment prov/offered at d/c* (NQF 1664, Joint Commission)</p> <p><i>**Since this is a new measure applied to the acute care setting, reporting will be for quarters 3 through 4 of the calendar year.</i></p> <p><i>EHR-based measure</i></p>
<b>Behavioral Health</b>	<p>NCQA: Follow-up After Hospitalization for Mental Illness (NQF 0576) (7-Day and 30-Day)</p> <p><i>* EHS will be calculating and stratifying this claims-based measure for the Medicaid population, however hospitals must demonstrate ability to stratify the measure per specification or a proxy measure.</i></p> <p><i>**CHA will report an EHR-based measure for a) the served uninsured population with an index hospitalization at CHA and b) for served the uninsured patient population on CHA's primary care panel with an index hospitalization at CHA.</i></p> <p><i>EHR-based measure</i></p>
	<p>CMS IPFQR: Screening for Metabolic Disorders</p> <p><i>**This measure is reported for an all-payer population.</i></p> <p><i>EHR-based measure</i></p>

<b>Measurement Period</b>	Calendar year 2023, unless otherwise specified above.
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## STRATIFICATION REQUIREMENTS

<b>Description</b>	Participating hospitals are required to generate or otherwise report on applicable quality measure rates stratified by race and ethnicity according to data standard requirements specified by EOHHS and summarized below:
<b>Variable</b>	<b>Standard</b>
Race	Office of Management and Budget
Ethnicity	Office of Management and Budget

## SUBMISSION REQUIREMENTS

<b>PY1 Requirement #1</b>	<p>Complete and timely (anticipated by a date following December 31, 2023, to be determined by EOHHS) submission to EOHHS of performance data including member-level race and ethnicity for measures specified by EOHHS above for stratification. A mid-point assessment is planned after the second quarter of the calendar year.</p> <p>In recognition that CHA is not participating in the Clinical Quality Incentive program from which a subset of hospital-based measures is initially drawn for health equity and to advance toward electronic measures, EOHHS has determined that CHA can annually report population-based e-measures (drawn from the electronic health record) in lieu of chart-abstraction/ sampling for measures. This is aligned with EOHHS' goals toward population-based data collection. Measures will be submitted following the year-end utilizing an EOHHS-approved template (with separate tabs for Medicaid and served uninsured patient populations) consistent with the CMS and Joint Commission portal fields used for e-measures.</p>
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## D. Equity Improvement Interventions

### OVERVIEW

<b>Measure Name</b>	Equity Improvement Interventions
<b>Steward</b>	EOHHS

<b>NQF Number</b>	N/A
<b>Data Source</b>	Hospital-submitted data
<b>Performance Status</b>	Pay-for-Reporting

## POPULATION HEALTH IMPACT

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

## MEASURE SUMMARY

<b>Description</b>	<p>Collaborating with Partnered-ACO(s), Hospitals will jointly design and implement one health equity focused Performance Improvement Projects (PIPs) in one of three MassHealth-defined domain areas: 1) Care Coordination/Integration, 2) Care for Acute and Chronic Conditions, and 3) Maternal Morbidity.</p> <p>While MassHealth does not propose to mandate specific interventions, Hospitals will be incentivized to implement ACO-focused PIPs designed to:</p> <ul style="list-style-type: none"> <li>• Support collaboration and information sharing,</li> <li>• Address mutually shared equity goals,</li> <li>• Achieve significant and sustained improvement in equity outcomes, and</li> <li>• Promote a program wide impact.</li> </ul> <p>These PIPs will build upon the framework for quality assessment and performance improvement programs required for Medicaid managed care plans and will require four key elements: performance measurement, implementation of interventions, evaluation of the interventions' impact using the performance measures, and activities to increase/sustain improvement.</p> <p>MassHealth will provide guidance to support PIP topic selection and measures to assess effectiveness. Hospitals will design interventions informed by existing data (e.g., historical performance data stratified by imputed race/ethnicity, existing literature on disparities in Massachusetts and in terms of health topics), needs assessments, and quality improvement methodology.</p> <p>In Performance Year 1, Hospitals will initiate Performance Improvement Project (PIP) planning activities for one health equity focused PIP with the expectation that planning for a second PIP will commence in Year 2.</p>
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	<p>ACO and hospital partners will continue to build on and continue performance improvement projects planned in Years 1 or 2 and initiated in Year 2 to meet performance targets for health equity measures and disparities reduction on disparities-sensitive quality measures in Years 3 through 5.</p> <p>The following outlines an example of a PIP that could be carried out through this initiative:</p> <p>Focus: Transitions of care for members with mental illness based on existing evidence of disparities by race and ethnicity.</p> <p>Topic: “Follow-Up After Hospitalization for Mental Illness” quality measure.</p> <p>Process: Hospitals work with partnered-ACO to:</p> <ul style="list-style-type: none"> <li>• Analyze past performance to identify disparate performance,</li> <li>• Conduct barrier and root causes analyses, and</li> <li>• Identify potential interventions.</li> </ul> <p>Hospitals design evidence-based interventions, with stakeholder engagement, implement the interventions, and evaluate overall impact.</p>
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## DEFINITIONS

