Technical Specifications for the MassHealth Hospital Quality and Equity Incentives Program (HQEIP)

Performance Year 1

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Table of Contents

A. Introduction

This document outlines the Performance Year (PY) 1 Technical Specifications for all hospitals participating in the Health Quality and Equity Incentive Program (HQEIP). These requirements apply to all HQEIP hospital participating in PY1 regardless of the year in which hospitals started the program.

For hospitals that opened or began participation in the HQEIP in a calendar year beginning 2024 or later, in accordance with Section 3.B of the HQEIP PY 1-5 Implementation Plan, MassHealth may update certain details included in these PY 1 Technical Specifications to account for the later performance period. Specifically, MassHealth may issue guidance to such hospitals in order to:
(1) update deliverable due dates;
(2) consolidate or simplify deliverables; or
(3) update metrics to account for current PY HQEIP requirements, measure stewards' adjustments to their measure slates, data no longer being relevant or useful for comparison or baseline purposes, or other circumstances necessitating adjustments as determined by MassHealth.

B. RELD SOGI Data Completeness

A.i. Race Data Completeness

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

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

ELIGIBLE POPULATION

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

DEFINITIONS

Complete Race Data	Complete race data is defined as: At least one (1) valid race value (valid race values are listed in Attachment 1). ○ If value is “UNK” it will not count toward the numerator. ○ If value is “ASKU,” it will count toward the numerator. ○ If value is “DONTKNOW,” it will count toward the numerator.

	○ Each value must be self-reported.
Data Collection	Race data may be collected: • by any member of the hospital care team; • over the phone, electronically (e.g. a patient portal), in person, by mail, etc.; • from an ACO; • must include one or more values in Attachment 1
Hospital File ["Enhanced Demographics Data File"]	The Center for Information and Analysis (CHIA) will intake race data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.
Measurement Year	Measurement Years 1-5 correspond to Calendar Years 2023-2027
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).
Rate of Race Data Completeness	There will be two rates reported for this measure, defined as. Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100 Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100
Self-Reported data	Race data must be self-reported. Race data that derived using an imputation methodology must not be included. For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy). Self-reported race data that has been rolled-up or transformed for reporting purposes may be included. For example, if a hospital's data systems include races that are included in HHS' data collection standards and an individual self-reports their race as "Samoan", then the

	hospital can report the value of “Native Hawaiian or Other Pacific Islander” since the value of Samoan is not a valid value in Attachment 1.

ADMINISTRATIVE SPECIFICATION

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

	○ If value is “DONTKNOW,” it will count toward the numerator. ○ Each value must be self-reported.
Exclusions	If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.

ADDITIONAL MEASURE INFORMATION

Required Reporting	The following information is required: • A valid MassHealth Member ID Format: Refer to CHIA Submission Guide • At least one (1) race value, as defined under “Complete Race Data” above Format: Refer to CHIA Submission Guide
Completeness Calculations	Completeness is calculated for: each individual Acute Hospital; and all acute hospitals.

Attachment 1. Race: Accepted Values

Description	Valid Values	Notes
American Indian/Alaska Native	1002-5	
Asian	2028-9	
Black/African American	2054-5	
Native Hawaiian or other Pacific Islander	2076-8	
White	2106-3	
Other Race	OTH	
Choose not to answer	ASKU	Member was asked to provide their race, and the member actively selected or indicated that they “choose not to answer.”

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

A.ii. Hispanic Ethnicity Data Completeness

OVERVIEW	
Measure Name	Rate of Hispanic Ethnicity Data Completeness – Acute Hospital
Steward	EOHHS
NQF Number	N/A
Data Source	Numerator source: Center for Health Informatics and Analysis (CHIA) "Enhanced Demographics Data File" Denominator sources: MassHealth encounter and MMIS claims data

Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

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

ELIGIBLE POPULATION

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

DEFINITIONS

Complete Hispanic ethnicity Data	Complete Hispanic ethnicity data is defined as: One (1) valid Hispanic ethnicity value (valid Hispanic ethnicity values are listed in Attachment 2). • If value is "UNK," it will not count toward the numerator. • If value is "ASKU it will count toward the numerator. • If value is "DONTKNOW" it will count toward the numerator. • Each value must be self-reported.
Data Collection	Hispanic ethnicity data may be collected • by any member of the hospital care team; • over the phone, electronically (e.g. a patient portal), in person, by mail, etc. • from an ACO; • must include one value in Attachment 2
Hospital File ["Enhanced Demographics Data File"]	The Center for Information and Analysis (CHIA) will intake Hispanic ethnicity data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.
Measurement Year	Measurement Years 1-5 correspond to Calendar Years 2023-2027
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).
Rate of Hispanic Ethnicity Data Completeness	There will be two rates reported for this measure. (Numerator 1 Population / Denominator 1 Population) * 100 (Numerator 2 Population / Denominator 2 Population) * 100
Self-Reported data	Hispanic ethnicity data must be self-reported. Hispanic ethnicity data that is a result of an imputation methodology must not be included. For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the

	individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy). Self-reported Hispanic ethnicity data that has been rolled-up or transformed for reporting purposes may be included. For example, if a hospital's data systems include ethnicities that are included in HHS' data collection standards (i.e., Mexican; Puerto Rican; Cuban; Another Hispanic, Latino/a, or Spanish origin) and an individual self-reports their ethnicity as "Puerto Rican", then the hospital can report the value of "Hispanic" since the value of Puerto Rican is not a valid value in Attachment 2.

ADMINISTRATIVE SPECIFICATION

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

	○ If value is “UNK,” it will not count toward the numerator. ○ If value is “ASKU,” it will count toward the numerator. ○ If value is “DONTKNOW,” it will count toward the numerator. ○ Each value must be self-reported.
Exclusions	If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.

ADDITIONAL MEASURE INFORMATION

Required Reporting	The following information is required: • A valid MassHealth Member ID Format: Refer to CHIA Submission Guide • At least one (1) ethnicity value, as defined under “Complete Hispanic Data” above Format: Refer to CHIA Submission Guide
Completeness Calculations	Completeness is calculated for: each individual acute hospital; and all acute hospitals.

Attachment 2. Hispanic Ethnicity: Accepted Values

Description	Valid Values	Notes
Hispanic or Latino	2135-2	
Not Hispanic or Latino	2186-5	
Choose not to answer	ASKU	Member was asked to provide their ethnicity, and the member actively selected or indicated that they “choose not to answer”.
Don’t know	DONTKNOW	Member was asked to provide their ethnicity, and the member actively selected or indicated that they did not know their ethnicity.

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

A.iii. English Proficiency Data Completeness

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

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

ELIGIBLE POPULATION

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

DEFINITIONS

Complete English Proficiency Data	Complete English Proficiency data is defined as: One (1) valid English Proficiency Value (valid English Proficiency values are listed in Attachment 3). • If value is “UNK,” it will not count toward the numerator.

	• If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. • Each value must be self-reported.
Data Collection	English Proficiency data may be collected • by any member of the hospital care team; • over the phone, electronically (e.g. a patient portal), in person, by mail, etc. • from an ACO; • must include one value in Attachment 3.
Hospital File [“Enhanced Demographics Data File”]	The Center for Information and Analysis (CHIA) will intake English Proficiency data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.
Measurement Year	Measurement Years 1-5 correspond to Calendar Years 2023-2027
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).
Rate of English Proficiency Data Completeness	There will be two rates reported for this measure. (Numerator 1 Population / Denominator 1 Population) * 100 (Numerator 2 Population / Denominator 2 Population) * 100
Self-Reported data	English Proficiency data must be self-reported. For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual’s behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).

ADMINISTRATIVE SPECIFICATION

Denominator	There are two denominators for this measure: **Denominator 1:** The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals. **Denominator 2:** The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.
Numerator	**Numerator 1:** For members in Denominator 1, identify those with complete English Proficiency data, defined as: One (1) valid English Proficiency value (valid English Proficiency values are listed in Attachment 3). ○ If value is "UNK," it will not count toward the numerator. ○ If value is "ASKU," it will count toward the numerator. ○ If value is "DONTKNOW," it will count toward the numerator. ○ Each value must be self-reported. **Numerator 2:** For members in Denominator 2, identify those with complete English Proficiency data, defined as: One (1) valid English Proficiency value (valid English Proficiency values are listed in Attachment 3). ○ If value is ",UNK" it will not count toward the numerator. ○ If value is "ASKU," it will count toward the numerator. ○ If value is "DONTKNOW," it will count toward the numerator. ○ Each value must be self-reported.
Exclusions	If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.

ADDITIONAL MEASURE INFORMATION

Required Reporting	The following information is required: • A valid MassHealth Member ID Format: Refer to CHIA Submission Guide • One (1) English Proficiency value, as defined under "Complete English Proficiency Data" above Format: Refer to CHIA Submission Guide
Completeness Calculations	Completeness is calculated for: each individual acute hospital and all acute hospitals.

