Performance Assessment Methodology Manual for the MassHealth Hospital Quality and Equity Incentive Program (HQEIP)

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

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MassHealth will hold each participating acute Hospital individually accountable for its performance on the Hospital Quality and Equity Incentive Program (HQEIP) performance measures and will make incentive payments based on such performance. This document describes MassHealth's HQEIP Performance Assessment Methodology (PAM) for Performance Years (PY) 3-5.

A. Individual Measure Scoring Approaches

Hospital performance assessment will be based on a point scoring approach for each measure type across the HQEIP's three domains. The maximum number of points that a Hospital may attain for each measure is 10 points based on thresholds, goals, and, as applicable, improvement targets. Further, bonus points may be earned for select pay-for-performance measures. Bonus points will be applied to the respective measure domain score.

There are two types of performance status:

1. **Pay-for-reporting (P4R) measures.** P4R measures will be assessed on a complete/incomplete basis for which the Hospitals that successfully submit timely, complete, and responsive information based on each measure's technical specifications will earn 10 points for the measure. Hospitals whose submissions were not timely, complete, and responsive will earn 0 points for the measure. In other words, a Hospital will receive either 0 or 10 points for P4R measures; MassHealth will not award partial credit for P4R measures.

2. **Pay-for-performance (P4P) measures.** Each Hospital may receive 0-10 points depending on each measure's performance compared to set performance thresholds, goals, and/or improvement targets for the individual measures. If the measure performance goal is exceeded, bonus points (which are applied to the domain score) may be earned for select P4P measures.

   Performance thresholds, goals, and improvement targets will be monitored and may be adjusted as needed.

Table 1, below, lists the performance status by measure.

Table 1. PY3-5 HQEIP Measures & Performance Status

Measures	Measure Component(s)/ Submeasures	PY3 2025	PY4 2026	PY5 2027
Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness	1. Race 2. Ethnicity 3. Language 4. Disability 5. Sexual Orientation 6. Gender Identity	P4P	P4P	P4P

Measures	Measure Component(s)/ Submeasures	PY3 2025	PY4 2026	PY5 2027
Health-Related Social Needs Screening	1. Screening rate 2. Screen positive rate a. food insecurity b. housing instability c. transportation needs d. utility difficulties	P4P (Component 1, Inpatient/ Observation Stay) P4R (Component 1, ED) P4R (Component 2, Inpatient/ Observation Stay & ED)	P4P (Component 1) P4R (Component 2)	P4P (Component 1) P4R (Component 2)
Quality Performance Disparities Reduction	1. Quality measure 1 2. Quality measure 2	P4R	P4P	P4P
Equity Improvement Interventions	1. Performance Improvement Project (PIP) 1 2. PIP 2	P4P	P4P	P4P
Meaningful Access to Healthcare Services for Persons with a Preferred Language Other than English	1. Self-assessment survey (only PY2 & PY3) 2. Addressing language access needs	P4P (Self-Assessment Survey) P4P (Inpatient/Observation Stay) P4R (ED)	P4P	P4P
Disability Competent Care	1. Staff training rate	P4P	P4P	P4P
Disability Accommodation Needs	1. Accommodation needs screening rate 2. Accommodation needs related to a disability documentation rate	P4P	P4P	P4P
Achievement of External Standards for Health Equity	1. The Joint Commission Health Care Equity certification	P4P	P4P	P4P
Patient Experience: Communication, Courtesy, and Respect	1. HCAHPS Questions Related to Nurse Communication (Composite 1) 2. HCAHPS Questions Related to Doctor	P4P	P4P	P4P

Measures	Measure Component(s)/ Submeasures	PY3 2025	PY4 2026	PY5 2027
	Communication (Composite 2)			
Joint Accountability	1. Partnered-ACO score	P4P	P4P	P4P

B. Performance Assessment Methodology

i. RELDSOGI, HRSN, Language Access, Disability Competent Care, Disability Accommodation Needs, and Patient Experience

a. Measure Assessment Overview and Scoring

As stated above, for P4R measures, the Hospital may achieve 10 points for timely, complete, and responsive submissions, or 0 points for untimely, incomplete, or unresponsive submissions. For P4P measures, each Hospital's performance on measures will be assessed based on meeting a minimum attainment threshold and towards meeting a performance goal to determine points. In addition to reaching the performance goal, submissions must be complete, timely, and responsive in order to earn the full 10 points. If the performance goal is not reached, partial credit may be earned (outlined below). Improvement points may also be earned by reaching improvement targets, whether the Hospital reaches the attainment threshold or not. A Hospital will earn 0 points if it does not complete the required submission(s).

Hospitals must meet the minimum denominator of at least 30 MassHealth patients in the PY to be eligible for scoring on each measure, submeasure, or setting (when applicable). If Hospitals do not meet the minimum denominator, the weighting of the measure, submeasure, or setting will be redistributed equally to the remaining eligible performance measures, submeasures, or settings in the domain.

For the measures listed in Table 2, three types of benchmarks have been established:

1. **Attainment Threshold:** The attainment threshold represents the minimum level of performance that must be attained on each individual measure to earn between 1-10 points.

2. **Performance Goal:** The performance goal represents the level of performance on each individual measure a Hospital must attain to score the maximum 10 points.

3. **Improvement Target:** The improvement target represents a specified percentage point improvement for each applicable measure where a Hospital may earn improvement points.

Improvement Targets are established by taking the difference between the attainment threshold and PY5 performance goal divided by number of program years (5 years):

$$\text{Improvement Target} = \frac{(\text{PY5 Performance Goal} - \text{PY3-5 Attainment Threshold})}{\text{\# of program years}}.$$

The baseline period for all measures except Disability Competent Care is the first full year of complete data in which the hospital also meets the minimum denominator threshold for the measure. The Disability Competent Care measure will use PY2 data as the baseline period., The potential for improvement points takes effect the first year following the baseline year for the measure. Specifically:

- Effective beginning PY3, improvement points may be earned for Disability Competent Care and Patient Experience, if the minimum denominator is met and
- Effective beginning PY4, improvement points may be earned for RELDSOGI, HRSN, Language Access, and Disability Accommodation Needs, if the minimum denominator is met.

The comparison year for improvement points is initially the baseline year for the measure. If the improvement target is reached, the comparison year then becomes the most recent highest-performing year (the year that the improvement points were earned).

4. Interaction of Attainment Threshold, Performance Goal, and Improvement Threshold

In PY3-5, if Hospitals do not reach performance goal(s), they may earn partial credit by the following opportunities:

a. If attainment threshold is met
   i. attainment points will be earned, which is calculated as: % of PY Performance Goal * 10;
   ii. *and* if improvement target is also met, 7 improvement points will be earned in addition to attainment points. The maximum number of points a Hospital can earn on a measure is capped at 10 points.

