

Commonwealth of Massachusetts
Executive Office Health and Human Services

RY2023 EOHHS Hospital Clinical Quality Incentive Program CQI Manual Release Notes (Version 1.1)

Supplement to:
**RY2023 EOHHS Hospital Clinical Quality Incentive
Program Technical Specifications Manual (v1.0)**

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Introduction

A. Purpose

The EOHHS Release Notes provide hospitals with interim updates on MassHealth Acute Hospital Clinical Quality Incentive (CQI) Program quality data collection and reporting requirements applicable to the current rate year EOHHS Technical Specifications Manual content posted on the Mass.Gov website. The EOHHS Acute Hospital Amendment 6 to RFA2023 introduces updates to MassHealth Clinical Quality Incentive (CQI) Program measure reporting. Release Notes (v1.1) provide instruction for hospitals to implement data collection and reporting on select measures.

1) Claims-Based Measure Update Effective with Q1-2023 Discharges: The MassHealth CQI Program reporting on the below claims-based measures will be effective with Q1-2023 discharges unless otherwise noted. All claims-based measures will be calculated by EOHHS on all Medicaid payer data from the Medicaid Management Information System (MMIS) fee-for-service claims and encounter data in the MassHealth Data Warehouse, using criteria and methods outlined in RY2023 Clinical Quality Incentive (CQI) Program Technical Specifications Manual (v1.0), Section 8.A. Hospitals are not responsible for any direct electronic data file reporting to EOHHS for this measure.

a) **Pediatric All-Condition Readmission Measure (PED-1)**

b) **Follow-Up After Psychiatric Hospitalization (BHC-1):** Please note, for RY2023 (CY2023) EOHHS is replacing the NCQA HEDIS Follow-up after Hospitalization for Mental Illness (FUH) measure with the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program FAPH measure. FAPH measure specifications are further outlined in the following release notes.

2) Clarifications to Data Specifications Effective with Q1-2023 Discharges:

a) **Medication Continuation Following Inpatient Psychiatric Discharge (BHC-2):** Clarified CQI 2023 Performance Period is *24-month* period January 1, 2022 thru December 31, 2023.

b) **Screening for Metabolic Disorders Measure (BHC-3):** Clarified “Improvement Noted As” *increase* in rate.

c) **MassHealth Perinatal Morbidity Structural Measure (PMSM-1):** Clarified the perinatal structural measure survey items in Table 7-1 of Section 7.C of the RY2023 Clinical Quality Incentive Program Technical Specifications Manual (v1.0).

3) Clarifications to Data Specifications Effective with Q3-2023 Discharges:

a) **Sex Data Element:** Added note to Appendix A-6 XML Schema to clarify how to submit data element.

B. EOHHS Manual Versions.

The CQI Release Notes version 1.1 document should be used in conjunction with the RY2023 EOHHS Hospital Clinical Quality Incentive Program Technical Specifications Manual (v1.0).

Hospitals are responsible for downloading and using the appropriate versions of EOHHS Manual and Appendix data tools that apply to each quarterly data period being collected and submitted. Failure to adhere to appropriate versions of data collection tools will result in MassQEX portal rejecting data files.

C. Specifications Manual for Joint Commission National Quality Measures.

EOHHS intends to align all CQI Technical Specifications and Release Notes with the most current version of nationally published Technical Specifications. For chart-abstracted measures, hospitals should use the applicable version of the Joint Commission Specifications that aligns with the discharge period being submitted. For example, when submitting Q3-2023 discharges, hospitals can reference Joint Commission specifications for the Q3-2023 discharge period (v2023B).

For chart-abstracted measures, hospital and vendor users of the Specifications Manual are responsible for updating their software and associated documentation based on the Joint Commission (TJC) and Center for Medicare and Medicaid Services (CMS) published manual production timelines.

D. Release Notes Guideline.

Updates in the EOHHS Release Notes are organized to supplement the EOHHS Manual table of contents core sections and appendices using the following headings:

1. **Key Impact** – identifies the EOHHS manual section that is impacted by the change listed (i.e.: measure specifications, data tools, dictionary, etc.). A key impact is defined as information that will substantively affect data collection and reporting file requirements.
2. **Description of Change** – identifies the specific content within the manual section where the change was made. (i.e.: measure specifications, flowcharts, data format, reporting values, etc.).
3. **Rationale** – a brief statement on the reason why the change was made.

Contact MassQEX Helpdesk at massqexhelp@telligen.com for any questions about the contents of this Release Notes document.

