



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

Performance Year 2 (Calendar Year 2024)

Version: May 19, 2025

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A. Introduction

This document outlines the Performance Years (PY) 2 Technical Specifications for all hospitals participating in the Health Quality and Equity Incentive Program (HQEIP). These requirements apply to all HQEIP hospitals participating in PY2 regardless of the year in which hospitals started the program.

For hospitals that are participating in the HQEIP and being held accountable to a performance year in a performance period other than the calendar year in which the majority of other hospitals are being held accountable to such performance year, in accordance with Section 3.B of the HQEIP PY 1-5 Implementation Plan, MassHealth may update certain details included in these PY2 Technical Specifications to account for the differing performance period. Specifically, MassHealth may issue guidance to such hospitals in order to:

- (1) update deliverable due dates;
- (2) consolidate or simplify deliverables; or
- (3) update metrics to account for current PY HQEIP requirements, measure stewards' adjustments to their measure slates, data no longer being relevant or useful for comparison or baseline purposes, or other circumstances necessitating adjustments as determined by MassHealth.

MassHealth reserves the right to request additional documentation related to the HQEIP measures for the purpose of auditing. 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. RELD SOGI Data Completeness

A.i. Race Data Completeness

OVERVIEW	
Measure Name	Rate of Race Data Completeness – Acute Hospital
Steward	MassHealth
NQF Number	N/A
Data Source	Numerator source: Center for Health Information and Analysis (CHIA) “Enhanced Demographics Data File” Denominator sources: MassHealth encounter and MMIS claims data
Performance Status: PY2	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	
Description	The percentage of members with self-reported race data that was collected by an acute hospital in the measurement year.
Numerator	Members with an inpatient 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.
Denominator	Members with an inpatient discharge and/or ED visit at an acute hospital during the measurement year.

ELIGIBLE POPULATION

Age	Members of any age
Continuous Enrollment	None
Anchor Date	None
Event/Diagnosis	<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"> Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>)¹. <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> Identify all Emergency Department visits (<u>ED Value Set</u>)².

DEFINITIONS

Complete Race Data	<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"> If value is “UNK” it will <u>not</u> count toward the numerator. If value is “ASKU,” it will count toward the numerator. If value is “DONTKNOW,” it will count toward the numerator. Each value must be self-reported.
Hospital File [“Enhanced Demographics Data File”]	<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</p>

¹ HEDIS® Value Set used with permission from NCQA

² HEDIS® Value Set used with permission from NCQA

	below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.
Measurement Year	Measurement Years 1-5 correspond to QEIP Performance Years 1-5.
Members	<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>
Rate of Race Data Completeness	<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>
Self-Reported data	<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 HHS' data collection standards and an individual self-reports their race as "Samoan", then the hospital can report the value of "Native Hawaiian or Other Pacific Islander" since the value of Samoan is not a valid value in Attachment 1.</p>

ADMINISTRATIVE SPECIFICATION

Denominator	<p>There are two denominators for this measure:</p> <p>Denominator 1:</p> <p>The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals.</p>
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	<p>Denominator 2:</p> <p>The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.</p>
Numerator	<p>There are two numerators for this measure:</p> <p>Numerator 1:</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"> • If value is “UNK,” it will <u>not</u> count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. • Each value must be self-reported. <p>Numerator 2:</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"> • If value is “UNK,” it will <u>not</u> count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. • Each value must be self-reported.
Exclusions	<p>If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.</p>

ADDITIONAL MEASURE INFORMATION

Required Reporting	<p>The following information is required:</p> <ul style="list-style-type: none"> • A valid MassHealth Member ID <p>Format: Refer to CHIA Submission Guide</p>
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	<ul style="list-style-type: none"> At least one (1) race value, as defined under “Complete Race Data” above <p>Format: Refer to CHIA Submission Guide</p>
Data Collection	<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"> By any modality that allows the patient (or a person legally authorized to respond on the patient’s behalf, such as a parent or legal guardian) to self-report race (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); By any entity interacting with the member (e.g. health plan, ACO, provider, staff); Must include one or more values in Attachment 1.
Completeness Calculations	Completeness is calculated for: each individual Acute Hospital.

Attachment 1. Race: Accepted Values

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

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

A.ii. Hispanic Ethnicity Data Completeness

OVERVIEW

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

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

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

ELIGIBLE POPULATION

Age	Members of any age
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Continuous Enrollment	None
Anchor Date	None
Event/Diagnosis	<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"> Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>)³. <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> Identify all Emergency Department visits (<u>ED Value Set</u>)⁴

DEFINITIONS

Complete Hispanic ethnicity Data	<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"> If value is “UNK,” it will <u>not</u> count toward the numerator. If value is “ASKU” it will count toward the numerator. If value is “DONTKNOW” it will count toward the numerator. Each value must be self-reported.
Hospital File [“Enhanced Demographics Data File”]	<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>

³ HEDIS® Value Set used with permission from NCQA

⁴ HEDIS® Value Set used with permission from NCQA

Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Members	<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>
Rate of Hispanic Ethnicity Data Completeness	<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>
Self-Reported data	<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 HHS' data collection standards (i.e., Mexican; Puerto Rican; Cuban; Another Hispanic, Latino/a, or Spanish origin) and an individual self-reports their ethnicity as "Puerto Rican", then the hospital can report the value of "Hispanic" since the value of Puerto Rican is not a valid value in Attachment 2.</p>

ADMINISTRATIVE SPECIFICATION

Denominator	<p>There are two denominators for this measure:</p> <p>Denominator 1:</p> <p>The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals.</p> <p>Denominator 2:</p> <p>The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.</p>
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Numerator	<p>There are two numerators for this measure:</p> <p>Numerator 1:</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"> • If value is “UNK,” it will <u>not</u> count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. • Each value must be self-reported. <p>Numerator 2:</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"> • If value is “UNK,” it will <u>not</u> count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. • Each value must be self-reported.
Exclusions	<p>If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.</p>

ADDITIONAL MEASURE INFORMATION

Required Reporting	<p>The following information is required:</p> <ul style="list-style-type: none"> • A valid MassHealth Member ID Format: Refer to CHIA Submission Guide • At least one (1) ethnicity value, as defined under “Complete Hispanic Data” above Format: Refer to CHIA Submission Guide
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Data Collection	<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"> • By any modality that allows the patient (or a person legally authorized to respond on the patient's behalf, such as a parent or legal guardian) to self-report Hispanic ethnicity (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 2.
Completeness Calculations	Completeness is calculated for: each individual Acute Hospital.

