Colorado Hospital Transformation Program (HTP)

Performance Measures Specifications

January 8, 2025

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Contents

I. General Guidance

Setting - Measures that are applicable to the inpatient setting exclude observation patients, unless otherwise noted.

Target Population – 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.

Pediatric patients will include ages 0-18 years except where indicated.

Timing and Time Interval – Each measure should collect and evaluate performance from October 1 through September 30 of each year, unless otherwise noted.

Age – The target population for certain measures includes a specified age range. Age is calculated based on the age of the patient at the date of discharge.

II. Measure Field Definitions

Definition – Defines the objective and parameters of the measure.

Measure Steward – Defines the health care entity that developed and maintains the detailed specification information regarding the measure. The National Quality Forum (NQF) code, or measure steward code reference may also be indicated.

Data Source – Defines the source of the measure information. This field will be either (1) Hospital self-reported data; or (2) Medicaid claims.

Numerator - Defines the specific criteria that identifies the portion of the patient population that meet the specific performance measurement.

Denominator - Defines the criteria which identifies the patient population eligible for measurement.

Exclusions – Defines the criteria that is removed from the measure count.

Target Population Notes – Indicates any additional population clarification.

Data Elements, Code Systems, Code Lists, Value Sets – Provides detailed information relative to the numerator and/or denominator criteria.

Risk Adjustment – Defines whether adjustment is applied to the measure.

Calculation Type (mode) - Defines the calculation type, typically a percentage, rate, or count.

- A percentage calculation measures the number of a certain set of events that are proportional to one another. The numerator and denominator are the same unit of measurement, and the numerator is a subset of the denominator.
- A rate is a specific kind of ratio, in which two measurements are related to each other but do not utilize the same unit of measurement. The numerator is not a subset of the denominator when a rate is calculated. A rate measures the number of events compared to another unit of measurement, for example the utilization per member months.

- A count is a simple sum of the actions that qualify for inclusion. For HTP measures, this can be a count of patients, visits, or days, depending on the measure.

Additional Considerations - Offers any additional information for clarification of measure reporting.

Benchmark Information – Defines the benchmark approach for baseline, PY3, PY4 and PY5.

III. Reducing Avoidable Hospitalization Utilization

SW-RAH1 - 30 Day All Cause Risk Adjusted Hospital Readmission

Definition: For Medicaid patients 18 years of age and older (18-64 years), the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

This measure is reported as the ratio of observed readmissions to expected readmissions based on risk adjustment for patient severity.

Measure Steward: NCQA - NQF 1768

Data Source: Medicaid Claims

Numerator: Count of observed 30-day Medicaid readmissions.

Count of observed 30-day Medicaid readmissions after a previous index admission. Each Medicaid readmission that also meets denominator criteria becomes a new index admission, and the 30-day counter starts again. Count a single readmission only once for the last Index admission if the single readmission is within 30 days of multiple index admissions.

Medicaid readmission: A Medicaid acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous Medicaid index admission discharge date.

Denominator: Count of expected 30-day Medicaid readmissions based on estimated readmission risk for each index admission.

Medicaid Index Admission: A Medicaid acute inpatient or observation stay.

Actual Readmission: Count of observed 30-day Medicaid readmissions after a previous index admission. Each Medicaid readmission that also meets denominator criteria becomes a new index admission, and the 30-day counter starts again. Count a single readmission only once for the last Index admission if the single readmission is within 30 days of multiple index admissions.

Expected Readmission: Count of expected 30-day Medicaid readmissions based on estimated readmission risk for each index admission.

This measure will be reported out as a ratio of actual readmission count to expected readmission count. A score over 1 indicates readmissions are higher than predicted based on estimated readmission risk for each index admission, a score less than 1 indicates that readmissions are lower than predicted based on estimated readmission risk for each index admission.

Exclusions:

- Patients with Medicare enrollment at any point 365 days prior to a discharge date through 30 days after the discharge date.
- Patients with Third Party Insurance at any point 365 days prior to a discharge date through 30 days after the discharge date.
- Patients with Managed Care at any point 365 days prior to a discharge date through 30 days after the discharge date.
- Patients with Emergency Medicaid at any point 365 days prior to a discharge date through 30 days after the discharge date.

Numerator:

Readmission: An acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous index admissions' discharge date

- Identify all Medicaid inpatient and observation stays (Observation Stay Value Set).
- Exclude Medicaid nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
- Exclude Medicaid acute inpatient hospital admissions with any of the following on the discharge claim:
    - ✓ Female members with a principal diagnosis of pregnancy (Pregnancy Value Set).
    - ✓ A principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).
    - ✓ Planned admissions using any of the following:

- A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set).
- A principal diagnosis of rehabilitation (Rehabilitation Value Set).
- An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set).
- A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

Denominator:

Index Admission: An acute inpatient or observation stay.

- Identify all Medicaid Index Admissions (inpatient stays, and observation stays included in the Observation Stay Value Set).
- Exclude Medicaid nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
- Exclude Medicaid hospital stays where the index admission date is the same as the index discharge date.
- Exclude Medicaid hospital stays for the following reasons:
  - ✓ The member dies during the stay
  - ✓ Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim
  - ✓ A principal diagnosis of a condition originating in the perinatal period (Perinatal Condition Value Set) on the discharge claim
- Exclude hospital stay with Discharge Status Codes on the discharge claim
  - ✓ 04 Discharged/transferred to a Facility that Provides Custodial or Supportive Care
  - ✓ 07 Left Against Medical Advice or Discontinued Care
  - ✓ 20 Expired
  - ✓ 30 Still a patient
  - ✓ 31 Still a Patient, Waiting Transfer
  - ✓ 32 Still a Patient, Waiting Placement

- ✓ 40 Expired at Home
- ✓ 41 Expired in Medical Facility
- ✓ 42 Expired - Place Unknown
- ✓ 43 Discharged/transferred to Federal Health Care Facility
- ✓ 51 Hospice - Medical Facility (Certified) Providing Hospice Level of Care
- ✓ 61 Discharged/transferred to a Hospital-Based Medicare Approved Swing Bed
- ✓ 62 Discharged/transferred to an Inpatient Rehabilitation Facility including Rehabilitation
- ✓ 63 Discharged/transferred to a Medicare Certified Long Term Care Hospital (LTCH)
- ✓ 64 Discharged/transferred to a Nursing Facility Certified under Medicaid but not Certified under Medicare
- ✓ 65 Discharged/transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital

Do not exclude chronic conditions from all-cause readmission as per HEDIS specification.

