



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

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**Performance Year 2 (Calendar Year 2024)**

**Version: July 2, 2025**

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# I. Introduction to CHA HQEIP Technical Specifications

## A. CHA-Specific Adaptations

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

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

EOHHS has determined that CHA shall annually report population-based electronic measures (drawn from the electronic health record) in lieu of chart-abstraction/sampling for the Section III.C. Quality Performance Disparities Reduction measures. This is aligned with EOHHS’ goals toward population-based data collection. Measures will be submitted following the year-end utilizing an EOHHS-approved template consistent with the CMS and Joint Commission portal fields used for e-measures.

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

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

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

MassHealth reserves the right to request additional documentation related to the HQEIP measures for the purpose of auditing. MassHealth anticipates auditing specific P4R measures for PY2, as described in the measure specifications, below. These audits are anticipated to be used for informational purposes in PY2 and to promote data quality for future PYs. MassHealth reserves the right to take further action on the results of an audit, as appropriate.

## **B. Patient Population Definitions**

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

The served uninsured population are patients who have the following:

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

The Medicaid population are MassHealth members who have the following:

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

## II. CHA HQEIP Hospital Technical Specifications

### A. RELD SOGI Data Completeness

#### A.i. Race Data Completeness

##### OVERVIEW

|                                    |  |
|------------------------------------|--|
| <b>Measure Name</b>                | Rate of Race Data Completeness – Acute Hospital  |
| <b>Steward</b>                     | MassHealth   |
| <b>NQF Number</b>                  | N/A  |
| <b>Data Source</b>                 | Numerator source: Center for Health Information and Analysis (CHIA)<br>“Enhanced Demographics Data File”<br><br>Denominator sources: MassHealth encounter and MMIS claims data |
| <b>Performance Status:<br/>PY2</b> | Pay-for-Reporting (P4R)  |

##### 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

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

## ELIGIBLE POPULATION

|                              |   |
|------------------------------|---|
| <b>Age</b>                   | Members of any age  |
| <b>Continuous Enrollment</b> | None  |
| <b>Anchor Date</b>           | None  |
| <b>Event/Diagnosis</b>       | <p>At least one inpatient discharge or ED visit at an acute hospital between January 1 and December 31 of the measurement year.</p> <p>To identify inpatient discharges:</p> <ul style="list-style-type: none"> <li>Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>)<sup>1</sup>.</li> </ul> <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> <li>Identify all Emergency Department visits (<u>ED Value Set</u>)<sup>2</sup>.</li> </ul> |

## DEFINITIONS

|  |  |
|--|--|
| <b>Complete Race Data</b>  | <p>Complete race data is defined as:</p> <p>At least one (1) valid race value (valid race values are listed in Attachment 1).</p> <ul style="list-style-type: none"> <li>If value is “UNK” it will <u>not</u> count toward the numerator.</li> <li>If value is “ASKU,” it will count toward the numerator.</li> <li>If value is “DONTKNOW,” it will count toward the numerator.</li> <li>Each value must be self-reported.</li> </ul>  |
| <b>Hospital File<br/>[“Enhanced<br/>Demographics Data<br/>File”]</b> | <p>The Center for Information and Analysis (CHIA) will intake race data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications</p> |

<sup>1</sup> HEDIS® Value Set used with permission from NCQA

<sup>2</sup> HEDIS® Value Set used with permission from NCQA

|                                       |  |
|---------------------------------------|--|
|                                       | and submissions guides for the intake of this Enhanced Demographics Data file.   |
| <b>Measurement Year</b>               | Measurement Years 1-5 correspond to QEIP Performance Years 1-5.  |
| <b>Members</b>                        | <p>Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).</p> <p>Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.</p>  |
| <b>Rate of Race Data Completeness</b> | <p>There will be two rates reported for this measure, defined as.</p> <p>Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100</p> <p>Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100</p>  |
| <b>Self-Reported data</b>             | <p>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).</p> <p>Self-reported race data that has been rolled-up or transformed for reporting purposes may be included. For example, if a hospital's data systems include races that are included in <a href="#">HHS' data collection standards</a> and an individual self-reports their race as "Samoan", then the hospital can report the value of "Native Hawaiian or Other Pacific Islander" since the value of Samoan is not a valid value in Attachment 1.</p> |

## ADMINISTRATIVE SPECIFICATION

|                    |  |
|--------------------|--|
| <b>Denominator</b> | <p>There are two denominators for this measure:</p> <p><b>Denominator 1:</b></p> <p>The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b></p> |
|--------------------|--|

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

## ADDITIONAL MEASURE INFORMATION

|                           |   |
|---------------------------|---|
| <b>Required Reporting</b> | <p>The following information is required:</p> <ul style="list-style-type: none"> <li>• A valid MassHealth Member ID<br/>Format: Refer to CHIA Submission Guide</li> <li>• At least one (1) race value, as defined under “Complete Race Data” above</li> </ul> |
|---------------------------|---|



|                                  |   |
|----------------------------------|---|
|                                  | Format: Refer to CHIA Submission Guide  |
| <b>Data Collection</b>           | <p>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.</p> <p>Self-reported race data may be collected:</p> <ul style="list-style-type: none"> <li>• 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.);</li> <li>• By any entity interacting with the member (e.g. health plan, ACO, provider, staff);</li> <li>• Must include one or more values in Attachment 1.</li> </ul> |
| <b>Completeness Calculations</b> | Completeness is calculated for: each individual Acute Hospital.   |

#### Attachment 1. Race: Accepted Values

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

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

## CHA-SPECIFIC ADAPTATIONS

|  |  |
|--|--|
| <b>Overview: Data Source</b>                       | Numerator source: Center for Health Informatics and Analysis (CHIA) “Enhanced Demographics Data File” and/or Hospital EHR<br><br>Denominator sources: MassHealth encounter and MMIS claims data and/or Hospital EHR  |
| <b>Measure Summary: Description</b>                | The percentage of members and served uninsured patients (reported separately) with self-reported race data that was collected by CHA in the measurement year.  |
| <b>Definitions: Members/Patients</b>               | The CHA population included in the measure is grouped as follows: <ul style="list-style-type: none"> <li>• MassHealth members</li> <li>• Served uninsured patients</li> </ul>  |
| <b>Definitions: Rate of Race Data Completeness</b> | There will be four rates reported for this measure:<br><br>Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100<br><br>Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100<br><br>Rate 3: (Numerator 3 Population / Denominator 3 Population) * 100 |

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

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

## A.ii. Hispanic Ethnicity Data Completeness

### OVERVIEW

|                                |  |
|--------------------------------|--|
| <b>Measure Name</b>            | Rate of Hispanic Ethnicity Data Completeness – Acute Hospital  |
| <b>Steward</b>                 | MassHealth   |
| <b>NQF Number</b>              | N/A  |
| <b>Data Source</b>             | Numerator source: Center for Health Information and Analysis (CHIA)<br>“Enhanced Demographics Data File”<br><br>Denominator sources: MassHealth encounter and MMIS claims data |
| <b>Performance Status: PY2</b> | Pay-for-Reporting  |

### POPULATION HEALTH IMPACT

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

### MEASURE SUMMARY

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

### ELIGIBLE POPULATION

|                              |                    |
|------------------------------|--------------------|
| <b>Age</b>                   | Members of any age |
| <b>Continuous Enrollment</b> | None               |

|                        |  |
|------------------------|--|
| <b>Anchor Date</b>     | None   |
| <b>Event/Diagnosis</b> | <p>At least one inpatient discharge and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year.</p> <p>To identify inpatient discharges:</p> <ul style="list-style-type: none"> <li>Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>)<sup>3</sup>.</li> </ul> <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> <li>Identify all Emergency Department visits (<u>ED Value Set</u>)<sup>4</sup></li> </ul> |

## DEFINITIONS

|  |   |
|--|---|
| <b>Complete Hispanic ethnicity Data</b>                  | <p>Complete Hispanic ethnicity data is defined as:</p> <p>One (1) valid Hispanic ethnicity value (valid Hispanic ethnicity values are listed in Attachment 2).</p> <ul style="list-style-type: none"> <li>If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>If value is “ASKU” it will count toward the numerator.</li> <li>If value is “DONTKNOW” it will count toward the numerator.</li> <li>Each value must be self-reported.</li> </ul>   |
| <b>Hospital File [“Enhanced Demographics Data File”]</b> | <p>The Center for Information and Analysis (CHIA) will intake Hispanic ethnicity data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.</p> |
| <b>Measurement Year</b>                                  | Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.  |

<sup>3</sup> HEDIS® Value Set used with permission from NCQA

<sup>4</sup> HEDIS® Value Set used with permission from NCQA

|   |  |
|---|--|
| <b>Members</b>                                      | <p>Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).</p> <p>Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.</p>  |
| <b>Rate of Hispanic Ethnicity Data Completeness</b> | <p>There will be two rates reported for this measure, defined as.</p> <p>Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100</p> <p>Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100</p>  |
| <b>Self-Reported data</b>                           | <p>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).</p> <p>Self-reported Hispanic ethnicity data that has been rolled-up or transformed for reporting purposes may be included. For example, if a hospital's data systems include ethnicities that are included in <a href="#">HHS' data collection standards</a> (i.e., Mexican; Puerto Rican; Cuban; Another Hispanic, Latino/a, or Spanish origin) and an individual self-reports their ethnicity as "Puerto Rican", then the hospital can report the value of "Hispanic" since the value of Puerto Rican is not a valid value in Attachment 2.</p> |

## ADMINISTRATIVE SPECIFICATION

|                    |  |
|--------------------|--|
| <b>Denominator</b> | <p>There are two denominators for this measure:</p> <p><b>Denominator 1:</b></p> <p>The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b></p> <p>The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.</p> |
| <b>Numerator</b>   | <p>There are two numerators for this measure:</p>  |

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

## ADDITIONAL MEASURE INFORMATION

|                           |   |
|---------------------------|---|
| <b>Required Reporting</b> | <p>The following information is required:</p> <ul style="list-style-type: none"> <li>• A valid MassHealth Member ID<br/>Format: Refer to CHIA Submission Guide</li> <li>• At least one (1) ethnicity value, as defined under “Complete Hispanic Data” above<br/>Format: Refer to CHIA Submission Guide</li> </ul> |
| <b>Data Collection</b>    | <p>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.</p>  |



|                                  |  |
|----------------------------------|--|
|                                  | <p>Self-reported Hispanic ethnicity data may be collected:</p> <ul style="list-style-type: none"> <li>• 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.);</li> <li>• By any entity interacting with the member (e.g. health plan, ACO, provider, staff);</li> <li>• Must include one or more values in Attachment 2.</li> </ul> |
| <b>Completeness Calculations</b> | Completeness is calculated for: each individual Acute Hospital.  |

## Attachment 2. Hispanic Ethnicity: Accepted Values

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

| Description | Valid Values | Notes  |
|-------------|--------------|--|
|             |              | <p>(a) the member was not asked to provide their ethnicity, or</p> <p>(b) the member was asked to provide their ethnicity, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.</p> |

## CHA-SPECIFIC ADAPTATIONS

|  |  |
|--|--|
| <b>Overview: Data Source</b>                                     | <p>Numerator source: Center for Health Informatics and Analysis (CHIA) “Enhanced Demographics Data File” and/or Hospital EHR</p> <p>Denominator sources: MassHealth encounter and MMIS claims data and/or Hospital EHR</p>   |
| <b>Measure Summary: Description</b>                              | The percentage of members and served uninsured patients (reported separately) with self-reported Hispanic ethnicity data that was collected by CHA in the measurement year.  |
| <b>Definitions: Members/Patients</b>                             | <p>The CHA population included in the measure is grouped as follows:</p> <ul style="list-style-type: none"> <li>• MassHealth members</li> <li>• Served uninsured patients</li> </ul>   |
| <b>Definitions: Rate of Hispanic Ethnicity Data Completeness</b> | <p>There will be four rates reported for this measure:</p> <p>Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100</p> <p>Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100</p> <p>Rate 3: (Numerator 3 Population / Denominator 3 Population) * 100</p> <p>Rate 4: (Numerator 4 Population / Denominator 4 Population) * 100</p> |
| <b>Administrative Specification: Denominators</b>                | <p>There are four denominators for this measure.</p> <p><b>Denominator 1:</b><br/>The eligible population for <b>MassHealth members</b> with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p>  |

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

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

### A.iii. Preferred Language Data Completeness

#### OVERVIEW

|                                |  |
|--------------------------------|--|
| <b>Measure Name</b>            | Rate of Language Data Completeness – Acute Hospital  |
| <b>Steward</b>                 | EOHHS  |
| <b>NQF Number</b>              | N/A  |
| <b>Data Source</b>             | Numerator source: Center for Health Information and Analysis (CHIA)<br>“Enhanced Demographics Data File”<br><br>Denominator sources: MassHealth encounter and MMIS claims data |
| <b>Performance Status: PY2</b> | Pay-for-Reporting  |

#### 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

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

#### ELIGIBLE POPULATION

|            |   |
|------------|---|
| <b>Age</b> | Members age 6 and older as of December 31 <sup>st</sup> of the measurement year |
|------------|---|

|                              |   |
|------------------------------|---|
| <b>Continuous Enrollment</b> | None  |
| <b>Anchor Date</b>           | None  |
| <b>Event/Diagnosis</b>       | <p>At least one inpatient discharge and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year.</p> <p>To identify inpatient discharges:</p> <ul style="list-style-type: none"> <li>Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>)<sup>5</sup>.</li> </ul> <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> <li>Identify all Emergency Department visits (<u>ED Value Set</u>)<sup>6</sup>.</li> </ul> |

## DEFINITIONS

|  |   |
|--|---|
| <b>Complete Preferred Written Language Data</b>          | <p>Complete Preferred Written Language (PWL) data is defined as:</p> <p>One (1) valid Preferred Written Language value (valid Preferred Written Language values are listed in Attachment 3).</p> <ul style="list-style-type: none"> <li>If value is “UNK,” it will not count toward the numerator.</li> <li>If value is “ASKU,” it will count toward the numerator.</li> <li>If value is “DONTKNOW,” it will count toward the numerator.</li> <li>Each value must be self-reported.</li> </ul>                            |
| <b>Complete Preferred Spoken Language Data</b>           | <p>Complete Preferred Spoken Language (PSL) data is defined as:</p> <p>One (1) valid Preferred Spoken Language value (valid Preferred Spoken Language values are listed in Attachment 3).</p> <ul style="list-style-type: none"> <li>If value is “UNK,” it will not count toward the numerator.</li> <li>If value is “ASKU,” it will count toward the numerator.</li> <li>If value is “DONTKNOW,” it will count toward the numerator.</li> <li>Each value must be self-reported.</li> </ul>                               |
| <b>Hospital File [“Enhanced Demographics Data File”]</b> | <p>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</p> |

<sup>5</sup> HEDIS® Value Set used with permission from NCQA

<sup>6</sup> HEDIS® Value Set used with permission from NCQA

|  |  |
|--|--|
|  | submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.   |
| <b>Measurement Year</b>  | Measurement Years 2-5 correspond to Calendar Years 2024-2027.  |
| <b>Members</b>   | <p>Individuals enrolled in MassHealth including:<br/>Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).</p> <p>Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.</p>  |
| <b>Rate of Preferred Written and Spoken Language Data Completeness</b> | <p>There will be four rates reported for this measure, defined as.</p> <p>Rate 1: <math>(\text{Numerator 1 (PWL) Population} / \text{Denominator 1 (IP) Population}) * 100</math></p> <p>Rate 2: <math>(\text{Numerator 1 (PSL) Population} / \text{Denominator 1 (IP) Population}) * 100</math></p> <p>Rate 3: <math>(\text{Numerator 2 (PWL) Population} / \text{Denominator 2 (ED) Population}) * 100</math></p> <p>Rate 4: <math>(\text{Numerator 2 (PSL) Population} / \text{Denominator 2 (ED) Population}) * 100</math></p> |
| <b>Self-Reported data</b>  | 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

|                    |  |
|--------------------|--|
| <b>Denominator</b> | <p>There are two denominators for this measure:</p> <p><b>Denominator 1:</b></p> <p>The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b></p> |
|--------------------|--|

|                   |   |
|-------------------|---|
|                   | The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.  |
| <b>Numerator</b>  | <p><b>Numerator 1:</b></p> <p>For members in Denominator 1, identify those with complete language data, (defined above under “Complete Language Data”) for each question below:</p> <ul style="list-style-type: none"> <li>• <a href="#">QMAT</a> Language Q1: In which language would you feel most comfortable reading medical or health care instructions? (or similar phrasing to elicit written language preference).</li> <li>• <a href="#">QMAT</a> Language Q2: What language do you feel most comfortable speaking with your doctor or nurse? (or similar phrasing to elicit spoken language preference).</li> </ul> <p><b>Numerator 2:</b></p> <p>For members in Denominator 2, identify those with complete language data, (defined above under “Complete Language Data”) for each question below:</p> <ul style="list-style-type: none"> <li>• <a href="#">QMAT</a> Language Q1: In which language would you feel most comfortable reading medical or health care instructions? (or similar phrasing to elicit written language preference).</li> <li>• <a href="#">QMAT</a> Language Q2: What language do you feel most comfortable speaking with your doctor or nurse? (or similar phrasing to elicit spoken language preference).</li> </ul> |
| <b>Exclusions</b> | If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.  |