Section I: Changes in CQI Release Notes (v 1.1)

The content below is organized to follow the Table of Contents in the RY2023 Clinical Quality Incentive Program Technical Specifications Manual (v1.0). This section summarizes the key impact, description of change and rationale for the updated requirements.

Table A – Changes to Data Reporting Specifications (CY2023 data)

Key Impact	Description of Change	Rationale
Section 1.D CY2023 Performance Period CQI Program Measures	<ul style="list-style-type: none">• <i>Change Medication Continuation Following Inpatient Psychiatric Discharge (BHC-2) reporting period.</i>	<ul style="list-style-type: none">• Update from a 12 month to a 24-month reporting period for this measure in order to align with the reporting period length used by the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program measure steward.
Section 7 Data-Entry Measures	<ul style="list-style-type: none">• <i>Change “Improvement Notes As” from “Decrease in Rate” to “Increase in Rate” for BHC-3 measure.</i>• <i>Modify Table 7.1 to display correct survey responses for Item 2.</i>	<ul style="list-style-type: none">• Ensure measure is consistent with the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program specifications.• Harmonize with Technical Specifications v16.2 in order to allow trending over time.
Section 8. Claims-Based Measure Specifications	<ul style="list-style-type: none">• <i>(NEW) Add measure specifications for Pediatric All-Condition Readmission (PED-1)</i>• <i>(NEW) Add measure specifications for IPFQR Follow-up after Psychiatric Hospitalization measure (BHC-1). This replaces the former BHC-1 measure: NCQA Follow-up after Hospitalization for Mental Illness.</i>	<ul style="list-style-type: none">• Provide data specifications for finalized measures.
Appendix A-6: XML Schema: MassHealth Chart Measures File (1.0)	<ul style="list-style-type: none">• <i>Add note to XML File Layout for Data Element, “Sex” to Appendix A-6: XML Schema: MassHealth Chart Measures File (1.1)</i>	<ul style="list-style-type: none">• Provide guidance on submission for data element.

Section II: CQI Program Measures and Performance Periods

Table 1-2.4. Other Claims-Based Measures

Quality Measure	CQI Program Domain CQI 2023	Collection Method	Payment	Comparison Year Period	Performance Period
Medication Continuation Following Inpatient Psychiatric Discharge (BHC-2)	Behavioral Health Care	Claims-based	R	N/A	<i>Jan 1, 2022 – Dec 31, 2023</i>

The BHC-2 measure uses a 24-month measure period from January 1, 2022 thru December 31, 2023. Hospitals are not responsible for any direct electronic data file reporting to EOHHS for this measure.

Section III: Data-Entry Measures

This section clarifies measure specifications for CY2023 data-entry measure BHC-3.

A. Behavioral Health Care Domain Data-Entry Measure

Measure Name: Screening for Metabolic Disorders Measure (BHC-3)

Description: Percentage of patients discharged from an Inpatient Psychiatric Facility (IPF) with a prescription for one or more routinely scheduled antipsychotic medications for which a structured metabolic screening for four elements was completed in the 12 months prior to discharge – either prior to or during the index IPF stay.

Measure Steward: CMS Inpatient Psychiatric Facility Quality Reporting (IPFQR)

Numerator Statement: The total number of patients who received a metabolic screening in the 12 months prior to discharge, either prior to or during the index IPF stay.

Denominator Statement: Discharges from an IPF during the measurement period with a prescription for one or more routinely scheduled antipsychotic medications.

Included Populations: All patients discharged from IPFs with one or more routinely scheduled antipsychotic medications during the measurement period.

Excluded Populations:

- Patients for whom a screening could not be completed due to the patient's enduring unstable medical condition or enduring unstable psychological condition.
- Patients with a LOS equal to or greater than 365 days, or equal to or less than three days.
- Patients who expired during the admission (Discharge Disposition = 6)

Risk Adjustment: No.

Measure Collection Method: Aggregate data submission via Web-based data entry tool via the secure MassQEX Portal.

Data Collection Approach: See version applicable to discharge periods Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program manual for detail that apply. <https://qualitynet.cms.gov/ipf/ipfqr/measures>

Measure Type: Process measure.

Data Accuracy: See FY2024 Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program manual for detail that apply. <https://qualitynet.cms.gov/ipf/ipfqr/measures>

Measure Analysis Suggestions: None

Sampling: Optional, per CMS sampling requirements

Data Reported As: Aggregate rate

Improvement Noted As: *Increase in the rate*

B. Perinatal Care Domain Data-Entry Measure

1. Measure Description

Measure Name: Perinatal Morbidity Structural Measure (PMSM-1)

Please refer to the specifications outlined in the RY2023 EOHHS Manual Release Notes v16.2 for guidance on submitting the PMSM-1 measure.