Attachment 2. Hispanic Ethnicity: Accepted Values

Description	Valid Values	Notes
Hispanic or Latino	2135-2	
Not Hispanic or Latino	2186-5	
Choose not to answer	ASKU	Member was asked to provide their ethnicity, and the member actively selected or indicated that they “choose not to answer”.
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	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.

Description	Valid Values	Notes
condition that alters consciousness).		
Unknown	UNK	<p>The ethnicity of the member is unknown since either:</p> <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>

A.iii. Preferred Language Data Completeness

OVERVIEW

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

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

ELIGIBLE POPULATION

Age	Members age 6 and older as of December 31 st of the measurement year
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Continuous Enrollment	None
Anchor Date	None
Event/Diagnosis	<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"> Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>)⁵. <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> Identify all Emergency Department visits (<u>ED Value Set</u>)⁶.

DEFINITIONS

Complete Preferred Written Language Data	<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"> If value is “UNK,” it will not count toward the numerator. If value is “ASKU,” it will count toward the numerator. If value is “DONTKNOW,” it will count toward the numerator. Each value must be self-reported.
Complete Preferred Spoken Language Data	<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"> If value is “UNK,” it will not count toward the numerator. If value is “ASKU,” it will count toward the numerator. If value is “DONTKNOW,” it will count toward the numerator. Each value must be self-reported.
Hospital File [“Enhanced Demographics Data File”]	<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</p>

⁵ HEDIS® Value Set used with permission from NCQA

⁶ HEDIS® Value Set used with permission from NCQA

	the hospital may not have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.
Measurement Year	Measurement Years 2-5 correspond to Calendar Years 2024-2027.
Members	<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>
Rate of Preferred Written and Spoken Language Data Completeness	<p>There will be four rates reported for this measure, defined as.</p> <p>Rate 1: (Numerator 1 (PWL) Population / Denominator 1 (IP) Population) * 100</p> <p>Rate 2: (Numerator 1 (PSL) Population / Denominator 1 (IP) Population) * 100</p> <p>Rate 3: (Numerator 2 (PWL) Population / Denominator 2 (ED) Population) * 100</p> <p>Rate 4: (Numerator 2 (PSL) Population / Denominator 2 (ED) Population) * 100</p>
Self-Reported data	For the purposes of this measure specification, data are defined as self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).

ADMINISTRATIVE SPECIFICATION

Denominator	<p>There are two denominators for this measure:</p> <p>Denominator 1:</p> <p>The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals.</p>
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	<p>Denominator 2: The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.</p>
Numerator	<p>Numerator 1:</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"> • 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). <p>Numerator 2:</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"> • QMAT Language Q1: In which language would you feel most comfortable reading medical or health care instructions? (or similar phrasing to elicit written language preference). • QMAT Language Q2: What language do you feel most comfortable speaking with your doctor or nurse? (or similar phrasing to elicit spoken language preference).
Exclusions	<p>If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.</p>

ADDITIONAL MEASURE INFORMATION

Required Reporting	<p>The following information is required:</p> <ul style="list-style-type: none"> • A valid MassHealth Member ID <p>Format: Refer to CHIA Submission Guide</p> <ul style="list-style-type: none"> • 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
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	Format: Refer to CHIA Submission Guide
Data Collection	<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"> • By any modality that allows the patient (or a person legally authorized to respond on the patient's behalf, such as a parent or legal guardian) to self-report preferred written and spoken languages (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 3; <ul style="list-style-type: none"> ○ If an acute hospital submits a value that is not included in Attachment 3 but allowable per the MassHealth Member File Specification, the value will be mapped to Other Preferred Written Language (OTH).
Completeness Calculations	<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 written 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 spoken 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 written 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 spoken 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 written 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 spoken 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 written 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 spoken language data <u>for question 2</u> that was collected by all acute hospitals in the measurement year.</p>
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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	

Description	Valid Values	Notes
Russian	ru	
Arabic	ar	
Other Preferred Written Language	OTH	If a hospital submits a value that is not included in Attachment 3 but allowable per CHIA EHRD, the value will be mapped to Other Preferred Written Language (OTH).
Choose not to answer	ASKU	Member was asked to provide their Preferred Written Language, and the member actively selected or indicated that they “choose not to answer.”
Don’t know	DONTKNOW	Member was asked to provide their Preferred Written Language, and the member actively selected or indicated that they did not know their Preferred Written Language.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	<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</p>

Description	Valid Values	Notes
		valid response, and should be assigned the value of ASKU instead of UNK.

Preferred Spoken Language

Description	Valid Values	Notes
English	en	-
Spanish	es	-
Portuguese	pt	-
Chinese	zh	If a hospital submits Cantonese (yue), Mandarin (cmn), or Min Nan Chinese (nan) it will be mapped to Chinese for the purposes of data completeness.
Haitian Creole	ht	
Sign Languages	sgn	If a hospital submits American Sign Language (ase) or Sign Languages (sgn), it will be mapped to Sign Languages for the purpose of data completeness
French	fr	-
Vietnamese	vi	-
Russian	ru	-
Arabic	ar	-
Other Preferred Spoken Language	OTH	If a hospital submits a value that is not included in Attachment 3 but allowable per CHIA EHRD, the value will be mapped to Other.
Choose not to answer	ASKU	Member was asked to provide their Preferred Spoken Language, and the member actively selected or indicated that they “choose not to answer.”