## ADDITIONAL MEASURE INFORMATION

|                           |   |
|---------------------------|---|
| <b>Required Reporting</b> | <p>The following information is required:</p> <ul style="list-style-type: none"> <li>• A valid MassHealth Member ID</li> </ul> <p>Format: Refer to CHIA Submission Guide</p> <ul style="list-style-type: none"> <li>• 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</li> </ul> <p>Format: Refer to CHIA Submission Guide</p> |
|---------------------------|---|



|                                  |  |
|----------------------------------|--|
| <b>Data Collection</b>           | <p>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.</p> <p>Self-reported Preferred Written and Spoken Language data may be collected:</p> <ul style="list-style-type: none"> <li>• 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.);</li> <li>• By any entity interacting with the member (e.g. health plan, ACO, provider, staff);</li> <li>• Must include one or more values in Attachment 3; <ul style="list-style-type: none"> <li>○ 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).</li> </ul> </li> </ul>  |
| <b>Completeness Calculations</b> | <p>Completeness is calculated per language question per denominator population per acute hospital and overall, as described below:</p> <p><i>For each individual acute hospital (Inpatient Denominator only):</i></p> <p>For acute hospital x, the percentage of members with self-reported preferred <b>written</b> language data <u>for question 1</u> that was collected by acute hospital x in the measurement year.</p> <p>For acute hospital x, the percentage of members with self-reported preferred <b>spoken</b> language data <u>for question 2</u> that was collected by acute hospital x in the measurement year.</p> <p><i>For each individual acute hospital (Emergency Department Denominator only):</i></p> <p>For acute hospital x, the percentage of members with self-reported preferred <b>written</b> language data <u>for question 1</u> that was collected by acute hospital x in the measurement year.</p> <p>For acute hospital x, the percentage of members with self-reported preferred <b>spoken</b> language data <u>for question 2</u> that was collected by acute hospital x in the measurement year.</p> <p><i>For all acute hospitals (Inpatient Denominator only)</i></p> |

|  |   |
|--|---|
|  | <p>For all acute hospitals, the percentage of members with self-reported preferred <b>written</b> language data <u>for question 1</u> that was collected by all acute hospitals in the measurement year.</p> <p>For all acute hospitals, the percentage of members with self-reported preferred <b>spoken</b> language data <u>for question 2</u> that was collected by all acute hospitals in the measurement year.</p> <p><i>For all acute hospitals (Emergency Department Denominator only)</i></p> <p>For all acute hospitals, the percentage of members with self-reported preferred <b>written</b> language data <u>for question 1</u> that was collected by all acute hospitals in the measurement year.</p> <p>For all acute hospitals, the percentage of members with self-reported preferred <b>spoken</b> language data <u>for question 2</u> that was collected by all acute hospitals in the measurement year.</p> |
|--|---|

### Attachment 3. Preferred Written and Spoken Language: Accepted Values

#### Preferred Written Language

| Description                      | Valid Values | Notes   |
|----------------------------------|--------------|---|
| English                          | en           |   |
| Spanish                          | es           |   |
| Portuguese                       | pt           |   |
| Chinese – Traditional            | zh-Hant      |   |
| Chinese Simplified               | zh-Hans      |   |
| Haitian Creole                   | ht           |   |
| French                           | fr           |   |
| Vietnamese                       | vi           |   |
| Russian                          | ru           |   |
| Arabic                           | ar           |   |
| Other Preferred Written Language | OTH          | If a hospital submits a value that is not included in Attachment 3 but allowable per CHIA EHRD, the value will be |

| Description   | Valid Values | Notes   |
|---|--------------|---|
|   |              | mapped to Other Preferred Written Language (OTH).   |
| <b>Choose not to answer</b>   | ASKU         | Member was asked to provide their Preferred Written Language, and the member actively selected or indicated that they “choose not to answer.”   |
| <b>Don’t know</b>   | DONTKNOW     | Member was asked to provide their Preferred Written Language, and the member actively selected or indicated that they did not know their Preferred Written Language.  |
| <b>Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)</b> | UTC          | Unable to collect this information on member due to lack of clinical capacity of member to respond.   |
| <b>Unknown</b>  | UNK          | <p>The Preferred Written Language of the member is unknown since either:</p> <p>(a) the member was not asked to provide their Preferred Written Language, or</p> <p>(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.</p> |

## 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 | <p>The Preferred Spoken Language of the member is unknown since either:</p> <p>(a) the member was not asked to provide their Preferred Spoken Language, or</p> <p>(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.</p> |

## CHA-SPECIFIC ADAPTATIONS

|   |  |
|---|--|
| <b>Overview: Data Source</b>  | Numerator source: Center for Health Informatics and Analysis (CHIA) “Enhanced Demographics Data File” and/or Hospital EHR Denominator sources: MassHealth encounter and MMIS claims data and/or Hospital EHR |
| <b>Measure Summary: Description</b>   | The percentage of members and served uninsured patients (reported separately) with self-reported language data that was collected by CHA in the measurement year.  |
| <b>Definitions: Members/ Patients</b>   | <p>The CHA population included in the measure is grouped as follows:</p> <ul style="list-style-type: none"> <li>• MassHealth members</li> <li>• Served uninsured patients</li> </ul>                         |
| <b>Definitions: Rate of Preferred Written and Spoken Language Data Completeness</b> | <p>There will be eight rates reported for this measure:</p> <p>MassHealth members:</p> <p>Rate 1: (Numerator 1 (PWL) Population / Denominator 1 (MassHealth IP) Population) * 100</p>                        |

|  |   |
|--|---|
|  | <p>Rate 2: (Numerator 1 (PSL) Population / Denominator 1 (MassHealth IP) Population) * 100</p> <p>Rate 3: (Numerator 2 (PWL) Population / Denominator 2 (MassHealth ED) Population) * 100</p> <p>Rate 4: (Numerator 2 (PSL) Population / Denominator 2 (MassHealth ED) Population) * 100</p> <p>Served uninsured patients:</p> <p>Rate 5: Numerator 3 (PWL) Population / Denominator 3 (served uninsured IP) Population) * 100</p> <p>Rate 6: (Numerator 3 (PSL) Population / Denominator 3 (served uninsured IP) Population) * 100</p> <p>Rate 7: (Numerator 4 (PWL) Population / Denominator 4 (served uninsured ED) Population) * 100</p> <p>Rate 8: (Numerator 4 (PSL) Population / Denominator 4 (served uninsured ED) Population) * 100</p> |
| <b>Administrative Specification: Denominator</b> | <p>There are four denominators for this measure.</p> <p><b>Denominator 1:</b><br/>The eligible population for <b>MassHealth members</b> with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b><br/>The eligible population for <b>MassHealth members</b> with <b>emergency department visit</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 3:</b><br/>The eligible population for served uninsured patients with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 4:</b><br/>The eligible population for served uninsured patients with <b>emergency department visit</b> claims/encounters from acute hospitals.</p>                    |
| <b>Administrative Specification: Numerator</b>   | <p>There are four numerators for this measure.</p> <p><b>Numerator 1:</b></p>   |

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).

**Numerator 3:**

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

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

**Numerator 4:**

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

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

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



#### A.iv. Disability Data Completeness

##### OVERVIEW

|                                |  |
|--------------------------------|--|
| <b>Measure Name</b>            | Rate of Disability Data Completeness – Acute Hospital  |
| <b>Steward</b>                 | MassHealth   |
| <b>NQF Number</b>              | N/A  |
| <b>Data Source</b>             | Numerator source: Center for Health Information and Analysis (CHIA)<br>“Enhanced Demographics Data File”<br><br>Denominator sources: MassHealth encounter and MMIS claims data |
| <b>Performance Status: PY2</b> | Pay-for-Reporting (P4R)  |

##### POPULATION HEALTH IMPACT

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

##### MEASURE SUMMARY

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

##### ELIGIBLE POPULATION

|            |  |
|------------|--|
| <b>Age</b> | Age varies by disability question: <ul style="list-style-type: none"><li>Disability Questions 1 and 2: no age specified;</li></ul> |
|------------|--|

|                              |   |
|------------------------------|---|
|                              | <ul style="list-style-type: none"> <li>Disability Questions 3 – 5: age 6 or older as of December 31st of the measurement year;</li> <li>Disability Question 6: age 16 or older as of December 31st of the measurement year.</li> </ul>  |
| <b>Continuous Enrollment</b> | None  |
| <b>Anchor Date</b>           | None  |
| <b>Event/Diagnosis</b>       | <p>At least one inpatient discharge and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year.</p> <p>To identify inpatient discharges:</p> <ul style="list-style-type: none"> <li>Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>)<sup>7</sup>.</li> </ul> <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> <li>Identify all Emergency Department visits (<u>ED Value Set</u>)<sup>8</sup>.</li> </ul> |

## DEFINITIONS

|  |  |
|--|--|
| <b>Complete Disability Data</b>                          | <p>Complete Disability data is defined as:</p> <p>One (1) valid disability value for each Disability Question (listed in Attachment 4).</p> <ul style="list-style-type: none"> <li>If value is “UNK,” it will not count toward the numerator.</li> <li>If value is “ASKU,” it will count toward the numerator.</li> <li>If value is “DONTKNOW,” it will count toward the numerator.</li> <li>Each value must be self-reported.</li> </ul>  |
| <b>Hospital File [“Enhanced Demographics Data File”]</b> | <p>The Center for Information and Analysis (CHIA) will intake disability data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA</p> |

<sup>7</sup> HEDIS® Value Set used with permission from NCQA

<sup>8</sup> HEDIS® Value Set used with permission from NCQA

|   |   |
|---|---|
|   | will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.  |
| <b>Measurement Year</b>                     | Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.  |
| <b>Members</b>                              | <p>Individuals enrolled in MassHealth including:<br/>Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).</p> <p>Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.</p> |
| <b>Rate of Disability Data Completeness</b> | <p>There will be two rates reported for this measure, defined as.</p> <p>Rate 1: <math>(\text{Numerator 1 Population} / \text{Denominator 1 Population}) * 100</math></p> <p>Rate 2: <math>(\text{Numerator 2 Population} / \text{Denominator 2 Population}) * 100</math></p>   |
| <b>Self-Reported data</b>                   | 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

|                      |  |
|----------------------|--|
| <b>Denominator</b>   | <p>There are two denominators for this measure:</p> <p><b>Denominator 1:</b></p> <p>The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b></p> <p>The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.</p> |
| <b>Numerator Set</b> | <p>There are two numerators for this measure:</p> <p><b>Numerator 1:</b></p>   |

For members in Denominator 1, identify those with complete disability data, (defined above under “Complete Disability Data”) for each question below:

Disability Q1 (all ages): Are you deaf or do you have serious difficulty hearing?

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

Disability Q3 (age 6 or older): Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

Disability Q4 (age 6 or older): Do you have serious difficulty walking or climbing stairs?

Disability Q5 (age 6 or older): Do you have difficulty dressing or bathing?

Disability Q6 (age 16 or older): Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

- If value is “UNK,” it will not count toward the numerator.
- If value is “ASKU,” it will count toward the numerator.
- If value is “DONTKNOW,” it will count toward the numerator.
- Each value must be self-reported.

**Numerator 2:**

For members in Denominator 2, identify those with complete disability data, (defined above under “Complete Disability Data”) for each question below:

Disability Q1 (all ages): Are you deaf or do you have serious difficulty hearing?

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

Disability Q3 (age 6 or older): Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

|                   |  |
|-------------------|--|
|                   | <p>Disability Q4 (age 6 or older): Do you have serious difficulty walking or climbing stairs?</p> <p>Disability Q5 (age 6 or older): Do you have difficulty dressing or bathing?</p> <p>Disability Q6 (age 16 or older): Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?</p> <ul style="list-style-type: none"> <li>• If value is "UNK" it will <u>not</u> count toward the numerator.</li> <li>• If value is "ASKU," it will count toward the numerator.</li> <li>• If value is "DONTKNOW," it will count toward the numerator.</li> <li>• Each value must be self-reported.</li> </ul> |
| <b>Exclusions</b> | If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.   |

## ADDITIONAL MEASURE INFORMATION

|                           |   |
|---------------------------|---|
| <b>Required Reporting</b> | <p>The following information is required:</p> <ul style="list-style-type: none"> <li>• A valid MassHealth Member ID<br/>Format: Refer to CHIA Submission Guide</li> <li>• At least one (1) valid disability value per question, as defined under "Complete Disability Data" above<br/>Format: Refer to CHIA Submission Guide</li> </ul>   |
| <b>Data Collection</b>    | <p>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.</p> <p>Self-reported disability data may be collected:</p> <ul style="list-style-type: none"> <li>• 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.);</li> <li>• By any entity interacting with the member (e.g. health plan, ACO, provider, staff);</li> <li>• Must include one or more values in Attachment 4.</li> </ul> |

|                                  |  |
|----------------------------------|--|
| <b>Completeness Calculations</b> | <p>Completeness is calculated per disability question per acute hospital and overall, as described below for questions 1 and 2, as an example:<br/>For each individual acute hospital:</p> <p>Example 1: For acute hospital x, the percentage of members with self-reported disability data <u>for question 1</u> that was collected by acute hospital x in the measurement year.</p> <p>Example 2: For acute hospital x, the percentage of members with self-reported disability data <u>for question 2</u> that was collected by acute hospital x in the measurement year.</p> <p>For all acute hospitals:</p> <p>Example 1: For all acute hospitals, the percentage of members with self-reported disability data <u>for question 1</u> that was collected by all acute hospitals in the measurement year.</p> <p>Example 2: For all acute hospitals, the percentage of members with self-reported disability data <u>for question 2</u> that was collected by all acute hospitals in the measurement year.</p> |
|----------------------------------|--|

#### Attachment 4. Disability: Accepted Values

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

| Description   | Valid Values | Notes  |
|---|--------------|--|
| <b>Yes</b>  | LA33-6       |  |
| <b>No</b>   | LA32-8       |  |
| <b>Choose not to Answer</b>                                     | ASKU         | Member was asked whether they are deaf or have difficulty hearing, and the member actively selected or indicated that they “choose not to answer.”                                   |
| <b>Don’t know</b>   | DONTKNOW     | Member was asked whether they are deaf or have difficulty hearing, and the member actively selected or indicated that they did not know if they are deaf or have difficulty hearing. |
| <b>Unable to collect this information on member due to lack</b> | UTC          | Unable to collect this information on member due to lack of clinical capacity of member to respond.  |

| Description   | Valid Values | Notes   |
|---|--------------|---|
| of clinical capacity of member to respond (e.g. clinical condition that alters consciousness) |              |   |
| Unknown   | UNK          | <p>Whether the member is deaf or has difficulty hearing is unknown since either:</p> <p>(a) the member was not asked whether they are deaf or have difficulty hearing, or</p> <p>(b) the member was asked whether they are deaf or have difficulty hearing, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.</p> |

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

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

| Description   | Valid Values | Notes   |
|---|--------------|---|
| respond (e.g. clinical condition that alters consciousness) |              |   |
| Unknown   | UNK          | <p>Whether the member is blind or has difficulty seeing is unknown since either:</p> <p>(a) the member was not asked whether they are blind or have difficulty seeing, or</p> <p>(b) the member was asked whether they are blind or have difficulty seeing, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.</p> |

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

| Description  | Valid Values | Notes   |
|--|--------------|---|
| Yes  | LA33-6       |   |
| No   | LA32-8       |   |
| Choose not to Answer   | ASKU         | Member was asked whether they have serious difficulty concentrating, remembering or making decisions, and the member actively selected or indicated that they “choose not to answer”.   |
| Don’t know   | DONTKNOW     | Member was asked whether they have serious difficulty concentrating, remembering or making decisions, and the member actively selected or indicated that they did not know whether they have serious difficulty concentrating, remembering or making decisions. |
| Unable to collect this information on member due to lack of clinical | UTC          | Unable to collect this information on member due to lack of clinical capacity of member to respond.   |



| Description   | Valid Values | Notes   |
|---|--------------|---|
| capacity of member to respond (e.g. clinical condition that alters consciousness) |              |   |
| Unknown   | UNK          | <p>Whether the member has difficulty concentrating, remembering or making decisions is unknown since either:</p> <p>(a) the member was not asked whether they have difficulty concentrating, remembering or making decisions, or</p> <p>(b) the member was asked whether they have difficulty concentrating, remembering or making decisions, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.</p> |

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

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

| Description  | Valid Values | Notes   |
|--|--------------|---|
| lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness) |              |   |
| Unknown  | UNK          | <p>Whether the member has difficulty walking or climbing stairs is unknown since either:</p> <p>(a) the member was not asked whether they have difficulty walking or climbing stairs, or</p> <p>(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.</p> |

### 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 | UTC          | Unable to collect this information on member due to lack of clinical capacity of member to respond.   |

| Description   | Valid Values | Notes  |
|---|--------------|--|
| capacity of member to respond (e.g. clinical condition that alters consciousness) |              |  |
| Unknown   | UNK          | <p>Whether the member has difficulty dressing or bathing is unknown since either:</p> <p>(a) the member was not asked whether they have difficulty dressing or bathing, or</p> <p>(b) the member was asked whether they have difficulty dressing or bathing, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.</p> |

**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 | UTC         | Unable to collect this information on member due to lack of clinical capacity of member to respond.  |

| Description   | Valid Value | Notes  |
|---|-------------|--|
| member to respond (e.g. clinical condition that alters consciousness) |             |  |
| Unknown   | UNK         | <p>Whether a member has difficulty doing errands is unknown since either:</p> <p>(a) the member was not asked whether they have difficulty doing errands, or</p> <p>(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.</p> |