Attachment 3. English Proficiency: Accepted Values

Description	Valid Values	Notes
Very well	VERWELL	
Well	WELL	
Not well	NOTWELL	
Not at all	NOTALL	
Choose not to answer	ASKU	Member was asked to provide their English Proficiency, and the member actively selected or indicated that they "choose not to answer."
Don't know	DONTKNOW	Member was asked to provide their English proficiency, and the member actively selected or indicated that they did not know their English proficiency.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.

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

A.iv. Disability Data Completeness

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

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

ELIGIBLE POPULATION

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

DEFINITIONS

Complete Disability Data	Complete Disability data is defined as:

	One (1) valid disability value for each Disability Question (listed in Attachment 4). • If value is “UNK,” it will not count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. • Each value must be self-reported.
Data Collection	Disability data may be collected • by any member of the ACO care team; • over the phone, electronically (e.g. a patient portal), in person, by mail, etc. • from an ACO; • must include one value in Attachment 4 for each question.
Hospital File [“Enhanced Demographics Data File”]	The Center for Information and Analysis (CHIA) will intake disability data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.
Measurement Year	Measurement Years 1-5 correspond to Calendar Years 2023-2027
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).
Rate of Disability Data Completeness	There will be two rates reported for this measure. (Numerator 1 Population / Denominator 1 Population) * 100 (Numerator 2 Population / Denominator 2 Population) * 100
Self-Reported data	Disability data must be self-reported. For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual’s behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).

ADMINISTRATIVE SPECIFICATION

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

	For members in Denominator 2, identify those with complete disability data, (defined above under “Complete Disability Data”) for each question below: Disability Q1 (all ages): Are you deaf or do you have difficulty hearing? Disability Q2 (all ages): Are you blind or do you have difficulty seeing? Disability Q3 (age 5 or older): Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? Disability Q4 (age 5 or older): Do you have difficulty walking or climbing stairs? Disability Q5 (age 5 or older): Do you have difficulty dressing or bathing? Disability Q6 (age 15 or older): Because of a physical, mental, or emotional condition, do you have difficulty doing errands such as visiting a doctor's office or shopping? o If value is “UNK” it will not count toward the numerator. o If value is “ASKU,” it will count toward the numerator. o If value is “DONTKNOW,” it will count toward the numerator. o Each value must be self-reported.
Exclusions	If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.

ADDITIONAL MEASURE INFORMATION

Required Reporting	For a given disability question, the following information is required: • A valid MassHealth Member ID Format: Refer to CHIA Submission Guide • At least one (1) valid disability value per question, as defined under “Complete Disability Data” above Format: Refer to CHIA Submission Guide
Completeness Calculations	Completeness is calculated per disability question per acute hospital and overall, as described below for questions 1 and 2, as an example: For each individual acute hospital:

	Example 1: For acute hospital x, the percentage of members with self-reported disability data for question 1 that was collected by acute hospital x in the measurement year. Example 2: For acute hospital x, the percentage of members with self-reported disability data for question 2 that was collected by acute hospital x in the measurement year. For all acute hospitals Example 1: For all acute hospitals, the percentage of members with self-reported disability data for question 1 that was collected by all acute hospitals in the measurement year. Example 2: For all acute hospitals, the percentage of members with self-reported disability data for question 2 that was collected by all acute hospitals in the measurement year.

Attachment 4. Disability: Accepted Values

Disability Q1: Are you deaf or do you have serious difficulty hearing?		
Description	**Valid Values**	**Notes**
Yes	LA33-6	
No	LA32-8	
Choose not to Answer	ASKU	Member was asked whether they are deaf or have difficulty hearing, and the member actively selected or indicated that they "choose not to answer."
Don't know	DONTKNOW	Member was asked whether they are deaf or have difficulty hearing, and the member actively selected or indicated that they did not know if they are deaf or have difficulty hearing.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.

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

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

Description	Valid Values	Notes
Yes	LA33-6	
No	LA32-8	
Choose not to Answer	ASKU	Member was asked whether they are blind or have difficulty seeing, and the member actively selected or indicated that they "choose not to answer."
Don't know	DONTKNOW	Member was asked whether they are blind or have difficulty seeing, and the member actively selected or indicated that they did not know whether they are blind or have difficulty seeing.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	Whether the member is blind or has difficulty seeing is unknown since either:

Description	Valid Values	Notes
		(a) the member was not asked whether they are blind or have difficulty seeing, or (b) the member was asked whether they are blind or have difficulty seeing, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response, and should be assigned the value of ASKU instead of UNK.

