# Colorado Hospital Transformation Program (HTP)

*Frequently Asked Questions (FAQ)*

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# I. Community Health Neighborhood Engagement (CHNE)

## General

Q: Are there are any guidelines/templates/requirements for CHNE Reporting?

A: Yes, please refer to the Community and Health Neighborhood Engagement (CHNE) Process section on the HTP website, which includes the guidebook, requirements overview, templates, and other resources. Additionally, hospitals can reference the Quarterly Reporting Tool in their CPAS accounts or review prior training materials, which are also posted to the HTP website.

Q: Are you all collecting information across hospitals the feedback from the engagement meetings to share best practices with all of us?

A: That is correct, we will be collecting the information over time to understand the types of feedback received. We hope this information will help us and provide additional guidance to hospitals moving forward.

Q: Do you envision any of the reporting requirements changing over the span of the 5 year program when it comes to reporting quarterly? Or what you see today is what we will report on for the next 5 years?

A: The requirements outlined for CHNE reporting will not change over the course of the program.

Q: Is supporting documentation required for CHNE reporting?

A: No, documentation is not required for continued CHNE reporting. Documentation will be important for demonstrating milestone completion.

Q: Will we be able to download our responses to keep a historical record?

A: A quarterly reporting summary will be sent out via email once the survey has been submitted. The summary will include a record of all responses.

Q: Can we enter information into the survey throughout the quarter rather than using the Quarterly Reporting Tool Excel sheet?

A: The survey will not be available until the first business day after the end of the quarter. Therefore, we recommend hospitals use the Quarterly Reporting Tool or other internally developed template/tool to prepare for quarterly reporting in advance.

Q: Do I need to complete sections of the survey for types of engagement that did not occur in the applicable quarter? For example, if we didn't have a public input engagement this quarter, do we need to answer those questions?

A: The first question in the CHNE section is a radio button indicating which types of CHNE occurred during the quarter (consultations with key stakeholders, community advisory meeting, and public engagement). Questions will populate in the survey based on that selection. Therefore, if public engagement was not selected, those questions will not populate in the survey.

Q: For the Quarterly report, do we only enter those community stakeholders that we worked with for this quarter or include past organizations too?

A: Focus only on what engagements there were in this quarter. The only exception is for the public input meeting required in PY1. Public input meetings that occurred in quarter 2 (January-March 2022) may count towards PY1Q3 CHNE.

Q: Will hospitals be penalized or deemed incomplete if they meet the minimum reporting requirements for the quarter, and additional engagements were unsatisfactory?

A: No, it would not count against the hospital. If there is an error or incomplete response that doesn't impact the ability to meet the requirements, the reviewers are making a learning note, but it would not be considered incomplete.

## Requirements

Q: What are the CHNE requirements for year 1?

A: In Program Year 1, CHNE includes the following activities, at a minimum: consultations with key stakeholders in quarters 3 and 4 and public input meeting in quarter 3 or 4. Public input meetings that occurred in quarter 2 (January-March 2022) may count towards PY1Q3 CHNE.

Q: Can we combine the key stakeholder meeting with community advisory as one event?

A: For PY1Q3 and PY1Q4, community advisory meetings can count towards meeting the CHNE requirements for key stakeholder engagement but should be reported as Community Advisory Meetings.

Q: For part of our routine CHNA process we held a town hall for community input, including on HTP measures, in October 2021. But since it wasn't in PY1Q3 or Q4 that can't count for the public input meeting?

A: Correct, that did not occur in PY1Q3 or Q4. We have made allowances to allow events occurring in Jan-Mar 2022 to count towards PY1Q3. This allowance is applicable to program year 1 only.

Q: For the CHNE requirements, do we need to have measure specific meetings/engagements per hospital per measure? For example, if we were to meet with a Behavioral Health Community Provider would that satisfy the CHNE for that hospital or would

we have to also schedule separate meetings with other stakeholders to cover the other measures? Also, would it be okay if we had one shared meeting/engagement where more than one hospital was present or do we need to have separate meetings/engagements per hospital?

A: We are looking for each hospital to report on the engagement they had with their community and/or stakeholders that quarter regarding HTP. It is not by measure. Multiple hospitals can be included in engagement but the engagement only counts if the hospital is actively discussing their particular program and interventions and not for hospitals that are only a passive attendee in the meeting/engagement.

Q: We are forming a hospital collaborative with representatives from all the regional hospitals. As part of the CHNE reporting, how should the collaboration be reflected? Do we list out all the different hospitals separately, or do we give this group a name and list it?

A: If multiple hospitals come together and meet with a specific organization i.e. HIE, RAE, etc., the CHNE should focus on the engagement with that community organization outside of HTP participating hospitals. The collaboration with other hospitals is great, but hospitals should focus their CHNE and reporting mostly on engaging stakeholders and organizations outside of hospitals. Project planning activities between hospitals will be part of interim activity and milestone reporting. Hospitals do not want their engagement to appear to be predominantly hospital-centric. The audience for your reporting is your community and the public as well as the HCPF review team and the state. If there is significant engagement between hospitals that is an important key stakeholder engagement, then hospitals should list that as Regional Hospital Collaboration, and include one line item with multiple dates in the CHNE reporting instead of reporting each hospital separately, and list it as key stakeholder engagement. With key stakeholders you can add more info in the "type of organization" block if deemed necessary; i.e. group of hospitals including x, y, z, etc. For community advisory you will be able to include the list of the organizations involved.