## CHA-SPECIFIC ADAPTATIONS

|  |  |
|--|--|
| <b>Overview: Data Source</b>                             | <p>Numerator source: Center for Health Informatics and Analysis (CHIA) “Enhanced Demographics Data File” and/or Hospital EHR</p> <p>Denominator sources: MassHealth encounter and MMIS claims data and/or Hospital EHR</p>   |
| <b>Measure Summary: Description</b>                      | The percentage of members and served uninsured patients (reported separately) with self-reported disability data that was collected by CHA in the measurement year.  |
| <b>Definitions: Members/ Patients</b>                    | <p>The eligible CHA population included in the measure is grouped as follows:</p> <ul style="list-style-type: none"> <li>• MassHealth members</li> <li>• Served uninsured patients</li> </ul>  |
| <b>Definitions: Rate of Disability Data Completeness</b> | <p>There will be four rates reported for this measure:</p> <p>Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100</p> <p>Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100</p> <p>Rate 3: (Numerator 3 Population / Denominator 3 Population) * 100</p> <p>Rate 4: (Numerator 4 Population / Denominator 4 Population) * 100</p> |

|  |  |
|--|--|
| <b>Administrative Specification: Denominator</b> | <p>There are four denominators for this measure.</p> <p><b>Denominator 1:</b><br/>The eligible population for <b>MassHealth members</b> with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b><br/>The eligible population for <b>MassHealth members</b> with <b>emergency department visit</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 3:</b><br/>The eligible population for <b>served uninsured patients</b> with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 4:</b><br/>The eligible population for <b>served uninsured patients</b> with <b>emergency department visit</b> claims/encounters from acute hospitals.</p>   |
| <b>Administrative Specification: Numerator</b>   | <p>There are four numerators for this measure:</p> <p><b>Numerator 1:</b><br/>For members in Denominator 1, identify those with complete disability data (defined above under “Complete Disability Data”) for each question below:</p> <p>Disability Q1 (all ages): Are you deaf or do you have serious difficulty hearing?</p> <p>Disability Q2 (all ages): Are you blind or do you have serious difficulty seeing, even when wearing glasses?</p> <p>Disability Q3 (age 5 or older): Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?</p> <p>Disability Q4 (age 5 or older): Do you have serious difficulty walking or climbing stairs?</p> <p>Disability Q5 (age 5 or older): Do you have difficulty dressing or bathing?</p> <p>Disability Q6 (age 15 or older): Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor’s office or shopping?</p> <ul style="list-style-type: none"> <li>• If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>• If value is “ASKU,” it will count toward the numerator.</li> <li>• If value is “DONTKNOW,” it will count toward the numerator.</li> </ul> |

|  |  |
|--|--|
|  | <ul style="list-style-type: none"> <li>Each value must be self-reported.</li> </ul> <p><b>Numerator 2:</b><br/>For members in Denominator 2, identify those with complete disability data (defined above under “Complete Disability Data”) as for Numerator 1 above.</p> <p><b>Numerator 3:</b><br/>For patients in Denominator 3, identify those with complete disability data (defined above under “Complete Disability Data”) as for Numerator 1 above.</p> <p><b>Numerator 4:</b><br/>For patients in Denominator 4, identify those with complete disability data (defined above under “Complete Disability Data”) as for Numerator 1 above.</p> |
| <b>Additional Measure Information: Required Reporting</b>        | Valid MassHealth Member IDs must be submitted for the MassHealth population, and must be submitted for the served uninsured population, when applicable. MRNs must be submitted for both the MassHealth and served uninsured populations.  |
| <b>Additional Measure Information: Completeness Calculations</b> | Completeness will be calculated separately for CHA’s Medicaid population and CHA’s served uninsured population.  |

## A.v. Sexual Orientation Data Completeness

### OVERVIEW

|                                |  |
|--------------------------------|--|
| <b>Measure Name</b>            | Rate of Sexual Orientation Data Completeness – Acute Hospital  |
| <b>Steward</b>                 | MassHealth   |
| <b>NQF Number</b>              | N/A  |
| <b>Data Source</b>             | Numerator source: Center for Health Information and Analysis (CHIA)<br>“Enhanced Demographics Data File”<br><br>Denominator sources: MassHealth encounter and MMIS claims data |
| <b>Performance Status: PY2</b> | Pay-for-Reporting  |

### POPULATION HEALTH IMPACT

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

### MEASURE SUMMARY

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

### ELIGIBLE POPULATION

|                              |  |
|------------------------------|--|
| <b>Age</b>                   | Members age 19 and older as of December 31 of the measurement year |
| <b>Continuous Enrollment</b> | None   |

|                        |  |
|------------------------|--|
| <b>Anchor Date</b>     | None   |
| <b>Event/Diagnosis</b> | <p>At least one inpatient discharge and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year.</p> <p>To identify inpatient discharges:</p> <ul style="list-style-type: none"> <li>Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>)<sup>9</sup>.</li> </ul> <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> <li>Identify all Emergency Department visits (<u>ED Value Set</u>)<sup>10</sup>.</li> </ul> |

## DEFINITIONS

|  |   |
|--|---|
| <b>Complete Sexual Orientation Data</b>                  | <p>Complete sexual orientation data is defined as:</p> <p>At least one (1) valid sexual orientation value (listed in Attachment 5).</p> <ul style="list-style-type: none"> <li>If value is “UNK,” it will not count toward the numerator.</li> <li>If value is “ASKU,” it will count toward the numerator.</li> <li>If value is “DONTKNOW,” it will count toward the numerator.</li> <li>Each value must be self-reported.</li> </ul>   |
| <b>Hospital File [“Enhanced Demographics Data File”]</b> | <p>The Center for Information and Analysis (CHIA) will intake sexual orientation data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.</p> |
| <b>Measurement Year</b>                                  | Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.  |

<sup>9</sup> HEDIS® Value Set used with permission from NCQA

<sup>10</sup> HEDIS® Value Set used with permission from NCQA



|   |   |
|---|---|
| <b>Members</b>                                      | <p>Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).</p> <p>Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.</p> |
| <b>Rate of Sexual Orientation Data Completeness</b> | <p>There will be two rates reported for this measure, defined as.</p> <p>Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100</p> <p>Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100</p>   |
| <b>Self-Reported data</b>                           | <p>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).</p>   |

## ADMINISTRATIVE SPECIFICATION

|                    |  |
|--------------------|--|
| <b>Denominator</b> | <p>There are two denominators for this measure:</p> <p><b>Denominator 1:</b></p> <p>The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b></p> <p>The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.</p>   |
| <b>Numerator</b>   | <p>There are two numerators for this measure:</p> <p><b>Numerator 1:</b></p> <p>For members in Denominator 1, identify those with complete sexual orientation data, defined as:</p> <p>At least one (1) valid sexual orientation value (valid sexual orientation values are listed in Attachment 5).</p> <ul style="list-style-type: none"> <li>If value is "UNK," it will <u>not</u> count toward the numerator.</li> </ul> |

|                   |   |
|-------------------|---|
|                   | <ul style="list-style-type: none"> <li>• If value is “ASKU,” it will count toward the numerator.</li> <li>• If value is “DONTKNOW,” it will count toward the numerator.</li> <li>• Each value must be self-reported.</li> </ul> <p><b>Numerator 2:</b></p> <p>For members in Denominator 2, identify those with complete sexual orientation value (valid sexual orientation values are listed in Attachment 5), defined as:</p> <p>At least one (1) valid sexual orientation value (valid sexual orientation values are listed in Attachment 5).</p> <ul style="list-style-type: none"> <li>• If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>• If value is “ASKU,” it will count toward the numerator.</li> <li>• If value is “DONTKNOW,” it will count toward the numerator.</li> <li>• Each value must be self-reported.</li> </ul> |
| <b>Exclusions</b> | If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.  |

## ADDITIONAL MEASURE INFORMATION

|                           |  |
|---------------------------|--|
| <b>Required Reporting</b> | <p>The following information is required:</p> <ul style="list-style-type: none"> <li>• A valid MassHealth Member ID<br/>Format: Refer to CHIA Submission Guide</li> <li>• At least one (1) valid sexual orientation value, as defined under “Complete Sexual Orientation Data” above<br/>Format: Refer to CHIA Submission Guide</li> </ul>   |
| <b>Data Collection</b>    | <p>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.</p> <p>Self-reported sexual orientation data may be collected:</p> <ul style="list-style-type: none"> <li>• 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.);</li> </ul> |

|                                  |   |
|----------------------------------|---|
|                                  | <ul style="list-style-type: none"> <li>• By any entity interacting with the member (e.g. health plan, ACO, provider, staff);</li> <li>• Must include one or more values in Attachment 5.</li> </ul> |
| <b>Completeness Calculations</b> | Completeness is calculated for: each individual Acute Hospital.   |

### Attachment 5. Sexual Orientation: Accepted Values

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

| Description | Valid Values | Notes   |
|-------------|--------------|---|
|             |              | (b) the member was asked to provide their sexual orientation, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK. |

## CHA-SPECIFIC ADAPTATIONS

|  |  |
|--|--|
| <b>Overview: Data Source</b>                                     | <p>Numerator source: Center for Health Informatics and Analysis (CHIA) “Enhanced Demographics Data File” and/or Hospital EHR</p> <p>Denominator sources: MassHealth encounter and MMIS claims data and/or Hospital EHR</p>   |
| <b>Measure Summary: Description</b>                              | The percentage of members and served uninsured patients (reported separately) with self-reported sexual orientation data that was collected by CHA in the measurement year.  |
| <b>Definitions: Members/Patients</b>                             | <p>The eligible CHA population included in the measure is grouped as follows:</p> <ul style="list-style-type: none"> <li>• MassHealth members</li> <li>• Served uninsured patients</li> </ul>  |
| <b>Definitions: Rate of Sexual Orientation Data Completeness</b> | <p>There will be four rates reported for this measure:</p> <p>Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100</p> <p>Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100</p> <p>Rate 3: (Numerator 3 Population / Denominator 3 Population) * 100</p> <p>Rate 4: (Numerator 4 Population / Denominator 4 Population) * 100</p> |
| <b>Administrative Specification: Denominator</b>                 | <p>There are four denominators for this measure.</p> <p><b>Denominator 1:</b><br/>The eligible population for <b>MassHealth members</b> with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b><br/>The eligible population for <b>MassHealth members</b> with <b>emergency</b></p>                               |

|  |   |
|--|---|
|  | <p><b>department visit</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 3:</b><br/>The eligible population for <b>served uninsured patients</b> with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 4:</b><br/>The eligible population for <b>served uninsured patients</b> with <b>emergency department visit</b> claims/encounters from acute hospitals.</p>   |
| <b>Administrative Specification: Numerator</b> | <p>There are four numerators for this measure:</p> <p><b>Numerator 1:</b><br/>For members in Denominator 1, identify those with complete sexual orientation data, defined as:</p> <p>At least one (1) valid sexual orientation value (valid sexual orientation values are listed in Attachment 5).</p> <ul style="list-style-type: none"> <li>• If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>• If value is “ASKU,” it will count toward the numerator.</li> <li>• If value is “DONTKNOW,” it will count toward the numerator.</li> <li>• Each value must be self-reported.</li> </ul> <p><b>Numerator 2:</b><br/>For members in Denominator 2, identify those with complete sexual orientation data, defined as:</p> <p>At least one (1) valid sexual orientation value (valid sexual orientation values are listed in Attachment 5).</p> <ul style="list-style-type: none"> <li>• If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>• If value is “ASKU,” it will count toward the numerator.</li> <li>• If value is “DONTKNOW,” it will count toward the numerator.</li> <li>• Each value must be self-reported.</li> </ul> <p><b>Numerator 3:</b><br/>For patients in Denominator 3, identify those with complete sexual orientation data, defined as:</p> <p>At least one (1) valid sexual orientation value (valid sexual orientation values are listed in Attachment 5).</p> <ul style="list-style-type: none"> <li>• If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>• If value is “ASKU,” it will count toward the numerator.</li> <li>• If value is “DONTKNOW,” it will count toward the numerator.</li> <li>• Each value must be self-reported.</li> </ul> <p><b>Numerator 4:</b></p> |

|  |   |
|--|---|
|  | <p>For patients in Denominator 4, identify those with complete sexual orientation data, defined as.</p> <p>At least one (1) valid sexual orientation value (valid sexual orientation values are listed in Attachment 5).</p> <ul style="list-style-type: none"> <li>• If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>• If value is “ASKU,” it will count toward the numerator.</li> <li>• If value is “DONTKNOW,” it will count toward the numerator.</li> <li>• Each value must be self-reported.</li> </ul> |
| <b>Additional Measure Information: Required Reporting</b>        | Valid MassHealth Member IDs must be submitted for the MassHealth population, and must be submitted for the served uninsured population, when applicable. MRNs must be submitted for both the MassHealth and served uninsured populations.   |
| <b>Additional Measure Information: Completeness Calculations</b> | Completeness will be calculated separately for CHA’s Medicaid population and CHA’s served uninsured population.   |

## A.vi. Gender Identity Data Completeness

### OVERVIEW

|                                |  |
|--------------------------------|--|
| <b>Measure Name</b>            | Rate of Gender Identity Data Completeness – Acute Hospital   |
| <b>Steward</b>                 | MassHealth   |
| <b>NQF Number</b>              | N/A  |
| <b>Data Source</b>             | Numerator source: Center for Health Information and Analysis (CHIA)<br>“Enhanced Demographics Data File”<br><br>Denominator sources: MassHealth encounter and MMIS claims data |
| <b>Performance Status: PY2</b> | Pay-for-Reporting  |

### POPULATION HEALTH IMPACT

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

### MEASURE SUMMARY

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

### ELIGIBLE POPULATION

|                              |  |
|------------------------------|--|
| <b>Age</b>                   | Members age 19 and older as of December 31 of the measurement year |
| <b>Continuous Enrollment</b> | None   |

|                        |   |
|------------------------|---|
| <b>Anchor Date</b>     | None  |
| <b>Event/Diagnosis</b> | <p>At least one inpatient discharge and/or ED visit at an acute hospital between January 1 and December 31 of the measurement year.</p> <p>To identify inpatient discharges:</p> <ul style="list-style-type: none"> <li>Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>)<sup>11</sup>.</li> </ul> <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> <li>Identify all Emergency Department visits (<u>ED Value Set</u>)<sup>12</sup>.</li> </ul> |

## DEFINITIONS

|  |  |
|--|--|
| <b>Complete Gender Identity Data</b>                     | <p>Complete gender identity data is defined as:</p> <p>At least one (1) valid gender identity value (listed in Attachment 6).</p> <ul style="list-style-type: none"> <li>If value is “UNK,” it will not count toward the numerator.</li> <li>If value is “ASKU,” it will count toward the numerator.</li> <li>If value is “DONTKNOW,” it will count toward the numerator.</li> <li>Each value must be self-reported.</li> </ul>  |
| <b>Hospital File [“Enhanced Demographics Data File”]</b> | <p>The Center for Information and Analysis (CHIA) will intake gender identity data for the measure numerator from the acute hospitals on a periodic basis. To support hospitals in patient attribution to MassHealth and optimize members captured in the numerator, CHIA will collect the data for all patient encounters and perform cross-database matching checks, which may enable inclusion of some members for which the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.</p> |
| <b>Measurement Year</b>                                  | Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.   |

<sup>11</sup> HEDIS® Value Set used with permission from NCQA

<sup>12</sup> HEDIS® Value Set used with permission from NCQA



|  |   |
|--|---|
| <b>Members</b>                                   | <p>Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).</p> <p>Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.</p> |
| <b>Rate of Gender Identity Data Completeness</b> | <p>There will be two rates reported for this measure, defined as.</p> <p>Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100</p> <p>Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100</p>   |
| <b>Self-Reported data</b>                        | <p>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).</p>   |

## ADMINISTRATIVE SPECIFICATION

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

|                   |  |
|-------------------|--|
|                   | <ul style="list-style-type: none"> <li>• If value is “ASKU,” it will count toward the numerator.</li> <li>• If value is “DONTKNOW,” it will count toward the numerator.</li> <li>• Each value must be self-reported.</li> </ul> <p><b>Numerator 2:</b></p> <p>For members in Denominator 2, identify those with complete gender identity data, defined as:</p> <p>At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 6).</p> <ul style="list-style-type: none"> <li>• If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>• If value is “ASKU,” it will count toward the numerator.</li> <li>• If value is “DONTKNOW,” it will count toward the numerator.</li> <li>• Each value must be self-reported.</li> </ul> |
| <b>Exclusions</b> | If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.   |

## ADDITIONAL MEASURE INFORMATION

|                           |   |
|---------------------------|---|
| <b>Required Reporting</b> | <p>The following information is required:</p> <ul style="list-style-type: none"> <li>• A valid MassHealth Member ID</li> </ul> <p>Format: Refer to CHIA Submission Guide</p> <ul style="list-style-type: none"> <li>• At least one (1) valid gender identity value, as defined under “Complete Gender Identity Data” above</li> </ul> <p>Format: Refer to CHIA Submission Guide</p>   |
| <b>Data Collection</b>    | <p>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.</p> <p>Self-reported gender identity data may be collected:</p> <ul style="list-style-type: none"> <li>• 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.);</li> <li>• By any entity interacting with the member (e.g. health plan, ACO, provider, staff);</li> </ul> |

|                                  |  |
|----------------------------------|--|
|                                  | <ul style="list-style-type: none"> <li>Must include one or more values in Attachment 6.</li> </ul> |
| <b>Completeness Calculations</b> | Completeness is calculated for: each individual Acute Hospital.                                    |