<b>Quarter</b>	The term “quarter” means a period of three calendar months ending on March 31, June 30, September 30, or December 31
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## SUBMISSION REQUIREMENTS

PY1 represents a pay-for-reporting year. Hospitals will be assessed on the timely and complete submission of 5 quarterly deliverables outlined in the table below:

Anticipated Deliverable Due Date (Quarter)	Deliverable	Description
March 31, 2023  (Quarter 1: January 1 – March 31, 2023)	1) Hospital Key Personnel/ Institutional Resources Document	<p>Identify:</p> <ul style="list-style-type: none"> <li>• PIP leads which include, but are not limited to, an Executive Sponsor, Clinical Lead, and Project Manager as well as other supporting staff.</li> </ul>

		<ul style="list-style-type: none"> <li>• Institutional resources that will support PIP process</li> </ul>
<p>June 30, 2023</p> <p>(Quarter 2: April 1 – June 30, 2023)</p>	2) PIP Partnership Form	<ul style="list-style-type: none"> <li>• Identify ACO partner(s)</li> <li>• Provide evidence that supports chosen ACO PIP partner(s)</li> </ul>
<p>September 30, 2023</p> <p>(Quarter 3: July 1 – September 30, 2023)</p>	<p>3) ACO Key Contact Form</p> <p>4) Mid-Year Planning Report</p>	<ul style="list-style-type: none"> <li>• Identify key ACO contacts from approved ACO partners that will be involved in PIP development</li> <li>• Draft shared health equity goal statement that aligns with partnership and PIP domains that can be selected for one PIP</li> <li>• Select and rationalize PIP domains for one PIP</li> </ul>
<p>December 31, 2023</p> <p>(Quarter 4: October 1 – December 31, 2023)</p>	5) PIP Planning Report	<p>Cumulative report which includes but is not limited to:</p> <ul style="list-style-type: none"> <li>• Restatement of deliverables 1-4 with any revisions required by EOHHS.</li> <li>• Description of PIP topics and rationale for PIP topic selection.</li> <li>• Description of PIP target populations.</li> <li>• Description of data-driven, evidence-based interventions.</li> <li>• Description of key indicators to measure intervention effectiveness, and overall performance of PIP.</li> </ul>

## CHA-SPECIFIC ADAPTATIONS

<b>Description</b>	CHA will develop the PIP related to the Medicaid ACO population. It is not applicable for the served uninsured patient population.
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## E. Meaningful Access to Healthcare Services for Individuals with Limited English Proficiency

### OVERVIEW

<b>Measure Name</b>	Meaningful Access to Healthcare Services for Individuals with Limited English Proficiency
<b>Steward</b>	Oregon Health Authority (adapted by EOHHS for implementation in the hospital and emergency department setting) <sup>2</sup>
<b>NQF Number</b>	N/A
<b>Data Source</b>	Hospital reporting
<b>Performance Status</b>	Pay-for-Reporting

### POPULATION HEALTH IMPACT

Access to high quality language services is essential to delivery of accessible, high quality care for individuals with Limited English Proficiency.

