Technical Specifications for the MassHealth Cambridge Health Alliance Hospital Quality and Equity Incentives Program (CHA-HQEIP)

Performance Years 3-5 (Calendar Years 2025-2027)

Version: May 19, 2025

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I. Introduction to CHA HQEIP Technical Specifications

A. CHA-Specific Adaptations

CHA will follow the technical specifications for the HQEIP for the Medicaid patient population with adaptations as identified in this document. Specifically, this document describes technical specifications with CHA Adaptations for:

- submission of electronic population-based measures (instead of chart-abstracted/sampled measures) for Quality Performance Disparities Reduction, which has been adjusted directly in the Quality Performance Disparities Reduction section to account for the CHA adaptations;
- the aligned measures for Quality Performance Disparities Reduction, which has been adjusted directly in the Quality Performance Disparities Reduction section to account for the CHA adaptations;
- ambulatory quality measures and other ambulatory-specific metrics for the served uninsured patient population within the CHA HQEIP, described in a new section specific to CHA; and
- adaptations to other HQEIP deliverables related to the Medicaid and served uninsured patient populations, described in the "CHA-Specific Adaptation" tables throughout the document.

EOHHS has determined that CHA shall annually report population-based electronic measures (drawn from the electronic health record) in lieu of chart-abstraction/sampling for the Section III.C. Quality Performance Disparities Reduction 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 consistent with the CMS and Joint Commission portal fields used for e-measures.

Related to Quality Performance Disparities Reduction, since CHA is not participating in the Clinical Quality Incentive (CQI) program from which initial hospital-based health equity measures are drawn, CHA will report a measure set in alignment with HQEIP with adaptation.

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

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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.

MassHealth reserves the right to request additional documentation related to the CHA-HQEIP measures for the purpose of auditing. While certain CHA-HQEIP measures are expected and identified as audit targets in the CHA-HQEIP PY3-5 Performance Assessment Methodology Manual, MassHealth reserves the right to implement audits or request additional documentation for any measure or any aspect of the CHA-HQEIP.

B. Patient Population Definitions

The CHA patient populations include: the "served uninsured" (or underinsured) patient populations and the Medicaid population.

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).

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II. CHA HQEIP Hospital Technical Specifications

A. RELD SOGI Data Completeness

A.i. Race Data Completeness

OVERVIEW	
Measure Name	Rate of Race Data Completeness – Acute Hospital
Steward	MassHealth
CBE ID Number	N/A
Data Source	Numerator source: Center for Health Information and Analysis (CHIA) "Enhanced Demographics Data File" Denominator sources: MassHealth encounter and MMIS claims data
Performance Status: PY3-5	Pay-for-Performance (P4P)

POPULATION HEALTH IMPACT

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

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

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ELIGIBLE POPULATION

Age	Members of any age
Continuous Enrollment	None
Anchor Date	None
Event/Diagnosis	At least one inpatient stay or ED visit at an acute hospital between January 1 and December 31 of the measurement year. To identify inpatient stay: • Identify all inpatient stay (Inpatient Stay Value Set)[1]. To identify emergency department visits: • Identify all Emergency Department visits (ED Value Set)[2].

DEFINITIONS

Complete Race Data	Complete race data is defined as: At least one (1) valid race value (valid race values are listed in Attachment 1). • 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.
Hospital File ["Enhanced Demographics Data File"]	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

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[1] HEDIS® Value Set used with permission from NCQA
[2] HEDIS® Value Set used with permission from NCQA

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	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.
Measurement Year	Measurement Years 1-5 correspond to QEIP Performance Years 1-5.
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.
Rate of Race Data Completeness	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
Self-Reported data	For the purposes of this measure specification, data are defined as self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy). 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 HHS' data collection standards 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

Denominator	There are two denominators for this measure:

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	Denominator 1: The eligible population for MassHealth members with inpatient stay claims/encounters from acute hospitals. **Denominator 2:** The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.
Numerator	There are two numerators for this measure: **Numerator 1:** For members in Denominator 1, identify those with complete race data, defined as: At least one (1) valid race value (valid race values are listed in Attachment 1). • If value is "UNK," it will <u>not</u> count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported. **Numerator 2:** For members in Denominator 2, identify those with complete race data, defined as: At least one (1) valid race value (valid race values are listed in Attachment 1). • If value is "UNK," it will <u>not</u> count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported.
Exclusions	If value is UTC, the inpatient stay or emergency department visit is excluded from the denominator.

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ADDITIONAL MEASURE INFORMATION

Required Reporting	The following information is required: • A valid MassHealth Member ID Format: Refer to CHIA Submission Guide • At least one (1) race value, as defined under "Complete Race Data" above Format: Refer to CHIA Submission Guide
Data Collection	For the purposes of this measure, race data must be self-reported. Race data that are derived using an imputation methodology do not contribute to completeness for this measure. Self-reported race data may be collected: • By any modality that allows the patient (or a person legally authorized to respond on the patient's behalf, such as a parent or legal guardian) to self-report race (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 1.
Completeness Calculations	Completeness is calculated for: each individual Acute Hospital.

Attachment 1. Race: Accepted Values

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

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Description	Valid Values	Notes
White	2106-3	
Other Race	OTH	
Choose not to answer	ASKU	Member was asked to provide their race, and the member actively selected or indicated that they "choose not to answer."
Don't know	DONTKNOW	Member was asked to provide their race, and the member actively selected or indicated that they did not know their race.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	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 response, and should be assigned the value of ASKU instead of UNK.

CHA-SPECIFIC ADAPTATIONS

Overview: Data Source	Numerator source: Center for Health Informatics and Analysis (CHIA) "Enhanced Demographics Data File" and/or Hospital EHR

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	Denominator sources: MassHealth encounter and MMIS claims data and/or Hospital EHR
Measure Summary: Description	The percentage of members and served uninsured patients (reported separately) with self-reported race data that was collected by CHA in the measurement year.
Definitions: Members/Patients	The CHA population included in the measure is grouped as follows: • MassHealth members • Served uninsured patients
Definitions: Rate of Race Data Completeness	There will be four rates reported for this measure: Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100 Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100 Rate 3: (Numerator 3 Population / Denominator 3 Population) * 100 Rate 4: (Numerator 4 Population / Denominator 4 Population) * 100
Administrative Specification: Denominator	There are four denominators for this measure. **Denominator 1**: The eligible population for **MassHealth members** with **inpatient discharge** claims/encounters from acute hospitals. **Denominator 2:** The eligible population for **MassHealth members** with **emergency department visit** claims/encounters from acute hospitals. **Denominator 3:** The eligible population for served uninsured patients with **inpatient discharge** claims/encounters from acute hospitals. **Denominator 4:** The eligible population for served uninsured patients with **emergency department visit** claims/encounters from acute hospitals.
Administrative Specification: Numerators	There are four numerators for this measure. **Numerator 1:** For members in **Denominator 1**, identify those with complete race data, defined as: At least one (1) valid race value (valid race values are listed in Attachment 1). o If value is "UNK," it will <u>not</u> count toward the numerator.

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	o If value is "ASKU," it will count toward the numerator.
	o If value is "DONTKNOW," it will count toward the numerator.
	o Each value must be self-reported.

	Numerator 2:
	For members in **Denominator 2**, identify those with complete race data, defined as:
	
	At least one (1) valid race value (valid race values are listed in Attachment 1).
	
	    o If value is "UNK," it will <u>not</u> count toward the numerator.
	
	    o If value is "ASKU," it will count toward the numerator.
	
	    o If value is "DONTKNOW," it will count toward the numerator.
	
	    o Each value must be self-reported.

	Numerator 3:
	For patients in **Denominator 3**, identify those with complete race data, defined as:
	
	At least one (1) valid race value (valid race values are listed in Attachment 1).
	
	    o If value is "UNK," it will <u>not</u> count toward the numerator.
	
	    o If value is "ASKU," it will count toward the numerator.
	
	    o If value is "DONTKNOW," it will count toward the numerator.
	
	    o Each value must be self-reported.

	Numerator 4:
	For patients in **Denominator 4**, identify those with complete race data, defined as:
	
	At least one (1) valid race value (valid race values are listed in Attachment 1).
	
	    o If value is "UNK," it will <u>not</u> count toward the numerator.
	
	    o If value is "ASKU," it will count toward the numerator.
	
	    o If value is "DONTKNOW," it will count toward the numerator.

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	○ Each value must be self-reported.
Additional Measure Information: Required Reporting	Valid MassHealth Member IDs must be submitted for the MassHealth population, and must be submitted for the served uninsured population, when applicable. MRNs must be submitted for both the MassHealth and served uninsured populations.
Additional Measure Information: Completeness Calculations	Completeness will be calculated separately for CHA's Medicaid population and CHA's served uninsured population.

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A.ii. Hispanic Ethnicity Data Completeness

OVERVIEW	
Measure Name	Rate of Hispanic Ethnicity Data Completeness – Acute Hospital
Steward	MassHealth
CBE ID Number	N/A
Data Source	Numerator source: Center for Health Information and Analysis (CHIA) "Enhanced Demographics Data File" Denominator sources: MassHealth encounter and MMIS claims data
Performance Status: PY3-5	Pay-for-Performance (P4P)

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

ELIGIBLE POPULATION	
Age	Members of any age

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Continuous Enrollment	None
Anchor Date	None
Event/Diagnosis	At least one inpatient stay and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year. To identify inpatient stays: • Identify all inpatient stays (<u>Inpatient Stay Value Set</u>)[3]. To identify emergency department visits: • Identify all Emergency Department visits (<u>ED Value Set</u>)[4]

DEFINITIONS

Complete Hispanic ethnicity Data	Complete Hispanic ethnicity data is defined as: One (1) valid Hispanic ethnicity value (valid Hispanic ethnicity values are listed in Attachment 2). • If value is "UNK," it will <u>not</u> count toward the numerator. • If value is "ASKU it will count toward the numerator. • If value is "DONTKNOW" it will count toward the numerator. • Each value must be self-reported.
Hospital File ["Enhanced Demographics Data File"]	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 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

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[3] HEDIS® Value Set used with permission from NCQA
[4] HEDIS® Value Set used with permission from NCQA

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	submissions guides for the intake of this Enhanced Demographics Data file.
Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.
Rate of Hispanic Ethnicity Data Completeness	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
Self-Reported data	For the purposes of this measure specification, data are defined as self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy). Self-reported Hispanic ethnicity data that has been rolled-up or transformed for reporting purposes may be included. For example, if a hospital's data systems include ethnicities that are included in HHS' data collection standards (i.e., Mexican; Puerto Rican; Cuban; Another Hispanic, Latino/a, or Spanish origin) and an individual self-reports their ethnicity as "Puerto Rican", then the hospital can report the value of "Hispanic" since the value of Puerto Rican is not a valid value in Attachment 2.

ADMINISTRATIVE SPECIFICATION

Denominator	There are two denominators for this measure: **Denominator 1:**

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	The eligible population for MassHealth members with inpatient stay claims/encounters from acute hospitals. **Denominator 2:** The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.
Numerator	There are two numerators for this measure: **Numerator 1:** For members in Denominator 1, identify those with complete Hispanic ethnicity data, defined as: One (1) valid Hispanic ethnicity value (valid Hispanic ethnicity values are listed in Attachment 2). • If value is "UNK," it will <u>not</u> count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported. **Numerator 2:** For members in Denominator 2, identify those with complete Hispanic ethnicity data, defined as: One (1) valid Hispanic ethnicity value (valid Hispanic ethnicity values are listed in Attachment 2). • If value is "UNK," it will <u>not</u> count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported.
Exclusions	If value is UTC, the inpatient stay or emergency department visit is excluded from the denominator.

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ADDITIONAL MEASURE INFORMATION

Required Reporting	The following information is required: • A valid MassHealth Member ID Format: Refer to CHIA Submission Guide • At least one (1) ethnicity value, as defined under "Complete Hispanic Data" above Format: Refer to CHIA Submission Guide
Data Collection	For the purposes of this measure, Hispanic ethnicity data must be self-reported. Hispanic ethnicity data that are derived using an imputation methodology do not contribute to completeness for this measure. Self-reported Hispanic ethnicity data may be collected: • By any modality that allows the patient (or a person legally authorized to respond on the patient's behalf, such as a parent or legal guardian) to self-report Hispanic ethnicity (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 2.
Completeness Calculations	Completeness is calculated for: each individual Acute Hospital.

Attachment 2. Hispanic Ethnicity: Accepted Values

Description	Valid Values	Notes
Hispanic or Latino	2135-2	
Not Hispanic or Latino	2186-5	
Choose not to answer	ASKU	Member was asked to provide their ethnicity, and the member actively selected or indicated that they "choose not to answer".

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Description	Valid Values	Notes
Don't know	DONTKNOW	Member was asked to provide their ethnicity, and the member actively selected or indicated that they did not know their ethnicity.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness).	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	The ethnicity of the member is unknown since either: (a) the member was not asked to provide their ethnicity, or (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.

CHA-SPECIFIC ADAPTATIONS

Overview: Data Source	Numerator source: Center for Health Informatics and Analysis (CHIA) "Enhanced Demographics Data File" and/or Hospital EHR Denominator sources: MassHealth encounter and MMIS claims data and/or Hospital EHR

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Measure Summary: Description	The percentage of members and served uninsured patients (reported separately) with self-reported Hispanic ethnicity data that was collected by CHA in the measurement year.
Definitions: Members/Patients	The CHA population included in the measure is grouped as follows: • MassHealth members • Served uninsured patients
Definitions: Rate of Hispanic Ethnicity Data Completeness	There will be four rates reported for this measure: Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100 Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100 Rate 3: (Numerator 3 Population / Denominator 3 Population) * 100 Rate 4: (Numerator 4 Population / Denominator 4 Population) * 100
Administrative Specification: Denominators	There are four denominators for this measure. **Denominator 1**: The eligible population for **MassHealth members** with **inpatient discharg**e claims/encounters from acute hospitals. **Denominator 2:** The eligible population for **MassHealth members** with **emergency department visit** claims/encounters from acute hospitals. **Denominator 3:** The eligible population for served uninsured patients with **inpatient discharge** claims/encounters from acute hospitals. **Denominator 4:** The eligible population for served uninsured patients with **emergency department visit** claims/encounters from acute hospitals.
Administrative Specification: Numerator	There are four numerators for this measure. **Numerator 1:** For members in **Denominator 1**, identify those with complete Hispanic ethnicity data, defined as: At least one (1) valid Hispanic ethnicity value (valid Hispanic ethnicity values are listed in Attachment 2).

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o   If value is "UNK," it will <u>not</u> count toward the numerator.

o   If value is "ASKU," it will count toward the numerator.

o   If value is "DONTKNOW," it will count toward the numerator.

o   Each value must be self-reported.

Numerator 2:
For members in **Denominator 2**, identify those with complete Hispanic ethnicity data, defined as:

At least one (1) valid Hispanic ethnicity value (valid Hispanic ethnicity values are listed in Attachment 2).

o   If value is "UNK," it will <u>not</u> count toward the numerator.

o   If value is "ASKU," it will count toward the numerator.

o   If value is "DONTKNOW," it will count toward the numerator.

o   Each value must be self-reported.

Numerator 3:

For patients in **Denominator 3**, identify those with complete Hispanic ethnicity data, defined as:

At least one (1) valid Hispanic ethnicity value (valid Hispanic ethnicity values are listed in Attachment 2).

o   If value is "UNK," it will <u>not</u> count toward the numerator.

o   If value is "ASKU," it will count toward the numerator.

o   If value is "DONTKNOW," it will count toward the numerator.

o   Each value must be self-reported.

Numerator 4:

For patients in **Denominator 4**, identify those with complete Hispanic ethnicity data, defined as:

At least one (1) valid Hispanic ethnicity value (valid Hispanic ethnicity values are listed in Attachment 2).

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	o If value is "UNK," it will <u>not</u> count toward the numerator.
	o If value is "ASKU," it will count toward the numerator.
	o If value is "DONTKNOW," it will count toward the numerator.
	o Each value must be self-reported.
Additional Measure Information: Required Reporting	Valid MassHealth Member IDs must be submitted for the MassHealth population, and must be submitted for the served uninsured population, when applicable. MRNs must be submitted for both the MassHealth and served uninsured populations.
Additional Measure Information: Completeness Calculations	Completeness will be calculated separately for CHA's Medicaid population and CHA's served uninsured population.

