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

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

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A. Introduction

This document outlines the Performance Years (PYs) 3-5 Technical Specifications for all hospitals participating in the Health Quality and Equity Incentive Program (HQEIP). These requirements apply to all HQEIP hospital participating in PY3-5 regardless of the year in which hospitals started the program.

For hospitals that are participating in the HQEIP and being held accountable to a performance year in a performance period other than the calendar year in which the majority of other hospitals are being held accountable to such performance year, in accordance with Section 3.B of the HQEIP PY 1-5 Implementation Plan, MassHealth may update certain details included in these PY 3-5 Technical Specifications to account for the differing 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.

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

B. RELD SOGI Data Completeness

A.i. Race Data Completeness

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY	
Description	In PY3, the percentage of members with self-reported race data that was collected or verified by an acute hospital in the measurement year. In PY4 & PY5, the percentage of members with self-reported race data that was collected or verified by an acute hospital within the past 3 years.
Numerator	In PY3, members with an inpatient discharge and/or emergency department (ED) visit at an acute hospital <u>and</u> self-reported race data that was collected or verified by an acute hospital during the measurement year.

	In PY4 & PY5, members with an inpatient discharge and/or emergency department (ED) visit at an acute hospital during the measurement year and self-reported race data that was collected or verified by an acute hospital within the past 3 years.
Denominator	Members with an inpatient discharge and/or ED visit at an acute hospital during the measurement year.

ELIGIBLE POPULATION

Age	Members below 65 years of age on the date of inpatient discharge or ED visit
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)[1]. To identify emergency department visits: • Identify all Emergency Department visits (ED Value Set)[2].

DEFINITIONS

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

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

	• Each value must be self-reported.
Hospital File [“Enhanced Demographics Data File”]	The Center for Information and Analysis (CHIA) will intake race data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (based on Acute Hospital submitted MassHealth Member ID) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.
Measurement Year	Measurement Years 1-5 correspond to QEIP Performance Years 1-5.
Members	Members as defined in the PY 1-5 Implementation Plan[3] , which may include individuals enrolled in MassHealth ACPP (also known as “Model A” ACO), PCACO (also known as “Model B”), MCO, the PCC Plan, and FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Codes in the measure population.
Rate of Race Data Completeness	There will be two rates reported for this measure, defined as. Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100 Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100
Self-Reported data	For the purposes of this measure specification, data are defined as self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual’s behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).

[3] Includes members under 65 years of age (for whom reporting on the applicable data element is required by MassHealth according to the applicable HQEIP technical specifications) 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.

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

Attachment 1. Race: Accepted Values

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

Description	Valid Values	Notes
		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	MassHealth
CBE ID Number	N/A
Data Source	Numerator source: Center for Health Information and Analysis (CHIA) "Enhanced Demographics Data File" Denominator sources: MassHealth encounter and MMIS claims data
Performance Status: PY3-5	Pay-for-Performance (P4P)

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

Description	In PY3, the percentage of members with self-reported Hispanic ethnicity data that was collected or verified by an acute hospital in the measurement year. In PY4 & PY5, the percentage of members with self-reported Hispanic ethnicity data that was collected or verified by an acute hospital within the past 3 years.
Numerator	In PY3, members with an inpatient discharge and/or emergency department (ED) visit at an acute hospital <u>and</u> self-reported Hispanic ethnicity data that was collected or verified by an acute hospital during the measurement year. In PY4 & PY5, members with an inpatient discharge and/or emergency department (ED) visit at an acute hospital during the measurement year <u>and</u>

	self-reported Hispanic ethnicity data that was collected or verified by an acute hospital within the past 3 years.
Denominator	Members with an inpatient discharge and/or ED visit at an acute hospital during the measurement year.

ELIGIBLE POPULATION

Age	Members below 65 years of age on the date of inpatient discharge or ED visit
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)[4]. To identify emergency department visits: • Identify all Emergency Department visits (ED Value Set)[5]

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.

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

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 (based on Acute Hospital submitted MassHealth Member ID) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.
Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Members	Members as defined in the PY 1-5 Implementation Plan,[6] which may include individuals enrolled in MassHealth ACPP (also known as "Model A" ACO), PCACO (also known as "Model B"), MCO, the PCC Plan, and FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Codes in the measure population.
Rate of Hispanic Ethnicity Data Completeness	There will be two rates reported for this measure, defined as. Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100 Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100
Self-Reported data	For the purposes of this measure specification, data are defined as self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy). Self-reported Hispanic ethnicity data that has been rolled-up or transformed for reporting purposes may be included. For example, if a hospital's data systems include ethnicities that are included in HHS' data collection standards (i.e., Mexican; Puerto Rican; Cuban; Another Hispanic, Latino/a, or Spanish origin) and an individual self-reports their ethnicity as "Puerto

[6] Includes members under 65 years of age (for whom reporting on the applicable data element is required by MassHealth according to the applicable HQEIP technical specifications) 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.

	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
Data Collection	For the purposes of this measure, Hispanic ethnicity data must be self-reported. Hispanic ethnicity data that are derived using an imputation methodology do not contribute to completeness for this measure. Self-reported Hispanic ethnicity data may be collected: • By any modality that allows the patient (or a person legally authorized to respond on the patient’s behalf, such as a parent or legal guardian) to self-report Hispanic ethnicity (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 2.
Completeness Calculations	Completeness is calculated for: each individual Acute Hospital.

Attachment 2. Hispanic Ethnicity: Accepted Values

Description	Valid Values	Notes
Hispanic or Latino	2135-2	

Description	Valid Values	Notes
Not Hispanic or Latino	2186-5	
Choose not to answer	ASKU	Member was asked to provide their ethnicity, and the member actively selected or indicated that they “choose not to answer”.
Don’t know	DONTKNOW	Member was asked to provide their ethnicity, and the member actively selected or indicated that they did not know their ethnicity.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness).	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	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. Preferred Language Data Completeness

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

Description	In PY3, the percentage of members with self-reported language data that was collected or verified by an acute hospital in the measurement year. In PY4 & PY5, the percentage of members with self-reported language data that was collected or verified by an acute hospital within the past 3 years. Rates are calculated separately for 2 language questions.
Numerator	In PY3, members with an inpatient discharge and/or emergency department (ED) visit at an acute hospital <u>and</u> self-reported language data that was collected or verified by an acute hospital during the measurement year. In PY4 & PY5, members with an inpatient discharge and/or emergency department (ED) visit at an acute hospital during the measurement year <u>and</u>

	self-reported language data that was collected or verified by an acute hospital within the past 3 years.
Denominator	Members with an inpatient discharge and/or ED visit at an acute hospital during the measurement year.

ELIGIBLE POPULATION

Age	Members age 6 and older and below 65 years of age on the date of inpatient discharge or ED visit
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)[7]. To identify emergency department visits: • Identify all Emergency Department visits (ED Value Set)[8].

DEFINITIONS

Complete Preferred Written Language Data	Complete Preferred Written Language (PWL) data is defined as: One (1) valid Preferred Written Language value (valid Preferred Written Language values are listed in Attachment 3). • If value is “UNK,” it will not count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator.

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

	• Each value must be self-reported.
Complete Preferred Spoken Language Data	Complete Preferred Spoken Language (PSL) data is defined as: One (1) valid Preferred Spoken Language value (valid Preferred Spoken Language values are listed in Attachment 3). • If value is "UNK," it will not count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported.
Hospital File ["Enhanced Demographics Data File"]	The Center for Information and Analysis (CHIA) will intake Preferred Written and Spoken Language data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (based on Acute Hospital submitted MassHealth Member ID) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.
Measurement Year	Measurement Years 2-5 correspond to Calendar Years 2024-2027.
Members	Members as defined in the PY 1-5 Implementation Plan,[9] which may include individuals enrolled in MassHealth ACPP (also known as "Model A" ACO), PCACO (also known as "Model B"), MCO, the PCC Plan, and FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Codes in the measure population.
Rate of Preferred Written and Spoken	There will be four rates reported for this measure, defined as.