### MEASURE SUMMARY

<b>Description</b>	<p>This measure assesses access to healthcare services for individuals with limited English Proficiency and has two components:</p> <p><b>Component 1. Organizational Self-Assessment</b></p>
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<sup>2</sup>Oregon Health Authority. Health Equity Measure: Meaningful Access to Health Care Services for Persons with Limited English Proficiency – MY2021 to MY2023. <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/2021-2023%20Measure%20Spec%20Sheet-Meaningful%20Access-8July2020.pdf>

	<p>This self-assessment evaluates capacity of a hospital 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> <ul style="list-style-type: none"> <li>• Identification and assessment for communication needs</li> <li>• Provision of Language Assistance Services</li> <li>• Training of staff on policies and procedures</li> <li>• Providing notice of language assistance services</li> </ul> <p><b>Component 2. Percent of member visits with interpreter needs in which interpreter services were provided.</b></p> <p>This component does not apply in PY1.</p>
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## SUBMISSION REQUIREMENTS

<b>PY1 Requirement #1</b>	Complete and timely (anticipated by December 31, 2023 or an earlier date specified by EOHHS) reporting of an organizational self-assessment of capacity related to providing access to high quality language services to patients.
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## CHA-SPECIFIC ADAPTATIONS

<b>CHA Adaptations</b>	<p>None for PY1</p> <p>Component 2 to be reported separately for the Medicaid and served uninsured patient populations (not in PY1).</p>
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## F. Disability Competencies

### OVERVIEW

<b>Metric Name</b>	Disability Competencies
<b>Steward</b>	EOHHS



<b>NQF Number</b>	N/A
<b>Data Source</b>	Hospital-reported data
<b>Performance Status</b>	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 hospitals 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

<b>Background</b>	Two evidence-based competency models may help health care organizations achieve disability competent care: 1) The <b>Disability Competencies</b> , <sup>3 4</sup> 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 [5,6] and 2) The Resources for Integrated Care (RIC) <b>Disability Core Competency (DCC) Model</b> , <sup>567</sup> a set of seven competency 'pillars' developed in 2017 for the practicing health care workforce. [2-4] Both models share common elements and an overarching goal to improve health care for persons with disabilities by
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<sup>3</sup> Haverkamp, S. M., Barnhart, W. R., Robinson, A. C., & Whalen Smith, C. N. (2021). What should we teach about disability? National consensus on disability competencies for health care education. *Disability and health journal*, 14(2), 100989. <https://doi.org/10.1016/j.dhjo.2020.100989>

<sup>4</sup> (2019). *Core Competencies on Disability for Health Care Education*. Alliance for Disability in Healthcare Education. [https://nisonger.osu.edu/wp-content/uploads/2019/08/post-consensus-Core-Competencies-on-Disability\\_8.5.19.pdf](https://nisonger.osu.edu/wp-content/uploads/2019/08/post-consensus-Core-Competencies-on-Disability_8.5.19.pdf)

<sup>5</sup> (n.d.). *Disability Competent Care*. Resources for Integrated Care. <https://www.resourcesforintegratedcare.com/disability-competent-care/>

<sup>6</sup> (2017). *Disability-Competent Care Self-Assessment tool (DCCAT) User Guide*. Resources for Integrated Care. [https://www.resourcesforintegratedcare.com/wp-content/uploads/2022/02/DCCAT\\_2017\\_User\\_Guide-1.pdf](https://www.resourcesforintegratedcare.com/wp-content/uploads/2022/02/DCCAT_2017_User_Guide-1.pdf)

<sup>7</sup> (2017). *Disability-Competent Care Self-Assessment tool*. Resources for Integrated Care. [https://www.resourcesforintegratedcare.com/wp-content/uploads/2022/02/DCCAT\\_Final-1.pdf?csrt=2670977806170881727](https://www.resourcesforintegratedcare.com/wp-content/uploads/2022/02/DCCAT_Final-1.pdf?csrt=2670977806170881727)