### Attachment 6. Gender Identity: Accepted Values

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

| Description | Valid Values | Notes  |
|-------------|--------------|--|
| Unknown     | UNK          | <p>The gender identity of the member is unknown since either:</p> <p>(a) the member was not asked to provide their gender identity, or</p> <p>(b) the member was asked to provide their gender identity, and a response was not given. Note that a member actively selecting or indicating the response “choose not to answer” is a valid response, and should be assigned the value of ASKU instead of UNK.</p> |

## CHA-SPECIFIC ADAPTATIONS

|   |  |
|---|--|
| <b>Overview: Data Source</b>                                  | <p>Numerator source: Center for Health Informatics and Analysis (CHIA) “Enhanced Demographics Data File” and/or Hospital EHR</p> <p>Denominator sources: MassHealth encounter and MMIS claims data and/or Hospital EHR</p>   |
| <b>Measure Summary: Description</b>                           | The percentage of members and served uninsured patients (reported separately) with self-reported gender identity data that was collected by CHA in the measurement year.   |
| <b>Definitions: Members/Patients</b>                          | <p>The eligible CHA population included in the measure is grouped as follows:</p> <ul style="list-style-type: none"> <li>MassHealth members</li> <li>Served uninsured patients</li> </ul>  |
| <b>Definitions: Rate of Gender Identity Data Completeness</b> | <p>There will be four rates reported for this measure:</p> <p>Rate 1: (Numerator 1 Population / Denominator 1 Population) * 100</p> <p>Rate 2: (Numerator 2 Population / Denominator 2 Population) * 100</p> <p>Rate 3: (Numerator 3 Population / Denominator 3 Population) * 100</p> <p>Rate 4: (Numerator 4 Population / Denominator 4 Population) * 100</p> |

|  |   |
|--|---|
| <b>Administrative Specification: Denominator</b> | <p>There are four denominators for this measure.</p> <p><b>Denominator 1:</b><br/>The eligible population for <b>MassHealth members</b> with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 2:</b><br/>The eligible population for <b>MassHealth members</b> with <b>emergency department visit</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 3:</b><br/>The eligible population for served uninsured patients with <b>inpatient discharge</b> claims/encounters from acute hospitals.</p> <p><b>Denominator 4:</b><br/>The eligible population for served uninsured patients with <b>emergency department visit</b> claims/encounters from acute hospitals.</p>  |
| <b>Administrative Specification: Numerator</b>   | <p>There are four numerators for this measure:</p> <p><b>Numerator 1:</b><br/>For members in Denominator 1, identify those with complete gender identity data, defined as:</p> <p>At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 5).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> <li>○ Each value must be self-reported.</li> </ul> <p><b>Numerator 2:</b><br/>For members in Denominator 2, identify those with complete gender identity data, defined as.</p> <p>At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 5).</p> <ul style="list-style-type: none"> <li>○ If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>○ If value is “ASKU,” it will count toward the numerator.</li> <li>○ If value is “DONTKNOW,” it will count toward the numerator.</li> </ul> |

|  |  |
|--|--|
|  | <ul style="list-style-type: none"> <li>Each value must be self-reported</li> </ul> <p><b>Numerator 3:</b><br/>For patients in Denominator 3, identify those with complete gender identity data, defined as:</p> <p>At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 5).</p> <ul style="list-style-type: none"> <li>If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>If value is “ASKU,” it will count toward the numerator.</li> <li>If value is “DONTKNOW,” it will count toward the numerator.</li> <li>Each value must be self-reported.</li> </ul> <p><b>Numerator 4:</b><br/>For patients in Denominator 4, identify those with complete gender identity data, defined as.</p> <p>At least one (1) valid gender identity value (valid gender identity values are listed in Attachment 5).</p> <ul style="list-style-type: none"> <li>If value is “UNK,” it will <u>not</u> count toward the numerator.</li> <li>If value is “ASKU,” it will count toward the numerator.</li> <li>If value is “DONTKNOW,” it will count toward the numerator.</li> <li>Each value must be self-reported.</li> </ul> |
| <b>Additional Measure Information: Required Reporting</b>        | Valid MassHealth Member IDs must be submitted for the MassHealth population, and must be submitted for the served uninsured population, when applicable. MRNs must be submitted for both the MassHealth and served uninsured populations.  |
| <b>Additional Measure Information: Completeness Calculations</b> | Completeness will be calculated separately for CHA’s Medicaid population and CHA’s served uninsured population.  |

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

| PERFORMANCE REQUIREMENTS AND ASSESSMENT |  |
|---|--|
| Performance Requirements                | <ol style="list-style-type: none"><li>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.</li><li>2) Timely, complete, and responsive submission to MassHealth anticipated by September 1, 2024 or a date specified by EOHHS, 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.</li></ol> |
| Performance Assessment                  | <ul style="list-style-type: none"><li>• A hospital will earn full 100% of the points attributed to the measure for timely submission of the 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 and timely, complete, and responsive submissions of the mapping and verification deliverable to MassHealth.</li><li>• A hospital will earn 0% of the points attributed to the measure if the hospital does not submit timely EHRD Data Collection Files and timely, complete, and responsive mapping and verification deliverable to MassHealth.</li></ul>  |

| CHA-SPECIFIC ADAPTATIONS |   |
|--------------------------|---|
| Performance Requirements | For the served uninsured patient population, this measure will be calculated by MassHealth using supplemental data submitted to MassHealth by CHA. CHA must submit data in a form and format to be further specified by MassHealth. Supplemental data must be submitted as one file containing annual data to MassHealth by March 31, 2025. |

**PERFORMANCE REQUIREMENTS AND ASSESSMENTS AND ASSESSMENT FOR PY3-5 TO BE FINALIZED PRIOR TO THE START OF PY3.**

## B. Health-Related Social Needs Screening

*Aligned with CMS' Screening for Social Drivers of Health Measure for the Merit-based Incentive Payment System (MIPS) Program<sup>13</sup>*

### OVERVIEW

|                                |  |
|--------------------------------|--|
| <b>Measure Name</b>            | Health-Related Social Needs (HRSN) Screening |
| <b>Steward</b>                 | MassHealth                                   |
| <b>NQF Number</b>              | N/A  |
| <b>Data Source</b>             | Supplemental Data                            |
| <b>Performance Status: PY2</b> | Pay-for-Reporting                            |

### POPULATION HEALTH IMPACT

Eliminating health care disparities is essential to improve quality of care for all patients. An important step in addressing health care disparities and improving patient outcomes is to screen for 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

|                    |   |
|--------------------|---|
| <b>Description</b> | <p>Percentage of acute hospital discharges during the measurement year where members were screened prior to discharge for health-related social needs (HRSN). Two rates are reported:</p> <ol style="list-style-type: none"><li>1. <b>Rate 1: HRSN Screening Rate:</b> Percentage of inpatient and observation stay discharges where members were screened using a standardized HRSN screening instrument prior to discharge for food, housing, transportation, and utility needs.</li><li>2. <b>Rate 2: HRSN Screen Positive Rate:</b> Rate of HRSN identified (i.e., screen positive) among cases in Rate 1 numerator. Four sub-rates</li></ol> |
|--------------------|---|

<sup>13</sup> 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 \(cms.gov\)](#)



are reported for each of the following domains of HRSN: food, housing, transportation, and utility.

## ELIGIBLE POPULATION

|   |  |
|---|--|
| <b>Ages</b>                                     | Members of any age   |
| <b>Continuous enrollment/<br/>Allowable gap</b> | None   |
| <b>Anchor date</b>                              | None   |
| <b>Measurement period</b>                       | July 1 – December 31, 2024   |
| <b>Event/diagnosis</b>                          | <p>Inpatient and observation stay discharges between July 1 and December 31 of the measurement year.</p> <p>To identify inpatient discharges:</p> <ul style="list-style-type: none"> <li>Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>)<sup>14</sup>.</li> </ul> <p>To identify observation stay discharges:</p> <ul style="list-style-type: none"> <li>Identify all Observation stays (<u>Observation Stay Value Set</u>)<sup>15</sup>.</li> </ul> |

## DEFINITIONS

|                         |  |
|-------------------------|--|
| <b>Measurement Year</b> | Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.   |
| <b>Members</b>          | <p>Individuals enrolled in MassHealth including:</p> <p>Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).</p> <p>Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.</p> |

<sup>14</sup> HEDIS® Value Set used with permission from NCQA

<sup>15</sup> HEDIS® Value Set used with permission from NCQA

|  |  |
|--|--|
| <b>Health-Related Social Needs</b>             | 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.  |
| <b>Standardized HRSN Screening Instruments</b> | <p>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.</p> <p>Examples of eligible screening tools include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Accountable Health Communities Health-Related Social Needs Screening Tool</li> <li>• The Protocol for Responding to and Assessing Patients' Risks and Experiences (PRAPARE) Tool</li> <li>• American Academy of Family Physicians (AAFP) Screening Tool</li> </ul> <p>Hospitals are not required to use the example screening tools listed above; hospitals may choose to use other screening instruments, or combinations of screening instruments, that include at least one screening question in each of the four required domains. MassHealth may require hospitals to report to MassHealth the screening tool(s) used for the purpose of performance on this measure.</p> |
| <b>Supplemental Data</b>                       | <p>Data supplementary to administrative claims data that documents at the member-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).</p> <p>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).</p>  |

## ADMINISTRATIVE SPECIFICATION

### RATE 1: HRSN Screening Rate

|                            |  |
|----------------------------|--|
| <b>Description</b>         | Percentage of inpatient and observation stay discharges where members were screened using a standardized HRSN screening instrument prior to discharge for food, housing, transportation, and utility needs.  |
| <b>Denominator</b>         | The eligible population  |
| <b>Numerator</b>           | <p>Inpatient and observation stay where, as documented in the acute hospital medical record, members were screened using a standardized HRSN screening instrument prior to discharge for food, housing, transportation, and/or utility needs.</p> <ul style="list-style-type: none"> <li>Includes eligible inpatient and observation stay discharges where documentation in the acute hospital medical record indicates that: <ul style="list-style-type: none"> <li>The member was offered HRSN screening and responded to one or more screening questions;</li> <li>The member was offered HRSN screening and actively opted out of screening (i.e. chose not to answer any questions); or</li> <li>The member was screened for HRSN in any setting (acute hospital or otherwise) within 90 days prior to the date of admission.</li> </ul> </li> <li>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.</li> </ul> |
| <b>Unit of measurement</b> | <p>Screens should be performed at the individual member level for adults and, as determined to be clinically appropriate by individuals performing HRSN screening, for children and youth.</p> <p>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.</p>   |
| <b>Exclusions</b>          | <p>Eligible events where:</p> <ul style="list-style-type: none"> <li>Member dies prior to discharge.</li> <li>Members in hospice (identified using the <u>Hospice Value Set</u>)<sup>16</sup>.</li> <li>Members not screened for food insecurity, housing instability, transportation needs, and utility difficulties because member was</li> </ul>  |

<sup>16</sup> HEDIS® Value Set used with permission from NCQA

unable to complete the screening and have no legal guardian or caregiver able to do so on their behalf. This should be documented in the medical record.

## RATE 2: HRSN Screen Positive Rate

|  |  |
|--|--|
| <b>Description</b>                         | 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. |
| <b>Denominator</b>                         | Discharges meeting the numerator criteria for Rate 1, as indicated by a positive need in any of the four screened domains.   |
| <b>Numerator 2a – Food insecurity</b>      | Discharges where a member screened positive for food needs and for whom results were electronically documented in the hospital's EHR (see Code List below).  |
| <b>Numerator 2b – Housing instability</b>  | Discharges where a member screened positive for housing needs and for whom results were electronically documented in the hospital's EHR (see Code List below).   |
| <b>Numerator 2c – Transportation needs</b> | Discharges where a member screened positive for transportation needs and for whom results were electronically documented in the hospital's EHR (see Code List below).                                    |
| <b>Numerator 2d – Utility difficulties</b> | Discharges where a member screened positive for utility needs and for whom results were electronically documented in the hospital's EHR (see Code List below).   |
| <b>Exclusions</b>                          | None   |

## DATA REPORTING REQUIREMENTS

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

## SUPPLEMENTAL DATA REPORTING REQUIREMENTS

For PY2, hospital must submit supplemental data for use by MassHealth for calculating Rate 1 and/or Rate 2. Such supplemental data must be submitted in a form and format to be specified by MassHealth, and must include:

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

- a) a patient was screened for food insecurity, housing instability, transportation needs, and utility difficulties during the performance period (corresponding to the definitions of administrative HCPCS code M1207 and/or HCPCS code G0136).
- b) a patient was not screened for food insecurity, housing instability, transportation needs, utility difficulties (corresponding to the meaning of the administrative HCPCS code M1208)
- c) there is a patient reason for not screening for food insecurity, housing instability, transportation needs, and utility difficulties (e.g., patient declined or other patient reasons.) (corresponding to the meaning of HCPCS code M1237)

| Code System | Code  | Meaning   |
|-------------|-------|---|
| HCPCS       | M1207 | Member screened for food insecurity, housing instability, transportation needs, utility difficulties [ <i>and interpersonal safety</i> <sup>4</sup> ].  |
| HCPCS       | M1208 | Member not screened for food insecurity, housing instability, transportation needs, utility difficulties [ <i>and interpersonal safety</i> <sup>4</sup> ].  |
| HCPCS       | M1237 | Member reason for not screening for food insecurity, housing instability, transportation needs, utility difficulties, [ <i>and interpersonal safety</i> <sup>4</sup> ] (e.g., member declined or other member reasons). |
| HCPCS       | G0136 | Administration of a standardized, evidence-based social determinants of health risk assessments tool, 5-15 minutes.   |

Notes:

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

2. **For Rate 2:** Data indicating identified needs, corresponding to the definitions of the following ICD-10 codes. Data may be captured using the following codes or other clinical record data (e.g., electronic health record data corresponding to these codes), which must be submitted as supplemental data to be recognized for the purpose of calculating this measure.

## Food Insecurity

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

## Housing Instability

### *Homelessness*

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

### *Housing Instability*

| ICD-10 Code Contributing to Rate 2 Numerators | Meaning   |
|---|---|
| <b>Z59.811</b>                                | Housing instability, housed, with risk of homelessness      |
| <b>Z59.812</b>                                | Housing instability, housed, homelessness in past 12 months |

| ICD-10 Code Contributing to Rate 2 Numerators | Meaning                                       |
|---|---|
| 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                                      |
|---|--|
| Z59.10  | Inadequate housing, unspecified              |
| Z59.11  | Inadequate housing environmental temperature |
| Z59.12  | Inadequate housing utilities                 |
| Z59.19  | Other Inadequate housing                     |

## Transportation Needs

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

## 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 |

| ICD-10 Code Contributing to Rate 2 Numerators | Meaning                      |
|---|------------------------------|
| <b>Z59.12</b>                                 | Inadequate housing utilities |

## PERFORMANCE REQUIREMENTS & ASSESSMENT

|                                 |   |
|---------------------------------|---|
| <b>Performance Requirements</b> | This measure will be calculated by MassHealth using supplemental data submitted to MassHealth by hospitals. Supplemental data must be submitted to MassHealth by <b>June 30, 2025</b> .   |
| <b>Performance Assessment</b>   | <p>Hospitals have opportunity to earn full or partial credit for the measure.</p> <p><b>Component 1: HRSN Screening Rate (75% of measure score)</b></p> <ul style="list-style-type: none"> <li>A hospital will earn 100% of the points attributed to Component 1 of measure if applicable supplemental data for the performance period (July 1, 2024-December 31, 2024) is submitted to MassHealth by <b>June 30, 2025</b>.</li> <li>A hospital will earn 0% of the points attributed to Component 1 of measure if no applicable supplemental data for Component 1 for the performance period (July 1, 2024-December 31, 2024) is submitted to MassHealth by <b>June 30, 2025</b>.</li> </ul> <p><b>Component 2: HRSN Screen Positive Rate (25% of measure score)</b></p> <ul style="list-style-type: none"> <li>A hospital will earn 100% of points attributed to Component 2 of the measure if applicable supplemental data for the performance period (July 1, 2024- December 31, 2024) is submitted to MassHealth by <b>June 30, 2025</b>.</li> <li>A hospital will earn 0% of the points attributed to Component 2 of the measure if no applicable supplemental data for Component 2 for the performance period (July 1, 2024-December 31, 2024) is submitted to MassHealth by <b>June 30, 2025</b>.</li> </ul> <p>MassHealth expects to audit the data submitted for Rates 1 and 2 by the hospital.</p> |



## CHA-SPECIFIC ADAPTATIONS

|  |   |
|--|---|
| <b>Measure Summary:<br/>Description</b>  | CHA will report two separate rates for the HRSN Screening Rate and the HRSN Screen Positive Rate (4 rates total): one for MassHealth members and one for the served uninsured patient population. |
| <b>Definitions:<br/>Members/Patients</b> | The eligible CHA population included in the measure is grouped as follows: <ul style="list-style-type: none"><li>• MassHealth members;</li><li>• Served uninsured patients.</li></ul>             |

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### PERFORMANCE REQUIREMENTS AND ASSESSMENTS AND ASSESSMENT FOR PY3-5 TO BE FINALIZED PRIOR TO THE START OF PY3.