OR

b. If attainment threshold is not met but improvement target is met, 7 improvement points will be earned.

OR

c. If both attainment threshold and improvement target are not met, partial improvement points proportional to the improvement target may be earned (see Example 1 in Appendix B: Scoring Examples).

Partial improvement points may not be earned in PYs 3 or 4 if the attainment threshold is met. However a stepwise approach is used so that if the target is met (e.g., cumulatively over multiple performance periods), the full 7 points are earned in the performance period in which the improvement target is attained.

In PY5 only, if attainment threshold is met, Hospitals who improve but do not reach the improvement target may earn partial improvement points. These points are proportional to the improvement target, with the maximum points available being the difference between the Hospital's measure score and 10. To illustrate the application of partial improvement points in PY5, see Example 2 in Appendix B: Scoring Examples.

The flowchart in Appendix A illustrates how points may be earned for a performance measure score in PY3-5.

Measure performance rates achieved by the Hospitals will be rounded to the nearest whole number. For example, an ethnicity data completeness rate of 74.3% will be rounded to 74%, and an ethnicity data completeness rate of 74.5% will be rounded to 75%. This rule will apply to all rounding for the HQEIP PAM.

Table 2, below, details the attainment thresholds, performance goals, and improvement targets for select P4P measures. Table 3 summarizes the submeasure or components of each measure and setting weights.

b. Patient Experience: Communication, Courtesy, and Respect

The patient experience measure utilizes the same attainment threshold, performance goal, and improvement target as above with the following modifications:

1. Hospitals will be scored based on the higher of their individual hospital performance or aggregate statewide performance on each composite. Doctor and Nurse Communication composites will be calculated using the submitted member level data. Hospitals must have a minimum denominator of at least 30 MassHealth patients to be scored on an individual basis and to be eligible for improvement points.
2. The improvement target is a 0.01 improvement for each Hospital composite score (nurse communication and doctor communication) calculated using submitted member level data.

Composites will be rounded to the nearest hundredth decimal place.

Table 2 and Table 3, below, also include details for the Patient Experience measures.

Table 2. PY3-5 Benchmarks by Measure

Measure	Attainment Threshold	Performance Goal			Improvement Target	Bonus Points	Additional Measure Requirement
		PY3 (2025)	PY4 (2026)	PY5 (2027)			
Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness¥	**R:** 40% **E:** 40% **L:** 15% **D:** 15% **SO:** 15% **GI:** 15%	**R:** 80% **E:** 80% **L:** 30% **D:** 30% **SO:** 30% **GI:** 30%	**R:** 80% **E:** 80% **L:** 50% **D:** 50% **SO:** 50% **GI:** 50%	**R:** 80% **E:** 80% **L:** 80% **D:** 80% **SO:** 80% **GI:** 80%	**R:** 8% **E:** 8% **L:** 13% **D:** 13% **SO:** 13% **GI:** 13%	+0.5 point if exceed goals on any 3 of 6 submeasures (Inpatient); +0.5 point if exceed goals on any 3 of 6 submeasures (ED) +1 point if exceed goals on all submeasures (Inpatient); +1 point if exceed goals on all submeasures (ED)	Entities must submit and pass mapping and verification tool for PAM to be applied; failure to pass mapping and verification on a data element/ category will result in a 0 score for the applicable sub-measure(s); In PY5 Update Date and/or Verification Date must be submitted in the Enhanced Demographics Data File for each data element, but will not be used for data completeness calculations
Health-Related Social Needs (HRSN) Screening±	Component 1	Component 1	Component 1	Component 1	Component 1 **Inpatient/ Observation**	+0.5 point if exceed PY performance goal (Inpatient/	Entities will report Component-2 rates, which will be P4R;

Measure	Attainment Threshold	Performance Goal			Improvement Target	Bonus Points	Additional Measure Requirement
		PY3 (2025)	PY4 (2026)	PY5 (2027)			
	Inpatient/ Observation Stay: 10% **ED:** 10% Component 2 N/A (P4R)	**Inpatient/ Observation Stay:** 30% **ED:** N/A Component 2 N/A (P4R)	**Inpatient/ Observation Stay:** 45% **ED:** 30% Component 2 N/A (P4R)	**Inpatient/ Observation Stay:** 60% **ED:** 45% Component 2 N/A (P4R)	**Stay:** 10% pts. **ED:** 7% pts. Component 2 N/A (P4R)	Observation Stay) +0.5 point if exceed PY performance goal (ED)	Entities may be required to pass an audit[Ω] of their data; failure to pass the audit will result in a 0 score for the P4P component of the measure and impact improvement point eligibility in the following year
Meaningful Access to Healthcare Services for Persons with a preferred language other than English	**Inpatient/ Observation Stay:** 25% **ED:** 25%	**Inpatient/ Observation Stay:** 50% **ED:** N/A	**Inpatient/ Observation Stay:** 75% **ED:** 50%	**Inpatient/ Observation Stay:** 85% **ED:** 75%	**Inpatient/ Observation Stay:** 12% pts. **ED:** 10% pts.	+0.5 point if exceed PY performance goal (Inpatient/ Observation Stay) +0.5 point if exceed PY performance goal (ED)	Entities must submit Language Access Self-Assessment Survey[€] (PY3: P4P; PY4 & 5: N/A); Entities may be required to pass an audit[Ω] of their data for the Provision of Interpreter Services Inpatient/ Observation Stay and ED component; failure to pass the audit will result in a 0 score for the measure

Measure	Attainment Threshold	Performance Goal			Improvement Target	Bonus Points	Additional Measure Requirement
		PY3 (2025)	PY4 (2026)	PY5 (2027)			
							and impact improvement point eligibility in the following year
Disability Competent Care	25%	45%	65%	85%	12% pts.	+1 point if exceed PY performance goal	N/A
Disability Accommodation Needs*	**Rate 1:** 25% **Rate 2:** 25%	**Rate 1:** 45% **Rate 2:** 50%	**Rate 1:** 65% **Rate 2:** 75%	**Rate 1:** 85% **Rate 2:** 85%	**Rate 1:** 12% pts. **Rate 2:** 12% pts.	+0.5 point if exceed PY performance goals for Rate 1 and Rate 2 (Inpatient/Observation Stay) +0.5 point if exceed PY performance goals for Rate 1 and Rate 2 (Ambulatory Radiology)	Entities may be required to pass an audit[Ω] of their data; failure to pass the audit will result in a 0 score for the measure and impact improvement point eligibility in the following year
Patient Experience: Communication, Courtesy, and Respect^	**Composite 1:** 0.50 **Composite 2:** 0.50	**Composite 1:** 0.84 **Composite 2:** 0.84			**Composite 1:** 0.01 pts. **Composite 2:** 0.01 pts.	N/A	Entities also submit MassHealth only patient-level data