Q: Some of the terminology used for CHNE is unclear. Can you clarify the differences between "consultation with key stakeholders", “community advisory meeting”, and "public engagement"? What does each term mean and what might qualify?

A: The different types of community engagement are detailed in the "Ongoing CHNE Requirements" document. This document can be found on the COHTP webpage, under "Community and Health Engagement Process".

## Consultations with Key Stakeholders

Q: In each quarter, will we be expected to meet with majority of our key stakeholders?

A: We want to know who you met with, but there is no minimum threshold on each quarter in terms of types of organizations or number of meetings. We have some recommended thoughts, as laid out in the Ongoing CHNE document. Depending on which

quarter, you will have different levels of engagement – and we understand that. We will be reviewing your engagement over time. If a hospital is only engaging with one stakeholder each quarter, we may flag those and reach out.

Q: If I meet with two stakeholders in one quarter does that count as two meetings?

A: It will count as two meetings within that quarter, but we would need to see consultations with key stakeholders in at least one other quarter to satisfy the annual requirement.

Q: We have a Patient Family Advisory Council. Can this count as public engagement if we speak specifically about our HTP projects?

A: The intention around public engagement is for the general public to be able to have information and provide feedback around HTP, which is broader than your PFAC. We want the public engagements to be more wide reaching. PFACs can count as consultations with key stakeholders.

Q: Next quarter, will organization information pre-populate or will we need to re-enter everything? We will likely meet with many of the same organizations every quarter.

A: For consultations with key stakeholders, the organization name will pre-populate in future quarters. The contact information will need to be re-entered every quarter. You can use the hospital quarterly reporting tool to paste information into surveys rather than starting from scratch.

Q: If a hospital completed the Community Health Needs Assessment (CHNA) during this quarterly reporting period, should it be reported as CHNE?

A: The completion of the CHNA itself does not qualify as CHNE; however, if there were engagements with stakeholders to prepare or review the CHNA where HTP was specifically discussed, those engagements could count as consultations with key stakeholders.

Q: Would secondary one-on-one meetings following the annual public input meeting count as a Consultation with Key Stakeholders?

A: If these individuals have been identified as key stakeholders that will be regularly engaged to discuss HTP updates and provide input and feedback, yes they may be listed in the key stakeholder section of the CHNE survey. If that is not the case, they should not be included.

Q: If a hospital has met with two individuals with entirely different roles but they are from the same organization, can the hospital list the organization twice under key stakeholders, and then list each of their names under the primary contact?

A: Please list the organization once. List both contacts if you believe they are both equally primary contacts or choose one contact to list. Then list each date you met with that organization.

## Community Advisory Meetings

Q: During community advisory meetings can we focus on common interventions (i.e. social needs screenings) rather than reviewing the entire implementation plan that may not be applicable to all stakeholders present?

A: Yes, hospitals can focus in on common interventions or interventions that are applicable to the stakeholders present. Community advisory meetings can serve as opportunities to workshop with other subject matter experts in the industry on specific HTP initiatives pertinent to your hospital and the stakeholders gathered.

Q: We can count the participants at the community advisory committees as consultations with key stakeholder for two of the four quarters. Am I interpreting that correctly?

A: For every year starting in PY2, hospitals are required to address consultations with key stakeholders two quarters, community advisory meetings in two different quarters, and public engagements just once.
If you don't have a community advisory meeting that quarter, you must have consultations with key stakeholders. If you have a community advisory meetings with stakeholders there, count it as a community advisory meetings not consultations with key stakeholders.

Q: Can participation at PIAC through our RAE count as community advisory meetings for those hospitals that do not have one in place?

A: If the RAE is organizing a PIAC meeting around HTP and gets feedback regarding HTP, then yes. The hospital should be engaged and sharing information regarding their specific HTP program with the PIAC in order for it to count as a community advisory meeting. You don't have to host a meeting for it to count. In some cases, if you participate in larger group discussions about HTP, it should suffice. It is so important that the discussions do include conversations about HTP.

## Public Engagement

Q: Is it correct that virtual public input meetings are allowed?

A: Yes, virtual meetings are an option. Hybrid and in-person are also options.

Q: If several hospitals in the area come together to hold the public meeting together, can we each count that?

A: If each hospital is presenting around their HTP and allowing for public feedback for each hospital's program, yes. If only one hospital is presenting, but others are attending, it would not count for those only in attendance.

### Learning Symposium

Q: Will there be a virtual option for the Learning Symposium?

A: As a reminder, it is an annual CHNE requirement to attend the Learning Symposium. Yes, there will be a virtual option.

## II. Interim Reporting

### General

Q: For interim reporting, can interim reporting only be used towards our upcoming milestone or can it be progress towards any milestones included in the implementation plan?

A: We want it to be predominantly focused on the upcoming milestone to ensure you're on track and that we're progressing as planned; however, if you would like to report additional information for work towards future milestones may do so.

Q: Are there any concerns if our interventions have similar interim activity?

A: The interim activities completed may be similar across multiple interventions, but most likely have an intervention specific component. Hospitals should address the intervention specific component when describing interim activities.