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

A.iv. Disability Data Completeness

OVERVIEW

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

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

ELIGIBLE POPULATION

Age	Age varies by disability question:
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	<ul style="list-style-type: none"> Disability Questions 1 and 2: no age specified; Disability Questions 3 – 5: age 6 or older as of December 31st of the measurement year; Disability Question 6: age 16 or older as of December 31st of the measurement year.
Continuous Enrollment	None
Anchor Date	None
Event/Diagnosis	<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"> Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>)⁷. <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> Identify all Emergency Department visits (<u>ED Value Set</u>)⁸.

DEFINITIONS

Complete Disability Data	<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"> If value is “UNK,” it will not count toward the numerator. If value is “ASKU,” it will count toward the numerator. If value is “DONTKNOW,” it will count toward the numerator. Each value must be self-reported.
Hospital File [“Enhanced Demographics Data File”]	<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</p>

⁷ HEDIS® Value Set used with permission from NCQA

⁸ HEDIS® Value Set used with permission from NCQA

	have a valid MassHealth ID. CHIA will validate submissions and send data for all identifiable members (as defined below) to MassHealth. CHIA will provide detailed data specifications and submissions guides for the intake of this Enhanced Demographics Data file.
Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Members	<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>
Rate of Disability Data Completeness	<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>
Self-Reported data	For the purposes of this measure specification, data are defined as self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).

ADMINISTRATIVE SPECIFICATION

Denominator	<p>There are two denominators for this measure:</p> <p>Denominator 1:</p> <p>The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals.</p> <p>Denominator 2:</p> <p>The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.</p>
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Numerator Set	<p>There are two numerators for this measure:</p> <p>Numerator 1:</p> <p>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"> • If value is “UNK,” it will <u>not</u> count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. • Each value must be self-reported. <p>Numerator 2:</p> <p>For members in Denominator 2, 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>
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	<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"> • If value is "UNK" it will <u>not</u> count toward the numerator. • If value is "ASKU," it will count toward the numerator. • If value is "DONTKNOW," it will count toward the numerator. • Each value must be self-reported.
Exclusions	If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.

ADDITIONAL MEASURE INFORMATION

Required Reporting	<p>The following information is required:</p> <ul style="list-style-type: none"> • A valid MassHealth Member ID Format: Refer to CHIA Submission Guide • At least one (1) valid disability value per question, as defined under "Complete Disability Data" above Format: Refer to CHIA Submission Guide
Data Collection	<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"> • 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.);

	<ul style="list-style-type: none"> • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 4.
Completeness Calculations	<p>Completeness is calculated per disability question per acute hospital and overall, as described below for questions 1 and 2, as an example: For each individual acute hospital:</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
Yes	LA33-6	
No	LA32-8	
Choose not to Answer	ASKU	Member was asked whether they are deaf or have difficulty hearing, and the member actively selected or indicated that they “choose not to answer.”

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

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

Description	Valid Values	Notes
Yes	LA33-6	
No	LA32-8	
Choose not to Answer	ASKU	Member was asked whether they are blind or have difficulty seeing, and the member actively selected or indicated that they "choose not to answer."
Don't know	DONTKNOW	Member was asked whether they are blind or have difficulty seeing, and the member actively selected or

Description	Valid Values	Notes
		indicated that they did not know whether they are blind or have difficulty seeing.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	<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

Description	Valid Values	Notes
		member actively selected or indicated that they did not know whether they have serious difficulty concentrating, remembering or making decisions.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	<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	

Description	Valid Values	Notes
Choose not to Answer	ASKU	Member was asked whether they have difficulty walking or climbing stairs, and the member actively selected or indicated that they “choose not to answer.”
Don’t know	DONTKNOW	Member was asked whether they have difficulty walking or climbing stairs, and the member actively selected or indicated that they did not know whether they have difficulty walking or climbing stairs.
Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
Unknown	UNK	<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	

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

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

A.v. Sexual Orientation Data Completeness

OVERVIEW

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

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

ELIGIBLE POPULATION

Age	Members age 19 and older as of December 31 of the measurement year
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Continuous Enrollment	None
Anchor Date	None
Event/Diagnosis	<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"> Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>)⁹. <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> Identify all Emergency Department visits (<u>ED Value Set</u>)¹⁰.

DEFINITIONS

Complete Sexual Orientation Data	<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"> If value is “UNK,” it will not count toward the numerator. If value is “ASKU,” it will count toward the numerator. If value is “DONTKNOW,” it will count toward the numerator. Each value must be self-reported.
Hospital File [“Enhanced Demographics Data File”]	<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>

⁹ HEDIS® Value Set used with permission from NCQA

¹⁰ HEDIS® Value Set used with permission from NCQA

Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Members	<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>
Rate of Sexual Orientation Data Completeness	<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>
Self-Reported data	For the purposes of this measure specification, data are defined as self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).

ADMINISTRATIVE SPECIFICATION

Denominator	<p>There are two denominators for this measure:</p> <p>Denominator 1:</p> <p>The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals.</p> <p>Denominator 2:</p> <p>The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.</p>
Numerator	<p>There are two numerators for this measure:</p> <p>Numerator 1:</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"> • If value is “UNK,” it will <u>not</u> count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. • Each value must be self-reported. <p>Numerator 2:</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"> • If value is “UNK,” it will <u>not</u> count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. • Each value must be self-reported.
Exclusions	<p>If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.</p>

ADDITIONAL MEASURE INFORMATION

Required Reporting	<p>The following information is required:</p> <ul style="list-style-type: none"> • A valid MassHealth Member ID Format: Refer to CHIA Submission Guide • At least one (1) valid sexual orientation value, as defined under “Complete Sexual Orientation Data” above Format: Refer to CHIA Submission Guide
Data Collection	<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"> • By any modality that allows the patient (or a person legally authorized to respond on the patient's behalf, such as a parent or legal guardian) to self-report sexual orientation (e.g. over the phone, electronically (e.g. a patient portal), in person, by mail, etc.); • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 5.
Completeness Calculations	Completeness is calculated for: each individual Acute Hospital.

