MassHealth

Executive Office of Health and Human Services

RY2018 MassHealth Acute Hospital Pay-for-Performance Program: Data Accuracy and Completeness Attestation Form

Instructions: Please enter all required information in blank spaces provided below and sign the form. **All information must be typed in this PDF form** using Adobe Reader version 5 or higher. Go to http://get.adobe.com/reader/ to download Adobe Reader.

HOSPITAL INFORMATION	
HOSPITAL NAME	**MASSHEALTH PROVIDER ID**
HOSPITAL STREET ADDRESS	**CITY, STATE, ZIP CODE**
HOSPITAL CEO NAME	**PHONE**

Pursuant to Section 7 of the Executive Office of Health and Human Services (EOHHS) Acute Hospital Request for Application (RFA), all hospitals participating in the RY2018 MassHealth Hospital Pay-for-Performance (P4P) quality reporting must meet data accuracy and completeness requirements to be eligible to receive incentive payments.

I understand that all RY2018 (calendar year 2017) quarterly data reported on behalf of this Hospital must meet submission deadlines and include the following information to meet data accuracy and completeness requirements:

- Chart-abstracted measure sets for the eligible patient population;
- Electronic data files submitted via the secure portal;
- ICD Population and sample counts data entry via the secure portal; and
- Medical records submitted for data validation purposes.

I certify under the pains and penalties of perjury that all information pertaining to RY2018 calendar year data requirements submitted by this Hospital, will be reviewed prior to submission by the authorized Hospital staff or third-party data vendor identified on the RY2018 Hospital Quality Contact Form.

Measures Exemption: I understand that the Hospital has no RY2018 data for the required quarter reporting of the measures checked off below. Please enter "X" in blank space for all that apply.

Quality Measure Set	Quarter 1 Jan 1 – Mar 30	Quarter 2 Apr 1 – June 30	Quarter 3 July 1 – Sept 30	Quarter 4 Oct 1 – Dec 31
Maternity (No obstetrical department)				
Newborn (No infants delivered)				
ED Throughput (No emergency dept.)				

I certify under the pains and penalties of perjury that all information submitted is true, accurate and complete in accordance with the applicable versions of EOHHS Technical Specifications Manuals to the best of my knowledge. I also certify that I am the provider, in the case of a legal entity, duly authorized to act on behalf of the provider, by signing and submitting this form on behalf of this hospital. 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

Mailing Instructions: The original signed form must be mailed, with a typed cover letter on Hospital stationery to: EOHHS MassHealth Office of Providers and Plans, Attention: Acute Hospital P4P Program, 100 Hancock Street (6th floor) Quincy, MA 02171.