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

Description	Valid Values	Notes
Yes	LA33-6	
No	LA32-8	
Choose not to Answer	ASKU	Member was asked whether they have serious difficulty concentrating, remembering or making decisions, and the member actively selected or indicated that they "choose not to answer".
Don't know	DONTKNOW	Member was asked whether they have serious difficulty concentrating, remembering or making decisions, and the member actively selected or indicated that they did not know whether they have serious difficulty concentrating, remembering or making decisions.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	Whether the member has difficulty concentrating, remembering or making decisions is unknown since either:

Description	Valid Values	Notes
		(a) the member was not asked whether they have difficulty concentrating, remembering or making decisions, or (b) the member was asked whether they have difficulty concentrating, remembering or making decisions, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.

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

Description	Valid Values	Notes
Yes	LA33-6	
No	LA32-8	
Choose not to Answer	ASKU	Member was asked whether they have difficulty walking or climbing stairs, and the member actively selected or indicated that they “choose not to answer.”
Don’t know	DONTKNOW	Member was asked whether they have difficulty walking or climbing stairs, and the member actively selected or indicated that they did not know whether they have difficulty walking or climbing stairs.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	Whether the member has difficulty walking or climbing stairs is unknown since either:

Description	Valid Values	Notes
		(a) the member was not asked whether they have difficulty walking or climbing stairs, or (b) the member was asked whether they have difficulty walking or climbing stairs, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response, and should be assigned the value of ASKU instead of UNK.

Disability Q5: Do you have difficulty dressing or bathing?

Description	Valid Values	Notes
Yes	LA33-6	
No	LA32-8	
Choose not to Answer	ASKU	Member was asked whether they have difficulty dressing or bathing, and the member actively selected or indicated that they "choose not to answer."
Don't know	DONTKNOW	Member was asked whether they have difficulty dressing or bathing, and the member actively selected or indicated that they did not know whether they have difficulty dressing or bathing.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	Whether the member has difficulty dressing or bathing is unknown since either: (a) the member was not asked whether they have difficulty dressing or bathing, or

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

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

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

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

A.v. Sexual Orientation Data Completeness

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

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

ELIGIBLE POPULATION

Age	Members age 18 and older as of December 31 of the measurement year
Continuous Enrollment	None
Anchor Date	None
Event/Diagnosis	At least one inpatient discharge and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year. To identify inpatient discharges: • Identify all inpatient discharges (Inpatient Stay Value Set). To identify emergency department visits: • Identify all Emergency Department visits (ED Value Set).

DEFINITIONS

Complete Sexual Orientation Data	Complete sexual orientation data is defined as: At least one (1) valid sexual orientation value (listed in Attachment 5). • If value is "UNK," it will not count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. Each value must be self-reported.
Data Collection	Sexual orientation data may be collected • by any member of the hospital care team; • over the phone, electronically (e.g. a patient portal), in person, by mail, etc. • from an ACO; • must include one or more values in Attachment 5
Hospital File ["Enhanced Demographics Data File"]	The Center for Information and Analysis (CHIA) will intake sexual orientation data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching

	checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.
Measurement Year	Measurement Years 1-5 correspond to Calendar Years 2023-2027
Members	Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).
Rate of Sexual Orientation Data Completeness	There will be two rates reported for this measure, defined as. Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100 Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100
Self-Reported data	Sexual orientation data must be self-reported. For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).

ADMINISTRATIVE SPECIFICATION

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

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

ADDITIONAL MEASURE INFORMATION

Required Reporting	The following information is required: • A valid MassHealth Member ID Format: Refer to CHIA Submission Guide • At least one (1) valid sexual orientation value, as defined under "Complete Sexual Orientation Data" above Format: Refer to CHIA Submission Guide
Completeness Calculations	Completeness is calculated for: each individual Acute Hospital; and all acute hospitals.

Attachment 5. Sexual Orientation: Accepted Values

Description	Valid Values	Notes
Bisexual	42035005	

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

A.vi. Gender Identity Data Completeness

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

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

ELIGIBLE POPULATION

Age	Members age 18 and older as of December 31 of the measurement year
Continuous Enrollment	None
Anchor Date	None
Event/Diagnosis	At least one inpatient discharge and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year.

	To identify inpatient discharges: • Identify all inpatient discharges (Inpatient Stay Value Set). To identify emergency department visits: • Identify all Emergency Department visits (ED Value Set).

DEFINITIONS

Complete Gender Identity Data	Complete gender identity data is defined as:
	At least one (1) valid gender identity value (listed in Attachment 6).
	  ○ If value is "UNK," it will not count toward the numerator.
	  ○ If value is "ASKU," it will count toward the numerator.
	  ○ If value is "DONTKNOW," it will count toward the numerator.
	• Each value must be self-reported.