	educating the health care workforce. <sup>8</sup> [1] Healthcare organizations may assess the degree to which they meet disability competencies using the Resources for Integrated Care (RIC) <b>Disability-Competent Care Self-Assessment Tool (DCCAT)</b> <sup>9</sup> and the <b>Disability-Competent Care Self-paced Training Assessment Review Tool (DCC-START)</b> . <sup>10</sup>
<b>Description</b>	<p>This measure evaluates whether hospitals have:</p> <ol style="list-style-type: none"> <li>1) Performed a self-assessment of disability-competent care;</li> <li>2) Identified at least three areas of competency in need of improvement; and</li> <li>3) Developed a disability competency training plan for patient-facing hospital staff.</li> </ol>
<b>Additional Measure information</b>	<p><b>Patient-facing staff:</b> any employed (part or full-time), non-agency hospital 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><b>Medical needs:</b> 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>

## SUBMISSION REQUIREMENTS

<b>PY1 Requirements #1</b>	<p>Complete and timely (<b>anticipated by August 11, 2023</b>) submission to EOHHS of the following: The Hospital's DCC Team's completed Resources for Integrated Care (RIC) <b>Disability-Competent Care Self-Assessment Tool (DCCAT)</b><sup>1</sup> report that includes the following:</p> <ol style="list-style-type: none"> <li>1) The members that composed your DCC Team. The members included on the Hospital's Disability Competent Care (DCC) Team can be decided by the hospital and which should represent a reasonable mix of</li> </ol>
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<sup>8</sup> Bowen, C. N., Havercamp, S. M., Karpiak Bowen, S., & Nye, G. (2020). A call to action: Preparing a disability-competent health care workforce. *Disability and health journal*, 13(4), 100941. <https://doi.org/10.1016/j.dhjo.2020.100941>

<sup>9</sup> (2017). *Disability-Competent Care Self-Assessment tool*. Resources for Integrated Care. [https://www.resourcesforintegratedcare.com/wp-content/uploads/2022/02/DCCAT\\_Final-1.pdf?csrt=2670977806170881727](https://www.resourcesforintegratedcare.com/wp-content/uploads/2022/02/DCCAT_Final-1.pdf?csrt=2670977806170881727)

<sup>10</sup> (n.d.). *Disability-Competent Care Self-Paced Training Assessment Review Tool*. Resources for Integrated Care. [https://www.resourcesforintegratedcare.com/dcc\\_start/](https://www.resourcesforintegratedcare.com/dcc_start/)

	<p>clinical and non-clinical patient-facing staff from different clinical departments. Further, we strongly recommend including individuals with disability on the Hospital's DCC Team.</p> <p>2) The results from the Hospital DCC Team's DCCAT-Hospital tool exercise. Hospitals will have freedom to further modify the 'base' DCCAT-Hospital Tool, e.g. remove, change or add new questions so long as the hospital submits documentation of (as part of their report) the modifications made along with the reason(s) for the modification(s).</p> <p>3) Informed by the results of the DCCAT-Hospital tool exercise above, hospitals will identify at least three (of seven) Disability Competent Care (DCC) Model Pillars that the hospital plans to target for improvement beginning in PY 2, based on interpretation of the results from this exercise.</p> <p>4) Lessons learned in narrative form by the hospital by creating this team and completing this DCCAT self-assessment exercise.</p>
<b>PY1 Requirement #2</b>	<p>Complete and timely (<b>anticipated by December 1, 2023</b>) submission to EOHHS of a plan for improving competency in targeted competency areas during PY 2, including:</p> <p>1) selected training tools and/or educational resources,</p> <p>2) which staff that will be assessed for post-educational/training competency, and</p> <p>3) approaches that will be used to assess post-education/training organizational and staff competency.</p> <p>This plan must describe how the hospital 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>

## CHA-SPECIFIC ADAPTATIONS

<b>CHA Adaptations</b>	None
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## G. Accommodation Needs Met

### OVERVIEW

Measure Name	Accommodation Needs Met: Structural Measure
Steward	EOHHS
NQF Number	N/A
Data Source	Hospital-reported Data
Performance Status	Pay-for-Reporting

### 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 hospitals have:</p> <ol style="list-style-type: none"><li>1) Assessed current state of hospital practice related to screening for accommodation needs at the point of care; and</li><li>2) Planned for how they will, beginning in PY2, screen patients for accommodation needs at the point of care and assess whether accommodation needs were met.</li></ol>
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### SUBMISSION REQUIREMENTS