[¥] R=Race; E=Ethnicity; L=Language; D=Disability; SO=Sexual Orientation; GI=Gender Identity

[±] Component 1: HRSN screening rate; Component 2: HRSN screen positive rates
[€] Scoring details included below
*Rate 1: Screening for accommodation needs; and Rate 2: Accommodation needs documented
^ Performance will be assessed based on statewide rates; hospitals with sufficient denominator (n=25) may be assessed on the higher of individual or statewide performance and may also earn improvement points
[Ω] Reference the QEIP User Guide on the Hospital Quality and Equity Incentive Program (HQEIP) webpage under the CQMV Portal Reporting System section for more information on audit

Table 3. Measure Weights for Settings and/or Submeasures (as applicable)

Measure	PY3 (2025)	PY4 (2026)	PY5 (2027)
Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness	**Submeasure weights:** • Race (~16.7%) • Ethnicity (~16.7%) • Language [with two equal sub-components of written and spoken – averaged] (~16.7%) • Disability [with 6 equal sub-components – averaged] (~16.7%) • Sexual Orientation (~16.7%) • Gender Identity (~16.7%) **Setting weights:** • Inpatient (50%) • ED (50%)	**Submeasure weights:** • Race (~16.7%) • Ethnicity (~16.7%) • Language [with two equal sub-components of written and spoken – averaged] (~16.7%) • Disability [with 6 equal sub-components – averaged] (~16.7%) • Sexual Orientation (~16.7%) • Gender Identity (~16.7%) **Setting weights:** • Inpatient (50%) • ED (50%)	**Submeasure weights:** • Race (~16.7%) • Ethnicity (~16.7%) • Language [with two equal sub-components of written and spoken – averaged] (~16.7%) • Disability [with 6 equal sub-components – averaged] (~16.7%) • Sexual Orientation (~16.7%) • Gender Identity (~16.7%) **Setting weights:** • Inpatient (50%) • ED (50%)
Health-Related Social Needs (HRSN) Screening[±]	• Component 1 Inpatient/ Observation Stay (50%) • Component 2 Inpatient/ Observation Stay (25%) • Components 1 & 2 ED (25%)	**Submeasure weights:** Component 1 (75%) Component 2 (25%) **Setting weights:** • Inpatient/Observation Stay (50%) • ED (50%)	**Submeasure weights:** Component 1 (75%) Component 2 (25%) **Setting weights:** • Inpatient/Observation Stay (50%) • ED (50%)

Measure	PY3 (2025)	PY4 (2026)	PY5 (2027)
Meaningful Access to Healthcare Services for Persons with a preferred language other than English	• Language Self-Assessment Survey (25%) • Provision of Interpreter Services Inpatient/Observation Stay (50%) • Provision of Interpreter Services ED (25%)	**Submeasure weights:** N/A **Setting weights:** • Inpatient/Observation Stay (50%) • ED (50%)	**Submeasure weights:** N/A **Setting weights:** • Inpatient/Observation Stay (50%) • ED (50%)
Disability Competent Care	N/A	N/A	N/A
Disability Accommodation Needs*	**Submeasure weights:** • Rate 1 (50%) • Rate 2 (50%) **Setting weights:** • Inpatient/Observation Stay (50%) • Ambulatory Radiology (50%)	**Submeasure weights:** • Rate 1 (50%) • Rate 2 (50%) **Setting weights:** • Inpatient/Observation Stay (50%) • Ambulatory Radiology (50%)	**Submeasure weights:** • Rate 1 (50%) • Rate 2 (50%) **Setting weights:** • Inpatient/Observation Stay (50%) • Ambulatory Radiology (50%)
Patient Experience	**Submeasure weights:** • Composite 1 (50%) • Composite 2 (50%)	**Submeasure weights:** • Composite 1 (50%) • Composite 2 (50%)	**Submeasure weights:** • Composite 1 (50%) • Composite 2 (50%)

‡Component 1: HRSN screening rate; Component 2: HRSN screen positive rates
*Rate 1: Screening for accommodation needs; and Rate 2: Accommodation needs documented

c. Meaningful Access to Healthcare Services for Persons with a Preferred Language other than English: Language Access Self-Assessment Survey (PY3 only)

The responses to the Language Access Self-Assessment Survey for Hospitals (the "Survey") will be used to determine whether a Hospital meets the submeasure reporting requirement for PY3. The Survey consists of five domains, and Hospitals **must score the points required** in each domain to pass that domain. The following table, Table 4, indicates the points for each Survey question that will be scored in PY3 and the points required to pass each domain. Hospital must **pass all five domains** to receive **full credit** for this deliverable. However, if Hospitals do not pass all five domains, they may receive partial credit for passing each domain. For each domain passed, the Hospital will earn a fifth of the full credit (e.g., if full credit = 10 points, Hospital passes only Domain 1, it will receive 2 points).

Table 4. Language Access Self-Assessment Survey Scoring

Domain	Survey Question	Scoring	Points Required to Pass Domain
Domain 1	A10	1 point will be awarded for answering "Yes" to any of the six items in the grid	2 points
	A13	1 point will be awarded for answering "Yes"	
Domain 2	B3	1 point will be awarded for answering "Yes" to any of the seven items in the grid	4 points
	B18a	1 point will be awarded for answering "Yes"	
	B18b	1 point will be awarded for answering "Yes"	
	B18c	1 point will be awarded for answering "Yes"	
Domain 3	C1	1 point will be awarded for answering "Yes"	1 point
Domain 4	D18	1 point will be awarded for answering "Yes"	1 point
Domain 5	E5	1 point will be awarded for answering "Yes"	1 point

ii. Quality Performance Disparities Reduction

Hospitals will be assessed on the two best performing measures for which they are eligible from the HQEIP quality measures listed in Table 5 in PY4 (CY2026) and PY5 (CY2027). This slate lists measures that have statistically significant race and/or ethnicity gaps for patient populations that met the minimum denominator (n >= 30) at the statewide level during the baseline period. The baseline period is CY2023 for all measures except SUB-2 for which it is CY2024. To be eligible for scoring on the included measures, Hospitals must meet the minimum denominator of 30 (non-stratified) for the measure in at least one of the following performance years: PY1 (CY2023), PY2 (CY2024), or PY3 (CY2025). Hospitals who do not qualify for two measures on the slate will be ineligible for the disparities

reduction measure, with associated measure weighting equally redistributed to their remaining eligible domains in the HQEIP program.