Below Release Notes show important updates to Table 7-1 in Section 7.C.

Performance Period: Hospital responses reflect activity taken during CY2023 (01/01/23 – 12/31/2023), as noted in Table 1.2 (Section 1.D).

2. Data Collection Method

Attestation Survey Content: The PMSM-1 measure includes five items framed as attestation statements that collect information on perinatal quality collaborative participation and in-hospital implementation activity. An example of the survey items and response formats follow.

Table 7-1: MassHealth PMSM-1 Survey Items

Item Number	Response Format
Item 1- <i>During CY2023</i> , the hospital participated in the following Perinatal Quality Collaborative (PQC) aimed at improving maternal morbidity outcomes during intrapartum care:	<u>Check one response:</u> <input type="checkbox"/> Massachusetts Perinatal Quality Collaborative (PQC) <input type="checkbox"/> Other State or National PQC (enter name): _____ <input type="checkbox"/> Both of above <input type="checkbox"/> None of above
Item 2 – <i>During CY2023</i> , the hospital implemented the following maternity bundles while partaking in PQC:	<u>Check all that apply:</u> <input type="checkbox"/> Obstetric Hemorrhage <input type="checkbox"/> Severe Hypertension/Preeclampsia <input type="checkbox"/> Safe Reduction of Primary Cesarean Birth <input type="checkbox"/> <u>Opioid/Substance Use Disorder</u> <input type="checkbox"/> <u>Reduce Peripartum Race/Ethnic Disparities</u> <input type="checkbox"/> <u>PNOIN Maternal Equity</u> <input type="checkbox"/> Other Bundle not listed (enter name): _____ <input type="checkbox"/> None of above
Item 3- <i>During CY2023</i> , the hospital was involved in the following PQC activities listed	<u>Check all that apply:</u> <input type="checkbox"/> Formal data user agreement <input type="checkbox"/> Actively submit and exchange data <input type="checkbox"/> Attend educational events (webinars, annual meetings) <input type="checkbox"/> Attend ongoing team meetings <input type="checkbox"/> None of above
Item 4 – <i>During CY2023</i> , the hospital participated in the PQC during the following periods:	<u>Check all that apply:</u> <input type="checkbox"/> Q1-2023 (Jan to March 2023) <input type="checkbox"/> Q2-2023 (Apr to June 2023) <input type="checkbox"/> Q3-2023 (July to Sept 2023) <input type="checkbox"/> Q4-2023 (Oct to Dec 2023) <input type="checkbox"/> None of above
Item 5 - <i>Prior to and through the end of CY2023</i> , the hospital has implemented the specific practices listed to manage one or more of the maternal morbidity areas listed.	<u>Enter X to indicate Yes for all that apply:</u> a) Unit Policy and Procedure – The hospital has an obstetrical complication policy and procedure (updated in last 2 years) that provides a Unit-standard approach using a stage-based management plan. b) Multidisciplinary Case Reviews – The hospital has procedures to perform multi-disciplinary systems-level reviews on all cases of severe maternal morbidity. c) Debriefs – The hospital has established an internal process to perform regular formal post-event debriefs on cases with major complications. d) Birth Unit Supplies – The hospital has the necessary supplies readily available on birthing unit (e.g.: in a cart or mobile box) to manage specific complications.

Item Number	Response Format
	<p>e) Patient, Family & Staff Support Protocols- The hospital has developed OB specific resources and protocols to support patients, family and staff through major OB complications.</p> <p>f) Electronic Health Record Integration – Most of the recommended safety practices are integrated into the hospitals electronic medical record system (i.e.: order sets, tracking tools, medications, clinical metrics, etc.)</p>

Updates to PMSM-1 Reporting Requirements in EOHHS Release Notes 16.2:

- **Section 2.B Data Collection Method (attestation survey content):** Minor wording edits to each PMSM-1 item on **Table 7-1** to preface CY2023 on all item questions. Removed items 1 to 4 N/A response option. Remove Item 5 question note that applied to non-birthing hospitals.
- **Section 2.B.3(a) Completing the Attestation Form (Hospital Response):** For CY2023 data, hospitals that do not provide labor/delivery care are no longer required to report or submit the PMSM-1 form. The N/A response option for items 1 to 4 is removed and no longer available to select.
- **Section 2.B.3.a Completing the Attestation Form (Table 10-2 MassHealth PMSM-Survey Item 5 Mock Template):** For CY2023 reporting, edit to column header is Opioid/Substance Use Disorder in OB Care.
- **Section 2.B.3(a) Completing the Attestation Form:** For CY2023 reporting, updated Item 1 response option instruction to “If select both of above” the hospital “Other state/National PQC” name is required or the portal will issue a warning of missing info in order to submit the form.
- **Section 2.B.3(b.1) MassQEX Portal Submission (Web Entry Tool):** For CY2023 reporting, hospitals that do not provide labor/delivery service are not required to complete or submit the PMSM-1 measure. The N/A response option has been removed on the CY23 web entry tool.
- **Section 2.D.(2.a) Measure Evaluation Method (Valid response)** – For CY2023 removal of N/A response option is not relevant to Yes/No coding convention.