Data Collection	Gender Identity data may be collected • by any member of the hospital care team; • over the phone, electronically (e.g. a patient portal), in person, by mail, etc. • from an ACO; • must include one or more values in Attachment 6
Hospital File ["Enhanced Demographics Data File"]	The Center for Information and Analysis (CHIA) will intake gender identity data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.
Measurement Year	Measurement Years 1-5 correspond to Calendar Years 2023-2027
Members	Individuals enrolled in MassHealth including:

	Model A ACO, Model B ACO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).
Rate of Gender Identity Data Completeness	There will be two rates reported for this measure. Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100 Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100
Self-Reported data	Gender Identity data must be self-reported. For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).

ADMINISTRATIVE SPECIFICATION

Denominator	There are two denominators for this measure: **Denominator 1:** The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals. **Denominator 2:** The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals
Numerator	There are two numerators for this measure: **Numerator 1:** For members in Denominator 1, identify those with complete sexual orientation data, defined as: At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 6). ○ If value is "UNK," it will not count toward the numerator. ○ If value is "ASKU," it will count toward the numerator. ○ If value is "DONTKNOW," it will count toward the numerator. ○ Each value must be self-reported. **Numerator 2:**

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

ADDITIONAL MEASURE INFORMATION

Required Reporting	The following information is required: • A valid MassHealth Member ID Format: Refer to CHIA Submission Guide • At least one (1) valid gender identity value, as defined under "Complete Gender Identity Data" above Format: Refer to CHIA Submission Guide
Completeness Calculations	Completeness is calculated for: each individual acute hospital; and all acute hospitals.

Attachment 6. Gender Identity: Accepted Values

Description	Valid Values	Notes
Male	446151000124109	
Female	446141000124107	
Genderqueer/gender nonconforming/non-binary; neither exclusively male nor female	446131000124102	

Description	Valid Values	Notes
Transgender man/trans man	407376001	
Transgender woman/trans woman	407377005	
Additional gender category or other	OTH	
Choose not to answer	ASKU	Member was asked to provide their gender identity, and the member actively selected or indicated that they “choose not to answer”.
Don’t know	DONTKNOW	Member was asked to provide their gender identity, and the member actively selected or indicated that they did not know their gender identity.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	The gender identity of the member is unknown since either: (a) the member was not asked to provide their gender identity, or (b) the member was asked to provide their gender identity, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.

C. Screening for Social Drivers of Health: Preparing for Reporting Beginning in PY2

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

OVERVIEW

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

POPULATION HEALTH IMPACT

Eliminating health care disparities is essential to improve quality of care for all patients. An important step in addressing health care disparities and improving patient outcomes is to screen for social drivers of health, including the immediate daily necessities prioritized by individuals that arise from the inequities caused by social determinants of health. Identification of such needs provides an opportunity to improve health outcomes through interventions such as referral to appropriate social services.

MEASURE SUMMARY

Description	This metric assesses essential foundational interventions by hospitals to prepare for accountability under the "Screening for Social Drivers of Health" measure (Steward: CMS),[1] which if finalized, would be implemented in the HQEIP beginning in PY2 to assess whether a hospital implements screening for all MassHealth patients that are 0-64 years old at time of admission for food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety. This measure assesses hospital performance in conducting necessary precursor activities in preparation for implementation of the finalized "Screening for Social Drivers of Health" measure in Performance Year 2.

[1] Centers for Medicare and Medicaid Services. Screening for Social Drivers of Health Measure; Hospital Inpatient Quality Reporting Program Resources. https://qualitynet.cms.gov/inpatient/iqr/resources

SUBMISSION REQUIREMENTS	
PY Requirement #1	Complete and timely **(anticipated by September 30, 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 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.

D. Stratified Reporting of Quality Data

OVERVIEW	
Measure Name	Stratified Reporting of Quality Data
Steward	EOHHS
NQF Number	N/A
Data Source	Administrative, Clinical
Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

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

APPLICABLE QUALITY MEASURES

Domain	Measure
Perinatal Care	PC-02: Cesarean Birth, NTSV
	PC-06: Unexpected Newborn Complications in Term Infants
Care Coordination	CCM-1:Reconciled medication list received by discharged patient
	CCM-2:Transition record with specified data elements received by discharge patient
	CCM-3: Timely transmission of transition record within 48 hours at discharge
	NCQA: Follow-up After ED Visit for Mental Illness (NQF 3489) (7-Day)
	**EHS will be calculating and stratifying this claims-based measure, however hospitals must demonstrate ability to stratify the measure per specification or a proxy measure.*
	NCQA: Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence (NQF 3488) (7-Day) * **EHS will be calculating and stratifying this claims-based measure, however hospitals must demonstrate ability to stratify the measure per specification or a proxy measure.*
Acute & Chronic Conditions	SUB-2: Alcohol Use – Brief Intervention Provided/Offered*
	SUB-3: Alcohol & Other Drug Use d/o – treatment prov/offered at d/c*
Behavioral Health	NCQA: Follow-up After Hospitalization for Mental Illness (NQF 0576) (7-Day and 30-Day)