Q: Is it appropriate to notate any issues/challenges the hospital identified, even if we are on target to meet the milestone?

A: If you're still on track to meet the upcoming milestone, you may include identifying barrier(s) and mitigation strategies as a part of your interim activities. If barriers are not related to the upcoming milestone, the barrier should not be included in the interim activity report.

Q: If we've already achieved the upcoming milestone, and report that achievement in our interim activity report, what do we report in the next interim activity report for the same upcoming milestone?

A: As indicated, address that the milestone has been completed. In future quarters you may address other activities that have occurred in the process of implementing the intervention. If you find yourself substantially ahead of where you thought you'd be, consider amending future milestones during milestone reporting.

Q: If a hospital indicates they are at risk for not meeting the upcoming milestone during interim reporting, how is this information used?

A: The Department will assess responses indicating hospitals are not on track to meet the upcoming milestone after all submissions have been reviewed. The Department will provide outreach and guidance as needed. Reporting on any concerns or risks does not impact your score negatively.

Q: There are three interim reports due previous to our first milestone report, correct? So, we will report three times on how we are progressing towards the first milestone?

A: Yes, there are 3 interim activity reports due before PY2Q2 milestone report; this includes PY1Q3, PY1Q4, and PY2Q1.

Q: Our first milestone says that we will build out a dashboard to track performance as part of our technology work. However, we have other technology work we are doing to build the measure (i.e. patient identification). Can we report on the technology development for patient identification even though our first milestone is related to dashboard building?

A: At a minimum, we will be reviewing to ensure what you have written crosswalks to your upcoming milestone. You can include additional information related to a particular functional area or future milestone; however, you don't want to include that information in lieu of what is applicable to the upcoming milestone. For this particular example, you could report on the progress for patient identification and explain how that is a necessary preliminary step before the hospital can build out the dashboard included in the first milestone.

Q: Do we need to report interim activity for each intervention, for the interim report to be considered complete?

A: Yes. Interim activities are required to be reported for each intervention. The survey will pre populate each intervention and the hospital will have to answer the interim activity questions for each intervention. CHNE is reported hospital wide while interim activity is reported by intervention.

Q: Just to confirm, we do not need to submit supporting documentation for interim activities?

A: Correct. Supporting documentation is not required for interim activities.

Q: What is expected to be submitted for the "interim activity" reports?

A: Hospitals will be asked questions via a Qualtrics survey regarding their progress towards the upcoming milestone, whether progress towards milestone completion is on track, and if not, what support may be needed. These are narrative based responses and no supporting documentation is required. The questions that will be asked are included in the Quarterly Reporting Guide published to the CO HTP website and within the Quarterly Reporting Tool.

Q: If the hospital's submission is complete and on time, would there be any additional comments in the determination letter such as best practices? Or should hospitals only anticipate comments if incomplete?

A: Comments will only be included in determination letters where submissions were deemed incomplete. The review team is compiling learning notes to discuss during the monthly hospital workgroups.

Q: If a hospital addresses a functional area that is not part of an upcoming milestone but the activity listed is still related to the upcoming milestone, will the interim activity be considered incomplete?

A: Hospitals should address at least one functional area of the upcoming milestone. Even if no progress has been made on the functional area specified in the hospital's Implementation Plan, the hospital should address that and the response will still be considered "complete" for the purposes of reporting.

Q: Are Performance Measure submission and Quarterly Reporting separate?

A: Yes, there is a survey for the Interim/CHNE questions, and the self-reported measure workbook will be submitted separately through CPAS. However, both submissions must be received by the PY2Q1 due date (January 31, 2023) in order for the hospital to earn the 0.5% at risk associated with timely reporting for the quarter.

## Functional Areas

Q: For interim activity reporting, if there is more than one functional area in a milestone (e.g. people, process) but the hospital has not done any work, or no significant work, under one of the functional areas in the quarter, can we just indicate that in the survey?

A: Yes, you are not required to have worked on all functional areas during the interim activity period, as long as the hospital is still on track to meet the upcoming milestone. For functional areas included in the upcoming milestone where activities have not been started, it would be helpful to notate. Otherwise, the response may appear incomplete.

## Qualtrics Survey

Q: Will we be able to download our responses to keep a historical record?

A: A quarterly reporting summary will be sent out via email once the survey has been submitted. The summary will include a record of all responses.

Q: What should the hospital do if there is a need to navigate back to make updates in the survey?

A: Go through all responses before you progress to review page. If you progress to the review page and need to make a change, email tech support (cohtp@mslc.com) to determine if the change warrants issuing a retake link.

Q: Is it a problem that the hospital submission did not include the date with the signature on the attestation?

A: No, that will not be an issue because the submission date is recorded with responses.

### Scoring Review and Reconsideration Period

Q: For interim reporting, if the progress that a hospital described towards their milestone has been insufficiently communicated or the hospital believes it was misunderstood by reviewers, will hospitals have the opportunity to make an argument to support our responses are complete and aligned with the milestone?

A: Hospitals can submit a Scoring Review and Reconsideration request form following initial determinations. This is the hospital's opportunity to request reconsideration of initial scores if they believe their submission has been scored in error. As a reminder, no revised submissions will be accepted during the Scoring Review and Reconsideration Period (SRRP).

