

Title page for the Commonwealth's Hospital Quality and Equity Initiative Implementation Plan

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| State | Massachusetts |
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Section 1. Overview of Massachusetts' Statewide Approach to Advance Healthcare Quality and Equity

A. Overview

Massachusetts shifted the delivery system at scale to value-based care under the previous MassHealth section 1115 demonstration approval period, transitioning over 80 percent of eligible Medicaid members into accountable care organizations (ACOs) that are at risk to deliver better health outcomes, lower cost, and improved member experience through integrated, coordinated care.

A key goal of the Commonwealth's in this demonstration period is to improve quality of care and advance health equity, with a focus on initiatives addressing health-related social needs (HRSN) and health disparities demonstrated by variation in quality performance. To support achievement of this goal, Massachusetts is centering equity alongside quality as a pillar of value-based care and as a priority for the state's health care system.

To that end, MassHealth will implement aligned quality and equity initiatives across delivery system settings:

1. MassHealth's Accountable Care Organizations (ACOs) and acute hospitals will be accountable to annual performance on a comprehensive set of quality performance metrics.
 - a. ACO quality performance will be incentivized through quality incentive programs proposed for implementation under managed care authority.
 - b. Acute hospital quality performance will be incentivized through the "Clinical Quality Incentive Program," proposed for implementation under State Plan authority (and described for reference in Appendix B).
2. MassHealth's ACOs and acute hospitals will also be accountable to annual performance on a comprehensive set of quality performance metrics that advance health equity.
 - a. ACO quality and equity performance will be incentivized through an equity incentive program proposed for implementation under managed care authority.
 - b. Acute hospital quality and equity performance will be incentivized through the Hospital Quality and Equity Initiative (HQEI), authorized under MassHealth Medicaid and CHIP Section 1115 Demonstration authority as described in the Demonstration's Special Terms and Conditions (STCs).

Together, this constellation of coordinated quality and equity initiatives will support Massachusetts in achieving its demonstration goal to improve quality of care and advance health equity.

B. Scope of this Implementation Plan

In accordance with STC 14 and as set forth in this document, the Commonwealth may allocate expenditure authority for the HQEI, which includes two components of Massachusetts's statewide strategy to advance health quality and equity, specifically the health quality and equity incentive programs for private acute hospitals and the sole non-state-owned public hospital,

Cambridge Health Alliance. These two incentive programs will be implemented by the Commonwealth and referred to herein as the “Hospital Quality and Equity Incentive Program (HQEIP)” and the “Cambridge Health Alliance Hospital Quality and Equity Incentive Program (CHA-HQEIP),” respectively.

This HQEIP Implementation Plan provides additional detail related to implementation of the Commonwealth’s HQEI, beyond those set forth in the MassHealth Medicaid and CHIP Section 1115 Demonstration Special Terms and Conditions (STCs), for Demonstration Approval Period (October 1, 2022 –December 31, 2027).

This Implementation Plan is specific to quality and equity incentive programming in the acute hospital setting being implemented under 1115 Demonstration authority; importantly, this Implementation Plan does not describe ACO, MCO, or acute hospital quality and equity initiatives implemented under separate federal authorities; those are described in more detail in vehicles relevant to each authority. Further, the main body of this Implementation Plan pertains to the HQEIP for private acute hospitals; the CHA-HQEIP Implementation Plan is described separately in Appendix C.

Section 2. Hospital Quality and Equity Incentive Program (HQEIP) Domains and Goals

A. Overview of Targeted Domains for Improvement in the HQEIP

For the HQEIP, the Commonwealth and participating private acute hospitals will be incentivized to pursue performance improvements in the domains specified in STC 14.2 and summarized in Table 1.

Table 1. Overview of Targeted Domains for Improvement for the HQEIP

| | |
|---|---|
| Domain 1: Demographic and Health-Related Social Needs Data | Massachusetts and its participating hospitals will be assessed on the completeness of beneficiary-reported demographic and health-related social needs data submitted in accordance with the Commonwealth’s data requirements as described in the HQEI Implementation Plan. Demographic and health-related social needs data will include at least the following categories: race, ethnicity, language, disability status, sexual orientation, gender identity, and health-related social needs. Data completeness will be assessed separately for each data element. |
| Domain 2: Equitable Quality and Access | Massachusetts and its participating hospitals will be assessed on performance and demonstrated improvements on access and quality metrics, including associated reductions in disparities. Metrics will focus on overall access; access for individuals with disabilities and/or language access needs; preventive, perinatal, and pediatric care services; care for chronic diseases and behavioral health; and care coordination. |
| Domain 3: Capacity and Collaboration | Massachusetts and its participating hospitals will be assessed on improvements in metrics such as provider and workforce capacity and collaboration between health system partners to improve quality and reduce health care disparities. |

B. Goals for each Domain of the HQEIP

Goals for MassHealth and participating hospitals for each HQEIP domain are specified in STC 14.3-14.5 and summarized below:

2. Demographic and Health-Related Social Needs (HRSN) Data Collection Domain Goals
 - a. MassHealth will submit to CMS an assessment of beneficiary-reported demographic and HRSN data adequacy and completeness for purposes of the HQEIP by July 1, 2023.
 - b. MassHealth and its participating hospitals will be incentivized through annual milestones to meet an interim goal of 80 percent data completeness for self-reported race and ethnicity data for MassHealth members¹ by the end of Performance Year (PY) 3 (DY 30).
 - c. MassHealth and its participating hospitals will be incentivized through annual milestones to achieve at least 80 percent data completeness for beneficiary-reported other demographic data (including at least language, disability status, sexual orientation, and gender identity) for MassHealth members¹ by the end of PY 5 (DY 32).
 - d. MassHealth and its participating hospitals will be incentivized to meaningfully improve rates of HRSN screenings from the baseline period by the end of PY 5 (DY 32). “Meaningful improvement” is further described in this Implementation Plan for PYs 2-5. To meet this goal, hospitals must not only conduct screenings of beneficiaries, but establish the capacity to track and report on screenings and referrals.
3. Equitable Quality and Access Domain Goals
 - a. MassHealth and its participating hospitals will be incentivized for performance on metrics such as those related to access to care (including for individuals with language access needs and/or disability), preventive, perinatal, and pediatric care, care for chronic diseases, behavioral health, care coordination, and/or patient experience. Subject to CMS approval and informed by the Needs Assessments, the Commonwealth will select a subset of metrics from the following priority areas (maternal health, care coordination, care for acute and/or chronic conditions, patient experience of and/or access to care), at least three relevant measures from “CMS’ Health Equity Measure Slate” for hospital performance and at least seven for statewide performance;
 - b. Metric performance expectations shall include, at a minimum:
 - i. Reporting on access and quality metric performance, including stratified by demographic factors (such as race, ethnicity, language, disability, sexual orientation, and gender identity); health-related social needs; and/or defined by other individual- or community-level markers or indices of social risk;

¹ Includes members under 65 years of age with MassHealth as their primary insurance, including those with MassHealth Standard, CommonHealth, CarePlus, and Family Assistance coverage types; excludes members with Medicare or another payer as primary payer.

- ii. Developing and implementing interventions aimed at improving quality and reducing observed disparities on metrics that account for clinical and social risk factors found through analysis to be associated with lower performance on such metrics and/or other appropriate individual/community-level markers or indices of social vulnerability;
- iii. Improving quality and/or closing disparities as measured through performance on a subset of access and quality metrics.
- c. For up to the first 3 performance years, performance will be based on expectations described in 2(b)(i) and 2(b)(ii), above. For at least the last two performance years, performance will also be based on expectations described in 2(b)(iii), above.

4. Capacity and Collaboration Domain Goals

- a. MassHealth and its participating hospitals will be incentivized to improve service capacity, workforce development, and health system collaboration to improve quality and reduce disparities. The metrics that assess improvement in this domain may relate to provider cultural competence and achievement of externally validated equity standards.
- b. MassHealth and its participating hospitals will be expected to meet a target of 80 percent of hospitals achieving rigorous standards regarding service capacity, access, and delivery of culturally and linguistically appropriate care by the end of PY 3 (DY 30), as established by a national quality or accreditation organization.

Section 3. HQEIP Conceptual Framework and Performance Year (PY) Metrics

A. Conceptual Framework

To meet domain goals for the HQEIP, it is anticipated that a wide range of acute hospital initiatives will be necessary. Representative initiatives expected to be undertaken by hospitals using earned incentive payments under the HQEIP are described further in the Conceptual Framework for the HQEIP described in Figure 1, and in the three domain-specific logic models provided in Figures 2-7.

Attachment J
 Hospital Quality and Equity Initiative Implementation Plan
 Performance Years 1-5

Figure 1. Overview of Conceptual Framework for the HQEIP

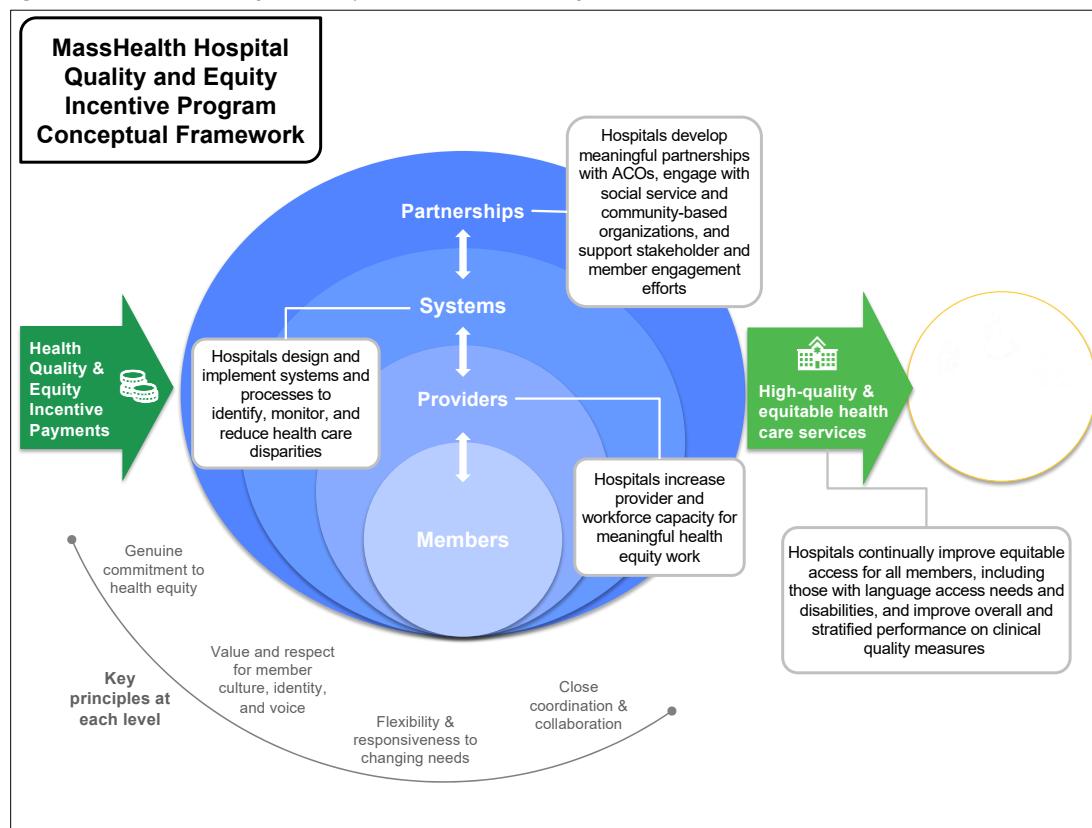


Figure 2. PY 1 Domain 1 Logic Model: Demographic & HRSN Data

| Hospital Inputs | Year 1 Hospital Activities | Year 1 Outcomes | Program Goals |
|---|---|--|---|
| <ul style="list-style-type: none"> Staff to support demographic & HRSN data collection activities Electronic Health Record and other systems upgrades Leadership commitment to improve demographic and HRSN data collection Staff training and education on competent collection Stakeholder engagement to inform collection | <ul style="list-style-type: none"> Hospitals perform an initial assessment of beneficiary-reported demographic and HRSN data adequacy and completeness, and plan for collecting additional demographic and HRSN data including strategies to be employed to provide information about community resources and support services Hospitals upgrade EHRs to ingest RELDSOGI and HRSN data in alignment with measure specifications Hospitals establish data sharing capacity to submit RELDSOGI | <ul style="list-style-type: none"> By the end of year 1, Hospitals have successfully established processes to submit RELDSOGI data files to EOHHS and relevant partners per minimum MassHealth standards By the end of year 1, Hospitals establish baseline completeness for RELDSOGI By the end of year 1, Hospitals demonstrate capacity to begin collecting health-related social needs data in inpatient settings in 2024 | <ul style="list-style-type: none"> By PY5, Hospitals achieve 80%+ completeness on RELDSOGI data to identify & monitor health disparities Increased screening for HRSN using validated/prespecified screening instruments Increased percentage of beneficiaries identified to have a HRSN that are linked to appropriate services |

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| Hospital Inputs | Year 1 Hospital Activities | Year 1 Outcomes | Program Goals |
|-----------------|---|-----------------|---------------|
| | <p>data to EOHHS and relevant partners</p> <ul style="list-style-type: none"> Hospitals report baseline completeness for RELDSOGI across inpatient and Emergency Department settings Hospitals train staff to collect RELDSOGI data from patients in a culturally competent and consistent way Hospitals select health-related social needs screening tool(s) and plan for training staff to perform culturally competent and trauma-informed screening and service linkage/delivery | | |

Figure 3. PY 1 Domain 2 Logic Model: Equitable Quality and Access

| Hospital Inputs | Year 1 Hospital Activities | Year 1 Outcomes | Program Goals |
|--|---|---|--|
| <ul style="list-style-type: none"> Systems and staff to support equity identification and stratified reporting Staff to oversee and implement PIPs, including communication and collaboration with partnered-ACOs, participation in learning collaborative Resources to address language access policies and procedures Resources to support language preference data Staff and resources to complete self-assessment of disability competency Staff trainings & assessment Implement supplemental accommodation screening questions in member experience surveys | <ul style="list-style-type: none"> Hospitals plan approach to identifying and evaluating health care disparities (e.g., through stratification of quality and other data by demographic characteristics & HRSN, = Hospitals complete quarterly deliverables for at least one ACO-partnered Performance Improvement Plan: <ul style="list-style-type: none"> Q1: List of key hospital staff responsible for conducting & overseeing PIP activities Q2: ACO Partnership proposal Q3: PIP Mid-Year Planning Report Q4: PIP Planning Report Hospitals screen for and document preferred spoken language for | <ul style="list-style-type: none"> Initial identification of disparities (by R/E) on measures identified by EOHHS from the CQI measure slate By the end of year 1, Hospitals have a joint PIP proposal/plan ready for implementation in PY2 By the end of year 1, Hospitals have an established ACO partnership to support further collaboration and PIP implementation in PY2 By the end of year 1, Hospitals report baseline performance in % of inpatient & ED visits where preferred language is screened By the end of year 1, Hospitals have developed a disability competency training plan for implementation in PY2 | <ul style="list-style-type: none"> Continuous identification & monitoring of statewide disparities in clinical quality measures Gap closure statewide in disparities in targeted quality measures by year 5 Identification of best practices for targeted equity improvement interventions Increased hospital and ACO collaboration on projects aimed at reducing disparities Members receive linguistically appropriate care, with no reported disparity 80% of all patient-facing staff and leadership demonstrating disability competency Gap closure on % of members reporting that |

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| Hospital Inputs | Year 1 Hospital Activities | Year 1 Outcomes | Program Goals |
|-----------------|---|--|------------------------------------|
| | <p>health care at the point of care</p> <ul style="list-style-type: none"> Hospitals perform a self-assessment of staff disability competencies identifying 3+ areas for improvement, and 2) a training plan for implementation 1/1/24, including staff included, tools used, strategies to assess competency Hospitals evaluate how patients are screened for accommodation needs, how needs are documented, and whether needs are met. Hospitals develop strategies for how, in PY2, they will enhance screening and evaluation of whether needs are met. | <ul style="list-style-type: none"> By the end of year 1, Hospitals demonstrate readiness to begin collecting member experience data specific to assessing whether accommodation needs are met for implementation in PY2 | their accommodation needs were met |

Figure 4. PY 1 Domain 3 Logic Model: Capacity & Collaboration

| Hospital Inputs | Year 1 Hospital Activities | Year 1 Outcomes | Program Goals |
|---|--|--|--|
| <ul style="list-style-type: none"> Staff and resources to support The Joint Commission accreditation surveys Staff to lead health equity efforts & develop a written action plan Resources for stakeholder engagement Staff and resources to implement supplemental questions & surveying methods Staff and resources to support cultural competence data reporting activities Staff and resources to develop and maintain ACO partnerships and collaboration | <ul style="list-style-type: none"> Hospitals achieve The Joint Commission's six new elements of performance related to health equity in the Leadership (LD) chapter, Standard LD.04.03.08) including related to: <ul style="list-style-type: none"> Identifying leadership to promote efforts to reduce disparities Developing a written action plan to reduce disparities Informing key stakeholders of progress towards reducing disparities Hospitals build capacity to report performance on a MassHealth-specific extract of HCAHPS participants in order to better understand MassHealth member experience | <ul style="list-style-type: none"> By the end of year 1, Hospitals meet The Joint Commission's six new elements of performance related to Health Equity By the end of year 1, Hospitals have the systems in place to report on MassHealth-specific inpatient experience, including related to cultural competence, as measured by HCAHPS surveys 5% of Hospital Health Equity Score determined by partnered ACO's Health Equity Score | <ul style="list-style-type: none"> Increase organizational capacity, structure, and workforce for meaningful health equity work Improve culturally competent care for MassHealth members, reduce reported incidents and experiences of bias and discrimination Increased collaboration between health system partners to improve quality and reduce health care disparities |

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| Hospital Inputs | Year 1 Hospital Activities | Year 1 Outcomes | Program Goals |
|-----------------|--|-----------------|---------------|
| | <ul style="list-style-type: none"> related to cultural competency Ongoing collaboration and communication with partnered ACO | | |

Figure 5. PY 2-5 Domain 1 Logic Model: Demographic and Health-Related Social Needs Data

| Hospital Inputs | Year 2-5 Hospital Activities | Year 2-5 Outcomes | Program Goals |
|---|---|--|---|
| <ul style="list-style-type: none"> Staff to support demographic & HRSN data collection activities Electronic Health Record and other systems upgrades Leadership commitment to improve demographic and HRSN data collection Staff training and education on competent collection Stakeholder engagement to inform collection | <ul style="list-style-type: none"> Identify areas for improved data collection strategies to achieve more complete and accurate RELDSOGI and HRSN data Continue to adapt electronic health records to support improved RELDSOGI and HRSN data collection and monitoring Implement high quality screening tools for collection of health-related social needs data Establish and implement culturally competent and trauma-informed practices for data collection Develop and refine practices to respond to identified needs, including through partnerships with health sector and non-health sector partners | <ul style="list-style-type: none"> Hospitals demonstrate increasingly complete, standardized, and accurate RELDSOGI data collected from MassHealth members Systems and workflows are evolved to support systematic RELDSOGI and HRSN data collection and reporting Hospitals are reporting routine training of staff in culturally competent and trauma-informed data collection, evolving to meet new needs as best practices emerge Hospitals are building capacity to respond to identified needs | <ul style="list-style-type: none"> To achieve at least 80% completeness for RELDSOGI data to aid in identifying & monitoring health and health care disparities To meaningfully improve rates of HRSN screening over baseline rates to systematically identify social drivers of health To ensure hospitals can track and report on HRSN screenings and referrals so that identified HRSN needs can be addressed |

Figure 6. PY 2-5 Domain 2 Logic Model: Equitable Quality and Access

| Hospital Inputs | Year 2-5 Hospital Activities | Year 2-5 Outcomes | Program Goals |
|---|---|---|--|
| <ul style="list-style-type: none"> Systems and staff to support stratified reporting, analysis, and monitoring Staff to oversee and implement ACO-partnered equity improvement projects | <ul style="list-style-type: none"> Hospitals routinely review and stratify quality data to identify and monitor health care disparities Hospitals perform analyses of identified disparities to understand root causes and to | <ul style="list-style-type: none"> Hospitals systematically stratify quality measures to monitor trajectory of improvement and inform prioritization of targeted areas for disparity reduction | <ul style="list-style-type: none"> To promote systematic identification and monitoring of disparities in clinical quality measures To achieve gap closure for targeted disparities in clinical quality performance |