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## C. Quality Performance Disparities Reduction

### OVERVIEW

|                                |  |
|--------------------------------|--|
| <b>Measure Name</b>            | Quality Performance Disparities Reduction  |
| <b>Steward</b>                 | MassHealth   |
| <b>NQF Number</b>              | N/A  |
| <b>Data Source</b>             | Administrative, Supplemental   |
| <b>Performance Status: PY2</b> | Pay-for-Reporting (P4R). CHA will report population-based electronic measures from the EHR, separately reported for the Medicaid and served uninsured patient populations, unless otherwise specified below. |

### 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 intervention to achieve more equitable care.

### MEASURE SUMMARY

|                    |  |
|--------------------|--|
| <b>Description</b> | This measure assesses targeted acute hospital quality measure performance stratified by race and ethnicity. Quality measures identified for reporting in this measure for PY2 (detailed in Table 1) are disparities-sensitive measures in the areas of maternal health, care coordination, and care for acute and chronic conditions that MassHealth has prioritized because of their importance to the MassHealth population. Of the included measures, a subset will be targeted for disparities reduction accountability in later years of the HQEIP. |
|--------------------|--|

### ELIGIBLE POPULATION

CHA will separately report each measure for the Medicaid population and the served uninsured population, as applicable. The eligible populations for each program measure for the Medicaid population identified in Table 1 for inclusion in this measure are defined in the CQI program technical measure specifications (see <https://www.mass.gov/info-details/masshealth-cqi-technical-specifications-manuals>).

## DEFINITIONS

|                         |   |
|-------------------------|---|
| <b>Measurement Year</b> | Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.  |
| <b>Proxy Measures</b>   | Measures used to approximate performance on quality measures. Proxy measures may use other data sources than the quality measure they are replacing, such as those that are more readily available to acute hospitals for monitoring throughout the performance year. |

## ADMINISTRATIVE SPECIFICATION

CHA must report data as follows for applicable measures included in Table 1:

- **For EHR measures**, CHA must submit stratified clinical quality measure data by self-reported race and ethnicity data alongside overall clinical quality measure data.
- **For claims-based measures**, CHA must demonstrate capacity to internally stratify performance data by race and ethnicity by submitting a stratified performance report for those measures (or proxy measures identified by CHA) to MassHealth. The stratification may use imputed or other sources of data for race and ethnicity stratification only where self-reported race and ethnicity are not available.

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

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

| Domain   | Measure  |
|--|--|
| Care Coordination  | <p>TOB-2: Tobacco U/se Treatment Provided or Offered (for CHA medical, surgical, and maternity inpatient units)</p> <p><i>EHR-based measure</i></p>  |
| Care Coordination  | <p>TOB-3: Tobacco Use Treatment Provided or Offered at Discharge (for CHA medical, surgical, and maternity inpatient units)</p> <p><i>EHR-based measure</i></p>  |
| Care Coordination  | <p>NCQA: Follow-up After ED Visit for Mental Illness (7 and 30 Day)</p> <p><i>**CHA will report an EHR-based measure for a) the served uninsured patient population with an index ED visit at CHA and b) for the served uninsured patient population on CHA's primary care panel with an index ED visit at CHA.</i></p>  |
| Care Coordination  | <p>NCQA: Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence (7 and 30 Day)</p> <p><i>**CHA will report an EHR-based measure for a) the served uninsured patient population with an index ED visit at CHA and b) for the served uninsured patient population on CHA's primary care panel with an index ED visit at CHA.</i></p>   |
| <p><b>Care Coordination (Served Uninsured only)</b></p> <p>[Replacement measure since Perinatal Measures do not apply to the served uninsured]</p> | <p>Follow-up After Hospitalization (medical-surgical discharges) for primary care patients in the public hospital's primary care system. NQF 0576 is adapted to medical-surgical admissions (7-Day).</p> <p>Description: The percentage of active primary care patients in the public hospital's primary care system who had a medical-surgical discharge from a CHA hospital and received a follow-up contact or CHA visit (ambulatory or specialty care) within seven calendar days of the discharge.</p> <p>Numerator: Follow-up contact or CHA visit (ambulatory or specialty care) within seven calendar days after the discharge from the denominator.</p> <p>Denominator: Medical-surgical discharges for active primary care patients from a CHA Hospital during the measurement period.</p> <p><i>EHR-based measure</i></p> |

| Domain                     | Measure   |
|----------------------------|---|
| Care Coordination          | <p>NCQA: Follow-up After Hospitalization for Mental Illness (NQF 0576) (7 and 30 day)</p> <p><i>**CHA will report an EHR-based measure for a) the served uninsured population with an index hospitalization at CHA and b) for the served uninsured patient population on CHA's primary care panel with an index hospitalization at CHA.</i></p> |
| Acute & Chronic Conditions | <p>SUB-2: Alcohol Use – Brief Intervention Provided or Offered</p> <p><i>EHR-based measure</i></p>  |
| Acute & Chronic Conditions | <p>SUB-3: Alcohol &amp; Other Drug Use Disorder – Treatment provided/offered at discharge</p> <p><i>EHR-based measure</i></p>   |

## ADDITIONAL MEASURE INFORMATION

|                  |   |
|------------------|---|
| General Guidance | <p>Race and ethnicity data standards for stratification:</p> <ul style="list-style-type: none"> <li>For EHR-based measures, CHA should submit race and ethnicity data as specified in CQI program standards for submission.</li> <li>For claims-based measures, CHA should stratify performance by race and ethnicity categories specified in the MassHealth “Race and Ethnicity Data Completeness” sub-measure specification.</li> </ul> <p>Race and ethnicity data completeness threshold: There is no race or ethnicity data completeness threshold required for reporting performance stratified by race and ethnicity for the purpose of this measure. CHA should report on all patients for whom they have race and ethnicity data.</p> |
|------------------|---|

## PERFORMANCE REQUIREMENTS AND ASSESSMENT

|                          |  |
|--------------------------|--|
| Performance Requirements | <p>By <b>March 31, 2025</b> (to be determined by MassHealth) timely and complete submission to MassHealth of PY2 reporting requirements specified in the “Administrative Specification” section above. Submissions must be in a form and format specified by MassHealth.</p> |
|--------------------------|--|

|                               |  |
|-------------------------------|--|
|                               | <p>In recognition that CHA is not participating in the Clinical Quality Incentive program from which a subset of hospital-based measures is initially drawn for health equity and to advance toward electronic measures, MassHealth has determined that CHA can annually report population-based e-measures (drawn from the electronic health record) in lieu of chart-abstraction/ sampling for measures. This is aligned with MassHealth's goals toward population-based data collection. Measures will be submitted following the year-end utilizing a MassHealth-approved template (with separate tabs for Medicaid and served uninsured patient populations) consistent with the CMS and Joint Commission portal fields used for e-measures.</p>  |
| <b>Performance Assessment</b> | <p>CHA will earn credit for performance on this measure as follows:</p> <ul style="list-style-type: none"> <li>• CHA will earn 50% of the points attributed to the measure for timely, complete, and responsive submission of all EHR measures to MassHealth, including required race and ethnicity variables.</li> <li>• CHA will earn 50% of the points attributed to the measure for timely, complete, and responsive submission of PY2 report of performance stratified by race and ethnicity for all applicable claims-based measures. In lieu of reporting performance according to CQI program specifications for claims-based measures, CHA may earn credit for reporting performance on proxy measures instead. In order to earn credit for this portion of the measure through report of proxy measure(s), CHA must adequately describe to MassHealth: (1) the proxy measure(s) being used, (2) rationale for using the proxy measure(s), and (3) how those measures are specified (including at a minimum a complete description of eligible population(s), denominator(s), numerator(s), exclusion(s), and data source(s).)</li> </ul> |

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**PERFORMANCE REQUIREMENTS AND ASSESSMENTS AND ASSESSMENT  
FOR PY3-5 TO BE FINALIZED PRIOR TO THE START OF PY3.**

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## D. Equity Improvement Interventions

### OVERVIEW

|                                |                                  |
|--------------------------------|----------------------------------|
| <b>Measure Name</b>            | Equity Improvement Interventions |
| <b>Steward</b>                 | MassHealth                       |
| <b>NQF Number</b>              | N/A                              |
| <b>Data Source</b>             | Supplemental Data                |
| <b>Performance Status: PY2</b> | 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

|                    |   |
|--------------------|---|
| <b>Description</b> | <p>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.</p> <p>Acute hospitals will be incentivized to implement ACO-partnered PIPs designed to:</p> <ul style="list-style-type: none"><li>• Support collaboration and information sharing,</li><li>• Address mutually shared equity goals,</li><li>• Achieve significant and sustained improvement in equity outcomes, and</li><li>• Promote program-wide impact.</li></ul> <p>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</p> |
|--------------------|---|

|  |  |
|--|--|
|  | 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 members. Additional information about eligible population selection may be provided by EOHHS.

## DEFINITIONS

|                         |  |
|-------------------------|--|
| <b>Measurement Year</b> | 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.

## PERFORMANCE REQUIREMENTS AND ASSESSMENT: PY2

|                                 |   |
|---------------------------------|---|
| <b>Performance Requirements</b> | <p>Timely submission to MassHealth of two required reports (the PIP1 Planning (Baseline) Report Resubmission and the PIP2 Planning (Baseline) Report. Submission dates for PIP1 and PIP2 reports are specified below.</p> <p><b>PIP1 and PIP2 Report Submission Dates for PY2</b></p> <p><b><u>Performance Year 2:</u></b></p> <ul style="list-style-type: none"> <li>• PIP1: PIP Planning (Baseline) Report Resubmission <ul style="list-style-type: none"> <li>○ Submission due date: 8/30/2024</li> </ul> </li> <li>• PIP2: PIP Planning (Baseline) Report <ul style="list-style-type: none"> <li>○ Submission due date: 3/31/2025</li> </ul> </li> </ul>  |
| <b>Performance Assessment</b>   | <p><b>REPORT SCORING</b></p> <p>MassHealth will score required reports as follows:</p> <ol style="list-style-type: none"> <li>1) The <b>PIP 1 Planning (Baseline) Report Resubmission</b> is pay-for-performance and will be scored as follows: <p><b><u>Abstract:</u></b> N/A, not scored</p> <p><b><u>Planning Section (25%):</u></b></p> <ul style="list-style-type: none"> <li>• Project Topic/Equity Statement [Topic/Rationale/ Shared Equity Statement] (15 pts)</li> <li>• Aim [Vision, Aim Statement(s), and Goal(s)] (10 pts)</li> </ul> <p><b><u>Implementation Section (35%):</u></b></p> <ul style="list-style-type: none"> <li>• Methodology (10 pts)</li> <li>• Barrier Analysis, Interventions, and Monitoring (update) (10 pts)</li> <li>• Intervention (15 pts)</li> </ul> <p><b>Total = 60 pts</b></p> <p><b>Overall Rating = Actual Weighted Score/ Max Possible Weighted Score</b></p> <ul style="list-style-type: none"> <li>• An Overall Rating of <math>\geq 85\%</math> meets the goal score for the report and will contribute 100% to the eligible weight that the report contributes to the measure score.</li> <li>• An Overall Rating of 60-84% partially meets the goal score for the report and will contribute partially to the eligible weight that the report contributes to the measure score as follows: PIP Overall Rating * 10.</li> <li>• An Overall Rating of less than 60% does not meet the threshold score for the report and will contribute 0% to the eligible weight the report contributes to the measure score.</li> </ul> </li> </ol> |

- 2) The **PIP 2 Planning (Baseline) Report** submission is pay-for-performance and will be scored as follows:

**Abstract:** N/A, not scored

**Planning Section (30%):**

- Project Topic/Attestations/Project Identifiers (5 pts)
- Partnership Equity and Vision Statements (10 pts)
- PIP Aim (15 pts)

**Implementation Section (45%):**

- Methodology (10 pts)
- Understanding and Addressing the Problems (20 pts)
- Intervention Tracking (15 pts)

**Total = 75 pts**

**Overall Rating = Actual Weighted Score/ Max Possible Weighted Score**

- An Overall Rating of  $\geq 85\%$  meets the goal score for the report and will contribute 100% to the eligible weight that the report contributes to the measure score.
- An Overall Rating of 50-84% partially meets the goal score for the report and will contribute partially to the eligible weight that the report contributes to the measure score as follows: PIP Overall Rating \* 10.
- An Overall Rating of less than 50% does not meet the threshold score for the report and will contribute 0% to the eligible weight the report contributes to the measure score.

Acute hospitals will be permitted one re-submission for each deliverable following receipt of feedback from the EQRO. As the EQRO offers ongoing technical assistance throughout the course of a PIP, acute hospitals may also revise previously reported elements, resulting in an adjusted score. The adjusted Overall Rating for the PIP1 Planning (Baseline) Resubmission Report and PIP 2 Planning (Baseline) Report will be used to calculate the Equity Improvement Interventions measure score.

**MEASURE WEIGHTING**

In PY2, two reports are due for the performance year and the two Overall Ratings will equally contribute to the measure score (50% each).

## CHA-SPECIFIC ADAPTATIONS

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

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### PERFORMANCE REQUIREMENTS AND ASSESSMENTS AND ASSESSMENT FOR PY3-5 TO BE FINALIZED PRIOR TO THE START OF PY3.

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

### OVERVIEW

|                                |   |
|--------------------------------|---|
| <b>Measure Name</b>            | Meaningful Access to Healthcare Services for Individuals with a Preferred Language other than English |
| <b>Steward</b>                 | MassHealth  |
| <b>NQF Number</b>              | N/A   |
| <b>Data Source</b>             | Supplemental  |
| <b>Performance Status: PY2</b> | Pay-for-Reporting   |

### POPULATION HEALTH IMPACT

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

### MEASURE SUMMARY

|                    |   |
|--------------------|---|
| <b>Description</b> | <p>This measure focuses on the provision of quality interpreter services through two components:</p> <ol style="list-style-type: none"><li>1. <b>Language Access Self-Assessment Survey:</b> Self-assessment of language access services</li><li>2. <b>Addressing Language Access Needs in Acute Hospital Settings:</b> Percentage of inpatient or observation stay discharges serving members who report a preferred spoken language other than English (including sign languages) during which either interpreter services or in-language services were utilized.</li></ol> |
|--------------------|---|

## ELIGIBLE POPULATION

### Component 1: Language Access Self-Assessment Survey

Not applicable

### Component 2: Addressing Language Access Needs in Acute Hospital Settings

|   |   |
|---|---|
| <b>Age</b>                                      | Members of any age  |
| <b>Continuous Enrollment/<br/>Allowable gap</b> | N/A   |
| <b>Anchor Date</b>                              | None  |
| <b>Measurement Period</b>                       | July 1, 2024 – December 31, 2024  |
| <b>Event/Diagnosis</b>                          | <p>A two-step process must be used to identify eligible discharges:</p> <p><b>Step 1.</b> Identify inpatient and observation stay discharges between July 1 and December 31 of the measurement year.</p> <ul style="list-style-type: none"><li>• To identify inpatient discharges:<ul style="list-style-type: none"><li>○ Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>)<sup>17</sup>.</li></ul></li><li>• To identify observation stay discharges:<ul style="list-style-type: none"><li>○ Identify all Observation stays (<u>Observation Stay Value Set</u>)<sup>18</sup>.</li></ul></li></ul> <p><b>Step 2.</b> For eligible inpatient and observation stay discharges 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).</p> |

<sup>17</sup> HEDIS® Value Set used with permission from NCQA

<sup>18</sup> HEDIS® Value Set used with permission from NCQA

## DEFINITIONS

|                                  |   |
|----------------------------------|---|
| <b>Measurement Year</b>          | Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.  |
| <b>Members</b>                   | <p>Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).</p> <p>Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.</p>   |
| <b>Interpreter services</b>      | <p>Interpreter services are defined as services that support spoken or sign language communication between users of different languages.</p> <p>Interpreter services may be delivered using any delivery modality that meets communication needs (e.g. in-person, telephonic, video)</p> <p>Interpreter services must be delivered by individuals employed or contracted by the acute hospital who are determined by the acute hospital to be competent. Competency may be demonstrated by factors such as bi- or multi-lingual proficiency, having received training that includes 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.</p> |
| <b>In-language Services</b>      | 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.   |
| <b>Preferred Spoken Language</b> | 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

|                    |  |
|--------------------|--|
| <b>Description</b> | Percentage of inpatient and observation stay discharges 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.  |
| <b>Denominator</b> | The eligible population  |
| <b>Numerator</b>   | Number of inpatient and observation stay discharges 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).  |
| <b>Exclusions</b>  | Eligible events where: <ul style="list-style-type: none"><li>• Member dies prior to discharge.</li><li>• Documentation in the medical record that member (or their caregiver, as applicable) refused interpreter services and/or in-language services.</li><li>• Documentation in the medical record of a medical reason where the member 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.</li></ul> |

## REPORTING METHOD

### Component 1: Language Access Self-Assessment Survey

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

Organizations are required to report performance as follows:

- 1. Sample:** Hospitals report performance for a sample of eligible inpatient and/or observation stay discharges. 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 the sample 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**. Sample size requirements may be modified at the discretion of MassHealth.
- 2. Full Eligible Population:** Hospitals report performance on eligible inpatient and/or observation stay discharges.

MassHealth reserves the right to audit the data submitted by the hospital.