Target Population Notes:

- Adult Medicaid (primary) patients, ages 18-64 as of the Index Discharge Date
- Continuous enrollment 365 days prior to the Index Discharge Date through 30 days after the index discharge date. No more than 45 total days gap in enrollment during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
- Hospice exclusion, Medicaid patients in hospice or using hospice services anytime during the measurement year were excluded by using HEDIS (Hospice Encounter Value Set, Hospice Intervention Value Set)
- Non-outlier Medicaid patients, Medicaid patients with four or more index admissions during the measurement year are outliers

Data Elements, Code Systems, Code Lists, Value Sets: Per HEDIS specification, except:

- Additional discharge status codes were excluded from the denominator

- To pull Medicaid inpatient stays, claim type code ('A', 'I') which are inpatient crossover claim and inpatient claim respectively, and billing provider type code '01' used instead of HEDIS (Inpatient Stay Value Set) revenue codes. We are including all Observation Stays as defined by HEDIS (Observation Stay Value Set) regardless of claim type code
- For the Risk Adjustment Comorbidity Category Determination, inpatient events were defined using claim type code ('A', 'I') which are inpatient crossover claim and inpatient claim respectively, instead using HEDIS (Nonacute Inpatient Value Set, Acute Inpatient Value Set, Inpatient Stay Value Set). Outpatient, Telephone, observation, and ED visits were identified using the HEDIS (Outpatient Value Set, Telephone Visits Value Set, Observation Value Set, ED Value Set)
- For the Surgery Risk Adjustment Determination, all Index admission with a surgery procedure code were assigned the surgery weight instead using the HEDIS (Surgery Procedure Value Set)

Risk Adjustment: For each Index admission among non-outlier members, use the following steps to identify risk adjustment categories based on presence of observation stay status at discharge, surgeries, discharge condition, comorbidity, age, and gender.

- Observation Stay: Determine if the Index admission at discharge was an observation stay (Observation Stay Value Set). For direct transfers, determine the hospitalization status using the last discharge.
- Surgeries: All Index admission with a surgery procedure code were assigned the surgery weight
- Discharge Condition: Assign a discharge Clinical Condition (CC) category code or codes to the Index admission based on its principal discharge diagnosis, using Table CC_Mapping. For direct transfers, use the principal discharge diagnosis from the last discharge. Exclude diagnoses that cannot be mapped to Table CC_Mapping.
- Comorbidities Refer to the Risk Adjustment Comorbidity Category Determination in the Guidelines for Risk Adjusted Utilization Measures.

PCR Risk Adjustment Tables from: https://store.ncqa.org/hedis-my-2022-risk-adjustment-tables.html

Calculation Type: Per HEDIS specification

Additional Considerations: Hospital score will be based on index admissions at their institutions. Readmissions include admissions to any hospital.

Benchmark Information:

- The benchmark for PY3 will be .85.
- The benchmark for PY4 will be .85.
- The benchmark for PY5 will be .85.

SW-RAH2 - Pediatric All-Condition Readmission Measure

Definition: This measure is a case-mix-adjusted readmission rate, defined as the percentage of admissions followed by 1 or more readmissions within 30 days, for patients less than 18 years old adjusted to reflect the readmission rate the hospital would have if it treated a patient cohort with the case mix composition of all eligible index admissions within the national hospital dataset used for analysis. Case mix adjustment follows methodologies developed by the Center of Excellence for Pediatric Quality Measurement.

Measure Steward: Center of Excellence for Pediatric Quality Measurement

Data Source: Hospital Self-report (Pediatric Health Information System (PHIS™), Children's Hospital Association)

Numerator: Number of Medicaid index admissions at general acute care hospitals for patients less than 18 years old that are followed by one or more readmissions to general acute care hospitals within 30 days.

Denominator: Total number of Medicaid index admissions

The actual hospital rate above is adjusted by the Pediatric Center of Excellence protocol to the readmission rate a hospital would have if it treated a patient cohort with the case mix composition of all eligible index admissions within the national hospital dataset used for analysis (PHIS). That case mix adjusted readmission rate follows case mix adjustment methodologies from the Pediatric Center of Excellence national dataset.

Exclusions:

Numerator: Readmissions for a planned procedure or for chemotherapy.

Denominator: Certain hospitalizations based on clinical criteria or for issues of data completeness or quality that could prevent assessment of eligibility for the measure cohort or compromise the accuracy of readmission rates. In addition, hospitalizations are excluded from the measure entirely if they meet specified clinical or data quality criteria, including: primary diagnosis for a mental health condition, hospitalization for birth of a healthy newborn, or hospitalization for obstetric care.

Exclusion Detail:

- The patient was 18 years old or greater at the time of admission.
- The hospitalization was for birth of a healthy newborn.
- The hospitalization was for obstetric care, including labor and delivery.
- The primary diagnosis code was for a mental health condition.
- The hospitalization was at a specialty or non-acute care hospital.
- The discharge disposition was death.
- The discharge disposition was leaving the hospital against medical advice.
- Patients who were in an observation stay.
- Records for the hospitalization contain incomplete data for variables needed to assess eligibility for the measure or calculate readmission rates, including hospital type, patient identifier, admission date, discharge date, disposition status, date of birth, primary diagnosis code, or gender.
- The hospital is in a State not being analyzed. (Records for these hospitalizations are still assessed as possible readmissions, but readmission rates are not calculated for the out-of- State hospitals due to their lack of complete data.)
- Thirty days of follow-up data are not available for assessing readmissions.
- The hospital has less than 80 percent of records with complete patient identifier, admission date, and discharge date or less than 80 percent of records with complete primary diagnosis codes. (Records for these hospitals are still assessed as possible readmissions, but readmission rates are not calculated for these hospitals due to their lack of complete data.)
- Records for the hospitalization contain data of questionable quality for calculating readmission rates, including:

- ✓ Inconsistent date of birth across records for a patient.
- ✓ Discharge date prior to admission date.
- ✓ Admission or discharge date prior to date of birth.
- ✓ Admission date after a discharge status of death during a prior hospitalization.

- Codes other than International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) procedure codes or International Classification of Diseases, Tenth Revision, Procedure Coding Systems (ICD-10-PCS) procedure codes are used for the primary procedure.

Target Population Notes: Pediatric Medicaid patients less than 18 years of age. PHIS data includes any case with a Medicaid primary payor, which may include pending Medicaid, Medicaid managed care, Emergency Medicaid, and dually eligible Medicaid-Medicare patients.

Data Elements, Code Systems, Code Lists, Value Sets: Per Center of Excellence for Pediatric Quality Measurement

Risk Adjustment: The hospital's actual readmission rate is adjusted to reflect the readmission rate the hospital would have if it treated a patient cohort with the case mix composition of all eligible index admissions within the PHIS dataset following the CEPQM methodology.

Calculation Type: The readmissions algorithm and adjustment methodology are a SAS program that was developed based on the specification provided by the Center of Excellence for Pediatric Quality Measurement.

Additional Considerations:

- For pediatric hospitals only.
- Hospitals included in the PHIS data set may include both in-state and out-of-state Medicaid in their reported data; therefore, hospitals reporting data for this measure may also include both in-state and out-of-state Medicaid to align with the data set utilized for setting benchmarks.

Benchmark Information: The benchmark will be set from the national PHIS data set for the HTP baseline period Oct. 1, 2021 – Sept. 30, 2022.

- The benchmark for PY3 will be the mean of the national data set which is 6.36%
- The benchmark for PY4 will be the mid-point between the mean and the top quartile of the national data set which is 6.07%
- The benchmark for PY5 will be the top quartile of the national data set which is 5.77%

RAH1 – Follow up Appointment with a Clinician and Notification to the Regional Accountable Entities (RAE) within One Business Day

Definition: Percentage of Medicaid patients discharged from an inpatient admission to home with a documented follow up appointment with a clinician and notification to the RAE within one business day.