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| Hospital Inputs | Year 2-5 Hospital Activities | Year 2-5 Outcomes | Program Goals |
|--|--|--|--|
| <ul style="list-style-type: none"> • Staff and resources to participate in equity learning collaborative • Interpreting resources to meet language access needs of MassHealth members • Staff and resources to assess gaps and implement targeted training programs to improve disability competent care • Staff and systems resources to collect member-reported experience data related to receiving needed accommodations for a disability • Resources for member and stakeholder engagement | <ul style="list-style-type: none"> • inform implementation of strategies to intervene on disparities, including through member engagement • Hospitals design and implement at least two ACO-partnered equity-focused performance improvement projects • Hospitals screen for and document primary language, need for interpreter services, and whether interpreter services were provided at the point of care • Hospitals work to understand gaps and barriers to high-quality implementation services and introduce strategies to improve language access • Using hospital-level self-assessment outputs, hospitals implement disability competency training plans for patient-facing staff • Hospitals establish and implement new strategies to collect member experience data specific to assessing whether accommodation needs are being met | <ul style="list-style-type: none"> • selected in partnership with EOHHS • Hospitals demonstrate robust and thoughtful implementation of two ACO-partnered equity-focused performance improvement plans, including demonstrated progress on interim milestones • Hospitals increasingly document and respond to language access needs • Hospitals increasingly train staff on disability competent care and ensure trained staff demonstrate requisite competencies • Hospitals collect and analyze member-reported data on whether accommodation needs related to a disability were met, with demonstrated improvements over time | <ul style="list-style-type: none"> • To increase hospital and ACO collaboration on interventions targeting equity priorities spanning settings of care • To enhance delivery of high-quality interpreter services to improve access to care • To ensure at least 80% of all patient-facing staff demonstrate disability competencies • To reduce access barriers for members with a disability by ensuring accommodation needs are met |

Figure 7. PY 2-5 Domain 3 Logic Model: Capacity & Collaboration

| Hospital Inputs | Year 2-5 Hospital Activities | Year 2-5 Outcomes | Program Goals |
|--|--|---|--|
| <ul style="list-style-type: none"> • Staff and resources to support demonstrated achievement of external health equity standards • Staff and resources to provide leadership and strategic guidance to the organization and to develop and update the health equity strategic plan | <ul style="list-style-type: none"> • Hospitals continue to maintain compliance with The Joint Commission's Health Equity Certification by PY3 and re-certify by PY5 • Hospitals begin measuring patient experience of culturally competent care and demonstrate improvement in | <ul style="list-style-type: none"> • Hospitals achieve The Joint Commission's Health Equity Certification by PY3 and re-certify by PY5 • Hospitals begin measuring patient experience of culturally competent care and demonstrate improvement in | <ul style="list-style-type: none"> • To build health system equity leadership, service capacity, workforce development, and health system collaboration, with over 80% of participating hospitals achieving rigorous standards established by a national quality or |

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| Hospital Inputs | Year 2-5 Hospital Activities | Year 2-5 Outcomes | Program Goals |
|--|---|--|---|
| <ul style="list-style-type: none"> • Staff and resources to support culturally competent care delivery • Staff and resources to develop and maintain ACO partnerships and collaboration • Resources for member and stakeholder engagement | <ul style="list-style-type: none"> • Hospitals routinely examine member experience data to inform understanding of provision of culturally competent care • Hospitals perform analyses to understand root causes of poor member experience and to inform implementation of strategies to improve culturally competent care, including through member engagement • Hospitals establish and maintain productive partnerships with ACOs to support establish shared goals and strengthen ACO and hospital health equity performance | <ul style="list-style-type: none"> • reported culturally competent care over time • Hospitals implement interventions to improve culturally competent care, demonstrated improved member experience over time • Hospitals and ACOs demonstrate successful collaboration through improved ACO and hospital health equity performance | <ul style="list-style-type: none"> • accreditation organization • To improve culturally competent care for MassHealth members • Increased collaboration between health system partners to improve quality and reduce health care disparities |

B. HQEIP Metrics and Reporting Requirements for PY 1

To establish a robust foundation for quality and equity improvement and to begin making progress towards five-year HQEIP domain goals, the first performance year of the HQEIP will hold private acute hospitals accountable to metrics (listed in Table 2) evaluating contributory health system level interventions in each HQEIP domain. These metrics and associated reporting and performance expectations (described in Table 3) were developed with input from health systems and providers through requests for information and comment, public meetings, and ongoing stakeholder engagement.

Table 2. HQEIP PY 1 Metrics

Table 2a. Domain 1. Demographic and Health-Related Social Needs Data

| Subdomain | Metric (Steward) | PY 1 Status* |
|--|--|-------------------------|
| Demographic Data Collection | Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (EOHHS) | Pay for Reporting (P4R) |
| Health-Related Social Needs Screening | Screening for Social Drivers of Health (CMS): Preparing for Reporting Beginning in PY 2 | P4R |

**Reporting requirements for each measure described in relevant technical specifications.*

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Table 2b. Domain 2. Equitable Quality and Access

| Subdomain | Metric (<i>Steward</i>) | PY 1 Status* |
|---------------------------|---|--------------|
| Equity Reporting | Stratified Reporting of Quality Data (<i>EOHHS</i>) | P4R |
| Equity Improvement | Equity Improvement Interventions (<i>EOHHS</i>) | P4R |
| Access | Meaningful Access to Healthcare Services for Persons with a preferred language other than English (Oregon Health Authority) | P4R |
| | Disability Competencies (<i>EOHHS</i>) | P4R |
| | Accommodation Needs Met (<i>EOHHS</i>) | P4R |

*Reporting requirements for each measure described in relevant technical specifications.

Table 2c. Domain 3. Capacity and Collaboration

| Subdomain | Metric (<i>Steward</i>) | PY 1 Status* |
|----------------------|---|--------------|
| Capacity | Achievement of External Standards for Health Equity (<i>EOHHS</i>) | P4R |
| | Patient Experience: Communication, Courtesy and Respect (<i>AHRQ</i>) | P4R |
| Collaboration | Joint Accountability for Partnered ACO Performance (<i>EOHHS</i>) | P4P |

*Reporting requirements for each measure described in relevant technical specifications.

Recognizing that taking on accountability for equity is new for most acute hospitals serving MassHealth members, all metrics are in pay-for-reporting status in PY 1. Interim and annual reporting requirements for PY 1 are designed to promote essential foundational capacity and readiness to assume progressive risk for health quality and equity performance in PY 2 through PY 5. PY 1 measure status and summarized reporting requirements are described in Table 3.

Approved technical specifications for the HQEIP PY 1 metrics will be made available through the Commonwealth's website and describe measure requirements in more detail.

Table 3. Summary of HQEIP PY 1 Reporting/Performance Requirements

Table 3a. Domain 1. Demographic and Health-Related Social Needs Data

| Metric | Reporting/Performance Requirements for PY 1 & Anticipated Due Dates |
|--|---|
| Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (<i>EOHHS</i>) | Timely (anticipated by December 31, 2023 , or a later date as specified by Massachusetts) submission to the Massachusetts Center for Health Informatics and Analysis of the “ <i>Enhanced Demographics Data File</i> ,” defined as the file including member-level demographic (including race, ethnicity, language, disability, sexual orientation, and gender identity) data collected by hospitals from MassHealth members |

| Metric | Reporting/Performance Requirements for PY 1 & Anticipated Due Dates |
|---|--|
| | during inpatient stays and/or emergency department visits during the Performance Year. |
| Screening for Social Drivers of Health (CMS): <i>Preparing for Reporting Beginning in PY 2</i> | Complete and timely (December 1, 2023) submission of a report to EOHHS describing: <ol style="list-style-type: none"> 1) One or more HRSN screening tool(s) selected by the hospital for intended use in screening patients beginning in PY 2; the selected tool(s) must meet requirements for screening tools for the “Screening for Social Drivers of Health” metric; and 2) A plan to begin screening for HRSN in inpatient settings in Q1 CY 2024 in order to have capacity to report on the “Screening for Social Drivers of Health” metric beginning in PY 2. |

Table 3b. Domain 2. Equitable Quality and Access

| Metric | Reporting/Performance Requirements for PY 1 & Anticipated Due Dates |
|--|---|
| Stratified Reporting of Quality Data (EOHHS) | Complete and timely (anticipated by a date following December 31, 2023 , to be determined by EOHHS) submission to EOHHS of performance data including member-level race and ethnicity for clinical measures selected by EOHHS for stratification from the Clinical Quality Incentive (CQI) measure slate. |
| Equity Improvement Interventions (EOHHS) | Complete and timely submission of quarterly deliverables for at least one ACO-partnered Performance Improvement Plan (PIP) as follows: <ul style="list-style-type: none"> • Q1: Complete and timely (anticipated by March 31, 2023) submission to EOHHS of Hospital Key Personnel/Institutional Resources Document • Q2: Complete and timely (anticipated by July 21, 2023) submission to EOHHS of the PIP Partnership Form • Complete and timely (anticipated by September 30, 2023) submission to EOHHS of the ACO Key Contact Form and the Mid-Year Planning Report • Complete and timely (anticipated by December 31, 2023) submission to EOHHS of the PIP Planning/Baseline Report, a comprehensive plan that incorporates information about PIP goals and objectives, baseline data, proposed interventions, and tracking measures. The PIP Planning/Baseline Report will serve as the blueprint for PIP Implementation in PY 2. Hospitals will be allowed to modify their ACO partner selection(s) at the discretion of EOHHS. |
| Meaningful Access to Healthcare Services for Persons with a preferred language other than English (Oregon Health Authority) | Complete and timely (anticipated by December 31, 2023 or an earlier date specified by EOHHS) reporting of an organizational self-assessment of capacity related to providing access to high quality language services to patients. |
| Disability Competencies (EOHHS) | Complete and timely (anticipated by December 1, 2023) submission to EOHHS of the following: |

| Metric | Reporting/Performance Requirements for PY 1 & Anticipated Due Dates |
|--|--|
| | <p>The Hospital's DCC Team's completed Resources for Integrated Care (RIC) Disability-Competent Care Self-Assessment Tool (DCCAT)¹ Report that includes the following:</p> <ol style="list-style-type: none"> 1) The members that composed your DCC Team. The members included on the Hospital's Disability Competent Care (DCC) Team can be decided by the hospital and which should represent a reasonable mix of clinical and non-clinical patient-facing staff from different clinical departments. Further, we strongly recommend including individuals with disability on the Hospital's DCC Team. 2) The summary from the Hospital DCC Team's DCCAT-Hospital tool 2 exercise. Hospitals will have freedom to further modify the 'base' DCCAT-Hospital Tool, e.g., remove, change or add new questions so long as the hospital submits documentation of (as part of their report) the modifications made along with the reason(s) for the modification(s). 3) Informed by the results of the DCCAT-Hospital tool exercise above, hospitals will identify at least three (of seven) Disability Competent Care (DCC) Model Pillars that the hospital plans to target for improvement beginning in PY 2, based on interpretation of the results from this exercise. 4) Lessons learned in narrative form by the hospital by creating this team and completing this DCCAT self-assessment exercise. <p>Complete and timely (anticipated by December 1, 2023) submission to EOHHS of a plan for improving competency in targeted competency areas during PY 2, including:</p> <ol style="list-style-type: none"> 1) selected training tools and/or educational resources, 2) which staff that will be assessed (including self-assessed) for post-educational/training competency, and 3) approaches that will be used to assess post-education/training organizational and staff competency. <p>This plan must describe how the hospital will be prepared to begin reporting performance in PY 2 on a process measure (in development by EOHHS) beginning in PY 2 that assesses the percent of patient-facing staff demonstrating competency in targeted competency areas for improvement.</p> |
| Accommodation Needs Met (EOHHS) | <p>Complete and timely (anticipated by December 1, 2023) submission to EOHHS of a report describing the hospital's current practice and future plans for the following:</p> <ol style="list-style-type: none"> 1) screening patients for accommodation needs* before or at the start of a patient encounter, and how the results of this screening is documented 2) other methods, if any, for documenting accommodation needs |

| Metric | Reporting/Performance Requirements for PY 1 & Anticipated Due Dates |
|--------|---|
| | <p>3) asking patients, at or after the end of a patient encounter, if they felt that their accommodation needs were met</p> <p>4) analyses that are performed at the organizational level to understand whether accommodation needs have been met.</p> <p><i>* For this report, accommodation needs are regarded to be needs related to a disability, including disabilities as a result of a physical, intellectual or behavioral health condition. For this report, this does not include needs for language interpreters, but does include accommodation needs for vision impairments (e.g., Braille) or hearing impairments (e.g., ASL interpreters).</i></p> |

Table 3c. Domain 3. Capacity and Collaboration

| Metric | Reporting/Performance Requirements for PY 1 & Anticipated Due Dates |
|---|--|
| Achievement of External Standards for Health Equity (EOHHS) | Complete and timely (anticipated by December 31, 2023) submission to EOHHS of an attestation that the hospital has completed The Joint Commission (TJC) surveys for health equity accreditation standards (specifically, 6 new elements of performance in the Leadership (LD) chapter, Standard LD.04.03.08.) |
| HCAHPS: Patient Experience: Communication, Courtesy and Respect (AHRQ) | Complete and timely (anticipated by a date following December 31, 2023 to be determined by EOHHS) submission to EOHHS of HCAHPS survey results for any MassHealth members participating in the hospital's HCAHPS survey sample during PY 1. |
| Joint Accountability for ACO Performance (EOHHS) | <p>In order to promote collaboration and coordinated interventions to promote health equity across health system settings and across the spectrum of ambulatory and inpatient care, acute hospitals will be required to partner with at least one and no more than two ACO(s) (identified as “Partnered ACO(s)”) serving a shared population in order to augment impact on health equity. To incentivize shared investment and goals across ACO and hospital entities, hospitals’ performance in this subdomain for PY 1 will equal its Partnered ACO’s Health Equity Score; if the hospital has more than one ACO Partner then its subdomain score will equal the average of each Partnered ACO’s Health Equity Score.</p> <p>Partnered ACOs will be held accountable for health equity performance in the same domains as their Partnered Hospitals, tailored to the ACO setting:</p> <ul style="list-style-type: none"> • Demographic data completion • HRSN screening and referrals • Stratified Reporting of Quality Data • Equity Improvement Interventions • Language Access • Disability Access and Accommodation • Achievement of External Standards for Health Equity |

| Metric | Reporting/Performance Requirements for PY 1 & Anticipated Due Dates |
|--------|---|
| | <ul style="list-style-type: none">• Member Experience: Cultural Competency <p>Each of these accountability components will contribute to the ACO's Health Equity Score.</p> |

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

If in a given performance period a hospital does not meet the minimum denominator or other technical requirements for a measure on the HQEIP measure slate, the weight attributed to that measure will be apportioned equally across the other measure(s) in the same domain for scoring purposes for that performance period. Beginning in PY3, if a hospital is unable to meet the minimum denominator or other technical requirements for at least 50% of the measures on the HQEIP metrics slate for a performance period, the hospital's participation in the HQEIP will be suspended for that performance period. A hospital may resume participation when it is able to meet the minimum denominator or other technical requirements for at least 50% of the measures on the HQEIP metrics slate, provided that such participation shall begin at the start of the subsequent performance period and provided that the hospital will be held accountable for the performance year requirements immediately following the last performance year in which the hospital participated.

For example, if EOHHS determines that a hospital is unable to meet the minimum denominator or other technical requirements of at least 50% of the measure slate for PY3 in calendar year 2025, then the hospital will not be able to participate in PY3 in the calendar year 2025. If the hospital is able to meet the minimum requirements to participate in at least 50% of the PY3 measure slate during calendar year 2026, the hospital will resume in the HQEIP in calendar year 2026, and will be held accountable to PY3 requirements in calendar year 2026.

A new hospital that was not enrolled in MassHealth at the start of the HQEIP can participate in the HQEIP, provided that participation is permitted to start only at the beginning of a performance period regardless of when the hospital began operations and enrolled in MassHealth. Regardless of the calendar year that a hospital enters the HQEIP, a new hospital beginning participation in the HQEIP will be held accountable to PY1 requirements for the first performance period it participates, and will proceed in the HQEIP in order of performance year. For the purposes of this paragraph, a new hospital means a hospital that newly begins hospital operations after the start of the HQEIP. A new hospital does not include a hospital that, after the start of the HQEIP, purchased, acquired or otherwise took over the operations of a hospital that existed and was enrolled in MassHealth at the beginning of the HQEIP. Such hospitals shall continue on the standard HQEIP PY trajectory, subject to terms of the previous paragraph.

For example, a new hospital able to participate in HQEIP beginning in calendar year 2025 will be held accountable to PY1 requirements in calendar year 2025, accountable to PY2 requirements in calendar year 2026, and accountable to PY3 requirements in calendar year 2027.

C. HQEIP Metrics for PYs 2-5

PYs 2-5 of the HQEIP will hold private acute hospitals accountable to metrics (listed in Table 4) evaluating performance in each HQEIP domain. These metrics were developed with input from health systems and providers through requests for information and comment, public meetings, and ongoing stakeholder engagement. In the event that a measure is retired by a measure steward for any reason, Massachusetts will replace the impacted measure, choosing from a CMS-approved measure that is already widely adopted within Massachusetts (or for which reliable data to establish a valid benchmark and performance changes are readily available) and supported by the findings from analysis and/or needs assessments described in Section 6 of this Addendum. Approved technical specifications for the HQEIP PY 2-5 metrics, which may be updated annually or more frequently as necessary, will be made available.

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 Hospital Quality and Equity Initiative Implementation Plan
 Performance Years 1-5

Table 4. HQEIP PY 2-5 Metrics

| Domain* | Measure Name | Measure Description | Data Source | Measure Steward [^] | Payment Status** | | | |
|---------|---|--|--------------------------------------|------------------------------|------------------|------|------|------|
| | | | | | 2024 | 2025 | 2026 | 2027 |
| DHRSN | Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness | Percentage of members with acute hospital discharges within the measurement year with self-reported RELDSOGI data. | Administrative | EOHHS | R | P | P | P |
| | Health-Related Social Needs (HRSN) Screening | Two rates: 1) HRSN Screening Rate: Percentage of acute hospital discharges where members were screened using a standardized health-related social needs (HRSN) screening instrument for food, housing, transportation, and utility needs; and 2) HRSN Screen Positive Rate: Rate of HRSN identified by HRSN screening associated with acute hospital discharges in Rate 1. | Admin/ Supplemental | EOHHS (CMS [~]) | R | P | P | P |
| EQA | Quality Performance Disparities Reduction | Acute hospital progress towards reducing racial and ethnic disparities in quality performance. Quality measures identified for inclusion in this measure (drawn from the MassHealth Clinical Quality Incentive (CQI) program) are disparities-sensitive measures in the areas of coordination of care, perinatal health, and/or care for acute and chronic conditions. | Administrative/ Hybrid/ Supplemental | EOHHS | R | R | P | P |
| | Equity Improvement Interventions | Assessment of rigorous design and implementation of two equity-focused performance improvement projects (PIPs) focused on coordination of care, perinatal health, and/or care for acute and chronic conditions. | Supplemental | EOHHS | P | P | P | P |
| | Meaningful Access to Healthcare Services for Persons with a Preferred Language other than English | Two components: 1) Language Access Self-Assessment Survey: Completion and reporting of a language access self-assessment survey; and 2) Addressing Language Access Needs in Acute Hospital Settings: Percentage of acute hospital stays serving members who report a preferred language other than English during which either interpreter servings or an in-language service provider was utilized. | Supplemental | EOHHS (OHA [^]) | R | P | P | P |
| | Disability Competent Care | Percentage 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 hospital in its DCC Training Plan Report, and 2) demonstrated competency in the relevant disability competency training area(s). | Supplemental | EOHHS | P | P | P | P |
| | Disability Accommodation Needs | Percentage of acute hospital discharges and/or encounters where 1) members with disability were screened for accommodation needs related to a disability, and 1) for those members screening positive for accommodation needs, a corresponding member-reported accommodation need was identified. | Supplemental | EOHHS | R | P | P | P |
| CC | Achievement of External Standards for Health Equity | Assessment of whether acute hospitals have achieved standards related to health equity established by The Joint Commission for its "Health Care Equity Certification" | Supplemental | EOHHS | R | P | P | P |
| | Patient Experience: Communication Courtesy and Respect | Assessment of MassHealth member perceptions of their hospital experience utilizing reported elements of the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey for patients' perspectives of hospital care experience related to communication, courtesy, and respect. | Supp/Survey | EOHHS | R | P | P | P |
| | Collaboration | Assessment of participating acute hospital collaboration with health system partners to promote high quality and equitable care. | Supplemental | EOHHS | P | P | P | P |

*DHRSN=Demographic and Health-Related Social Needs Data; EQA=Equitable Quality and Access ; CC=Capacity and Collaboration; ** R=Pay-for-Reporting, P=Pay-for-Performance

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Hospital Quality and Equity Initiative Implementation Plan

Performance Years 1-5

^ EOHHS=Massachusetts Executive Office of Health and Human Services; CMS=Centers for Medicare & Medicaid Services; OHA=Oregon Health Authority

~ Adapted for HQEIP use from CMS' "Screening for Social Drivers of Health" and "Screen Positive Rate for Social Drivers of Health", and OHA metrics, respectively.