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A.iii. Preferred Language Data Completeness

OVERVIEW	
Measure Name	Rate of Language Data Completeness – Acute Hospital
Steward	EOHHS
CBE ID Number	N/A
Data Source	Numerator source: Center for Health Information and Analysis (CHIA) "Enhanced Demographics Data File" Denominator sources: MassHealth encounter and MMIS claims data
Performance Status: PY3-5	Pay-for-Performance (P4P)

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

Description	The percentage of members with self-reported language data that was collected by an acute hospital in the measurement year. Rates are calculated separately for 2 language questions.
Numerator	Members with an inpatient stay and/or emergency department (ED) visit at an acute hospital <u>and</u> self-reported language data that was collected by an acute hospital in the measurement year.
Denominator	Members with an inpatient stay and/or ED visit at an acute hospital during the measurement year.

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ELIGIBLE POPULATION

Age	Members age 6 and older as of December 31st of the measurement year
Continuous Enrollment	None
Anchor Date	None
Event/Diagnosis	At least one inpatient stay and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year. To identify inpatient stays: • Identify all inpatient stay (Inpatient Stay Value Set)[5]. To identify emergency department visits: • Identify all Emergency Department visits (ED Value Set)[6].

DEFINITIONS

Complete Preferred Written Language Data	Complete Preferred Written Language (PWL) data is defined as: One (1) valid Preferred Written Language value (valid Preferred Written Language 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.
Complete Preferred Spoken Language Data	Complete Preferred Spoken Language (PSL) data is defined as: One (1) valid Preferred Spoken Language value (valid Preferred Spoken Language 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.

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[5] HEDIS® Value Set used with permission from NCQA
[6] HEDIS® Value Set used with permission from NCQA

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	• Each value must be self-reported.
Hospital File ["Enhanced Demographics Data File"]	The Center for Information and Analysis (CHIA) will intake Preferred Written and Spoken Language 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.
Measurement Year	Measurement Years 2-5 correspond to Calendar Years 2024-2027.
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.
Rate of Preferred Written and Spoken Language Data Completeness	There will be four rates reported for this measure, defined as. Rate 1: (Numerator 1 (PWL) Population / Denominator 1 (IP) Population) * 100 Rate 2: (Numerator 1 (PSL) Population / Denominator 1 (IP) Population) * 100 Rate 3: (Numerator 2 (PWL) Population / Denominator 2 (ED) Population) * 100 Rate 4: (Numerator 2 (PSL) Population / Denominator 2 (ED) Population) * 100
Self-Reported data	For the purposes of this measure specification, data are defined as self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized

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	representative, guardian, conservator, holder of power of attorney, or health-care proxy).

ADMINISTRATIVE SPECIFICATION	
Denominator	There are two denominators for this measure: **Denominator 1:** The eligible population for MassHealth members with inpatient stay claims/encounters from acute hospitals. **Denominator 2:** The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.
Numerator	**Numerator 1:** For members in Denominator 1, identify those with complete language data, (defined above under "Complete Language Data") for each question below: - QMAT Language Q1: In which language would you feel most comfortable reading medical or health care instructions? (or similar phrasing to elicit written language preference). - QMAT Language Q2: What language do you feel most comfortable speaking with your doctor or nurse? (or similar phrasing to elicit spoken language preference). **Numerator 2:** For members in Denominator 2, identify those with complete language data, (defined above under "Complete Language Data") for each question below: - QMAT Language Q1: In which language would you feel most comfortable reading medical or health care instructions? (or similar phrasing to elicit written language preference).

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	• QMAT Language Q2: What language do you feel most comfortable speaking with your doctor or nurse? (or similar phrasing to elicit spoken language preference).
Exclusions	If value is UTC, the inpatient stay or emergency department visit is excluded from the denominator.

ADDITIONAL MEASURE INFORMATION

Required Reporting	The following information is required: • A valid MassHealth Member ID Format: Refer to CHIA Submission Guide • At least one (1) Preferred Written and Spoken Language value per question, as defined under "Complete Preferred Written Language Data" and "Complete Preferred Spoken Language Data" above Format: Refer to CHIA Submission Guide
Data Collection	For the purposes of this measure, Preferred Written and Spoken Language data must be self-reported. Preferred Written and Spoken Language data that are derived using an imputation methodology do not contribute to completeness for this measure. Self-reported Preferred Written and Spoken Language data may be collected: • By any modality that allows the patient (or a person legally authorized to respond on the patient's behalf, such as a parent or legal guardian) to self-report preferred written and spoken languages (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 3; o If an acute hospital submits a value that is not included in Attachment 3 but allowable per the MassHealth Member

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	File Specification, the value will be mapped to Other Preferred Written Language (OTH).
Completeness Calculations	Completeness is calculated per language question per denominator population per acute hospital and overall, as described below:
	For each individual acute hospital (Inpatient Denominator only):
	For acute hospital x, the percentage of members with self-reported preferred **written** language data for question 1 that was collected by acute hospital x in the measurement year.
	For acute hospital x, the percentage of members with self-reported preferred **spoken** language data for question 2 that was collected by acute hospital x in the measurement year.
	For each individual acute hospital (Emergency Department Denominator only):
	For acute hospital x, the percentage of members with self-reported preferred **written** language data for question 1 that was collected by acute hospital x in the measurement year.
	For acute hospital x, the percentage of members with self-reported preferred **spoken** language data for question 2 that was collected by acute hospital x in the measurement year.
	For all acute hospitals (Inpatient Denominator only)
	For all acute hospitals, the percentage of members with self-reported preferred **written** language data for question 1 that was collected by all acute hospitals in the measurement year.
	For all acute hospitals, the percentage of members with self-reported preferred **spoken** language data for question 2 that was collected by all acute hospitals in the measurement year.
	For all acute hospitals (Emergency Department Denominator only)
	For all acute hospitals, the percentage of members with self-reported preferred **written** language data for question 1 that was collected by all acute hospitals in the measurement year.

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For all acute hospitals, the percentage of members with self-reported preferred **spoken** language data for question 2 that was collected by all acute hospitals in the measurement year.

Attachment 3. Preferred Written and Spoken Language: Accepted Values

Preferred Written Language

Description	Valid Values	Notes
English	en	
Spanish	es	
Portuguese	pt	
Chinese – Traditional	zh-Hant	
Chinese Simplified	zh-Hans	
Haitian Creole	ht	
French	fr	
Vietnamese	vi	
Russian	ru	
Arabic	ar	
Other Preferred Written Language	OTH	If a hospital submits a value that is not included in Attachment 3 but allowable per CHIA EHRD, the value will be mapped to Other Preferred Written Language (OTH).
Choose not to answer	ASKU	Member was asked to provide their Preferred Written Language, and the member actively selected or indicated that they "choose not to answer."
Don't know	DONTKNOW	Member was asked to provide their Preferred Written Language, and the

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Description	Valid Values	Notes
		member actively selected or indicated that they did not know their Preferred Written Language.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	The Preferred Written Language of the member is unknown since either: (a) the member was not asked to provide their Preferred Written Language, or (b) the member was asked to provide their Preferred Written Language, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response, and should be assigned the value of ASKU instead of UNK.

Preferred Spoken Language

Description	Valid Values	Notes
English	en	-
Spanish	es	-
Portuguese	pt	-

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Chinese	zh	If a hospital submits Cantonese (yue), Mandarin (cmn), or Min Nan Chinese (nan) it will be mapped to Chinese for the purposes of data completeness.
Haitian Creole	ht	
Sign Languages	sgn	If a hospital submits American Sign Language (ase) or Sign Languages (sgn), it will be mapped to Sign Languages for the purpose of data completeness
French	fr	-
Vietnamese	vi	-
Russian	ru	-
Arabic	ar	-
Other Preferred Spoken Language	OTH	If a hospital submits a value that is not included in Attachment 3 but allowable per CHIA EHRD, the value will be mapped to Other.
Choose not to answer	ASKU	Member was asked to provide their Preferred Spoken Language, and the member actively selected or indicated that they "choose not to answer."
Don't know	DONTKNOW	Member was asked to provide their Preferred Spoken Language, and the member actively selected or indicated that they did not know their Preferred Spoken Language.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g.	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.

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clinical condition that alters consciousness)		
Unknown	UNK	The Preferred Spoken Language of the member is unknown since either: (a) the member was not asked to provide their Preferred Spoken Language, or (b) the member was asked to provide their Preferred Spoken Language, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response, and should be assigned the value of ASKU instead of UNK.

CHA-SPECIFIC ADAPTATIONS

Overview: Data Source	Numerator source: Center for Health Informatics and Analysis (CHIA) "Enhanced Demographics Data File" and/or Hospital EHR Denominator sources: MassHealth encounter and MMIS claims data and/or Hospital EHR
Measure Summary: Description	The percentage of members and served uninsured patients (reported separately) with self-reported language data that was collected by CHA in the measurement year.
Definitions: Members/ Patients	The CHA population included in the measure is grouped as follows: • MassHealth members • Served uninsured patients
Definitions: Rate of Preferred Written and Spoken Language Data Completeness	There will be eight rates reported for this measure: MassHealth members: Rate 1: (Numerator 1 (PWL) Population / Denominator 1 (MassHealth IP) Population) * 100 Rate 2: (Numerator 1 (PSL) Population / Denominator 1 (MassHealth IP) Population) * 100

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	Rate 3: (Numerator 2 (PWL) Population / Denominator 2 (MassHealth ED) Population) * 100
	Rate 4: (Numerator 2 (PSL) Population / Denominator 2 (MassHealth ED) Population) * 100
	Served uninsured patients:
	Rate 5: Numerator 3 (PWL) Population / Denominator 3 (served uninsured IP) Population) * 100
	Rate 6: (Numerator 3 (PSL) Population / Denominator 3 (served uninsured IP) Population) * 100
	Rate 7: (Numerator 4 (PWL) Population / Denominator 4 (served uninsured ED) Population) * 100
	Rate 8: (Numerator 4 (PSL) Population / Denominator 4 (served uninsured ED) Population) * 100
Administrative Specification: Denominator	There are four denominators for this measure. **Denominator 1**: The eligible population for **MassHealth members** with **inpatient discharge** claims/encounters from acute hospitals. **Denominator 2:** The eligible population for **MassHealth members** with **emergency department visit** claims/encounters from acute hospitals. **Denominator 3:** The eligible population for served uninsured patients with **inpatient discharge** claims/encounters from acute hospitals. **Denominator 4:** The eligible population for served uninsured patients with **emergency department visit** claims/encounters from acute hospitals.
Administrative Specification: Numerator	There are four numerators for this measure. **Numerator 1:** For members in Denominator 1, identify those with complete language data, (defined above under "Complete Language Data") for each question below:

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- QMAT Language Q1: In which language would you feel most comfortable reading medical or health care instructions? (or similar phrasing to elicit written language preference).
- QMAT Language Q2: What language do you feel most comfortable speaking with your doctor or nurse? (or similar phrasing to elicit spoken language preference).

Numerator 2:
For members in Denominator 2, identify those with complete language data, (defined above under "Complete Language Data") for each question below:

- QMAT Language Q1: In which language would you feel most comfortable reading medical or health care instructions? (or similar phrasing to elicit written language preference).
- QMAT Language Q2: What language do you feel most comfortable speaking with your doctor or nurse? (or similar phrasing to elicit spoken language preference).

Numerator 3:
For patients in Denominator 3, identify those with complete language data, (defined above under "Complete Language Data") for each question below:

- QMAT Language Q1: In which language would you feel most comfortable reading medical or health care instructions? (or similar phrasing to elicit written language preference).
- QMAT Language Q2: What language do you feel most comfortable speaking with your doctor or nurse? (or similar phrasing to elicit spoken language preference).

Numerator 4:
For patients in Denominator 4, identify those with complete language data, (defined above under "Complete Language Data") for each question below:

- QMAT Language Q1: In which language would you feel most comfortable reading medical or health care instructions? (or similar phrasing to elicit written language preference).
- QMAT Language Q2: What language do you feel most comfortable speaking with your doctor or nurse? (or similar phrasing to elicit spoken language preference).

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Additional Measure Information: Required Reporting	Valid MassHealth Member IDs must be submitted for the MassHealth population, and must be submitted for the served uninsured population, when applicable. MRNs must be submitted for both the MassHealth and served uninsured populations.
Additional Measure Information: Completeness Calculations	Completeness will be calculated separately for CHA's Medicaid population and CHA's served uninsured population.

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A.iv. Disability Data Completeness

OVERVIEW	
Measure Name	Rate of Disability Data Completeness – Acute Hospital
Steward	MassHealth
CBE ID Number	N/A
Data Source	Numerator source: Center for Health Information and Analysis (CHIA) "Enhanced Demographics Data File" Denominator sources: MassHealth encounter and MMIS claims data
Performance Status: PY3-5	Pay-for-Performance (P4P)

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY	
Description	The percentage of 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.
Numerator	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.
Denominator	Members with an inpatient stay or ED visit at an acute hospital during the measurement year.

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ELIGIBLE POPULATION

Age	Age varies by disability question: • Disability Questions 1 and 2: no age specified; • Disability Questions 3 – 5: age 6 or older as of December 31st of the measurement year; • Disability Question 6: age 16 or older as of December 31st of the measurement year.
Continuous Enrollment	None
Anchor Date	None
Event/Diagnosis	At least one inpatient stay and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year. To identify inpatient stays: • Identify all inpatient stays (Inpatient Stay Value Set)[7]. To identify emergency department visits: • Identify all Emergency Department visits (ED Value Set)[8].

DEFINITIONS

Complete Disability Data	Complete Disability data is defined as: One (1) valid disability value for each Disability Question (listed in Attachment 4). • 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.

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[7] HEDIS® Value Set used with permission from NCQA
[8] HEDIS® Value Set used with permission from NCQA

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Hospital File ["Enhanced Demographics Data File"]	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.
Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.
Rate of Disability Data Completeness	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
Self-Reported data	For the purposes of this measure specification, data are defined as self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).

ADMINISTRATIVE SPECIFICATION

Denominator	There are two denominators for this measure: **Denominator 1:**

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	The eligible population for MassHealth members with inpatient stay claims/encounters from acute hospitals.
	Denominator 2:
	The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.
Numerator Set	There are two numerators for this measure:
	Numerator 1:
	For members in Denominator 1, identify those with complete disability data, (defined above under "Complete Disability Data") for each question below:
	Disability Q1 (all ages): Are you deaf or do you have serious difficulty hearing?
	Disability Q2 (all ages): Are you blind or do you have serious difficulty seeing, even when wearing glasses?
	Disability Q3 (age 5 or older): Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
	Disability Q4 (age 5 or older): Do you have serious difficulty walking or climbing stairs?
	Disability Q5 (age 5 or older): Do you have difficulty dressing or bathing?
	Disability Q6 (age 15 or older): Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?
	- If value is "UNK," it will <u>not</u> count toward the numerator. - If value is "ASKU," it will count toward the numerator. - If value is "DONTKNOW," it will count toward the numerator. - Each value must be self-reported.
	Numerator 2:
	For members in Denominator 2, identify those with complete disability data, (defined above under "Complete Disability Data") for each question

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	below:
	Disability Q1 (all ages): Are you deaf or do you have serious difficulty hearing?
	Disability Q2 (all ages): Are you blind or do you have serious difficulty seeing, even when wearing glasses?
	Disability Q3 (age 5 or older): Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
	Disability Q4 (age 5 or older): Do you have serious difficulty walking or climbing stairs?
	Disability Q5 (age 5 or older): Do you have difficulty dressing or bathing?
	Disability Q6 (age 15 or older): Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? • If value is "UNK" it will not count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported.
Exclusions	If value is UTC, the inpatient stay or emergency department visit is excluded from the denominator.