PY1 Requirement #1	<p>Complete and timely (<b>anticipated by December 1, 2023</b>) submission to EOHHS of a report describing the hospital's current practice and future plans for the following:</p> <ol style="list-style-type: none"><li>1) screening patients for accommodation needs* before or at the start of a patient encounter, and how the results of this screening is documented</li><li>2) other methods, if any, for documenting accommodation needs</li><li>3) asking patients, at or after the end of a patient encounter, if they felt that their accommodation needs were met</li><li>4) analyses that are performed at the organizational level to understand whether accommodation needs have been met.</li></ol> <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</i></p>
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*behavioral health condition. For this report, this does not include needs for language interpreters, but does include accommodation needs for vision impairments (e.g., Braille) or hearing impairments (e.g., ASL interpreters).*

## CHA-SPECIFIC ADAPTATIONS

### CHA Adaptations

None

## H. Achievement of External Standards for Health Equity

### OVERVIEW

<b>Measure Name</b>	Achievement of External Standards for Health Equity
<b>Steward</b>	EOHHS
<b>NQF Number</b>	N/A
<b>Data Source</b>	External Accreditation/Certification Report
<b>Performance Status</b>	Pay-for-Reporting

### POPULATION HEALTH IMPACT

To be successful in addressing persistent and longstanding health disparities, healthcare organizations must adopt structures and systems that systemically and comprehensively prioritize health equity as a fundamental component of high quality care. These goals include collaboration and partnership with other sectors that influence the health of individuals, adoption and implementation of a culture of equity, and the creation of structures that support a culture of equity.<sup>11</sup> External health equity certification independently and objectively assesses attainment of these and other relevant health equity goals to ensure that healthcare organizations are providing a comprehensively high standard of equitable care.

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<sup>11</sup> The National Quality Forum. A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity. [https://www.qualityforum.org/Publications/2017/09/A\\_Roadmap\\_for\\_Promoting\\_Health\\_Equity\\_and\\_Eliminating\\_Disparities\\_The\\_Four\\_I\\_s\\_for\\_Health\\_Equity.aspx](https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities_The_Four_I_s_for_Health_Equity.aspx)

## MEASURE SUMMARY

<b>Description</b>	<p>Effective January 1, 2023, The Joint Commission will introduce new and revised requirements<sup>12</sup> to reduce health care disparities for organizations participating in its hospital accreditation program. The new accreditation standards are aimed at reducing health care disparities as a quality and safety priority. Six new elements of performance in the Leadership (LD) chapter, Standard LD.04.03.08, emphasize fundamental processes including related to:</p> <ol style="list-style-type: none"><li>1) identifying health equity leadership;</li><li>2) understanding patients' health-related social needs and providing information about needed community resources and supports;</li><li>3) evaluation of health care disparities, including through stratification of key quality and safety data using sociodemographic characteristics, social needs, or social determinants of patient health;</li><li>4) creation of a written action plan describing how health care disparities will be addressed;</li><li>5) monitoring the effectiveness of interventions to reduce health care disparities; and</li><li>6) informing key stakeholders about its progress to reduce identified health care disparities.</li></ol> <p>These standards are intended to serve as a foundation for future work to address health care disparities, specifically through The Joint Commission's planned Health Care Equity Certification,<sup>13</sup> which will build on the equity-focused Accreditation standards to recognize organizations that go above and beyond to provide high quality and equitable care.</p>
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## SUBMISSION REQUIREMENTS

<b>PY1 Requirement #1</b>	By <b>December 31, 2023</b> , submit to EOHHS an attestation that the hospital has completed The Joint Commission (TJC) surveys for health equity accreditation standards (specifically, 6 new elements of performance in the Leadership (LD) chapter, Standard LD.04.03.08.) Hospitals that are currently accredited by TJC and due for triennial surveying in 2023 may meet the requirement through inclusion of the health equity standards in their scheduled survey; hospitals that are not currently accredited by TJC and TJC-
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<sup>12</sup> The Joint Commission. New and Revised Requirements to Reduce Health Care Disparities. <https://www.jointcommission.org/standards/prepublication-standards/new-and-revised-requirements-to-reduce-health-care-disparities/>