	** EHS will be calculating and stratifying this claims-based measure, however hospitals must demonstrate ability to stratify the measure per specification or a proxy measure.*
	CMS IPFQR: Screening for Metabolic Disorders

STRATIFICATION REQUIREMENTS

Description	Participating hospitals are required to generate or otherwise report on applicable quality measure rates stratified by race and ethnicity according to data standard requirements specified by EOHHS and summarized below:
Variable	**Standard**
Race	OFFICE OF MANAGEMENT AND BUDGET
Ethnicity	OFFICE OF MANAGEMENT AND BUDGET

SUBMISSION REQUIREMENTS

PY1 Requirement #1	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. For chart-based measures from the Clinical Quality Incentive measure slate specified for stratification in PY1 as above, for each record hospitals must also submit member-level self-reported race and ethnicity on the quarterly submission cycle as for reporting measure performance. For claims-based measures from the Clinical Quality Incentive measure slate specified for stratification in PY1 as above, hospitals must demonstrate capacity to internally stratify performance data by race and ethnicity by submitting a stratified performance report for those measures or approximate or proxy measures to EOHHS.

E. Equity Improvement Interventions

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

Description	Collaborating with Partnered-ACO(s), Hospitals will jointly design and implement one health equity focused Performance Improvement Projects (PIPs) in one of three MassHealth-defined domain areas: 1) Care Coordination/Integration, 2) Care for Acute and Chronic Conditions, and 3) Maternal Morbidity. While MassHealth does not propose to mandate specific interventions, Hospitals will be incentivized to implement ACO-focused PIPs designed to: • Support collaboration and information sharing, • Address mutually shared equity goals, • Achieve significant and sustained improvement in equity outcomes, and • Promote a program wide impact. These PIPs will build upon the framework for quality assessment and performance improvement programs required for Medicaid managed care plans and will require four key elements: performance measurement, implementation of interventions, evaluation of the interventions' impact using the performance measures, and activities to increase/sustain improvement.

	MassHealth will provide guidance to support PIP topic selection and measures to assess effectiveness. Hospitals will design interventions informed by existing data (e.g., historical performance data stratified by imputed race/ethnicity, existing literature on disparities in Massachusetts and in terms of health topics), needs assessments, and quality improvement methodology. In Performance Year 1, Hospitals will initiate Performance Improvement Project (PIP) planning activities for one health equity focused PIP with the expectation that planning for a second PIP will commence in Year 2. ACO and hospital partners will continue to build on and continue performance improvement projects planned in Years 1 or 2 and initiated in Year 2 to meet performance targets for health equity measures and disparities reduction on disparities-sensitive quality measures in Years 3 through 5. The following outlines an example of a PIP that could be carried out through this initiative: Focus: Transitions of care for members with mental illness based on existing evidence of disparities by race and ethnicity. Topic: "Follow-Up After Hospitalization for Mental Illness" quality measure. Process: Hospitals work with partnered-ACO to: • Analyze past performance to identify disparate performance, • Conduct barrier and root causes analyses, and • Identify potential interventions. Hospitals design evidence-based interventions, with stakeholder engagement, implement the interventions, and evaluate overall impact.

DEFINITIONS

Quarter	The term "quarter" means a period of three calendar months ending on March 31, June 30, September 30, or December 31

SUBMISSION REQUIREMENTS

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

Anticipated Deliverable Due Date (Quarter)	Deliverable	Description
March 31, 2023 (Quarter 1: January 1 – March 31, 2023)	**1) Hospital Key Personnel/ Institutional Resources Document**	Identify: • PIP leads which include, but are not limited to, an Executive Sponsor, Clinical Lead, and Project Manager as well as other supporting staff. • Institutional resources that will support PIP process
June 30, 2023 (Quarter 2: April 1 – June 30, 2023)	**2) PIP Partnership Form**	• Identify ACO partner(s) • Provide evidence that supports chosen ACO PIP partner(s)
September 30, 2023 (Quarter 3: July 1 – September 30, 2023)	**3) ACO Key Contact Form** **4) Mid-Year Planning Report**	• Identify key ACO contacts from approved ACO partners that will be involved in PIP development • Draft shared health equity goal statement that aligns with partnership and PIP domains that can be selected for one PIP • Select and rationalize PIP domains for one PIP
December 31, 2023 (Quarter 4: October 1 – December 31, 2023)	**5) PIP Planning Report**	Cumulative report which includes but is not limited to: • Restatement of deliverables 1-4 with any revisions required by EOHHS. • Description of PIP topics and rationale for PIP topic selection.