ADDITIONAL MEASURE INFORMATION

Required Reporting	The following information is required:
	
	• A valid MassHealth Member ID
	
	  Format: Refer to CHIA Submission Guide
	
	• At least one (1) valid disability value per question, as defined under "Complete Disability Data" above
	
	  Format: Refer to CHIA Submission Guide

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Data Collection	For the purposes of this measure, disability data must be self-reported. Disability data that are derived using an imputation methodology do not contribute to completeness for this measure. Self-reported disability data may be collected: - By any modality that allows the patient (or a person legally authorized to respond on the patient's behalf, such as a parent or legal guardian) to self-report disability (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); - By any entity interacting with the member (e.g. health plan, ACO, provider, staff); - Must include one or more values in Attachment 4.
Completeness Calculations	Completeness is calculated per disability question per acute hospital and overall, as described below for questions 1 and 2, as an example: For each individual acute hospital: 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. 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. For all acute hospitals: 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. 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.

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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**
Yes	LA33-6	
No	LA32-8	
Choose not to Answer	ASKU	Member was asked whether they are deaf or have difficulty hearing, and the member actively selected or indicated that they "choose not to answer."
Don't know	DONTKNOW	Member was asked whether they are deaf or have difficulty hearing, and the member actively selected or indicated that they did not know if they are deaf or have difficulty hearing.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	Whether the member is deaf or has difficulty hearing is unknown since either: (a) the member was not asked whether they are deaf or have difficulty hearing, or (b) the member was asked whether they are deaf or have difficulty hearing, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response, and should be assigned the value of ASKU instead of UNK.

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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: (a) the member was not asked whether they are blind or have difficulty seeing, or (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.

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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: (a) the member was not asked whether they have difficulty concentrating, remembering or making decisions, or

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Description	Valid Values	Notes
		(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.

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.

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Description	Valid Values	Notes
Unknown	UNK	Whether the member has difficulty walking or climbing stairs is unknown since either: (a) the member was not asked whether they have difficulty walking or climbing stairs, or (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	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.

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Description	Valid Values	Notes
alters consciousness)		
Unknown	UNK	Whether the member has difficulty dressing or bathing is unknown since either:
		(a) the member was not asked whether they have difficulty dressing or bathing, or
		(b) the member was asked whether they have difficulty dressing or bathing, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response, and should be assigned the value of ASKU instead of UNK.

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

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

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Description	Valid Value	Notes
respond (e.g. clinical condition that alters consciousness)		
Unknown	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

Overview: Data Source	Numerator source: Center for Health Informatics and Analysis (CHIA) "Enhanced Demographics Data File" and/or Hospital EHR Denominator sources: MassHealth encounter and MMIS claims data and/or Hospital EHR
Measure Summary: Description	The percentage of members and served uninsured patients (reported separately) with self-reported disability data that was collected by CHA in the measurement year.
Definitions: Members/ Patients	The eligible CHA population included in the measure is grouped as follows: • MassHealth members • Served uninsured patients
Definitions: Rate of Disability Data Completeness	There will be four rates reported for this measure: Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100 Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100

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	Rate 3: (Numerator 3 Population / Denominator 3 Population) * 100 Rate 4: (Numerator 4 Population / Denominator 4 Population) * 100
Administrative Specification: Denominator	There are four denominators for this measure. **Denominator 1**: The eligible population for **MassHealth members** with **inpatient discharge** claims/encounters from acute hospitals. **Denominator 2:** The eligible population for **MassHealth members** with **emergency department visit** claims/encounters from acute hospitals. **Denominator 3:** The eligible population for **served uninsured patients** with **inpatient discharge** claims/encounters from acute hospitals. **Denominator 4:** The eligible population for **served uninsured patients** with **emergency department visit** claims/encounters from acute hospitals.
Administrative Specification: Numerator	There are four numerators for this measure: **Numerator 1**: For members in Denominator 1, identify those with complete disability data (defined above under "Complete Disability Data") for each question below: Disability Q1 (all ages): Are you deaf or do you have serious difficulty hearing? Disability Q2 (all ages): Are you blind or do you have serious difficulty seeing, even when wearing glasses? Disability Q3 (age 5 or older): Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? Disability Q4 (age 5 or older): Do you have serious difficulty walking or climbing stairs? Disability Q5 (age 5 or older): Do you have difficulty dressing or bathing? Disability Q6 (age 15 or older): Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

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	- If value is "UNK," it will <u>not</u> count toward the numerator. - If value is "ASKU," it will count toward the numerator. - If value is "DONTKNOW," it will count toward the numerator. - Each value must be self-reported. **Numerator 2**: For members in Denominator 2, identify those with complete disability data (defined above under "Complete Disability Data") as for Numerator 1 above. **Numerator 3**: For patients in Denominator 3, identify those with complete disability data (defined above under "Complete Disability Data") as for Numerator 1 above. **Numerator 4**: For patients in Denominator 4, identify those with complete disability data (defined above under "Complete Disability Data") as for Numerator 1 above.
Additional Measure Information: Required Reporting	Valid MassHealth Member IDs must be submitted for the MassHealth population, and must be submitted for the served uninsured population, when applicable. MRNs must be submitted for both the MassHealth and served uninsured populations.
Additional Measure Information: Completeness Calculations	Completeness will be calculated separately for CHA's Medicaid population and CHA's served uninsured population.

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A.v. Sexual Orientation Data Completeness

OVERVIEW	
Measure Name	Rate of Sexual Orientation Data Completeness – Acute Hospital
Steward	MassHealth
CBE ID Number	N/A
Data Source	Numerator source: Center for Health Information and Analysis (CHIA) "Enhanced Demographics Data File" Denominator sources: MassHealth encounter and MMIS claims data
Performance Status: PY3-5	Pay-for-Performance (P4P)

POPULATION HEALTH IMPACT

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

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

ELIGIBLE POPULATION	
Age	Members age 19 and older as of December 31 of the measurement year

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Continuous Enrollment	None
Anchor Date	None
Event/Diagnosis	At least one inpatient stay and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year. To identify inpatient stays: • Identify all inpatient stays (<u>Inpatient Stay Value Set</u>)[9]. To identify emergency department visits: • Identify all Emergency Department visits (<u>ED Value Set</u>)[10].

DEFINITIONS

Complete Sexual Orientation Data	Complete sexual orientation data is defined as: At least one (1) valid sexual orientation value (listed in Attachment 5). • 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.
Hospital File ["Enhanced Demographics Data File"]	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.

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[9] HEDIS® Value Set used with permission from NCQA
[10] HEDIS® Value Set used with permission from NCQA

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Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.
Rate of Sexual Orientation Data Completeness	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
Self-Reported data	For the purposes of this measure specification, data are defined as self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).

ADMINISTRATIVE SPECIFICATION

Denominator	There are two denominators for this measure: **Denominator 1:** The eligible population for MassHealth members with inpatient stay claims/encounters from acute hospitals. **Denominator 2:** The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.
Numerator	There are two numerators for this measure: **Numerator 1:**

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	For members in Denominator 1, identify those with complete sexual orientation data, defined as:
	At least one (1) valid sexual orientation value (valid sexual orientation values are listed in Attachment 5).
	• If value is "UNK," it will <u>not</u> count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported.
	Numerator 2:
	For members in Denominator 2, identify those with complete sexual orientation value (valid sexual orientation values are listed in Attachment 5), defined as:
	At least one (1) valid sexual orientation value (valid sexual orientation values are listed in Attachment 5).
	• If value is "UNK," it will <u>not</u> count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported.
Exclusions	If value is UTC, the inpatient stay or emergency department visit is excluded from the denominator.

ADDITIONAL MEASURE INFORMATION

Required Reporting	The following information is required:
	• A valid MassHealth Member ID
	Format: Refer to CHIA Submission Guide
	• At least one (1) valid sexual orientation value, as defined under "Complete Sexual Orientation Data" above
	Format: Refer to CHIA Submission Guide

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Data Collection	For the purposes of this measure, sexual orientation data must be self-reported. Sexual orientation data that are derived using an imputation methodology do not contribute to completeness for this measure. Self-reported sexual orientation data may be collected:
	• By any modality that allows the patient (or a person legally authorized to respond on the patient's behalf, such as a parent or legal guardian) to self-report sexual orientation (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 5.
Completeness Calculations	Completeness is calculated for: each individual Acute Hospital.

Attachment 5. Sexual Orientation: Accepted Values

Description	Valid Values	Notes
Bisexual	42035005	
Straight or heterosexual	20430005	
Lesbian or gay	38628009	
Queer, pansexual, and/or questioning	QUEER	
Something else	OTH	
Choose not to answer	ASKU	Member was asked to provide their sexual orientation, and the member actively selected or indicated that they "choose not to answer".
Don't know	DONTKNOW	Member was asked to provide their sexual orientation, and the member actively selected or indicated that they did not know their sexual orientation.
Unable to collect this information on	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.

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Description	Valid Values	Notes
member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)		
Unknown	UNK	The sexual orientation of the member is unknown since either: (a) the member was not asked to provide their sexual orientation, or (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.

CHA-SPECIFIC ADAPTATIONS

Overview: Data Source	Numerator source: Center for Health Informatics and Analysis (CHIA) "Enhanced Demographics Data File" and/or Hospital EHR Denominator sources: MassHealth encounter and MMIS claims data and/or Hospital EHR
Measure Summary: Description	The percentage of members and served uninsured patients (reported separately) with self-reported sexual orientation data that was collected by CHA in the measurement year.
Definitions: Members/Patients	The eligible CHA population included in the measure is grouped as follows: • MassHealth members • Served uninsured patients

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Definitions: Rate of Sexual Orientation Data Completeness	There will be four rates reported for this measure: Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100 Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100 Rate 3: (Numerator 3 Population / Denominator 3 Population) * 100 Rate 4: (Numerator 4 Population / Denominator 4 Population) * 100
Administrative Specification: Denominator	There are four denominators for this measure. **Denominator 1**: The eligible population for **MassHealth members** with **inpatient discharg**e claims/encounters from acute hospitals. **Denominator 2:** The eligible population for **MassHealth members** with **emergency department visit** claims/encounters from acute hospitals. **Denominator 3:** The eligible population for **served uninsured patients** with **inpatient discharge** claims/encounters from acute hospitals. **Denominator 4:** The eligible population for **served uninsured patients** with **emergency department visit** claims/encounters from acute hospitals.
Administrative Specification: Numerator	There are four numerators for this measure: **Numerator 1**: For members in Denominator 1, identify those with complete sexual orientation data, defined as: At least one (1) valid sexual orientation value (valid sexual orientation values are listed in Attachment 5). • If value is "UNK," it will <u>not</u> count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported. **Numerator 2**: For members in Denominator 2, identify those with complete sexual orientation data, defined as.

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	At least one (1) valid sexual orientation value (valid sexual orientation values are listed in Attachment 5). • If value is "UNK," it will <u>not</u> count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported. **Numerator 3**: For patients in Denominator 3, identify those with complete sexual orientation data, defined as: At least one (1) valid sexual orientation value (valid sexual orientation values are listed in Attachment 5). • If value is "UNK," it will <u>not</u> count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported. **Numerator 4**: For patients in Denominator 4, identify those with complete sexual orientation data, defined as. At least one (1) valid sexual orientation value (valid sexual orientation values are listed in Attachment 5). • If value is "UNK," it will <u>not</u> count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported.
Additional Measure Information: Required Reporting	Valid MassHealth Member IDs must be submitted for the MassHealth population, and must be submitted for the served uninsured population, when applicable. MRNs must be submitted for both the MassHealth and served uninsured populations.
Additional Measure Information: Completeness Calculations	Completeness will be calculated separately for CHA's Medicaid population and CHA's served uninsured population.

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A.vi. Gender Identity Data Completeness

OVERVIEW	
Measure Name	Rate of Gender Identity Data Completeness – Acute Hospital
Steward	MassHealth
CBE ID Number	N/A
Data Source	Numerator source: Center for Health Information and Analysis (CHIA) "Enhanced Demographics Data File" Denominator sources: MassHealth encounter and MMIS claims data
Performance Status: PY3-5	Pay-for-Performance (P4P)

POPULATION HEALTH IMPACT

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

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

ELIGIBLE POPULATION	
Age	Members age 19 and older as of December 31 of the measurement year

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Continuous Enrollment	None
Anchor Date	None
Event/Diagnosis	At least one inpatient stay and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year. To identify inpatient stays: • Identify all inpatient stays (Inpatient Stay Value Set)[11]. To identify emergency department visits: • Identify all Emergency Department visits (ED Value Set)[12].

DEFINITIONS

Complete Gender Identity Data	Complete gender identity data is defined as: At least one (1) valid gender identity value (listed in Attachment 6). • 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.
Hospital File ["Enhanced Demographics Data File"]	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.

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[11] HEDIS® Value Set used with permission from NCQA
[12] HEDIS® Value Set used with permission from NCQA

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Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.
Rate of Gender Identity Data Completeness	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
Self-Reported data	For the purposes of this measure specification, data are defined as self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).

ADMINISTRATIVE SPECIFICATION

Denominator	There are two denominators for this measure: **Denominator 1:** The eligible population for MassHealth members with inpatient stay claims/encounters from acute hospitals. **Denominator 2:** The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.
Numerator	There are two numerators for this measure: **Numerator 1:**

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	For members in Denominator 1, identify those with complete gender identity data, defined as:
	At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 6).
	- If value is "UNK," it will <u>not</u> count toward the numerator. - If value is "ASKU," it will count toward the numerator. - If value is "DONTKNOW," it will count toward the numerator. - Each value must be self-reported.
	Numerator 2:
	For members in Denominator 2, identify those with complete gender identity data, defined as:
	At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 6).
	- If value is "UNK," it will <u>not</u> count toward the numerator. - If value is "ASKU," it will count toward the numerator. - If value is "DONTKNOW," it will count toward the numerator. - Each value must be self-reported.
Exclusions	If value is UTC, the inpatient stay or emergency department visit is excluded from the denominator.

ADDITIONAL MEASURE INFORMATION

Required Reporting	The following information is required:
	• A valid MassHealth Member ID
	Format: Refer to CHIA Submission Guide
	• At least one (1) valid gender identity value, as defined under "Complete Gender Identity Data" above
	Format: Refer to CHIA Submission Guide

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Data Collection	For the purposes of this measure, gender identity data must be self-reported. Gender identity data that are derived using an imputation methodology do not contribute to completeness for this measure. Self-reported gender identity data may be collected:
	• By any modality that allows the patient (or a person legally authorized to respond on the patient's behalf, such as a parent or legal guardian) to self-report gender identity (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.);
	• By any entity interacting with the member (e.g. health plan, ACO, provider, staff);
	• Must include one or more values in Attachment 6.
Completeness Calculations	Completeness is calculated for: each individual Acute Hospital.

Attachment 6. Gender Identity: Accepted Values

Description	Valid Values	Notes
Male	446151000124109	
Female	446141000124107	
Genderqueer/gender nonconforming/non-binary; neither exclusively male nor female	446131000124102	
Transgender man/trans man	407376001	
Transgender woman/trans woman	407377005	
Additional gender category or other	OTH	

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Description	Valid Values	Notes
Choose not to answer	ASKU	Member was asked to provide their gender identity, and the member actively selected or indicated that they "choose not to answer".
Don't know	DONTKNOW	Member was asked to provide their gender identity, and the member actively selected or indicated that they did not know their gender identity.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	The gender identity of the member is unknown since either: (a) the member was not asked to provide their gender identity, or (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.

CHA-SPECIFIC ADAPTATIONS

Overview: Data Source	Numerator source: Center for Health Informatics and Analysis (CHIA) "Enhanced Demographics Data File" and/or Hospital EHR

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	Denominator sources: MassHealth encounter and MMIS claims data and/or Hospital EHR
Measure Summary: Description	The percentage of members and served uninsured patients (reported separately) with self-reported gender identity data that was collected by CHA in the measurement year.
Definitions: Members/Patients	The eligible CHA population included in the measure is grouped as follows: • MassHealth members • Served uninsured patients
Definitions: Rate of Gender Identity Data Completeness	There will be four rates reported for this measure: Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100 Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100 Rate 3: (Numerator 3 Population / Denominator 3 Population) * 100 Rate 4: (Numerator 4 Population / Denominator 4 Population) * 100
Administrative Specification: Denominator	There are four denominators for this measure. **Denominator 1**: The eligible population for **MassHealth members** with **inpatient discharg**e claims/encounters from acute hospitals. **Denominator 2:** The eligible population for **MassHealth members** with **emergency department visit** claims/encounters from acute hospitals. **Denominator 3:** The eligible population for served uninsured patients with **inpatient discharge** claims/encounters from acute hospitals. **Denominator 4:** The eligible population for served uninsured patients with **emergency department visit** claims/encounters from acute hospitals.
Administrative Specification: Numerator	There are four numerators for this measure: **Numerator 1**: For members in Denominator 1, identify those with complete gender identity data, defined as: At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 5).