D. Additional Detail on Identification of Health-Related Social Needs Screening and Referrals

1. Identification of Members with Unmet Health-Related Social Needs

MassHealth will incentivize participating acute hospitals to begin HRSN screening beginning in PY 2 through inclusion of a MassHealth-adapted version of the CMS “Social Drivers of Health” metric on the HQEIP measure slate. Accordingly, screening will be conducted in alignment with parameters specified in the measure, including related to targeted screening domains (including, at a minimum, food, housing, transportation, and utilities) and screening tools. Screening will be required to be conducted at least once annually to meet performance expectations for the metric. MassHealth, as part of its ongoing performance management of hospitals, will require hospitals to report annually to MassHealth on how the approaches they are using for HRSN screening are culturally appropriate and/or culturally informed, and will provide education and/or technical assistance to support attainment of culturally competent and/or trauma-informed screening practices.

Additional information related to screening and identification of members for HRSN services not specific to the HQEIP is described in Attachment T of the STCs, the “Health-Related Social Needs Implementation Plan.”

5. HRSN Referrals

Acute hospitals will be accountable for establishing approaches to link members to HRSN services and other resources to address identified HRSN. In PY 1, hospitals will be expected to prepare for HRSN data collection by:

- Completing and reporting to MassHealth an initial assessment of beneficiary-reported HRSN 1) data adequacy and completeness across hospital settings, and 2) strategies employed to provide information about community resources and support services;
- Selecting HRSN screening tool(s);
- Adapting systems to capture and exchange HRSN data electronically;
- Training staff to competently collect HRSN data using culturally competent and trauma informed approaches; and
- Developing strategies to respond to identified HRSN that address any gaps revealed in the self-assessment, including services provided by other state agencies that address members’ HRSN.

The Commonwealth intends to ensure that HRSN data collection mechanisms to support participation in the HQEIP include explanatory text setting forth the anticipated uses of the collected data and that members generally have the option to decline to respond to questions (e.g., “choose not to answer”). Furthermore, hospitals are required to comply with applicable privacy and security laws as covered entities and through contractual obligations.

MassHealth intends to procure a vendor to implement an HRSN electronic referral platform that hospitals can use to electronically refer members with identified HRSNs to entities that can help to address those needs, such as social services organizations (SSOs). This platform would also facilitate a “closed feedback loop” process, where SSOs could provide back to hospitals the outcomes of those HRSN referrals (e.g., whether services were provided and impact of those services on the identified HRSNs). This platform will provide MassHealth with the ability to centrally track hospital HRSN referrals and outcomes when such referrals are made. MassHealth anticipates launching the platform in 2026. In support of the platform launch, MassHealth will provide technical assistance to hospitals and SSOs on how best to use the platform. MassHealth has received approval for an Advanced Planning Document in support of implementation of this HRSN electronic referral platform.

MassHealth will only report aggregate HRSN referral and outcomes data once the HRSN electronic referral platform is in place, in lieu of standing up an interim manual process that will then be replaced with the HRSN electronic referral platform.

6. Member Eligibility for HRSN Services

HRSN services that may be covered by the Commonwealth are described in STC 15.3, and further described in Attachment T of the STCs, the “Health-Related Social Needs Implementation Plan.” Covered populations for HRSN services are described in STC 15.5 and further detailed in Attachment P of the STCs, the “Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services”, and Attachment T of the STCs, the “Health-Related Social Needs Implementation Plan.”

Section 4. Hospital Quality and Equity Initiative (HQEIP) Payment and Corrective Action Plan

A. Hospital Quality and Equity Initiative Payment

The HQEIP section 1115 expenditure authority will support the launch and maintenance of the HQEIP and the CHA-HQEIP to improve health care quality and equity within the Commonwealth. Payment for the CHA-HQEIP is described separately in Appendix C. For PY 1-5, Massachusetts will set the maximum budgeted annual incentive amount for HQEIP at \$350M, below the maximum authority of \$400M. Table 5 shows budgeted amounts of funding for the HQEIP, as well as the percentage of funding distributed to each HQEIP domain in accordance with STC 14.7(a).

Table 5. PY 1-5 Budget Allocation for the HQEIP (in millions)

| Demonstration Year(s) | DY 27-28 | DY 29 | DY 30 | DY 31 | DY 32 |
|-----------------------|----------------|---------|---------|---------|---------|
| Performance Year(s) | CY 2022(Q4)-23 | CY 2024 | CY 2025 | CY 2026 | CY 2027 |

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 Hospital Quality and Equity Initiative Implementation Plan
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| Demonstration Year(s) | DY 27-28 | DY 29 | DY 30 | DY 31 | DY 32 |
|-----------------------|---------------|---------------|---------------|---------------|---------------|
| Domain 1 (25%) | \$87.5M | \$87.5M | \$87.5M | \$87.5M | \$87.5M |
| Domain 2 (50%) | \$175M | \$175M | \$175M | \$175M | \$175M |
| Domain 3 (25%) | \$87.5M | \$87.5M | \$87.5M | \$87.5M | \$87.5M |
| TOTAL (100%) | \$350M | \$350M | \$350M | \$350M | \$350M |

Funding for the HQEIP is divided into three provider-specific tiers. Provider-specific tiers are defined by hospital safety net designation, with funding distributed between tiers as described in Table 6.

For a provider to be in tier 1 or tier 2, it must be a safety net provider. As defined in the 1115 waiver STC's and Attachment N, safety net providers are acute hospitals that meet certain payer mix criteria (must have a Medicaid payer mix greater than 20% and a Commercial payer mix less than 50%) and are not identified as Massachusetts essential hospitals or Massachusetts critical access hospitals with fewer than 30 beds. To be in tier 1, a safety net provider must have historical involvement in the delivery system transformation initiative; specifically, the safety net provider must have received delivery system transformation initiative payments in 2015-2017. All other safety net providers are allocated to tier 2, and all other non-safety net providers (private acute hospitals) are allocated to tier 3.

Table 6. HQEIP PY 1 Funding by Safety Net Group Tier (in millions)

| Tier | Tier Definition | Funding Amount PY1 | Funding Amount PY2 | Funding Amount PY3 | Funding Amount PY4 | Funding Amount PY5 |
|--------------|------------------------------|--------------------|--------------------|--------------------|--------------------|--------------------|
| Tier 1 | Safety Net Group 1 Providers | \$129M | \$129M | \$129M | \$129M | \$129M |
| Tier 2 | Safety Net Group 2 Providers | \$101M | \$101M | \$101M | \$101M | \$101M |
| Tier 3 | All Other Private Hospitals | \$120M | \$120M | \$120M | \$120M | \$120M |
| TOTAL | | \$350M | \$350M | \$350M | \$350M | \$350M |

For hospitals in Tiers 2 and 3, each hospital's maximum incentive payment will be equal to their pro-rata share of tier funding, determined by dividing each hospital's FY 2019 Medicaid Gross Patient Service Revenues by all FY 19 Medicaid Gross Patient Service Revenues within the

respective tier. For hospitals in Tier 1, each hospital's maximum incentive payment will be equal to \$1M, plus their pro-rata share of remaining tier funding, determined by dividing each hospital's FY 2019 Medicaid Gross Patient Service Revenues by all FY 2019 Medicaid Gross Patient Service Revenues within the tier. If a hospital newly begins participating in the HQEIP after the beginning of the first performance period, as described in Section 3.B, Massachusetts will collect from the hospital projected Medicaid Gross Patient Service Revenues for the first 12 months that the hospital is in operation to determine an appropriate maximum incentive amount. If a hospital's participation in the HQEIP is suspended for one or more performance periods, as described in Section 3.B, Massachusetts will assign the hospital a maximum incentive amount of \$0 for the performance periods the hospital is suspended from participation.

In HQEIP PY 1, Massachusetts intends to make four interim payments and one reconciliation payment to acute hospitals. In order to receive interim payments, hospitals must meet key milestones ("gates") determined by Massachusetts to be foundational to successful performance in the HQEIP; these "gates" are a form of "pay-for-reporting" where timely and complete submission of gate deliverables will be required for interim payments to be made. Across these interim payments, Massachusetts will withhold 10% of each hospital's maximum annual incentive payment. As appropriate, the remaining 10% will be paid out as a reconciliation payment in CY 2024, based on the hospitals' final PY 1 health equity performance determined by performance on the HQEIP metric slate and successfully meeting payment gate reporting deliverables; if at the conclusion of PY 1 a hospital's HQEIP performance results in earning less than 90% of its allocated incentive amount, funds will be recouped in the reconciliation payment process to ensure hospitals are paid only what they earn on the basis of their HQEIP performance for PY 1. The Health Quality and Equity Independent Assessor is not required to review relevant submissions (as described in Section 6.C) before interim payments are made. If the Independent Assessor's review finds that gating deliverables were not complete, then reconciliation payment may be withheld until they are re-submitted and complete.

Table 7. HQEIP Payment Gates for PY 1

| Gated Payment | Gate Description | Anticipated Gate Deliverable Due Date |
|--------------------|--|---------------------------------------|
| Q4 CY 2022 Payment | Participation Attestation – Timely and complete submission to Massachusetts of an attestation to participate in the HQEIP for PY 1, including an attestation to collaborate with a Model A or B ACO (or a request for exemption from the ACO collaboration requirement). | Dec. 19, 2022 |
| Q1 CY 2023 Payment | Qualified Interpreters Attestation – Complete and timely submission to Massachusetts of an attestation that, by December 31, 2023, the hospital will implement a process for qualifying language interpreters. | March 31, 2023 |
| Q2 CY 2023 Payment | Race, Ethnicity, Language, Disability status (RELD) Sexual Orientation, Gender Identity (SOGI) Assessment – Timely and complete submission to Massachusetts of an initial assessment of 1) beneficiary-reported demographic data adequacy and completeness, and 2) a proposed plan for collecting demographic data including data sources. MassHealth anticipates collecting additional information | June 2, 2023 |

| Gated Payment | Gate Description | Anticipated Gate Deliverable Due Date |
|-----------------------------|--|---------------------------------------|
| | about data submission plans in advance of the submission of the Enhanced Demographic Data File. Health-Related Social Needs (HRSN) Assessment – Timely and complete submission to Massachusetts of an initial assessment of 1) beneficiary-reported HRSN data adequacy and completeness, and 2) strategies employed to provide information about referrals including to community resources and support services | |
| Q3 CY 2023 Payment | Disability Competency Self-Assessment Attestation – An attestation that the hospital is working towards timely and complete submission to Massachusetts of a report on the results of the disability competencies self-assessment, including identified disability competencies targeted for improvement in PY 2. | September 18, 2023 |
| PY 1 Reconciliation Payment | Health Equity Strategic Plan : Timely and complete submission to Massachusetts of a Health Equity Strategic Plan as required by EOHHS. | Dec. 31, 2023 |

In each year PY 2-5 of the HQEIP, Massachusetts intends to make four interim payments to acute hospitals and complete one performance reconciliation for each acute hospital that may lead to a further payment or a recoupment. Massachusetts will withhold between 10-40% (specific percentage to be determined annually by MassHealth based on prior performance data and other factors) of each hospital's maximum annual incentive payment from their interim payments. Based on a hospital's final HQEIP health equity score for each performance year, the remaining earned incentive will be paid out as a reconciliation payment in the following calendar year or unearned funds will be recouped, as applicable. Interim payments will be made automatically, with the exception that it is anticipated that the fourth interim payment for each PY will only be paid out once hospitals have submitted a complete annual Health Quality and Equity Strategic Plan update (anticipated to be due by the end of the PY). Additional quarterly payment "gates" may be instituted at the discretion of MassHealth.

E. HQEI Corrective Action Plan

Given the importance of establishing foundational capacity for health equity accountability in the first performance year of the HQEIP and in order to set hospitals up for success in subsequent performance years, the Commonwealth will actively manage performance of participating acute hospitals to optimize performance. The Commonwealth will rigorously evaluate interim and annual deliverables to identify providers that are not on track to meet program objectives and to support concurrent corrective action for successful achievement of expectations.

Underperforming participating hospitals will be notified by the Commonwealth on a periodic basis and will be supported to achieve performance year objectives.

Performance management of acute hospitals for the HQEIP in PY 1 will be multilayered:

- MassHealth program teams will be working closely with the hospitals to clearly communicate expectations of the HQEIP, maintaining an open dialogue with hospitals to

respond to questions and requests for support. As part of this effort, MassHealth intends to coordinate bi-monthly educational meetings with the hospitals and providers to discuss topics including related to HQEIP performance, with at least two educational sessions per year dedicated to the HQEIP. Additional sessions and conferences between acute hospitals and EOHHS to support performance may be convened with each hospital individually at the hospital's request or at the request of the Commonwealth. Further, MassHealth will also hold regular office hours with acute hospitals to assist in program implementation.

- The Commonwealth will use its established and contracted quality performance vendors who support current quality and equity measurement initiatives to assist in the monitoring, reporting and evaluation of acute hospital performance on HQEIP metrics.
- MassHealth will be supported in monitoring HQEIP performance by its "Health Quality and Equity Program Management Vendor." This vendor will support assessment of HQEIP documentation and deliverables and will support hospitals to meet program requirements. This vendor will also provide additional support as directed by EOHHS, such as thought leadership, help developing tools to assess deliverables, and development of materials to support public-facing reports.
- The quarterly payment strategy employed by MassHealth will provide a strong incentive to make steady progress towards PY 1 goals; missing key milestones will have immediate, tangible impacts on interim incentive payments.

Together these activities will allow the Commonwealth to recognize and intervene on deficits in acute hospital performance to optimize performance. Hospital accountability to the state is further detailed in Section 5; hospitals will not be eligible to earn back unearned funds in PY 1.

In PY 2-5, the Commonwealth will actively manage performance of the participating hospitals to optimize performance using a similar performance management approach also including a corrective action plan (CAP) process (required to be implemented by STC 14.12) consisting of the following elements:

- i. MassHealth will rigorously evaluate interim and annual deliverables to identify the participating hospitals that are not on track to meet objectives. Underperforming hospitals will be notified by and expected to engage with MassHealth on a periodic basis to discuss performance and obstacles and opportunities for improvement.
- ii. MassHealth will provide support and technical assistance to all hospitals on an ongoing basis throughout the Section 1115 Demonstration period through applicable interventions including engagement with individual hospitals, data reporting and analysis, hospital technical forums dedicated to health quality and equity hosted by MassHealth, and technical assistance provided by MassHealth clinical and quality experts.
- iii. Beginning in PY 3 and annually thereafter through PY 5, hospitals will also be incentivized to improve through a CAP process overseen by MassHealth. The CAP process will offer participating hospitals an opportunity to identify areas of poor performance on the HQEIP slate, evaluate root causes of such poor performance, and use rapid-cycle equity improvement interventions to make progress towards improved performance on HQEIP metrics. MassHealth may require certain poor-performing

hospitals to participate in the CAP process; hospitals not required by MassHealth to participate in the CAP process may choose to voluntarily participate. The CAP process will include the following aspects:

- i. Hospitals participating in a CAP intervention in a given PY will select an area of underperformance on one or more metrics on the HQEIP measure slate. HQEIP measure focus areas must be selected and justified by hospitals within the first quarter of a CAP-eligible PY using data such as prior year(s) performance data (as available), hospital-generated internal performance monitoring data, and MassHealth hospital monitoring data. HQEIP metrics that may be selected as topic areas for CAP interventions will be provided by MassHealth annually.
- ii. Hospitals participating in a CAP intervention must develop a CAP intervention proposal to be submitted to MassHealth within the first quarter of the performance year describing one or more proposed intervention(s) that directly address the area of underperformance, including how the proposed interventions(s) will address known root causes and/or obstacles to performance and the hospital's rationale for why addressing the root cause and/or obstacle through the proposed CAP intervention will lead to expected performance improvement. The CAP proposal must include one or more quantitative key performance indicator(s) and performance targets for such indicators. The key performance indicators should be interim markers of success anticipated to impact performance on an HQEIP metric; they must be designed to allow for frequent monitoring throughout the duration of a CAP intervention. At least one key performance indicator must relate to eliciting direct member input to inform performance improvement on the targeted HQEIP and/or CAP intervention implementation.
- iii. MassHealth (together with its vendor(s) as applicable) will evaluate (using criteria such as relevance of the intervention to MassHealth members, feasibility of completion within the required time period, appropriateness of key performance indicators, etc.) and approve CAP proposals, requiring proposing hospitals to make modifications prior to approval as necessary to ensure CAP interventions are rigorous and in alignment with programmatic requirements.
- iv. Participating hospitals will implement approved CAP interventions by the end of the given PY, submitting a final report to MassHealth at the end of the PY describing the outcomes of the intervention including performance on key performance indicators.
- v. MassHealth will evaluate CAP final reports to determine performance. Hospitals that achieve targeted key performance indicators will be eligible to earn health equity score "bonus points," to be added to their health equity scores for the PY during which the CAP intervention was conducted. Bonus points (between 5 to 12 absolute percentage points, with the specific amount dependent upon factors such as PY and hospital tier, to be determined at EOHHS' discretion) may only increase a health equity score for the PY up to 100% of the eligible amount for the PY; bonus points may not result in a hospital's health equity score exceeding 100% for the PY.

Together these activities will allow MassHealth to recognize and intervene on deficits in hospital health quality and equity performance with the goal to promote quality and equity for all MassHealth members served by hospitals, regardless of the hospital's initial HQEIP

performance. This framework will support MassHealth to proactively manage performance risks through collaboration with hospitals and active performance management.

Section 5. HQEI Accountability Framework (State Accountability to CMS; Acute Hospital Accountability to the State)

A. State Accountability to CMS for the HQEI for PY 1

The State has structured an accountability framework for the HQEI under which MassHealth is accountable to CMS for statewide achievement of HQEI goals. MassHealth's failure to achieve the standards set for these goals may result in the loss of HQEI expenditure authority according to the at-risk schedule set forth in STC 14.9 and included in Table 8 below.

Table 8. Statewide funding At-Risk by Demonstration Year

| Demonstration Year | DY 27-28 | DY 29 | DY 30 | DY 31 | DY 32 |
|---|------------------------|----------------|----------------|----------------|----------------|
| Performance Year | Q4 2022-Q4 2023 (PY 1) | CY 2024 (PY 2) | CY 2025 (PY 3) | CY 2026 (PY 4) | CY 2027 (PY 5) |
| Funding at-risk for statewide achievement | 5 percent | 15 percent | 20 percent | 25 percent | 25 percent |

STC 14.9(a)(i) establishes the components of statewide accountability calculations. Consistent with STC 14.9, the statewide accountability in the first performance year is described in Table 9 below. Each domain will be assigned a weight for PY 1. The State will calculate the Statewide Accountability Score by multiplying the Score for each State HQEI domain by the associated weight and then summing the totals together. For example, PY Statewide Accountability Score = Domain 1 Score * 20% + Domain 2 Score * 20% + Domain 3 Score * 20% + Statewide Reporting of CMS Health Equity Measures Score * 40%. Statewide Accountability performance will be calculated as described in Table 10.