Attachment 5. Sexual Orientation: Accepted Values

Description	Valid Values	Notes
Bisexual	42035005	
Straight or heterosexual	20430005	
Lesbian or gay	38628009	
Queer, pansexual, and/or questioning	QUEER	
Something else	OTH	
Choose not to answer	ASKU	Member was asked to provide their sexual orientation, and the member actively selected or indicated that they "choose not to answer".
Don't know	DONTKNOW	Member was asked to provide their sexual orientation, and the member actively selected or indicated that they did not know their sexual orientation.
Unable to collect this information on 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 sexual orientation of the member is unknown since either:</p> <p>(a) the member was not asked to provide their sexual orientation, or</p> <p>(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.</p>

A.vi. Gender Identity Data Completeness

OVERVIEW

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

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

ELIGIBLE POPULATION

Age	Members age 19 and older as of December 31 of the measurement year
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Continuous Enrollment	None
Anchor Date	None
Event/Diagnosis	<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"> Identify all inpatient discharges (<u>Inpatient Stay Value Set</u>)¹¹. <p>To identify emergency department visits:</p> <ul style="list-style-type: none"> Identify all Emergency Department visits (<u>ED Value Set</u>)¹².

DEFINITIONS

Complete Gender Identity Data	<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"> If value is “UNK,” it will not count toward the numerator. If value is “ASKU,” it will count toward the numerator. If value is “DONTKNOW,” it will count toward the numerator. Each value must be self-reported.
Hospital File [“Enhanced Demographics Data File”]	<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>
Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.

¹¹ HEDIS® Value Set used with permission from NCQA

¹² HEDIS® Value Set used with permission from NCQA

Members	<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>
Rate of Gender Identity Data Completeness	<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>
Self-Reported data	<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

Denominator	<p>There are two denominators for this measure:</p> <p>Denominator 1:</p> <p>The eligible population for MassHealth members with inpatient discharge claims/encounters from acute hospitals.</p> <p>Denominator 2:</p> <p>The eligible population for MassHealth members with emergency department visit claims/encounters from acute hospitals.</p>
Numerator	<p>There are two numerators for this measure:</p> <p>Numerator 1:</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"> • If value is “UNK,” it will <u>not</u> count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. • Each value must be self-reported. <p>Numerator 2:</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"> • If value is “UNK,” it will <u>not</u> count toward the numerator. • If value is “ASKU,” it will count toward the numerator. • If value is “DONTKNOW,” it will count toward the numerator. • Each value must be self-reported.
Exclusions	If value is UTC, the inpatient discharge or emergency department visit is excluded from the denominator.

ADDITIONAL MEASURE INFORMATION

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

	<ul style="list-style-type: none"> • By any entity interacting with the member (e.g. health plan, ACO, provider, staff); • Must include one or more values in Attachment 6.
Completeness Calculations	Completeness is calculated for: each individual Acute Hospital.

Attachment 6. Gender Identity: Accepted Values

Description	Valid Values	Notes
Male	446151000124109	
Female	446141000124107	
Genderqueer/gender nonconforming/non-binary; neither exclusively male nor female	446131000124102	
Transgender man/trans man	407376001	
Transgender woman/trans woman	407377005	
Additional gender category or other	OTH	
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	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.

Description	Valid Values	Notes
that alters consciousness)		
Unknown	UNK	<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>

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

PERFORMANCE REQUIREMENTS AND ASSESSMENT	
Performance Requirements	<div>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.</div> <div>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.</div>
Performance Assessment	<div>• 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.</div> <div>• 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.</div>

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

C. Health-Related Social Needs Screening

Aligned with CMS’ Screening for Social Drivers of Health Measure for the Merit-based Incentive Payment System (MIPS) Program¹³

OVERVIEW

Measure Name	Health-Related Social Needs (HRSN) Screening
Steward	MassHealth
NQF Number	N/A
Data Source	Supplemental 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 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">Rate 1: HRSN Screening Rate: 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.Rate 2: HRSN Screen Positive Rate: Rate of HRSN identified (i.e., screen positive) among cases in Rate 1 numerator. Four sub-rates
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¹³ Aligned with CMS’ Screening for Social Drivers of health Measure for the Merit-based Incentive Payment System (MIPS) Program. [Centers for Medicare and Medicaid Services Measures Inventory Tool \(cms.gov\)](#)

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

ELIGIBLE POPULATION

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

DEFINITIONS

Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Members	<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</p>

¹⁴ HEDIS® Value Set used with permission from NCQA

¹⁵ HEDIS® Value Set used with permission from NCQA

	patients with the Payer Source Type/ Payer Source Codes in the measure population.
Health-Related Social Needs	The immediate daily necessities that arise from the inequities caused by the social determinants of health, such as a lack of access to basic resources like stable housing, an environment free of life-threatening toxins, healthy food, utilities including heating and internet access, transportation, physical and mental health care, safety from violence, education and employment, and social connection.
Standardized HRSN Screening Instruments	<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"> • Accountable Health Communities Health-Related Social Needs Screening Tool • The Protocol for Responding to and Assessing Patients' Riss and Experiences (PRAPARE) Tool • American Academy of Family Physicians (AAFP) Screening Tool <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>
Supplemental Data	<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

Description	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.
Denominator	The eligible population
Numerator	<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"> Includes eligible inpatient and observation stay discharges where documentation in the acute hospital medical record indicates that: <ul style="list-style-type: none"> The member was offered HRSN screening and responded to one or more screening questions; The member was offered HRSN screening and actively opted out of screening (i.e. chose not to answer any questions); or The member was screened for HRSN in any setting (acute hospital or otherwise) within 90 days prior to the date of admission. Includes screenings rendered by any clinical provider (e.g., an ACO clinical provider, hospital clinical provider), non-clinical staff (e.g., patient navigator), health plan staff and/or Community Partner staff.
Unit of measurement	<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>
Exclusions	<p>Eligible events where:</p> <ul style="list-style-type: none"> Member dies prior to discharge. Members in hospice (identified using the <u>Hospice Value Set</u>)¹⁶. Members not screened for food insecurity, housing instability,

¹⁶ HEDIS® Value Set used with permission from NCQA

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.