[9] Includes members under 65 years of age (for whom reporting on the applicable data element is required by MassHealth according to the applicable HQEIP technical specifications) 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.

Language Data Completeness	Rate 1: (Numerator 1 (PWL) Population / Denominator 1 (IP) Population) * 100 Rate 2: (Numerator 1 (PSL) Population / Denominator 1 (IP) Population) * 100 Rate 3: (Numerator 2 (PWL) Population / Denominator 2 (ED) Population) * 100 Rate 4: (Numerator 2 (PSL) Population / Denominator 2 (ED) Population) * 100
Self-Reported data	For the purposes of this measure specification, data are defined as self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized 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 language data, (defined above under "Complete Language Data") for each question below: • QMAT Language Q1: In which language would you feel most comfortable reading medical or health care instructions? (or similar phrasing to elicit written language preference).

	• QMAT Language Q2: What language do you feel most comfortable speaking with your doctor or nurse? (or similar phrasing to elicit spoken language preference). **Numerator 2:** For members in Denominator 2, identify those with complete language data, (defined above under "Complete Language Data") for each question below: • QMAT Language Q1: In which language would you feel most comfortable reading medical or health care instructions? (or similar phrasing to elicit written language preference). • QMAT Language Q2: What language do you feel most comfortable speaking with your doctor or nurse? (or similar phrasing to elicit spoken language preference).
Exclusions	If value is UTC, the inpatient 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) Preferred Written and Spoken Language value per question, as defined under "Complete Preferred Written Language Data" and "Complete Preferred Spoken Language Data" above Format: Refer to CHIA Submission Guide
Data Collection	For the purposes of this measure, Preferred Written and Spoken Language data must be self-reported. Preferred Written and Spoken Language data that are derived using an imputation methodology do not contribute to completeness for this measure.

	Self-reported Preferred Written and Spoken Language data may be collected: • By any modality that allows the patient (or a person legally authorized to respond on the patient's behalf, such as a parent or legal guardian) to self-report preferred written and spoken languages (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 3; ○ If an acute hospital submits a value that is not included in Attachment 3 but allowable per the MassHealth Member File Specification, the value will be mapped to Other Preferred Written Language (OTH).
Completeness Calculations	Completeness is calculated per language question per denominator population per acute hospital and overall, as described below: *For each individual acute hospital (Inpatient Denominator only):* For acute hospital x, the percentage of members with self-reported preferred **written** language data for question 1 that was collected or verified by acute hospital x in the measurement year for PY3 and within the past 3 years for PY4 & PY5. For acute hospital x, the percentage of members with self-reported preferred **spoken** language data for question 2 that was collected or verified by acute hospital x in the measurement year for PY3 and within the past 3 years for PY4 & PY5. *For each individual acute hospital (Emergency Department Denominator only):* For acute hospital x, the percentage of members with self-reported preferred **written** language data for question 1 that was collected or verified by acute hospital x in the measurement year for PY3 and within the past 3 years for PY4 & PY5. For acute hospital x, the percentage of members with self-reported preferred **spoken** language data for question 2 that was collected or verified by acute

	hospital x in the measurement year for PY3 and within the past 3 years for PY4 & PY5. *For all acute hospitals (Inpatient Denominator only)* For all acute hospitals, the percentage of members with self-reported preferred **written** language data for question 1 that was collected or verified by all acute hospitals in the measurement year for PY3 and within the past 3 years for PY4 & PY5. For all acute hospitals, the percentage of members with self-reported preferred **spoken** language data for question 2 that was collected or verified by all acute hospitals in the measurement year for PY3 and within the past 3 years for PY4 & PY5. *For all acute hospitals (Emergency Department Denominator only)* For all acute hospitals, the percentage of members with self-reported preferred **written** language data for question 1 that was collected or verified by all acute hospitals in the measurement year for PY3 and within the past 3 years for PY4 & PY5. For all acute hospitals, the percentage of members with self-reported preferred **spoken** language data for question 2 that was collected or verified by all acute hospitals in the measurement year for PY3 and within the past 3 years for PY4 & PY5.

Attachment 3. Preferred Written and Spoken Language: Accepted Values

Preferred Written Language

Description	Valid Values	Notes
English	en	
Spanish	es	
Portuguese	pt	
Chinese – Traditional	zh-Hant	
Chinese Simplified	zh-Hans	

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

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

Preferred Spoken Language

Description	Valid Values	Notes
English	en	-
Spanish	es	-
Portuguese	pt	-
Chinese	zh	If a hospital submits Cantonese (yue), Mandarin (cmn), or Min Nan Chinese (nan) it will be mapped to Chinese for the purposes of data completeness.
Haitian Creole	ht	
Sign Languages	sgn	If a hospital submits American Sign Language (ase) or Sign Languages (sgn), it will be mapped to Sign Languages for the purpose of data completeness
French	fr	-
Vietnamese	vi	-
Russian	ru	-

Arabic	ar	-
Other Preferred Spoken Language	OTH	If a hospital submits a value that is not included in Attachment 3 but allowable per CHIA EHRD, the value will be mapped to Other.
Choose not to answer	ASKU	Member was asked to provide their Preferred Spoken Language, and the member actively selected or indicated that they "choose not to answer."
Don't know	DONTKNOW	Member was asked to provide their Preferred Spoken Language, and the member actively selected or indicated that they did not know their Preferred Spoken Language.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	The Preferred Spoken Language of the member is unknown since either: (a) the member was not asked to provide their Preferred Spoken Language, or (b) the member was asked to provide their Preferred Spoken Language, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid

		response, and should be assigned the value of ASKU instead of UNK.

A.iv. Disability Data Completeness

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

Description	In PY3, the percentage of members with self-reported disability data that was collected or verified by an acute hospital during the measurement year. In PY4 & PY5, the percentage of members with self-reported disability data that was collected or verified by an acute hospital within the past 3 years. Rates are calculated separately for 6 disability questions.

Numerator	In PY3, members with an inpatient discharge or emergency department (ED) visit at an acute hospital and self-reported disability data that was collected or verified by an acute hospital in the measurement year. In PY4 & PY5, Members with an inpatient discharge or emergency department (ED) visit at an acute hospital during the measurement year and self-reported disability data that was collected or verified by an acute hospital within the past 3 years.
Denominator	Members with an inpatient discharge 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 (under 65 years of age on the date of inpatient discharge or ED visit); • Disability Questions 3 – 5: age 6 or older as of December 31st of measurement year and under 65 years of age on the date of inpatient discharge or ED visit; • Disability Question 6: age 16 or older as of December 31st of measurement year and under 65 years of age on the date of inpatient discharge or ED visit.
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)[10]. To identify emergency department visits:

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

	• Identify all Emergency Department visits (ED Value Set)[11].

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.
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 (based on Acute Hospital submitted MassHealth Member ID) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.
Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Members	Members as defined in the PY 1-5 Implementation Plan,[12] which may include individuals enrolled in MassHealth ACPP (also known as "Model A" ACO), PCACO (also known as "Model B"), MCO, the PCC Plan, and FFS (includes MassHealth Limited).

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

[12] Includes members under 65 years of age (for whom reporting on the applicable data element is required by MassHealth according to the applicable HQEIP technical specifications) 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.

	Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Codes in the measure population.
Rate of Disability Data Completeness	There will be two rates reported for this measure, defined as. Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100 Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100
Self-Reported data	For the purposes of this measure specification, data are defined as self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).

ADMINISTRATIVE SPECIFICATION

Denominator	There are two denominators for this measure: **Denominator 1:** 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 (under 65 years of age on the date of the discharge or visit): Are you deaf or do you have serious difficulty hearing?

	Disability Q2 (under 65 years of age on the date of the discharge or visit): Are you blind or do you have serious difficulty seeing, even when wearing glasses? Disability Q3 (age 6 or older as of December 31st of measurement year and under 65 years of age on the date of the discharge or visit): Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? Disability Q4 (age 6 or older as of December 31st of measurement year and under 65 years of age on the date of the discharge or visit): Do you have serious difficulty walking or climbing stairs? Disability Q5 (age 6 or older as of December 31st of measurement year and under 65 years of age on the date of the discharge or visit): Do you have difficulty dressing or bathing? Disability Q6 (age 16 or older as of December 31st of measurement year and under 65 years of age on the date of the discharge or visit): Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? • If value is “UNK,” it will not count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. • Each value must be self-reported. **Numerator 2:** For members in Denominator 2, identify those with complete disability data, (defined above under “Complete Disability Data”) for each question below: Disability Q1 (under 65 years of age on the date of the discharge or visit): Are you deaf or do you have serious difficulty hearing? Disability Q2 (under 65 years of age on the date of the discharge or visit): Are you blind or do you have serious difficulty seeing, even when wearing glasses? Disability Q3 (age 6 or older as of December 31st of measurement year and under 65 years of age on the date of the discharge or visit): Because of a

	physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? Disability Q4 (age 6 or older as of December 31st of measurement year and under 65 years of age on the date of the discharge or visit): Do you have serious difficulty walking or climbing stairs? Disability Q5 (age 6 or older as of December 31st of measurement year and under 65 years of age on the date of the discharge or visit): Do you have difficulty dressing or bathing? Disability Q6 (age 16 or older as of December 31st of measurement year and under 65 years of age on the date of the discharge or visit): Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? • If value is "UNK" it will not count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported.
Exclusions	If value is UTC, the inpatient 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 disability value per question, as defined under "Complete Disability Data" above Format: Refer to CHIA Submission Guide
Data Collection	For the purposes of this measure, disability data must be self-reported. Disability data that are derived using an imputation methodology do not contribute to completeness for this measure. Self-reported disability data may be collected:

	• By any modality that allows the patient (or a person legally authorized to respond on the patient's behalf, such as a parent or legal guardian) to self-report disability (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 4.
Completeness Calculations	Completeness is calculated per disability question per acute hospital and overall, as described below for questions 1 and 2, as an example: For each individual acute hospital: Example 1: For acute hospital x, the percentage of members with self-reported disability data for question 1 that was collected or verified by acute hospital x in the measurement year for PY3 and within the past 3 years for PY4 & PY5. Example 2: For acute hospital x, the percentage of members with self-reported disability data for question 2 that was collected or verified by acute hospital x in the measurement year for PY3 and within the past 3 years for PY4 & PY5. 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 or verified by all acute hospitals in the measurement year for PY3 and within the past 3 years for PY4 & PY5. Example 2: For all acute hospitals, the percentage of members with self-reported disability data for question 2 that was collected or verified by all acute hospitals in the measurement year for PY3 and within the past 3 years for PY4 & PY5.

Attachment 4. Disability: Accepted Values

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

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

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

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

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

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

Description	Valid Values	Notes
		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: (a) the member was not asked whether they have difficulty walking or climbing stairs, or

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

Disability Q5: Do you have difficulty dressing or bathing?

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

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

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

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

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

A.v. Sexual Orientation Data Completeness

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

Description	In PY3, the percentage of members with self-reported sexual orientation data that was collected or verified by an acute hospital in the measurement year. In PY4 & PY5, the percentage of members with self-reported sexual orientation data that was collected or verified by an acute hospital within the past 3 years.
Numerator	In PY3, members with an inpatient discharge and/or emergency department (ED) visit at an acute hospital <u>and</u> self-reported sexual orientation data that was collected or verified by an acute hospital during the measurement year. In PY4 & PY5, members with an inpatient discharge and/or emergency department (ED) visit at an acute hospital during the measurement year <u>and</u>

	self-reported sexual orientation data that was collected or verified by an acute hospital within the past 3 years.
Denominator	Members with an inpatient discharge and/or ED visit at an acute hospital during the measurement year.

ELIGIBLE POPULATION

Age	Members age 19 and older and below 65 years of age on the date of inpatient discharge or ED visit
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)[13]. To identify emergency department visits: • Identify all Emergency Department visits (ED Value Set)[14].

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.

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

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 (based on Acute Hospital submitted MassHealth Member ID) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.
Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Members	Members as defined in the PY 1-5 Implementation Plan,[15] which may include individuals enrolled in MassHealth ACPP (also known as "Model A" ACO), PCACO (also known as "Model B"), MCO, the PCC Plan, and FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Codes in the measure population.
Rate of Sexual Orientation Data Completeness	There will be two rates reported for this measure, defined as. Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100 Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100
Self-Reported data	For the purposes of this measure specification, data are defined as self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).

ADMINISTRATIVE SPECIFICATION

Denominator	There are two denominators for this measure:

[15] Includes members under 65 years of age (for whom reporting on the applicable data element is required by MassHealth according to the applicable HQEIP technical specifications) 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.

	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 sexual orientation value (valid sexual orientation values are listed in Attachment 5), defined as: At least one (1) valid sexual orientation value (valid sexual orientation values are listed in Attachment 5). • If value is "UNK," it will 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
Data Collection	For the purposes of this measure, sexual orientation data must be self-reported. Sexual orientation data that are derived using an imputation methodology do not contribute to completeness for this measure. Self-reported sexual orientation data may be collected: • By any modality that allows the patient (or a person legally authorized to respond on the patient's behalf, such as a parent or legal guardian) to self-report sexual orientation (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 5.
Completeness Calculations	Completeness is calculated for: each individual Acute Hospital.

Attachment 5. Sexual Orientation: Accepted Values

Description	Valid Values	Notes
Bisexual	42035005	
Straight or heterosexual	20430005	
Lesbian or gay	38628009	
Queer, pansexual, and/or questioning	QUEER	
Something else	OTH	

Description	Valid Values	Notes
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	MassHealth
CBE ID Number	N/A
Data Source	Numerator source: Center for Health Information and Analysis (CHIA) "Enhanced Demographics Data File" Denominator sources: MassHealth encounter and MMIS claims data
Performance Status: PY3-5	Pay-for-Performance (P4P)

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

Description	In PY3, the percentage of members with self-reported gender identity data that was collected or verified by an acute hospital in the measurement year. In PY4 & PY5, the percentage of members with self-reported gender identity data that was collected or verified by an acute hospital within the past 3 years.
Numerator	In PY3, members with an inpatient discharge and/or emergency department (ED) visit at an acute hospital <u>and</u> self-reported gender identity data that was collected or verified by an acute hospital during the measurement year. In PY4 & PY5, members with an inpatient discharge and/or emergency department (ED) visit at an acute hospital during the measurement year <u>and</u> self-reported gender identity data that was collected or verified by an acute hospital within the past 3 years.

Denominator	Members with an inpatient discharge and/or ED visit at an acute hospital during the measurement year.

ELIGIBLE POPULATION

Age	Members age 19 and older and below 65 years of age on the date of inpatient discharge or ED visit
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)[16]. To identify emergency department visits: • Identify all Emergency Department visits (ED Value Set)[17].