		• Description of PIP target populations. • Description of data-driven, evidence-based interventions. • Description of key indicators to measure intervention effectiveness, and overall performance of PIP.

F. Meaningful Access to Healthcare Services for Individuals with Limited English Proficiency

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

[2]Oregon Health Authority. Health Equity Measure: Meaningful Access to Health Care Services for Persons with Limited English Proficiency – MY2021 to MY2023. https://www.oregon.gov/oha/HPA/dsi-tc/Documents/2021-2023%20Measure%20Spec%20Sheet-Meaningful%20Access-8July2020.pdf

Description	This measure assesses access to healthcare services for individuals with limited English Proficiency and has two components: **Component 1. Organizational Self-Assessment** This self-assessment evaluates capacity of a hospital related to providing high quality communication services to patients. The survey will capture information pertinent to providing high quality language services, including related to: • Identification and assessment for communication needs • Provision of Language Assistance Services • Training of staff on policies and procedures • Providing notice of language assistance services **Component 2. Percent of member visits with interpreter needs in which interpreter services were provided.** This component does not apply in PY1.

SUBMISSION REQUIREMENTS

PY1 Requirement #1	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.

G. Disability Competencies

OVERVIEW

Metric Name	Disability Competencies
Steward	EOHHS
NQF Number	N/A
Data Source	Hospital-reported data
Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

Background	Two evidence-based competency models may help health care organizations achieve disability competent care: 1) The ***Disability Competencies,***[3] [4]a set of six core competencies developed in 2015 by the Alliance for Disability in Health Care Education (ADHCE) for the future health care workforce [5,6] and 2) The Resources for Integrated Care (RIC) ***Disability Core Competency (DCC) Model,***[567] a set of seven competency 'pillars' developed in 2017 for the practicing health care workforce. [2-4] Both models share common elements and an overarching goal to improve health care for persons with disabilities by educating the health care workforce.[8] [1] Healthcare organizations may assess the degree to which they meet disability competencies using the Resources for Integrated Care (RIC) ***Disability-Competent Care Self-***

[3] Havercamp, S. M., Barnhart, W. R., Robinson, A. C., & Whalen Smith, C. N. (2021). What should we teach about disability? National consensus on disability competencies for health care education. *Disability and health journal*, *14*(2), 100989. https://doi.org/10.1016/j.dhjo.2020.100989

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

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

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

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

[8] Bowen, C. N., Havercamp, S. M., Karpiak Bowen, S., & Nye, G. (2020). A call to action: Preparing a disability-competent health care workforce. *Disability and health journal*, *13*(4), 100941. https://doi.org/10.1016/j.dhjo.2020.100941

	Assessment Tool (DCCAT)[9] and the ***Disability-Competent Care Self-paced Training Assessment Review Tool (DCC-START).***[10]
Description	This measure evaluates whether hospitals have: 1) Performed a self-assessment of disability-competent care; 2) Identified at least three areas of competency in need of improvement; and 3) Developed a disability competency training plan for patient-facing hospital staff.
Additional Measure information	**Patient-facing staff**: any employed (part or full-time), non-agency hospital staff whose role requires engagement with patients (and/or a patient's caregiver(s)). Patient-facing staff may serve in clinical roles (e.g. provider) or non-clinical roles (e.g., transport staff, diagnostic (lab, radiology) support staff, food services, registration.) **Medical needs**: the needs related to the medical evaluation, assessment, diagnostic, functional and therapeutic care needs of a patient including patients who may have additional needs for assistance or accommodation due to their disability.

SUBMISSION REQUIREMENTS

PY1 Requirements #1	Complete and timely (**anticipated by August 11, 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: 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.

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

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

	2) The results from the Hospital DCC Team's DCCAT-Hospital tool exercise. Hospitals will have freedom to further modify the 'base' DCCAT-Hospital Tool, e.g. remove, change or add new questions so long as the hospital submits documentation of (as part of their report) the modifications made along with the reason(s) for the modification(s). 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.
PY1 Requirement #2	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: 1) selected training tools and/or educational resources, 2) which staff that will be assessed for post-educational/training competency, and 3) approaches that will be used to assess post-education/training organizational and staff competency. 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.