Detailed definition of terms and instructions on how to complete each PMSM-1 survey item are provided in the RY2023 EOHHS Manual Release Notes v16.2 and RY23 CQI Release Notes (v1.1) for guidance on submitting the CY2023 PMSM-1 measure.

Section IV: Claims-Based Measures Specifications

This section includes measure specifications for the CY2023 claims-based measure: PED-1.

1. Care Coordination and Integration of Care Domain

I) Pediatric Readmission (PED-1)

For detailed description of the applicable measure specifications for PED-1, please see published specifications from measure steward, located here: <https://www.childrenshospital.org/research/centers/center-excellence-pediatric-quality-measurement-cepqm-research/cepqm-measures/pediatric-readmissions>

Measure Name: Pediatric All-Condition Readmission Measure

Description: Rate of 30-day readmission for hospitalizations at general acute care hospitals for patients less than 18 years old. This measure has case-adjustment.

Measure Steward: Boston Children's Hospital

Initial Population: General acute care hospitalizations for patients less than 18 years of age.

Denominator: Initial population.

Numerator Statement: The first unplanned admission to any acute care hospital within 30 days of discharge from a prior hospitalization at an acute care hospital.

Risk Adjustment: Yes.

Improvement Noted as: Decrease in the rate

Payer-Population: All Medicaid population

Data Calculation Approach: EOHHS will calculate using MassHealth Claims Data File. Please section 8.A of EOHHS Technical Specifications Manual or information.

Data Accuracy: See Children's Hospital Pediatric All-Condition Readmission Measure Specifications for detail that apply.

Measure Analysis Suggestions: None

Sampling: Not applicable.

Data Reported As: Aggregate rate generated from claims data.

2. Behavioral Health Care Domain

I) Follow-up After Psychiatric Hospitalization (BHC-1)

For detailed description of the applicable measure specifications for BHC-1, please see published specifications from measure steward, located here: <https://qualitynet.cms.gov/ipf>

Please note: In the RY2023 EOHHS Hospital Clinical Quality Incentive Program Technical Specifications Manual (v1.0), the BHC-1 measure was the NCQA HEDIS Follow-up after Hospitalization for Mental Illness (FUH) measure. EOHHS has replaced FUH with the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) program claims-based measure, Follow-up After Psychiatric Hospitalization (FAPH).

Measure Name: Follow-up After Psychiatric Hospitalization (BHC-1)

Description: The percentage of inpatient psychiatric facility (IPF) hospitalizations for treatment of select mental health or substance use disorders that were followed by an outpatient mental health care or substance use disorder (SUD) encounter.

Two rates are reported:

- The percentage of discharges for which the patient received follow-up within 7 days of discharge
- The percentage of discharges for which the patient received follow-up within 30 days of discharge

Measure Steward: CMS Inpatient Psychiatric Facility Quality Reporting (IPFQR)

Initial Population: N/A

Denominator: MassHealth Medicaid discharges during the measurement period for patients with a principal diagnosis of mental health or substance use disorders. Specifically, the measure includes IPF discharges for which the patient was:

- Discharged with a principal diagnosis of mental health, including dementia, or substance use disorders that would necessitate follow-up care with a mental health professional.
- Discharged alive to ensure they are eligible for follow-up care.
- Enrolled during the month of the discharge date and at least one month after the discharge date to ensure data are available to capture the index admission and follow-up visits.
- Continuous enrollment.
- Six years of age or older on the date of discharge.

Numerator Statement: The number of discharges from an IPF that are followed by an outpatient mental health care or SUD treatment encounter within 7 and 30 days after discharge.

Risk Adjustment: No.

Improvement Noted as: Increase in the rate

Payer-Population: All Medicaid population

Data Calculation Approach: EOHHS will calculate using MassHealth Claims Data File. Please section 8.A of EOHHS Technical Specifications Manual for information.

Data Accuracy: See IPFQR specifications for detail that apply.

Measure Analysis Suggestions: None

Sampling: Not applicable.

Data Reported As: Aggregate rate generated from claims data.