DEFINITIONS

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

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

Demographics Data File"]	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 (based on Acute Hospital submitted MassHealth Member ID) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.
Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Members	Members as defined in the PY 1-5 Implementation Plan,[18] which may include individuals enrolled in MassHealth ACPP (also known as "Model A" ACO), PCACO (also known as "Model B"), MCO, the PCC Plan, and FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Codes in the measure population.
Rate of Gender Identity Data Completeness	There will be two rates reported for this measure, defined as. Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100 Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100
Self-Reported data	For the purposes of this measure specification, data are defined as self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).

ADMINISTRATIVE SPECIFICATION

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

[18] Includes members under 65 years of age (for whom reporting on the applicable data element is required by MassHealth according to the applicable HQEIP technical specifications) 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.

	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 gender identity data, defined as: At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 6). • If value is "UNK," it will 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 gender identity data, defined as: At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 6). • If value is "UNK," it will 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
Data Collection	For the purposes of this measure, gender identity data must be self-reported. Gender identity data that are derived using an imputation methodology do not contribute to completeness for this measure. Self-reported gender identity data may be collected: • By any modality that allows the patient (or a person legally authorized to respond on the patient's behalf, such as a parent or legal guardian) to self-report gender identity (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 6.
Completeness Calculations	Completeness is calculated for: each individual Acute Hospital.

Attachment 6. Gender Identity: Accepted Values

Description	Valid Values	Notes
Male	446151000124109	
Female	446141000124107	
Genderqueer/gender nonconforming/non-binary; neither exclusively male nor female	446131000124102	
Transgender man/trans man	407376001	

Description	Valid Values	Notes
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.

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

MEASURE REQUIREMENTS AND ASSESSMENT: PY3-5		
Measure Requirements	**PY3-4**	1) Timely (as specified by CHIA and MassHealth) submission to the Massachusetts Center for Health Information and Analysis of the Electronic Health Record Dataset (EHRD) Data Collection File as described in the EHRD Submission Guide for CYQ1 through Q4 2024 for inclusion in the "Enhanced Demographics Data File" sent by CHIA to MassHealth. a. Within the EHRD Data Collection File submission, the date the value is updated ("<*RELDSOGI field*> Update Date") or verified ("<*RELDSOGI field*> Verification Date") associated with each RELDSOGI data element may be submitted but is not required. 2) Timely, complete, and responsive submission to MassHealth by September 1 of the performance year (e.g., September 1, 2026 for PY4), of a RELD SOGI mapping and verification deliverable including descriptions of member-reported demographic data collection efforts as specified by MassHealth, in a form and format to be specified by MassHealth.
	PY5	1) Timely (as specified by CHIA and MassHealth) submission to the Massachusetts Center for Health Information and Analysis of the Electronic Health Record Dataset (EHRD) Data Collection File as described in the EHRD Submission Guide for CYQ1 through Q4 2024 for inclusion in the "Enhanced Demographics Data File" sent by CHIA to MassHealth. a. Within the EHRD Data Collection File submission, the date the value is updated ("<*RELDSOGI field*> Update Date") and/or verified ("<*RELDSOGI field*> Verification Date") associated with each RELDSOGI data element must be submitted. 2) Timely, complete, and responsive submission to MassHealth by September 1, 2027 of a RELD SOGI mapping and verification deliverable, the form and format of which is to be specified by MassHealth, which includes descriptions of member-reported demographic data collection efforts as requested by MassHealth.

Performance Assessment	See the MassHealth Hospital Quality and Equity Incentives Program (HQEIP) Performance Assessment Methodology Manual.

C. Health-Related Social Needs Screening

Aligned with CMS' Screening for Social Drivers of Health Measure for the Merit-based Incentive Payment System (MIPS) Program[19]

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

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

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

	patients were screened using a standardized HRSN screening instrument prior to discharge for food, housing, transportation, and utility needs. 2. Rate 2: HRSN Screen Positive Rate: Rate of HRSN identified (i.e., screen positive) among cases in Rate 1 numerator. Four sub-rates are reported for each of the following domains of HRSN: food, housing, transportation, and utility.

ELIGIBLE POPULATION

Ages	Members under 65 years of age on the date of inpatient discharge or ED visit
Continuous enrollment/ Allowable gap	None
Anchor date	None
Measurement Years	PY3: January 1, 2025 – December 31, 2025 PY4: January 1, 2026 – December 31, 2026 PY5: January 1, 2027 – December 31, 2027
Event/diagnosis	Inpatient discharge, observation stays, and emergency department visits between January 1 and December 31 of the measurement year. To identify inpatient discharges: • Identify all inpatient discharges (Inpatient Stay Value Set)[20]. To identify observation stays: • Identify all Observation stay discharges (Observation Stay Value Set)[21]. To identify emergency department visits: • Identify all Emergency Department Visits (ED Value Set)[22].

[20] HEDIS® Value Set used with permission from NCQA
[21] HEDIS® Value Set used with permission from NCQA
[22] HEDIS® Value Set used with permission from NCQA

DEFINITIONS	
Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Members	Members as defined in the PY 1-5 Implementation Plan,[23] which may include individuals enrolled in MassHealth ACPP (also known as "Model A" ACO), PCACO (also known as "Model B"), MCO, the PCC Plan, and FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Codes in the measure population.
Health-Related Social Needs	The immediate daily necessities that arise from the inequities caused by the social determinants of health, such as a lack of access to basic resources like stable housing, an environment free of life-threatening toxins, healthy food, utilities including heating and internet access, transportation, physical and mental health care, safety from violence, education and employment, and social connection.
Standardized HRSN Screening Instruments	A standardized health-related social needs screening instrument is defined as a standardized assessment, survey, tool or questionnaire that is used to evaluate social needs. HRSN screening tools used for the purpose of performance on this measure must include at least one screening question in each of the four required domains. Examples of eligible screening tools include, but are not limited to: • Accountable Health Communities Health-Related Social Needs Screening Tool • The Protocol for Responding to and Assessing Patients' Risk and Experiences (PRAPARE) Tool • American Academy of Family Physicians (AAFP) Screening Tool Hospitals are not required to use the example screening tools listed above; hospitals may choose to use other screening instruments, or combinations of screening instruments, that include at least one screening question in each of

[23] Includes members under 65 years of age (for whom reporting on the applicable data element is required by MassHealth according to the applicable HQEIP technical specifications) 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.

	the four required domains. MassHealth may require hospitals to report to MassHealth the screening tool(s) used for the purpose of performance on this measure.
Supplemental Data	Data supplementary to administrative claims data that documents at the patient-level 1) when a health-related social needs screen was performed, and/or 2) whether health-related social needs were identified (and if so, in which domain needs were identified). Such supplemental data may be derived from clinical records (such as electronic health records and case management records) or other databases available to entities. Such supplemental data may document screens conducted by billing providers and/or non-billing providers (such as community health workers, medical assistants, and social workers).

ADMINISTRATIVE SPECIFICATION

RATE 1: HRSN Screening Rate

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

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

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

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

Numerator 1b includes visits where:

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

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

	hospital clinical provider), non-clinical staff (e.g., patient navigator), health plan staff and/or Community Partner staff.
Unit of measurement	Screens should be performed at the individual patient level for adults and, as determined to be clinically appropriate by individuals performing HRSN screening, for children and youth. Screening may be performed at the household level on behalf of dependents residing in one household; if screening is performed at the household level, then results must be documented in the respondent's medical record and in each dependent's medical record in order for the screen to be counted in the numerator for each individual.
Exclusions	Eligible events where: • Patient dies prior to discharge. • Patients in hospice (identified using the Hospice Value Set)[24]. • Patients not screened for food insecurity, housing instability, transportation needs, and utility difficulties because patient was unable to complete the screening and have no legal guardian or caregiver able to do so on their behalf or because patient left against medical advice (AMA), eloped or left without being seen (LWOBS). This should be documented in the medical record.