A documented follow up appointment or notification to the RAE within one business day alone is not considered adequate for this measure. The measure is reported as one overall score counting in the numerator only those patients who receive both a documented follow up appointment AND notification to their RAE within one business day.

Measure Steward: Colorado Department of Health Care Policy and Financing

Data Source: Hospital self-reported data

Numerator: Medicaid patients discharged to home from an inpatient admission with a follow up appointment documented in the medical record and notification to their RAE within one business day. Patients who do not receive both a documented follow up appointment and notification to their RAE within one business day are excluded from the numerator.

Denominator: Medicaid patients discharged to home from an inpatient admission.

Exclusions:

- Patients discharged Against Medical Advice (AMA).
- Patients discharged to home hospice
- Patients receiving inpatient hospice care.

Target Population Notes: Adult and Pediatric Medicaid (primary) patients

Data Elements, Code Systems, Code Lists, Value Sets:

- EMR or patient record data extraction or chart review documenting follow up appointment and RAE.
- Discharge counts.

Risk Adjustment: Not applicable

Calculation Type: Percentage

Additional Considerations: This will require a hospital to work collaboratively with the primary RAE to identify appropriate follow up clinician and facilitate appointment access and scheduling in addition to determining appropriate protocols and standards for reporting. Clinicians includes physicians, nurse practitioners, physician assistants, nurses, and other allied health professionals.

Telehealth appointments are acceptable to meet this measure. Hospitals will submit a report listing all Medicaid patient discharges and documenting follow up appointment and RAE follow up status for each admission.

Benchmark Information:

- The benchmark for PY3 will be 80%
- The benchmark for PY4 will be 85%
- The benchmark for PY5 will be 90%

RAH2 – Emergency Department (ED) Visits for which the Member Received Follow up within 30 days of the ED Visit

Definition: Percentage of level 4 and 5 Medicaid patient emergency encounters where the patient is discharged to home in which the patient has a follow up visit with a clinician within 30 days of discharge.

Measure Steward: Colorado Department of Health Care Policy and Financing

Data Source: Medicaid Claims

Numerator: Medicaid patients with a level 4 or 5 emergency encounter discharged to home with a follow up visit with a clinician within 30 days.

Denominator: Medicaid patients with a level 4 or 5 emergency encounter discharged to home.

Exclusions:

- Patients that are discharged AMA or discontinued care.
- Patients not continuously enrolled for 30 days after the ED visit.
- Patients that are enrolled in Medicare at any point from the ER visit through the 30 day follow up window.
- Patients with a third-party insurance at any point from the ER visit through the 30 day follow up window.
- Patients with a Managed Care at any point from the ER visit through the 30 day follow up window.
- Patients with Emergency Medicaid at any point from the ER visit through the 30 day follow up window.
- ER visits are excluded from the numerator.

Target Population Notes: Adult and Pediatric Medicaid (primary) patients

Data Elements, Code Systems, Code Lists, Value Sets:

- ED level 4 and 5 codes are 99284 and 99285
- Ambulatory visit defined by specific E&M codes or provider types
- The numerator (i.e., the Follow-ups) are identified based on the following criteria:
    - ✓ Procedure Codes in ('99201','99202','99203','99204','99205','99211','99212','99213', '99214','99215','99304','99305','99306','99307','99308','99309', '99310','99311','99312','99313','99315','99316','99318','99341', '99342','99343','99344','99345','99347','99348','99349','99350', '99381','99382','99383','99384','99385','99386','99387','99391', '99392','99393','99394','99395','99396','99397','99401','99402', '99403','99404','99406','99407','99408','99409','99411','99412', '99415','99416','99420','99429','99460','99461','99463') OR

- ✓ Billing Provider Type in (‘32’,’45’,’61’) - which are FQHC, RHS, and IHS respectively OR
- ✓ Rendering Provider Type in ('32','45','61') - which are FQHC, RHS, and IHS respectively

Risk Adjustment: Not applicable

Calculation Type: Percentage

Additional Considerations:

- This measure would require hospitals to work with the primary RAE to ensure optimal patient access and follow up.
- Additional claim type definition
  - ✓ Claim Type Code include Outpatient crossover Claims (C), Outpatient Claims (O) and Revenue Code include ('0450','0451','0452','0456','0459','0981') or
  - ✓ Claim Type Code include Professional crossover Claims (B), Professional Claims (M) and Procedure Codes between '99281' AND '99285' or
  - ✓ Claim Type Code include Professional crossover Claims (B), Professional Claims (M) and Place of Service Code = ‘23’ and (Procedure Code between '10021' AND '69979' or Procedure Code = '69990')
- Eligibility
  - ✓ Health Program Code used include ‘MEDA’, ‘MEDB’ for Medicare exclusion
  - ✓ Excluded Title XIX Aid Codes are F3 and F4 (QMB/SLMB)
  - ✓ Excluded Aid Codes include 'N1', 'N2', 'N4', 'K2', 'K7', 'F3', 'F4'

Benchmark Information:

Greater than 10 hospitals selected this measure:

- The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1 (baseline), which is 67.2%
- The benchmark for PY4 will be 5% improvement of the PY3 benchmark, which is 70.5%

- The benchmark for PY5 will be 5% improvement of the PY4 benchmark, which is 74%

RAH3 - Home Management Plan of Care (HMPC) Document Given to Pediatric Asthma Patient/Caregiver

Definition: An assessment that there is documentation in the medical record that a Home Management Plan of Care (HMPC) document was given to the pediatric asthma patient/caregiver.

Measure Steward: The Joint Commission

Data Source: Hospital self-report

Numerator: Pediatric asthma inpatients with documentation that they or their caregivers were given a written Home Management Plan of Care (HMPC) document that addresses all of the following:

- Arrangements for follow-up care
- Environmental control and control of other triggers
- Method and timing of rescue actions
- Use of controllers
- Use of relievers

Denominator: Pediatric asthma inpatients (age 2 years through 17 years) discharged with a principal diagnosis of asthma.

Exclusions:

- Patients discharged AMA.
- Patients with an age less than 2 years or 18 years or greater
- Patients who have a Length of Stay greater than 120 days
- Patients enrolled in clinical trials

Target Population Notes: Pediatric all payor patients ages 2 through 17 years

Data Elements, Code Systems, Code Lists, Value Sets:

- Patient record data or chart extraction documenting HMPC
- Discharge counts

Risk Adjustment: Not applicable

Calculation Type: Percentage

Additional Considerations: None

Benchmark Information:
10 or less hospitals selected this measure:

- The benchmark for PY3 will be 80%
- The benchmark for PY4 will be 85%
- The benchmark for PY5 will be 90%

RAH4 – Percentage of Patients with Ischemic Stroke who are Discharged on Statin Medication (Joint Commission STK-06)

Definition: This measure captures the proportion of ischemic stroke patients who are prescribed or continuing to take statin medication at hospital discharge.

Measure Steward: The Joint Commission

Data Source: Hospital self-report

Numerator: Inpatient hospitalizations for patients prescribed or continuing to take statin medication at hospital discharge.

Denominator: Inpatient hospitalizations for patients with a principal diagnosis of ischemic stroke.