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- o If value is "UNK," it will not count toward the numerator.

- o If value is "ASKU," it will count toward the numerator.

- o If value is "DONTKNOW," it will count toward the numerator.

- o Each value must be self-reported.

Numerator 2:
For members in Denominator 2, identify those with complete gender identity data, defined as.

At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 5).

- o If value is "UNK," it will not count toward the numerator.

- o If value is "ASKU," it will count toward the numerator.

- o If value is "DONTKNOW," it will count toward the numerator.

- o Each value must be self-reported

Numerator 3:
For patients in Denominator 3, identify those with complete gender identity data, defined as:

At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 5).

- o If value is "UNK," it will not count toward the numerator.

- o If value is "ASKU," it will count toward the numerator.

- o If value is "DONTKNOW," it will count toward the numerator.

- o Each value must be self-reported.

Numerator 4:
For patients in Denominator 4, identify those with complete gender identity data, defined as.

At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 5).

- o If value is "UNK," it will not count toward the numerator.

- o If value is "ASKU," it will count toward the numerator.

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	o If value is "DONTKNOW," it will count toward the numerator.
	o Each value must be self-reported.
Additional Measure Information: Required Reporting	Valid MassHealth Member IDs must be submitted for the MassHealth population, and must be submitted for the served uninsured population, when applicable. MRNs must be submitted for both the MassHealth and served uninsured populations.
Additional Measure Information: Completeness Calculations	Completeness will be calculated separately for CHA's Medicaid population and CHA's served uninsured population.

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

MEASURE REQUIREMENTS AND ASSESSMENT: PY3-5		
Measure Requirements	**PY3-4**	1) Timely (as specified by CHIA and MassHealth) submission to the Massachusetts Center for Health Information and Analysis of the Electronic Health Record Dataset (EHRD) Data Collection File as described in the EHRD Submission Guide for CYQ1 through Q4 for inclusion in the "Enhanced Demographics Data File" sent by CHIA to MassHealth. a. Within the EHRD Data Collection File submission, the date the value is updated ("*<RELDSOGI field>* Update Date") or verified ("*<RELDSOGI field>* Verification Date") associated with each RELDSOGI data element may be submitted but is not required. 2) Timely, complete, and responsive submission to MassHealth by September 1 of the performance year (e.g., September 1, 2026 for PY4), of a RELD SOGI mapping and verification deliverable including descriptions of member-reported demographic data collection efforts as specified by MassHealth, in a form and format to be specified by MassHealth.
	PY5	1) Timely (as specified by CHIA and MassHealth) submission to the Massachusetts Center for Health Information and Analysis of the Electronic Health Record Dataset (EHRD) Data Collection File as described in the EHRD Submission Guide for CYQ1 through Q4 for inclusion in the "Enhanced Demographics Data File" sent by CHIA to MassHealth. a. Within the EHRD Data Collection File submission, the date the value is updated ("*<RELDSOGI field>* Update Date") and/or verified ("*<RELDSOGI field>* Verification Date") associated with each RELDSOGI data element must be submitted. 2) Timely, complete, and responsive submission to MassHealth by September 1, 2027 of a RELD SOGI mapping and verification deliverable, the form and format of which is to be specified by MassHealth, which includes descriptions of member-reported demographic data collection efforts as requested by MassHealth.

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Performance Assessment	See the MassHealth Cambridge Health Alliance Hospital Quality and Equity Incentives Program (CHA-HQEIP) Performance Assessment Methodology Manual.

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B. Health-Related Social Needs Screening

Aligned with CMS' Screening for Social Drivers of Health Measure for the Merit-based Incentive Payment System (MIPS) Program[13]

OVERVIEW

Measure Name	Health-Related Social Needs (HRSN) Screening
Steward	MassHealth
CBE ID Number	N/A
Data Source	Supplemental Data, Administrative Data, Encounter data
Performance Status: PY3	Pay-for-Performance (P4P): Inpatient, Observation Stay / Pay-for-Reporting (P4R): ED
Performance Status: PY4 & 5	Pay-for-Performance (P4P)

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 health-related social needs (HRSN), the immediate daily necessities prioritized by individuals that arise from the inequities caused by social determinants of health. Identification of such needs provides an opportunity to improve health outcomes through interventions such as referral to appropriate social services.

MEASURE SUMMARY

Description	Percentage of acute hospital inpatient stay, observation stay, and emergency department visits during the measurement year where patients were screened prior to discharge for health-related social needs (HRSN). Two rates are reported: 1. **Rate 1: HRSN Screening Rate**: Percentage of acute inpatient stay, observation stay, and emergency department visits where patients

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[13] Aligned with CMS' Screening for Social Drivers of health Measure for the Merit-based Incentive Payment System (MIPS) Program. Centers for Medicare and Medicaid Services Measures Inventory Tool (cms.gov)

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were screened using a standardized HRSN screening instrument prior to discharge for food, housing, transportation, and utility needs.

2. **Rate 2: HRSN Screen Positive Rate**: Rate of HRSN identified (i.e., screen positive) among cases in Rate 1 numerator. Four sub-rates are reported for each of the following domains of HRSN: food, housing, transportation, and utility.

ELIGIBLE POPULATION

Ages	Members of any age
Continuous enrollment/ Allowable gap	None
Anchor date	None
Measurement periods	PY3: January 1, 2025 – December 31, 2025 PY4: January 1, 2026 – December 31, 2026 PY5: January 1, 2027 – December 31, 2027
Event/diagnosis	Inpatient, observation stays, and emergency department visits between January 1 and December 31 of the measurement year. To identify inpatient stays: • Identify all inpatient stays (Inpatient Stay Value Set)[14]. To identify observation stays: • Identify all Observation stay discharges (Observation Stay Value Set)[15]. To identify emergency department visits: • Identify all Emergency Department Visits (ED Value Set)[16].

[14] HEDIS® Value Set used with permission from NCQA
[15] HEDIS® Value Set used with permission from NCQA
[16] HEDIS® Value Set used with permission from NCQA

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DEFINITIONS	
Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.
Health-Related Social Needs	The immediate daily necessities that arise from the inequities caused by the social determinants of health, such as a lack of access to basic resources like stable housing, an environment free of life-threatening toxins, healthy food, utilities including heating and internet access, transportation, physical and mental health care, safety from violence, education and employment, and social connection.
Standardized HRSN Screening Instruments	A standardized health-related social needs screening instrument is defined as a standardized assessment, survey, tool or questionnaire that is used to evaluate social needs. HRSN screening tools used for the purpose of performance on this measure must include at least one screening question in each of the four required domains. Examples of eligible screening tools include, but are not limited to: • Accountable Health Communities Health-Related Social Needs Screening Tool • The Protocol for Responding to and Assessing Patients' Risk and Experiences (PRAPARE) Tool • American Academy of Family Physicians (AAFP) Screening Tool Hospitals are not required to use the example screening tools listed above; hospitals may choose to use other screening instruments, or combinations of screening instruments, that include at least one screening question in each of the four required domains. MassHealth may require hospitals to report to MassHealth the screening tool(s) used for the purpose of performance on this measure.

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Supplemental Data	Data supplementary to administrative claims data that documents at the patient-level 1) when a health-related social needs screen was performed, and/or 2) whether health-related social needs were identified (and if so, in which domain needs were identified). Such supplemental data may be derived from clinical records (such as electronic health records and case management records) or other databases available to entities. Such supplemental data may document screens conducted by billing providers and/or non-billing providers (such as community health workers, medical assistants, and social workers).

ADMINISTRATIVE SPECIFICATION

RATE 1: HRSN Screening Rate

Description	Percentage of acute inpatient and observation stays where patients were screened using a standardized HRSN screening instrument prior to discharge for food, housing, transportation, and utility needs.
Denominator	**Denominator 1a:** The eligible population where the patient discharge type is an inpatient stay or an observation stay **Denominator 1b:** The eligible population where the patient discharge type is an emergency department visit
Numerator	**Numerator 1a:** Inpatient and observation stays where, as documented in the acute hospital medical record, patients were screened using a standardized HRSN screening instrument prior to discharge for food, housing, transportation, and/or utility needs. Numerator 1a includes stays where: 1) For eligible inpatient and observation stays, documentation in the acute hospital medical record indicates that: a) The patient was offered HRSN screening during the inpatient stay or observation stay by acute hospital staff/provider and responded to one or more screening questions;

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b) The patient was offered HRSN screening during the inpatient stay or observation stay by acute hospital staff and actively opted out of screening (i.e. chose not to answer any questions); **or**

2) For eligible inpatient and observation stays, documentation in the acute hospital medical record indicates that the patient was screened for HRSN in any setting (acute hospital or otherwise) within 90 days prior to the date of admission. Includes screenings rendered by any staff or provider, not limited to acute hospital staff or providers (e.g., an ACO clinical provider, hospital clinical provider), non-clinical staff (e.g., patient navigator), health plan staff and/or Community Partner staff.

Numerator 1b: Emergency department visits where, as documented in the acute hospital medical record, patients were screened using a standardized HRSN screening instrument for food, housing, transportation, and/or utility needs.

Numerator 1b includes visits where:

1) For eligible emergency department visits, documentation in the acute hospital medical record indicates that:
   c) The patient was offered HRSN screening during the emergency department visit or within 14 calendar days following discharge by acute hospital staff/provider and responded to one or more screening questions; **or**
   d) The patient was offered HRSN screening during the emergency department visit or within 14 calendar days following discharge by acute hospital staff and actively opted out of screening (i.e., chose not to answer any questions); **or**

2) For eligible emergency department visits, documentation in the acute hospital medical record indicates that the patient was screened for HRSN in any setting (acute hospital or otherwise) within 90 days prior to the date of the emergency department visit. Includes screenings rendered by any clinical provider (e.g., an ACO clinical provider, hospital clinical provider), non-clinical staff (e.g., patient navigator), health plan staff and/or Community Partner staff.

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Unit of measurement	Screens should be performed at the individual patient level for adults and, as determined to be clinically appropriate by individuals performing HRSN screening, for children and youth. Screening may be performed at the household level on behalf of dependents residing in one household; if screening is performed at the household level, then results must be documented in the respondent's medical record and in each dependent's medical record in order for the screen to be counted in the numerator for each individual.
Exclusions	Eligible events where: • Patient dies prior to discharge. • Patients in hospice (identified using the Hospice Value Set)[17]. • Patients not screened for food insecurity, housing instability, transportation needs, and utility difficulties because patient was unable to complete the screening and have no legal guardian or caregiver able to do so on their behalf. This should be documented in the medical record.

RATE 2: HRSN Screen Positive Rate

Description	Rate of HRSN identified (i.e., positive screen) among cases in numerator for Rate 1. Four sub-rates are reported for each of the following domains of HRSNs: food, housing, transportation, and utility.
Denominator	Stays and visits meeting criteria for numerator 1a and/or 1b
Numerator 2a – Food insecurity	Stays and visits where a patient screened positive for one or more food need(s)
Numerator 2b – Housing instability	Stays and visits where a patient screened positive for one or more housing need(s)
Numerator 2c – Transportation needs	Stays and visits where a patient screened positive for one or more transportation need(s)
Numerator 2d – Utility difficulties	Stays and visits where a patient screened positive for one or more utility need(s)

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[17] HEDIS® Value Set used with permission from NCQA

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Exclusions	None

DATA REPORTING REQUIREMENTS

This measure will be calculated by MassHealth using administrative and/or supplemental data submitted to MassHealth by hospitals as follows. Data must be submitted in a form and format specified by MassHealth.

ADMINISTRATIVE DATA REPORTING REQUIREMENTS

Rate 1: The following codes will be the administrative data utilized to calculate Rate 1:

Code System	Code	Meaning
HCPCS	M1207	Patient screened for food insecurity, housing instability, transportation needs, utility difficulties [*and interpersonal safety*[18]].
HCPCS	M1208	Patient not screened for food insecurity, housing instability, transportation needs, utility difficulties [*and interpersonal safety*[3]].
HCPCS	M1237	Patient reason for not screening for food insecurity, housing instability, transportation needs, utility difficulties, [*and interpersonal safety*[3]] (e.g., patient declined or other patient reasons)
HCPCS	G0136	Administration of a standardized, evidence-based social determinants of health risk assessments tool, 5-15 minutes

Notes:
- Patients in the denominator where M1207 is coded will count towards the numerator.
- Patients in the denominator where M1237 is coded will count towards the numerator.
- Patients in the denominator where M1208 is coded will not count towards the numerator.

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[18] The HCPCS M1207, M1208, and M1237 codes include interpersonal safety as a screening domain. However, screening for interpersonal safety will not contribute toward performance on this HQEIP measure due to concerns about privacy and safety related to capturing this information through the same vehicle as other HRSN domains.

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- Patients in the denominator where M1207, M1237, or M1208 are not coded will not count towards the numerator.
- Patients in the denominator where HCPCS code G0136 is coded will count towards numerator.

Rate 2: The following ICD-10 codes, which may be documented in any diagnosis field, are the administrative data that will be utilized to calculate Rate 2 numerators:

Food Insecurity

ICD-10 Code Contributing to Rate 2 Numerators	Meaning
E63.9	Nutritional deficiency, unspecified
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z91.11	Patient's noncompliance with dietary regimen
Z91.110	Patient's noncompliance with dietary regimen due to financial hardship
Z91.A10	Caregiver's noncompliance with patient's dietary regimen due to financial hardship

Housing Instability

Homelessness

ICD-10 Code Contributing to Rate 2 Numerators	Meaning
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness

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Housing Instability

ICD-10 Code Contributing to Rate 2 Numerators	Meaning
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.2	Discord with neighbors, lodgers and landlord

Inadequate Housing

ICD-10 Code Contributing to Rate 2 Numerators	Meaning
Z58.6	Inadequate drinking-water supply
Z59.1	Inadequate housing, unspecified
Z59.11	Inadequate housing environmental temperature
Z59.12	Inadequate housing utilities
Z59.19	Other Inadequate housing

Transportation Needs

ICD-10 Code Contributing to Rate 2 Numerators	Meaning
Z59.82	Transportation insecurity

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Utility Difficulties

ICD-10 Code Contributing to Rate 2 Numerators	Meaning
Z58.6	Inadequate drinking-water supply
Z58.81	Basic services unavailable in physical environment
Z59.12	Inadequate housing utilities

SUPPLEMENTAL DATA REPORTING REQUIREMENTS

In lieu of or in addition to administrative data described above, hospitals may choose to submit supplemental data (i.e. electronic health record or other medical record data demonstrating HRSN screening rates and/or identified needs) for use by MassHealth for calculating Rate 1 and/or Rate 2.

1. **For Rate 1:** Supplemental data indicating any of the following may be submitted:
   a) a patient was screened for food insecurity, housing instability, transportation needs, and utility difficulties during the performance period (corresponding to the definitions of administrative HCPCS code M1207 and/or HCPCS code G0136);
   b) a patient was not screened for food insecurity, housing instability, transportation needs, utility difficulties (corresponding to the definition of the administrative HCPCS code M1208);
   c) there is a patient reason for not screening for food insecurity, housing instability, transportation needs, and utility difficulties (e.g., patient declined or other patient reasons.) (corresponding to the definition of HCPCS code M1237).

2. **For Rate 2:** Supplemental data indicating identified needs, corresponding to the definitions of the ICD-10 codes listed in the "Administrative Data Reporting Requirements" section of this specification, may be submitted. Data may be captured using the ICD-10 codes or other health record data (e.g., electronic health record data corresponding to these codes).

MEASURE REQUIREMENTS & ASSESSMENT

Measure Requirements	PY3-5	Submission to MassHealth by **June 30 following each PY** (e.g., June 30, 2027 for PY4) of required administrative and/or supplemental data.

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Performance Assessment	See the MassHealth Cambridge Health Alliance Hospital Quality and Equity Incentives Program (CHA-HQEIP) Performance Assessment Methodology Manual.
	MassHealth expects to audit the data submitted for Rates 1 and 2 by CHA.