RATE 2: HRSN Screen Positive Rate

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

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

Numerator 2c – Transportation needs	Stays and visits where a patient screened positive for one or more transportation need(s)
Numerator 2d – Utility difficulties	Stays and visits where a patient screened positive for one or more utility need(s)
Exclusions	None

DATA REPORTING REQUIREMENTS

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

ADMINISTRATIVE DATA REPORTING REQUIREMENTS

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

Code System	Code	Meaning
HCPCS	M1207	Patient screened for food insecurity, housing instability, transportation needs, utility difficulties [*and interpersonal safety*[25]].
HCPCS	M1208	Patient not screened for food insecurity, housing instability, transportation needs, utility difficulties [*and interpersonal safety*[3]].
HCPCS	M1237	Patient reason for not screening for food insecurity, housing instability, transportation needs, utility difficulties, [*and interpersonal safety*[3]] (e.g., patient declined or other patient reasons)
HCPCS	G0136[26]	Administration of a standardized, evidence-based social determinants of health risk assessments tool, 5-15 minutes

[25] The HCPCS M1207, M1208, and M1237 codes include interpersonal safety as a screening domain. However, screening for interpersonal safety will not contribute toward performance on this HQEIP measure due to concerns about privacy and safety related to capturing this information through the same vehicle as other HRSN domains.
[26] Code no longer applicable beginning January 1, 2026.

Notes:

- Patients in the denominator where M1207 is coded will count towards the numerator.
- Patients in the denominator where M1237 is coded will count towards the numerator.
- Patients in the denominator where M1208 is coded will not count towards the numerator.
- Patients in the denominator where M1207, M1237, or M1208 are not coded will not count towards the numerator.
- Patients in the denominator where HCPCS code G0136 is coded will count towards numerator. This code will no longer be applicable beginning January 1, 2026.

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

Food Insecurity

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

Housing Instability

Homelessness

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

Housing Instability

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

Inadequate Housing

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

Transportation Needs

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

Utility Difficulties

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

SUPPLEMENTAL DATA REPORTING REQUIREMENTS

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

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

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

MEASURE REQUIREMENTS & ASSESSMENT

Measure Requirements	**PY3-5**	Submission to MassHealth by 5pm June 30 following each PY (e.g., June 30, 2027 for PY4) of required administrative and/or supplemental data. Hospitals are required to submit the supplemental file with data completed for the entire eligible population, per the Eligible Population definitions provided in this Technical Specification.
Performance Assessment		See the MassHealth Hospital Quality and Equity Incentives Program (HQEIP) Performance Assessment Methodology Manual. MassHealth expects to audit the data submitted for Rates 1 and 2 by the hospital.

D. Quality Performance Disparities Reduction

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

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

ELIGIBLE POPULATION

The eligible populations for each program measure (with the exception of SMM) in Table 1 are defined in the CQI program technical measure specifications (see https://www.mass.gov/info-details/masshealth-cqi-technical-specifications-manuals). Numerator and denominator codes for the SMM measure are defined by the AIM SMM codes list available on the following website: https://saferbirth.org/severe-maternal-morbidity/. The measure is run for patients aged 8-65 years.

DEFINITIONS

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

ADMINISTRATIVE SPECIFICATION

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

- An assessment of the opportunity for disparities reduction on the full list of measures specified by MassHealth, including how each measure does or doesn't represent an opportunity for the hospital with regards to disparities reduction based on race/ethnicity; and
- Identification and proposal of measures and patient populations to focus on for disparities reduction efforts to impact at hospital-level or statewide level in PY4 and PY5.

In PY4-5, acute hospitals will be assessed on disparities reduction for a subset of their eligible measures in Table 1. Measure performance will be calculated by MassHealth with no additional data reporting required by hospitals.

Table 1: MEASURES IDENTIFIED FOR INCLUSION IN THIS HQEIP "QUALITY PERFORMANCE DISPARITIES REDUCTION" MEASURE for PY3-5

Domain	Type	Measure
Perinatal Care	Chart-Based	PC-02: Cesarean Birth, NTSV
	Claims-Based	Severe Maternal Morbidity (SMM) as defined by the AIM SMM codes list available on the following website:

Domain	Type	Measure
		https://saferbirth.org/severe-maternal-morbidity/
Care Coordination	Claims-based	NCQA: Follow-up After ED Visit for Substance Use (7 and 30 Day)
	Claims-based	NCQA: Follow-up After Hospitalization for Mental Illness (7 and 30 day)
Acute & Chronic Conditions	Chart-Based	SUB-2: Alcohol Use – Brief Intervention Provided or Offered

ADDITIONAL MEASURE INFORMATION

General Guidance	Race and ethnicity data completeness threshold: There is no race or ethnicity data completeness threshold required for reporting performance stratified by race and ethnicity for the purpose of this measure. Hospitals should report on all patients for whom they have race and ethnicity data.

MEASURE REQUIREMENTS AND ASSESSMENT: PY3-5

Measure Requirements	**PY3**	By December 12, 2025 or such other time as specified by MassHealth, timely, complete, and responsive submission to MassHealth of a "*PY3 Measure Assessment Report*." Submissions must be in a form and format specified by MassHealth.
	PY4-5	Submission requirements will vary by targeted disparities reduction measure; hospitals must submit measure data, as applicable, in a form and format specified by MassHealth.
Performance Assessment	**PY3**	Hospitals will earn credit for performance on this measure only through: • Timely, complete, and responsive submission to MassHealth of the measure assessment report. All required questions must be answered or submission will not be considered complete.

	PY4-5	See the MassHealth Hospital Quality and Equity Incentives Program (HQEIP) Performance Assessment Methodology Manual.

E. Equity Improvement Interventions

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

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

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

ELIGIBLE POPULATION

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

DEFINITIONS

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

ADMINISTRATIVE SPECIFICATION

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

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

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

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

MEASURE REQUIREMENTS AND ASSESSMENT: PY3-5		

Measure Requirements	**PY3-5**	Timely, complete, and responsive submission to MassHealth of required reports in PY as listed below. Submission dates for PIP1 and PIP2 reports are specified below.
		
		PIP1 and PIP2 Report Submission Dates by Performance Year
		
		Performance Year 3:
		• PIP1: Remeasurement 1 Report
		  ○ Submission due date: 8/29/2025
		• PIP2: Remeasurement 1 Report
		  ○ Submission due date: 10/19/2026
		Performance Year 4:
		• PIP1: Closure Report
		  ○ Submission due date 7/31/2026
		• PIP2: Remeasurement 2 Report
		  ○ Submission due date: 10/1/2027
		Performance Year 5:
		• PIP2: Closure Report
		  ○ Submission due date: 8/1/2028
		
		Remeasurement 1 and 2 Report Sections & Weights
		
		Planning Section (25%):
		• Project Topic/Equity Statement [Topic/Rationale/ Shared Equity Statement] (15 pts)
		• Aim [Vision, Aim Statement(s), and Goal(s)] (10 pts)
		Implementation Section (50%):
		• Methodology (10 pts)

		• Barrier Analysis, Interventions, and Monitoring (update) (10 pts) • Intervention (15 pts) • Results (15 pts) **Validity and Sustainability Section (25%):** • Discussion [Discussion and Validity of Reported Improvement] (15 pts) • Sustainability (10 pts) *Only scored in Closure Report* Total = 90 pts **Closure Report Sections & Weights** **Abstract:** N/A, not scored **Planning Section (25%):** • Project Topic/Equity Statement [Topic/Rationale/ Shared Equity Statement] (15 pts) • Aim [Vision, Aim Statement(s), and Goal(s)] (10 pts) **Implementation Section (50%):** • Methodology (10 pts) • Barrier Analysis, Interventions, and Monitoring (update) (10 pts) • Intervention (15 pts) • Results (15 pts) **Validity & Sustainability Section (25%):** • Discussion [Discussion and Validity of Reported Improvement] (15 pts) • Next Steps [Sustainability] (10 pts) Total = 100 pts Acute hospitals will be permitted one opportunity to revise and re-submit each deliverable following receipt of feedback from the EQRO.
Performance Assessment		See the MassHealth Hospital Quality and Equity Incentives Program (HQEIP) Performance Assessment Methodology Manual.