Exclusions:

- Inpatient hospitalizations for patients admitted for elective carotid intervention. This exclusion is implicitly modeled by only including non-elective hospitalizations.
- Inpatient hospitalizations for patients discharged to another hospital.
- Inpatient hospitalizations for patients who left against medical advice.
- Inpatient hospitalizations for patients who expired.
- Inpatient hospitalizations for patients discharged to home for hospice care.

- Inpatient hospitalizations for patients discharged to a health care facility for hospice care.
- Inpatient hospitalizations for patients with comfort measures documented.
- Less than 18 years of age.
- Length of Stay greater than 120 days.
- Patients enrolled in clinical trials
- Patients with a reason for not prescribing statin medication at discharge

Target Population Notes: Adult all payor patients

Data Elements, Code Systems, Code Lists, Value Sets: Per TJC specifications https://manual.jointcommission.org/releases/TJC2022A/MIF0131.html

Risk Adjustment: Not applicable

Calculation Type: Percentage

Additional Considerations: This measure is a part of a set of eight nationally implemented measures that address stroke care (STK-1: Venous Thromboembolism (VTE) Prophylaxis, STK-2: Discharged on Antithrombotic Therapy, STK-3: Anticoagulation Therapy for Atrial Fibrillation/Flutter, STK-4: Thrombolytic Therapy, STK-5: Antithrombotic Therapy By End of Hospital Day 2, STK-8: Stroke Education, and STK-10: Assessed for Rehabilitation) that are used in The Joint Commissions hospital accreditation and Disease-Specific Care certification programs.

Benchmark Information:

- The benchmark for PY3 will be 95%
- The benchmark for PY4 will be 95%
- The benchmark for PY5 will be 95%

IV. Core Populations

SW-CP1 – Social Needs Screening and Notification

Definition: Measurement of the number of Medicaid patients discharged to home from an inpatient admission who have formal social needs screening done during the admission, with results documented in the medical record and, if there is a positive social needs screen, referral/referral information as appropriate and available, and notification to the RAE for notification domains utilizing a process that is mutually agreed upon with the RAE that includes indicating which of the notification domains needs were identified.

A patient with a positive social needs screen must receive a referral/referral information as appropriate and available, and the RAE notified of any positive screens within the notification domains for the patient to be considered having met this measure and included in the numerator. Screening alone without referral/referral information as part of the intervention and RAE notification for a patient who screens positive is not considered adequate for this measure.

Social needs screening should include at a minimum, five core domains consisting of housing instability; food insecurity; transportation problems; utility help needs; and interpersonal safety. Hospitals will report the number of identified needs in each of the 5 domains.

The notification domains for the measure are: housing instability; food insecurity; transportation problems; and utility help needs. Interpersonal Safety is not a notification domain and patient level information regarding positive screens for interpersonal safety should not be sent to the RAE.

Measure Steward: Colorado Department of Health Care Policy and Financing

Data Source: Hospital self-report

Numerator: Number of Medicaid patients discharged to home from an inpatient admission who have formal social needs screening done during the admission, with results and if the screen is positive, referral/referral information as appropriate and available, and notification to the RAE of the positive screens within the notification domains including which domains where needs were identified.

The numerator consists of the total number of patients screened who do not have positive screen and patients with positive screens and the RAE notified of positive screens for the notification domains where needs were identified. Patients who screen positive in the notification domains where no notification to the RAE occurs are excluded from the numerator.

Denominator: Medicaid patients discharged to home with an inpatient admission.

Exclusions:

- Patients discharged AMA.
- Patients discharged to home hospice
- Patients receiving inpatient hospice care.
- Patient refusal/not capable for all 5 screening domains. If the patient answers screening questions for 1 or more domains, the screen should be included in the measure.

Target Population Notes: Adult and Pediatric Medicaid (primary) patients

Data Elements, Code Systems, Code Lists, Value Sets:

- Patient record data extraction or chart review documenting screening and referral notification
- Discharge counts

Risk Adjustment: Not applicable

Calculation Type: Percentage

Additional Considerations: This measure incents hospitals to implement screening for social needs and to work collaboratively with their community and their primary RAE to increase the options for and number of referrals to community-based agencies to address social needs. The reporting measurement requires the total number of positive screens to be reported and which domains needs were identified in. The referral/referral information process is not a reporting element of the measure.

If a patient answers some questions of a screen and refuses/not capable for others, it is still considered a completed screen for reporting in the numerator.

Hospitals shall engage and work with Community Based Organizations and employ best practices for referral/referral information with particular attention to best practices in regard to interpersonal safety needs.

A hospital can utilize a previous screen for discussing social needs with a patient during the inpatient encounter and is considered an updated current screen. Any previously identified social needs still present or new needs identified shall be notified to the RAE including which domains. This will allow for a more meaningful conversation with the patient regarding their needs.

For a patient who is being discharged after childbirth, the screen is for the mother if the mother is covered by Medicaid or the child if only the child is covered by Medicaid. Medicaid Pending and Emergency Medicaid should be excluded.

Measure performance will be based on the total percentage of screens and notifications to the RAE, where applicable, as defined in the numerator; however, the following counts are also required to be reported:

1. Total number of screens conducted that result in identified needs in any domain
2. Total number of screens identifying housing instability needs
3. Total number of screens identifying food insecurity needs
4. Total number of screens identifying transportation problem needs
5. Total number of screens identifying utility help needs
6. Total number of screens identifying interpersonal safety needs

Positive screen results are to be counted in each domain area. If multiple domains are identified during a screening, a count will be recorded in each domain. Therefore, counts for domains 2-6 are not expected to add up to the total number of screens conducted (domain 1).

Benchmark Information:

- The benchmark for PY3 will be 80%
- The benchmark for PY4 will be 85%
- The benchmark for PY5 will be 90%

CP1 – Readmission Rate for a High Frequency Chronic Condition 30 Day (Adult)

Definition: For Medicaid patients 18 years of age and older (18-64 years) who have a high frequency chronic condition, the number of acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days.

High frequency conditions are defined as hypertension, diabetes mellitus, heart failure, COPD, and asthma.

Measure Steward: Colorado Department of Health Care Policy and Financing

Data Source: Medicaid claims

Numerator: Medicaid Readmissions for patients with a high frequency chronic condition. Readmissions defined as an acute inpatient or observation stay for any diagnosis[1] with an admission date within 30 days of a previous Index admission's discharge date.

Denominator: Medicaid Index Admission with a high frequency chronic condition as of the Index discharge date with an acute inpatient or observation stay.

Exclusions:

- Patients with Medicare enrollment at any point 365 days prior to a discharge date through 30 days after the discharge date
- Patients with Third Party Insurance at any point 365 days prior to a discharge date through 30 days after the discharge date
- Patients with Managed Care at any point 365 days prior to a discharge date through 30 days after the discharge date
- Patient with Emergency Medicaid at any point 365 days prior to a discharge date through 30 days after the discharge date

Numerator:

- Identify all inpatient and observation stays (Observation Stay Value Set).
- Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

[1] All diagnosis codes, not just primary diagnosis.