Table 5. Eligible HQEIP Quality Measures and Statistically Significant Racial/Ethnic Disparities

Eligible Measures	Eligible Disparity Gaps Statewide Statistically Significant Disparities
Cesarean Birth, NTSV (MAT-4)	• Asian (reference group) and African American
Severe Maternal Morbidity (SMM)	• White (reference group) and African American
Follow-up After ED Visit for Substance Use (FUA) – 7 and 30 Day *(7 and 30 day submeasures equally weighted)*	• Non-Hispanic (reference group) and Hispanic • White (reference group) and African American • White (reference group) and Asian
Follow-up After Hospitalization for Mental Illness (FUH) – 7 and 30 Day *(7 and 30 day submeasures equally weighted)*	• White (reference group) and African American • White (reference group) and Asian
Alcohol Use – Brief Intervention Provided or Offered (SUB-2)	• Non-Hispanic (reference group) and Hispanic • White (reference group) and African American • White (reference group) and Asian

Hospitals will be assessed on performance on the measures above, with the opportunity to be scored on the higher of their individual hospital performance or statewide performance, for all measures except SMM. The SMM measure will be assessed only at the statewide level. To be assessed at the hospital level, the hospital must have sufficient volume (n >= 30) for the measure for the patient populations included in the eligible disparity gap(s) and have a baseline gap of at least 2%.

Birthing hospitals will be assessed on the higher of MAT-4 or SMM and their next highest-performing eligible measure. Note that this second measure may be the other maternal health measure. For example, if SMM is the better performing as compared to MAT-4, then SMM will be the first assessed measure. If MAT-4 is the next best performing measure, it will be the second assessed measure. Non-birthing hospitals eligible for FUH will be scored on FUH and their next highest-performing eligible measure from the slate. Please reference Appendix C for a diagram outlining the measure selection logic.

The disparity gap will be evaluated by comparing the reference group (highest performing group at baseline) to the statistically significantly lower performing racial or ethnic comparison group at baseline. Racial and ethnic disparities will be assessed separately (e.g., SUB-2 Hispanic vs. non-Hispanic, SUB-2 White vs. African American), and each individual disparity for a measure will be assessed separately (e.g., SUB-2 White vs. Asian, White vs. African American). Additionally, for FUA and FUH, there will be equal weighting on the 7-day and 30-day sub-measures.

Table 6 outlines the point scoring for this measure, including the threshold, goal, partial credit, and bonus opportunities. Hospitals will receive points for their two best statewide eligible measures by assessing the gap closure in absolute or relative percentage points between the reference and comparison group as compared to baseline. Note that the gap closure cannot be at expense of higher-

performing group at baseline. Percentage points will be rounded to the nearest whole number (e.g., 1.5% rounds to 2%).

Please see Appendix D for scoring examples.

Table 6. Points Scoring for the HQEIP Quality Performance Disparities Reduction Measure

Threshold	Goal	Partial Credit	Bonus Points
All measures: Statewide or hospital gap size has not widened from baseline = **4 points**	All measures except SMM: 2% point absolute closure of statewide or hospital* baseline gap = **10 points** SMM: 2% point± relative closure of statewide baseline gap = 10 points	All measures except SMM: >=1% point but <2% point absolute closure of statewide or hospital* baseline gap = **7 points** SMM: >=1% point but <2% point relative closure of statewide baseline gap = **7 points**	+1 point if state or hospital* exceeds performance goal

± For example, if the baseline gap for SMM is 141 (per 10,000 deliveries), then 2% absolute closure would be 141 x 2% = 2.82 (rounded to 3).
*Hospital must meet have sufficient volume (n >= 30) for the measure for the patient populations included in the eligible disparity gap(s) and have a baseline gap of at least 2%. Does not apply to SMM measure.

iii. Equity Improvement Interventions

For each Performance Improvement Project (PIP), there are three required reports.

The required reports will be scored as follows:

1. The **Remeasurement 1 and 2 Reports** will be scored as follows:
   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)
   - Interventions (15 pts)
   - Results (15 pts)

   Validity and Sustainability (25%)
   - Discussion [Discussion and Validity of Reported Improvement] (15 pts)
   - Sustainability (10 pts) *Only scored in Closure Report*

   Total = 90 pts
   Overall Rating = Actual Weighted Score/ Max Possible Weighted Score

2. The **Closure Report** 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

Measure Points

- **Overall Rating of >= 85%** meets the goal score for the report and will earn 10 points.
- 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 earn 0 points.

Note: one re-submission is permitted, and the re-submitted report score will be re-scored. The revised report score will be used to calculate the measure score. Report score will be rounded to the nearest whole number.

In PY3 and PY4, two reports are due in each PY, and the two Overall Ratings will equally contribute to the measure score (50% each). In PY5, one report is due for the PY, and the single Overall Rating will constitute the measure score. Table 7 below outlines the measure weighting for the PIP reports.

Table 7. Measure Weighting for PIP Reports by PY

	PY3 (2025)	PY4 (2026)	PY5 (2027)
PIP1 Reporting	Remeasurement 1 Report	Closure Report	None
PIP2 Reporting	Remeasurement 1 Report	Remeasurement 2 Report	Closure Report
Weighting	PIP1 (50% weight) PIP2 (50% weight) e.g., (PIP1 Overall Rating + PIP2 Overall Rating)/2	PIP1 (50% weight) PIP2 (50% weight) e.g., (PIP1 Overall Rating + PIP2 Overall Rating)/2	PIP2 (100% weight)

iv. Achievement of External Standards for Health Equity

The goal for this measure is for Hospital, including additional acute hospital site(s), to achieve The Joint Commission's (TJC) Health Care Equity Certification (HCE)[1] by the end of PY3 and re-certification by the end of PY5. At minimum (threshold), Hospital is to achieve TJC's HCE[1] by end of PY5. Hospitals will earn 100% of the points attributed to the measure for certification, maintenance of certification, or re-certification in the PY. If certification is not achieved by end of PY3 (e.g., in PY4 or PY5), Hospitals may earn partial credit for progress towards initial certification. Table 8 outlines the points scoring for this measure.