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

OVERVIEW

Measure Name	Meaningful Access to Healthcare Services for Individuals with a Preferred Language other than English
Steward	MassHealth
CBE ID Number	N/A
Data Source	Supplemental
Performance Status: PY3	Pay-for-Performance (P4P): Language Access Self-Assessment Survey and Inpatient/ Observation Stay (Component 2) Pay-for-Reporting (P4R): ED (Component 2)
Performance Status: PY4 & 5	Pay-for-Performance (P4P): Inpatient/ Observation Stay and ED

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

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

ELIGIBLE POPULATION

Component 1: Language Access Self-Assessment Survey

Not applicable

Component 2: Addressing Language Access Needs in Acute Hospital Settings

Members	Members as defined in the PY 1-5 Implementation Plan,[27] which may include individuals enrolled in MassHealth ACPP (also known as "Model A" ACO), PCACO (also known as "Model B"), MCO, the PCC Plan, and FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Codes in the measure population.
Age	Members under 65 years of age on the date of the inpatient or observation stay discharge or ED visit
Continuous Enrollment/ Allowable gap	N/A
Anchor Date	None
Measurement Years	PY3: January 1, 2025 – December 31, 2025 PY4: January 1, 2026 – December 31, 2026 PY5: January 1, 2027 – December 31, 2027
Event/Diagnosis	A two-step process must be used to identify eligible stays and visits: **Step 1**. Identify inpatient discharges, observation stays, and emergency department visits between January 1 and December 31 of the measurement year. • To identify inpatient discharges:

[27] Includes members under 65 years of age (for whom reporting on the applicable data element is required by MassHealth according to the applicable HQEIP technical specifications) 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.

	○ Identify all inpatient discharges (Inpatient Stay Value Set)[28]. • To identify observation stays: ○ Identify all Observation stays (Observation Stay Value Set)[29]. • To identify emergency department visits: ○ Identify all Emergency Department visits (ED Value Set)[30]. **Step 2**. For eligible inpatient discharges, observation stays, and emergency department visits identified in Step 1, identify those where a patient reported a preferred spoken language other than English (including sign languages), as documented in the medical record or language services documentation system (e.g., vendor logs).

DEFINITIONS

Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Members	Members as defined in the PY 1-5 Implementation Plan,[31] which may include individuals enrolled in MassHealth ACPP (also known as "Model A" ACO), PCACO (also known as "Model B"), MCO, the PCC Plan, and FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Codes in the measure population.
Language Assistance Services	For the purposes of the HQEIP: • Language assistance services are defined[32] as oral or sign language assistance, including interpretation in non-English language provided in-person or remotely by a qualified interpreter for an individual who prefers a language other than English, and the use of services of

[28] HEDIS® Value Set used with permission from NCQA
[29] HEDIS® Value Set used with permission from NCQA
[30] HEDIS® Value Set used with permission from NCQA
[31] Includes members under 65 years of age (for whom reporting on the applicable data element is required by MassHealth according to the applicable HQEIP technical specifications) 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.
[32] Adapted from the Centers for Medicare and Medicaid Services' *Nondiscrimination in Health Programs and Activities* rule. 2024-08711.pdf (govinfo.gov)

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

ADMINISTRATIVE SPECIFICATIONS

Component 1: Language Access Self-Assessment Survey

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

Component 2: Addressing Language Access Needs in Acute Hospital Settings

Description	Percentage of inpatient discharges, observation stays, and emergency department visits serving patients who report a preferred spoken language other than English (including sign languages) during which either interpreter services or in-language services were utilized.
Denominator	**Denominator rate 1:** The eligible population where the patient discharge type is an inpatient stay or an observation stay **Denominator rate 2:** The eligible population where the patient discharge type is an emergency department visit
Numerator	**Numerator rate 1:** Number of inpatient discharges and observation stays serving patients who reported a preferred spoken language other than English (including sign languages) during which interpreter services or in-language services were utilized at least once during the stay, as documented in the medical record or language services documentation system (e.g., vendor logs). **Numerator rate 2:** Number of emergency department visits serving patients who reported a preferred spoken language other than English (including sign languages) during which interpreter services or in-language services were utilized, as documented in the medical record or language services documentation system (e.g., vendor logs).
Exclusions	Eligible events where: • Patient dies prior to discharge. • Documentation in the medical record that patient (or their caregiver, as applicable) refused interpreter services and/or in-language services. • Documentation in the medical record of a medical reason where the patient cannot request interpreter services and/or in-language services (e.g., cognitive limitations) and there is no caregiver or legal guardian able to do so on the patient's behalf or because patient left against medical advice (AMA), eloped or left without being seen (LWOBS).

REPORTING METHOD

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

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

Component 2: Addressing Language Access Needs in Acute Hospital Settings

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

Sample: Hospitals report performance for two samples:

a. eligible inpatient discharges and observation stays; and

b. eligible emergency department visits.

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

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

MEASURE REQUIREMENTS & ASSESSMENT: PY3-5

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

		supplemental file format specified by MassHealth for the respective rate year • Hospitals are required to submit the supplemental file with data completed for the eligible population, as defined by the Eligible Population definitions provided in this Technical Specification. MassHealth expects to audit the data submitted for Component 2 by the hospital.
	PY4	**Component 2: Addressing Language Access Needs in Acute Hospital Settings** • By June 30, 2027, hospitals must submit to MassHealth required data for either a sample(s) or the full eligible population, using one of the "reporting methods" described above. Hospitals must submit data in the supplemental file format specified by MassHealth. MassHealth expects to audit the data submitted for Component 2 by the hospital.
	PY5	**Component 2: Addressing Language Access Needs in Acute Hospital Settings** • By June 30, 2028, hospitals must submit to MassHealth required data for either a sample(s) or the full eligible population, using one of the specified "reporting methods" described above. Hospitals must submit data in a form and format to be further specified by MassHealth. MassHealth expects to audit the data submitted for Component 2 by the hospital.
Performance Assessment		See the MassHealth Hospital Quality and Equity Incentives Program (HQEIP) Performance Assessment Methodology Manual.