- Exclude acute inpatient hospital admissions with any of the following on the discharge claim:
    - ✓ Female members with a principal diagnosis of pregnancy (Pregnancy Value Set).
    - ✓ A principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).
    - ✓ Planned admissions using any of the following:
        - A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set).
        - A principal diagnosis of rehabilitation (Rehabilitation Value Set).
        - An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set).
        - A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

Denominator:

- Identify all inpatient and observation stays (Observation Stay Value Set).
- Exclude all claims without a diagnosis code of:
    - ✓ Chronic condition: Hypertension
        - ICD-10 Code: All codes beginning with I10, I11, I12, I13, I15, I16
    - ✓ Chronic condition: Diabetes mellitus
        - ICD-10 Code: All codes beginning with E08, E09, E10, E11, E13
    - ✓ Chronic condition: Heart failure
        - ICD-10 Code: All codes beginning with I50
    - ✓ Chronic condition: COPD
        - ICD-10 Code: All codes beginning with J41, J42, J43, J44
    - ✓ Chronic condition: Asthma
        - ICD-10 Code: All codes beginning with J45
- Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

- Exclude hospital stays where the index admission date is the same as the index discharge date
- Exclude hospital stays for the following reasons:
    - ✓ The member dies during the stay
    - ✓ Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim
    - ✓ A principal diagnosis of a condition originating in the perinatal period (Perinatal Condition Value Set) on the discharge claim
- Exclude hospital stay with Discharge Status Codes on the discharge claim
    - ✓ 04 Discharged/transferred to a Facility the Provides Custodial or Supportive Care
    - ✓ 07 Left Against Medical Advice or Discontinued Care
    - ✓ 20 Expired
    - ✓ 30 Still a patient
    - ✓ 31 Still a Patient, Waiting Transfer
    - ✓ 32 Still a Patient, Waiting Placement
    - ✓ 40 Expired at Home
    - ✓ 41 Expired in Medical Facility
    - ✓ 42 Expired - Place Unknown
    - ✓ 43 Discharged/transferred to Federal Health Care Facility
    - ✓ 51 Hospice - Medical Facility (Certified) Providing Hospice Level of Care
    - ✓ 61 Discharged/transferred to a Hospital-Based Medicare Approved Swing Bed
    - ✓ 62 Discharged/transferred to an Inpatient Rehabilitation Facility including Rehabilitation
    - ✓ 63 Discharged/transferred to a Medicare Certified Long Term Care Hospital (LTCH)
    - ✓ 64 Discharged/transferred to a Nursing Facility Certified under Medicaid but not certified under Medicare
    - ✓ 65 Discharged/transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital

Target Population Notes:

- Adult Medicaid (primary) patients, ages 18-64 as of the Index Discharge Date.
- Continuous enrollment 365 days prior to the Index Discharge Date through 30 days after the index discharge date. No more than 45 total days gap in enrollment during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
- Hospice exclusion, Medicaid patients in hospice or using hospice services anytime during the measurement year were excluded by using HEDIS (Hospice Encounter Value Set, Hospice Intervention Value Set).
- Non-outlier Medicaid patients, Medicaid patients with four or more index admissions during the measurement year are outliers.

Data Elements, Code Systems, Code Lists, Value Sets:

Use any diagnosis code on the discharge claim (including primary and secondary diagnosis codes)

- Chronic condition: Hypertension
    - ✓ ICD-10 Code: All codes beginning with I10, I11, I12, I13, I15, I16
- Chronic condition: Diabetes mellitus
    - ✓ ICD-10 Code: All codes beginning with E08, E09, E10, E11, E13
- Chronic condition: Heart failure
    - ✓ ICD-10 Code: All codes beginning with I50
- Chronic condition: COPD
    - ✓ ICD-10 Code: All codes beginning with J41, J42, J43, J44
- Chronic condition: Asthma
    - ✓ ICD-10 Code: All codes beginning with J45

Data elements align with HEDIS specification, <u>except</u>:

- Patient status codes excluded
- Additional discharge status codes were excluded from the denominator
- To pull Medicaid inpatient stays, claim type code ('A', 'I') which are inpatient crossover claim and inpatient claim respectively, and billing provider type code '01' used instead of HEDIS (Inpatient Stay Value Set)

revenue codes. We are including all Observation Stays as defined by HEDIS (Observation Stay Value Set) regardless of claim type code

Risk Adjustment: Not applicable

Calculation Type: Percentage

Additional Considerations: This measure would be applicable to hospitals who want to implement enhanced transitions of care support for a cohort of Medicaid patients discharged with a chronic condition. This will include addressing both medical issues and social determinants of health.

Benchmark Information:

10 or more hospitals selected this measure:

- The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1, which is .066.
- The benchmark for PY4 will be 5% improvement of the PY3 benchmark, which is .062.
- The benchmark for PY5 will be 5% improvement of the PY4 benchmark, which is .059.

CP1 – Pediatric Readmissions Rate Chronic Condition 30 Day

Definition: This report contains detailed measure specifications for calculating case-mix-adjusted, 30-day all-condition readmission rates for the pediatric Medicaid population less than 18 years old.

Chronic conditions are defined as hypertension, diabetes mellitus, heart failure, COPD, and asthma.

Measure Steward: Center of Excellence for Pediatric Quality Measurement - NQF 2393

Data Source: Hospital self-reported (from Pediatric Health Information System (PHIS™), Children's Hospital Association)

Numerator: Number of Medicaid index admissions for patients less than 18 years old at the time of admission with 1 or more readmissions within 30 days with a chronic condition.

Denominator: Total number of Medicaid index admissions for patients less than 18 years old at the time of admission with a chronic condition as of the Index discharge date.

Exclusions:

- Exclude all claims without a diagnosis code of:
    - ✓ Chronic condition: Hypertension
        - ICD-10 Code: All codes beginning with I10, I11, I12, I13, I14, I15, I16
    - ✓ Chronic condition: Diabetes mellitus
        - ICD-10 Code: All codes beginning with E08, E09, E10, E11, E13
    - ✓ Chronic condition: Heart failure
        - ICD-10 Code: All codes beginning with I50
    - ✓ Chronic condition: COPD
        - ICD-10 Code: All codes beginning with J40, J41, J42, J43, J44
    - ✓ Chronic condition: Asthma
        - ICD-10 Code: All codes beginning with J45

Exclusions at hospital level:

- Specialty hospitals
    - ✓ Non-acute care institutions, such as rehabilitation and long-term care facilities
    - ✓ Admissions for obstetric conditions, mental health conditions, and birth of healthy newborns
    - ✓ Readmissions for planned procedures and chemotherapy.

Exclusions at episode of care level:

- Episodes of care for patients >=18 years or 0 days old at the time of admission
- Episodes of care with a discharge disposition of death
- Episodes of care with a discharge disposition of leaving the hospital against medical advice

- Episodes of care for which 30 days of follow-up data are unavailable because the dataset's time range for claims does not include the full 30 days

Target Population Notes: Pediatric Medicaid patients less than 18 years of age. PHIS data includes any case with a Medicaid primary payor, which may include pending Medicaid, Medicaid managed care, Emergency Medicaid, and dually eligible Medicaid-Medicare patients.