RATE 2: HRSN Screen Positive Rate

Description	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.
Denominator	Discharges meeting the numerator criteria for Rate 1, as indicated by a positive need in any of the four screened domains.
Numerator 2a – Food insecurity	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).
Numerator 2b – Housing instability	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).
Numerator 2c – Transportation needs	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).
Numerator 2d – Utility difficulties	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).
Exclusions	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> ⁴].
HCPCS	M1208	Member not screened for food insecurity, housing instability, transportation needs, utility difficulties [<i>and interpersonal safety</i> ⁴].
HCPCS	M1237	Member reason for not screening for food insecurity, housing instability, transportation needs, utility difficulties, [<i>and interpersonal safety</i> ⁴] (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 the 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
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
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

PERFORMANCE REQUIREMENTS & ASSESSMENT

Performance Requirements	This measure will be calculated by MassHealth using supplemental data submitted to MassHealth by hospitals. Supplemental data must be submitted to MassHealth by June 30, 2025 .
Performance Assessment	<p>Hospitals have opportunity to earn full or partial credit for the measure.</p> <p>Component 1: HRSN Screening Rate (75% of measure score)</p> <ul style="list-style-type: none"> 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 June 30, 2025. 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 June 30, 2025. <p>Component 2: HRSN Screen Positive Rate (25% of measure score)</p> <ul style="list-style-type: none"> 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 June 30, 2025. 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 June 30, 2025. <p>MassHealth expects to audit the data submitted for Rates 1 and 2 by the hospital.</p>

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

D. Quality Performance Disparities Reduction

OVERVIEW

Measure Name	Quality Performance Disparities Reduction
Steward	MassHealth
NQF Number	N/A
Data Source	Administrative, Supplemental
Performance Status: PY2	Pay-for-Reporting (P4R)

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

Description	This measure assesses targeted acute hospital quality measure performance stratified by race and ethnicity. Quality measures identified for reporting in this measure for PY2 (drawn from the MassHealth Clinical Quality Incentive (CQI) Program and detailed in Table 1) are disparities-sensitive measures in the areas of maternal health, care coordination, care for acute & chronic conditions, patient experience, and access to care that have been prioritized by MassHealth because of their importance to the MassHealth population. A subset of CQI measures selected for stratified reporting will be targeted for disparities reduction accountability in later years of the HQEIP.
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ELIGIBLE POPULATION

The eligible populations for each CQI program measure identified in Table 1 for inclusion in this measure are defined in CQI program technical measure specifications (see <https://www.mass.gov/info-details/masshealth-cqi-technical-specifications-manuals>).

DEFINITIONS

Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
Applicable Measures	Measures drawn from the MassHealth Clinical Quality Incentive Program slate that are included in Table 1 of this specification.
Proxy Measures	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

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

- **For chart-based measures**, hospitals must submit member-level self-reported race and ethnicity data alongside clinical quality measure data as part of the quarterly quality measure submission cycle (via the MassQEX portal).
- **For claims-based measures**, hospitals 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 the hospital) 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.
- **For the HCAHPS survey**, hospitals must submit aggregate results for all surveyed MassHealth members for each of the seven composites specified in the EOHHS Hospital Clinical Quality Incentive Program Technical Specifications. These data are not required to be stratified by race and ethnicity. In PY2, hospitals may submit MassHealth composite top box results for discharges beginning no later than July 1, 2024.

Reference for calculating top box results:

Calculation of HCAHPS Scores: From Raw Data to Publicly Reported Results, 2011

<https://www.hcahpsonline.org/globalassets/hcahps/technical-specifications/calculation-of-hcahps-scores2.pdf>

Table 1: MASSHEALTH CLINICAL QUALITY INCENTIVE PROGRAM MEASURES IDENTIFIED FOR INCLUSION IN THIS HQEIP QUALITY PERFORMANCE DISPARITIES REDUCTION MEASURE

Domain	Type	Measure
Perinatal Care	Chart-Based	PC-02: Cesarean Birth, NTSV
Perinatal Care	Chart-Based	PC-06: Unexpected Newborn Complications in Term Infants
Care Coordination	Chart-Based	CCM-1: Reconciled medication list received by discharged patient
Care Coordination	Chart-Based	CCM-2: Transition record with specified data elements received by discharge patient
Care Coordination	Chart-Based	CCM-3: Timely transmission of transition record within 48 hours at discharge
Care Coordination	Claims-based	NCQA: Follow-up After ED Visit for Mental Illness (7 and 30 Day)
Care Coordination	Claims-based	NCQA: Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence (7 and 30 Day)
Care Coordination	Claims-based	NCQA: Follow-up After Hospitalization for Mental Illness (NQF 0576) (7 and 30 day)
Acute & Chronic Conditions	Chart-Based	SUB-2: Alcohol Use – Brief Intervention Provided or Offered
Acute & Chronic Conditions	Chart-Based	SUB-3: Alcohol & Other Drug Use Disorder – Treatment provided/offered at discharge
Patient Experience	Survey	AHRQ: HCAHPS Survey: Stratified by MassHealth population only, willingness to recommend and selected composites.

ADDITIONAL MEASURE INFORMATION

General Guidance	<p>Race and ethnicity data standards for stratification:</p> <ul style="list-style-type: none"> For chart-based measures, hospitals should submit race and ethnicity data as specified in CQI program standards for submission. For claims-based measures, hospitals should stratify performance by race and ethnicity categories specified in the MassHealth “Race and Ethnicity Data Completeness” sub-measure specification. <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. Hospitals should report on all patients for whom they have race and ethnicity data.</p>
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PERFORMANCE REQUIREMENTS AND ASSESSMENT