## III. Milestone Reporting

### General

Q: In the first milestone report (submitted at the end of PY2Q2- April 2023) is it true that hospitals can report on the activities they completed from November 2021 through March 2023? So the first report would technically contain activities that occurred over the course of about a year and a half as opposed to most of the other reports, which will only contain activities that occurred over 6 months, right?

A: Correct. The first milestone report submitted in April of 2023 will include activities completed related to the PY2Q2 milestone, which may have occurred between the implementation plan approval in November 2021 through the end of PY2Q2.

Q: How does it work if we completed a milestone before the milestone reporting quarter? For example, one of our milestones was to have our initial kickoff meeting and this was already conducted.

A: Address that the milestone has been completed in the first milestone report. If you find yourself substantially ahead of where you thought you'd be, consider amending future milestones during milestone reporting.

Q: Submissions for milestones occur in the 30 days AFTER the end of the reporting quarter, right? So, milestone reporting for PY3Q2 would be due on October 31, 2024? Or would it be due on September 30, 2024?

A: Yes, milestones are reported in the thirty days after the end of the reporting quarter. However, PY3Q2 is January-March 2024, so the milestone reporting would be due by April 30, 2024. HTP follows the Federal fiscal year rather than the calendar year.

Q: If our data source comes from Medicaid claims, does our organization have to do anything further to make sure it's correct for HTP?

A: No. HCPF will be pulling and validating the claims data from paid claims in the MMIS. The department will be providing detailed data files for claims measures to hospitals so that you have the information for reference and to use in monitoring and evaluating your interventions.

## Milestone Amendments

Q: What are the requirements in terms of the frequency of milestone amendments?

A: Milestone amendments only occur during milestone reporting (Q2 and Q4 of program years 2-5). Milestones can only be amended for future quarters, not the current quarter.

Q: Can you amend the same milestone more than once as long as it's in the future?

A: Yes

Q: A future milestone states, "create transmission ADT report" for COE1. If we decide to go with a different type of report like CCD or something other than ADT, but still are creating a transmission report, do I need to make an amendment or is that level of detail not required? I'm hoping as long as we are still creating a transmission report, then the type isn't as big of a deal in my mind, but I wanted to confirm.

A: If the details of the milestone are accomplished and documented in the documentation, that's fine. But if the details of the milestone are no longer correct or will not be supported in the revised type of report, an amendment is needed.

Q: Do we need approval from HCPF before amended milestones can be considered official and binding?

A: Yes. Milestone amendments will be subject to the same review criteria as the implementation plans. Details are included in the Quarterly Reporting Guide.

Q: Can we do milestone amendments for multiple future milestones or just the next single milestone?

A: You can amend any future milestone – there is no restriction on the number of future milestones you can amend. Hospitals can also amend a milestone more than once, as long as the amendment is submitted and approved in an appropriate reporting quarter (Q2/Q4). Note, milestone amendments will not be accepted for a current quarter, only future quarters. Further, hospitals can only submit milestone amendments during milestone reporting periods (during Q2 and Q4 milestone reporting, not Q1 and Q3).

Q: If we have completed a milestone for a future quarter, can the hospital undergo a milestone amendment for the intervention during the current reporting quarter?

A: In this case, the hospital may not need to file an amendment. It is perfectly acceptable for the hospital to have completed the milestone early, as long as all the appropriate supporting documentation is saved and ready for submission during the appropriate quarter.

Q: If our organization has blocked the use of Macros in excel documents, how can our team properly utilize the Milestone Amendment Form?

A: Your hospital should reach out to cohtp@mslc.com with your concern. MSLC will provide an alternative template with macros disabled.

## Supporting Documentation

Q: Do you need supporting documentation in years 4-5 too for the milestones?

A: Yes. Although there is no at risk tied to meeting the milestones in those years, there is a requirement that documentation be submitted in order to meet the timely reporting requirement.

Q: As a part of the hospital index milestone reporting, is it preferred to have separate documents by functional area or can the hospital include people, process, patient engagement, technology in one document?

A: The preference is to have separate documents per functional area per intervention, since that is how the milestone codes are laid out and how the survey will prompt the hospitals to complete their reporting / uploads. The hospital may also submit the same document multiple times, but renamed with each functional area and with the key information for that functional area highlighted for the reviewer.

Q: If a hospital has the same document for all interventions, do they need to upload the same document multiple times?

A: There should be separate documents for each intervention, in accordance with the implementation plan. The hospital will need to indicate where in the document that each milestone achievement should be reviewed.

Q: Can a hospital direct reviewers to two documents for one Functional Area?

A: Yes, as long as the hospital is careful to note where in each document to look for each functional area. The hospital can do so by adding reviewer notes in the survey or document itself, as well as properly utilizing the naming conventions provided.

Q: What format should supporting documentation be saved in?

A: CPAS can accommodate multiple file formats, including png, pdf, Word, Excel.

Q: Are the FA portion of the milestone codes (.1-.4) assigned to each functional area already?

A: Yes. The milestone codes we are populating come directly from the hospital Implementation Plans saved on CPAS, and have been assigned according to intervention.