CHA-SPECIFIC ADAPTATIONS

Measure Summary: Description	CHA will report two separate rates for the HRSN Screening Rate and the HRSN Screen Positive Rate (4 rates total): one for MassHealth members and one for the served uninsured patient population.
Definitions: Members/Patients	The eligible CHA population included in the measure is grouped as follows: • MassHealth members; • Served uninsured patients.

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C. Quality Performance Disparities Reduction

OVERVIEW

Measure Name	Quality Performance Disparities Reduction
Steward	MassHealth
CBE ID Number	N/A
Data Source	Administrative, Supplemental
Performance Status: PY3	Pay for Reporting (P4R)
Performance Status: PY4 & 5	Pay-for-Performance (P4P)

POPULATION HEALTH IMPACT

Equitable care is an important pillar of high quality care. Stratification of quality measures by social risk factors supports identification of health and health care disparities and focused interventions to achieve more equitable care.

MEASURE SUMMARY

Description	This measure assesses performance on reducing disparities on targeted quality performance measures associated with race, ethnicity, and/or other demographic or social risk factors.
	Quality performance measures targeted for disparities reduction for the purpose of this measure are from the MassHealth Clinical Quality Incentive (CQI) program or CHA's HQEIP-specific quality slate, with the exception of the Severe Maternal Morbidity (SMM) measure, and are listed in Table 1. Alternative standard quality measures may be approved by MassHealth on an individual hospital basis.
	Targeted quality measures have been selected by MassHealth because they are disparities-sensitive measures in the topic areas of maternal health, care coordination, and/or care for acute & chronic conditions.

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ELIGIBLE POPULATION

The eligible populations for each program measure are the Medicaid population and the served uninsured population, unless otherwise specified. The eligible populations for each program measure for the Medicaid population identified in Table 1 for inclusion in this measure, with the exception of the SMM and TOB2-3 measures, are defined in the CQI program technical measure specifications (see https://www.mass.gov/info-details/masshealth-cqi-technical-specifications-manuals). Numerator and denominator codes for the SMM measure are defined by the AIM SMM codes list available on the following website: https:// https://saferbirth.org/severe-maternal-morbidity/. The measure is run for patients aged 8-65 years. Specifications for TOB-2 and TOB-3 measures are available from The Joint Commission.

DEFINITIONS

Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Applicable Measures	Measures in Table 1 of this specification.

ADMINISTRATIVE SPECIFICATION

In PY3, CHA must complete and submit a *"PY3 Measure Assessment Report."* The report must be submitted in a form and format specified by MassHealth, and must include:

- An assessment of the opportunity for disparities reduction on the full list of measures specified by MassHealth, including how each measure does or doesn't represent an opportunity for the hospital with regards to disparities reduction based on race/ethnicity, or other demographic or social risk factors;
- The measure(s) the hospital proposes to focus on for disparities reduction in PY3-5, as well as a description of what is known about the hospital's historical aggregate performance on the selected measures, including performance stratified by race and ethnicity, and other evidence demonstrating the opportunity for improvement;
- Any request(s), for MassHealth's consideration, to focus on alternative standard quality measures for the purpose of this "Quality Performance Disparities Reduction" measure. Use of alternative measures is subject to approval by MassHealth.

In PY4-5, CHA will be assessed on disparities reduction for a subset of the measures in Table 1 (and any alternative measures as applicable), as specified by MassHealth in its approvals of CHA's *"PY3 Measure Assessment Report."* CHA will be assessed separately on disparities reduction measures for

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its Medicaid and served uninsured patient populations. If CHA chooses alternative measures (which must be approved by EHS), it must report data stratified by race and ethnicity to MassHealth. Claims-based, chart-based, and EHR measure performance will be calculated by MassHealth with no additional data reporting required by CHA.

Table 1: MEASURES IDENTIFIED FOR INCLUSION IN THIS CHA-HQEIP QUALITY PERFORMANCE DISPARITIES REDUCTION MEASURE	
Domain	Measure
Perinatal Care	PC-02: Cesarean Birth, NTSV **Only applicable for the Medicaid population* *EHR-based measure*
Perinatal Care	Severe Maternal Morbidity (SMM) as defined by the AIM SMM codes list available on the following website: https://saferbirth.org/severe-maternal-morbidity/ **Only applicable for the Medicaid population*
Care Coordination	TOB-2: Tobacco U/se Treatment Provided or Offered (for CHA medical, surgical, and maternity inpatient units) *EHR-based measure*
Care Coordination	TOB-3: Tobacco Use Treatment Provided or Offered at Discharge (for CHA medical, surgical, and maternity inpatient units) *EHR-based measure*
Care Coordination	NCQA: Follow-up After ED Visit for Mental Illness (7 and 30 Day) ***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.*
Care Coordination	NCQA: Follow-up After ED Visit for Substance Use (7 and 30 Day)

Domain	Measure
	**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.
Care Coordination	NCQA: Follow-up After Hospitalization for Mental Illness (NQF 0576) (7 and 30 day) ***CHA will report an EHR-based measure for a) the served uninsured population with an index hospitalization at CHA and b) for the served uninsured patient population on CHA's primary care panel with an index hospitalization at CHA.*
Acute & Chronic Conditions	SUB-2: Alcohol Use – Brief Intervention Provided or Offered *EHR-based measure*
Acute & Chronic Conditions	SUB-3: Alcohol & Other Drug Use Disorder – Treatment provided/offered at discharge *EHR-based measure*
Alternative Measures	Alternative standard quality measures used by hospitals for their Clinical Quality Incentive program or other relevant MassHealth quality programs, approved by MassHealth for use in this QEIP "Quality Performance Disparities Reduction" measure.

ADDITIONAL MEASURE INFORMATION	
General Guidance	**Race and ethnicity data standards for stratification:** • For any hospital-submitted measure, CHA must stratify performance by race and ethnicity categories specified in the MassHealth "Race and Ethnicity Data Completeness" sub-measure specification. **Race and ethnicity data completeness threshold:** There is no race or ethnicity data completeness threshold required for reporting performance stratified by race and ethnicity for the purpose of this measure. CHA should report on all patients for whom they have race and ethnicity data.

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MEASURE REQUIREMENTS AND ASSESSMENT: PY3-5

Measure Requirements	PY3	By **October 31, 2025 or such other time as specified by MassHealth,** timely, complete, and responsive submission to MassHealth of a "*PY3 Measure Assessment Report*." Submissions must be in a form and format specified by MassHealth.
	PY4-5	Submission requirements will vary by targeted disparities reduction measure; hospitals must submit measure data, as applicable, in a form and format specified by MassHealth.
Performance Assessment	PY3	CHA will earn credit for performance on this measure only through: • Timely, complete, and responsive submission to MassHealth of the measure assessment report. All required questions must be answered or submission will not be considered complete. • Approval by MassHealth of alternative measures, when applicable, as determined by EOHHS.
	PY4-5	See the MassHealth Cambridge Health Alliance Hospital Quality and Equity Incentives Program (CHA-HQEIP) Performance Assessment Methodology Manual.

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D. Equity Improvement Interventions

OVERVIEW

Measure Name	Equity Improvement Interventions
Steward	MassHealth
CBE ID Number	N/A
Data Source	Supplemental Data
Performance Status: PY3-5	Pay for Performance (P4P)

POPULATION HEALTH IMPACT

Rigorous, collaborative, equity-focused performance improvement projects will support acute hospitals to reduce disparities on access and quality metrics.

MEASURE SUMMARY

Description	Collaborating with Partnered-ACO(s), over the course of the five-year HQEIP acute hospitals will jointly design and implement two health equity-focused Performance Improvement Projects (PIPs) in two of three MassHealth-defined quality and equity priority domain areas: 1) Care Coordination/Integration, 2) Care for Acute and Chronic Conditions, and 3) Maternal Morbidity. Acute hospitals will be incentivized to implement ACO-partnered PIPs designed to: • Support collaboration and information sharing, • Address mutually shared equity goals, • Achieve significant and sustained improvement in equity outcomes, and • Promote program-wide impact. PIPs will build upon the framework for quality assessment and performance improvement programs required for Medicaid managed care plans and will

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	require four key elements: performance measurement, implementation of interventions, evaluation of the interventions' impact using performance measures, and activities to increase/sustain improvement.

ELIGIBLE POPULATION

The eligible population for each equity-focused PIP is defined by the partnered entities in the PIP Planning (Baseline) Report. MassHealth will permit acute hospitals to use ACO-specific, all-MassHealth, and/or all-payer data to assess performance on the health equity PIPs. The denominator for the PIP must include MassHealth patients. Additional information about eligible population selection may be provided by EOHHS.

DEFINITIONS

Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.

ADMINISTRATIVE SPECIFICATION

Two Equity-focused PIPs must be completed over PY1-5, each spanning three performance years. Each PIP will require submission to MassHealth of four required reports over each PIP's respective three-year duration as follows:

- PIP Planning (Baseline) Report/Baseline Resubmission Report: a comprehensive plan that includes but is not limited to the following items: Shared acute hospital/ACO equity statement, PIP aim, objectives and goals, baseline performance data, data sources and collection methodology, data sharing plans between ACOs and acute hospitals, barrier identification, proposed interventions, and tracking measures.
- Remeasurement 1 Report: A comprehensive report that incorporates feedback from ongoing technical assistance with the EQRO regarding PIP implementation. The Remeasurement 1 Report is used to assess PIP methodology, progress towards implementing interventions following one remeasurement period, and performance towards achieving the health equity goals established in the Planning (Baseline) Report.
- Remeasurement 2 Report: a comprehensive report that integrates feedback from ongoing technical assistance with the EQRO regarding PIP implementation. The Remeasurement 2 Report is used to assess PIP methodology, progress towards implementing interventions following a second remeasurement period, performance towards achieving the health equity goals established in the Planning (Baseline) Report and Remeasurement 1 Report, and initial plans for continuation of partnership arrangements and/or interventions beyond the PIP.

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- Closure Report: a comprehensive report focused on finalizing project activities following a final remeasurement period, analyzing the impacts of interventions, assessing performance between baseline and remeasurement periods using selected indicators, identification of any successes and/or challenges, and plans for continuation of partnership arrangements and/or interventions beyond the PIP.

Additional detail about requirements for each report is available in the Reporting Template and Validation Tool.

MEASURE REQUIREMENTS AND ASSESSMENT: PY3-5

Measure Requirements	**PY3-5**	Timely, complete, and responsive submission to MassHealth of four required reports (the PIP Planning (Baseline) Report, the Remeasurement 1 Report, and the Remeasurement 2 Report, and the Closure Report) is required. Submission dates for PIP1 and PIP2 reports are specified below.
		PIP1 and PIP2 Report Submission Dates by Performance Year
		Performance Year 1:
		• PIP1: PIP Planning (Baseline) Report
		o Submission due date: 12/31/2023
		Performance Year 2:
		• PIP1: PIP Planning (Baseline) Report Resubmission
		o Submission due date: 8/30/2024
		• PIP2: PIP Planning (Baseline) Report
		o Submission due date: 3/30/2025
		Performance Year 3:
		• PIP1: Remeasurement 1 Report
		o Submission due date: 8/29/2025
		• PIP2: Remeasurement 1 Report
		o Submission due date: 10/1/2026
		Performance Year 4:
		• PIP1: Closure Report
		o Submission due date: 8/1/2026
		• PIP2: Remeasurement 2 Report
		o Submission due date: 10/1/2027
		Performance Year 5:
		• PIP2: Closure Report

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        o   Submission due date: 8/1/2028

Remeasurement 1 Report Sections & Weights

    <u>**Abstract:**</u> N/A, not scored
    <u>**Planning Section (33.3%):**</u>
- Project Topic/Equity Statement [Topic/Rationale/ Shared Equity Statement] (15 pts)
- Aim [Vision, Aim Statement(s), and Goal(s)] (10 pts)

<u>**Implementation Section (66.6%):**</u>
- Methodology (10 pts)
- Barrier Analysis, Interventions, and Monitoring (update) (10 pts)
- Intervention (15 pts)
- Results (15 pts)

Total = 75 pts

Remeasurement 2 and Closure Reports Sections & Weights

    <u>**Abstract:**</u> <u>N/A, not scored</u>
    <u>**Planning Section (25%):**</u>
- Project Topic/Equity Statement [Topic/Rationale/ Shared Equity Statement] (15 pts)
- Aim [Vision, Aim Statement(s), and Goal(s)] (10 pts)

<u>**Implementation Section (50%):**</u>
- Methodology (10 pts)
- Barrier Analysis, Interventions, and Monitoring (update) (10 pts)
- Intervention (15 pts)
- Results (15 pts)

<u>**Validity & Sustainability Section (25%):**</u>
- Discussion [Discussion and Validity of Reported Improvement] (15 pts)
- Next Steps [Sustainability] (10 pts)

Total = 100 pts

Acute hospitals will be permitted one opportunity to revise and re-submit each deliverable following receipt of feedback from the EQRO.

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Performance Assessment	See the MassHealth Cambridge Health Alliance Hospital Quality and Equity Incentives Program (CHA-HQEIP) Performance Assessment Methodology Manual.

CHA-SPECIFIC ADAPTATIONS

Eligible Population	CHA's PIP1 focuses on their Medicaid ACO population. CHA will develop PIP2 related to the Medicaid population, inclusive of the Medicaid ACO population. PIPs are not applicable for the served uninsured patient population.

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E. Meaningful Access to Healthcare Services for Individuals with a Preferred Language other than English

OVERVIEW	
Measure Name	Meaningful Access to Healthcare Services for Individuals with a Preferred Language other than English
Steward	MassHealth
CBE ID Number	N/A
Data Source	Supplemental
Performance Status: PY3	Pay-for-Performance (P4P): Language Access Self-Assessment Survey and Inpatient/ Observation Stay Pay-for-Reporting (P4R): ED
Performance Status: PY4 & 5	Pay-for-Performance (P4P)

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

Description	This measure focuses on the provision of quality language assistance services through two components: 1. **Language Access Self-Assessment Survey:** Self-assessment of language access services 2. **Addressing Language Access Needs in Acute Hospital Settings**: Percentage of inpatient stays, observation stays, and emergency department visits for patients who report a preferred language other than English (including spoken languages and/or sign languages) during which either interpreter services or in-language services were used.

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ELIGIBLE POPULATION

Component 1: Language Access Self-Assessment Survey

Not applicable

Component 2: Addressing Language Access Needs in Acute Hospital Settings

Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.
Age	Members of any age
Continuous Enrollment/ Allowable gap	N/A
Anchor Date	None
Measurement Periods	PY3: January 1, 2025 – December 31, 2025 (P4P - July 1, 2025 – December 31, 2025) PY4: January 1, 2026 – December 31, 2026 PY5: January 1, 2027 – December 31, 2027
Event/Diagnosis	A two-step process must be used to identify eligible stays and visits: **Step 1**. Identify inpatient, observation stays, and emergency department visits between July 1 and December 31 of the measurement year. • To identify inpatient stays: o Identify all inpatient stays (Inpatient Stay Value Set)[19].

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[19] HEDIS® Value Set used with permission from NCQA

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- To identify observation stays:
  - Identify all Observation stays (<u>Observation Stay Value Set</u>)[20].

- To identify emergency department visits:
  - Identify all Emergency Department visits (<u>ED Value Set</u>)[21].

Step 2. For eligible inpatient stays, observation stays, and emergency department visits identified in Step 1, identify those where a patient reported a preferred spoken language other than English (including sign languages), as documented in the medical record or language services documentation system (e.g., vendor logs).

DEFINITIONS

Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.
Language Assistance Services	For the purposes of the HQEIP: • Language assistance services are defined[22] as oral or sign language assistance, including interpretation in non-English language provided in-person or remotely by a qualified interpreter for an individual who prefers a language other than English, and the use of services of qualified bilingual or multilingual staff to communicate directly with individuals who prefer a language other than English for health care. • Language assistance services must be delivered by individuals employed or contracted by the acute hospital who are determined by the acute hospital to be qualified to provide interpreter services.