Table 9. Statewide Accountability to CMS for HQEI Performance in PY 1

Table 9a. Achievement of or improvement toward performance goals on the following measures across participating hospitals (drawn from STC 14.3, 14.4, and 14.5)

| Percent of At-risk funding for PY 1 | Statewide Performance Component |
|-------------------------------------|--|
| 25% | 1) Domain 1: a. 80% of participating hospitals reporting baseline RELDSOGI rates. b. 80% of participating hospitals reporting baseline HRSN rates |
| 25% | 2) Domain 2: Massachusetts reporting to CMS on historical hospital quality data stratified by race and ethnicity as well as by pediatric and adult populations to contribute to informing selection of targeted areas for disparities reduction in subsequent program years |

| Percent of At-risk funding for PY 1 | Statewide Performance Component |
|-------------------------------------|--|
| 25% | 3) Domain 3: 80% of participating hospitals achieve new and revised requirements to reduce health care disparities, specifically, the new standards in The Joint Commission (TJC) Accreditation Leadership (LD) chapter with 6 new elements of performance (EPs). Standard LD.04.03.08 will be effective January 1, 2023. |

Table 9b. Statewide reporting on a selection of metrics agreed upon by CMS and the Commonwealth from the draft CMS Health Equity Measure Slate for DY27 and DY28

| Percent of At-risk funding for PY 1 | Statewide Performance Component |
|-------------------------------------|--|
| 25% | 4) Statewide Reporting for PY 1 on: <ul style="list-style-type: none"> Childhood Immunization Status (CIS-CH) Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD) Controlling High Blood Pressure (CBP-AD) Timeliness of Prenatal Care (PPC-CH and PPC-AD) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD ad FUA-CH)* Follow-up after Hospitalization for Mental Illness (FUH-AD) Cesarean Birth (TJC PC02) |
| N/A | 5) Maternal Morbidity Measure (to be specified by CMS) |

Table 10. Statewide Accountability: Performance Calculations for PY 1

| Statewide Performance Component | PY 1 Performance Calculation |
|--|---|
| 1) Domain 1: <ol style="list-style-type: none"> 80% of hospitals reporting baseline RELDSOGI rates. 80% of hospitals reporting baseline HRSN rates. | <p>Domain 1 performance will be weighted equally across subcomponents a and b, calculated as described below:</p> <p>a. RELDSOGI baseline reporting performance calculation Massachusetts will calculate the percentage of participating hospitals reporting to EOHHS complete baseline RELDSOGI rates for PY1.</p> <ul style="list-style-type: none"> If the Commonwealth meets or surpasses the target of 80% for PY 1, the State will earn a 100% score for this component for PY1. If at least 40% of participating hospitals reporting to EOHHS complete and timely baseline RELDSOGI rates, the State will earn a proportionate score of $((completeness \% / 80 \%) * 100)$ for this component for PY 1. If less than 40% of participating hospitals and report to EOHHS complete and timely baseline RELDSOGI rates, the State will earn a score of 0% for this component for PY 1. <p>b. HRSN baseline reporting calculation</p> |

| Statewide Performance Component | PY 1 Performance Calculation |
|---|---|
| | <p>Massachusetts will calculate the percentage of participating hospitals reporting to EOHHS complete baseline HRSN rates for PY1.</p> <ul style="list-style-type: none"> • If the Commonwealth meets or surpasses the target of 80% for PY 1, the State will earn a 100% score for this component for PY1. • If at least 40% of participating hospitals reporting to EOHHS complete and timely baseline HRSN rates, the State will earn a proportionate score of $((completeness \% / 80 \%) * 100)$ for this component for PY 1. • If less than 40% of participating hospitals and report to EOHHS complete and timely baseline HRSN rates, the State will earn a score of 0% for this component for PY 1. |
| 2) Domain 2: EOHHS reporting to CMS on historical hospital quality data stratified by race and ethnicity to contribute to informing targeted areas for disparities reduction | <p>Massachusetts will report to CMS on historical hospital quality data stratified by race and ethnicity (self-reported and/or imputed) to inform targeted areas for disparities reduction by January 12, 2024. Specifically, the Commonwealth will report stratified performance data at the hospital level for clinical quality metrics that were used in MassHealth quality incentive programs in the three most recent performance years for which data are available for analysis (CY 2019-CY 2021).</p> <ul style="list-style-type: none"> • If the Commonwealth submits a complete report to CMS by January 12, 2024, the Commonwealth will earn a score of 100% for this component for PY 1. |
| 3) Domain 3: 80% of participating hospitals achieve new and revised requirements to reduce health care disparities, specifically, the new standards in the Leadership (LD) chapter with 6 new elements of performance (EPs). Standard LD.04.03.08 will be effective January 1, 2023. | <p>Massachusetts will calculate the percentage of participating hospitals achieving new and revised Joint Commission accreditation requirements (specifically, the new standards in the Leadership (LD) chapter with 6 new elements of performance, Standard LD.04.03.08.)</p> <ul style="list-style-type: none"> • If the Commonwealth meets or surpasses the target of 80% for PY 1, the State will earn a 100% score for this component for PY 1. • If at least 40% of participating hospitals achieve the requirements, the Commonwealth will earn a score of $((completeness \% / 80 \%) * 100)$ for this component for PY 1. • If less than 40% of participating hospitals achieve the requirements, the Commonwealth will earn a score of 0% for this component for PY 1. |
| 4) Statewide Reporting for Performance Year 1 (metrics specified in Table 9) | <p>Massachusetts will report statewide performance on specified metrics to CMS by December 31, 2024.</p> <ul style="list-style-type: none"> • If the Commonwealth submits a complete report of performance on the specified metrics to CMS by December 31, 2024 (allowing for claims runout and processing), the State will earn a score of 100% for this component for PY 1. |
| 5) Maternal Morbidity Measure (to be specified by CMS) | Not applicable |

F. State Accountability to CMS for the HQEI for PY 2-5

STC 14.9(a)(i) establishes the components of statewide accountability calculations. Consistent with this framework, the state proposes statewide accountability for PY 2-5 as described in Table 11. Each component is assigned a weight for each PY as specified. The state will calculate the statewide accountability score by multiplying the score for each state accountability component by the associated weight, summing the totals together, and then adding in any bonus points (earned as described in Table 12).

The statewide accountability score will be used to calculate any reduction in at-risk statewide expenditure authority as follows:

- If the statewide accountability score for a given PY is $\geq 90\%$, there will be no reduction in statewide expenditure authority within that performance year.
- If the statewide accountability score for a given PY is $< 90\%$, any at-risk statewide expenditure authority reduction (as described in Table 5) will be calculated as follows:

At-risk statewide expenditure authority for the PY (in \$)(1 - (statewide accountability score for the PY/100))*

Statewide Accountability Performance Calculations are described in Table 12.

Table 11. Statewide Accountability to CMS for HQEI PY 2-5

| Statewide Accountability Component | HQEIP Domain | Statewide Accountability Measure Category | Statewide Accountability Measure | Statewide Performance Targets | | | | | |
|--|--|---|--|-------------------------------|--------|-----------------|---------------------------|---------------------------|-----------------|
| | | | | PY 2 | PY 3 | WEIGHT (PY 2-3) | PY 4 | PY 5 | WEIGHT (PY 4-5) |
| Achievement of or improvement toward performance goals on a selection of HQEIP metrics | Demographic and HRSN Data | Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity (RELDsOgi) Data Completeness | Completeness of self-reported data for MassHealth members | 40% RE | 80% RE | 20 | 40% RELDsOgi [^] | 80% RELDsOgi [^] | 15 |
| | | Health-Related Social Needs (HRSN) Screening | % of MassHealth members screened for HRSN | 10% | 20% | 7.5 | 30% | 60% | 20 |
| | | | % of hospitals reporting identified HRSN needs | 20% | 40% | 7.5 | 60% | 80% | |
| | Capacity and Collaboration | Patient Experience: Communication, Courtesy, and Respect | % of hospitals reporting member experience data related to cultural competency | 50% | 60% | 10 | 70% | 80% | 10 |
| | | External Standards for Health Equity | % of hospitals achieving The Joint Commission's standards for Health Equity | n/a | 80% | 10 | n/a | 80% | 10 |
| Equitable Quality and Access | Disability Competent Care Competencies | % of hospitals reporting % of staff trained on disability competent care | | 25% | 40% | 7.5 | 55% | 70% | 7.5 |

| Statewide Accountability Component | HQEIP Domain | Statewide Accountability Measure Category | Statewide Accountability Measure | Statewide Performance Targets | | | | | |
|---|--------------|--|--|-------------------------------|--------------|-----------------|--------|--------|-----------------|
| | | | | PY 2 | PY 3 | WEIGHT (PY 2-3) | PY 4 | PY 5 | WEIGHT (PY 4-5) |
| | | Language Access | % of hospitals reporting rate of receipt of interpreter services | 50% | 65% | 7.5 | 80% | n/a | 7.5 |
| Maternal Morbidity Measures | | Disparities Reduction: Follow Up After Hospitalization for Mental Illness (FUH) and Maternal Morbidity Measures (MMM) | % of hospitals successfully implementing Equity Improvement Projects | 80% | 80% | 20 | n/a | n/a | n/a |
| | | | Race & Ethnicity disparities reduction statewide on FUH and MMM (benchmarks to be approved by CMS pending baseline data) | n/a | n/a | n/a | TBD* | TBD* | 20 |
| Achievement of or improvement towards aggregate performance goals on a selection of CMS Health Equity Measure Slate** metrics | | <ul style="list-style-type: none"> Childhood Immunization Status Follow-up After Emergency Department Visit for Alcohol & Other Drug Abuse or Dependence Controlling High Blood Pressure Timeliness of Prenatal Care | Statewide aggregate reporting on selected CMS Health Equity Slate** measures | All measures | All measures | 10 | n/a | n/a | n/a |
| | | | Achieve aggregate performance of >/= National Medicaid xx%ile in the prior performance year or 2023, whichever is lower. | n/a | n/a | n/a | 75%ile | 90%ile | 10 |

* Proposed approach described in Table 12 **Measures drawn from January 2023 draft version of the CMS Health Equity Slate

^CMS and MassHealth may revisit PY 4 and PY 5 targets based on additional information and findings from initial PYs.

Table 12. State Accountability: Performance Calculations for PY 2-5

| Statewide Accountability Component | HQEIP Domain | PY 2-5 Statewide Performance Calculations (Calculation of performance for each PY specified below ²) |
|--|---|--|
| 1) Achievement of or improvement toward performance goals on a selection of HQEIP measures | a. Demographic and Health-Related Social Needs Data | <p>RELDsOGI Completeness</p> <ul style="list-style-type: none"> For PY 2-5, Massachusetts will calculate the percentage of MassHealth Members¹ with complete data for each relevant data element. <ul style="list-style-type: none"> In PY 2-3, completeness will be calculated for Race and Ethnicity data elements In PY 4-5, completeness will be calculated for Race, Ethnicity, Language, Disability, Sexual Orientation and Gender Identity data elements |

| Statewide Accountability Component | HQEIP Domain | PY 2-5 Statewide Performance Calculations (Calculation of performance for each PY specified below ²) |
|--|--|--|
| | | <ul style="list-style-type: none"> ○ For each PY, completeness for each applicable data element for that performance year (each considered a submeasure) will contribute equally to an average completeness for the PY. (For example, for PY 2, statewide performance = (Race submeasure score + Ethnicity submeasure score)/2 ● Calculation of each submeasure that contributes to the measure score for each PY is described below² |
| | | <u>Health-Related Social Needs Screening³</u> <ul style="list-style-type: none"> ● For PY 2-5, Massachusetts will calculate performance for two measures: <ul style="list-style-type: none"> ○ The percentage of MassHealth Members¹ with at least one inpatient discharge within the PY at a participating hospital that were screened for health-related social needs within the performance year ○ The percentage of participating hospitals reporting identified HRSN data to EOHHS. ● Calculation of each submeasure that contributes to the measure score for each PY is described below² |
| b. Capacity and Collaboration | Patient Experience: Communication, Courtesy, and Respect ³ | <ul style="list-style-type: none"> ● For PY 2-5, Massachusetts will calculate the percentage of participating hospitals reporting member experience data related to cultural competency. ● Calculation of the measure score for each PY is described below² |
| | Achievement of External Standards for Health Equity ³ | <ul style="list-style-type: none"> ● For PY 3 and PY 5, Massachusetts will calculate the percentage of participating hospitals that have achieved the Joint Commission's Health Care Equity Certification. ● Calculation of the measure score for each PY is described below² |
| c. Equitable Quality and Access | Disability Competent Care ³ | <ul style="list-style-type: none"> ● PY 2-5, Massachusetts will calculate the percentage of participating hospitals reporting the percent of applicable patient-facing staff that have been trained in disability competent care within the previous 24 months. ● Calculation of the measure score for each PY is described below² |
| | Language Access ³ | <ul style="list-style-type: none"> ● For PY 2-5, Massachusetts will calculate the percentage of participating hospitals reporting the rate of receipt of interpreter services for members with a preferred language other than English according to applicable HQEIP specifications. ● Calculation of the measure score for each PY is described below² |
| | Disparities Reduction: Follow up After Hospitalization for Mental Illness (FUH) and Maternal Morbidity Measures (MMM) ³ | <ul style="list-style-type: none"> ● For PY 2-3, Massachusetts will assess the percentage of participating hospitals successfully implementing ACO-hospital partnered equity-focused equity improvement projects focused on FUH, MMM, and/or another measure as approved by EOHHS (for example, for acute hospitals with neither birthing nor inpatient psychiatric services, EOHHS may allow pursuit of disparities reduction for other quality topics to meet HQEIP performance requirements). Successful implementation will be determined by submission of required quarterly performance deliverables specified in the Equity Improvement Project measure specification resulting in an average score for the measure for the PY across hospitals of at least 60%. ● At least 12 months prior to the start of PY 4, Massachusetts will report available aggregate and race and ethnicity-stratified performance for all included hospitals accountable to disparities reduction on FUH and MMM, propose specific disparity reduction priorities for these metrics (e.g. to reduce the performance disparity between the highest performing racial/ethnic group and one or more other racial/ethnic groups) as well as disparities reduction targets, subject to CMS approval. In addition to the FUH measure, one or more of the MMM will be prioritized for specific disparity reduction priorities and disparities reduction targets. ● For PY 4-5, Massachusetts will calculate statewide performance on the prioritized measures stratified by race and ethnicity in order to measure progress on reducing the specific disparity reduction priorities proposed by MassHealth and approved by CMS prior to PY 4. ● For the purpose of this statewide accountability measure category:³ |
| 2) Maternal Morbidity Measures | | |

| Statewide Accountability Component | HQEIP Domain | PY 2-5 Statewide Performance Calculations (Calculation of performance for each PY specified below ²) |
|---|--------------|---|
| | | <ul style="list-style-type: none"> ○ FUH is the “Follow-Up After Hospitalization for Mental Illness” measure (CMIT #268) ○ MMM are three measures impacting maternal morbidity and mortality relevant to the acute hospital setting: <ul style="list-style-type: none"> ▪ Prenatal and Postpartum care – Postpartum Care (CMIT #581) ▪ Cesarean Birth (CMIT #508 or the Joint Commission measure PC-02) ▪ Severe Obstetric Complications (CMIT #1633) |
| 3) Achievement of or improvement towards aggregate performance goals on a selection of CMS Health Equity Measure Slate metrics | | <p><u>CMS Health Equity Measure Slate Metrics Statewide Performance Calculation</u></p> <ul style="list-style-type: none"> • For PY 2-3, Massachusetts will calculate statewide aggregate performance on the CMS Health Equity Slate Measures specified in Table 9. <ul style="list-style-type: none"> ○ If the Commonwealth submits a complete aggregate performance report to CMS within 12 months following the end of the relevant PY, the Commonwealth will earn a score of 100% for this component. • For PY 4-5, Massachusetts will calculate statewide aggregate national Medicaid performance percentiles for each of the four specified measures. For each PY, the national Medicaid performance percentile for each measure will contribute equally to an average national Medicaid performance percentile for the PY. |

¹ Includes members under 65 years of age with MassHealth as their primary insurance, including those with MassHealth Standard, CommonHealth, CarePlus, and Family Assistance coverage types; excludes members with Medicare or another payer as primary payer.

² For each measure (and/or submeasure) in each PY:

- If the Commonwealth meets the performance target for the PY, the State will earn a 100% score for the measure/submeasure.
- If the Commonwealth meets or surpasses a threshold benchmark of (performance target * 0.25), the State will earn a proportionate score of $((actual\% / target\%) * 100)$ for the measure/submeasure for the PY.
- If the Commonwealth exceeds the performance target for the PY, the State will earn bonus percentage points up to half of the total percentage points designated for the measure/submeasure, awarded on a linear basis for performance exceeding the goal benchmark by up to 10% (i.e. if measure performance exceeds the goal benchmark by 10%, the state will earn bonus points equaling half of the total percentage points awarded for the measure/submeasure; if measure performance exceeds the goal benchmark by 5%, the state will earn bonus points equaling one quarter of the total percentage points awarded for the measure/submeasure)
- If the Commonwealth does not meet or surpass the threshold benchmark of (performance target * 0.25), the State will earn a score of 0% for the measure

³PY2-5 Statewide Performance Calculations for these measures for each given performance year will be based on performance of only those hospitals that are active in that performance year's requirements during the corresponding demonstration year as listed in Table 8. For example, for PY3, only those hospitals that are actively pursuing PY3 requirements would contribute to Statewide Performance Calculations. If an acute hospital is active in the HQEIP, but within Performance Year 3 in a staggered performance year pattern due to its status as a new entrant into the program or because its participation was suspended for a performance period, as such scenarios described in Section 3.B, that hospital would be excluded for the purpose of Statewide Performance Calculations.

G. Acute Hospital Accountability to the State for the HQEIP for PY 1

Regardless of MassHealth's performance with respect to its accountability to CMS, MassHealth will separately hold each participating acute hospital individually accountable for its performance on the HQEIP performance measures.

Total incentive amounts for each hospital for PY 1 will be distributed according to the weighting described in Table 13. Performance expectations for each metric are summarized in Table 4 above and detailed further in relevant technical specifications.

Table 13. PY 1 HQEIP Metric Weights

Table 13a. Domain 1. Demographic and Health-Related Social Needs Data (25%)

| Subdomain | HQEIP Metric (<i>Steward</i>) | PY 1 Weight (%) |
|--|--|-----------------|
| Demographic Data Collection | Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (EOHHS) | 15 |
| Health-Related Social Needs Screening | Health-Related Social Needs Screening (EOHHS/CMS) | 10 |

Table 13b. Domain 2. Equitable Quality and Access (50%)

| Subdomain | HQEIP Metric (<i>Steward</i>) | PY 1 Weight (%) |
|---------------------------|---|-----------------|
| Equity Reporting | Quality Performance Disparities Reduction (EOHHS) | 10 |
| Equity Improvement | Equity Improvement Interventions (EOHHS) | 10 |
| Access | Meaningful Access to Healthcare Services for Individuals with a Preferred Language other than English (EOHHS/OHA) | 10 |
| | Disability Competent Care (EOHHS) | 10 |
| | Disability Accommodation Needs (EOHHS) | 10 |

Table 13c. Domain 3. Capacity and Collaboration (25%)

| Subdomain | HQEIP Metric (<i>Steward</i>) | PY 1 Weight (%) |
|-----------------|---|-----------------|
| Capacity | Achievement of External Standards for Health Equity (EOHHS) | 10 |

| Subdomain | HQEIP Metric (<i>Steward</i>) | PY 1 Weight (%) |
|----------------------|--|-----------------|
| | Patient Experience: Communication, Courtesy, and Respect (<i>EOHHS/AHRQ</i>) | 10 |
| Collaboration | Collaboration (<i>EOHHS</i>) | 5 |

H. Acute Hospital Accountability to the State for the HQEIP for PY 2-5

Regardless of MassHealth's performance with respect to its accountability to CMS, MassHealth will separately hold each participating hospital individually accountable for its performance on the HQEIP performance measures as described in STC 14.6. MassHealth's framework for the HQEIP Performance Assessment Methodology (PAM), which may be adjusted annually as needed (for example, to transition measures from pay-for-reporting to pay-for-performance, accommodate new contextual inputs, address extenuating circumstances impacting performance, etc.), is described below. Measure-specific PAM, including benchmarks, improvement targets and measure score calculation approach, will be described in each measure specification, to be made available on MassHealth's website.²

- i. **Benchmarking:** MassHealth will establish performance targets or benchmarks no later than the start of the first pay-for-performance period for the metric and/or, in accordance with STC 14.6, no later than by July 1, 2025 (whichever is later).
 - a. Benchmarks for quantitative measures will include an attainment threshold and goal benchmark and will be set to apply to the full applicable performance period.
 - b. Establishment of benchmarks will be informed by inputs such as initial HQEIP performance data, historical hospital data/performance, external data/trends, and/or predetermined performance targets determined by MassHealth.
- ii. **Improvement Targets:** MassHealth will establish annual performance improvement targets for performance metrics, as applicable, no later than the start of each pay-for-performance period for the metric and/or, in accordance with STC 14.6, no later than by July 1, 2025 (whichever is later).
 - a. Specific approaches for each measure, defined no later than July 1, 2025, will be intended to apply to the full applicable performance period.
 - i. Before July 1, 2025, annual "meaningful improvement" targets for HRSN screening specifically (as referenced in STC 14.3.d) will be defined each year in annual updates to the technical specifications; after July 1, 2025, annual "meaningful improvement" targets for the remaining years of the demonstration period (including PY 4-5) will be reported to CMS.
 - b. The approaches and actual improvement targets may differ by measure based on factors such as performance trends or type of measure; approaches may include year-over-year self-improvement, gap-to-goal percentage point

² <https://www.mass.gov/masshealth-quality-and-equity-incentive-programs>

increase, absolute percentage point increases, set milestones and/or goals for improvement.