Data Elements, Code Systems, Code Lists, Value Sets: Use any diagnosis code on the claim code (including primary and secondary claim codes)

- Chronic condition: Hypertension
    - ✓ ICD-10 Code: All codes beginning with I10, I11, I12, I13, I14, I15, I16
- Chronic condition: Diabetes mellitus
    - ✓ ICD-10 Code: All codes beginning with E08, E09, E10, E11, E13
- Chronic condition: Heart failure
    - ✓ ICD-10 Code: All codes beginning with I50
- Chronic condition: COPD
    - ✓ ICD-10 Code: All codes beginning with J40, J41, J42, J43, J44
- Chronic condition: Asthma
    - ✓ ICD-10 Code: All codes beginning with J45

Risk Adjustment: The hospital's actual readmission rate is adjusted to reflect the readmission rate the hospital would have if it treated a patient cohort with the case mix composition of all eligible index admissions within the PHIS dataset following the CEPQM methodology.

Calculation Type: The readmissions algorithm and adjustment methodology are a SAS program[2] that was developed based on the specifications provided by the Center of Excellence for Pediatric Quality Measurement.

Additional Considerations:

Measure Specification Documentation:

[2] Pediatric Readmissions | Boston Children's Hospital (childrenshospital.org)

Provide name and email to access the specification and the SAS code at the following source:

www.childrenshospital.org/Research/Centers-Departmental-Programs/center-of-excellence-for-pediatric-quality-measurement-cepqm/cepqm-measures/pediatric-readmissions/content

Benchmark Information: The benchmark will be set from the national PHIS data set for the HTP baseline period Oct. 1, 2021 – Sept. 30, 2022.

- The benchmark for PY3 will be the mean of the national data set which is 5.92%
- The benchmark for PY4 will be the mid-point between the mean and the top quartile of the national data set which is 5.87%
- The benchmark for PY5 will be the top quartile of the national data set which is 5.81%

CP2 – Pediatric Bronchiolitis Appropriate Use of Bronchodilators

Definition: Percentage of patients with a primary diagnosis of bronchiolitis admitted to the inpatient setting who receive bronchodilators (Note: lower percentage is better).

Measure Steward: Children's Hospital Association

Data Source: Hospital self-report

Numerator: Number of patients with a primary diagnosis of bronchiolitis admitted to the inpatient or observation setting who receive bronchodilators.

Denominator: Number of patients with a primary diagnosis of bronchiolitis admitted to the inpatient or observation setting.

Exclusions: Patients on mechanical ventilation, those with a LOS > 10 days, and those with complex chronic conditions as defined in Pediatric Complex Chronic Conditions classification system version 2. (PCCCv2) (Feudtner, C., Feinstein, J.A., Zhong, W., Hall, M., and Dai D. Pediatric complex chronic conditions classification system version 2: updated for ICD-10 and complex medical technology dependence and transplantation. BMC Pediatrics. 2014 Aug

8; 14:199. DOI: 10.1186/1471-2431-14-199. PMID: 25102958; PMCID: PMC4134331.)

Target Population Notes: Pediatric all payor patients age 1 month to 24 months old as of admission date

Data Elements, Code Systems, Code Lists, Value Sets: EMR or medical record documentation

Risk Adjustment: Not applicable

Timing and Time Intervals: Measure reported December to April

Calculation Type: Percentage

Additional Considerations: Please note this measure will be under annual review as developments and evidence-based research becomes available due to COVID-19.

Benchmark Information:

- The benchmark for PY3 will be 46%
- The benchmark for PY4 will be 40%
- The benchmark for PY5 will be 35%

CP3 – Pediatric Sepsis Timely Antibiotics

Definition: Percentage of pediatric patients with suspected sepsis who receive antibiotics in less than or equal to 3 hours after an initial diagnosis of suspected sepsis. This includes patients in the emergency department, urgent care and inpatient settings.

Measure Steward: Children's Hospital Association

Data Source: Hospital self-report

Numerator: Number of pediatric patients in the emergency department, urgent care, observation and inpatient settings who receive antibiotics in less than or equal to 3 hours after an initial diagnosis of suspected sepsis.

Denominator: Number of pediatric patients in the emergency department, urgent care, observation and inpatient settings who are diagnosed as suspected sepsis at some point during their visit or hospitalization.

Exclusions:

- Patients admitted to the NICU

Target Population Notes: Pediatric all payor patients less than 18 years old as of date of diagnosis with expected sepsis

Data Elements, Code Systems, Code Lists, Value Sets: EMR or medical record documentation

Risk Adjustment: Not applicable

Calculation Type: Percentage

Additional Considerations: None

Benchmark Information:

- The benchmark for PY3 will be 80%
- The benchmark for PY4 will be 85%
- The benchmark for PY5 will be 90%

CP4 – Screening for Transitions of Care Supports in Adults with Disabilities

Definition: The percent of admitted patients, 18 years and older, with disabilities screened for transitions of care supports. Screening shall include an assessment of functional status using the "Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set Version 4.0" available at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual.html or similar comprehensive screen and if needed supports are identified, contact appropriate agencies to put in additional services.

Measure Steward: Colorado Department of Health Care Policy and Financing

Data Source: Hospital self-report

Numerator: Patients with a disability per Social Security Administration listings (www.ssa.gov/disability/professionals/bluebook/AdultListings.htm) admitted

to the hospital who have a documented screening for transitions of care supports in the medical record; if needed supports are identified, contact appropriate agencies to put in additional services.

Denominator: Patients with a disability per Social Security Administration listings (www.ssa.gov/disability/professionals/bluebook/AdultListings.htm) admitted to the hospital.

Exclusions: Patient refusal.

Target Population Notes: Adult all payor patients 18 years of age and older

Data Elements, Code Systems, Code Lists, Value Sets: EMR or medical record documentation

Risk Adjustment: Not applicable

Calculation Type: Percentage

Additional Considerations: None

Benchmark Information:

- The benchmark for PY3 will be 80%
- The benchmark for PY4 will be 85%
- The benchmark for PY5 will be 90%

CP5 – Reducing Neonatal Complications

Definition: Reducing the percent of infants with unexpected newborn complications among full term newborns with no preexisting conditions.

Severe complications include neonatal death, transfer to another hospital for higher level of care, severe birth injuries such as intracranial hemorrhage or nerve injury, neurologic damage, severe respiratory and infectious complications such as sepsis.

Moderate complications include diagnoses or procedures that raise concern but at a lower level than the list for severe, e.g. use of CPAP or bone fracture. Examples include less severe respiratory complications e.g. Transient Tachypnea of the Newborn, or infections with a longer length of stay not

including sepsis, infants who have a prolonged length of stay of over five days. (Note: lower percentage is better).

Measure Steward: The Joint Commission PC-06 (Version 2023A) https://manual.jointcommission.org/releases/TJC2023A/MIF0393.html

Data Source: Hospital self-report

Numerator: Newborns with severe complications and moderate complications

Severe Complications:

- Death
- Transfer to another acute care facility for higher level of care
    - ✓ ICD-10-CM Principal Diagnosis Code, ICD-10-CM Other Diagnosis Codes, ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for Severe Morbidities as defined in the following Joint Commission National Quality Measures Code Tables:
        - 11.36 Severe Birth Trauma
        - 11.37 Severe Hypoxia/Asphyxia
        - 11.38 Severe Shock and Resuscitation
        - 11.39 Neonatal Severe Respiratory Complications
        - 11.40 Neonatal Severe Infection
        - 11.41 Neonatal Severe Neurological Complications
        - 11.42 Severe Shock and Resuscitation Procedures
        - 11.43 Neonatal Severe Respiratory Procedures
        - 11.44 Neonatal Severe Neurological Procedures
- Patients with Length of Stay greater than 4 days AND an ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for Sepsis as defined in the Joint Commission National Quality Measures Code Table 11.45 Neonatal Severe Septicemia.