<sup>13</sup> The Joint Commission. Advancing Health Care Equity, Together. <https://www.jointcommission.org/our-priorities/health-care-equity/>

	accredited hospitals that are not due for their triennial accreditation survey in 2023 must participate in a “standalone” health equity survey by December 31, 2023. TJC remediation must be complete by April 30, 2024 to receive credit for the measure; hospital must attest to EOHHS to meeting this deadline.
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## CHA-SPECIFIC ADAPTATIONS

CHA Adaptations	None
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## I. HCAHPS: Items Related to Cultural Competency

### OVERVIEW

Measure Name	Patient Experience: Cultural Competence
Steward	EOHHS; using data from HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey: Agency for Healthcare Research and Quality
NQF Number	0166
Data Source	Survey
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 evaluates MassHealth member perspectives on hospital care as measured using the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey for patient experience in the acute hospital setting. The HCAHPS survey is administered by Massachusetts acute care hospitals to an all-payer sample; this measure requires hospitals to extract and report to MassHealth survey results for any MassHealth member participating in the HCAHPS survey for the Performance Year as part of a
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	<p>hospital's all-payer sample (selected according to AHRQ sampling methodologies).</p> <p>MassHealth member results will be reported for the full HCAHPS survey instrument, including standard items relating to provision of culturally competent care such as:</p> <ul style="list-style-type: none"> <li>• During this hospital stay, how often did nurses treat you with courtesy and respect?</li> <li>• During this hospital stay, how often did nurses listen carefully to you?</li> <li>• During this hospital stay, how often did nurses explain things in a way you could understand?</li> <li>• During this hospital stay, how often did doctors treat you with courtesy and respect?</li> <li>• During this hospital stay, how often did doctors listen carefully to you?</li> <li>• During this hospital stay, how often did doctors explain things in a way you could understand?</li> </ul> <p>HCAHPS Resources: <a href="#">HCAHPS: Patients' Perspectives of Care Survey   CMS</a>; <a href="#">HCAHPS Fact Sheet 2022</a>; <a href="#">Survey Instruments (hcahpsonline.org)</a></p>
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## PATIENT EXPERIENCE SURVEY REQUIREMENTS

<b>Description</b>	<ul style="list-style-type: none"> <li>• Hospitals must extract and report to MassHealth HCAHPS survey results for any MassHealth members participating in the HCAHPS survey as part of standard, all-payer sampling methodologies specified by AHRQ for the Performance Year.</li> </ul>
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## SUBMISSION REQUIREMENTS

<b>PY1 Requirement #1</b>	Complete and timely ( <b>anticipated by a date following December 31, 2023</b> to be determined by EOHHS) submission to EOHHS of HCAHPS survey results for any MassHealth members participating in the hospital's HCAHPS survey sample during PY 1.
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## CHA-SPECIFIC ADAPTATIONS

<b>CHA Adaptations</b>	None
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## J. Stratified Reporting of Ambulatory Quality Data, CHA-HQEIP

### OVERVIEW

<b>Measure Name</b>	Stratified Reporting of Ambulatory Quality Data, CHA-HQEIP
<b>Steward</b>	See below
<b>NQF Number</b>	See below
<b>Data Source</b>	Administrative, Clinical. CHA will report population-based electronic measures from the EHR.
<b>Performance Status</b>	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 developing ambulatory patient data for the uninsured patient population. By collecting and analyzing quality measures, hospitals and care systems can identify where health care disparities exist—and then focus interventions to reduce the disparities. Hospitals 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

<b>Description</b>	This measure evaluates MassHealth member perspectives on hospital care as measured using the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey for patient experience in the acute hospital setting. The HCAHPS survey is administered by Massachusetts acute care hospitals to an all-payer sample; this measure requires hospitals to extract and report to MassHealth survey results for any MassHealth member participating in the
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### PATIENT EXPERIENCE SURVEY REQUIREMENTS