G. Disability Competent Care

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

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

ELIGIBLE POPULATION

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

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

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

DEFINITIONS

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

ADMINISTRATIVE SPECIFICATIONS

Rate 1: The percent of applicable patient-facing acute hospital staff who, in the past 24 months, 1) completed disability competency training to address Disability Competent Care (DCC) pillars selected by the acute hospital in its DCC Training Plan Report and 2) demonstrated competency in the relevant disability competency training area(s).
Rate 1 will be calculated as follows for acute hospitals that have selected three training areas (for hospitals that select more than three training areas, Rate 1 will be calculated by equally distributing performance credit across the total number of training areas):

> Rate 1 = 100* (# of patient-facing staff with demonstrated competency in training area 1 + # of patient-facing staff with demonstrated competency in training area 2 + # of patient-facing staff with demonstrated competency in training area 3)/(Eligible population for training area 1+ Eligible population for training area 2 + Eligible population for training area 3)

Denominator	The total eligible population
Numerator	For patient-facing staff in the denominator, identify those that have, within the preceding 24 months: • completed any applicable disability competency training(s); and • demonstrated competency in each applicable training area.
Anchor Date	None
Measurement Years	PY3: January 1, 2025 – December 31, 2025 PY4: January 1, 2026 – December 31, 2026 PY5: January 1, 2027 – December 31, 2027
Exclusions	Patient-facing staff that otherwise would fall into the denominator because of applicability of their roles to a targeted disability competency area who, as of the last day of the measurement year, have been employed with the hospital less than 180 calendar days.
Other	If a hospital wishes to change its targeted DCC training area (i.e., DCC training pillar) and/or targeted patient-facing staff population from its approved DCC Training Plan in PY1, the hospital should submit an updated DCC Training Plan to MassHealth for review and approval.

MEASURE REQUIREMENTS & ASSESSMENT: PY3-5

Measure Requirements	**PY3-5**	Rate 1 will be calculated by hospitals and results will be submitted by acute hospitals to MassHealth, in a form and format specified by MassHealth by February 27 following the PY (e.g., February 27, 2027 for PY4). 1. Specific Reporting Requirements for Rate 1 include--For each disability competency training area, report to MassHealth: a. The number of patient-facing staff targeted for disability competency training, including a description of the targeted staff and how they were selected for inclusion in the eligible population;

		b. The number of patient-facing staff who completed and demonstrated competency in the applicable training area.
Performance Assessment		See the MassHealth Hospital Quality and Equity Incentives Program (HQEIP) Performance Assessment Methodology Manual.

H. Disability Accommodation Needs

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

Description	The percentage of eligible hospital stays and/or encounters where 1) patients were screened for accommodation needs related to a disability and 2) for those patients screening positive for accommodation needs related to a disability, a corresponding patient-reported accommodation need was documented. Two separate rates are calculated for (a) inpatient and observation stays, and (b) ambulatory radiology: Rate 1: Accommodation Needs Screening: Percentage of eligible inpatient discharges and observation stays, or ambulatory radiology encounters where patients with a disability were screened for accommodation needs related to a disability, and the results of the screen were documented electronically in the acute hospital medical record.

	Rate 2: Accommodation Needs Related to a Disability Documented: Percentage of eligible inpatient discharges and observation stays or ambulatory radiology encounters where patients screened positive for accommodation needs related to a disability and for which patient-requested accommodation(s) related to a disability were documented electronically in the acute hospital medical record.

ELIGIBLE POPULATION

Members	Members as defined in the PY 1-5 Implementation Plan,[33] which may include individuals enrolled in MassHealth ACPP (also known as "Model A") ACO, PCA (also known as "Model B"), MCO, the PCC Plan, and FFS (includes MassHealth Limited). Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Codes in the measure population.
Ages	At least 6 years of age and under 65 years of age on the date of the inpatient or observation stay discharge or ambulatory radiology encounter
Continuous enrollment/ allowable gap	None
Anchor Date	None
Measurement Years	PY3: January 1, 2025 – December 31, 2025 PY4: January 1, 2026 – December 31, 2026 PY5: January 1, 2027 – December 31, 2027
Event	A two-step process will identify eligible events: **Step 1**. Identify inpatient discharges, observation stays, and ambulatory radiology encounters between January 1 and December 31 of the measurement year:

[33] Includes members under 65 years of age (for whom reporting on the applicable data element is required by MassHealth according to the applicable HQEIP technical specifications) 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.

	To identify inpatient discharges:
	• Identify all inpatient discharges (Inpatient Stay Value Set)[34].
	
	To identify observation stays:
	• Identify all Observation stay discharges (Observation Stay Value Set)[35].
	
	• To identify ambulatory radiology encounters :
	  ○ Identify all the ambulatory radiology encounters in the on-campus outpatient setting
	  ▪ Identify all on-campus ambulatory radiology encounters using the Radiology CPT Code Sets:
	  • 77046-77067 Radiology: Breast Mammography
	  • 77071-77092 Radiology: Bone/Joint Studies
	  • 78000-79999 Radiology: Nuclear Medicine
	  • 70010-76499 Radiology: Diagnostic Radiology (Diagnostic Imaging)
	  • 76500-76999 Radiology: Diagnostic Ultrasound.
	Note: Patients needing to be served in ambulatory radiology as an outpatient visit for the CPT code sets outlined above should be included. Radiology services included as part of an ED visit or inpatient stay are excluded.
	
	Step 2. For eligible stays and encounters identified in Step 1, identify those where a patient has a self-reported disability (see definition for "Patient with Self-reported Disability" below).
	• For all inpatient visits within the measurement year: patients with a self-reported disability identified *at or prior to the visit*.
	• For all outpatient radiology visits and observation stays: patients with a self-reported disability at *any time prior to the visit or stay*.

Exclusions	Eligible events where: • The patient dies prior to discharge. • The patient was not screened because patient was unable to complete the screening and had no legal guardian or caregiver able to do so on their behalf or because patient left against medical advice (AMA), eloped

[34] HEDIS® Value Set used with permission from NCQA
[35] HEDIS® Value Set used with permission from NCQA

	or left without being seen (LWOBS). This should be documented in the medical record.

DEFINITION	
Patient with Self-reported Disability	Patients with self-reported disability are defined as patients that, as documented in the acute hospital medical record, have responded "Yes" to one or more of the following six questions: • Disability Q1 (under 65 years of age on the date of the discharge or encounter): Are you deaf or do you have serious difficulty hearing? • Disability Q2 (under 65 years of age on the date of the discharge or encounter): Are you blind or do you have serious difficulty seeing, even when wearing glasses? • Disability Q3 (age 6 or older as of December 31st of measurement year and under 65 years of age on the date of the discharge or encounter): Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? • Disability Q4 (age 6 or older as of December 31st of measurement year and under 65 years of age on the date of the discharge or encounter): Do you have serious difficulty walking or climbing stairs? • Disability Q5 (age 6 or older as of December 31st of measurement year and under 65 years of age on the date of the discharge or encounter): Do you have difficulty dressing or bathing? • Disability Q6 (age 16 or older as of December 31st of measurement year and under 65 years of age on the date of the discharge or encounter): Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?
Accommodation Needs Related to a Disability	Accommodations needs related to a disability (including physical, intellectual and/or behavioral health disabilities) that are necessary to facilitate equitable access to high quality health care. Medical record documentation of patient-requested accommodation needs for the purpose of calculating Rate 2 may be specific (e.g. patient requests American Sign Language Interpreter) or categorical (e.g. patient requests communication accommodations) at the discretion of the acute hospital.

Accommodation Needs Screening	One or more questions posed to patients by hospital providers or staff that are intended to identify whether patients with disability need any accommodation needs related to a disability to facilitate equitable access to high quality health care. • Screening question(s) may be broad (e.g. Is there anything you need help with today to access your care?) or more specific (e.g., Do you have a need for an assistive listening device, mobility assistance, longer appointment time, or other accommodation?). • Accommodation needs screening may be conducted at the point of service (e.g. during a live in-person encounter) or asynchronously (e.g. through a patient portal).