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[20] HEDIS® Value Set used with permission from NCQA
[21] HEDIS® Value Set used with permission from NCQA
[22] Adapted from the Centers for Medicare and Medicaid Services' *Nondiscrimination in Health Programs and Activities* rule. <u>2024-08711.pdf (govinfo.gov)</u>

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	Technologies such as smartphones, Applications, portable interpretation devices, or Artificial intelligence used for interpretation do not count as language assistance services. • Competency may be specifically defined by the hospital. It may be defined as possessing the skills and ethics of interpreting, and knowledge in both languages regarding the specialized terms (e.g., medical terminology) and concepts relevant to clinical and non-clinical encounters. • Language assistance services may be delivered using any delivery mode that meets communication needs (e.g., in-person, telephonic, video)
In-language Services	Services where a multilingual staff member or provider provides care in a non-English language preferred by the patient, without the use of an interpreter.
Preferred Spoken Language	Refers to a patient's preferred language other than English for health care. For the purpose of this measure, and in alignment with the Preferred Language Data Completeness measure, preferred spoken language may include visual languages expressed through physical movements, such as sign languages.

ADMINISTRATIVE SPECIFICATIONS

Component 1: Language Access Self-Assessment Survey

Acute hospitals must complete the Language Access Self-Assessment Survey (to be provided by MassHealth), which assesses language service infrastructure and programming.

Component 2: Addressing Language Access Needs in Acute Hospital Settings

Description	Percentage of inpatient stays, observation stays, and emergency department visits serving patients who report a preferred spoken language other than English (including sign languages) during which either interpreter services or in-language services were utilized.

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Denominator	**Denominator rate 1:** The eligible population where the patient discharge type is an inpatient stay or an observation stay **Denominator rate 2:** The eligible population where the patient discharge type is an emergency department visit
Numerator	**Numerator rate 1:** Number of inpatient stays and observation stays serving patients who reported a preferred spoken language other than English (including sign languages) during which interpreter services or in-language services were utilized at least once during the stay, as documented in the medical record or language services documentation system (e.g., vendor logs). **Numerator rate 2:** Number of emergency department visits serving patients who reported a preferred spoken language other than English (including sign languages) during which interpreter services or in-language services were utilized, as documented in the medical record or language services documentation system (e.g., vendor logs)
Exclusions	Eligible events where: • Patient dies prior to discharge. • Documentation in the medical record that patient (or their caregiver, as applicable) refused interpreter services and/or in-language services. • Documentation in the medical record of a medical reason where the patient cannot request interpreter services and/or in-language services (e.g., cognitive limitations) and there is no caregiver or legal guardian able to do so on the patient's behalf.

REPORTING METHOD

Component 1: Language Access Self-Assessment Survey (PY3 Only)

Completed Language Access Self-Assessment Surveys must be submitted to MassHealth in a form and **format** to be specified by MassHealth.

Component 2: Addressing Language Access Needs in Acute Hospital Settings

Hospitals are required to report performance using one of the following reporting methods:

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1. **Sample:** Hospitals report performance for two samples:
    a. eligible inpatient and observation stays; and
    b. eligible emergency department visits.

Hospitals must provide a list of the eligible patient populations to determine the sample using a systematic random sampling methodology determined by MassHealth. The minimum required sample size for each of two samples is 411 records or all discharges (whichever is less). MassHealth will provide guidance prior to data collection to identify the sample (e.g. sample reflects every "nth" discharge from the list of eligible records. Additionally, hospitals may use a 5% oversample to draw from only to replace cases taken out of the eligible population because of measure exclusions, otherwise, these records will not be reported on in the final denominator. The total sample size *with* oversample included will be **432** for each of the two samples. Sample size requirements may be modified at the discretion of MassHealth.

2. **Full Eligible Population:** Hospitals report performance on the full eligible population for each relevant setting.

MEASURE REQUIREMENTS & ASSESSMENT: PY3-5

Measure Requirements	PY3	**Component 1: Language Access Self-Assessment Survey** • By **December 31, 2025,** hospitals must submit the completed Language Access Self-Assessment Survey in the form and format specified by MassHealth. **Component 2: Addressing Language Access Needs in Acute Hospital Settings** • By **June 30, 2026,** hospitals must submit to MassHealth required data for either a sample(s) or the full eligible population, using one of the specified "reporting methods" described above. Hospitals must submit data in a form and format to be further specified by MassHealth. MassHealth expects to audit the data submitted for Component 2 by CHA.

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	PY4	Component 2: Addressing Language Access Needs in Acute Hospital Settings • By **June 30, 2027,** hospitals must submit to MassHealth required data for either a sample(s) or the full eligible population, using one of the "reporting methods" described above. Hospitals must submit data in a form and format to be further specified by MassHealth. MassHealth expects to audit the data submitted for Component 2 by CHA.
	PY5	Component 2: Addressing Language Access Needs in Acute Hospital Settings • By **June 30, 2028,** hospitals must submit to MassHealth required data for either a sample(s) or the full eligible population, using one of the specified "reporting methods" described above. Hospitals must submit data in a form and format to be further specified by MassHealth. MassHealth expects to audit the data submitted for Component 2 by CHA.
Performance Assessment		See the MassHealth Cambridge Health Alliance Hospital Quality and Equity Incentives Program (CHA-HQEIP) Performance Assessment Methodology Manual.

CHA-SPECIFIC ADAPTATIONS

Measure Summary: Description	CHA will separately report two percentages for Component 2: one for MassHealth members and one for served uninsured patients.
Component 2: Members/Patients	The eligible CHA population included in the measure is grouped as follows: • MassHealth members; • Served uninsured patients.

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Definitions: Members/Patients	The eligible CHA population included in the measure is grouped as follows:
	• MassHealth members;
	• Served uninsured patients.

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F. Disability Competent Care

Measure Name	Disability Competent Care
Steward	MassHealth
CBE ID Number	N/A
Data Source	Supplemental Data
Performance Status: PY3-5	Pay-for-Performance (P4P)

POPULATION HEALTH IMPACT

Despite evidence of health care disparities experienced by people with disabilities, many health care workers lack adequate training to competently meet their health care needs. 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 patients with disabilities.

MEASURE SUMMARY

Description	The percent of applicable patient-facing acute hospital staff who, in the past 24 months, 1) completed disability competency training to address Disability Competent Care (DCC) pillars selected by the acute hospital in its DCC Training Plan Report and 2) demonstrated competency in the relevant disability competency training area(s).

ELIGIBLE POPULATION

Acute hospitals must describe how they will define applicable patient-facing staff for each disability competency training area in their DCC Training Plan report, which must be approved by MassHealth. The approved population of "applicable patient-facing staff" is the eligible population for this measure.

Eligible populations for each training area may overlap such that some (or all) staff are targeted for training in more than one training area.

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The total eligible population for the measure includes staff in any of the eligible populations for each training area.

DEFINITIONS	
Applicable Patient-facing Staff	Applicable patient-facing staff are employed acute hospital staff whose role requires regular interaction with patients (and/or patients' caregivers). Patient-facing staff may be clinical (i.e., providing or supporting clinical services, such as clinical providers) or non-clinical (i.e., providing or non-clinical services, such as food service staff, administrative staff, etc.). Contracted providers or staff are not included in this definition of patient-facing staff.
Demonstrated Competency	Demonstrated competency in a targeted disability competent care training area is defined as demonstrated ability to apply the knowledge and/or skills targeted for improvement through a disability competent care training exercise. For example, demonstrated competency may be achieved through satisfactory performance on post-test assessments of knowledge and/or skills.
Supplemental Data	Acute hospital data drawn from organizational databases or otherwise related to staff training.

ADMINISTRATIVE SPECIFICATIONS

Rate 1: The percent of applicable patient-facing acute hospital staff who, in the past 24 months, 1) completed disability competency training to address Disability Competent Care (DCC) pillars selected by the acute hospital in its DCC Training Plan Report and 2) demonstrated competency in the relevant disability competency training area(s).

Denominator	The total eligible population
Numerator	For patient-facing staff in the denominator, identify those that have, within the preceding 24 months: • completed any applicable disability competency training(s); and

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	• demonstrated competency in each applicable training area.
Anchor Date	None
Measurement Periods	PY3: January 1, 2025 – December 31, 2025 PY4: January 1, 2026 – December 31, 2026 PY5: January 1, 2027 – December 31, 2027
Exclusions	Patient-facing staff that otherwise would fall into the denominator because of applicability of their roles to a targeted disability competency area who, as of the last day of the measurement year, have been employed with the hospital less than 180 calendar days.
Other	If CHA wishes to change its targeted DCC training area (i.e., DCC training pillar) and/or targeted patient-facing staff population from its approved DCC Training Plan in PY1, CHA should submit an updated DCC Training Plan to MassHealth for review and approval.

MEASURE REQUIREMENTS & ASSESSMENT: PY3-5

Measure Requirements	**PY3-5**	Rate 1 will be calculated by hospitals and results will be submitted by acute hospitals to MassHealth, in a form and format specified by MassHealth by **March 31 following the PY** (e.g., March 31, 2027 for PY4).
		
		1. Specific Reporting Requirements for Rate 1 include--
		For each disability competency training area, report to MassHealth:
		    a. The number of patient-facing staff targeted for disability competency training, including a description of the targeted staff and how they were selected for inclusion in the eligible population;
		    b. The number of patient-facing staff who completed and demonstrated competency in the applicable training area.

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Performance Assessment	See the MassHealth Cambridge Health Alliance Hospital Quality and Equity Incentives Program (CHA-HQEIP) Performance Assessment Methodology Manual.

CHA-SPECIFIC ADAPTATIONS

CHA Adaptations	None

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G. Disability Accommodation Needs

<table>
<tr><td colspan="2">OVERVIEW</td></tr>
<tr><td>Measure Name</td><td>Disability Accommodation Needs</td></tr>
<tr><td>Steward</td><td>MassHealth</td></tr>
<tr><td>CBE ID Number</td><td>N/A</td></tr>
<tr><td>Data Source</td><td>Supplemental Data</td></tr>
<tr><td>Performance Status: PY3-5</td><td>Pay-for-Performance (P4P)</td></tr>
</table>

POPULATION HEALTH IMPACT

Patients with disabilities continue to experience health care disparities related to lack of accommodations to access services. In order to reduce inequities experienced by individuals who have disabilities, accommodation needs must be identified at the point of care.

MEASURE SUMMARY

<table>
<tr><td>Description</td><td>The percentage of eligible hospital stays and/or encounters where 1) patients were screened for accommodation needs related to a disability and 2) for those patients screening positive for accommodation needs related to a disability, a corresponding patient-reported accommodation need was documented.

Two rates are calculated:

Rate 1: Accommodation Needs Screening: Percentage of eligible inpatient stays, observation stays, and ambulatory radiology encounters where patients with disability were screened for accommodation needs related to a disability and the results of the screen were documented electronically in the acute hospital medical record.

Rate 2: Accommodation Needs Related to a Disability: Percentage of eligible inpatient stays, observation stays, and ambulatory</td></tr>
</table>

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	radiology encounters where patients screened positive for accommodation needs related to a disability and for which patient-requested accommodation(s) related to a disability were documented electronically in the acute hospital medical record.

ELIGIBLE POPULATION

Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.
Ages	At least 5 years of age on the date of discharge
Continuous enrollment/ allowable gap	None
Anchor Date	None
Measurement Periods	PY3: January 1, 2025 – December 31, 2025 PY4: January 1, 2026 – December 31, 2026 PY5: January 1, 2027 – December 31, 2027

Event	A two-step process will identify eligible events:
	
	Step 1. Identify inpatient stays, observation stays, and ambulatory radiology encounters between January 1 and December 31 of the measurement year:
	• To identify inpatient stays:
	    o Identify all inpatient stays;
	• To identify observation stays:
	    o Identify all observation stays;
	• To identify ambulatory radiology encounters in the on-campus-outpatient setting (Place of Service = 22):
	    o Identify all ambulatory radiology encounters using the Radiology CPT Code Sets:

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	77046-77067 Radiology: Breast Mammography 77071-77092 Radiology: Bone/Joint Studies 78000-79999 Radiology: Nuclear Medicine 70010-76499 Radiology: Diagnostic Radiology (Diagnostic Imaging) 76500-76999 Radiology: Diagnostic Ultrasound. **Step 2**. For eligible stays and encounters identified in Step 1, identify those where a patient is identified as having a disability using at least one or both of the following criteria: - A patient has a self-reported disability; - A patient is eligible for MassHealth on the basis of a disability per MassHealth administrative data records. Note: Please note, hospitals are responsible for identifying the eligible population in Step 1. MassHealth will draw from member enrollment and demographic data to identify only patients with a disability for the denominator in Step 2. The final rates will reflect the patients included in the supplemental file (Step 1) who have a self-reported disability (Step 2).
Exclusions	Eligible events where: - The patient dies prior to discharge. - The patient was not screened because patient was unable to complete the screening and had no caregiver able to do so on their behalf. This should be documented in the medical record.

DEFINITION

| **Patient with Self-reported Disability** | Patients with self-reported disability are defined as patients that, as documented in the acute hospital medical record, have responded "Yes" to one or more of the following six questions at any time prior to or during the event: Disability Q1 (all ages): Are you deaf or do you have serious difficulty hearing? Disability Q2 (all ages): Are you blind or do you have serious difficulty seeing, even when wearing glasses? Disability Q3 (age 6 or older as of December 31st of measurement year): Because of a physical, mental, or emotional condition, do you |

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	have serious difficulty concentrating, remembering, or making decisions? • Disability Q4 (age 6 or older as of December 31st of measurement year): Do you have serious difficulty walking or climbing stairs? • Disability Q5 (age 6 or older as of December 31st of measurement year): Do you have difficulty dressing or bathing? • Disability Q6 (age 16 or older as of December 31st of measurement year): Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?
Patient with Eligibility for MassHealth on the Basis of a Disability	Disability for the purpose of MassHealth eligibility determination is established by: (a) certification of legal blindness by the Massachusetts Commission for the Blind (MCB); (b) a determination of disability by the Social Security Administration (SSA); or (c) a determination of disability by UMass Disability Evaluation Services (DES).
Accommodation Needs Related to a Disability	Accommodations needs related to a disability (including physical, intellectual and/or behavioral health disabilities) that are necessary to facilitate equitable access to high quality health care. Medical record documentation of patient-requested accommodation needs for the purpose of calculating Rate 2 may be specific (e.g. patient requests American Sign Language Interpreter) or categorical (e.g. patient requests communication accommodations) at the discretion of the acute hospital.
Accommodation Needs Screening	One or more questions posed to patients by hospital providers or staff that are intended to identify whether patients with disability need any accommodation needs related to a disability to facilitate equitable access to high quality health care. • Screening question(s) may be broad (e.g. Is there anything you need help with today to access your care?) or more specific (e.g., Do you have a need for an assistive listening device, mobility assistance, longer appointment time, or other accommodation?). • Accommodation needs screening may be conducted at the point of service (e.g. during a live in-person encounter) or asynchronously (e.g. through a patient portal).

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ADMINISTRATIVE SPECIFICATIONS

RATE 1: Accommodation Needs Screening

Denominator	The eligible population
Numerator	Number of eligible events where, as documented in the acute hospital medical record: • The patient was offered accommodation needs screening and responded; o To meet this requirement, the patient may instead actively validate that ongoing accommodation need(s) as documented in the acute hospital medical record continue to be sufficient; Or • The patient was offered accommodation needs screening and actively opted out of screening (i.e., chose not to answer any questions). If the patient responded to the accommodation needs screening, documentation must include the result of the screening, including at a minimum the following results: • Positive: the patient indicated a need for accommodation related to a disability. • Negative: the patient did not indicate any accommodation need related to a disability. Screening may be rendered by any acute hospital provider or staff.

RATE 2: Accommodation Needs Related to a Disability

Denominator	Cases in the eligible population with a positive accommodation needs screen.
Numerator	Denominator event where documentation in the acute hospital medical record describes: • Patient-requested accommodation(s) related to a disability documented either as a specific accommodation (e.g., patient requests American Sign Language Interpreter) or categorical (e.g.,

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	patient requests communication accommodations) at the discretion of the acute hospital.

REPORTING METHOD

Report to MassHealth on all inpatient stays, observation stays, and ambulatory radiology encounters identified in Step 1 of the process to identify eligible events. Hospitals must submit data in a form and format to be further specified by MassHealth.