### PERFORMANCE REQUIREMENTS & ASSESSMENT FOR PY2

|                                 |   |
|---------------------------------|---|
| <b>Performance Requirements</b> | <p><b>Component 1: Language Access Self-Assessment Survey</b><br/>By <b>January 31, 2025</b> hospitals must submit the completed Language Access Self-Assessment Survey in the form and format specified by MassHealth.</p> <p><b>Component 2: Addressing Language Access Needs in Acute Hospital Settings</b><br/>By <b>June 30, 2025</b>, hospitals must report to MassHealth data using either a patient sample or the full eligible population methodology, as specified in “Reporting Method” above. Hospitals must submit data in a form and format to be further specified by MassHealth.</p>        |
| <b>Performance Assessment</b>   | <p>Hospitals have the opportunity to earn full or partial credit for the measure.</p> <p><b>Component 1: Language Access Self-Assessment Survey (50% of measure score):</b></p> <ul style="list-style-type: none"> <li>A hospital will earn 100% of the points attributed to Component 1 of the measure for timely, complete, and responsive submission of the Language Access Self-Assessment Survey to MassHealth by <b>January 31, 2025</b>.</li> <li>A hospital will earn 0% of the points attributed to Component 1 of the measure if it does not submit a timely, complete, and responsive</li> </ul> |



|  |  |
|--|--|
|  | <p>Language Access Self-Assessment Survey to MassHealth by <b>January 31, 2025.</b></p> <p><b>Component 2: Addressing Language Access Needs in Acute Hospitals Settings (50% of measure score):</b></p> <ul style="list-style-type: none"> <li>A hospital will earn 100% of the points attributed to Component 2 of the measure if, for a sample or the full population, required administrative and/or supplemental data for the performance period (July 1, 2024-December 31, 2024) is submitted to MassHealth by <b>June 30, 2025.</b></li> <li>A hospital will earn 0% of the points attributed to Component 2 of the measure if reporting requirements are not met by <b>June 30, 2025.</b></li> </ul> <p>MassHealth expects to audit the data submitted for Component 2 by the hospital.</p> |
|--|--|

### CHA-SPECIFIC ADAPTATIONS

|                                      |   |
|--------------------------------------|---|
| <b>Measure Summary: Description</b>  | CHA will separately report two percentages for Component 2: one for MassHealth members and one for served uninsured patients.   |
| <b>Component 2: Members/Patients</b> | <p>The eligible CHA population included in the measure is grouped as follows:</p> <ul style="list-style-type: none"> <li>MassHealth members;</li> <li>Served uninsured patients.</li> </ul> |
| <b>Definitions: Members/Patients</b> | <p>The eligible CHA population included in the measure is grouped as follows:</p> <ul style="list-style-type: none"> <li>MassHealth members;</li> <li>Served uninsured patients.</li> </ul> |

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### PERFORMANCE REQUIREMENTS AND ASSESSMENTS AND ASSESSMENT FOR PY3-5 TO BE FINALIZED PRIOR TO THE START OF PY3.

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## F. Disability Competent Care

### OVERVIEW

|                               |                           |
|-------------------------------|---------------------------|
| <b>Metric Name</b>            | Disability Competent Care |
| <b>Steward</b>                | MassHealth                |
| <b>NQF Number</b>             | N/A                       |
| <b>Data Source</b>            | Supplemental Data         |
| <b>PY2 Performance Status</b> | 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 ACOs to identify and prepare for addressing unmet needs for healthcare worker education and training to promote core competencies in providing care to members with disabilities.

### MEASURE SUMMARY

|                    |  |
|--------------------|--|
| <b>Description</b> | 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

|  |   |
|--|---|
| <b>Applicable Patient-facing Staff</b> | <p>Applicable patient-facing staff are employed acute hospital staff whose role requires regular interaction with patients (and/or patients' caregivers).</p> <p>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.).</p> <p>Contracted providers or staff are not included in this definition of patient-facing staff.</p> |
| <b>Demonstrated Competency</b>         | <p>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.</p>   |
| <b>Supplemental Data</b>               | <p>Acute hospital data drawn from organizational databases or otherwise related to staff training.</p>  |

## 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).

|                           |  |
|---------------------------|--|
| <b>Denominator</b>        | The total eligible population  |
| <b>Numerator</b>          | <p>For patient-facing staff in the denominator, identify those that have, within the preceding 24 months:</p> <ul style="list-style-type: none"> <li>completed any applicable disability competency training(s); and</li> <li>demonstrated competency in each applicable training area.</li> </ul> |
| <b>Anchor Date</b>        | None   |
| <b>Measurement Period</b> | July 1, 2024 – December 31, 2024   |

|                   |   |
|-------------------|---|
| <b>Exclusions</b> | 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. |
|-------------------|---|

## PERFORMANCE REQUIREMENTS & ASSESSMENT FOR PY2

|                                 |   |
|---------------------------------|---|
| <b>Performance Requirements</b> | <p>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, no later than a date following <b>March 31, 2025</b>.</p> <ol style="list-style-type: none"> <li>Specific Reporting Requirements for Rate 1 include:<br/>For each disability competency training area, report to MassHealth: <ol style="list-style-type: none"> <li>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;</li> <li>The number of patient-facing staff who completed and demonstrated competency in the applicable training area.</li> </ol> </li> <li>Achievement of the PY2 training target of 25% for Rate 1.</li> </ol>   |
| <b>Performance Assessment</b>   | <p>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):</p> $\text{Rate 1} = 100 * (\# \text{ of patient-facing staff with demonstrated competency in training area 1} + \# \text{ of patient-facing staff with demonstrated competency in training area 2} + \# \text{ of patient-facing staff with demonstrated competency in training area 3}) / (\text{Eligible population for training area 1} + \text{Eligible population for training area 2} + \text{Eligible population for training area 3})$ <p>Full or partial credit may be earned by acute hospitals as follows:</p> <ol style="list-style-type: none"> <li>A hospital will earn 100% of the points attributed to the measure for timely, complete, and responsive submission of Specific Reporting Requirements for Rate 1 (by <b>March 31, 2025</b>) and it achieves or exceeds the PY2 training target of 25% for Rate 1.</li> <li>A hospital will earn a percentage of the points attributed to the measure for timely, complete, and responsive submission of Specific Reporting Requirements for Rate 1 (by <b>March 31, 2025</b>) and its Rate 1 for PY2 is higher than the performance target for PY1 (0%). The hospital will earn proportional points as follows:</li> </ol> |

|  |   |
|--|---|
|  | <p><i>a. Measure Score: Rate 1/25%*Measure weight</i></p> <p>3. A hospital will earn 0% of the points attributed to the measure if the hospital does not submit a timely, complete, and responsive submission of Specific Reporting Requirements for Rate 1 (not submitted <b>March 31, 2025</b>).</p> <p>Bonus points: a hospital will earn 1 bonus point if it exceeds the PY2 training target of 25%. Bonus points will be applied to the domain score but cannot result in a domain score exceeding 100%.</p> |
|--|---|

## CHA-SPECIFIC ADAPTATIONS

|                 |      |
|-----------------|------|
| CHA Adaptations | None |
|-----------------|------|

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**Performance Requirements and Assessment for PY3-5 To Be Finalized Prior to the Start of PY3.**

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# G. Disability Accommodation Needs

| OVERVIEW                |                                |
|-------------------------|--------------------------------|
| Measure Name            | Disability Accommodation Needs |
| Steward                 | MassHealth                     |
| NQF Number              | N/A                            |
| Data Source             | Supplemental Data              |
| Performance Status: PY2 | Pay-for-Reporting (P4R)        |

## 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 | <p>The percentage of eligible acute hospital discharges and/or encounters where 1) members were screened for accommodation needs related to a disability and 2) for those members screening positive for accommodation needs related to a disability, a corresponding member-reported accommodation need was identified.</p> <p>Two rates are calculated:</p> <p>Rate 1: Accommodation Needs Screening: Percentage of eligible inpatient discharges, observation discharges, and ambulatory radiology encounters where members with disability were screened for accommodation needs related to a disability and the results of the screen were documented electronically in the acute hospital medical record.</p> <p>Rate 2: Accommodation Needs Related to a Disability: Percentage of eligible inpatient discharges, observation discharges, and ambulatory radiology encounters where members screened positive for accommodation needs related to a disability and for</p> |
|-------------|--|

|  |  |
|--|--|
|  | which member-requested accommodation(s) related to a disability were documented electronically in the acute hospital medical record. |
|--|--|

## ELIGIBLE POPULATION

|   |  |
|---|--|
| <b>Members</b>                              | <p>Individuals enrolled in MassHealth including: Model A ACO, Model B ACO, MCO, the PCC Plan, SCO, One Care, PACE, FFS (includes MassHealth Limited).</p> <p>Please refer to the HQEIP Technical Specification Addendum for a list of included CHIA Medicaid payer codes that apply to the HQEIP. Only include patients with the Payer Source Type/ Payer Source Codes in the measure population.</p>  |
| <b>Ages</b>                                 | At least 5 years of age on the date of discharge   |
| <b>Continuous enrollment/ allowable gap</b> | None   |
| <b>Anchor date</b>                          | None   |
| <b>Measurement Period</b>                   | July 1, 2024 - December 31, 2024   |
| <b>Event</b>                                | <p>A two-step process will identify eligible events:</p> <p><b>Step 1.</b> Identify inpatient discharges, observation stay discharges, and ambulatory radiology encounters between July 1 and December 31 of the measurement year:</p> <ul style="list-style-type: none"> <li>• To identify inpatient discharges: <ul style="list-style-type: none"> <li>○ Identify all inpatient discharges;</li> </ul> </li> <li>• To identify observation stay discharges: <ul style="list-style-type: none"> <li>○ Identify all Observation stays discharges;</li> </ul> </li> <li>• To identify ambulatory radiology encounters in the on-campus outpatient setting (Place of Service = 22): <ul style="list-style-type: none"> <li>○ Identify all ambulatory radiology encounters using the Radiology CPT Code Sets: <ul style="list-style-type: none"> <li>▪ 77046-77067 Radiology: Breast Mammography</li> <li>▪ 77071-77092 Radiology: Bone/Joint Studies</li> <li>▪ 78000-79999 Radiology: Nuclear Medicine</li> <li>▪ 70010-76499 Radiology: Diagnostic Radiology (Diagnostic Imaging)</li> </ul> </li> </ul> </li> </ul> |

|                   |   |
|-------------------|---|
|                   | <ul style="list-style-type: none"> <li>76500-76999 Radiology: Diagnostic Ultrasound</li> </ul> <p><b>Step 2.</b> For eligible discharges and encounters identified in Step 1, identify those where a patient is identified as having a disability using at least one or both of the following criteria:</p> <ul style="list-style-type: none"> <li>A patient has self-reported disability;</li> <li>A patient is eligible for MassHealth on the basis of a disability.</li> </ul> |
| <b>Exclusions</b> | <p>Eligible events where:</p> <ul style="list-style-type: none"> <li>The member died prior to discharge.</li> <li>The member was not screened because member was unable to complete the screening and had no caregiver able to do so on their behalf. This should be documented in the medical record.</li> </ul>   |

## DEFINITION

|   |   |
|---|---|
| <b>Patient with Self-reported Disability</b>                                | <p>Patients with self-reported disability are defined as patients that, as documented in the acute hospital medical record, have responded “Yes” to one or more of the following six questions at any time prior to or during the event:</p> <ul style="list-style-type: none"> <li>Disability Q1 (all ages): Are you deaf or do you have serious difficulty hearing?</li> <li>Disability Q2 (all ages): Are you blind or do you have serious difficulty seeing, even when wearing glasses?</li> <li>Disability Q3 (age 6 or older as of December 31st of measurement year): Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?</li> <li>Disability Q4 (age 6 or older as of December 31st of measurement year): Do you have serious difficulty walking or climbing stairs?</li> <li>Disability Q5 (age 6 or older as of December 31st of measurement year): Do you have difficulty dressing or bathing?</li> <li>Disability Q6 (age 16 or older as of December 31st of measurement year): Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?</li> </ul> |
| <b>Patient with Eligibility for MassHealth on the Basis of a Disability</b> | <p>Disability is established by:</p> <p>(a) certification of legal blindness by the Massachusetts Commission for the Blind (MCB);</p> <p>(b) a determination of disability by the Social Security Administration (SSA); or</p> <p>(c) a determination of disability by the Disability Evaluation Services (DES).</p>  |



|  |   |
|--|---|
| <b>Accommodation Needs Related to a Disability</b> | <p>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.</p> <p>Medical record documentation of member-requested accommodation needs for the purpose of calculating Rate 2 may be specific (e.g. member requests American Sign Language Interpreter) or categorical (e.g. member requests communication accommodations) at the discretion of the acute hospital.</p>   |
| <b>Accommodation Needs Screening</b>               | <p>One or more questions posed to members by hospital providers or staff that are intended to identify whether members with disability need any accommodation needs related to a disability to facilitate equitable access to high quality health care.</p> <ul style="list-style-type: none"> <li>• 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?).</li> <li>• 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).</li> </ul> |

## ADMINISTRATIVE SPECIFICATIONS

### RATE 1: Accommodation Needs Screening

|                    |   |
|--------------------|---|
| <b>Denominator</b> | The eligible population   |
| <b>Numerator</b>   | <p>Number of eligible events where, as documented in the acute hospital medical record:</p> <ul style="list-style-type: none"> <li>• The member was offered accommodation needs screening and responded; <ul style="list-style-type: none"> <li>○ To meet this requirement, the member may instead actively validate that ongoing accommodation need(s) as documented in the acute hospital medical record continue to be sufficient; or</li> </ul> </li> <li>• The member was offered accommodation needs screening and actively opted out of screening (i.e., chose not to answer any questions).</li> </ul> <p>If the member responded to the accommodation needs screening, documentation must include the result of the screening, including at a minimum the following results:</p> |

|  |   |
|--|---|
|  | <ul style="list-style-type: none"> <li>Positive: the member indicated a need for accommodation related to a disability.</li> <li>Negative: the member did not indicate any accommodation need related to a disability.</li> </ul> <p>Screening may be rendered by any acute hospital provider or staff.</p> |
|--|---|

## RATE 2: Accommodation Needs Related to a Disability

|                    |  |
|--------------------|--|
| <b>Denominator</b> | Number of eligible events in the numerator for Rate 1 for which the accommodation needs screen was positive.   |
| <b>Numerator</b>   | <p>Denominator event where documentation in the acute hospital medical record describes:</p> <ul style="list-style-type: none"> <li>Member-requested accommodation(s) related to a disability documented either as a specific accommodation (e.g., member requests American Sign Language Interpreter) or categorical (e.g., member requests communication accommodations) at the discretion of the acute hospital.</li> </ul> |

## REPORTING METHOD

Report to MassHealth on all inpatient discharges, observation discharges, 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.

## PERFORMANCE REQUIREMENT AND ASSESSMENT FOR PY2

|                                 |   |
|---------------------------------|---|
| <b>Performance Requirements</b> | <p><b>Reporting Element 1</b></p> <p>By <b>March 31, 2025</b>, 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:</p> <ul style="list-style-type: none"> <li>The accommodation needs screening question(s) used by acute hospitals for the purpose of meeting performance requirements of this measure.</li> <li>A description of how member-requested accommodation needs are documented in the medical record including: <ul style="list-style-type: none"> <li>a. entry mode (free text vs. fixed-field);</li> <li>b. specific fixed field options (if used); and</li> </ul> </li> </ul> |
|---------------------------------|---|

|                               |  |
|-------------------------------|--|
|                               | <p>c. where accommodation needs information is displayed (e.g., top or sidebar of electronic health record, problem list, etc.)</p> <p><b>Reporting Element 2</b><br/>By <b>June 30, 2025</b> hospitals must submit for dates of service from July 1, 2024-December 31, 2024, data elements required to calculate Rates 1 and 2. Hospitals must submit data in a form and format to be further specified by MassHealth.</p> <p>MassHealth reserves the right to request additional documentation related to the calculation of Rate 1 and Rate 2 to for the purpose of auditing.</p>   |
| <b>Performance Assessment</b> | <ul style="list-style-type: none"> <li>A hospital will earn 20% of the points attributed to the measure for a timely, complete, and responsive submission of Reporting Element 1 to MassHealth by <b>March 31, 2025</b>.</li> <li>A hospital will earn 80% of the points attributed to the measure for a timely, complete, and responsive submission of Reporting Element 2 to MassHealth by <b>June 30, 2025</b>.</li> <li>A hospital will earn 0% of the points attributed to the measure if the hospital does not submit a timely, complete, and responsive submission of Reporting Element 1 and Reporting Element 2 to MassHealth by <b>March 31, 2025 and June 30, 2025, respectively</b>.</li> </ul> <p>MassHealth expects to audit the data submitted for Rates 1 and 2 by the hospital.</p> |

## CHA-SPECIFIC ADAPTATIONS

|                                      |  |
|--------------------------------------|--|
| <b>Measure Summary: Description</b>  | CHA will report two separate rates for the Accommodations Needs Screening and the Accommodation Needs Related to a Disability (4 rates total): one for MassHealth members and one for the served uninsured patient population. |
| <b>Definitions: Members/Patients</b> | <p>The eligible CHA population included in the measure is grouped as follows:</p> <ul style="list-style-type: none"> <li>MassHealth members;</li> <li>Served uninsured patients.</li> </ul>                                    |

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**Performance Requirements and Assessment for PY3-5 To Be Finalized Prior to the Start of PY3.**

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# H. Achievement of External Standards for Health Equity

## OVERVIEW

|                                |   |
|--------------------------------|---|
| <b>Measure Name</b>            | Achievement of External Standards for Health Equity |
| <b>Steward</b>                 | MassHealth  |
| <b>NQF Number</b>              | N/A   |
| <b>Data Source</b>             | Supplemental Data                                   |
| <b>Performance Status: PY2</b> | Pay-for-Reporting (P4R)                             |

## POPULATION HEALTH IMPACT

To be successful in addressing persistent and longstanding health disparities, healthcare organizations must adopt structures and systems that systemically and comprehensively prioritize health equity as a fundamental component of high-quality care. These goals include collaboration and partnership with other sectors that influence the health of individuals, adoption and implementation of a culture of equity, and the creation of structures that support a culture of equity.<sup>19</sup> External health equity certification independently and objectively assesses attainment of these and other relevant health equity goals to ensure that healthcare organizations are providing a comprehensively high standard of equitable care.