Moderate Complications:

- ICD-10-CM Principal Diagnosis Code, ICD-10-CM Other Diagnosis Codes, ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for moderate complications as defined in the following Joint Commission National Quality Measures Code Tables:

- ✓ 11.46 Moderate Birth Trauma
- ✓ 11.47 Moderate Respiratory Complications
- ✓ 11.48 Moderate Respiratory Complications Procedures
- ✓ ICD-10-CM Principal Diagnosis Code for single liveborn newborn as defined in the Joint Commission National Quality Measures Code Table 11.20.2 Single Liveborn Newborn-Vaginal AND Length of Stay greater than 2 days
  OR
  ICD-10-CM Principal Diagnosis Code for single liveborn newborn as defined in the Joint Commission National Quality Measures Code Table 11.20.3 Single Liveborn Newborn-Cesarean AND Length of Stay greater than 4 days
  AND ANY
  ICD-10-CM Principal Diagnosis Code, ICD-10-CM Other Diagnosis Codes, ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for moderate complications as defined in the following Joint Commission National Quality Measures Code Tables:
  - 11.49 Moderate Birth Trauma with LOS
  - 11.50 Moderate Respiratory Complications with LOS
  - 11.51 Moderate Neurological Complications with LOS Procedures
  - 11.52 Moderate Respiratory Complications with LOS Procedures
  - 11.53 Moderate Infection with LOS
- ✓ Patients with Length of Stay greater than 5 days and NO ICD-10-CM Principal Diagnosis Code, ICD-10-CM Other Diagnosis Codes, ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for jaundice or social indications as defined in the following Joint Commission National Quality Measures Code Tables:
  - 11.33 Neonatal Jaundice
  - 11.34 Phototherapy
  - 11.35 Social Indications

Denominator: Liveborn single term newborns 2500 gm or over in birth weight.

Exclusions:

Numerator: None

Denominator:

- Patients who are not born in the hospital or are part of multiple gestation pregnancies with no ICD-10-CM Principal Diagnosis Code for single liveborn newborn as defined in the Joint Commission National Quality Measures Code Table Number 11.20.1: Single Liveborn Newborn
- Birth Weight less than 2500g
- Patients who are not term or with less than 37 weeks gestation completed
- Patients whose term status or gestational age is missing and birthweight less than 3000 gm
- ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for congenital malformations and genetic diseases as defined in the Joint Commission National Quality Measures Code Table 11.30 Congenital Malformations
- ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for pre-existing fetal conditions as defined in the Joint Commission National Quality Measures Code Table 11.31 Fetal Conditions
- ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for maternal drug use exposure in-utero as defined in the Joint Commission National Quality Measures Code Table 11.32 Maternal Drug Use

Target Population Notes: All payor

Data Elements, Code Systems, Code Lists, Value Sets:

Numerator:

- Admission Date
- Discharge Date
- Discharge Disposition
- Other Diagnosis Codes
- Principal Diagnosis Code
- Other Procedure Codes
- Principal Procedure Code

Denominator:

- Birth Weight
- Birthdate

- Other Diagnosis Codes
- Principal Diagnosis Code
- Other Procedure Codes
- Principal Procedure Code
- Term Newborn

Joint Commission National Quality Measures Code Tables referenced above are located at the following webpage:
https://manual.jointcommission.org/releases/TJC2022B/AppendixATJC.html

Risk Adjustment: Not applicable

Calculation Type: The result is expressed as a rate per 1000 live births.

Additional Considerations:
Hospitals with over 300 deliveries a year are mandated to report this to The Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Hospitals are required to report on the following stratifications:

- Severe Complications
- Moderate Complications
- Total Complications

Benchmark Information:

- The benchmark for PY3 is the median for Colorado calculated from the Joint Commission 2020 Health Care Quality data download, which is 25.72%.
- The benchmark for PY4 is the mid-point between the benchmarks for PY3 and PY5, which is 21.88%.
- The benchmark for PY5 is the top quartile (top 25%) for Colorado calculated from the Joint Commission 2020 Health Care Quality data download, which is 18.04%.

CP6 – Screening and Referral for Perinatal and Post-Partum Depression and Anxiety and Notification of Positive Screens to the RAE

Definition: Percentage of pregnant Medicaid patients screened at any hospital encounter identified through an Inpatient (IP), Emergency Department (ED), or Observation hospital claim for perinatal and post-partum anxiety and depression during pregnancy or the postpartum period (60 days) with the RAE notified within one business day if the screen is positive.

The RAE must be notified within one business day if a patient has a positive screen for that patient to be considered having met this measure and included in the numerator. Screening alone without RAE notification for a Medicaid patient who screens positive is not considered adequate for this measure. The measure is reported as one overall score counting all patients who are screened and screen negative, and patients with positive screens only if the RAE is notified about them within one business day.

Measure Steward: Colorado Department of Health Care Policy and Financing

Data Source: Hospital self-report

Numerator: The number of Medicaid hospital encounters identified through an Inpatient (IP), Emergency Department (ED), or Observation hospital claim for women who are pregnant or in the post-partum period (60 days) at which a screening for anxiety and depression was done and RAE notified within one business day if the screen was positive.

The numerator consists of the number of patients screened who do not have positive screen and the number of patients with positive screens for whom the RAE is notified within one business day. Patients who are screened, and screen positive, for whom the RAE is not notified within one business are excluded from the numerator.

Denominator: The number of Medicaid hospital encounters identified through an Inpatient (IP), Emergency Department (ED), or Observation hospital claim of women who are pregnant or in the post-partum period (60 days).

Exclusions:

- Patients discharged AMA.
- Patient refusal.
- Patients discharged to home hospice
- Patients receiving inpatient hospice care.

Target Population Notes: Medicaid (primary) patients

Data Elements, Code Systems, Code Lists, Value Sets: EMR or medical record documentation

Risk Adjustment: Not applicable

Calculation Type: Percentage

Additional Considerations: This measure would require hospitals to work with their primary RAE to ensure optimal patient access and follow up. Notification to the RAE should not take the place of or delay appropriate referral when mental health referral resources are known and available. If a screening took place in the last 7 days and was positive, that screening is valid and re-screening is not required.

Measure performance will be based on the total percentage of screens and notifications to the RAE, where applicable, as defined in the numerator; however, the hospitals will also be required to report a count of the total positive screens.

A normalized and validated depression and anxiety screening tool developed for the patient population in which it is being utilized is required by this measure.

Benchmark Information:

- The benchmark for PY3 will be 80%
- The benchmark for PY4 will be 85%
- The benchmark for PY5 will be 90%

CP7 – Increase Access to Specialty Care

Definition: The annual number of Medicaid visits with specialist physicians contracted through or employed by a hospital.

Measure Steward: Colorado Department of Health Care Policy and Financing

Data Source: Hospital self-report

Numerator: This is a simple count of the number of Medicaid visits with specialty physicians contracted through or employed by a hospital as described above.