<b>Description</b>	This metric outlines ambulatory-focused reporting requirements for applicable ambulatory quality measures for the served uninsured patient population in the public hospital's primary care system, as defined by EOHS for performance year 1. The quality measures span wellness,
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	prevention, and screening; access; outreach and care coordination; and chronic health conditions domains.
	<b>A.</b>

**APPLICABLE AMBULATORY QUALITY MEASURES FOR PERFORMANCE YEAR 1  
for “Served Uninsured Patients” in CHA’s primary care system^**

**REPORTING REQUIREMENTS**

Measure	Domain	Measure ID/ Steward
1. Well-Child Visits in the First 30 Months of Life (Total Rate)	Wellness, Prevention, and Screening	HEDIS 2022 (W30) NQF 1392, NCQA (adapted to apply to the served uninsured population)*
2. Child and Adolescent well care visit (Total Rate)	Wellness, Prevention, and Screening	HEDIS 2022 (WCV) NQF 1516, NCQA (adapted to apply to the served uninsured population)*
3. Childhood Immunization - Combo 10	Wellness, Prevention, and Screening	NQF 0038, NCQA (adapted to apply to the served uninsured population)*
4. Immunization for Adolescents - Combo 2	Wellness, Prevention, and Screening	NQF 1407, NCQA (adapted to apply to the served uninsured population)*
5. Achieve Outreach to Defined % of New or Past Due Served Uninsured Patients in Primary Care Panel Population  <i>**Since this is a new measure for the served uninsured population, reporting will be for quarters 3 through 4 of the calendar year.</i>	Access; Outreach and Care Coordination	State Developed  (specification below)
6. Cancer Screening Measure(s) TBD  <i>CHA will develop/explore:</i>  <ul style="list-style-type: none"> <li>• <i>breast cancer screening (NQF 2372),</i></li> <li>• <i>cervical cancer screening (CCS) (NQF 0032), and</i></li> </ul>	Wellness, Prevention, and Screening	HEDIS 2022 (adapted to apply to the served uninsured population)*

<ul style="list-style-type: none"> <li>• <i>colorectal cancer screening (NQF 0034) (COL) measures to identify opportunities. Based on findings, a subset may be incorporated within the measure slate in subsequent years.</i></li> </ul>		
7. Hypertension: Controlling high blood pressure	Chronic Health Conditions	HEDIS 2022, NQF 0018, NCQA (adapted to apply to the served uninsured population)*
8. Comprehensive Diabetes Care: Poor Control (>9%)	Chronic Health Conditions	HEDIS 2022, NQF 0059, NCQA (adapted to apply to the served uninsured population)*
9. Diabetes & Hypertension Education: Percentage of high-risk diabetic and hypertensive primary care panel patients receiving enhanced diabetes management services, including nursing-led self-management education, pharmacist-led medication management services, or other care team member support	Chronic Health Conditions; Outreach and Care Coordination	Custom  Intermediate measure associated with measures 7 and 8 above.  (specification below)
10. Depression Screening and Follow-Up	Wellness, Prevention, and Screening	CMS measure (Adapted to apply to the served uninsured population)

**\*Adaptation for served uninsured population:** HEDIS measures can be adjusted for non-health plan reporting. In accordance with such NCQA guidance and to adapt for the served uninsured population, the measures denoted above will be adjusted for the non-clinical component of “continuous enrollment, allowable gap, anchor date,” which are not applicable to served uninsured populations.

**^Definition for served uninsured patient population in public hospital’s primary care system: active primary care patient:**

Active primary care patient is defined as a patient that had a face-to-face or telehealth visit in the last 2 years where the patient is empaneled at one of CHA’s primary care locations assigned in the EHR.

For ambulatory measures for active patients on CHA’s primary care panel, coverage is pulled on the last encounter that was assigned as the Primary Benefit Plan and Secondary Benefit Plan in the EHR.

**Data Source:** EHR reported measures

**Measurement Period:** Calendar Year 2023, unless otherwise specified above.

**Updates of Measure Specifications:**

In the event that a measure specification is updated by the measure steward, that update will be reflected in the applicable period.