ADMINISTRATIVE SPECIFICATIONS

RATE 1: Accommodation Needs Screening	
Denominator	Denominator 1: The eligible population for inpatient discharges and observation stays. Denominator 2: The eligible population for ambulatory radiology encounters.
Numerator	Numerator 1: Number of eligible events for inpatient discharges and observation stays where, as documented in the acute hospital medical record: • The patient was offered accommodation needs screening and responded; ○ To meet this requirement, the patient may instead actively validate that ongoing accommodation need(s) as documented in the acute hospital medical record continue to be sufficient; Or • The patient was offered accommodation needs screening and actively opted out of screening (i.e., chose not to answer any questions). Numerator 2: Number of eligible events for ambulatory radiology encounters where, as documented in the acute hospital medical record:

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

RATE 2: Accommodation Needs Related to a Disability Documented	
Denominator	Denominator 1: Cases in the eligible population for inpatient discharges and observation stays with a positive accommodation needs screen. Denominator 2: Cases in the eligible population for ambulatory radiology encounters with a positive accommodation needs screen.
Numerator	Numerator 1: Denominator event for inpatient discharges and observation stays where documentation in the acute hospital medical record describes: • Patient-requested accommodation(s) related to a disability documented either as a specific accommodation (e.g., patient requests American Sign Language Interpreter) or categorical (e.g., patient requests communication accommodations) at the discretion of the acute hospital. Numerator 2: Denominator event for ambulatory radiology encounters where documentation in the acute hospital medical record describes:

	• Patient-requested accommodation(s) related to a disability documented either as a specific accommodation (e.g., patient requests American Sign Language Interpreter) or categorical (e.g., patient requests communication accommodations) at the discretion of the acute hospital.

REPORTING METHOD

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

MEASURE REQUIREMENT AND ASSESSMENT: PY3-5

Measure Requirements	By 5pm on June 30 following the PY (e.g., June 30, 2027 for PY4), hospitals must report to MassHealth data for the full population. Hospitals must submit data in a form and format to be further specified by MassHealth. Required reporting elements will include: • For dates of service in the respective PY, data elements required to calculate Rates 1 and 2 as specified in the file specifications submitted via MassQEX. MassHealth expects to audit the data submitted for Rates 1 and 2 by the hospital.
Performance Assessment	See the MassHealth Hospital Quality and Equity Incentives Program (HQEIP) Performance Assessment Methodology Manual.

I. Achievement of External Standards for Health Equity

OVERVIEW

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

POPULATION HEALTH IMPACT

To be successful in addressing persistent and longstanding health disparities, healthcare organizations must adopt structures and systems that systemically and comprehensively prioritize health equity as a fundamental component of high-quality care. These goals include collaboration and partnership with other sectors that influence the health of individuals, adoption and implementation of a culture of equity, and the creation of structures that support a culture of equity.[36] External health equity certification independently and objectively assesses attainment of these and other relevant health equity goals to ensure that healthcare organizations are providing a comprehensively high standard of equitable care.

MEASURE SUMMARY

Description	Assessment of hospital progress towards and achievement of The Joint Commission's requirements for its voluntary "Health Care Equity Certification"[37] intended to recognize acute hospitals that go above and beyond to high quality and equitable care. Specifically: A. Achievement of The Joint Commission's introduced revised requirements[38] (effective January 1, 2023) to reduce health care disparities for organizations

[36] The National Quality Forum. A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity.
[37] Effective February 2026, per The Joint Commission, the Health Care Equity Certification has been renamed as Excellent Health Outcomes for All (EHOA) Certification
[38] 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/.

	participating in its hospital accreditation program including six new elements of performance in the Leadership (LD) chapter, Standard LD.04.03.08. B. Achievement of The Joint Commission's Health Care Equity Certification[39], which builds on the equity-focused Accreditation standards to recognize organizations that go above and beyond to provide high quality and equitable care.

MEASURE REQUIREMENT AND ASSESSMENT: PY3-5

Measure Requirements	**PY3**	**Achievement of Health Care Equity (HCE) Certification**[40] By January 31, 2026 a hospital must submit to MassHealth an attestation that the hospital (and if applicable, additional acute care hospital sites operated by the hospital) has achieved HCE Certification by December 31, 2025 as demonstrated by: • Completion of HCE Certification review conducted by The Joint Commission; • Completion of the Evidence of Standards Compliance (ESC) process for any identified Requirements for Improvement (if applicable); and • Receipt of a HCE certification decision of "Certified."
	PY4	**Maintenance of HCE Certification**[38] By January 31, 2027, a hospital must submit to MassHealth an attestation that the hospital (and if applicable, additional acute care hospital sites operated by the hospital) has maintained HCE Certification during PY as demonstrated by: • Completion of an Intracycle Monitoring Call with The Joint Commission; and • Re-applying to The Joint Commission for the next 2-year cycle of HCE Certification, as applicable per HCE expiration date.

[39] The Joint Commission. Advancing Health Care Equity, Together. https://www.jointcommission.org/our-priorities/health-care-equity/.
[40] Effective February 2026, per The Joint Commission, the Health Care Equity Certification has been renamed as Excellent Health Outcomes for All (EHOA) Certification

	PY5	**Achievement of HCE[41] Re-Certification** By January 31, 2028 a hospital must submit to MassHealth an attestation that the hospital (and if applicable, additional acute care hospital sites operated by the hospital) has achieved HCE re-Certification during PY as demonstrated by: • For hospitals that did not re-apply during previous PY, re-applying to The Joint Commission for the next 2-year cycle of HCE. • Completion of Joint Commission Health Care Equity (HCE) re-certification review conducted (typically occurs +/- 45 days of the 2-year anniversary of the original certification decision); • Completion of the Evidence of Standards Compliance (ESC) process for any identified Requirements for Improvement (if applicable); and • Receipt of a Health Care Equity re-certification decision of "Certified."
Performance Assessment		See the MassHealth Hospital Quality and Equity Incentives Program (HQEIP) Performance Assessment Methodology Manual.

[41] Effective February 2026, per The Joint Commission, the Health Care Equity Certification has been renamed as Excellent Health Outcomes for All (EHOA) Certification

J. Patient Experience: Communication, Courtesy, and Respect

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

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

ELIGIBLE POPULATION

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

ADMINISTRATIVE SPECIFICATION

Two composites, each comprised of a subset of questions drawn by MassHealth from the HCAHPS survey, contribute to the *Patient Experience: Communication, Courtesy, and Respect measure*. Each composite includes three questions drawn from the HCAHPS[42] survey.

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

Composite 1: HCAHPS Questions Related to Nurse Communication

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

Composite 2: HCAHPS Question Related to Doctor Communication

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

MEASURE REQUIREMENT AND ASSESSMENT: PY3-5

Measure Requirements	**PY3-5**	Based on surveys received through December 31 of the respective Performance Year, the following data should be submitted in a form and format as directed by MassHealth by June 30 of the following PY (e.g., June 30, 2026 for PY3; June 30, 2027 for PY4): 1. Total number of MassHealth adult (18+) acute inpatient discharges in the respective Performance Year

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

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

K. Collaboration

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

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

MEASURE REQUIREMENT AND ASSESSMENT: PY3-5

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

		• Disability Access and Accommodation • Achievement of External Standards for Health Equity • Cultural Competency Each of these accountability components contribute to a Health Equity Score for each MassHealth ACO. Acute hospitals must annually submit an attestation of partnership by March 31 of respective PY (e.g., March 31, 2025 for PY3) stating their selected ACO partner(s) for the Performance Year in the form and format specified by MassHealth.
Performance Assessment		See the MassHealth Hospital Quality and Equity Incentives Program (HQEIP) Performance Assessment Methodology Manual.