Table 8. Points Scoring for Achievement of TJC's HCE [1] by PY

PY3 (2025)	PY4 (2026)	PY5 (2027)
• Achieve HCE certification[1] = **10 points** *OR* • Progress towards HCE certification[1] = **5 points** (TJC review conducted) *OR* • Not achieve or make progress towards HCE certification[1] = **0 points** *OR* • Maintenance of HCE certification[1] achieved in PY2 = **10 points + 1 bonus point**	• Maintain or achieve HCE certification[1] = **10 points** *OR* • Progress towards HCE certification[1] = **5 points** (TJC review conducted) *OR* • Not achieve or make progress towards HCE certification[1] = **0 points**	• Maintain or achieve HCE certification[1] = **10 points** *OR* • Progress towards HCE certification[1] = **5 points** (TJC review conducted) *OR* • Not achieve or make progress towards HCE certification[1] = **0 points**

v. Collaboration

A Hospital's performance on the Collaboration measure for a given Performance Year will equal the Health Equity Score of its Partnered ACO(s) for the **same** Performance Year. If a Hospital has more than one ACO Partner, its measure score for a given Performance Year will equal the average of each Partnered ACO's Health Equity Score for the **same** Performance Year. Please refer to the PY1-5 ACO Quality and Equity Incentive Program (QEIP) Implementation Plan and associated program documents for more information on ACO Health Equity scoring.

a. <u>Hospital with one ACO partner</u> = (ACO partner Health Equity Score) / 10

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b. *Hospital with two ACO partners = [(ACO partner1 Health Equity Score + ACO partner2 Health Equity Score) / 2] / 10*

C. Performance Measure, Domain, and Health Equity Scoring

i. Measure Scoring

Performance measure scores for each measure will be defined as a ratio between 0-1. The score will be calculated as follows:

Performance Measure Score = Points earned for each measure / Maximum number of points allowable for the measure.

Some performance measures have submeasures for which submeasure performance scores will be calculated in the same manner. The submeasures will be weighted as stated in Table 3 and Table 5 to calculate a composite performance measure score between 0-1. For submeasures the score is calculated as follows:

*Performance Measure Score = Sum of each (Submeasure Score * Submeasure Weighting)*.

Some performance measures also encompass implementation in multiple settings (e.g., inpatient and ED).

ii. Domain Scoring

A domain score will be calculated by taking each performance measure score in the domain and calculating the sum of each performance measure score multiplied by its respective measure weight:

*Domain Score = Sum of each (Performance Measure Score * Performance Measure Weight* 100)*

Table 9 specifies measure weight by performance year. If a Hospital is not eligible for a measure (e.g., does not meet the denominator criteria or minimum volume), the weighting will be redistributed equally to the other eligible performance measures in the domain. Any bonus points earned for a measure will be added to the Domain score and will not exceed the maximum eligible Domain points. For example, Domain score for Domain 1 (DHRSN) will be capped at 25 points as the maximum eligible points for Domain 1 (DHRSN) is 25 points.

Table 9. PY 3-5 HQEIP Metric Weights

Domain*	Measure Name	Measure Weight (%) by Performance Year			Domain Weight (%)
		PY3 (2025)	PY4 (2026)	PY5 (2027)	
DHRSN	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness	10	15	15	25
	Health-Related Social Needs (HRSN) Screening	15	10	10	
EQA	Quality Performance Disparities Reduction	10	20	20	50
	Equity Improvement Interventions	10	5	5	
	Meaningful Access to Healthcare Services for Persons with a preferred language other than English	10	10	10	
	Disability Competent Care	10	5	5	
	Accommodation Needs Met	10	10	10	
CC	Achievement of External Standards for Health Equity	10	10	10	25
	Patient Experience: Communication, Courtesy and Respect	10	10	10	
	Collaboration	5	5	5	
TOTAL					**100**

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

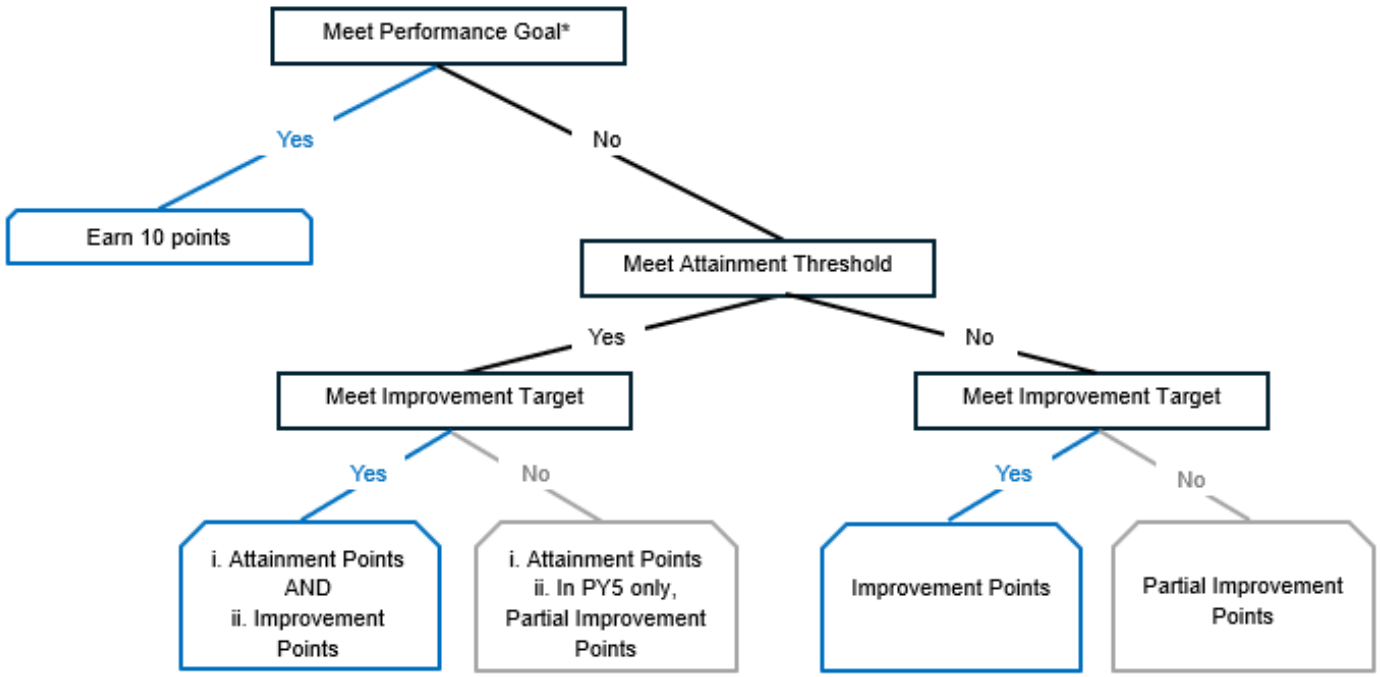
iii. Health Equity Scoring

A health equity score will be calculated by taking each domain score and calculating the sum of each domain score:

Health Equity Score = *Sum of each Domain Score*

Any bonus points earned through Corrective Action Plans will then be added to determine the final HQEIP Health Equity Score for the PY, not to exceed 100%. The Health Equity score will be rounded to the nearest hundredth. The final Health Equity Score will be used to calculate the participating Hospital's earned incentive payment.