- iii. **Performance Measure Score Calculation:** The performance measure scoring approach will be consistent, as applicable, with other MassHealth incentive programs or other incentive program practices. MassHealth will establish a methodology for performance measure scoring for each measure, to be specified in technical specifications, no later than the first day of the performance period to which the methodology applies.
 - a. **Pay-for-reporting (P4R) measures.** P4R measures will be assessed on a pass/fail basis for which the hospitals who successfully report complete and timely data based on each measure's technical specifications will receive full points or credit for the metric.
 - b. **Pay-for-performance (P4P) measures.** The performance measure scoring and approach will be consistent, as applicable, with other MassHealth incentive programs or other incentive program practices, described below.
 - i. Measure scoring will include the following components for each measure:
 - 1. Attainment points ranging from 0-10 points.
 - 2. Improvement points ranging from 0-10 points.
 - 3. Potential bonus points (with a cap) to ensure all participating hospital have incentive to improve, including high-performing hospitals (required by STC 14.6).
 - ii. Performance measure scores for each measure will be defined as a ratio between 0-1. Scores will be calculated by the sum of the points earned for each measure divided by the maximum number of points allowable for the measure. The maximum number of points allowable for the measure is the sum of the attainment, improvement and potential bonus points with a determined cap. The score will be calculated as follows: *Performance Measure Score = Points earned for each measure / Maximum number of points allowable for the measure.*
 - iii. Some performance measures may have identified sub-measures for which sub-measure performance scores will be calculated in the same manner, but then typically equally weighted to calculate a composite performance measure score. For sub-measures the score is calculated as follows: *Performance Measure Score = Sum of each (Sub-measure Score X Sub-measure Weighting).*
- iv. **Domain Score Calculation:** The domain scoring and approach will, as applicable, be consistent with other MassHealth incentive programs or other incentive program practices. Domain scoring includes the following components:
 - a. Using the predetermined weights specified in Table 14, a domain score will be calculated by taking each performance measure score in the domain and calculating the sum of each performance measure score multiplied by its respective performance measure weight: *Domain Score = Sum of each (Performance Measure Score * Performance Measure Weight).*

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- b. If a hospital is not eligible for a measure (e.g., does not meet the denominator criteria or minimum volume), the weighting will be redistributed equally to the eligible performance measures in the domain.
- v. **Health Equity Score Calculation:** The overall Health Equity Scoring approach will, as applicable, be consistent with other MassHealth incentive programs or other incentive program practices. The overall Health Equity Score includes the following components. Using the predetermined weights specified in Table 14 and STC 14.7, a health equity score will be calculated by taking each domain score and calculating the sum of each domain score multiplied by its respective domain weight: *Health Equity Score = Sum of each (Domain Score * Domain Weight)*. Any bonus points earned through Corrective Action Plans (described in Section 4.B of this Addendum) will then be added to determine the final HQEIP Health Equity Score for the PY, not to exceed 100%. The final Health Equity Score will be used to calculate the participating hospital's earned incentive payment.

Table 14. PY 2-5 HQEIP Metric Weights

| Domain* & Domain Weight (%) | Measure Name | Measure Weight (%) by Performance Year | | | |
|--------------------------------------|---|---|------|------|------|
| | | 2024 | 2025 | 2026 | 2027 |
| DHRSN (25%) | Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness | 10 | 10 | 15 | 15 |
| | Health-Related Social Needs (HRSN) Screening | 15 | 15 | 10 | 10 |
| EQA (50%) | Quality Performance Disparities Reduction | 10 | 10 | 20 | 20 |
| | Equity Improvement Interventions | 10 | 10 | 5 | 5 |
| | Meaningful Access to Healthcare Services for Persons with a preferred language other than English | 10 | 10 | 10 | 10 |
| | Disability Competencies | 10 | 10 | 5 | 5 |
| | Accommodation Needs Met | 10 | 10 | 10 | 10 |
| CC (25%) | Achievement of External Standards for Health Equity | 10 | 10 | 10 | 10 |

| Domain* & Domain Weight (%) | Measure Name | Measure Weight (%) by Performance Year | | | |
|--------------------------------------|---|---|------------|------------|------------|
| | | 2024 | 2025 | 2026 | 2027 |
| | Patient Experience: Communication, Courtesy and Respect | 10 | 10 | 10 | 10 |
| | Collaboration | 5 | 5 | 5 | 5 |
| TOTAL | | 100 | 100 | 100 | 100 |

*DHRSN=Demographic and Health-Related Social Needs Data; EQA=Equitable Quality and Access ; CC=Capacity and Collaboration

Section 6. Analysis & Needs Assessment and Advisory Functions

A. Analysis & Needs Assessment for PY 1

To inform development of the HQEI, including areas for prioritization and improvement, Massachusetts engaged in a robust assessment of needs. Initial program design took into account: 1) an understanding of the population served by the acute hospital program; 2) member and community and other stakeholder quality and equity priorities for the acute hospital program; 3) an assessment of significant health needs amongst the served acute hospital population; 4) an investigation of the acute hospital resources potentially available to address the significant health needs; 5) an evaluation of the impact of historical and current MassHealth programs on quality and equity; and 6) a review of relevant guidance and literature related to promoting quality and health equity in Medicaid programs and within health systems.

Avenues for input included:

1. Strategic planning process to identify MassHealth health equity priorities and member needs.
2. Robust review of data, including:
 - a. Historical acute hospital quality performance data, including stratified by available social risk factors
 - b. Acute hospital utilization data (inpatient and emergency department)
 - c. Equity data from the Massachusetts Department of Public Health
3. Literature review
4. A public request for information related to introducing health equity as a component of value-based care.
5. A public request for information related to strengthening member engagement including to inform health equity programming.
6. Data from surveyed hospitals and health plans related to health equity data collection and use.
7. Recommendations from the EOHHS Quality Measure Alignment Task Force related to health equity data and principles for health equity accountability.

8. Numerous public meetings
9. Regular engagement with acute hospital stakeholders, directly and through professional society and other advocacy groups.

Massachusetts anticipates updating its statewide assessment of needs on an annual basis to inform ongoing program priorities and target areas for performance improvement. In addition to inputs used to inform initial program development, the Commonwealth will also consider, at a minimum:

10. HQEIP interim and annual performance data
11. Findings from HQEIP Needs Assessments conducted by participating hospitals. This Needs Assessment may build on requirements for Community Health Needs Assessments (CHNAs) required to be conducted by non-profit acute hospitals by the Massachusetts Office of the Attorney General. CHNAs include numerous elements, including importantly, identification of health disparities and particular types of health differences that are closely linked with economic, social, or environmental disadvantage as part of their assessment of significant health needs of the community.
12. Ongoing stakeholder engagement, including provider, health system, member, and community engagement.

The hospital-level and statewide needs assessments will inform all aspects of the program, but in particular will inform selection of quality and access metrics for improvement and/or disparities reduction entering into performance in later years of the program.

I. [Analysis & Needs Assessment for PY 2-5](#)

Participating hospitals and MassHealth will leverage needs assessments throughout the PY2-5 performance period to inform and shape HQEIP implementation. Needs assessments conducted by participating hospitals will prioritize target areas of access or quality inequities for interventions. These needs assessments will also serve as a data input for MassHealth's statewide needs assessment to identify priority quality and equity areas and to ensure program implementation is targeted towards addressing those priority areas.

In PY 1, hospitals drew from their recent Community Health Needs Assessments (CHNAs) and Community Health Improvement Plans (CHIPs) to inform HQEIP implementation. CHNAs are required to be conducted by non-profit acute hospitals by the Massachusetts Office of the Attorney General and include numerous elements including, importantly, identification of health disparities and particular types of health differences that are closely linked with economic, social, or environmental disadvantage that contribute to significant health needs of their communities. Participating hospitals must interpret their most recent CHNAs and CHIPs to identify health quality and equity needs relevant to the MassHealth population, and must incorporate their assessment into the hospitals' annual Health Quality and Equity Strategic Plan update.

In PY 2-5, hospitals will be required to report annually to MassHealth on ongoing needs assessment of health quality and equity priorities, including through conduction of triennial CHNA's and annual CHIPs in the context of their required annual Health Quality and Equity Strategic Plan updates. This reporting will be required to be included in participating acute

hospitals' required annual Health Quality and Equity Strategic Plan updates. Hospitals will be required to report on identified quality and equity needs of the MassHealth population, how they are using data on identified needs to inform HQEIP implementation, complementary equity-oriented activities conducted external to the HQEIP that may impact MassHealth populations, and progress towards addressing identified needs. Hospitals will also be required to report on how HQEIP data will inform future CHNAs and CHIPs.

In PY 2-5, MassHealth will continue to assess needs of the MassHealth population in order to inform HQEIP implementation. Needs assessment activities may include review and analysis of inputs such as:

1. MassHealth interim and annual equity performance data from the HQEIP;
2. MassHealth aggregate and stratified quality performance data, including from the MassHealth acute hospital program;
3. MassHealth utilization data, including inpatient, emergency department, and outpatient utilization related to the MassHealth acute hospital program;
4. Public health data on disparities from the Massachusetts Department of Public Health;
5. Data collected from hospitals and other MassHealth providers related to health equity data collection and equity programming, including hospital-level needs assessments;
6. Input provided through public meetings;
7. Input provided by members, providers, advocates, or other interested members of the public, including collected through public forums, specific member engagement forums, or other venues;
8. Input provided by hospital stakeholders, directly and through professional society and other advocacy groups; and
9. Environmental scans.

Collected data will be used to better understand the evolution of quality and equity needs of MassHealth members throughout the duration of the Section 1115 Demonstration period and further to inform implementation of the HQEIP to optimize addressing identified needs.

J. HQEI Advisory Committee

MassHealth will convene and oversee a Hospital Quality and Equity Initiative Advisory Committee (the "HQEIA Committee") that will serve as an advisory group offering expertise in health care quality and equity measurement, quality and equity improvement, and clinical, demographic, and HRSN data used in performance improvement initiatives, and best practices, as set forth in STC 14.23. Final decision-making authority over the demonstration will be retained by MassHealth (with CMS approval, as applicable), although MassHealth will consider all HQEIA Committee recommendations.

As part MassHealth's larger stakeholder engagement strategy, the HQEIA Committee will be part of a group scoped to discuss broader topics including, but not limited to, behavioral health integration, primary care sub-capitation, and care coordination. As such, this HQEIA Committee will bring a variety of stakeholders with broad perspective together, which will support the mission of improving clinical performance of HQEI activities. The HQEIA Committee may be comprised of stakeholders including, but not limited to:

- Advocacy groups
- Providers and provider associations
- Hospitals
- ACOs and Health Plans
- Social Service and Community Partner organizations
- MassHealth members
- Community representatives and/or advocates

At least 30% of HQEIA Committee members will be required to have significant expertise or experience in health quality and equity, including but not limited to employment in health quality and equity in hospitals, in government service, at managed care plans, at health systems, from companies providing health quality and equity services to above listed provider types and managed care plans, and/or lived experience. The state will work to minimize possible conflicts of interest.

K. Independent Assessor

MassHealth will identify an Independent Assessor with expertise in delivery system improvement to assist with HQEI administration, oversight, and monitoring. Broadly over the course of this Section 1115 demonstration, the Independent Assessor, in collaboration with other entities identified by MassHealth as needed (e.g., health quality and equity program management vendor), will review selected proposals, progress reports and other related documents identified for review by MassHealth, to ensure compliance with the approved STCs, the HQEI Implementation Plan, and any applicable Protocols. In PY1 specifically, the Independent Assessor will review the following three planning deliverables: the health quality and equity strategic plans, the RELD SOGI and HRSN Assessments, and self-assessments of staff disability competencies. In PY 2-5, specifically, each year the Independent Assessor will review the Health Quality and Equity Strategic Plan updates, along with one representative deliverable from each of the three HQEI domains, and make recommendations to MassHealth for document approvals. Additionally, once annually, the Independent Assessor will make recommendations to MassHealth for program improvement based on its document review. Final decision-making authority regarding program improvement recommendations rests with MassHealth. However, MassHealth will carefully consider the Independent Assessor's recommendations. MassHealth has the authority to change Independent Assessors at MassHealth's discretion.

Appendix A. List of MassHealth Acute Hospitals by Safety Net Group Tier

| Hospital | Tier |
|---|--------|
| Boston Medical Center | Tier 1 |
| Holyoke Medical Center | Tier 1 |
| Lawrence General Hospital | Tier 1 |
| Mercy Medical Center | Tier 1 |
| Signature Healthcare Brockton Hospital | Tier 1 |
| Baystate Franklin Medical Center | Tier 2 |
| Baystate Medical Center | Tier 2 |
| Baystate Wing Hospital | Tier 2 |
| Berkshire Medical Center | Tier 2 |
| Heywood Hospital | Tier 2 |
| Lowell General Hospital | Tier 2 |
| Martha's Vineyard Hospital | Tier 2 |
| MetroWest Medical Center | Tier 2 |
| Morton Hospital | Tier 2 |
| Noble Hospital | Tier 2 |
| North Shore Medical Center | Tier 2 |
| Shriners Hospitals for Children Boston | Tier 2 |
| Southcoast Hospitals Group | Tier 2 |
| Good Samaritan Medical Center | Tier 2 |
| Holy Family Hospital Inc. | Tier 2 |
| Tufts Medical Center | Tier 2 |
| Anna Jaques Hospital | Tier 3 |
| Athol Memorial Hospital | Tier 3 |
| Beth Israel Deaconess Hospital – Milton | Tier 3 |
| Beth Israel Deaconess Hospital – Needham | Tier 3 |
| Beth Israel Deaconess Hospital – Plymouth | Tier 3 |
| Beth Israel Deaconess Medical Center | Tier 3 |
| Boston Children's Hospital | Tier 3 |
| Brigham and Women's Faulkner Hospital | Tier 3 |
| Brigham and Women's Hospital | Tier 3 |
| Cape Cod Hospital | Tier 3 |
| Cooley Dickinson Hospital | Tier 3 |
| Dana-Farber Cancer Institute | Tier 3 |
| Emerson Hospital | Tier 3 |
| Fairview Hospital | Tier 3 |
| Falmouth Hospital | Tier 3 |
| Harrington Memorial Hospital | Tier 3 |
| HealthAlliance Hospital | Tier 3 |

Attachment J
Hospital Quality and Equity Initiative Implementation Plan
Performance Years 1-5

| Hospital | Tier |
|---|--------|
| Lahey Health - Winchester Hospital | Tier 3 |
| Lahey Hospital and Medical Center | Tier 3 |
| Marlborough Hospital - A member of the UMASS Memorial Health Center | Tier 3 |
| Massachusetts Eye and Ear Infirmary | Tier 3 |
| Massachusetts General Hospital | Tier 3 |
| Melrose Wakefield Hospital (formerly Hallmark Health) | Tier 3 |
| Milford Regional Medical Center | Tier 3 |
| Mount Auburn Hospital | Tier 3 |
| Nantucket Cottage Hospital | Tier 3 |
| New England Baptist Hospital | Tier 3 |
| Newton-Wellesley Hospital | Tier 3 |
| Northeast Hospital (Beverly Hospital) | Tier 3 |
| Saint Vincent Hospital | Tier 3 |
| South Shore Hospital | Tier 3 |
| Saint Anne's Hospital Inc. | Tier 3 |
| St. Elizabeth's Medical Center | Tier 3 |
| Sturdy Memorial Hospital | Tier 3 |
| UMass Memorial Medical Center | Tier 3 |
| Cambridge Health Alliance | N/A |

Appendix B. Overview of the MassHealth Acute Hospital Clinical Quality Incentive Program

MassHealth has had a longstanding commitment to promoting high quality care for its members spanning medical, behavioral health, and long-term services and supports. Specifically, for over a decade, MassHealth has incentivized quality performance for its private acute hospitals (including the single non-state-owned public acute hospital).

For the 1115 waiver renewal period from Calendar Year (CY) 2022 – CY 2027, MassHealth intends to continue and enhance its quality measurement program for acute hospitals, referred to as the Clinical Quality Incentive (CQI) program. The CQI will be implemented under State Plan Authority to provide opportunities for acute hospitals to earn incentives for quality reporting and performance on quality measures pertinent to MassHealth quality priorities. The incentive is designed to reward hospitals for excelling in and improving quality of care delivered to MassHealth members, and is aligned with articulated goals in MassHealth's 2022 Comprehensive Quality Strategy³:

- 1) **Promote better care:** Promote safe and high-quality care for MassHealth members.
- 2) **Promote equitable care:** Achieve measurable reductions in health and health care quality inequities related to race, ethnicity, language, disability, sexual orientation, gender identity, and other social risk factors that MassHealth members experience.
- 3) **Make care more value-based:** Ensure value-based care for our members by holding providers accountable for cost and high quality of patient-centered, equitable care.
- 4) **Promote person- and family- centered care:** Strengthen member and family-centered approaches to care and focus on engaging members in their health.
- 5) **Improve care through better integration, communication, and coordination** across the care continuum and across care teams for our members.

Measures included in the CQI are selected to be disparities-sensitive standard quality metrics aligned with MassHealth quality priorities, including related to preventive, perinatal, and pediatric care; care coordination; care for acute and chronic conditions; and member experience (see Table 1 for example measures for the Acute Hospital Clinical Quality Incentive program for CY 2023; measures to be specified through state plan amendment). Acute Hospitals will earn incentive payments based on improvement towards and achievement of performance targets specified by MassHealth.

³ Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid. MassHealth 2022 Comprehensive Quality Strategy. <https://www.mass.gov/doc/masshealth-2022-comprehensive-quality-strategy-2/download>

Attachment J
 Hospital Quality and Equity Initiative Implementation Plan
 Performance Years 1-5

Table 1. Example Measures for the Acute Hospital Quality Clinical Quality Incentive program for

| Quality Domain | Quality Measure (Steward) |
|--|--|
| Preventive, Perinatal, and Pediatric Care | <ul style="list-style-type: none"> • Cesarean Birth, Nulliparous, Singleton, Vertex (<i>TJC</i>) • Unexpected Newborn Complications in Term Infants (<i>TJC</i>) • Perinatal Morbidity Structural Measure (Includes a survey question that aligns with the CMS 0418 Maternal Morbidity Structural Measure) (<i>EOHHS</i>) • Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (<i>NCQA</i>) • Pediatric All-Condition Readmissions Measure (<i>COEPQM</i>) |
| Care Coordination/Integration | <ul style="list-style-type: none"> • Reconciled Medication List Received by Discharged Patient (<i>CMS</i>) • Transition Record with Specified Data Elements Received by Discharged Patient (<i>CMS</i>) • Timely Transmission of Transition Record within 48 hours at Discharge (<i>CMS</i>) • Plan All-Cause Readmissions Adult (7 day and 30 day) (<i>NCQA</i>) • Follow-up After ED Visit for Mental Illness (7 day and 30 day) (<i>NCQA</i>) • Follow-Up After ED Visit for Alcohol or Drug Abuse or Dependence (7 day and 30 day) (<i>NCQA</i>) • Follow-up After Hospitalization for Mental Illness (7 day and 30 day) (<i>NCQA</i>) |
| Care for Acute and Chronic Conditions | <ul style="list-style-type: none"> • Alcohol Use – Brief Intervention Provided or Offered (<i>TJC Sub-2</i>) • Alcohol & Other Drug Use Disorder – Treatment Provided/Offered at Discharge (<i>TJC Sub-3</i>) • Safe Use of Opioids – Concurrent Prescribing (<i>CMS</i>) • Medication Continuation Following Inpatient Psychiatric Discharge (<i>CMS</i>) • Screening for Metabolic Disorders (<i>CMS</i>) |
| Patient Safety | <ul style="list-style-type: none"> • PSI-90: Patient Safety and Adverse Events Composite (<i>AHRQ</i>) • HAI: CLABSI, CAUTI, MRSA, CDI, SSI (<i>CDC</i>) |
| Patient Experience | <ul style="list-style-type: none"> • HCAHPS: Hospital Consumer Assessment of Healthcare Provider Systems Survey (<i>AHRQ</i>). Includes 7 survey dimensions: 1) nurse communication, 2) doctor communication, 3) responsiveness of hospital staff, 4) communication about medicines, 5) discharge information, 6) overall rating and 7) three item care transition. |

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Appendix C. Cambridge Health Alliance Hospital Quality and Equity Incentive Program

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Section 1. Overview of Massachusetts' Statewide Approach to Advance Healthcare Quality and Equity

A. Overview

An overview of Massachusetts' statewide approach to advance healthcare quality and equity that pertains to the Cambridge Health Alliance Hospital Quality and Equity Incentive Program (CHA-HQEIP) is included in the Hospital Quality and Equity Initiative (HQEI) Performance Year (PY) 1-5 Implementation Plan (referred to in this Appendix C as "Attachment J"), Section 1.A.

B. Scope of Appendix C

Attachment J provides additional detail related to implementation of the Commonwealth's HQEI, beyond those requirements set forth in the MassHealth Medicaid and CHIP Section 1115 Demonstration Special Terms and Conditions (STCs). Attachment J applies during the performance years of the demonstration Approval Period (October 1, 2022 – December 31, 2027).

This Appendix C provides additional detail related to implementation of the Cambridge Health Alliance Hospital Quality and Equity Incentive Program (CHA-HQEIP), a component of the HQEI.

Section 2. Cambridge Health Alliance Hospital Quality and Equity Incentive Program (CHA-HQEIP) Design and Goals

A. Overview of Targeted Domains for Improvement in the CHA-HQEIP

For the CHA-HQEIP, Cambridge Health Alliance (CHA) will implement a program to improve health care quality and equity and develop interventions for both its Medicaid population and the uninsured individuals it serves (described in STC 14.16 and 14.17). Further, it will address both hospital and ambulatory performance (described in STC 14.17).