# IV. Performance Measures

## General Guidance

Q: Can you confirm that hospitals do not need to do anything in the performance phase other than continue to submit data if applicable? That is just when HCPF will be measuring hospitals, which overlaps with the planning & implementation and continuous improvement phases, correct?

A: Hospitals will be asked to report on performance measures that are not derived from claims data. For example, RAH4 is not calculated using claims data and will be reported by the hospital if the hospital selected that measure. The reporting tool used during the PY 0 Rehearsal Period will be used in subsequent years for hospital self-reported measures. Performance reporting for PY2 will occur in PY3Q2 (January 2024) and does occur concurrently with planning and implementation and continuous improvement phases for milestones.

Q: Could you please let me know how you define “third party insurance clients”? Is that commercial insurance?

A: Third party does include commercial insurance. It is possible for Medicaid beneficiaries to have more than one source of healthcare coverage, and by law the third party resource must meet their legal obligation before the Medicaid program pays for care.

Q: Does “all Medicaid patients” include primary AND secondary Medicaid or just primary?

A: For all measures (excluding the readmission measure) only Medicaid Primary is included, so secondary and third party are excluded.

Q: When should hospitals expect to receive PY1 hospital self-reported measure workbooks for data submission, and will they download them from CPAS?

A: The PY1 performance measure data submission period will be January 2023. The MSLC team will be uploading new templates ahead of the submission period starting Jan 1.

Q: For measures with fixed numerical benchmarks already established that are not reliant upon the baseline data, such as the SW-CP1, what is the expectation for reporting on baseline data in January 2023 if a hospital is still building out the data tracking and reporting system at that time?

A: If a measure has a fixed numerical benchmark already established that is not reliant upon the baseline data, reporting incomplete or no data will not impact the hospital's performance or reporting for the HTP.

Q: The baseline data availability policy indicates that if a hospital enters "NDA" for a measure, the data for that measure will still have to be provided once it becomes available if needed for the achievement threshold. At what point are hospitals required to submit this data for applicable measures?

A: If a hospital enters "NDA" for a measure with a fixed benchmark, their reporting score related to the PY1 submission will not be impacted. However, if the measure requires PY1 data for the achievement threshold, the hospital must provide the complete and accurate PY1 data during the PY2 measure submission period in January 2024. The measures with a fixed benchmark that also have an achievement threshold based on PY1 are the following: COE4 - Energy Star Certification Achievement and Score Improvement for Hospitals; CP3 - Pediatric Sepsis - Timely Antibiotics; CP4 - Screening for Transitions of Care Supports in Adults with Disabilities; RAH3 - Home Management Plan of Care (HMPC) Document Given to Pediatric Asthma Patient/Caregiver (eCQM); and SW-BH2 - Pediatric Screening for Depression in Inpatient and Emergency Department Including Suicide Risk.

## General Specifications

Q: Do any of the measures include dual eligible patients (Medicare and Medicaid)?

A: For hospital self-reported measures specific to the Medicaid population, this only applies to Medicaid primary patients and will exclude dual eligible, Medicaid pending, and emergency Medicaid patients.
For Medicaid claim measures calculated by HCPF, the population will exclude Medicaid managed care, dual eligible, Medicaid pending, and emergency Medicaid patients.

Q: On any of the measures that deal with inpatients, are patients that are admitted to observation included in the numerator

A: No, measures that are applicable to the inpatient setting exclude observation patients, unless otherwise noted.

## Claims Measures

Q: Should we be validating the data hospitals received for claims-based measures or are you all confident in the accuracy?

A: Yes, we are confident and doing a lot of data validation and testing internally. However, we do want you all to review to determine if our calculations match your records and ensure you understand how the measures are being calculated.

## Benchmarks

Q: For benchmarks, when you say the benchmark for PY3 is 80% does that mean hospitals should reach 80% during PY2 in order to receive funds in PY3 or does it mean they need to reach 80% by the end of PY3, which would then be analyzed/paid out in PY4?

A: The benchmark is related to the performance period. So the benchmark for PY3 is related to the performance period of PY3, which is 10/1/2023-9/30/2024. We will be collecting measure data annually in January for the prior program year, then we'll analyze the data and set benchmarks for the following year. Details are included in the Scoring Framework posted on the CO HTP website.

Q: Can you please clarify if we need to meet or exceed benchmarks in PY4 and PY5 or do we need to achieve a set percentage, like 5%, improvement in PY4 and PY5?

A: The first year for performance is PY3. You need to meet or exceed benchmarks in years 3, 4 and 5. The type of benchmark varies by measure. See the Scoring Framework or Measure Specifications posted on the CO HTP website for benchmark details.

Q: What does 5% improvement mean? Is that 5% relative or fixed?

A: The 5% is relative rather than fixed. For example, if the PY3 benchmark is 70% and the PY4 benchmark requires a 5% improvement upon the PY3 benchmark, the PY4 benchmark is **not** 75%. The benchmark is to improve by 5%. 5% improvement of a 70% benchmark is 3.5%. Therefore, the PY4 benchmark in this example would be 73.5%.

## Performance Measure BH1

Q: SBIRT screening question - Do we have to use a specific screen to identify positive scores, or can we make that determination at the hospital level?