D. Appendix A: Performance Measure Score Point Flowchart



Attainment Points = % of PY Performance Goal * 10

Improvement Points = 7 points

Partial Improvement Points (proportion to improvement target) = (Current Hospital PY rate – Previous Hospital PY rate) / Improvement Target

*If exceed Performance Goal, bonus point(s), as applicable to the measure, is added to Domain Score

E. Appendix B: Scoring Examples

Example 1. PY3 – Disability Competent Care: Not Meet Attainment Threshold and Not Meet Improvement Target

The Hospital reported a 15% Training Rate in PY2 and a 20% Training Rate in PY3.

Disability Competent Care Measure Benchmarks:

Attainment Threshold	Performance Goal – PY2	Performance Goal – PY3	Improvement Target
25%	25%	45%	12% pts

Steps for *Calculating Improvement Points*

1. Partial improvement = (Current Hospital PY rate – Previous Hospital PY rate) / Improvement target = (20% - 15%) / 12% = 0.42
2. Maximum eligible improvement points = 7.00 points
3. Partial improvement points = Eligible improvement * Partial improvement = 7.00 * 0.42 = 2.94 points

Example 2. PY5 – Disability Competent Care: Meet Attainment Threshold and Not Meet Improvement Target

The Hospital had a 60% Training Rate in PY4 and a 70% Training Rate in PY5.

Disability Competent Care Measure Benchmarks:

Attainment Threshold	Performance Goal – PY4	Performance Goal – PY5	Improvement Target
25%	65%	85%	12% pts

In this example, in PY5, the Hospital's Disability Component Care measure would be calculated as follows:

- Earned attainment points = % of Performance Goal * 10 = (70 / 85) * 10 = 8.24 points
- Maximum eligible improvement = Maximum measure points – Earned attainment points = 10.00 – 8.24 = 1.76 points
- Partial improvement (proportion to improvement target) = (Current Hospital PY rate – Previous Hospital PY rate) / Improvement Target = (70% - 60%) / 12% = 0.83
- Improvement points = Maximum eligible improvement * Partial improvement = 1.76 * 0.83 = 1.46 points

Total PY5 Performance Measure Score = Attainment points + Improvement points = 8.24 + 1.46 = **9.70 points**

Example 3. PY3 – Achievement of External Standards for Health Equity (TJC's Health Care Equity Certification (HCE))[2]

The Hospital reported to MassHealth in PY3 that their status is *Progress Towards HCE certification*.

Steps for Health Equity Scoring

1. Measure Points	**Measure points = 5** (Measure type: P4P) Note: Referencing Table 6 above, *Progress towards HCE certification* (i.e., TJC review conducted) = 5 points.
2. Performance Measure Score	**Performance Measure Score = $\frac{5}{10}$ = 0.50**
3. Domain Score Domain 3 Measure Weights • Achievement of Ext Stds. for HE (10%) • Patient Experience (10%) • Collaboration (5%)	• *Achievement of Ext Stds. for HE = (0.5 * 0.1) * 100 = 5.00* • Patient Experience = (1 * 0.1) * 100 = 10.00 • Collaboration = (0.8 * 0.05) * 100 = 4.00 **Domain 3 Score** = 10 + 5 + 4 = **19.00**
4. Health Equity Score	• Domain 1 Score = 20.00 • Domain 2 Score = 46.00 • *Domain 3 Score = 19.00* **Health Equity Score** = 20 + 46 + 19 = 85.00

[2] Currently named Excellent Health Outcomes for All Certification

Example 4. PY4 – Health-Related Social Needs (HRSN) Screening

The Hospital reported to MassHealth in PY3 and PY4:

Setting	Component 1 - PY3	Component 2 - PY3	Component 1 - PY4	Component 2 – PY4
Inpatient/Observation Stay	41%	Data submitted	50%	Data submitted
ED	19%	Data submitted	24%	Data submitted

Benchmarks & Setting Weights:

Component	Attainment Threshold	Performance Goal - PY4	Improvement Target	Bonus Point	Setting Weight
Component 1±	**Inpatient & Observation Stay:** 10% **ED:** 10%	**Inpatient & Observation Stay:** 45% **ED:** 30%	**Inpatient & Observation Stay:** 10% pts **ED:** 7% pts	+0.5 point if exceed PY performance goal (Inpatient/Observation Stay); +0.5 point if exceed PY performance goal (ED)	**Inpatient & Observation Stay** (50%) **ED** (50%)
Component 2*	**N/A — P4R**				

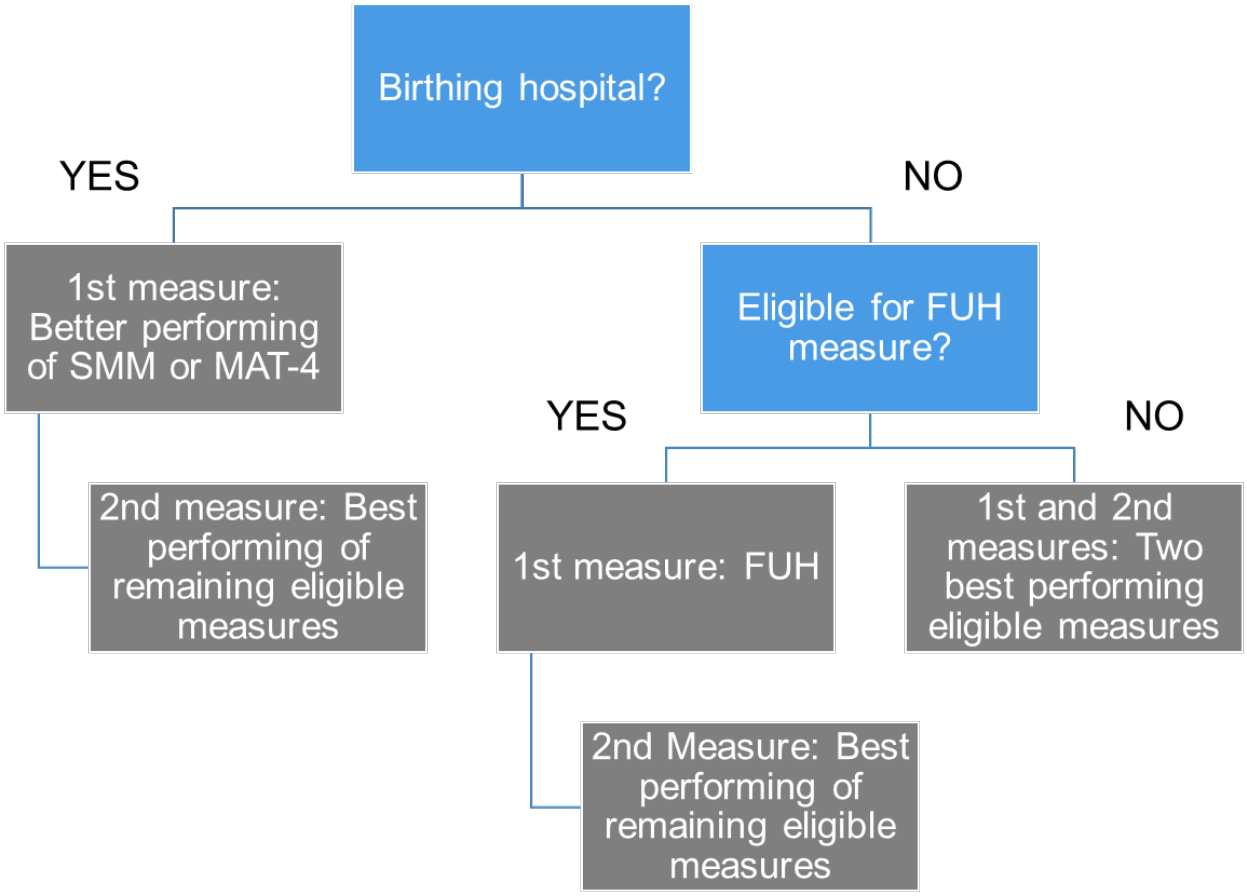
±Component 1: HRSN screening rate
*Component 2: HRSN screen positive rates