1. Hospital Performance Component of the CHA-HQEIP

As specified in STC 14.17(a), seventy percent of the incentive payment for CHA will be allocated to CHA's reporting and/or performance on the HQEIP domains, described in Attachment J, Section 2.A. CHA will be held to an aligned improvement methodology, measure selection, and benchmarking methodology for Medicaid beneficiaries as established in STC 14.6 for private acute hospitals. However, in addition to the Medicaid population, CHA will also be held responsible for the served uninsured patient population within its service area, which will be measured separately. Recognizing adaptation necessary for an uninsured population, the specific applicable domain elements, weighting, measurement, performance assessment methodology, and attribution methodology for the uninsured population for PY 1-5 are described in this Appendix C.

2. Ambulatory Performance Component of the CHA-HQEIP

As specified in STC 14.17(b), thirty percent of the incentive payment for CHA will be allocated to CHA's reporting and/or performance on ambulatory quality measures for the served uninsured population and payment may be based on both overall improvement and disparities reduction on those measures. The details for the methodology and measures for PY 1-5 are described in this Appendix C.

Section 3. CHA-HQEIP Conceptual Framework and Performance Year (PY) Metrics

A. Conceptual Framework

An overview of the conceptual framework that pertains to CHA-HQEIP is included in Attachment J, Section 3.A.

B. Hospital Performance Component of the CHA-HQEIP: Metrics and Reporting Requirements for PY 1

To establish a robust foundation for quality and equity improvement and to begin making progress towards five-year HQEI domain goals, the first performance year of the CHA-HQEIP hospital performance component will hold CHA accountable to metrics (listed in Table 1) evaluating contributory health system level interventions in each CHA-HQEIP domain. These metrics and associated reporting and performance expectations (described in Table 2) were developed with input from health systems and providers through requests for information and comment, public meetings, and ongoing stakeholder engagement.

Table 1. PY 1 Metrics for the Hospital Performance Component of the CHA-HQEIP

Table 1a. Domain 1. Demographic and Health-Related Social Needs Data

| Subdomain | Metric (Steward) | PY 1 Status* |
|--|--|-------------------------|
| Demographic Data Collection | Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (EOHHS) | Pay for Reporting (P4R) |
| Health-Related Social Needs Screening | Screening for Social Drivers of Health (CMS): Preparing for Reporting Beginning in PY 2 | P4R |

*Reporting requirements for each measure described in relevant technical specifications.

Table 1b. Domain 2. Equitable Quality and Access

| Subdomain | Metric (Steward) | PY 1 Status* |
|---------------------------|--|--------------|
| Equity Reporting | Stratified Reporting of Quality Data (EOHHS) | P4R |
| Equity Improvement | Equity Improvement Interventions (EOHHS) | P4R |

| Subdomain | Metric (<i>Steward</i>) | PY 1 Status* |
|-----------|---|--------------|
| Access | Meaningful Access to Healthcare Services for Persons with a preferred language other than English (Oregon Health Authority) | P4R |
| | Disability Competencies (<i>EOHHS</i>) | P4R |
| | Accommodation Needs Met (<i>EOHHS</i>) | P4R |

*Reporting requirements for each measure described in relevant technical specifications.

Table 1c. Domain 3. Capacity and Collaboration

| Subdomain | Metric (<i>Steward</i>) | PY 1 Status* |
|---------------|---|--------------|
| Capacity | Achievement of External Standards for Health Equity (<i>EOHHS</i>) | P4R |
| | Patient Experience: Communication, Courtesy and Respect (<i>AHRQ</i>) | P4R |
| Collaboration | Joint Accountability for Partnered ACO Performance (<i>EOHHS</i>) | P4P |

*Reporting requirements for each measure described in relevant technical specifications.

Recognizing that taking on accountability for equity is new for most acute hospitals serving MassHealth members, all metrics are in pay-for-reporting status in PY 1. Interim and annual reporting requirements for PY 1 are designed to promote essential foundational capacity and readiness to assume progressive risk for health quality and equity performance in PY 2 through PY 5. Table 2 summarizes PY 1 reporting/performance expectations for the hospital performance component of the CHA-HQEIP.

In general, measures included in the CHA-HQEIP will closely align with specifications for the HQEIP for the majority of measures, adapted minimally to additionally encompass both the Medicaid population and CHA's served uninsured population. For two measures, the **Stratified Reporting of Quality Data** and the **Meaningful Access to Healthcare Services for Persons with a Preferred Language Other than English** metrics, EOHHS will make additional adaptations specific to the CHA-HQEIP, as follows:

- 1) For both metrics, EOHHS will allow CHA to annually report population-based electronic measures (drawn from the electronic health record) in lieu of chart-abstraction/sampling. This is aligned with EOHHS' goals toward population-based data collection. Measures will be submitted following the PY utilizing an EOHHS-approved template consistent with the CMS and Joint Commission portal fields used for e-measures.
- 2) For the **Stratified Reporting of Quality Data** metric, EOHHS will allow CHA to report on the HQEIP measure set with adaptations (described below and detailed in the technical specifications). EOHHS is allowing these adaptations because CHA does not

participate in the Clinical Quality Incentive (CQI) program from which initial hospital-based health equity measures are drawn for PY 1. Specifically:

- a. EOHHS will allow CHA to substitute Tobacco Use Screening and Treatment Measures (TOB 1-3, listed below) in lieu of CCM Measures (CCM 1-3). These replacement measures will be reported separately for the Medicaid and served uninsured patient populations:
 - Tobacco Use Screening (TOB-1) (*NQF 1651, Joint Commission*) (for CHA medical, surgical, and maternity inpatient units)
 - Tobacco Use Treatment Provided or Offered (TOB-2) (*NQF 1654, Joint Commission*) (for CHA medical, surgical, and maternity inpatient units)
 - Tobacco Use Treatment Provided or Offered at Discharge (TOB-3) (*NQF 1656, Joint Commission*) (for CHA medical, surgical, and maternity inpatient units).

The tobacco measures are an area of particular interest to EOHHS relative to the Medicaid population. The Joint Commission sets forth compelling rationale for a focus on these interventions. Tobacco use is the single greatest cause of disease in the United States, according to the Centers for Disease Control and Prevention.⁴ Smoking is a known cause of cancer, heart disease, stroke, complications of pregnancy, chronic obstructive pulmonary disease, other respiratory problems, poorer wound healing, and many other diseases.⁵ Evidence-based tobacco dependence interventions – brief clinician advice, individual, group, or telephone counseling, and use of FDA-approved medications – are both clinically and cost effective in reducing the risk of tobacco-related disease and improving outcomes for those already experiencing a tobacco-related disease.⁶ Hospitalization is an opportunity to provide cessation assistance.

- b. EOHHS will allow CHA to report the same hospital-based quality measures for the Medicaid and served uninsured patient populations with the exception of the perinatal measures, which will be reported for the Medicaid population only

⁴ Centers for Disease Control and Prevention. (2014). *Current cigarette smoking among adults—United States, 2005–2013*. Morbidity and Mortality Weekly Report (MMWR), 63(47), 1108–1112. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6347a4.htm?s_cid=mm6347a4_w.

⁵ U.S. Department of Health and Human Services. (2014). *The health consequences of smoking—50 years of progress: A report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved from <http://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf>.

⁶ Rigotti, N. A., Clair, C., Munafo, M. R., & Stead, L. F. (2012). *Interventions for smoking cessation in hospitalised patients*. Cochrane Database of Systematic Reviews. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/22592676>. U.S. Department of Health and Human Services. (2008). *Tobacco use and dependence guideline panel. Treating tobacco use and dependence: 2008 update*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK63952/>. U.S. Department of Health and Human Services. (2000). *Reducing tobacco use: A report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

(since served uninsured patients are likely to become eligible for Medicaid if they are pregnant and are anticipated to be captured in the Medicaid population). For the served uninsured population, in lieu of perinatal measures, CHA will report Follow-up After Hospitalization (for medical and surgical discharges), which is an important indicator for served uninsured patients.

- c. 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.

Approved technical specifications for the CHA-HQEIP PY1 metrics will be made available through the Commonwealth's website and describe measure requirements in more detail.⁷

Table 2. CHA-HQEIP Hospital Component adaptations to HQEIP reporting/performance requirements for PY 1

Table 2a. Domain 1. Demographic and Health-Related Social Needs Data -- Reporting/Performance Requirements for PY 1 & Anticipated Due Dates

| Metric | HQEIP Requirements | Adapted Requirements for the CHA-HQEIP, if any |
|---|--|---|
| Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (EOHHS) | Timely (anticipated by December 31, 2023, or a later date as specified by Massachusetts) submission to the Massachusetts Center for Health Informatics and Analysis of the “ <i>Enhanced Demographics Data File</i> ,” defined as the file including member-level demographic (including race, ethnicity, language, disability, sexual orientation, and gender identity) data collected by hospitals from MassHealth members during inpatient stays and/or emergency department visits during the Performance Year. | CHA will submit a single file for Medicaid and served uninsured patients for this metric |
| Screening for Social Drivers of Health (CMS): Preparing for Reporting Beginning in PY 2 | Complete and timely (December 1, 2023) submission of a report to EOHHS describing: 1) One or more HRSN screening tool(s) selected by the hospital for intended use in screening patients beginning in PY 2; the selected tool(s) must meet requirements for screening | CHA will submit one report covering the Medicaid and served uninsured patient population for this metric, which will include a section discussing |

⁷ <https://www.mass.gov/masshealth-quality-and-equity-incentive-programs>

| Metric | HQEIP Requirements | Adapted Requirements for the CHA-HQEIP, if any |
|--------|---|--|
| | <ul style="list-style-type: none"> tools for the “Screening for Social Drivers of Health” metric; and 2) A plan to begin screening for HRSN in inpatient settings in Q1 CY 2024 in order to have capacity to report on the “Screening for Social Drivers of Health” metric beginning in PY 2. | aspects specific to the served uninsured population. |

Table 2b. Domain 2. Equitable Quality and Access -- Reporting/Performance Requirements for PY 1 & Anticipated Due Dates

| Metric | HQEIP Requirements | Adapted Requirements for the CHA-HQEIP, if any |
|---|--|--|
| Stratified Reporting of Quality Data (EOHHS) | Complete and timely (anticipated by a date following December 31, 2023 , to be determined by EOHHS) submission to EOHHS of performance data including member-level race and ethnicity for clinical measures selected by EOHHS for stratification from the Clinical Quality Incentive (CQI) measure slate and as described in Section 3.B of this Appendix C. | CHA will separately report stratified quality measures for the Medicaid and served uninsured patient population. See technical specifications related to the filing of population-based electronic measures and adaptations with aligned measures. |
| Equity Improvement Interventions (EOHHS) | <p>Complete and timely submission of quarterly deliverables for at least one ACO-partnered Performance Improvement Plan (PIP) as follows:</p> <ol style="list-style-type: none"> 1) Q1: Complete and timely (anticipated by March 31, 2023) submission to EOHHS of Hospital Key Personnel/Institutional Resources Document 2) Q2: Complete and timely (anticipated by July 21, 2023) submission to EOHHS of the PIP Partnership Form | CHA will develop the PIP related to the Medicaid ACO population. It is not applicable for the served uninsured patient population. |

| Metric | HQEIP Requirements | Adapted Requirements for the CHA-HQEIP, if any |
|--|---|---|
| | <p>3) Complete and timely (anticipated by September 30, 2023) submission to EOHHS of the ACO Key Contact Form and the Mid-Year Planning Report</p> <p>Complete and timely (anticipated by December 31, 2023) submission to EOHHS of the PIP Planning/Baseline Report, a comprehensive plan that incorporates information about PIP goals and objectives, baseline data, proposed interventions, and tracking measures. The PIP Planning/Baseline Report will serve as the blueprint for PIP Implementation in PY 2.</p> | |
| Meaningful Access to Healthcare Services for Persons with a Preferred Language Other than English (Oregon Health Authority) | <p>Complete and timely (anticipated by December 31, 2023, or an earlier date specified by EOHHS) reporting of an organizational self-assessment of capacity related to providing access to high quality language services to patients.</p> | <p>None for PY 1</p> <p>Note: EOHHS expects to require CHA to separately report percent of member visits with interpreter needs in which interpreter services were provided for the Medicaid and served uninsured patient populations, beginning in PY 2.</p> |
| Disability Competencies (EOHHS) | <p>Complete and timely (anticipated by December 1, 2023) submission to EOHHS of the following: The Hospital's DCC Team's completed Resources for Integrated Care (RIC) Disability-Competent Care Self-Assessment Tool (DCCAT)¹ Report that includes the following:</p> <p>5) The members that composed the Hospital's Disability Competent Care (DCC) Team. The members included on the Hospital's DCC Team can be decided by the hospital and which should</p> | <p>CHA will submit one file the Medicaid and served uninsured patient population for this metric.</p> |

| Metric | HQEIP Requirements | Adapted Requirements for the CHA-HQEIP, if any |
|--------|--|--|
| | <p>represent a reasonable mix of clinical and non-clinical patient-facing staff from different clinical departments. Further, we strongly recommend including individuals with disability on the Hospital's DCC Team.</p> <p>6) The summary results from the Hospital DCC Team's DCCAT-Hospital tool exercise. Hospitals will have freedom to further modify the 'base' DCCAT-Hospital Tool, e.g., remove, change, or add new questions so long as the hospital submits documentation of (as part of their report) the modifications made along with the reason(s) for the modification(s).</p> <p>7) Informed by the results of the DCCAT-Hospital tool exercise above, hospitals will identify at least three (of seven) Disability Competent Care (DCC) Model Pillars that the hospital plans to target for improvement beginning in PY 2, based on interpretation of the results from this exercise.</p> <p>8) Lessons learned in narrative form by the hospital by creating this team and completing this DCCAT self-assessment exercise.</p> <p>Complete and timely (anticipated by December 1, 2023) submission to EOHHS of a plan for improving competency in targeted competency areas during PY 2, including:</p> <p>4) selected training tools and/or educational resources,</p> <p>5) which staff that will be assessed for post-educational/training competency, and</p> <p>6) approaches that will be used to assess post-education/training organizational and staff competency.</p> | |

| Metric | HQEIP Requirements | Adapted Requirements for the CHA-HQEIP, if any |
|--|--|--|
| | <p>This plan must describe how the hospital will be prepared to begin reporting performance in PY 2 on a process measure (in development by EOHHS) beginning in PY 2 that assesses the percent of patient-facing staff demonstrating competency in targeted competency areas for improvement.</p> | |
| Accommodation Needs Met (EOHHS) | <p>Complete and timely (anticipated by December 1, 2023) submission to EOHHS of a report describing the hospital's current practice and future plans for the following:</p> <ol style="list-style-type: none"> 1) screening patients for accommodation needs** before or at the start of a patient encounter, and how the results of this screening is documented. 2) other methods, if any, for documenting accommodation needs. 3) asking patients, at or after the end of a patient encounter, if they felt that their accommodation needs were met. 4) analyses that are performed at the organizational level to understand whether accommodation needs have been met. <p><i>** For this report, accommodation needs are needs related to a disability, including disabilities as a result of a physical, intellectual, or behavioral health condition. For this report, this does not include needs for language interpreters, but does include accommodation needs for vision impairments (e.g., Braille) or hearing impairments (e.g., ASL interpreters).</i></p> | <p>CHA will submit one report covering the Medicaid and served uninsured patient population for this metric.</p> |

| Metric | HQEIP Requirements | Adapted Requirements for the CHA-HQEIP, if any |
|---|---|--|
| Achievement of External Standards for Health Equity (EOHHS) | <p>Complete and timely (anticipated by December 31, 2023) submission to EOHHS of an attestation that the hospital has completed The Joint Commission (TJC) surveys for health equity accreditation standards (specifically, 6 new elements of performance in the Leadership (LD) chapter, Standard LD.04.03.08.)</p> | <p>CHA will submit one attestation for this metric.</p> |
| HCAHPS: Patient Experience: Communication, Courtesy and Respect (AHRQ) | <p>Complete and timely (anticipated by a date following December 31, 2023 to be determined by EOHHS) submission to EOHHS of HCAHPS survey results for any MassHealth members participating in the hospital's HCAHPS survey sample during PY 1.</p> | <p>CHA will submit HCAHPS survey results related to MassHealth members for this metric.</p> |
| Joint Accountability for ACO Performance (EOHHS) | <p>In order to promote collaboration and coordinated interventions to promote health equity across health system settings and across the spectrum of ambulatory and inpatient care, acute hospitals will be required to partner with at least one and no more than two ACO(s) (identified as “Partnered ACO(s)”) serving a shared population in order to augment impact on health equity. To incentivize shared investment and goals across ACO and hospital entities, hospitals’ performance in this subdomain for PY 1 will equal its Partnered ACO’s Health Equity Score; if the hospital has more than one ACO Partner then its subdomain score will equal the average of each Partnered ACO’s Health Equity Score.</p> <p>Partnered ACOs will be held accountable for health equity performance in the same domains as their Partnered Hospitals, tailored to the ACO setting:</p> <ul style="list-style-type: none"> • Demographic data completion • HRSN screening and referrals | <p>CHA will participate in this metric for its MassHealth ACO members. It is not applicable for the served uninsured patient population.</p> |

| Metric | HQEIP Requirements | Adapted Requirements for the CHA-HQEIP, if any |
|--------|---|--|
| | <ul style="list-style-type: none">• Stratified Reporting of Quality Data• Equity Improvement Interventions• Language Access• Disability Access and Accommodation• Achievement of External Standards for Health Equity• Member Experience: Cultural Competency <p>Each of these accountability components will contribute to the ACO's Health Equity Score.</p> | |

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

MassHealth will score CHA on each measure unless it does not meet eligibility requirements for a specific measure (e.g., it does not meet the minimum denominator requirement or other technical requirements). If this occurs, the weight attributed to such a measure will be redistributed equally to other measures in the same domain. Beginning in PY3, if CHA is unable to meet the minimum denominator or other technical requirements for at least 50% of the measures on the CHA-HQEIP metrics slate and 50% of the Ambulatory performance metrics slate for a performance period, CHA's participation in the CHA-HQEIP will be suspended for that performance period. CHA may resume participation when it is able to meet the minimum denominator or other technical requirements for at least 50% of the measures on the CHA-HQEIP metrics slate and 50% of the Ambulatory performance metrics slate, provided that such participation shall begin at the start of the subsequent performance period and provided that the CHA will be held accountable for the performance year requirements immediately following the last performance year in which CHA participated.

C. Ambulatory Performance Component of the CHA-HQEIP: Metrics and Reporting Requirements for PY 1

For the ambulatory performance component of the CHA-HQEIP, the targeted population includes MassHealth members and the “served uninsured population” defined as patients

who received at least one primary care visit from CHA during the performance year who have:

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

Ambulatory performance will be demonstrated in three domains, aligned with HQEIP and CHA-HQEIP hospital component domains, during PY 1. Performance metrics expectations for the ambulatory performance component of the CHA-HQEIP are described below and in Table 3; additional detail related to performance metrics is provided in ambulatory metric technical specifications for the CHA-HQEIP.

1. **Ambulatory Domain 1: Health-Related Social Needs**

CHA will be assessed on improvements to address the health-related social needs of the served uninsured patient population in the public hospital's primary care system.

2. **Ambulatory Domain 2: Equitable Quality and Access**

CHA will be assessed on improvements in three areas of equitable access and quality:

- **Ambulatory Quality Reporting and Performance:** CHA will be assessed on performance reporting of ambulatory quality and access metrics for the served uninsured population in the public hospital's primary care system. Measure categories include: 1) Wellness, Prevention, and Screening 2) Chronic Health Conditions; 3) Access; and 4) Outreach & Care Coordination. Initial measures for stratification in PY 1 are identified in Table 3. Based on the initial development of measures in PY 1 and ongoing findings, adjustments and/or replacement measures may be proposed in future years based on the findings, denominator size, assessment of opportunities, etc., for incorporation in PY 2 - 5.
- **Ambulatory Quality Improvement Initiative(s):** CHA will develop performance improvement milestone(s) that address inequities in the served uninsured patient population. Projects may include healthcare delivery system intervention(s) on defined ambulatory measure(s) or underserved geographic-based or patient population intervention(s). Milestones to be completed include pre-approved initiative elements, a submitted mid-point assessment report, and a final achievement report. The final achievement report will be adjudicated and scored by EOHHS following the end of the performance year.
- Additionally, CHA will identify and measure progress towards disparities reduction on a subset of identified ambulatory measures during the progression of the demonstration period, with pay-for-performance on disparities reduction achievement on a subset of measures no earlier than PY 4.