A: Screening instrument and scoring methodology used by individual hospitals must be consistent with CMS guidance and approved by the state. Please reference:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SBIRT_Factsheet_ICN904084.pdf
https://hcpf.colorado.gov/sbirt-manual

## Performance Measure BH2

Q: Would administering medication internally or referring externally count towards the measure?

A: The measure includes the initiation of MAT. Whether you refer internally or externally is up to hospital.

Q: What if the patient has repeated admissions? Will each visit where MAT is initiated be included or only the initial visit?

A: The measure is counted by visit, not by patient. Any visit where the MAT is initiated would be counted.

Q: Does the MAT measure only apply to members seen in the ED and discharged home? Or does it also include members admitted through the ED?

A: All ED visits where denominator criteria are met should be included.

Q: Could further clarification be provided on the initiation of the MAT?

A: The induction must occur at the hospital, rural health center, or provision of home induction. The continuation of MAT does not have to be conducted at the hospital.

## Performance Measure COE1

Q: For COE1, the measure specification is "Successful transmission of a summary of care record, as described in the intervention, to a Medicaid patient's PCP or other healthcare professional within one business day of discharge from an inpatient facility to home". What "other healthcare professional" would be acceptable?
Along this vein, could the patient's PCP be a health neighborhood, practice or a Federally-qualified health centers versus a named provider?

A: Healthcare professionals that would be appropriate to follow up with after the inpatient stay (i.e. a specialist). It is up to hospital/physicians to determine what is appropriate in terms of getting the summary of care to the next level of care.
Align with ACC and use portal to identify PCP. It does not have to be one specific person. It could be an organization name.

Q: For COE1, does this measure include inpatients discharged from a psychiatric unit?

A: The measure includes all patients discharged from an inpatient facility to home.

Q: For COE1, in the measure specification under Target Population Notes, it states Adult and Pediatric Medicaid (primary) patients. What is meant by the "primary" reference?

A: This refers to primary Medicaid which excludes pending Medicaid, emergency Medicaid, Medicaid managed care, and dual eligible (Medicare/Medicaid) claims.

## Performance Measure CP1

Q: What is the reporting score impact if the hospital did not have any admissions with a particular chronic condition (i.e. COPD) for CP1 (pediatric) and therefore needs to report 0?

A: The individual chronic conditions reported under CP1 (pediatric) will be allowed numerator entries of zero if there were no admissions with that particular condition. A numerator greater than zero is required for the primary measure (readmissions for any chronic condition) in order for the data submission to be considered complete.

Q: Are patients with a primary diagnosis of COVID at admission and readmission excluded from the readmission data set?

A: No, COVID patients are not excluded.

## Performance Measure CP6

Q: CP6 - Does this measure require that we screen patients that are pre or postnatal patients in the ED?

A: Yes

Q: When it says (60) days, is this only referring to the postpartum period and NOT perinatal (the sentence almost makes it seem like both)? If so, does this mean screening needs to happen within 60 days of birth to fit within this measure? Additionally, how often do we need to complete these screenings?

A: 60 days is referring to the postpartum period. 60 days after the baby is delivered.

Q: How often do we need to complete these screenings? Does screening have to be done for every visit?

A: The screen should be repeated for every visit if the prior screen was negative. If a screen is positive, no need to repeat in subsequent visits.

Q: For OP claims, are encounters for ancillary services like lab or imaging included or is this just specifically for OP ED or observation type visits in our inpatient units?

A: We are only looking at IP and OP hospital claims, not clinic visits or lab work.

Q: For CP6 (Pregnancy Screening Anxiety and/or Depression), our teams wanted to know what counts as outpatient hospital claims (OP). Would Observation and ED discharge?

A: Yes both would count as they are reported on Outpatient claims.
8.300.3.B Covered Hospital Services – Outpatient Hospital Services are a Medicaid benefit when determined Medically Necessary and provided by or under the direction of a physician. Outpatient Hospital Services are limited to the scope of Outpatient Hospital Services as defined in 42 C.F.R. Section 440.20. 1. Observation Stays Observation stays are a covered

benefit as follows: a. Clients may be admitted as Outpatients to Observation Stay status. b. With appropriate documentation, clients may stay in observation more than 24 hours, but an Observation Stay shall not exceed forty-eight hours in length. c. A physician's order must be written prior to initiation of the Observation Stay. d. Observation Stays end when the physician orders either Inpatient admission or discharge from observation. e. An Inpatient admission cannot be converted to an Outpatient Observation Stay after the client is discharged. 2. Outpatient Hospital Psychiatric Services Outpatient psychiatric services, including prevention, diagnosis and treatment of emotional or mental disorders, are Medicaid benefits at DRG Hospitals. a. Psychiatric outpatient services are not a Medicaid benefit in free-standing psychiatric hospitals. 3. Emergency Care a. Emergency Care Services are a Medicaid benefit, and are exempt from primary care provider referral. b. An appropriate medical screening examination and ancillary services such as laboratory and radiology shall be available to any individual who comes to the emergency treatment facility for examination or treatment of an emergent or apparently emergent medical condition and on whose behalf the examination or treatment is requested.

## Performance Measure CP7

Q: Do telehealth services count for expanding access to specialty care?

A: While we do have a separate telehealth measure for HTP, we would also accept telehealth visits as an appropriate approach for providing access to specialists.