## MEASURE SUMMARY

|                    |  |
|--------------------|--|
| <b>Description</b> | <p>Assessment of hospital progress towards and achievement of The Joint Commission's requirements for its voluntary "Health Care Equity Certification" intended to recognize acute hospitals that go above and beyond to high quality and equitable care. Specifically:</p> <p>A. Achievement of The Joint Commission's introduced revised requirements<sup>20</sup> (effective January 1, 2023) to reduce health care disparities for organizations participating in its hospital accreditation program including six new elements of performance in the Leadership (LD) chapter, Standard LD.04.03.08.</p> |
|--------------------|--|

<sup>19</sup> The National Quality Forum. A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity.

<sup>20</sup> The Joint Commission. New and Revised Requirements to Reduce Health Care Disparities.

<https://www.jointcommission.org/standards/prepublication-standards/new-and-revised-requirements-to-reduce-health-care-disparities/>.

B. Achievement of The Joint Commission’s Health Care Equity Certification<sup>21</sup>, which builds on the equity-focused Accreditation standards to recognize organizations that go above and beyond to provide high quality and equitable care.

## PERFORMANCE REQUIREMENT AND ASSESSMENT FOR PY2

|                                 |  |
|---------------------------------|--|
| <b>Performance Requirements</b> | <p>By <b>January 31, 2025</b>, submit to MassHealth an attestation that the hospital has initiated the process with TJC to achieve its “Health Care Equity Certification” as demonstrated by the following activities, each of which must be completed by December 31, 2024:</p> <ul style="list-style-type: none"> <li>• Submission of an application for Health Care Equity Certification to The Joint Commission.</li> <li>• Attendance at (or asynchronous viewing of) the 2024 training webinar hosted by the MHA on The Joint Commission’s HCE certification program by at least one staff member per hospital.</li> <li>• Completion of a self-evaluation of compliance (Health Care Equity Certification Standards Checklist) with Joint Commission HCE certification standards, describing development and in-progress and/or planned implementation of actions to address areas of non-compliance.</li> </ul>  |
| <b>Performance Assessment</b>   | <ul style="list-style-type: none"> <li>• A hospital will earn 100% of the points attributed to the measure for a timely, complete, and responsive submission of an attestation that all three requirements were met by December 31, 2024 to MassHealth by <b>January 31, 2025</b>.</li> <li>• A hospital will earn 100% of the points attributed to the measure for a timely, complete, and responsive submission of an attestation that hospital achieved the Health Care Equity Certification by Dec. 31, 2024 to MassHealth by <b>January 31, 2025</b>.</li> <li>• A Hospital will earn 0% of the points attributed to the measure for a submission of an attestation that fewer than three requirements have been met by December 31, 2024 to MassHealth by <b>January 31, 2025</b>.</li> <li>• A hospital will earn 0% of the points attributed to the measure if a hospital does not submit a timely, completely, and responsive submission of an attestation that all three requirements were met by December 31, 2024 to MassHealth by <b>January 31, 2025</b>.</li> </ul> |

<sup>21</sup> The Joint Commission. Advancing Health Care Equity, Together. <https://www.jointcommission.org/our-priorities/health-care-equity/>.

## CHA-SPECIFIC ADAPTATIONS

|                 |      |
|-----------------|------|
| CHA Adaptations | None |
|-----------------|------|

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**Performance Requirements and Assessment for PY3-5 To Be Finalized Prior to the Start of PY3.**

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# I. Patient Experience: Communication, Courtesy, and Respect

## OVERVIEW

|                                |  |
|--------------------------------|--|
| <b>Measure Name</b>            | Patient Experience: Communication, Courtesy, and Respect   |
| <b>Steward</b>                 | MassHealth, using selected questions from the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey |
| <b>NQF Number</b>              | 0166   |
| <b>Data Source</b>             | Survey   |
| <b>Performance Status: PY2</b> | Pay-for-Reporting (P4R)  |

## 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

|                    |  |
|--------------------|--|
| <b>Description</b> | The <i>Patient Experience: Communication, Courtesy, and Respect</i> 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).

## 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<sup>22</sup> survey.

Acute hospitals must report data related to the following HCAHPS questions contributing to this measure for the eligible population. 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)

## PERFORMANCE REQUIREMENT AND ASSESSMENT FOR PY2

### Performance Requirements

The following data should be submitted in a form and format as directed by MassHealth by **June 30, 2025** (based on surveys received through December 31, 2024):

1. Total number of MassHealth acute inpatient discharges in PY2;
  2. Total number of MassHealth HCAHPS-eligible inpatient discharges in PY2;
  3. Total number of MassHealth HCAHPS-eligible members sampled to participate in the HCAHPS survey in PY2;
  4. Total number of submitted HCAHPS surveys for MassHealth HCAHPS-eligible inpatient discharges in PY2;
  5. Response rate\* of MassHealth HCAHPS-eligible members participating in the HCAHPS survey in PY2;
- \*Response rate is defined as the total MassHealth HCAHPS surveys submitted (Item 4) over the total MassHealth HCAHPS-eligible members sampled (Item 3).*

<sup>22</sup> Hospitals should utilize the HCAHPS survey version corresponding for use with the specified measurement period.



|                               |  |
|-------------------------------|--|
|                               | <p>6. For the HCAHPS Eligible Population in PY2:</p> <ol style="list-style-type: none"> <li>Member-level responses for: <ol style="list-style-type: none"> <li>Nurse Communication Composite (Q1, Q2, Q3)</li> <li>Physician Communication Composite (Q5, Q6, Q7)</li> </ol> </li> <li>Each composite and associated demographic “About You” response Overall Health, Overall Mental/Emotional Health, Race, Ethnicity, Language (<i>note these elements are in the survey, Q24, Q25, Q27, Q28, Q29</i>). <i>These stratifications may be used for analysis purposes at the state-wide level.</i></li> </ol> |
| <b>Performance Assessment</b> | <ul style="list-style-type: none"> <li>A hospital will earn 100% of the points attributed to the measure for a timely, complete, and responsive submission of all required data elements to MassHealth by <b>June 30, 2025</b>.</li> <li>A hospital will earn 0% of the points attributed to the measure if the hospital does not report all required data elements in a timely, complete, and responsive submission to MassHealth by <b>June 30, 2025</b>.</li> </ul>   |

## CHA-SPECIFIC ADAPTATIONS

|                        |      |
|------------------------|------|
| <b>CHA Adaptations</b> | None |
|------------------------|------|

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**Performance Requirements and Assessment for PY3-5 To Be Finalized  
Prior to the Start of PY3.**

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## J. Collaboration

### OVERVIEW

|                                |                           |
|--------------------------------|---------------------------|
| <b>Measure Name</b>            | Collaboration             |
| <b>Steward</b>                 | MassHealth                |
| <b>NQF Number</b>              | N/A                       |
| <b>Data Source</b>             | Supplemental Data         |
| <b>Performance Status: PY2</b> | 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

|                    |   |
|--------------------|---|
| <b>Description</b> | Assessment of participating acute hospital collaboration with MassHealth Accountable Care Organizations to promote high quality and equitable care. |
|--------------------|---|

### PERFORMANCE REQUIREMENT AND ASSESSMENT FOR PY2

|                                 |  |
|---------------------------------|--|
| <b>Performance Requirements</b> | <p>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:</p> <ul style="list-style-type: none"><li>• Demographic data completion</li><li>• Health-Related Social Needs Screening and Referrals</li><li>• Quality Performance Disparities Reduction</li><li>• Equity Improvement Interventions</li><li>• Language Access</li><li>• Disability Access and Accommodation</li><li>• Achievement of External Standards for Health Equity</li><li>• Cultural Competency</li></ul> |
|---------------------------------|--|

|                               |   |
|-------------------------------|---|
|                               | Each of these accountability components contribute to a Health Equity Score for each MassHealth ACO.  |
| <b>Performance Assessment</b> | <p>To incentivize shared investment and goals across ACO and hospital entities, a participating acute hospitals' performance in this subdomain for a given Performance Year will equal the Health Equity Score of its Partnered ACO(s) for the same Performance Year. Please refer to the PY1-5 ACO Quality and Equity Incentive Program (QEIP) Implementation Plan.</p> <p>If a participating acute hospital has more than one ACO Partner, its subdomain score for a given Performance Year will equal the average of each Partnered ACO's Health Equity Score for the same Performance Year.</p> |

### CHA-SPECIFIC ADAPTATIONS

|                        |      |
|------------------------|------|
| <b>CHA Adaptations</b> | None |
|------------------------|------|

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**Performance Requirements and Assessment for PY3-5 To Be Finalized Prior to the Start of PY3.**

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### III. CHA HQEIP Ambulatory Technical Specifications

#### K. Health-Related Social Needs Screening

*Aligned with CMS’ Screening for Social Drivers of Health Measure for the Merit-based Incentive Payment System (MIPS) Program<sup>23</sup>*

##### OVERVIEW

|                         |  |
|-------------------------|--|
| Measure Name            | Health-Related Social Needs (HRSN) Screening |
| Steward                 | MassHealth                                   |
| NQF Number              | N/A  |
| Data Source             | Supplemental Data, Encounter Data            |
| Performance Status: PY2 | Pay-for-Reporting                            |

##### POPULATION HEALTH IMPACT

Eliminating health care disparities is essential to improve quality of care for all patients. An important step in addressing health care disparities and improving patient outcomes is to screen for 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 | <p>Percentage of encounters in CHA’s primary care system during the measurement year where served uninsured patients with an encounter were screened for health-related social needs (HRSN). Two rates are reported:</p> <p>Rate 1: HRSN Screening Rate: Percentage of encounters in CHA’s primary care system during the measurement year where patients with an encounter were screened for health-related social needs using a standardized HRSN screening instrument for food, housing, transportation, and utility needs.</p> |
|-------------|--|

<sup>23</sup> 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 \(cms.gov\)](#)

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

## ELIGIBLE POPULATION

|   |  |
|---|--|
| <b>Members</b>                                  | Served uninsured patients  |
| <b>Ages</b>                                     | 0-64 years of age on the date of the encounter   |
| <b>Continuous enrollment/<br/>Allowable gap</b> | N/A  |
| <b>Anchor date</b>                              | Served uninsured on outpatient encounter date  |
| <b>Measurement period</b>                       | July 1 – December 31, 2024   |
| <b>Event/diagnosis</b>                          | <p>Active primary care patients with an outpatient encounter in CHA's primary care system within the performance year.</p> <p>Active primary care patient is defined as a patient that had a face-to-face or telehealth visit in the last 2 years where the patient is empaneled at one of CHA's primary care locations assigned in the EHR.</p> <p>For ambulatory measures for active patients on CHA's primary care panel, coverage is pulled on the last encounter that was assigned as the Primary Benefit Plan and Secondary Benefit Plan in the EHR.</p> <p>CHA may report all screenings for a given patient in the measurement year but for the purpose of rate calculations, the most recent screening will be used</p> |

## DEFINITIONS

|                                    |  |
|------------------------------------|--|
| <b>Measurement Year</b>            | Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.   |
| <b>Health-Related Social Needs</b> | 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.   |
| <b>Standardized HRSN Screening Instruments</b> | <p>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.</p> <p>Examples of eligible screening tools include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Accountable Health Communities Health-Related Social Needs Screening Tool</li> <li>• The Protocol for Responding to and Assessing Patients' Riss and Experiences (PRAPARE) Tool</li> <li>• American Academy of Family Physicians (AAFP) Screening Tool</li> </ul> <p>CHA is not required to use the example screening tools listed above; hospitals may choose to use other screening instruments, or combinations of screening instruments, that include at least one screening question in each of the four required domains. MassHealth may require CHA to report to MassHealth the screening tool(s) used for the purpose of performance on this measure.</p> |
| <b>Supplemental Data</b>                       | <p>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).</p> <p>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).</p>   |

## ADMINISTRATIVE SPECIFICATION

### RATE 1: HRSN Screening Rate

|                    |  |
|--------------------|--|
| <b>Description</b> | Percentage of patients with an encounter in CHA's primary care system during the measurement year who were screened using a standardized |
|--------------------|--|

|                            |   |
|----------------------------|---|
|                            | HRSN screening instrument for food, housing, transportation, and utility needs.   |
| <b>Denominator</b>         | The eligible population   |
| <b>Numerator</b>           | <p>Number of encounters in CHA's primary care system where, as documented in the medical record, patients were screened using a standardized HRSN screening instrument for food, housing, transportation, and/or utility needs.</p> <ul style="list-style-type: none"> <li>Includes encounters where documentation in the medical record indicates that: <ul style="list-style-type: none"> <li>The patient was offered HRSN screening and responded to one or more screening questions;</li> <li>The patient was offered HRSN screening and actively opted out of screening (i.e. chose not to answer any questions);</li> <li>The patient was screened for HRSN in any setting (acute hospital or otherwise) within the measurement year of the encounter.</li> </ul> </li> <li>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.</li> </ul> |
| <b>Unit of measurement</b> | <p>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.</p> <p>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.</p>   |
| <b>Exclusions</b>          | <p>Eligible events where:</p> <ul style="list-style-type: none"> <li>Patients in hospice (identified using the <u>Hospice Value Set</u>)<sup>24</sup>.</li> <li>Patients not screened for food insecurity, housing instability, transportation needs, and utility difficulties because member was unable to complete the screening and have no legal guardian or caregiver able to do so on their behalf. This should be documented in the medical record.</li> </ul>   |

<sup>24</sup> HEDIS® Value Set used with permission from NCQA

## RATE 2: HRSN Screen Positive Rate

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

## DATA REPORTING REQUIREMENTS

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

## SUPPLEMENTAL DATA REPORTING REQUIREMENTS

For PY2, CHA must submit supplemental data (i.e., electronic health record or other medical record data demonstrating HRSN screening rates and/or identified needs) for use by MassHealth for calculating Rate 1 and/or Rate 2. Such supplemental data must be submitted in a form and format to be specified by MassHealth, and must include:



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

- a) a patient was screened for food insecurity, housing instability, transportation needs, and utility difficulties during the performance period (corresponding to the definitions of administrative HCPCS code M1207 and/or HCPCS code G0136).
- b) a patient was not screened for food insecurity, housing instability, transportation needs, utility difficulties (corresponding to the meaning of the administrative HCPCS code M1208)
- c) there is a patient reason for not screening for food insecurity, housing instability, transportation needs, and utility difficulties (e.g., patient declined or other patient reasons.) (corresponding to the meaning of HCPCS code M1237)

| Code System | Code  | Meaning   |
|-------------|-------|---|
| HCPCS       | M1207 | Patient screened for food insecurity, housing instability, transportation needs, utility difficulties [ <i>and interpersonal safety</i> <sup>4</sup> ].   |
| HCPCS       | M1208 | Patients not screened for food insecurity, housing instability, transportation needs, utility difficulties [ <i>and interpersonal safety</i> <sup>4</sup> ].  |
| HCPCS       | M1237 | Patients reason for not screening for food insecurity, housing instability, transportation needs, utility difficulties, [ <i>and interpersonal safety</i> <sup>4</sup> ] (e.g., member declined or other member reasons). |
| HCPCS       | G0136 | Administration of a standardized, evidence-based social determinants of health risk assessments tool, 5-15 minutes.   |

Notes:

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

**4. For Rate 2:** Data indicating identified needs, corresponding to the definitions of the following ICD-10 codes. Data may be captured using the following codes or other clinical record data (e.g., electronic health record data corresponding to these codes), which must be submitted as supplemental data to be recognized for the purpose of calculating this measure.