Performance Requirements	Timely and complete submission to MassHealth of PY2 reporting requirements specified in the “Administrative Specification” section above by the anticipated dates included in the ‘Performance Assessment’ section below. Submissions must be in a form and format specified by MassHealth.
Performance Assessment	<p>Hospitals will earn credit for performance on this measure as follows:</p> <ul style="list-style-type: none"> Chart-based measures (Requirement 1): A hospital will earn 40% of the points attributed to the measure for timely, complete, and responsive submission of MassHealth required race and ethnicity variables through the MassQEX portal for all applicable chart-based measures. A hospital will earn 0% of the points attributed to the measure if hospital does not achieve timely, complete, and responsive submission of MassHealth required race and ethnicity variables through the MassQEX portal for all applicable chart-based measures. Claims-based measures (Requirement 2): A hospital will earn 40% 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 by March 31, 2025. In lieu of reporting performance according to CQI program specifications for claims-based measures, hospitals 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), hospitals 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)). A hospital will earn 0% of the points attributed to the measure if

	<p>hospital does not achieve a timely, complete, and responsive submission of PY2 report of performance stratified by race and ethnicity for all applicable claims-based measures by March 31, 2025.</p> <ul style="list-style-type: none">• HCAHPS survey (Requirement 3): A hospital will earn 20% of the points attributed to the measure for timely, complete, and responsive submission of MassHealth member aggregated data for the HCAHPS composites specified in the CQI Technical Specifications submitted through MassQEX portal by June 30, 2025. A hospital will earn 0% of the points attributed to the measure if no MassHealth member aggregated data for the HCAHPS composites is submitted MassHealth by June 30, 2025. Submission of the HCAHPS composite data via the MassQEX portal will be done in conjunction with submission of data for the Patient Experience: Communication, Courtesy, and Respect measure.
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**PERFORMANCE REQUIREMENTS AND ASSESSMENTS AND ASSESSMENT
FOR PY3-5 TO BE FINALIZED PRIOR TO THE START OF PY3.**

E. Equity Improvement Interventions

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

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

MEASURE SUMMARY

Description	<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">• Support collaboration and information sharing,• Address mutually shared equity goals,• Achieve significant and sustained improvement in equity outcomes, and• Promote program-wide impact. <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>
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	interventions, evaluation of the interventions' impact using performance measures, and activities to increase/sustain improvement.
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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

Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
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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: PY2-5

Performance Requirements	<p>Timely submission to MassHealth of four required reports (the PIP Planning (Baseline) Report, the Remeasurement 1 Report, and the Remeasurement 2 Report, and the Closure Report) is required. Submission dates for PIP1 and PIP2 reports are specified below.</p> <p>PIP1 and PIP2 Report Submission Dates by Performance Year</p> <p><u>Performance Year 1:</u></p> <ul style="list-style-type: none"> • PIP1: PIP Planning (Baseline) Report <ul style="list-style-type: none"> ○ Submission due date: 12/31/2023 <p><u>Performance Year 2:</u></p> <ul style="list-style-type: none"> • PIP1: PIP Planning (Baseline) Report Resubmission <ul style="list-style-type: none"> ○ Submission due date: 8/30/2024 • PIP2: PIP Planning (Baseline) Report <ul style="list-style-type: none"> ○ Submission due date: 3/30/2025 <p><u>Performance Year 3:</u></p> <ul style="list-style-type: none"> • PIP1: Remeasurement 1 Report <ul style="list-style-type: none"> ○ Submission due date: 8/1/2025 • PIP2: Remeasurement 1 Report <ul style="list-style-type: none"> ○ Submission due date: 10/1/2026 <p><u>Performance Year 4:</u></p> <ul style="list-style-type: none"> • PIP1: Closure Report <ul style="list-style-type: none"> ○ Submission due date: 8/1/2026 • PIP2: Remeasurement 2 Report <ul style="list-style-type: none"> ○ Submission due date: 10/1/2027 <p><u>Performance Year 5:</u></p> <ul style="list-style-type: none"> • PIP2: Closure Report <ul style="list-style-type: none"> ○ Submission due date: 8/1/2028
Performance Assessment	<p>REPORT SCORING</p> <p>MassHealth will score required reports as follows:</p> <ol style="list-style-type: none"> 1) The PIP Planning (Baseline) Report is pay-for-reporting only and full credit will be provided for complete and timely reporting.

2) The **Remeasurement 1 Report** will be scored as follows:

Abstract: N/A, not scored

Planning Section (33.3%):

- Project Topic/Equity Statement [Topic/Rationale/ Shared Equity Statement] (15 pts)
- Aim [Vision, Aim Statement(s), and Goal(s)] (10 pts)

Implementation Section (66.6%):

- Methodology (10 pts)
- Barrier Analysis, Interventions, and Monitoring (update) (10 pts)
- Intervention (15 pts)
- Results (15 pts)

Total = 75 pts

Overall Rating = Actual Weighted Score/ Max Possible Weighted Score

3) The **Remeasurement 2 and Closure Reports** will be scored as follows:

Abstract: N/A, not scored

Planning Section (25%):

- Project Topic/Equity Statement [Topic/Rationale/ Shared Equity Statement] (15 pts)
- Aim [Vision, Aim Statement(s), and Goal(s)] (10 pts)

Implementation Section (50%):

- Methodology (10 pts)
- Barrier Analysis, Interventions, and Monitoring (update) (10 pts)
- Intervention (15 pts)
- Results (15 pts)

Validity & Sustainability Section (25%):

- Discussion [Discussion and Validity of Reported Improvement] (15 pts)
- Next Steps [Sustainability] (10 pts)

Total = 100 pts

Overall Rating = Actual Weighted Score/ Max Possible Weighted Score

- 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 will be used to calculate the Equity Improvement Interventions measure score.

MEASURE WEIGHTING

In PY1 and PY5, one report is due for the performance year. For PY1, the measure is P4R only. For PY5, the single Overall Rating will constitute the measure score.

In PY2-PY4, two reports are due for each performance year and the two Overall Ratings (or P4R credit, as applicable) will equally contribute to the measure score (50% each).