MEASURE REQUIREMENT AND ASSESSMENT: PY3-5

Measure Requirements	By **June 30 following the PY** (e.g., June 30,, 2027 for PY4), hospitals must report to MassHealth data for the full population. Hospitals must submit data in a form and format to be further specified by MassHealth. Required reporting elements will include: • For dates of service in the respective PY, data elements required to calculate Rates 1 and 2 as specified in the file specifications submitted via MassQEX. MassHealth expects to audit the data submitted for Rates 1 and 2 by the hospital.
Performance Assessment	See the MassHealth Cambridge Health Alliance Hospital Quality and Equity Incentives Program (CHA-HQEIP) Performance Assessment Methodology Manual.

CHA-SPECIFIC ADAPTATIONS

Measure Summary: Description	CHA will report two separate rates for the Accommodations Needs Screening and the Accommodation Needs Related to a Disability (4 rates total): one for MassHealth members and one for the served uninsured patient population.
Definitions: Members/Patients	The eligible CHA population included in the measure is grouped as follows: • MassHealth members; • Served uninsured patients.

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H. Achievement of External Standards for Health Equity

OVERVIEW

Measure Name	Achievement of External Standards for Health Equity
Steward	MassHealth
CBE ID Number	N/A
Data Source	Supplemental Data
Performance Status: PY3-5	Pay-for-Performance (P4P)

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.[23] 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.

MEASURE SUMMARY

Description	Assessment of hospital progress towards and achievement of The Joint Commission's requirements for its voluntary "Health Care Equity Certification" intended to recognize acute hospitals that go above and beyond to high quality and equitable care. Specifically: A. Achievement of The Joint Commission's introduced revised requirements[24] (effective January 1, 2023) to reduce health care disparities for organizations participating in its hospital accreditation program including six new elements of performance in the Leadership (LD) chapter, Standard LD.04.03.08.

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[23] The National Quality Forum. A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity.
[24] 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/.

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		B. Achievement of The Joint Commission's Health Care Equity Certification[25], which builds on the equity-focused Accreditation standards to recognize organizations that go above and beyond to provide high quality and equitable care.

MEASURE REQUIREMENT AND ASSESSMENT: PY3-5		
Measure Requirements	PY3	**Achievement of Health Care Equity (HCE) Certification** By December 31, 2025 a hospital must submit to MassHealth an attestation that the hospital has achieved HCE Certification as demonstrated by: • Completion of HCE Certification review conducted by The Joint Commission; • Completion of the Evidence of Standards Compliance (ESC) process for any identified Requirements for Improvement (if applicable); and • Receipt of a HCE certification decision of "Certified."
	PY4	**Maintenance of HCE Certification** By December 31, 2026, a hospital must submit to MassHealth an attestation that the hospital has maintained HCE Certification as demonstrated by: • Submission of an acceptable Intracycle Evaluation Report to The Joint Commission by the one-year anniversary of the HCE certification award; • Completion of an Intracycle Monitoring Call with The Joint Commission, including submission of an attestation of continuing compliance with TJC HCE certification standards; and • Re-applying to The Joint Commission for the next 2-year cycle of Health Care Equity Certification.
	PY5	**Achievement of HCE Re-Certification** By December 31, 2027 a hospital must submit to MassHealth an attestation that the hospital has achieved HCE re-Certification as demonstrated by:

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[25] The Joint Commission. Advancing Health Care Equity, Together. https://www.jointcommission.org/our-priorities/health-care-equity/.

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	• Completion of Joint Commission Health Care Equity (HCE) re-certification review conducted (typically occurs +/- 45 days of the 2-year anniversary of the original certification decision); • Completion of the Evidence of Standards Compliance (ESC) process for any identified Requirements for Improvement (if applicable); and • Receipt of a Health Care Equity re-certification decision of "Certified."
Performance Assessment	See the MassHealth Cambridge Health Alliance Hospital Quality and Equity Incentives Program (CHA-HQEIP) Performance Assessment Methodology Manual.

CHA-SPECIFIC ADAPTATIONS

CHA Adaptations	None

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I. Patient Experience: Communication, Courtesy, and Respect

OVERVIEW

Measure Name	Patient Experience: Communication, Courtesy, and Respect
Steward	MassHealth, using selected questions from the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey
CBE ID Number	0166
Data Source	Survey
Performance Status: PY3-5	Pay-for-Performance (P4P)

POPULATION HEALTH IMPACT

Using patient-reported experience, hospitals can assess the extent to which patients are receiving care that is respectful of and responsive to their individual preferences, needs, and values. Key components include effective communication, courtesy, and respect.

MEASURE SUMMARY

Description	The *Patient Experience: Communication, Courtesy, and Respect* measure evaluates MassHealth member perceptions of their hospital experience. The measure utilizes elements of the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey for patients' perspectives of hospital care experience specifically related to communication, courtesy, and respect.

ELIGIBLE POPULATION

The eligible population for this measure is any MassHealth member who was sampled and responded to the acute hospital's HCAHPS survey during the performance year. Members should have Medicaid as the primary payer (e.g., exclude dual eligible members) as defined in the CQI program technical measure specifications (see https://www.mass.gov/infodetails/masshealth-cqi-technical-specifications-manuals)

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Two composites, each comprised of a subset of questions drawn by MassHealth from the HCAHPS survey, contribute to the *Patient Experience: Communication, Courtesy, and Respect measure.* Each composite includes three questions drawn from the HCAHPS[26] survey.

Acute hospitals must report member-level data via HCAHPS XML files for the following HCAHPS questions that make up the Nurse Communication and Doctor Communication composites for the eligible population. Starting in PY3, MassHealth will calculate the Composites results using submitted member-level data and hospitals are not required to submit composite results via data-entry. HCAHPS questions included in this measure are as follows (each referenced using the question number (Q) from the HCAHPS survey):

Composite 1: HCAHPS Questions Related to Nurse Communication
- During this hospital stay, how often did nurses treat you with courtesy and respect? (Q1)
- During this hospital stay, how often did nurses listen carefully to you? (Q2)
- During this hospital stay, how often did nurses explain things in a way you could understand? (Q3)

Composite 2: HCAHPS Question Related to Doctor Communication
- During this hospital stay, how often did doctors treat you with courtesy and respect? (Q5)
- During this hospital stay, how often did doctors listen carefully to you? (Q6)
- During this hospital stay, how often did doctors explain things in a way you could understand? (Q7)

MEASURE REQUIREMENT AND ASSESSMENT: PY3-5

Measure Requirements	PY3-5	Based on surveys received through December 31 of the respective Performance Year, the following data should be submitted in a form and format as directed by MassHealth by **June 30 of the following PY** (e.g., June 30, 2026 for PY3; June 30, 2027 for PY4): 1. Total number of MassHealth acute inpatient discharges in the respective Performance Year

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[26] Hospitals should utilize the HCAHPS survey version corresponding for use with the specified measurement period.

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		2. Total number of MassHealth HCAHPS-eligible acute inpatient discharges in the respective Performance Year
		3. Total number of MassHealth HCAHPS-eligible members sampled to participate in the HCAHPS survey in respective Performance Year
		4. Total number of submitted HCAHPS surveys for MassHealth HCAHPS-eligible inpatient discharges in the respective Performance Year
		5. Response rate* of MassHealth HCAHPS-eligible members participating in the HCAHPS survey in PY2
		*Response rate is defined as the total MassHealth HCAHPS surveys submitted (Item 4) over the total MassHealth HCAHPS-eligible members sampled (Item 3).
		6. For the Eligible Population in the respective Performance Year:
		a. Member-level HCAHPS XML files in order to calculate the following composites:
		1. Nurse Communication Composite (Q1, Q2, Q3)
		2. Physician Communication Composite (Q4, Q5, Q6)
		b. Each composite and associated demographic "About You" response Overall Health, Overall Mental/Emotional Health, Race, Ethnicity, Language (*note these elements are in the survey, Q27, Q28, Q31, Q32, Q29). These stratifications may be used for analysis purposes at the state-wide level.*
		Please note: Hospitals must submit **all required XML elements**, per published HCAHPS XML File Specifications: https://hcahpsonline.org/en/technical-specifications/ Hospitals are required to submit for Medicaid only.

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| Performance Assessment | See the MassHealth Cambridge Health Alliance Hospital Quality and Equity Incentives Program (CHA-HQEIP) Performance Assessment Methodology Manual. |

CHA-SPECIFIC ADAPTATIONS

| CHA Adaptations | None |

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J. Collaboration

OVERVIEW

Measure Name	Collaboration
Steward	MassHealth
CBE ID Number	N/A
Data Source	Supplemental Data
Performance Status: PY3-5	Pay-for-Performance (P4P)

POPULATION HEALTH IMPACT

Collaboration and coordinated interventions to promote health equity across health systems and sectors are essential to achieving high quality and equitable care.

MEASURE SUMMARY

Description	Assessment of participating acute hospital collaboration with MassHealth Accountable Care Organizations to promote high quality and equitable care.

MEASURE REQUIREMENT AND ASSESSMENT: PY3-5

Measure Requirements	**PY3-5**	Acute hospitals must partner with at least one and no more than two MassHealth Accountable Care Organization(s) (identified as "Partnered ACO(s)") to facilitate collaboration on shared health equity goals. MassHealth Accountable Care Organizations are accountable to aligned health equity priorities as MassHealth acute hospitals, including related to: • Demographic data completion • Health-Related Social Needs Screening and Referrals • Quality Performance Disparities Reduction • Equity Improvement Interventions • Language Access

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		- Disability Access and Accommodation - Achievement of External Standards for Health Equity - Cultural Competency Each of these accountability components contribute to a Health Equity Score for each MassHealth ACO. Acute hospitals must annually submit an attestation of partnership stating their selected ACO partner(s) for the Performance Year in the form and format specified by MassHealth.
Performance Assessment		See the MassHealth Cambridge Health Alliance Hospital Quality and Equity Incentives Program (CHA-HQEIP) Performance Assessment Methodology Manual.

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CHA-SPECIFIC ADAPTATIONS

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CHA Adaptations	None

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III. CHA HQEIP Ambulatory Technical Specifications

K. Health-Related Social Needs Screening

Aligned with CMS' Screening for Social Drivers of Health Measure for the Merit-based Incentive Payment System (MIPS) Program[27]

OVERVIEW	
Measure Name	Health-Related Social Needs (HRSN) Screening
Steward	MassHealth
NQF Number	N/A
Data Source	Supplemental Data, Encounter Data
Performance Status: PY3	Pay-for-Reporting
Performance Status: PY4 & 5	Pay-for-Performance

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 health-related social needs (HRSN), the immediate daily necessities prioritized by individuals that arise from the inequities caused by social determinants of health. Identification of such needs provides an opportunity to improve health outcomes through interventions such as referral to appropriate social services.

MEASURE SUMMARY	
Description	Percentage of served uninsured patients with an encounter in CHA's primary care system during the measurement year who were screened for health-related social needs (HRSN). Two rates are reported: Rate 1: HRSN Screening Rate: Percentage of patients with an encounter in CHA's primary care system during the measurement year who were screened

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[27] Aligned with CMS' Screening for Social Drivers of health Measure for the Merit-based Incentive Payment System (MIPS) Program. Centers for Medicare and Medicaid Services Measures Inventory Tool (cms.gov)

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for health-related social needs using a standardized HRSN screening instrument for food, housing, transportation, and utility needs.

Rate 2: HRSN Screen Positive Rate: Rate of HRSN identified (i.e., screen positive) among cases in Rate 1 numerator. Four sub-rates are reported for each of the following domains of HRSNs: food, housing, transportation, and utility.

ELIGIBLE POPULATION

Members	Served uninsured patients
Ages	Members of any age
Continuous enrollment/ Allowable gap	N/A
Anchor date	Served uninsured on outpatient encounter date
Measurement period	PY3: January 1, 2025 – December 31, 2025 PY4: January 1, 2026 – December 31, 2026 PY5: January 1, 2027 – December 31, 2027
Event/diagnosis	Active primary care patients with an outpatient encounter in CHA's primary care system within the performance year. 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. CHA may report all screenings for a given patient in the measurement year but for the purpose of rate calculations, the most recent screening will be used.

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DEFINITIONS	
Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Health-Related Social Needs	The immediate daily necessities that arise from the inequities caused by the social determinants of health, such as a lack of access to basic resources like stable housing, an environment free of life-threatening toxins, healthy food, utilities including heating and internet access, transportation, physical and mental health care, safety from violence, education and employment, and social connection.
Standardized HRSN Screening Instruments	A standardized health-related social needs screening instrument is defined as a standardized assessment, survey, tool or questionnaire that is used to evaluate social needs. HRSN screening tools used for the purpose of performance on this measure must include at least one screening question in each of the four required domains. Examples of eligible screening tools include, but are not limited to: • Accountable Health Communities Health-Related Social Needs Screening Tool • The Protocol for Responding to and Assessing Patients' Riss and Experiences (PRAPARE) Tool • American Academy of Family Physicians (AAFP) Screening Tool CHA is not required to use the example screening tools listed above; hospitals may choose to use other screening instruments, or combinations of screening instruments, that include at least one screening question in each of the four required domains. MassHealth may require CHA to report to MassHealth the screening tool(s) used for the purpose of performance on this measure.
Supplemental Data	Data supplementary to administrative claims data that documents at the patient level 1) when a health-related social needs screen was performed, and/or 2) whether health-related social needs were identified (and if so, in which domain needs were identified). Such supplemental data may be derived from clinical records (such as electronic health records and case management records) or other databases available to entities. Such supplemental data may document screens conducted by billing providers and/or non-billing providers (such as community health workers, medical assistants, and social workers).

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ADMINISTRATIVE SPECIFICATION

RATE 1: HRSN Screening Rate

Description	Percentage of patients with an encounter in CHA's primary care system during the measurement year who were screened using a standardized HRSN screening instrument for food, housing, transportation, and utility needs.
Denominator	The eligible population
Numerator	Number of encounters in CHA's primary care system where, as documented in the medical record, patients were screened using a standardized HRSN screening instrument for food, housing, transportation, and/or utility needs. • Includes encounters where documentation in the medical record indicates that: 　○ The patient was offered HRSN screening and responded to one or more screening questions; 　○ The patient was offered HRSN screening and actively opted out of screening (i.e. chose not to answer any questions); • Includes screenings rendered by any clinical provider (e.g., an ACO clinical provider, hospital clinical provider), non-clinical staff (e.g., patient navigator), health plan staff.
Unit of measurement	Screens should be performed at the individual patient level for adults and, as determined to be clinically appropriate by individuals performing HRSN screening, for children and youth. Screening may be performed at the household level on behalf of dependents residing in one household; if screening is performed at the household level, then results must be documented in the respondent's medical record and in each dependent's medical record in order for the screen to be counted in the numerator for each individual.
Exclusions	Eligible events where: • Patients in hospice (identified using the <u>Hospice Value Set</u>)[28]. • Patients not screened for food insecurity, housing instability, transportation needs, and utility difficulties because member was unable to complete the screening and have no legal guardian or caregiver able to do so on their behalf. This should be documented in

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[28] HEDIS® Value Set used with permission from NCQA

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	the medical record.

RATE 2: HRSN Screen Positive Rate

Description	Rate of HRSN identified (i.e., positive screen) among cases in numerator for Rate 1. Four sub-rates are reported for each of the following domains of HRSNs: food, housing, transportation, and utility.
Denominator	Patients who meet the numerator criteria for Rate 1, as indicated by a positive need in any of the four screened domains.
Numerator 2a – Food insecurity	Number of patients who screened positive for food needs and for whom results are electronically documented in the hospital's EHR (see Code List below).
Numerator 2b – Housing instability	Number of patients who screened positive for housing needs and for whom results are electronically documented in the hospital's EHR (see Code List below).
Numerator 2c – Transportation needs	Number of patients who screened positive for transportation needs and for whom results are electronically documented in the hospital's EHR (see Code List below).
Numerator 2d – Utility difficulties	Number of patients who screened positive for utility needs and for whom results are electronically documented in the hospital's EHR (see Code List below).
Exclusions	None

DATA REPORTING REQUIREMENTS

This measure will be calculated by MassHealth using supplemental data submitted to MassHealth by CHA as follows. Administrative data will not be used for calculation of this measure in PY2. Data must be submitted in a form and format specified by MassHealth.