H. Accommodation Needs Met

OVERVIEW	
Measure Name	Accommodation Needs Met: Structural Measure
Steward	EOHHS
NQF Number	N/A

Data Source	Hospital-reported Data
Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

Description	This measure evaluates whether hospitals have: 1) Assessed current state of hospital practice related to screening for accommodation needs at the point of care; and 2) Planned for how they will, beginning in PY2, screen patients for accommodation needs at the point of care and assess whether accommodation needs were met.

SUBMISSION REQUIREMENTS

PY1 Requirement #1	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: 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. ** 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. Achievement of External Standards for Health Equity

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

Description	Effective January 1, 2023, The Joint Commission will introduce new and revised requirements[12] to reduce health care disparities for organizations participating in its hospital accreditation program. The new accreditation standards are aimed at reducing health care disparities as a quality and safety priority. Six new elements of performance in the Leadership (LD) chapter, Standard LD.04.03.08, emphasize fundamental processes including related to:

[11] The National Quality Forum. A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity. https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities__The_Four_I_s_for_Health_Equity.aspx

[12] The Joint Commission. New and Revised Requirements to Reduce Health Care Disparities. https://www.jointcommission.org/standards/prepublication-standards/new-and-revised-requirements-to-reduce-health-care-disparities/

	1) identifying health equity leadership; 2) understanding patients' health-related social needs and providing information about needed community resources and supports; 3) evaluation of health care disparities, including through stratification of key quality and safety data using sociodemographic characteristics, social needs, or social determinants of patient health; 4) creation of a written action plan describing how health care disparities will be addressed; 5) monitoring the effectiveness of interventions to reduce health care disparities; and 6) informing key stakeholders about its progress to reduce identified health care disparities. These standards are intended to serve as a foundation for future work to address health care disparities, specifically through The Joint Commission's planned Health Care Equity Certification,[13] which will build on the equity-focused Accreditation standards to recognize organizations that go above and beyond to provide high quality and equitable care.

SUBMISSION REQUIREMENTS

PY1 Requirement #1	By **December 31, 2023**, submit to EOHHS an attestation that the hospital has completed The Joint Commission (TJC) surveys for health equity accreditation standards (specifically, 6 new elements of performance in the Leadership (LD) chapter, Standard LD.04.03.08.) Hospitals that are currently accredited by TJC and due for triennial surveying in 2023 may meet the requirement through inclusion of the health equity standards in their scheduled survey; hospitals that are not currently accredited by TJC and TJC-accredited hospitals that are not due for their triennial accreditation survey in 2023 must participate in a "standalone" health equity survey by December 31, 2023. TJC remediation must be complete by April 30, 2024 to receive credit for the measure; hospital must attest to EOHHS to meeting this deadline.

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

J. HCAHPS: Items Related to Cultural Competency

OVERVIEW

Measure Name	Patient Experience: Cultural Competence
Steward	EOHHS; using data from HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey: Agency for Healthcare Research and Quality
NQF Number	0166
Data Source	Survey
Performance Status	Pay-for-Reporting

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

Description	This measure evaluates MassHealth member perspectives on hospital care as measured using the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey for patient experience in the acute hospital setting. The HCAHPS survey is administered by Massachusetts acute care hospitals to an all-payer sample; this measure requires hospitals to extract and report to MassHealth survey results for any MassHealth member participating in the HCAHPS survey for the Performance Year as part of a hospital's all-payer sample (selected according to AHRQ sampling methodologies). MassHealth member results will be reported for the full HCAHPS survey instrument, including standard items relating to provision of culturally competent care such as: • During this hospital stay, how often did nurses treat you with courtesy and respect? • During this hospital stay, how often did nurses listen carefully to you? • During this hospital stay, how often did nurses explain things in a way you could understand? • During this hospital stay, how often did doctors treat you with courtesy and respect?

	• During this hospital stay, how often did doctors listen carefully to you? • During this hospital stay, how often did doctors explain things in a way you could understand? HCAHPS Resources: HCAHPS: Patients' Perspectives of Care Survey | CMS; HCAHPS_Fact_Sheet_2022; Survey Instruments (hcahpsonline.org)

PATIENT EXPERIENCE SURVEY REQUIREMENTS

Description	• Hospitals must extract and report to MassHealth HCAHPS survey results for any MassHealth members participating in the HCAHPS survey as part of standard, all-payer sampling methodologies specified by AHRQ for the Performance Year.

SUBMISSION REQUIREMENTS

PY1 Requirement #1	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.