## Performance Measure PH1

Q: If a patient has an inpatient visit and their primary care provider is from outside of our hospital district (we have an associated Rural Health Clinic with PCP's) are those excluded? We can't know if they have a wellness visit if it is outside of our system

A: No they aren't excluded. PH1 is claims based so HCPF is pulling that information from Medicaid claims. The intervention is based on how the hospital plans to increase well visits. Measurement will be based on claims and hospital won't have to report.

## Performance Measure RAE Notification Measures

Q: RAEs don't know what information they want. Is this something hospitals need to determine?

A: HCPF will be sending a flat file to indicate exactly what data is needed for applicable measures.

## Performance Measure RAH1

Q: If a patient is refusing to allow the hospital to make a follow up appointment at discharge, as the measure requires, can this be excluded from the measure denominator?

A: The measure will not exclude these patients from the denominator. The measure does not expect 100% performance for earning at-risk and does not measure follow up appointment completion.

Q: The measure states "Hospitals will submit a report listing all Medicaid patient discharges and documenting follow up appointment and RAE follow up status for each admission." Does this only apply to telemedicine visits, or the entire RAH1 population?

A: The measure does apply to the entire RAH1 population, not solely telemedicine visits.

## Performance Measure RAH4

Q: What are the state's thoughts on CMS's retirement of STK-06 (aka RAH4 data source) and the expectations for benchmarks/performance as it relates to the data source in future years after this is retired?

A: CMS was previously listed as the measure steward. While CMS is retiring the measure from certain Federal programs to focus on other priority areas, it is still a valuable and active measure. The measure steward will be corrected to the Joint Commission.

## Performance Measure SW-BH1

Q: Can you please provide additional details or an example of how to execute a mutual discharge plan with the RAE for every patient with a primary or secondary mental illness or SUD diagnosis? What constitutes a ‘mutually agreed upon discharge plan’? There is an extremely high volume of patients with secondary mental illness or SUD diagnoses seen in the ED. Many patients have a secondary diagnosis of Nicotine dependence, but are seen for an unrelated injury. I am not sure how staff will connect with the RAE to plan the discharge for all of these patients.

A: Mutually agreed upon does not mean the discharge planning process has to be mutually executed between the hospital and the RAE every time there is a discharge. It also doesn't mean the patient has to agree with hospital and RAE. We want to emphasize the importance of collaboration with the hospital and RAE on the front end. These two parties agree on how the discharge process is going to work.

Q: Obtaining coding that will give us our primary or secondary diagnosis will never occur within one business day - allowing us to notify the RAE within one business day - our coding usually takes 72 hours at a minimum. How is this concern being mitigated?

A: Hospitals should use admission diagnosis/ reason for visit rather than final diagnosis.

Q: Very rarely will you see someone with SUD as an admission diagnosis. How should that be handled for SW-BH1?

A: That is a great point and a reason why the intervention is important - to help identify these conditions as soon as possible.

Q: The measure specifications indicate notifying the RAE of principal/secondary dx of mental illness or SUD within one business day. Is this referring to one business day of discharge?

A: Yes, that is correct one business day from discharge.

Q: Does marijuana and tobacco count as substances for pregnant patients?

A: The measure does not differentiate between maternal and other patients. The patient needs to have a diagnosis of SUD. The diagnosis codes are listed in the HTP measure specs and are in line with the covered services under the Regional Accountable Entities.

Q: The measure specs discuss patients discharged from the hospital or emergency department. We're assuming hospital is referring to the inpatient setting; however, does this also include observation?

A: The measure includes inpatient and emergency department patients discharged to home. If observation is occurring in the emergency department those patients can be included. If patients are seen in a non-ED outpatient setting they should not be included. If the observation results in an inpatient admission, they can be included.

Q: For patients who are transferred to a behavioral health facility, are they also included in this measure? Meaning we are to notify the RAE within one business day of transfer?

A: The measure only includes patients discharged to home. Transfers are not included.

## Performance Measures SW-BH3

Q: Would Suboxone count towards ALTOs for patients with SUD? Will it be one of the medications that are part of opioid lists?

A: Generally speaking, CHA is aware that there are some medications, both ALTOs and Opioids that may not be captured in the measure specifications document that hospitals will use over the course of the next 5 years. However, when CHA originally compiled that list, they aimed to include the most frequently used ALTOs and Opioids. For hospitals to continue to be judged on the same medications throughout the course of the program, CHA has tended to not amend the ALTO and opioid lists as they believe the current list meets the intended goal. Further, since Suboxone is technically an opioid that is typically used to treat OUD and very rarely for analgesia is does not really fit the criteria of a medication that would be part

of this measure. If you have any additional questions or concerns about this though, please reach out to the CHA.

Q: For the ICD-10 CM primary and secondary codes ranges, will we get a more specific list so that our teams know if any diagnoses are excluded?

A: Although we do list inclusion and exclusion code ranges, effectively any diagnoses that are not in the inclusion criteria are excluded.

## Performance Measure SW-CP1

Q: Do hospitals have to identify if the patient “refuses” to take the screener? Or is the denominator based only on those who elected to be screened?

A: If a patient refuses screen for all 5 screening domains, they can be excluded entirely from the measure. However, if the patient answers screening questions for 1 or more domains, the screen should be included in the measure.