Steps for Health Equity Scoring

1. Measure Points	<u>Inpatient/Observation Stay</u>
	Component 1
	• Exceeded Performance Goal in PY4
	• Submeasure Score = **10.00 points**
	  ○ 10 points for reaching Performance Goal
	  ○ 0.5 bonus point for exceeding Performance Goal (bonus point added during domain scoring)
	Component 2
	• Submeasure Score = **10.00 points**
	
	<u>ED</u>
	Component 1
	• Not reach Performance Goal in PY4
	• Meet Attainment Threshold of 10% in PY4
	  ○ Attainment Points = (24 / 30) * 10 = 8.00 points

	• Not reach Improvement Target [difference between PY4 & PY3 Rate 1] ○ (24% - 19% = 5% points < 7% points) • Submeasure Score = **8.00 points** *Component 2* • Submeasure Score = **10.00 points** <u>Component Weight</u> Inpatient/Observation Stay → (10.00*0.75) + (10.00*0.25) = 10.00 ED → (8.00*0.75) + (10.00*0.25) = 8.50 <u>Setting Weight (50% each)</u> (10.00*0.5) + (8.50*0.5) = 5.00 + 4.25 = 9.25 points **Measure points = 9.25 points**
2. Performance Measure Score	**Performance Measure Score = $\frac{9.25}{10}$ = 0.93**
3. Domain Score <u>Domain 1 Measure Weights</u> • RELD SOGI Data Completeness (15%) • HRSN Screening (10%)	RELD SOGI Data Completeness = (0.87 * 0.15) * 100 = 13.05 [Performance Measure Score = 0.87] *HRSN Screening = (0.93 * 0.1) * 100 = 9.30* **Domain 1 Score** = 13.05 + 9.30 + *0.5 bonus point* = **22.85**
4. Health Equity Score	*Domain 1 Score = 22.85* Domain 2 Score = 46.28 Domain 3 Score = 19.37 **Health Equity Score** = 22.85 + 46.28 + 19.37 = **88.50**

F. Appendix C: Quality Performance Disparities Reduction Measure Logic Selection



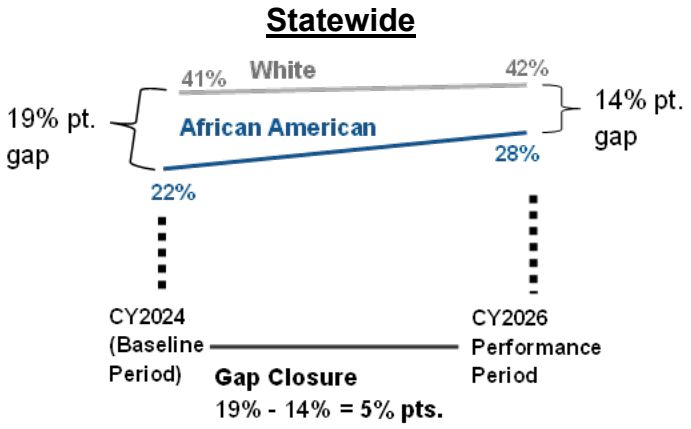
G. Appendix D: Quality Performance Disparities Reduction Measure Scoring Examples

Example 1. Statewide SUB-2 Measure Performance

In the baseline period (CY2024), a significant disparity was observed between the White patient population (reference group) and African American patient population (comparison group).

The statewide goal is 2% point absolute closure of the statewide baseline gap (full credit or 10 points earned) with a +1 bonus point opportunity if state exceeds performance goal.

	SUB-2 CY2024 (Baseline Period)	SUB-2 CY2026 (Performance Period)
White (reference group)	41%	42%
African American (comparison group)	22%	28%
Gap	**19% points**	**14% points**



Determination of Measure Score

1. Met the statewide goal of 2% point gap closure? *Yes → eligible for full points*
2. Did the state exceed the performance goal? *Yes, gap closed by 5% points → eligible for bonus point*