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

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

OVERVIEW

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

Description	<p>This measure focuses on the provision of quality interpreter services through two components:</p> <ol style="list-style-type: none"> 1. Language Access Self-Assessment Survey: Self-assessment of language access services 2. Addressing Language Access Needs in Acute Hospital Settings: 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.
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ELIGIBLE POPULATION

Component 1: Language Access Self-Assessment Survey

Not applicable

Component 2: Addressing Language Access Needs in Acute Hospital Settings

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

DEFINITIONS

Measurement Year	Measurement Years 1-5 correspond to HQEIP Performance Years 1-5.
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¹⁷ HEDIS® Value Set used with permission from NCQA

¹⁸ HEDIS® Value Set used with permission from NCQA

Members	<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>
Interpreter services	<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>
In-language Services	<p>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.</p>
Preferred Spoken Language	<p>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.</p>

ADMINISTRATIVE SPECIFICATIONS

Component 1: Language Access Self-Assessment Survey

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

Component 2: Addressing Language Access Needs in Acute Hospital Settings

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

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.

PERFORMANCE REQUIREMENTS & ASSESSMENT FOR PY2

Performance Requirements	<p>Component 1: Language Access Self-Assessment Survey By January 31, 2025 hospitals must submit the completed Language Access Self-Assessment Survey in the form and format specified by MassHealth.</p> <p>Component 2: Addressing Language Access Needs in Acute Hospital Settings By June 30, 2025, 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>
Performance Assessment	<p>Hospitals have the opportunity to earn full or partial credit for the measure.</p> <p>Component 1: Language Access Self-Assessment Survey (50% of measure score):</p> <ul style="list-style-type: none"> 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 January 31, 2025. 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 Language Access Self-Assessment Survey to MassHealth by January 31, 2025. <p>Component 2: Addressing Language Access Needs in Acute Hospitals Settings (50% of measure score):</p> <ul style="list-style-type: none"> 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 June 30, 2025.

- | | |
|--|---|
| | <ul style="list-style-type: none">• A hospital will earn 0% of the points attributed to Component 2 of the measure if reporting requirements are not met by June 30, 2025. |
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MassHealth expects to audit the data submitted for Component 2 by the hospital.

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

G. Disability Competent Care

OVERVIEW

Metric Name	Disability Competent Care
Steward	MassHealth
NQF Number	N/A
Data Source	Supplemental Data
PY2 Performance Status	Pay-for-Performance (P4P)

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

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

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

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

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

DEFINITIONS	
Applicable Patient-facing Staff	<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>
Demonstrated Competency	<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>
Supplemental Data	<p>Acute hospital data drawn from organizational databases or otherwise related to staff training.</p>

ADMINISTRATIVE SPECIFICATIONS	
<p>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).</p>	
Denominator	The total eligible population
Numerator	<p>For patient-facing staff in the denominator, identify those that have, within the preceding 24 months:</p> <ul style="list-style-type: none">completed any applicable disability competency training(s); anddemonstrated competency in each applicable training area.

Anchor Date	None
Measurement Period	July 1, 2024 – December 31, 2024
Exclusions	Patient-facing staff that otherwise would fall into the denominator because of applicability of their roles to a targeted disability competency area who, as of the last day of the measurement year, have been employed with the hospital less than 180 calendar days.

PERFORMANCE REQUIREMENTS & ASSESSMENT FOR PY2

Performance Requirements	<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 March 31, 2025.</p> <ol style="list-style-type: none"> Specific Reporting Requirements for Rate 1 include: For each disability competency training area, report to MassHealth: <ol style="list-style-type: none"> 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; The number of patient-facing staff who completed and demonstrated competency in the applicable training area. Achievement of the PY2 training target of 25% for Rate 1.
Performance Assessment	<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"> 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 March 31, 2025) and it achieves or exceeds the PY2 training target of 25% for Rate 1.

2. 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 **March 31, 2025**) and its Rate 1 for PY2 is higher than the performance target for PY1 (0%). The hospital will earn proportional points as follows:
 - a. *Measure Score: Rate 1/25%*Measure weight*
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 **March 31, 2025**).

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%.

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

H. 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</p>
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	positive for accommodation needs related to a disability and for which member-requested accommodation(s) related to a disability were documented electronically in the acute hospital medical record.
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ELIGIBLE POPULATION

Ages	At least 5 years of age on the date of discharge
Continuous enrollment/ allowable gap	None
Anchor date	None
Measurement Period	July 1, 2024 - December 31, 2024
Event	<p>A two-step process will identify eligible events:</p> <p>Step 1. 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"> • To identify inpatient discharges: <ul style="list-style-type: none"> ○ Identify all inpatient discharges; • To identify observation stay discharges: <ul style="list-style-type: none"> ○ Identify all Observation stays discharges; • To identify ambulatory radiology encounters in the on-campus outpatient setting (Place of Service = 22): <ul style="list-style-type: none"> ○ Identify all ambulatory radiology encounters using the Radiology CPT Code Sets: <ul style="list-style-type: none"> ▪ 77046-77067 Radiology: Breast Mammography ▪ 77071-77092 Radiology: Bone/Joint Studies ▪ 78000-79999 Radiology: Nuclear Medicine ▪ 70010-76499 Radiology: Diagnostic Radiology (Diagnostic Imaging) ▪ 76500-76999 Radiology: Diagnostic Ultrasound <p>Step 2. 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"> • A patient has self-reported disability;

	<ul style="list-style-type: none"> A patient is eligible for MassHealth on the basis of a disability.
Exclusions	<p>Eligible events where:</p> <ul style="list-style-type: none"> The member died prior to discharge. 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.