Q: If we've done a social needs screening through the clinic, but a patient is being seen in the ED, does the clinic SDoH screen count? Or does the ED need to conduct a new screen to meet the SW-CP1 metric? To elaborate, since our ED and clinics both use EPIC, the ED would be able to see in EPIC that the social needs screener has been completed.

A: A new social needs screen should be conducted for every new visit. Prior screens can and should be reviewed to allow for a more meaningful conversation with the patient regarding their needs.

Q: Are there any recommended practices for screening patients under 18?

A: When screening patients under 18 years of age, the legal guardian can prepare the screening.

Q: When hospitals are calculating SDoH numbers, are they counting patients that have been screened in all five domains and then reporting them by domain, or are they reporting patients that might have a "partial" screening and reporting the domains in which they are screened positive? Which would be correct for HTP?

A: The only excluded demographics are those who refuse the screening, and patients that are unable to complete the screening. If the patient completes screening questions for one or more domains, the screen should be included in the measure.

Q: Does a partial screen factor into the numerator value? If a patient was only screened in one domain, screened positive, and not screened in any other domain, do we report them as positive in this domain and include them in the performance?

A: Yes the patient would be included, if patient refuses the other items. If the hospital does not have a screener for all domains and is choosing to only screen in one domain as a hospital choice, then none of the screens would count toward the numerator.

## Performance Measure SW-COE1

Q: What is the target population for the Hospital Index measure?

A: The target population at the broadest level consists of Medicaid patients that receive services under the associated procedural codes.

Q: Does the Hospital Index tool drill down to the Medicaid population?

A: Yes, the tool includes the Medicaid population and can drill down to claim and patient-level detail, including episodes.

Q: Is the intervention relating to the process hospitals put in place to address the data in the Hospital Index as opposed to the outcomes?

A: The intervention for the Hospital Index measure is how hospitals are using the tool to build a continuous learning and improvement environment. It should result in informing delivering of care downstream. The intervention should be addressing those processes the hospital puts in place to use the data to inform care delivery, not on outcomes within the procedure types.

Q: When will Hospital Index be updated with more current data, and how current will it be?

A: Data updates during the HTP will be every April. There are multiple updates and revisions as part of the data dress rehearsal so the update for 2022 will be in June.

Q: What is the benchmark for the Hospital Index measure? Is the goal a score of 100 for everyone?

A: There will be no benchmark for PY3 and all at-risk will be granted. The benchmark for PY4 and PY5 will be performance against the Index benchmark of 100.
If your hospital score is higher than 100 then you have actionable costs that are higher than the average and if your hospital score is lower than 100 you are performing better. The initial Index of 100 will be fixed and not recalculated each year so that hospitals' performance can be measured against a fixed target.

Q: In the implementation plan for the hospital index, some of the data requested is on race to further evaluate the top 5 episodes to improve. We noticed that data is not included in the hospital index. Do you have any insight on where or how we can find this data?

A: There are filters/toggles available within the dashboards for race/ethnicity, age, and gender. Episodes can also be filtered by Category of Service.

Q: Where should hospitals direct questions related to the Hospital Index?

A: Please direct all hospital index measure questions to HCPF_prometheus@state.co.us.

Q: For submission of summary of care documents, we have noticed the upload can include a large number of pages due to inclusion of lab data. Does the Department have additional guidance on this moving forward? How will this affect hospital reporting?

A: CMS' guidance around meaningful use requires a provider to have the ability to send all laboratory test results in the summary of care document. However, the provider may work with their system developer to establish clinically relevant parameters based on their specialty, patient population, or for certain transitions and referrals that allow for clinical relevance to determine the most appropriate results for given transition or referral, rather than submitting the totality of the Summary of Care documents. A provider who limits the results in a summary of care document must send the full results upon the request of the receiving provider or upon the request of the patient.

## Performance Measure SW-PH1

Q: Are the following populations included in this measure: IP rehab, newborns, BH Stays?

A: Yes, inpatient settings include inpatient hospitals, birthing centers, inpatient psychiatric facilities, and residential substance abuse treatment facilities.

## Performance Measures: COE2

Q: In what settings do we need to be improving telemedicine? Would it be primary care, inpatient, ED? Would a brief telehealth consult in a department in which we do not utilize telemedicine, qualify?

A: We want the trigger to be hospital patients. The provision of telemedicine could be in the clinic if owned/operated by the hospital, IP, or ED but does not have to occur in every setting. We are looking that hospitals will be expanding access in some way from the baseline to better than the benchmark. Consults would not qualify under the measure as that is a separate measure in HTP. We are looking for encounters between a clinician and a patient that meets the same standard of care as an in-person visit.

## Performance Measures: SW-BH1

Q: Where are the HTP 'Value Sets' specified in the measure specifications located?

A: The department evaluates value sets according to HEDIS specifications. These specifications can be found on the NCQA (National Committee for Quality Assurance) website:

https://store.ncqa.org/hedis-my-2022-risk-adjustment-tables.html

## Performance Measures: RAH2

Q: Is there anything saying for ED Level 4-5 to have a 30 day follow up with patient's PCP after discharge home within one's RAE.

A: RAH2 is for any Medicaid patients seen. The follow up does not necessarily need to be with a PCP.