Full Credit (achieving goal) + Bonus = 10 points + 1 point = 11 points

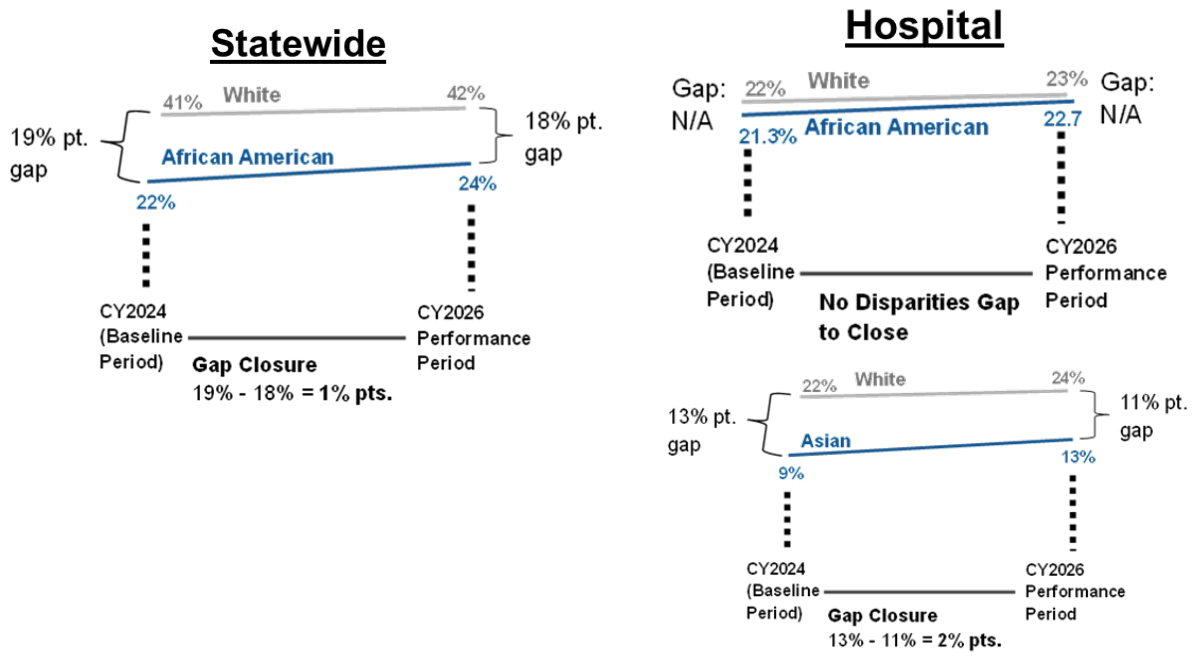
Example 2. Statewide & Hospital SUB-2 Measure Performance

In the baseline period (CY2024), a significant disparity was observed between the White patient population (reference group) and African American patient population (comparison group).

Partial credit of 7 points may be earned if there is a >=1% point but <2% point absolute closure of the statewide or hospital baseline gap if the Hospital.

Statewide Performance	SUB-2 CY2024 (Baseline Period)	SUB-2 CY2026 (Performance Period)
White (reference group)	41%	42%
African American (comparison group)	22%	24%
Gap	**19% points**	**18% points**

Hospital Performance	SUB-2 CY2024 (Baseline Period)	SUB-2 CY2026 (Performance Period)
White (reference group)	22%	23%
African American (comparison group)	21.3%	22.7%
Gap	**N/A (no disparities gap to close)**	**N/A (no disparities gap to close)**
White (reference group)	22%	23%
Asian (comparison group)	9%	13%
Gap	**13% points**	**11% points**



Measure Score

1. Met the statewide goal of 2% point gap closure? *No*
2. Did the state exceed the performance goal? *No*
3. Did the state partially close the gap between >=1% point to 2% point? *Yes, gap closed by 1% points → eligible for partial credit*
4. Did the hospital achieve the performance goal compared to own baseline for the same statewide disparity gap? *No. While the Hospital closed the gap between White and Asian by 2% points, the Hospital did not close the gap for the same subgroup as the statewide disparity (i.e., White and African-American) → not eligible for full credit*

Partial Credit = 7 points

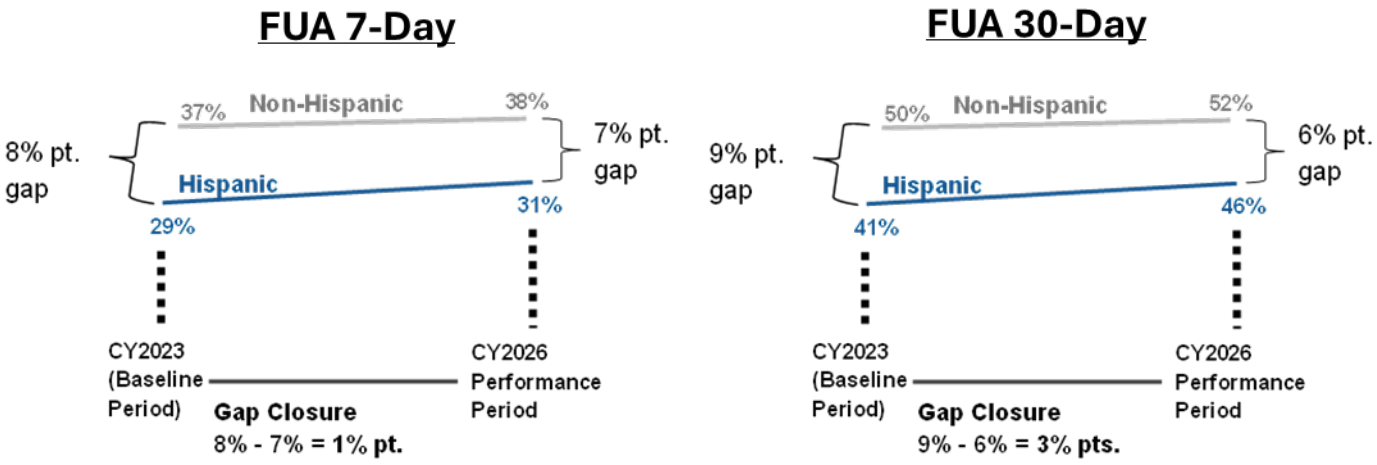
Example 3. Statewide FUA Measure Performance

In the baseline period (CY2023), a significant disparity was observed between the White patient population (reference group) and Asian patient population (comparison group).

The statewide goal is 2% point absolute closure of the statewide baseline gap (full credit or 10 points earned) with a +1 bonus point opportunity if the state exceeds performance goal.

Partial credit of 7 points may be earned if there is a >=1% point but <2% point absolute closure of the statewide baseline gap.

Statewide Performance	FUA CY2023 (Baseline Period)	FUA CY2026 (Performance Period)
Non-Hispanic (reference group) 7-Day	37%	38%
Hispanic (comparison group) 7-Day	29%	31%
Gap 7-Day	**8% points**	**7% points**
Non-Hispanic (reference group) 30-Day	50%	52%
Hispanic (comparison group) 30-Day	41%	46%
Gap 30-Day	**9% points**	**6% points**



Determination of Measure Score: FUA 7- Day	Determination of Measure Score: FUA 30- Day

1. Met the statewide goal of 2% point gap closure? *No* 2. Did the state exceed the performance goal? *N/A* 3. Did the state partially close the gap between >=1% point to 2% point? *Yes, gap closed by 1% points → eligible for partial credit*	1. Met the statewide goal of 2% point gap closure? *Yes → eligible for full points* 2. Did the state exceed the performance goal? *Yes, gap closed by 5% points → eligible for bonus point*
Partial Credit = 7 points	**Full Credit (achieving goal) + Bonus = 10 points + 1 point = 11 points**

To calculate the final measure for FUA, the two submeasures (i.e., 7-Day and 30-Day) will be equally weighed.

Final Measure Score for FUA = (7 * 0.5) + (11 * 0.5) = 9 points