In the event that an ambulatory measure is retired by a measure steward for any reason, EOHHS may replace the impacted measure, choosing from a CMS-approved measure that is already widely adopted within Massachusetts (or for which reliable data to establish a valid benchmark and performance changes are readily available) and supported by the findings from analysis and/or needs assessment.

**Technical Updates:**

Updates to technical specifications shall not require CMS approval insofar as the updates do not alter the intention of the measure, but must be documented in the Monitoring Reports and/or Implementation Plan, as appropriate, pursuant to STC 14.18.

**Notes:** This initial measure slate is subject to updates in a future year. Based on the initial stratification of measures in year 1 and ongoing findings, adjustments and/or replacement measures may be proposed in future years based on the findings, denominator size, assessment of opportunities, etc., for incorporation in the Addendum for performance years 2 - 5.

**Measure 5 Specification:**

**Achieve Outreach to Defined Percentage of New or Past Due Served Uninsured Patients in Primary Care Panel Population**

**Measure Description:**

Percentage of new and inactive served uninsured primary care patients for whom CHA has successfully completed outreach within the 12-month measurement period.

**Measure Definition:**

Numerator: Patients in the denominator who have met any of the following criteria within the 12-month reporting period:

- Patient has or had a scheduled appointment in the CHA primary care system, or
- At least one completed or arrived face-to-face or telehealth visit, taking place at a CHA primary care setting

Denominator: Patients who are served uninsured patients and identified in the 12- month measurement period with any of the following:

- New patients assigned to a CHA primary care location
- Inactive patients who currently have a CHA primary care location, assigned, but are not active primary care patients (patients who have not been seen in the public hospital's primary care system > 2 years).

### **Measure 9 Specification: Diabetes & Hypertension Education**

#### **Measure Description:**

Percentage of high-risk diabetic and hypertensive primary care panel patients (ages 18 to 64) receiving enhanced diabetes or hypertension management services, including nursing-led self-management education, pharmacist-led medication management services, or other care team member support in the 12-month measurement period.

#### **Measure Definition:**

Numerator: Patients in the denominator who had the appropriate documentation for a pharmacist visit (telephone, face-to-face, telehealth) for diabetes or hypertension OR a nurse visit (telephone, face-to-face, telehealth) for diabetes or hypertension within the 12-month measurement period.

Denominator: Patients who meet the following conditions:

Last hemoglobin A1c was > 8% in the last 12-month measurement period OR last blood pressure readings of systolic > 140 or diastolic > 90 during the 12-month measurement period

AND

who were active primary care patients, ages 18 to 64, with a face-to-face visit/telehealth visit within the 12-month measurement period.

### **Measure 10 Specification: Depression Screening and Follow-Up**

#### **Measure Description:**

The percentage of patients 12 to 64 years of age on the date of an encounter with an outpatient visit during the measurement year AND screened for clinical depression using a standardized tool during the measurement year, AND, if screened positive, a follow-up plan is documented on the date of or up

to 2 days after the date of the positive screen. Note: depression screening may also occur up to 14 days prior to the date of the encounter.

**Measure Definition:**

Numerator: Patients 12 to 64 years of age on the date of an encounter with an outpatient visit during the measurement year AND screened for clinical depression using a standardized tool during the measurement year, AND, if screened positive, a follow-up plan is documented on the date of or up to 2 days after the date of the positive screen. Note: depression screening may also occur up to 14 days prior to the date of the encounter.

Denominator: Patients 12-64 years of age on the date of the encounter, with an outpatient visit during the measurement year

## REPORTING REQUIREMENTS

<b>Description</b>	Participating hospitals are required to generate or otherwise report on applicable quality measure rates according to data standard requirements specified by EOHHS and summarized below.
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## SUBMISSION REQUIREMENTS

<b>PY1 Requirement #1</b>	<p>Complete and timely (anticipated by a date following December 31, 2023 to be determined by EOHHS) submission to EOHHS of performance data for measures specified by EOHHS above. A mid-point assessment is planned after the second quarter of the calendar year.</p> <p>EOHHS has determined that CHA can annually report e-measures (drawn from the electronic health record). This is aligned with EOHHS' goals toward population-based data collection. Measures will be submitted following the year-end utilizing an EOHHS-approved template for the served uninsured patient population).</p>
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