SUPPLEMENTAL DATA REPORTING REQUIREMENTS

CHA must submit supplemental data (i.e., electronic health record or other medical record data demonstrating HRSN screening rates and/or identified needs) for use by MassHealth for calculating Rate 1 and/or Rate 2. Such supplemental data must be submitted in a form and format to be specified by MassHealth, and must include:

1. **For Rate 1:** Data indicating any of the following:

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a) a patient was screened for food insecurity, housing instability, transportation needs, and utility difficulties during the performance period (corresponding to the definitions of administrative HCPCS code M1207 and/or HCPCS code G0136);

b) a patient was not screened for food insecurity, housing instability, transportation needs, utility difficulties (corresponding to the meaning of the administrative HCPCS code M1208);

c) there is a patient reason for not screening for food insecurity, housing instability, transportation needs, and utility difficulties (e.g., patient declined or other patient reasons.) (corresponding to the meaning of HCPCS code M1237).

Code System	Code	Meaning
HCPCS	M1207	Patient screened for food insecurity, housing instability, transportation needs, utility difficulties [*and interpersonal safety[A]*].
HCPCS	M1208	Patients not screened for food insecurity, housing instability, transportation needs, utility difficulties [*and interpersonal safety[A]*].
HCPCS	M1237	Patients reason for not screening for food insecurity, housing instability, transportation needs, utility difficulties, [*and interpersonal safety[A]*] (e.g., member declined or other member reasons).
HCPCS	G0136	Administration of a standardized, evidence-based social determinants of health risk assessments tool, 5-15 minutes.

Notes:
- Patients in the denominator with screening results corresponding to code M1207 will count towards the numerator.
- Patients in the denominator with screening results corresponding to code M1237 will count towards the numerator.
- Patients in the denominator with screening results corresponding to code M1208 will not count towards the numerator.
- Patients in the denominator where HCPCS code G0136 is coded will count towards numerator.

2. **For Rate 2:** Data indicating identified needs, corresponding to the definitions of the following ICD-10 codes. Data may be captured using the following codes or other clinical record data (e.g., electronic health record data corresponding to these codes)

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Food Insecurity

ICD-10 Code Contributing to Rate 2 Numerators	Meaning
E63.9	Nutritional deficiency, unspecified
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z91.11	Patient's noncompliance with dietary regimen
Z91.110	Patient's noncompliance with dietary regimen due to financial hardship
Z91.A10	Caregiver's noncompliance with patient's dietary regimen due to financial hardship

Housing Instability

Homelessness

ICD-10 Code Contributing to Rate 2 Numerators	Meaning
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness

Housing Instability

ICD-10 Code Contributing to Rate 2 Numerators	Meaning
Z59.811	Housing instability, housed, with risk of homelessness

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ICD-10 Code Contributing to Rate 2 Numerators	Meaning
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.2	Discord with neighbors, lodgers, and landlord

Inadequate Housing

ICD-10 Code Contributing to Rate 2 Numerators	Meaning
Z58.6	Inadequate drinking-water supply
Z59.10	Inadequate housing, unspecified
Z59.11	Inadequate housing environmental temperature
Z59.12	Inadequate housing utilities
Z59.19	Other Inadequate housing

Transportation Needs

ICD-10 Code Contributing to Rate 2 Numerators	Meaning
Z59.82	Transportation insecurity

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Utility Difficulties

ICD-10 Code Contributing to Rate 2 Numerators	Meaning
Z58.6	Inadequate drinking-water supply
Z58.81	Basic services unavailable in physical environment
Z59.12	Inadequate housing utilities

PERFORMANCE REQUIREMENTS & ASSESSMENT FOR PY3-5

Performance Requirements	Submission to MassHealth by **June 30 following each PY** (e.g., June 30, 2027 for PY4) of required supplemental data.
Performance Assessment	See the MassHealth Cambridge Health Alliance Hospital Quality and Equity Incentives Program (CHA-QEIP) Performance Assessment Methodology Manual. MassHealth expects to audit the data submitted for Rates 1 and 2 by CHA.

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L. CHA-HQEIP Ambulatory Quality Performance Disparities Reduction

OVERVIEW

Measure Name	CHA-HQEIP Ambulatory Quality Performance Disparities Reduction
Steward	MassHealth
NQF Number	N/A
Data Source	Administrative, Supplemental. CHA will report population-based electronic measures from the EHR.
Performance Status: PY3	Pay-for-Reporting (P4R)
Performance Status: PY4 & 5	Pay for Performance (P4P)

POPULATION HEALTH IMPACT

Eliminating or reducing health care disparities is essential to improve quality of care for all patients. By collecting and stratifying quality measures, CHA can further identify where health care disparities exist—and then focus interventions to reduce observed disparities and promote equitable care.

MEASURE SUMMARY

Description	This measure assesses performance on reducing disparities on targeted quality performance measures for the served uninsured patient population in CHA's primary care system. The quality measures identified for inclusion in this measure span wellness, prevention, and screening; access; outreach and care coordination; and chronic health conditions domains.

ELIGIBLE POPULATION

Served uninsured patients who are active primary care patients in CHA's primary care system:
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.

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ADMINISTRATIVE SPECIFICATION

In PY3, CHA must complete and submit a "*PY3 Measure Assessment Report.*" The report must be submitted in a form and format specified by MassHealth, and must include:

- An assessment of the opportunity for disparities reduction on the full list of measures specified by MassHealth, including how each measure does or doesn't represent an opportunity for CHA for its served uninsured patients;
- The measures the hospital proposes to focus on for disparities reduction in PY3-5, including what's known about historical performance and other evidence presenting opportunity for improvement.

In PY4-5, CHA will be assessed on disparities reduction for a subset of the measures in Table 1 as specified by MassHealth in its approvals of individual CHA's "*PY3 Measure Assessment Report.*"

Table 1: AMBULATORY QUALITY MEASURES IDENTIFIED FOR INCLUSION IN THIS CHA-HQEIP 'AMBULATORY QUALITY PERFORMANCE DISPARITIES REDUCTION MEASURE'

Domain	Measure ID/Steward	Measure
Wellness, Prevention, and Screening	HEDIS 2022 (W30) NQF 1392, NCQA (adapted to apply to the served uninsured population)*	Well-Child Visits in the First 30 Months of Life (Total Rate)
Wellness, Prevention, and Screening	HEDIS 2022 (WCV) NQF 1516, NCQA (adapted to apply to the served uninsured population)*	Child and Adolescent well care visit (Total Rate)
Wellness, Prevention, and Screening	NQF 0038, NCQA (adapted to apply to the served uninsured population)*	Childhood Immunization - Combo 10
Wellness, Prevention, and Screening	NQF 1407, NCQA (adapted to apply to the served uninsured population)*	Immunization for Adolescents - Combo 2

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Domain	Measure ID/Steward	Measure
Wellness, Prevention, and Screening	HEDIS 2022 (adapted to apply to the served uninsured population)*	Cancer Screening Measure(s) TBD *CHA will develop/explore:* ● *breast cancer screening (NQF 2372),* ● *cervical cancer screening (CCS) (NQF 0032), and* ● *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.*
Chronic Health Conditions	HEDIS 2022, NQF 0018, NCQA (adapted to apply to the served uninsured population)*	Hypertension: Controlling high blood pressure
Chronic Health Conditions	HEDIS 2022, NQF 0059, NCQA (adapted to apply to the served uninsured population)*	Comprehensive Diabetes Care: Poor Control (>9%)
Wellness, Prevention, and Screening	CMS measure (Adapted to apply to the served uninsured population)	Depression Screening and Follow-Up

*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.

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

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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.

PERFORMANCE REQUIREMENTS AND ASSESSMENT FOR PY3-5		
Performance Requirements	**PY3**	By **October 31, 2025 or such other time as specified by MassHealth,** timely, complete, and responsive submission to MassHealth of a "*PY3 Measure Assessment Report.*" Submissions must be in a form and format specified by MassHealth.
	PY4-5	Submission requirements will vary by targeted disparities reduction measure; CHA must submit measure data, as applicable, in a form and format specified by MassHealth.
Performance Assessment	**PY3-5**	See the MassHealth Cambridge Health Alliance Hospital Quality and Equity Incentives Program (CHA-QEIP) Performance Assessment Methodology Manual.

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M. Equity Improvement Intervention

<table>
<tr><td colspan="2">OVERVIEW</td></tr>
<tr><td>Measure Name</td><td>Equity Improvement Interventions</td></tr>
<tr><td>Steward</td><td>MassHealth</td></tr>
<tr><td>NQF Number</td><td>N/A</td></tr>
<tr><td>Data Source</td><td>Supplemental Data</td></tr>
<tr><td>Performance Status: PY3-5</td><td>Pay for Performance (P4P)</td></tr>
</table>

POPULATION HEALTH IMPACT

Equity-focused ambulatory quality improvement projects focused on the served uninsured patient population will lead to demonstrated improvements on access and quality metrics, including by contributing to reductions in disparities for the served uninsured patient population, leading to overall improved health outcomes.

MEASURE SUMMARY

<table>
<tr><td>Description</td><td>CHA will develop and implement no more than one performance improvement milestone project at a time during each performance period that addresses inequities in the served uninsured patient population. The project may include a healthcare delivery system intervention focused on a defined ambulatory measure, an underserved geographic-based area and/or a patient sub-population within the served uninsured population.

Across PY2-5, CHA will submit the following deliverables to MassHealth:
Planning Report: a comprehensive equity improvement intervention plan that includes but is not limited to the following items: health equity aim, objectives and overall goals to address the served uninsured patient population, inclusive of a problem statement, population description/characteristics, scope of opportunity for improvement, barrier identification, proposed intervention or project, and at least 1-2 mid-point milestones and 1-2 year end goals that may be clearly determined or measured (e.g., time-bound, quantitative and qualitative processes or results).</td></tr>
</table>

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	● Midpoint Report: a comprehensive report that includes progress on the mid-point milestones, and identification of successes and barriers, including plans for mid-course adjustments (as needed). ● Performance Period-End Report: a comprehensive report that includes an overview of the project, accomplishments, and progress on year-end goals (one to two) and identification of successes and challenges with a plan for a continued or new equity intervention for the next performance year.

PERFORMANCE REQUIREMENTS AND ASSESSMENT FOR PY3-5

Performance Requirements	The reporting timeline for the deliverables described above is outlined below. ● Planning Report ○ Submission due date: January 31 of same PY (e.g., for PY4 due date: 1/31/26) ○ Payment Status: P4P ● Mid-Point Report ○ Submission due date: August 31 of same PY (e.g., for PY4 due date: 8/31/26) ○ Payment Status: P4P ● Performance Period-End Report ○ Submission due date: January 31 – February 28 of the following PY (e.g., for PY4 due date: 1/31/2027 – 2/28/2027) ○ Payment Status: P4P The elements and weights of each report are included below. ● **Planning Report (40%)** ○ Elements: ▪ Aim, Objective, Goals ▪ Problem Statement, Scope of Opportunity ▪ Approach – Project Summary ▪ Barrier analysis and intervention ▪ Definition of 1-2 Milestones (mid-point deliverables) and 1-2 Goals (year-end goals) – metric and data sources identified ● **Mid-Point Report (30%)** ○ Mid-year progress summary report narrative ○ Elements: ▪ Summary of implementation and milestones ▪ Success and barriers identified ▪ Course correction identified as appropriate ● **Performance Period-End Report (30%)** ○ Year-end progress report narrative ○ Elements:

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	▪ Achievement of milestone(s) and goal(s) Lessons learned identified CHA will formally be permitted one re-submission for each deliverable following receipt of feedback or questions for clarification from MassHealth that may result in an adjusted score.
Performance Assessment	See the MassHealth Cambridge Health Alliance Hospital Quality and Equity Incentives Program (CHA-QEIP) Performance Assessment Methodology Manual.

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N. Community Collaboration Equity Improvement Intervention

OVERVIEW	
Measure Name	Community Collaboration Equity Improvement Intervention
Steward	MassHealth
NQF Number	N/A
Data Source	Supplemental Data
Performance Status: PY3-5	Pay-for-Performance (P4P)

POPULATION HEALTH IMPACT

The equity-focused community collaboration improvement intervention milestone intends to foster cross sector collaboration that is integral to meaningful advancement in improving health and well-being of patients and communities served.* This is especially critical in addressing the needs of the served uninsured patient population and the underserved population.

*Pathways to Population Health (P2PH) is a unifying framework intended to support health care professionals in identifying opportunities for their organizations to make practical, meaningful, and sustainable advancements in improving the health and well-being of the patients and communities they serve. It was created through a partnership of the Institute for Healthcare Improvement, American Hospital Association, Health Research & Educational Trust, Network for Regional Healthcare Improvement, Stakeholder Health, and Public Health Institute funded by the Robert Wood Johnson Foundation.

Saha, S., Loehrer, S., Cleary-Fisherman, M., Johnson, K., Chenard, R., Gunderson, G., Goldberg. R., Little, J., Resnick, J., Cutts, T., and Barnett K. Pathways To Population Health: An Invitation To Health Care Change Agents. Boston: 100 Million Healthier Lives, convened by the Institute for Healthcare Improvement; 2017.

MEASURE SUMMARY

Description	CHA will develop and implement no more than one community collaboration milestone at a time during each performance period that addresses opportunities for health care and promote health equity for the served uninsured patient population and the communities served, working across the CHA delivery system or network and/or through internal community health and/or external community partnership. The intervention milestone will be related to the goals of Domain 1 (Health-Related Social Needs) or Domain 2 (Equitable Access and Quality) for the served uninsured population.
	Across PY3-5, CHA will submit the following deliverables to EOHHS:

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	● Planning Report: a comprehensive plan that includes but is not limited to the following items: health equity aim, objectives and overall goals to address the served uninsured patient population, inclusive of a problem statement, population description/characteristics, scope of opportunity for improvement, barrier identification, proposed intervention or project, and 1-2 mid-point milestones and 1-2 year end goals that may be clearly determined (e.g., time-bound, quantitative and qualitative processes or results). ● Midpoint Report: A comprehensive report that includes progress on the 1-2 milestones, and identification of successes and challenges, including plans for mid-course adjustments (as needed). ● Performance Period-End Report: A comprehensive report that includes an overview of the project, accomplishments, and progress on year-end goals (one to two) and identification of successes and challenges with a plan for a continued or new equity intervention for the next performance year.

PERFORMANCE REQUIREMENTS AND ASSESSMENT FOR PY3-5

Performance Requirements	The reporting timeline for the deliverables described above is outlined below.
	
	● Planning Report
	 ○ Submission due date: January 31 of same PY (e.g., for PY4 due date: 1/31/26)
	 ○ Payment Status: P4P
	● Mid-Point Report
	 ○ Submission due date: August 31 of same PY (e.g., for PY4 due date: 8/31/26)
	 ○ Payment Status: P4P
	● Performance Period-End Report
	 ○ Submission due date: January 31 – February 28 of the following PY (e.g., for PY4 due date: 1/31/2027 – 2/28/2027)
	 ○ Payment Status: P4
	
	The elements and weights of each report are included below.
	
	● **Planning Report (40%)**
	 ○ Elements:
	  ▪ Aim, Objective, Goals
	  ▪ Problem Statement, Scope of Opportunity
	  ▪ Approach – Project Summary
	  ▪ Barrier analysis and intervention
	  ▪ Definition of 1-2 Milestones (mid-point deliverables) and 1-2 Goals (year-end goals) – metric and data sources identified

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	- **<u>Mid-Point Report (30%)</u>**
	   o Mid-year progress summary report narrative
	   o Elements:
	      ▪ Summary of implementation and milestones
	      ▪ Success and barriers identified
	      ▪ Course correction identified as appropriate
	- **<u>Performance Period-End Report (30%)</u>**
	   o Year-end progress report narrative
	   o Elements:
	      ▪ Achievement of milestone(s) and goal(s)
	       Lessons learned identified
	
	CHA will formally be permitted one re-submission for each deliverable following receipt of feedback or questions for clarification from MassHealth that may result in an adjusted score.

Performance Assessment	See the MassHealth Cambridge Health Alliance Hospital Quality and Equity Incentives Program (CHA-QEIP) Performance Assessment Methodology Manual.

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