3. Ambulatory Domain 3: Capacity and Collaboration

CHA will be assessed on improvement in metrics such as collaboration between health system partners and the community to address opportunities for health care for the served uninsured and underserved patient populations.

Table 3. CHA-HQEIP Ambulatory Performance Component: PY 1 Metrics and Summary of Performance Expectations

Table 3a. Ambulatory Domain 1. Health-Related Social Needs

| CHA-HQEIP Ambulatory Performance Domain | Metric | Performance Expectations for PY 1 (Status) |
|---|--|--|
| Health-Related Social Needs | Resource Listing to Respond to Health-Related Social Needs for the Underserved: Submission to EOHHS of an updated resource listing and description of workflows for referral to resources to address health-related social needs, including for underserved populations. | Complete and timely (anticipated by December 1, 2023) submission of a health-related social needs resource listing and overview. (P4R) |

Table 3b. Ambulatory Domain 2. Equity Quality and Access

| CHA-HQEIP Ambulatory Performance Domain | Metric | Performance Expectations for PY 1 (Status) |
|---|---|---|
| Ambulatory Quality Reporting and Performance | Reporting of Ambulatory Quality Data for Served Uninsured Patients in public hospital's primary care system: <ul style="list-style-type: none"> Well-Child Visits in the First 30 Months of Life Child and Adolescent Well Care Visit Childhood Immunization (CIS-CH) Immunization for Adolescents Cancer Screening Measure(s) TBD Hypertension: Controlling high blood pressure (CBP-AD) Comprehensive Diabetes Care: Poor Control (>9%) (HPC-AD) Achieve Outreach to Defined % of New or Past Due Served Uninsured Patients in Primary Care Panel Population Diabetes & Hypertension Education | Complete and timely (by March 30, 2024) submission to EOHHS of ambulatory quality measure performance data for served uninsured patients in the public hospital's primary care system for the ambulatory measures in Table 6. (P4R) |

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| CHA-HQEIP Ambulatory Performance Domain | Metric | Performance Expectations for PY 1 (Status) |
|---|--|--|
| | Depression Screening and Follow-up | |
| Ambulatory Quality Improvement Initiatives | <p>Needs Assessment and Analysis of Served Uninsured Patient Population: Gather information and assess opportunities for improving care delivery for the served uninsured, such as through data, patient and provider focus groups/interviews, incorporating information from the public hospital system's recent community regional well-being assessment to inform future year efforts.</p> | <p>Complete and timely (anticipated by December 1, 2023) submission to EOHHS of a needs assessment report and analysis of the served uninsured patient population which may include: Information gathered and assessment of opportunities for improving care delivery for the served uninsured, such as through data, patient and provider focus groups/interviews and incorporating information from the public hospital system's recent community regional wellbeing assessment to inform future year efforts. (P4R)</p> |
| Ambulatory Quality Improvement Initiatives | Equity Improvement Intervention | Complete and timely submission of deliverables for one Performance Improvement Project Plan milestone for implementation |

| CHA-HQEIP Ambulatory Performance Domain | Metric | Performance Expectations for PY 1 (Status) |
|---|--------|--|
| | | beginning in PY 2 as follows: Complete and timely (by December 31, 2023) submission to EOHHS of the Performance Improvement Project Plan Milestone Planning Report |

Table 3c. Ambulatory Domain 3. Capacity and Collaboration

| CHA-HQEIP Ambulatory Performance Domain | Metric | Performance Expectations for PY 1 (Status) |
|---|---|--|
| | Completion of Supplement to the Health Equity Strategic Plan | Complete and timely (by December 31, 2023) submission to EOHHS of a supplement to the required Health Equity Strategic Plan (EOHHS) specifically addressing the health equity strategy for the served uninsured population. (P4R) |

D. Hospital Performance Component of the CHA-HQEIP: Metrics for PYs 2-5

Performance years 2-5 of the CHA-HQEIP will hold CHA accountable to metrics (listed in Table 4) evaluating performance in each CHA-HQEIP domain. These metrics were developed with input from health systems and providers through requests for information and comment, public meetings, and ongoing stakeholder engagement. In the event that a measure is retired by a measure steward for any reason, Massachusetts will replace the impacted measure, choosing from a CMS-approved measure that is already widely adopted within Massachusetts (or for which reliable data to establish a valid benchmark and performance changes are readily available) and supported by the findings from analysis and/or needs assessments. Approved technical specifications for the CHA-HQEIP PY2-5 metrics may be

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updated annually or more frequently as necessary and will be made available through the Commonwealth's website.

Table 4. PY 2-5 Metrics for the Hospital Performance Component of the CHA-HQEIP

| Domain* | Measure Name | Measure Description | Data Source | Measure Steward [^] | Payment Status** | | 2024 | 2025 | 2026 | 2027 |
|---------|---|---|-----------------------------|------------------------------|------------------|------|------|------|------|------|
| | | | | | 2024 | 2025 | | | | |
| DHRSN | Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness | Percentage of members with acute hospital discharge within the measurement year with self-reported RELDSOGI data. | Administrative/Supplemental | EOHHS | R | P | P | P | | |
| | Health-Related Social Needs (HRSN) Screening | Two rates: 1) HRSN Screening Rate: Percentage of acute hospital discharges where members were screened using a standardized health-related social needs (HRSN) screening instrument for food, housing, transportation, and utility needs; 2) HRSN Screen Positive Rate: Rate of HRSN identified by HRSN screening associated with acute hospital discharges in Rate 1. | Supplemental | EOHHS (CMS [~]) | R | P | P | P | | |
| EQA | Quality Performance Disparities Reduction | Acute hospital progress towards reducing racial and ethnic disparities in quality performance. Quality measure identified for inclusion in this measure are disparities-sensitive measures in the areas of coordination of care, perinatal health, and/or care for acute and chronic conditions. | Administrative/Supplemental | EOHHS | R | R | P | P | P | |
| | Equity Improvement Interventions | Assessment of rigorous design and implementation of two equity-focused performance improvement projects (PIPs) focused on coordination of care, perinatal health, and/or care for acute and chronic conditions. | Supplemental | EOHHS | P | P | P | P | P | |
| CC | Meaningful Access to Healthcare Services for Persons with a Preferred Language Other than English | Two components: 1) Language Access Self-Assessment Survey: Completion and reporting of a language access self-assessment survey; and 2) Addressing Language Access Needs in Acute Hospital Settings: Percentage of acute hospital stays serving members who report a preferred language other than English during which either interpreter services or an in-language service provider were utilized. | Administrative/Supplemental | EOHHS (OHA [^]) | R | P | P | P | P | |
| | Disability Competent Care | 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 hospital in its DCC Training Plan Report and 2) demonstrated competency in the relevant disability competency training area(s). | Supplemental | EOHHS | P | P | P | P | P | |
| | Disability Accommodation Needs | Percentage of acute hospital discharges and/or encounters where 1) members with disability were screened for accommodation needs related to a disability, and, 2) for those members screening positive for accommodation needs, a corresponding member-reported accommodation need was identified. | Supplemental | EOHHS | R | P | P | P | P | |
| | Achievement of External Standards for Health Equity | Assessment of whether acute hospitals have achieved standards related to health equity established- by The Joint Commission for its "Health Care Equity Certification." | Supplemental | EOHHS | R | P | P | P | P | |
| | Patient Experience: Communication, Courtesy and Respect | Assessment of MassHealth member perceptions of their hospital experience utilizing reported elements of the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey for patients' perspectives of hospital care experience related to communication, courtesy, and respect. . | Supp/Survey | EOHHS | R | P | P | P | P | |
| | Collaboration | Assessment of participating acute hospital collaboration with health system partners to promote high quality and equitable care. | Supplemental | EOHHS | P | P | P | P | P | |

*DHRSN=Demographic and Health-Related Social Needs Data; EQA=Equitable Quality and Access ; CC=Capacity and Collaboration; ** R=Pay-for-Reporting, P=Pay-for-Performance

[^] EOHHS=Massachusetts Executive Office of Health and Human Services; CMS=Centers for Medicare & Medicaid Services; OHA=Oregon Health Authority[~] Adapted for HQEIP use from CMS "Screening for Social Drivers of Health" and "Screen Positive Rate for Social Drivers of Health" metrics

In general, measures included in the CHA-HQEIP closely align with specifications for the HQEIP for the majority of measures, adapted minimally to additionally encompass both the Medicaid population and CHA's served uninsured population.⁸ For two measures, the **Quality Performance Disparities Reduction** and the **Meaningful Access to Healthcare Services for Persons a Preferred Language Other than English** metrics, EOHHS will make additional adaptations specific to the CHA-HQEIP, as follows:

- 3) For both metrics, EOHHS will allow CHA to annually report population-based electronic measures (drawn from the electronic health record) in lieu of chart-abstraction/sampling. 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.
- 4) For the **Quality Performance Disparities Reduction** metric, EOHHS will allow CHA to report on the HQEIP measure set with adaptations (described in Table 5 and detailed in the technical specifications). EOHHS is allowing these adaptations because CHA does not participate in the Clinical Quality Incentive (CQI) program from which initial hospital-based health equity measures are drawn for PY 2-5. Specifically:
 - d. EOHHS will allow CHA to substitute Tobacco Use Screening and Treatment Measures (TOB 1-3, listed below) in lieu of CCM Measures (CCM 1-3). These replacement measures will be reported separately for the Medicaid and served uninsured patient populations:
 - Tobacco Use Screening (TOB-1) (*NQF 1651, Joint Commission*) (for CHA medical, surgical, and maternity inpatient units)
 - Tobacco Use Treatment Provided or Offered (TOB-2) (*NQF 1654, Joint Commission*) (for CHA medical, surgical, and maternity inpatient units)
 - Tobacco Use Treatment Provided or Offered at Discharge (TOB-3) (*NQF 1656, Joint Commission*) (for CHA medical, surgical, and maternity inpatient units).
 - e. EOHHS will allow CHA to report the same hospital-based quality measures for the Medicaid and served uninsured patient populations with the exception of the perinatal measures, which will be reported only for the Medicaid population (since served uninsured patients are likely to become eligible for Medicaid if they are pregnant and are anticipated to be captured in the Medicaid population). For the served uninsured population, in lieu of perinatal measures, CHA will report Follow-up After Hospitalization (for medical and surgical discharges), an important indicator for served uninsured patients.

⁸ 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.

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- f. 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.

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Table 5. CHA-HQEIP Hospital Component Adaptations to HQEIP Reporting/Performance Requirements for PY 2-5

Table 5a. Domain 1. Demographic and Health-Related Social Needs Data

| Metric | HQEIP Measure Description | Adapted Requirements for the CHA-HQEIP, if any |
|---|--|---|
| Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (EOHHS) | Percentage of members with acute hospital discharges within the measurement year with self-reported RELDSOGI data. | Single file submission separately reporting Medicaid and served uninsured patients. EOHHS may consider separate targets for the served uninsured patients and Medicaid patients, including based on initial performance. |
| Health-Related Social Needs Screening (EOHHS) | Two rates: 1) HRSN Screening Rate: Percentage of acute hospital discharges where members were screened using a standardized health-related social needs (HRSN) screening instrument for food, housing, transportation, and utility needs; and 2) HRSN Screen Positive Rate: Rate of HRSN identified by HRSN screening associated with acute hospital discharges in Rate 1. | CHA will separately report rate for Medicaid and served uninsured patients. EOHHS may consider separate targets for the served uninsured patients and Medicaid patients, including based on initial performance. |

Table 5b. Domain 2. Equitable Access and Quality

| Metric | HQEIP Measure Description | Adapted Requirements for the CHA-HQEIP, if any |
|--|---|---|
| Quality Performance Disparities Reduction (EOHHS) | Assessment of improvement towards and/or achievement of reduced disparities in quality performance between racial and/or ethnic or other subgroups on measures prioritized for disparities by EOHHS, including focused on coordination of care, perinatal health, and/or care for acute and chronic conditions. | CHA will separately report stratified quality measures for the Medicaid and served uninsured patient population. Please see the adaptations on the quality performance measures noted above (and in the technical specifications). Recognizing that the served uninsured patient population is unique, the measures for improvement, specific measurement and performance assessment methodology, inclusive of approach for improvement targets and/or methodology will be developed for the served uninsured. |

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| Metric | HQEIP Measure Description | Adapted Requirements for the CHA-HQEIP, if any |
|--|--|---|
| Equity Improvement Interventions (EOHHS) | Assessment of rigorous design and implementation of two equity-focused performance improvement projects (PIPs) focused on coordination of care, perinatal health, and/or care for acute and chronic conditions. | CHA will develop the second PIP related to the Medicaid population inclusive of the Medicaid ACO population. |
| Meaningful Access to Healthcare Services for Persons with a Preferred Language Other than English (EOHHS) | Two components: 1) Language Access Self-Assessment Survey: Completion and reporting of a language access self-assessment survey; and 2) Addressing Language Access Needs in Acute Hospital Settings: Percentage of acute hospital stays serving members who report a preferred language other than English during which either interpreter servings or an in-language service provider was utilized. | CHA will separately report percent of member visits with interpreter needs in which interpreter services were provided for the Medicaid and served uninsured patient populations. |
| Disability Competent Care (EOHHS) | Percentage of 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 hospital in its DCC Training Plan Report, and 2) demonstrated competency in the relevant disability competency training area(s).. | None |
| Disability Accommodation Needs (EOHHS) | Percentage of acute hospital discharges and/or encounters where 1) members with disability were screened for accommodation needs related to a disability, and, 2) for those members screening positive for accommodation needs, a corresponding member-reported accommodation need was identified. | CHA will separately report rates for Medicaid and served uninsured patients. |

Table 5c. Domain 3. Capacity and Collaboration

| Metric | HQEIP Measure Description | Adapted Requirements for the CHA-HQEIP, if any |
|--|--|--|
| Achievement of External Standards for Health Equity (EOHHS) | Assessment of whether acute hospitals have achieve standards related to health equity established by The Joint Commission for its “Health Care Equity Certification.” | None |
| Patient Experience: Communication Courtesy and Respect | Assessment of MassHealth member perceptions of their hospital experience utilizing reported elements of the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey | None |

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| Metric | HQEIP Measure Description | Adapted Requirements for the CHA-HQEIP, if any |
|----------------------|--|---|
| | for patients' perspectives of hospital care experience related to communication, courtesy, and respect. . | |
| Collaboration | Assessment of participating acute hospital collaboration with health system partners to promote high quality and equitable care. | None |

E. Ambulatory Performance Component of the CHA-HQEIP: Metrics for Performance Years 2-5

For the ambulatory performance component of the CHA-HQEIP, the targeted population includes the “served uninsured patient population” defined as patients active in CHA’s public hospital primary care system (according to the metric descriptions in the technical specifications) who have:

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

Ambulatory performance will be demonstrated in three domains, aligned with HQEIP and CHA-HQEIP hospital performance component domains, during PY2-5. Performance metrics expectations for the ambulatory performance component of the CHA-HQEIP are described below and in Table 6; additional detail related to performance metrics is provided in ambulatory metric technical specifications for the CHA-HQEIP.

Ambulatory Domain 1: Health-Related Social Needs

CHA will be assessed on improvements to address the health-related social needs of the served uninsured patient population in the public hospital’s primary care system.

Ambulatory Domain 2: Equitable Quality and Access

CHA will be assessed on improvements in three areas of equitable access and quality:

- **Ambulatory Quality Reporting and Performance:** CHA will be assessed on performance reporting of ambulatory quality and access metrics for the served uninsured patient population in the public hospital’s primary care system. Measure categories include: 1) Wellness, Prevention, and Screening 2) Chronic Health Conditions; 3) Access; and 4) Outreach & Care Coordination. Adjustments and/or replacement measures may be proposed in future years based on the initial development of measures in PY1, ongoing findings, denominator size, assessment of opportunities, etc.
- **Ambulatory Quality Improvement Initiative:** CHA will develop and implement no more than one performance improvement milestone 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 on a defined ambulatory measure or underserved geographic-based or patient population intervention. Milestones to be completed include pre-approved initiative elements, submitted mid-point assessment report, and a final achievement report. The final achievement report will be adjudicated and scored by EOHHS following the performance year-end.
- Additionally, CHA will identify and measure progress towards disparities reduction for the served underinsured patient population on a subset of identified ambulatory measures during the progression of the demonstration period, with pay-for-performance on disparities reduction achievement on a subset of measures no earlier than PY4. Disparities are aimed to be identified for the served uninsured patient population as a whole (as compared to other patient populations in their system).

Ambulatory Domain 3: Capacity and Collaboration

CHA will be assessed on improvement in metrics such as collaboration between health system partners and the community to address opportunities for health care for the served uninsured and underserved patient populations.

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Table 6. CHA HQEIP Ambulatory Performance Component: Performance Year 2-5 Metrics and Summary of Performance Expectations

| Domain | Measure Name | Measure Description | Data Source | Measure Steward [^] | Payment Status | | | |
|--------|--|---|--------------|------------------------------|----------------|---------------|------|------|
| | | | | | R=reporting | P=performance | 2024 | 2025 |
| 2026 | 2027 | | | | | | | |
| HRSN | Health-Related Social Needs (HRSN) Screening | Two rates: (1) HRSN Screening Rate: Percentage of served uninsured patients with an encounter in CHA's primary care system screened using a standardized health-related social needs (HRSN) screening instrument for food, housing, transportation, and utility needs; and (2) HRSN Screen Positive Rate: Rate of HRSN identified by HRSN screening associated with an encounter in CHA's primary care system in Rate 1.. | Supplemental | EOHHS (CMS~) | R | R | P | P |
| EQA | Quality Performance Disparities Reduction | Submission to EOHHS of ambulatory quality measure performance data for served uninsured patients in the public hospital's primary care system. This measure assesses quality performance for the served uninsured subgroup for the purpose of identifying, monitoring, and improving upon disparities. Quality measures identified for inclusion in this measure are prioritized for disparities by EOHHS. | Supplemental | EOHHS | R | R | P | P |
| | Needs Assessment and Analysis of Served Uninsured Patient Population | Submission to EOHHS of a needs assessment report and analysis of the <u>served</u> uninsured patient population. | Supplemental | EOHHS | R | R | R | R |
| | Equity Improvement Intervention | Assessment of development and implementation of one performance improvement milestone that addresses inequities in the served uninsured patient population. Milestones to be completed include pre-approved initiative elements, submitted mid-point assessment report, and a final achievement report. | Supplemental | EOHHS | P | P | P | P |
| CC | Community Collaboration Equity Improvement Intervention | Assessment of development and implementation of one performance improvement milestone that addresses inequities in the served uninsured patient population through collaboration with a CHA community health function and/or community partnerships. Milestones to be completed include pre-approved initiative elements, submitted mid-point assessment report, and a final achievement report. | Supplemental | EOHHS | P | P | P | P |
| | Completion of Supplement to the Health Equity Strategic Plan | Submission to EOHHS of a supplement to the required Health Equity Strategic Plan (EOHHS) specifically addressing the health equity strategy for the served uninsured population. | Supplemental | EOHHS | R | R | R | R |

~ Adapted for HQEIP use from CMS "Screening for Social Drivers of Health" and "Screen Positive Rate for Social Drivers of Health" metrics

F. Additional Detail on Identification of Health-Related Social Needs Screening and Referrals

Additional detail on identification of health-related social needs and health-related social needs referrals that pertain to the hospital-based component of the CHA-HQEIP is described in Attachment J, Section 3.D.

Section 4: CHA-HQEIP Payment and Corrective Action Plan

G. CHA-HQEIP Payment

Payment for the HQEIP that pertains to the HQEIP is described in Attachment J, Section 4.A. Payment pertaining to the CHA-HQEIP is described here in this Appendix C.

Section 1115 expenditure authority will support the launch and maintenance of the CHA-HQEIP to improve health care quality and equity. Table 7 shows the annual expenditure authority for the CHA-HQEIP by demonstration and performance years, as well as the allotments for hospital and ambulatory performance in accordance with STC 14.17.

Table 7. Annual Expenditure Authority Allotments for the CHA HQEIP (in millions)

| Performance Year | PY 1 | PY 2 | PY 3 | PY 4 | PY 5 | |
|---------------------------|--------------|--------------|--------------|--------------|--------------|--------------|
| Demonstration Year | DY 27 | DY 28 | DY 29 | DY 30 | DY 31 | DY 32 |
| Hospital performance | \$15.75M | \$63M | \$63M | \$63M | \$63M | \$63M |
| Ambulatory performance | \$6.75M | \$27M | \$27M | \$27M | \$27M | \$27M |
| Total Annual Limit | \$22.5M | \$90M | \$90M | \$90M | \$90M | \$90M |

In PY 1, MassHealth intends to make four interim payments and one reconciliation payment to CHA accounting for performance on both hospital and ambulatory components. In order to receive interim payments, CHA must meet key hospital and ambulatory milestones (“gates”) determined by Massachusetts to be foundational to successful performance in the CHA-HQEIP; these “gates” are a form of “pay-for-reporting” where timely and complete submission of gate deliverables will be required for interim payments to be made. Interim payments include both hospital and ambulatory performance dollar amounts. Across these interim payments, Massachusetts will withhold 10% of CHA’s maximum annual incentive payment. As appropriate, the remaining 10% will be paid out as a reconciliation payment in CY 2024, based on CHA’s final PY 1 health equity performance determined by performance on the CHA-HQEIP metric slate and successfully meeting payment gate reporting deliverables; if at the conclusion of PY 1 CHA’s performance results in earning less than 90% of its allocated incentive amount, funds will be recouped in the reconciliation payment process to ensure CHA is paid only what it earns on the basis of its CHA-HQEIP performance for PY1. The Health Quality and Equity Independent Assessor is not required to review relevant submissions (as described in Attachment J, Section 10.B. before interim payments are made. If the Independent Assessor’s review finds that gating deliverables were not complete, then reconciliation payment may be withheld until they are re-submitted and complete.