DEFINITION

Members	<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>
Patient with Self-reported Disability	<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"> Disability Q1 (all ages): Are you deaf or do you have serious difficulty hearing? Disability Q2 (all ages): Are you blind or do you have serious difficulty seeing, even when wearing glasses? Disability Q3 (age 6 or older as of December 31st of measurement year): Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? Disability Q4 (age 6 or older as of December 31st of measurement year): Do you have serious difficulty walking or climbing stairs? Disability Q5 (age 6 or older as of December 31st of measurement year): Do you have difficulty dressing or bathing? Disability Q6 (age 16 or older as of December 31st of measurement year): Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?
Patient with Eligibility for	<p>Disability is established by:</p>

MassHealth on the Basis of a Disability	(a) certification of legal blindness by the Massachusetts Commission for the Blind (MCB); (b) a determination of disability by the Social Security Administration (SSA); or (c) a determination of disability by the Disability Evaluation Services (DES).
Accommodation Needs Related to a Disability	Accommodations needs related to a disability (including physical, intellectual and/or behavioral health disabilities) that are necessary to facilitate equitable access to high quality health care. Medical record documentation of 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.
Accommodation Needs Screening	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. <ul style="list-style-type: none"> • Screening question(s) may be broad (e.g. Is there anything you need help with today to access your care?) or more specific (e.g., Do you have a need for an assistive listening device, mobility assistance, longer appointment time, or other accommodation?). • Accommodation needs screening may be conducted at the point of service (e.g. during a live in-person encounter) or asynchronously (e.g. through a patient portal).

ADMINISTRATIVE SPECIFICATIONS

RATE 1: Accommodation Needs Screening

Denominator	The eligible population
Numerator	Number of eligible events where, as documented in the acute hospital medical record: <ul style="list-style-type: none"> • The member was offered accommodation needs screening and responded; <ul style="list-style-type: none"> ○ 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

	<ul style="list-style-type: none"> The member was offered accommodation needs screening and actively opted out of screening (i.e., chose not to answer any questions). <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"> Positive: the member indicated a need for accommodation related to a disability. Negative: the member did not indicate any accommodation need related to a disability. <p>Screening may be rendered by any acute hospital provider or staff.</p>
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RATE 2: Accommodation Needs Related to a Disability

Denominator	Number of eligible events in the numerator for Rate 1 for which the accommodation needs screen was positive.
Numerator	<p>Denominator event where documentation in the acute hospital medical record describes:</p> <ul style="list-style-type: none"> 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.

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

Performance Requirements	<p>Reporting Element 1</p> <p>By March 31, 2025, 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>
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	<ul style="list-style-type: none"> • The accommodation needs screening question(s) used by acute hospitals for the purpose of meeting performance requirements of this measure. • A description of how member-requested accommodation needs are documented in the medical record including: <ul style="list-style-type: none"> a. entry mode (free text vs. fixed-field); b. specific fixed field options (if used); and c. where accommodation needs information is displayed (e.g., top or sidebar of electronic health record, problem list, etc.) <p>Reporting Element 2</p> <p>By June 30, 2025 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>
Performance Assessment	<ul style="list-style-type: none"> • 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 March 31, 2025. • 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 June 30, 2025. • 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 March 31, 2025 and June 30, 2025, respectively. <p>MassHealth expects to audit the data submitted for Rates 1 and 2 by the hospital.</p>

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

I. Achievement of External Standards for Health Equity

OVERVIEW

Measure Name	Achievement of External Standards for Health Equity
Steward	MassHealth
NQF Number	N/A
Data Source	Supplemental Data
Performance Status: PY2	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.¹⁹ External health equity certification independently and objectively assesses attainment of these and other relevant health equity goals to ensure that healthcare organizations are providing a comprehensively high standard of equitable care.

MEASURE SUMMARY

Description	<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 requirements²⁰ (effective January 1, 2023) to reduce health care disparities for organizations</p>
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¹⁹ The National Quality Forum. A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity.

²⁰ 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/>.

	<p>participating in its hospital accreditation program including six new elements of performance in the Leadership (LD) chapter, Standard LD.04.03.08.</p> <p>B. Achievement of The Joint Commission’s Health Care Equity Certification²¹, which builds on the equity-focused Accreditation standards to recognize organizations that go above and beyond to provide high quality and equitable care.</p>
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PERFORMANCE REQUIREMENT AND ASSESSMENT FOR PY2

Performance Requirements	<p>By January 31, 2025, 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"> • Submission of an application for Health Care Equity Certification to The Joint Commission. • 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. • 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.
Performance Assessment	<ul style="list-style-type: none"> • 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 January 31, 2025. • 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 January 31, 2025. • 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 January 31, 2025. • 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

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

	attestation that all three requirements were met by December 31, 2024 to MassHealth by January 31, 2025 .
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Performance Requirements and Assessment for PY3-5 To Be Finalized Prior to the Start of PY3.

J. Patient Experience: Communication, Courtesy, and Respect

OVERVIEW

Measure Name	Patient Experience: Communication, Courtesy, and Respect
Steward	MassHealth, using selected questions from the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey
NQF Number	0166
Data Source	Survey
Performance Status: PY2	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

Description	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.
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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 HCAHPS²² 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;

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

	<p><i>*Response rate is defined as the total MassHealth HCAHPS surveys submitted (Item 4) over the total MassHealth HCAHPS-eligible members sampled (Item 3).</i></p> <p>6. For the HCAHPS Eligible Population in PY2:</p> <ol style="list-style-type: none"> Member-level responses for: <ol style="list-style-type: none"> Nurse Communication Composite (Q1, Q2, Q3) Physician Communication Composite (Q5, Q6, Q7) 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>
Performance Assessment	<ul style="list-style-type: none"> 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 June 30, 2025. 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 June 30, 2025.

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

K. Collaboration

OVERVIEW

Measure Name	Collaboration
Steward	MassHealth
NQF Number	N/A
Data Source	Supplemental Data
Performance Status: PY2	Pay-for-Performance (P4P)

POPULATION HEALTH IMPACT

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

MEASURE SUMMARY

Description	Assessment of participating acute hospital collaboration with MassHealth Accountable Care Organizations to promote high quality and equitable care.
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PERFORMANCE REQUIREMENT AND ASSESSMENT FOR PY2

Performance Requirements	<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">• Demographic data completion• Health-Related Social Needs Screening and Referrals• Quality Performance Disparities Reduction• Equity Improvement Interventions• Language Access• Disability Access and Accommodation• Achievement of External Standards for Health Equity
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	<ul style="list-style-type: none"> • Cultural Competency Each of these accountability components contribute to a Health Equity Score for each MassHealth ACO.
Performance Assessment	<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>

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