## 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                                      |
|---|--|
| <b>Z59.10</b>                                 | Inadequate housing, unspecified              |
| <b>Z59.11</b>                                 | Inadequate housing environmental temperature |
| <b>Z59.12</b>                                 | Inadequate housing utilities                 |
| <b>Z59.19</b>                                 | Other Inadequate housing                     |

### **Transportation Needs**

| ICD-10 Code Contributing to Rate 2 Numerators | Meaning                   |
|---|---------------------------|
| <b>Z59.82</b>                                 | Transportation insecurity |

### **Utility Difficulties**

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

### **PERFORMANCE REQUIREMENTS & ASSESSMENT FOR PY2**

|                                 |   |
|---------------------------------|---|
| <b>Performance Requirements</b> | This measure will be calculated by MassHealth using supplemental data submitted to MassHealth by hospitals. Supplemental data must be submitted to MassHealth by <b>June 30, 2025</b> . |
|---------------------------------|---|

|                               |  |
|-------------------------------|--|
| <b>Performance Assessment</b> | <p>Hospitals have opportunity to earn full or partial credit for the measure.</p> <p><b>Component 1: HRSN Screening Rate (75% of measure score)</b></p> <ul style="list-style-type: none"> <li>• A hospital will earn 100% of the points attributed to Component 1 of measure if applicable supplemental data for the performance period (July 1, 2024-December 31, 2024) is submitted to MassHealth by <b>June 30, 2025</b>.</li> <li>• A hospital will earn 0% of the points attributed to Component 1 of measure if no applicable supplemental data for Component 1 for the performance period (July 1, 2024-December 31, 2024) is submitted to MassHealth by <b>June 30, 2025</b>.</li> </ul> <p><b>Component 2: HRSN Screen Positive Rate (25% of measure score)</b></p> <ul style="list-style-type: none"> <li>• A hospital will earn 100% of points attributed to Component 2 of the measure if applicable supplemental data for the performance period (July 1, 2024- December 31, 2024) is submitted to MassHealth by <b>June 30, 2025</b>.</li> <li>• A hospital will earn 0% of the points attributed to Component 2 of the measure if no applicable supplemental data for Component 2 for the performance period (July 1, 2024-December 31, 2024) is submitted to MassHealth by <b>June 30, 2025</b>.</li> </ul> <p>MassHealth expects to audit the data submitted for Rates 1 and 2 by CHA.</p> |
|-------------------------------|--|

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**PERFORMANCE REQUIREMENTS AND ASSESSMENTS AND ASSESSMENT  
FOR PY3-5 TO BE FINALIZED PRIOR TO THE START OF PY3.**

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## L. CHA-HQEIP Ambulatory Quality Performance Disparities Reduction

### OVERVIEW

|                                |  |
|--------------------------------|--|
| <b>Measure Name</b>            | CHA-HQEIP Ambulatory Quality Performance Disparities Reduction                                   |
| <b>Steward</b>                 | MassHealth   |
| <b>NQF Number</b>              | N/A  |
| <b>Data Source</b>             | Administrative, Supplemental. CHA will report population-based electronic measures from the EHR. |
| <b>Performance Status: PY2</b> | Pay-for-Reporting (P4R)  |

### POPULATION HEALTH IMPACT

Eliminating or reducing health care disparities is essential to improve quality of care for all patients. One step in addressing health care disparities and improving patient outcomes is stratifying ambulatory patient data for the uninsured patient population. By collecting and stratifying quality measures, hospitals and care systems can further identify where health care disparities exist—and then focus interventions to reduce observed disparities and promote equitable care.

### MEASURE SUMMARY

|                    |  |
|--------------------|--|
| <b>Description</b> | This measure assesses ambulatory quality performance for the served uninsured patient population in the public hospital's primary care system for the purpose of identifying, monitoring, and improving upon disparities. The quality measures identified for inclusion in this measure span wellness, prevention, and screening; access; outreach and care coordination; and chronic health conditions domains. Of the included measures, a subset will be targeted for disparities reduction accountability in later years of the HQEIP. |
|--------------------|--|

### ELIGIBLE POPULATION

**Served uninsured patients who are active primary care patients in public hospital's primary care system:** Active primary care patient is defined as a patient that had a face-to-face or telehealth visit in the last 2 years where the patient is empaneled at one of CHA's primary care locations assigned in the EHR. For ambulatory measures for active patients on CHA's primary care panel, coverage is pulled on

the last encounter that was assigned as the Primary Benefit Plan and Secondary Benefit Plan in the EHR.

**Table 1: AMBULATORY QUALITY MEASURES IDENTIFIED FOR INCLUSION IN THIS HQEIP ‘AMBULATORY QUALITY PERFORMANCE DISPARITIES REDUCTION MEASURE’**

| Domain  | Measure ID/Steward   | Measure  |
|---|--|--|
| <b>Wellness, Prevention, and Screening</b>    | HEDIS 2022 (W30) NQF 1392, NCQA (adapted to apply to the served uninsured population)* | Well-Child Visits in the First 30 Months of Life (Total Rate)  |
| <b>Wellness, Prevention, and Screening</b>    | HEDIS 2022 (WCV) NQF 1516, NCQA (adapted to apply to the served uninsured population)* | Child and Adolescent well care visit (Total Rate)  |
| <b>Wellness, Prevention, and Screening</b>    | NQF 0038, NCQA (adapted to apply to the served uninsured population)*                  | Childhood Immunization - Combo 10  |
| <b>Wellness, Prevention, and Screening</b>    | NQF 1407, NCQA (adapted to apply to the served uninsured population)*                  | Immunization for Adolescents - Combo 2   |
| <b>Access; Outreach and Care Coordination</b> | State Developed<br>(specification below)   | Achieve Outreach to Defined % of New or Past Due Served Uninsured Patients in Primary Care Panel Population  |
| <b>Wellness, Prevention, and Screening</b>    | HEDIS 2022 (adapted to apply to the served uninsured population)*                      | <p>Cancer Screening Measure(s) TBD</p> <p><i>CHA will develop/explore:</i></p> <ul style="list-style-type: none"> <li>• <i>breast cancer screening (NQF 2372),</i></li> <li>• <i>cervical cancer screening (CCS) (NQF 0032), and</i></li> <li>• <i>colorectal cancer screening (NQF 0034) (COL) measures to identify opportunities.</i></li> </ul> |

| Domain   | Measure ID/Steward  | Measure   |
|--|---|---|
|  |   | <i>Based on findings, a subset may be incorporated within the measure slate in subsequent years.</i>  |
| <b>Chronic Health Conditions</b>                                 | HEDIS 2022, NQF 0018, NCQA (adapted to apply to the served uninsured population)*                       | Hypertension: Controlling high blood pressure   |
| <b>Chronic Health Conditions</b>                                 | HEDIS 2022, NQF 0059, NCQA (adapted to apply to the served uninsured population)*                       | Comprehensive Diabetes Care: Poor Control (>9%)   |
| <b>Chronic Health Conditions; Outreach and Care Coordination</b> | Custom<br><br>Intermediate measure associated with measures 7 and 8 above.<br><br>(specification below) | Diabetes & Hypertension Education: Percentage of high-risk diabetic and hypertensive primary care panel patients receiving enhanced diabetes management services, including nursing-led self-management education, pharmacist-led medication management services, or other care team member support |
| <b>Wellness, Prevention, and Screening</b>                       | CMS measure (Adapted to apply to the served uninsured population)                                       | Depression Screening and Follow-Up  |

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

### **Updates of Measure Specifications:**

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

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

### **Technical Updates:**

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

**Measure 5 Specification: Achieve Outreach to Defined % of New or Past Due Served Uninsured Patients in Primary Care Panel Population**

**Measure Description:**

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

**Measure Definition:**

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

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

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

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

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

**Measure Description:**

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

**Measure Definition:**

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

Denominator: Patients who meet the following conditions:

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



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

| PERFORMANCE REQUIREMENTS AND ASSESSMENT FOR PY2 |   |
|---|---|
| Performance Requirements                        | <p>By <b>March 31, 2025</b>, CHA must submit to MassHealth of PY2 (CY2024) measure performance for the served uninsured patient population for measures selected by MassHealth above.</p> <p>MassHealth has determined that CHA can annually report population-based e-measures (drawn from the electronic health record). This is aligned with MassHealth’s goals toward population-based data collection. Measures will be submitted following the year-end utilizing a MassHealth-approved template (for the served uninsured patient population) consistent with the CMS and Joint Commission portal fields used for e-measures.</p> <p><i>These measures will inform ambulatory PY3 requirements for measures and baselines identified for future year (beyond PY3) disparities reduction.</i></p> |
| Performance Assessment                          | <p>CHA will earn credit for performance on this measure as follows:</p> <ul style="list-style-type: none"><li>• CHA will earn 100% of the points attributed to the measure for timely, complete, and responsive submission of all measures to MassHealth for the served uninsured population.</li><li>• CHA will earn 0% of the points attributed to the measure if submission is not timely, complete, and responsive of all measures to MassHealth for the served uninsured population.</li></ul>   |

**PERFORMANCE REQUIREMENTS AND ASSESSMENTS AND ASSESSMENT  
FOR PY3-5 TO BE FINALIZED PRIOR TO THE START OF PY3.**

# M. Equity Improvement Intervention

## OVERVIEW

|                         |   |
|-------------------------|---|
| Measure Name            | Equity Improvement Interventions                  |
| Steward                 | MassHealth  |
| NQF Number              | N/A   |
| Data Source             | Supplemental Data                                 |
| Performance Status: PY2 | Pay-for-Reporting (P4R)/Pay for Performance (P4P) |

## POPULATION HEALTH IMPACT

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

## MEASURE SUMMARY

|             |  |
|-------------|--|
| Description | <p>CHA will develop and implement no more than one performance improvement milestone project at a time during each performance period that addresses inequities in the served uninsured patient population. The project may include a healthcare delivery system intervention focused on a defined ambulatory measure, an underserved geographic-based area and/or a patient sub-population within the served uninsured population.</p> <p>Across PY2-5, CHA will submit the following deliverables to MassHealth:</p> <ul style="list-style-type: none"><li>• <u>Planning Report</u>: a comprehensive equity improvement intervention plan that includes but is not limited to the following items: health equity aim, objectives and overall goals to address the served uninsured patient population, inclusive of a problem statement, population description/characteristics, scope of opportunity for improvement, barrier identification, proposed intervention or project, and at least 1-2 mid-point milestones and 1-2 year end goals that may be clearly determined or measured (e.g., time-bound, quantitative and qualitative processes or results).</li><li>• <u>Midpoint Report</u>: a comprehensive report that includes progress on the mid-point milestones, and identification of successes and barriers, including plans for mid-course adjustments (as needed).</li></ul> |
|-------------|--|

- **Performance Period-End Report:** a comprehensive report that includes an overview of the project, accomplishments, and progress on year-end goals (one to two) and identification of successes and challenges with a plan for a continued or new equity intervention for the next performance year.

## PERFORMANCE REQUIREMENTS AND ASSESSMENT FOR PY2

|                                 |  |
|---------------------------------|--|
| <b>Performance Requirements</b> | <p>The reporting timeline for the deliverables described above is outlined below. Deliverables for subsequent years are expected to follow the same timeline.</p> <ul style="list-style-type: none"> <li>• <b>Mid-Point Report</b> <ul style="list-style-type: none"> <li>○ Submission due date: 8/31/2024</li> <li>○ Payment Status: P4P</li> </ul> </li> <li>• <b>Performance Period-End Report</b> <ul style="list-style-type: none"> <li>○ Submission due date: 1/31/2025 – 2/28/2025</li> <li>○ Payment Status: P4P</li> </ul> </li> </ul>  |
| <b>Performance Assessment</b>   | <p><b>Pay-for-Performance (P4P)</b> The overall performance assessment approach will encourage a high quality project and intervention as well as gauge and assess progress towards achieving health equity goal(s) focused on the served uninsured population.</p> <p>The scoring methodology used to assess the intervention reporting deliverables and highlights specific scoring elements and associated weighting is summarized below. CHA will formally be permitted one re-submission for each deliverable following receipt of feedback or questions for clarification from MassHealth that may result in an adjusted score.</p> <p>CHA may earn a maximum of 100%, with each report equally contributing to the measure score (50% each).</p> <ul style="list-style-type: none"> <li>• <b>Mid-Point Report (50%)</b> <ul style="list-style-type: none"> <li>○ Mid-year progress summary report narrative</li> <li>○ Elements: <ul style="list-style-type: none"> <li>▪ Summary of implementation and milestones</li> <li>▪ Success and barriers identified</li> <li>▪ Course correction identified as appropriate</li> </ul> </li> </ul> </li> <li>• <b>Performance Period-End Report (50%)</b> <ul style="list-style-type: none"> <li>○ Year-end progress report narrative</li> <li>○ Elements: <ul style="list-style-type: none"> <li>▪ Achievement of milestone(s) and goal(s)</li> <li>▪ Lessons learned identified</li> </ul> </li> </ul> </li> </ul> |

## REPORT SCORING

- **Total Points of  $\geq 8$  points** meets the goal score for the report and will earn 10 points.
- A **Total Points of 5-7.9 points** partially meets the goal score for the report and will contribute partially to the eligible weight that the report contributes to the measure score as follows: EII Report Total Points \* 10.
- An **Overall Rating of less than 5 points** does not meet the threshold score for the report and will earn 0 points.

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It is anticipated that in PY3-PY5, performance requirements and assessment will include similar report timing and deliverables. Performance will be assessed based on development of plans, defined milestones and goals, and reported progress and/or accomplishment of the milestones and goals. Plans for new projects or continued sustainability or expanded scope of the prior performance year intervention will roll into the subsequent year for performance.

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# N. Community Collaboration Equity Improvement Intervention

## OVERVIEW

|                                |   |
|--------------------------------|---|
| <b>Measure Name</b>            | Community Collaboration Equity Improvement Intervention |
| <b>Steward</b>                 | MassHealth  |
| <b>NQF Number</b>              | N/A   |
| <b>Data Source</b>             | Supplemental Data                                       |
| <b>Performance Status: PY2</b> | Pay-for-Performance (P4P)                               |

## POPULATION HEALTH IMPACT

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

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

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

## MEASURE SUMMARY

|                    |   |
|--------------------|---|
| <b>Description</b> | CHA will develop and implement no more than one community collaboration milestone at a time during each performance period that addresses opportunities for health care and promote health equity for the served uninsured patient population and the communities served, working across the CHA delivery system or network and/or through internal community health and/or external community partnership. The intervention milestone will be related to the goals of Domain 1 (Health-Related Social Needs) or Domain 2 (Equitable Access and Quality) for the served uninsured population.<br><br>Across PY2-5, CHA will submit the following deliverables to EOHHS: |
|--------------------|---|

|  |   |
|--|---|
|  | <ul style="list-style-type: none"> <li>• <u>Planning Report</u>: a comprehensive plan that includes but is not limited to the following items: health equity aim, objectives and overall goals to address the served uninsured patient population, inclusive of a problem statement, population description/characteristics, scope of opportunity for improvement, barrier identification, proposed intervention or project, and 1-2 mid-point milestones and 1-2 year end goals that may be clearly determined (e.g., time-bound, quantitative and qualitative processes or results).</li> <li>• <u>Midpoint Report</u>: A comprehensive report that includes progress on the 1-2 milestones, and identification of successes and challenges, including plans for mid-course adjustments (as needed).</li> <li>• <u>Performance Period-End Report</u>: A comprehensive report that includes an overview of the project, accomplishments, and progress on year-end goals (one to two) and identification of successes and challenges with a plan for a continued or new equity intervention for the next performance year.</li> </ul> |
|--|---|

## PERFORMANCE REQUIREMENTS AND ASSESSMENT FOR PY2

|                                 |  |
|---------------------------------|--|
| <b>Performance Requirements</b> | <p>The reporting timeline for the deliverables described above is outlined below. Deliverables for subsequent years are expected to follow the same timeline.</p> <ul style="list-style-type: none"> <li>• <u>Planning Report</u> <ul style="list-style-type: none"> <li>○ Submission due date: 1/30/2024</li> <li>○ Payment Status: P4P</li> </ul> </li> <li>• <u>Mid-Point Report</u> <ul style="list-style-type: none"> <li>○ Submission due date: 8/31/2024</li> <li>○ Payment Status: P4P</li> </ul> </li> <li>• <u>Performance Period-End Report</u> <ul style="list-style-type: none"> <li>○ Submission due date: 1/31/2025 – 2/28/2025</li> <li>○ Payment Status: P4P</li> </ul> </li> </ul> |
| <b>Performance Assessment</b>   | <p><b>Pay-for-Performance (P4P)</b> The overall performance assessment approach will encourage a high quality project and intervention as well as gauge and assess progress towards achieving health equity goal(s) focused on the served uninsured population.</p> <p>The scoring methodology used to assess the intervention reporting deliverables and highlights specific scoring elements and associated weighting is summarized below. CHA will formally be permitted one re-submission for each deliverable following receipt of feedback or questions for clarification from MassHealth that may result in an adjusted score.</p>  |

CHA may earn a maximum of 100%, with each report contributing to the measure score as specified below:

- **Planning Report (40%)**
  - Elements:
    - Aim, Objective, Goals
    - Problem Statement, Scope of Opportunity
    - Approach – Project Summary
    - Barrier analysis and intervention
    - Definition of 1-2 Milestones (mid-point deliverables) and 1-2 Goals (year-end goals) – metric and data sources identified
- **Mid-Point Report (30%)**
  - Mid-year progress summary report narrative
  - Elements:
    - Summary of implementation and milestones
    - Success and barriers identified
    - Course correction identified as appropriate
- **Performance Period-End Report (30%)**
  - Year-end progress report narrative
  - Elements:
    - Achievement of milestone(s) and goal(s)
    - Lessons learned identified

#### **REPORT SCORING**

- **Total Points of  $\geq 8$  points** meets the goal score for the report and will earn 10 points.
- **A Total Points of 5-7.9 points** partially meets the goal score for the report and will contribute partially to the eligible weight that the report contributes to the measure score as follows: EII Report Total Points \* 10.
- **An Overall Rating of less than 5 points** does not meet the threshold score for the report and will earn 0 points.

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It is anticipated that in PY3-PY5, performance requirements and assessment will include similar report timing and deliverables. Performance will be assessed based on development of plans, defined milestones and goals, and reported progress and/or accomplishment of the milestones and goals. Plans for new projects or continued sustainability or expanded scope of the prior performance year intervention will roll into the subsequent year for performance.

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