RY26 MassHealth Hospital Clinical Quality Incentive Program: Data Accuracy and Completeness Attestation Form

INSTRUCTIONS

Under the Acute Hospital Request for Application (RFA) (Section 7B), each hospital must attest to exceptions that apply to quality reporting during the contract Rate Year. The hospital must enter all required information and include a signature and date on the signed form.

HOSPITAL INFORMATION

Hospital Name _____ Inpatient MassHealth Provider ID _____

Mailing Address _____ City, State, Zip Code _____

Name of CEO name _____ Phone _____

Under Section 7B of the RY2026 Executive Office of Health and Human Services (EOHHS) Acute Hospital RFA and Contract, all hospitals participating in the MassHealth Hospital Clinical Quality Incentive (CQI) Program must meet data accuracy and completeness requirements used to calculate all quality domain category assignments.

Data accuracy and completeness are defined as information that complies with all EOHHS technical specifications and formats for the MassHealth reported chart-based maternity measures, and national quality measure data sources (CMS Hospital Inpatient Quality Reporting, Inpatient Psychiatric Facility Quality Reporting programs, and the National Healthcare Safety Network) used by EOHHS to calculate specific quality domain categories.

MEASURES REPORTING EXCEPTION

I hereby certify that the Hospital will have no data to report on the specific quality measures listed below. Enter an "X" under the applicable quarter to confirm there is no data to report.

Measure Name	Calendar Year	Jan.1 to Mar. 31	Apr. 1 to Jun. 30	Jul.1 to Sep. 30	Oct. 1 to Dec. 31
Central Line-Associated Bloodstream Infection *(Hospital does not meet NHSN ward locations criteria)*	CY2025				
Catheter-Associated Urinary Tract Infection *(Hospital does not meet NHSN ward locations criteria)*	CY2025				
Methicillin-Resistant Staphylococcus Aureus bacteremia *(Hospital did not report to NHSN for the data period)*	CY2025				
Clostridium Difficile Infection *(Hospital did not report to NHSN for the data period)*	CY2025				
SSI: Colon and abdominal hysterectomy surgeries *(Hospital did not report to NHSN for the data period)*	CY2025				
Hospital Patient Experience Survey *(CMS granted exemption for HCAHPS reporting applies)*	CY2025				

Measure Name	Calendar Year	Jan.1 to Mar. 31	Apr. 1 to Jun. 30	Jul.1 to Sep. 30	Oct. 1 to Dec. 31
Perinatal Measures *(Hospital is not a birthing hospital with deliveries)*	CY2026				
Screening for Metabolic Disorders *(Hospital does not participate in the CMS IPFQR program)*	CY2026				

HOSPITAL CEO ATTESTATION

I certify under the penalties of perjury that all information submitted is true, accurate, and complete in accordance with requirements outlined in the applicable versions of EOHHS Technical Specifications Manuals to the best of my knowledge. By signing and submitting this form on behalf of this hospital, I also certify that I am the provider (in the case of a legal entity, duly authorized to act on behalf of the provider). I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained therein.

Hospital CEO Signature: Date Signed:

_____ _____

Printed Legal Name and Title of Signatory

_____

Printed Legal Name of Acute Care Hospital Represented by Signatory

_____

Only the following forms of signature will be accepted:

- *(Preferred method)* Electronic signature affixed using a digital tool such as Adobe Sign or DocuSign; or
- Electronic signature that is:
  - Hand drawn using a mouse or finger if working from a touch screen device; or
  - An uploaded image of the signatory's hand drawn signature.
- Traditional "wet signature" (ink on paper). Print out one original of the signature page, have an authorized signatory sign it, and scan the signed page.

Please note: If using an electronic signature, the signature must be visible and must be accompanied by the signatory's printed legal name and title, the printed legal name of the acute care hospital represented by the signatory, and the signature date. Typed text of a name not generated by a digital tool such as Adobe Sign or DocuSign, even in computer-generated cursive script, or an electronic symbol, are not acceptable forms of electronic signature.

INSTRUCTIONS FOR SUBMITTING YOUR REQUEST

Email Instruction: Please send a scanned copy of the completed, signed form to the EOHHS business mailbox: Masshealthhospitalquality@mass.gov.

Print Clear