While they are aligned with gates for the HQEIP for private hospitals, CHA payment gates (Table 8) are specific to the CHA-HQEIP program and incorporate additional expectations relevant to the ambulatory performance component of the program. DY 27 amounts will be payable as part of the Q4 2022 payment and gate.

Table 8. CHA-HQEIP Payment Gates

| Gated Payment | Gate Description | Anticipated Gate Deliverable Due Date |
|----------------------|--|--|
| Q4 2022 Payment | Participation Attestation – Timely and complete submission to MassHealth of an attestation to participate in the HQEIP for PY 1, including an attestation to collaborate with an ACO (or a request for exemption from the ACO collaboration requirement.) | Dec 19, 2022 or date specified by EOHHS |
| Q1 2023 Payment | Qualified Interpreters Attestation – Complete and timely submission to MassHealth of an attestation that, by December 31, 2023, the hospital will implement a process for qualifying language interpreters. | Mar 31, 2023 |
| Q2 2023 Payment | RELD SOGI Assessment – Timely and complete submission to MassHealth of an initial assessment of 1) beneficiary-reported demographic data adequacy and completeness, and 2) a proposed plan for collecting demographic data including data sources. MassHealth anticipates collecting additional information about data submission plans in advance of the submission of the Enhanced Demographic Data File. | June 2, 2023 |
| | HRSN Assessment – Timely and complete submission to MassHealth of an initial assessment of 1) beneficiary-reported health related social needs data adequacy and completeness, and 2) strategies employed to provide information about community resources and support services. Aligned with HQEIP with the addition of an ambulatory assessment related to served uninsured patients served in the public hospital's primary care system. | June 2, 2023 |
| Q3 2023 Payment | Disability Competency Self-Assessment Attestation – An attestation that the hospital is working towards timely and complete submission to Massachusetts of a report on the results of the disability competencies self-assessment, including identified disability competencies targeted for improvement in PY 2. | September 18, 2023 |

| Gated Payment | Gate Description | Anticipated Gate Deliverable Due Date |
|------------------------|---|---------------------------------------|
| Reconciliation Payment | Health Equity Strategic Plan – Timely and complete submission to MassHealth of a Health Equity Strategic Plan as required by EOHHS. Aligned with HQEIP with the addition of an added component of the strategic plan describing strategy related to serving CHA's served uninsured population. | Dec 31, 2023 |

In each year PY2-5 of the HQEIP, Massachusetts intends to make four interim payments to CHA and complete one performance reconciliation that may lead to a further payment or a recoupment. Massachusetts will withhold between 10-15% (specific percentage to be determined annually by MassHealth based on prior performance data and other factors) of the CHA's maximum annual incentive payment from their interim payments. Based on CHA's final HQEIP health equity score for each PY, the remaining earned incentive will be paid out as a reconciliation payment in the following calendar year or unearned funds will be recouped, as applicable. Interim payments will be made automatically, with the exception that it is anticipated that the fourth interim payment for each PY will only be paid once the hospital has submitted a complete annual Health Quality and Equity Strategic Plan update (anticipated to be due by the end of the PY). CHA must also submit a supplement to the required Health Quality and Equity Strategic Plan update specifically addressing the health equity strategy for the served uninsured population. Additional quarterly payment "gates" may be instituted at the discretion of MassHealth.

H. CHA-HQEIP Hospital Component Corrective Action Plan

The corrective action plan for the HQEIP that pertains to the Hospital Component of the CHA-HQEIP is described in Attachment J, Section 4.B.

I. CHA-HQEIP Ambulatory Component Corrective Action Plan

- i. In addition to the CAP process outlined in Section 4.B of this Appendix C for hospital-based measures, CHA will have a CAP process for the ambulatory component of their plan. Beginning in PY3 and annually thereafter through PY5, CHA will be incentivized to improve through a CAP process overseen by MassHealth for their ambulatory performance component. The CAP process will offer CHA an opportunity to identify areas of poor performance on the ambulatory HQEIP slate, evaluate root causes of such poor performance, and use rapid-cycle equity improvement interventions to make progress towards improved performance on ambulatory HQEIP metrics. MassHealth may require CHA to participate in the CAP process or CHA may choose to voluntarily participate. If performed in a given PY, the CAP process will include the following aspects:

- a. To identify a CAP intervention in a given PY, CHA will select an area of underperformance on one or more metrics on the ambulatory HQEIP measure slate. HQEIP measure focus areas must be selected and justified within the first quarter of a CAP-eligible PY using data such as prior year(s) performance data (as available), internal performance monitoring data, and MassHealth monitoring data.
- b. To conduct a CAP, CHA must develop a CAP intervention proposal to be submitted to MassHealth within the first quarter of the PY describing the proposed intervention that directly addresses the area of underperformance, including how the proposed interventions will address known root causes and/or obstacles to performance and the hospital's rationale for why addressing the root cause and/or obstacle through the proposed CAP intervention will lead to expected performance improvement. The CAP proposal may include programmatic milestone(s) and must include one or more quantitative key performance indicator(s) and performance targets for such indicators. The key performance indicators should be interim markers of success anticipated to impact performance on an HQEIP metric; they must be designed to allow for frequent monitoring throughout the duration of a CAP intervention. At least one key performance indicator must relate to eliciting direct patient input to inform performance improvement on the targeted HQEIP and/or CAP intervention implementation.
- c. MassHealth (together with its vendor(s) as applicable) will evaluate (using criteria such as relevance of the intervention to MassHealth members, feasibility of completion within the required time period, appropriateness of key performance indicators, etc.) and approve CAP proposals, requiring CHA to make modifications prior to approval as necessary to ensure CAP interventions are rigorous and in alignment with programmatic requirements.
If participating, CHA will implement approved CAP interventions by the end of the given PY, submitting a final report to MassHealth after the end of the PY describing the results of the intervention including performance on key performance indicators or elements.,
- d. MassHealth will evaluate CAP final reports to determine performance. If CHA achieves targeted milestone(s) and/or key performance indicator(s) it will be eligible to earn health equity score "bonus points," to be added to its ambulatory health equity score for the PY during which the CAP intervention was conducted. Bonus points may increase the health equity score for the ambulatory component of the PY to up to 100% of the eligible amount for the PY; bonus points may not result in CHA's ambulatory health equity score exceeding 100% for the PY.

Section 5. HQEI Accountability Framework (State Accountability to CMS; CHA Accountability to the State) for PY 1

A. State Accountability to CMS for the HQEI

State accountability for the HQEI, which includes the CHA-HQEIP, is described in the Attachment J, Section 5.A.

B. CHA Accountability to the State for the CHA-HQEIP in PY1

Regardless of MassHealth's performance with respect to its accountability to CMS, MassHealth will hold CHA individually accountable for its CHA-HQEIP performance. As described in STC 14.17(c), to determine the total earned incentive payment, Massachusetts will sum the payment earned from CHA's performance described in STC 14.17 and detailed further in Section 3 of this Appendix C, above. Total incentive amounts for CHA for PY 1 of the CHA-HQEIP will be distributed according to the weighting described in Tables 9 and 10.

Table 9. PY 1 CHA Hospital Performance Component Metric Weights

Table 9a. Domain 1. Demographic and Health-Related Social Needs Data (25%)

| Subdomain | CHA-HQEIP Metric (<i>Steward</i>) | PY 1 Weight (%) |
|---|--|-----------------|
| Demographic Data Collection | Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (EOHHS) | 15 |
| Screening for Social Drivers of Health: <i>Preparing for Reporting Beginning in PY 2</i> | Health-Related Social Needs Screening (EOHHS/CMS) | 10 |

Table 9b. Domain 2. Equitable Quality and Access (50%)

| Subdomain | CHA-HQEIP Metric (<i>Steward</i>) | PY 1 Weight (%) |
|-------------------------|--|---|
| Equity Reporting | Quality Performance Disparities Reduction (EOHHS) (See Table 2) | 10 (5 pertaining to the MassHealth population) |

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| Subdomain | CHA-HQEIP Metric (<i>Steward</i>) | PY 1 Weight (%) |
|---------------------------|--|--|
| | | and 5 pertaining to the served uninsured population) |
| Equity Improvement | Equity Improvement Interventions (<i>EOHHS</i>) | 10 |
| Access | Meaningful Access to Healthcare Services for Persons with a Preferred Language Other than English (<i>EOHHS/OHA</i>) | 10 |
| | Disability Competent Care (<i>EOHHS</i>) | 10 |
| | Disability Accommodation Needs (<i>EOHHS</i>) | 10 |

Table 9c. Domain 3. Capacity and Collaboration (25%)

| Subdomain | CHA-HQEIP Metric (<i>Steward</i>) | PY 1 Weight (%) |
|----------------------|--|-----------------|
| Capacity | Achievement of External Standards for Health Equity (<i>EOHHS</i>) | 10 |
| | HCAHPS: Items Related to Cultural Competency (<i>AHRQ</i>) | 10 |
| Collaboration | Collaboration (<i>EOHHS</i>) | 5 |

Table 10. PY 1 CHA Ambulatory Performance Component Metric Weights

Table 10a. Domain 1. Health-Related Social Needs

| Subdomain | CHA Ambulatory HQEIP Metric (<i>Steward</i>) | PY 1 Weight (%) |
|-----------|--|-----------------|
| | HRSN Resource Listing (<i>EOHHS</i>) | 15 |

Table 10b. Domain 2. Equitable Quality and Access

| Subdomain | CHA Ambulatory HQEIP Metric (<i>Steward</i>) | PY 1 Weight (%) |
|---|---|-----------------|
| Ambulatory Quality Reporting and Performance | Ambulatory Quality Performance (<i>EOHHS</i>) | 15 |
| Ambulatory Quality Improvement Initiative(s) | Needs Assessment and Analysis of Served Uninsured Population (<i>EOHHS</i>) | 25 |
| | Equity Improvement Intervention (<i>EOHHS</i>) | 15 |

Table 10c. Domain 3. Capacity and Collaboration

| Subdomain | CHA Ambulatory HQEIP Metric (<i>Steward</i>) | PY 1 Weight (%) |
|-----------|---|-----------------|
| | Completion of Served Uninsured Component of Health Equity Strategic Plan (<i>EOHHS</i>) | 30 |

C. CHA Accountability to the State for the Hospital Component of the CHA-HQEIP in PY2-5

Acute hospital accountability to the State for the HQEIP, which includes CHA accountability, is described in Attachment J, Section 5.B.

Regardless of MassHealth's performance with respect to its accountability to CMS, MassHealth will hold CHA individually accountable for its CHA-HQEIP performance. As described in STC 14.17(c), to determine the total earned incentive payment, Massachusetts will sum the payment earned from CHA's performance described in STC 14.17 and detailed further in Section 3 of this Appendix C, above. Total incentive amounts for CHA for PY2-5 of the CHA-HQEIP will be distributed according to the weighting described in Tables 11 and 12.

The Performance Assessment Methodology (PAM) Framework outlined in Attachment J, Section 5.B.i, pertains to the hospital component of the CHA-HQEIP, with the exception of measures that include separate reporting of data for the Medicaid and served uninsured populations (outlined in Table 5). MassHealth may determine that unique improvement targets and/or methodology are needed for the served uninsured population, as informed by initial HQEIP performance data and other deliverables. As noted above in Section 3.B. of this Appendix C and Table 5, CHA will separately report stratified quality measures for the Medicaid and served uninsured patient population. Recognizing that the served uninsured

patient population is unique, the measures for improvement, specific measurement and performance assessment methodology, inclusive of approach for improvement targets and/or methodology will be developed for the served uninsured.

D. CHA Accountability to the State for the Ambulatory Component of the CHA-HQEIP in PY2-5

MassHealth's framework for the ambulatory component of the CHA-HQEIP PAM, which may be adjusted annually as needed (for example to transition measures from pay-for-reporting to pay-for-performance, accommodate new contextual inputs, address extenuating circumstances impacting performance, etc.), is described below. Measure-specific PAM, including improvement targets and/or methodology and measure score calculation approach, will be described in each measure specification, to be made available on MassHealth's website, and may be adjusted as needed to account for the unique nature of the population and approaches in the ambulatory component of the CHA-HQEIP.

- i. **Benchmarking:** MassHealth will establish performance targets and/or benchmarks no later than the start of the first pay-for-performance period for the metric and/or, in accordance with STC 14.6, no later than by July 1, 2025 (whichever is later).
 - a. Benchmarks for quantitative measures will include an attainment threshold and goal benchmark and will be set to apply to the full applicable performance period. To the extent that external benchmarks for the served uninsured population are not available, targets may be defined by improvement over self or other relevant methodology.
 - b. Establishment of benchmarks will be informed by inputs such as initial HQEIP performance data, initial ambulatory uninsured performance data, historical hospital data/performance, external data/trends, and/or predetermined performance targets determined by MassHealth.
- ii. **Improvement Targets:** MassHealth will establish annual performance improvement targets for performance metrics, as applicable, no later than the start of each pay-for-performance period for the metric and/or, in accordance with STC 14.6, no later than by July 1, 2025 (whichever is later).
 - a. Specific approaches for each measure, defined no later than July 1, 2025, will be intended to apply to the full applicable performance period.
 - i. Before July 1, 2025, annual "meaningful improvement" targets for HRSN screening specifically (as referenced in STC 14.3.d) will be defined each year in annual updates to the technical specifications; after July 1, 2025, annual "meaningful improvement" targets for the remaining years of the demonstration period (including PY4-5) will be reported to CMS.
 - b. The approaches and actual improvement targets may differ by measure based on factors such as performance trends or type of measure; approaches may include year-over-year self-improvement, gap-to-goal percentage point increase, absolute percentage point increases, set milestones and/or goals for improvement.
- iii. **Performance Measure Score Calculation:** The performance measure scoring approach will be consistent, as appropriate, with other MassHealth incentive programs or other incentive program practices. MassHealth will establish a

methodology for performance measure scoring for each measure, to be specified in technical specifications, no later than the first day of the performance period to which the methodology applies.

- a. **Pay-for reporting (P4R) measures.** P4R measures will be assessed on a pass/fail basis for which the hospital who successfully reports complete and timely data based on each measure's technical specifications will receive full points or credit for the metric.
- b. **Pay-for-performance (P4P) measures.** The performance measure scoring and approach will, as appropriate, be consistent with other MassHealth incentive programs or other incentive program practices.
 - i. Measure scoring may include the following components for each measure:
 1. Attainment points ranging from 0-10 points
 2. Improvement points ranging from 0-10 points
 3. Potential bonus points (with a cap)
 - ii. Performance measure scores for each measure may defined as a ratio between 0-1. Scores will be calculated by the sum of the points earned for each measure divided by the maximum number of points allowable for the measure. The maximum number of points allowable for the measure is the sum of the attainment, improvement and potential bonus points with a determined cap. The score will be calculated as follows: *Performance Measure Score = Points earned for each measure / Maximum number of points allowable for the measure.*
 - iii. Some performance measures may have identified sub-measures for which sub-measure performance scores will be calculated in the same manner, but then typically equally weighted to calculate a composite performance measure score. For sub-measures the score is calculated as follows: *Performance Measure Score = Sum of each (Sub-measure Score X Sub-measure Weighting).*
- iv. **Domain Score Calculation:** The domain scoring and approach will, as appropriate, be consistent with other MassHealth incentive programs or other incentive program practices. Domain scoring may include the following components:
 - a. Using the predetermined weights specified in Table 11, a domain score will be calculated by taking each performance measure score in the domain and calculating the sum of each performance measure score multiplied by its respective performance measure weight: *Domain Score = Sum of each (Performance Measure Score * Performance Measure Weight).*
 - b. If CHA is not eligible for a measure (e.g., does not meet the denominator criteria or minimum volume), the weighting will be redistributed equally to the eligible performance measures in the domain.
- v. **Health Equity Score for the Ambulatory Component of the CHA-HQEIP Calculation:** The overall health equity scoring approach will be consistent with other MassHealth incentive programs or other incentive program practices. Using the predetermined weights specified in Table 11 and STC 14.7, a health equity score will be calculated by taking each domain score and calculating the sum of each domain

score multiplied by its respective domain weight: *Health Equity Score for the Ambulatory Component of the CHA-HQEIP = Sum of each (Ambulatory Domain Score * Ambulatory Domain Weight)*). Any bonus points earned through ambulatory component Corrective Action Plans (described in Section 4.C of this Appendix C) will then be used to determine the final Health Equity Score for the Ambulatory Component of the CHA-HQEIP, not to exceed 100%.

vi. **Overall Health Equity Score for CHA-HQEIP:** CHA's overall health equity score will equal the weighted sum of the final Health Equity Score for the Ambulatory Component of the CHA (described in Section 5.D of this Appendix C, and accounting for 30% of the overall Health Equity Score) and the final Health Equity Score for the Hospital Component of the CHA-HQEIP (described in section 5.C of this Appendix C, and accounting for 70% of the overall Health Equity Score). The overall Health Equity Score will be used to calculate CHA's earned incentive payment.

Table 11. Performance Years 2-5 CHA Hospital Performance Component Metric Weights

| Domain* & Domain Weight (%) | Measure Name | Measure Weight (%) by Performance Year | | | |
|--------------------------------------|--|---|------|------|------|
| | | 2024 | 2025 | 2026 | 2027 |
| DHRSN (25%) | Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness [^] | 10 | 10 | 15 | 15 |
| | Health-Related Social Needs (HRSN) Screening [^] | 15 | 15 | 10 | 10 |
| EQA (50%) | Quality Performance Disparities Reduction [^] | 10 | 10 | 20 | 20 |
| | Equity Improvement Interventions | 10 | 10 | 5 | 5 |
| | Meaningful Access to Healthcare Services for Persons with a preferred language other than English [^] | 10 | 10 | 10 | 10 |
| | Disability Competencies | 10 | 10 | 5 | 5 |
| | Accommodation Needs Met | 10 | 10 | 10 | 10 |
| CC (25%) | Achievement of External Standards for Health Equity | 10 | 10 | 10 | 10 |

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| Domain* & Domain Weight (%) | Measure Name | Measure Weight (%) by Performance Year | | | |
|--------------------------------------|---|---|------------|------------|------------|
| | | 2024 | 2025 | 2026 | 2027 |
| | Patient Experience: Communication, Courtesy and Respect | 10 | 10 | 10 | 10 |
| | Collaboration | 5 | 5 | 5 | 5 |
| TOTAL | | 100 | 100 | 100 | 100 |

*DHRN=Demographic and Health-Related Social Needs Data; EQA=Equitable Quality and Access; CC=Capacity and Collaboration

[^]For measures that report separately on the Medicaid and served uninsured patient populations, weighting within the measure will be 75% for Medicaid patients and 25% for the served uninsured patients.

Table 12. Performance Year 2-5 CHA Ambulatory Performance Component Metric Weights

| Domain* & Domain Weight (%) | Measure Name | Measure Weight (%) by Performance Year | | | |
|--------------------------------------|--|---|------|------|------|
| | | 2024 | 2025 | 2026 | 2027 |
| DHRN (25%) | Race, Ethnicity, Language, Health-Related Social Needs (HRSN) Screening | 25 | 25 | 25 | 25 |
| EQA (45%) | Quality Performance Disparities Reduction | 20 | 20 | 20 | 20 |
| | Needs Assessment and Analysis of Served Uninsured Population | 10 | 10 | 10 | 10 |
| | Equity Improvement Interventions | 15 | 15 | 15 | 15 |
| CC (30%) | Community Collaboration Equity Improvement Intervention | 20 | 20 | 20 | 20 |
| | Completion of Served Uninsured Component of Health Equity Strategic Plan | 10 | 10 | 10 | 10 |

Section 6. Analysis and Needs Assessment and Advisory Functions

The Analysis and Needs Assessment activities, HQEI Advisory Committee description, and Independent Assessor information that pertain to the CHA-HQEIP are described in Attachment J, Section 6. Additional descriptions pertaining to the ambulatory served uninsured population will also be included in the needs assessment as described in Table 6.