Denominator: None

Exclusions: None

Target Population Notes: Medicaid (primary) patients

Data Elements, Code Systems, Code Lists, Value Sets: Visit counts from hospital systems or records

Risk Adjustment: Not applicable

Calculation Type: Visit count

Additional Considerations: This measure is appropriate for hospitals who provide significant ambulatory specialty care through employed physicians and are committed to improving specialty access for Medicaid patients through increased appointment availability and patient support for completing the visit.

Benchmark Information:

- The benchmark for PY3 will be 5% improvement of the hospital's PY1 (baseline) score
- The benchmark for PY4 will be 5% improvement of the PY3 benchmark
- The benchmark for PY5 will be 5% improvement of the PY4 benchmark

V. Behavioral Health/Substance Use Disorder

SW-BH1 – Collaboratively develop and implement a mutually agreed upon discharge planning and notification process with the appropriate RAE's for eligible patients with a diagnosis of mental illness or substance use disorder (SUD) discharged from the hospital or ED

Definition: Percentage of eligible Medicaid patients 18 years or older discharged to home from inpatient, observation, or the emergency department with a principal or secondary diagnosis of mental illness or SUD at the time of discharge with a collaboratively mutually agreed upon discharge planning and notification process with or to the RAE within one business day.

The Substance Abuse and Mental Health Services Administration defines SUD as alcoholism and drug dependence and addiction or the use of alcohol or drugs that is compulsive or dangerous.[3]

Measure Steward: Colorado Department of Health Care Policy and Financing

Data Source: Hospital self-report

[3] https://store.samhsa.gov/system/files/sma14-4126.pdf

Numerator: Number of eligible Medicaid patients discharged to home from inpatient, observation, or the emergency department with a principal or secondary diagnosis of mental illness or SUD at the time of discharge with a collaboratively mutually agreed upon discharge planning and notification process with or to the RAE within one business day.

Denominator: Number of eligible Medicaid patients discharged to home from inpatient, observation, or the emergency department with a principal or secondary diagnosis of mental illness or SUD at the time of discharge.

Exclusions:

- Patients discharged AMA or discontinued care.
- Patients discharged to home hospice
- Patients receiving inpatient hospice care.

Target Population Notes: Adult Medicaid (primary) patients 18 years of age and older

Risk Adjustment: Not applicable

Calculation Type: Percentage

Data Elements, Code Systems, Code Lists, Value Sets: See Tables 1 – 2.

1. **Mental Health Covered Diagnoses ICD-10-CM Code Ranges**

Start Value	End Value
F20.0	F42.3
F42.8	F48.1
F48.9	F51.03
F51.09	F51.12
F51.19	F51.9

2. **Substance Use Disorder Covered Diagnoses ICD-10-CM Code Ranges**

Start Value	End Value
F10.10	F10.26
F10.28	F10.96
F10.98	F13.26
F13.28	F13.96
F13.98	F18.159

F53.0	F53.10
F60.0	F64.9
F68.10	F69
F90.0	F98.4
F98.8	F99
R45.1	R45.2
R45.5	R45.82

F18.18	F18.259
F18.28	F18.959
F18.980	F19.16
F19.18	F19.26
F19.28	F19.99

Note: The ICD 10 for suicidal and homicidal ideation is R45.851, and is found as a sub-component of R.45.8

Additional Considerations: Eligible patients are those for whom state and/or federal statutes allow notification without consent, or who give consent if required. Implementation plans for this measure must include a robust process for identifying mental health and SUD at time of discharge and as part of discharge diagnosis. For any patients for whom state and/or federal statutes require consent for notification, interventions must include processes for obtaining consent.

If the hospital is unable to have billing coding or final billed diagnosis in time to notify the RAE within one business day, discharge diagnosis should be utilized.

Notifications to the RAE should be for diagnoses that are relevant at the time of discharge, and not historical diagnosis or other social or medical history that is not deemed to be a current diagnosis by the attending diagnosing clinician.

The hospital should work with their primary RAE for this measure.

Benchmark Information:

- The benchmark for PY3 will be 80%
- The benchmark for PY4 will be 85%

- The benchmark for PY5 will be 90%

SW-BH2 – Pediatric Screening for Depression in Inpatient and ED Including Suicide Risk

Definition: Percent of pediatric patients 12-17 years of age, discharged to home from an inpatient or emergency department encounter who were screened for depression including suicide risk.

Measure Steward: Colorado Department of Health Care Policy and Financing

Data Source: Hospital self-report

Numerator: Number of pediatric patients (12 years or older) with an inpatient or emergency department encounter who were screened for depression including suicide risk.

Denominator: Number of pediatric patients with an inpatient or emergency department encounter.

Exclusions:
- Patients discharged AMA.
- Patient refusal

Target Population Notes: Pediatric all payor patients 12-17 years of age

Data Elements, Code Systems, Code Lists, Value Sets: EMR or medical record documentation

Risk Adjustment: Not applicable

Calculation Type: Percentage

Additional Considerations: For patients admitted IP from the ED only one screen is required before discharge to home.

Benchmark Information:
- The benchmark for PY3 will be 80%
- The benchmark for PY4 will be 85%
- The benchmark for PY5 will be 90%

SW-BH3 – Using Alternatives to Opioids (ALTO) in Hospital Emergency Departments (ED): 1) Report use of opioids 2) Increase use of ALTO

Definition: This is a two-part measure: 1) report use of opioids and 2) increase use of ALTO.

Report use of opioids – Emergency Department (ED) encounters with administration of an opioid as listed in the ***Opioids of Interest*** per 1,000 ED encounters for patients ages 18 years and older, among cases meeting the inclusion and exclusion criteria below.

Increase use of ALTO – Emergency Department (ED) encounters with administration of an ALTO as listed in the ***ALTO of Interest*** per 1,000 ED encounters for patients ages 18 years and older, among cases meeting the inclusion and exclusion criteria below.

Measure Steward: Colorado Hospital Association (CHA); American College of Emergency Physicians (ACEP)

Data Source: Hospital self-report

Part 1 – Report Use of Opioids

- ***Numerator:*** Total ED encounters in which medications listed in Opioids of Interest were administered, among cases meeting the inclusion and exclusion criteria below.
- ***Denominator:*** Total number of ED encounters for diagnoses meeting the inclusion and exclusion criteria below.

Part 2 – Increase use of ALTO

- ***Numerator:*** Total ED encounters in which medications listed in ALTO of Interest were administered, among cases meeting the inclusion and exclusion criteria below. For example, if a patient was given two ALTOs with the same medication name in two separate encounters, both encounters would count in the Numerator of this metric.
- ***Denominator:*** Total number of ED encounters for diagnoses meeting the inclusion and exclusion criteria below.

Opioids of Interest **(all routes):** Every medication has an approved name, which is a generic name. If a generic medication is made by several different

pharmaceutical companies, it is given a brand or trade name. If your hospital policy does not require generic names be used throughout the facility, unless a brand name is required (e.g., those where the bioavailability may be different, such as Lithium), ensure these are captured but **not** counted twice.

- Carfentanil
- Codeine
- Codeine-Acetaminophen*
- Codeine Poli-Chlorphenir Poli
- Fentanyl
- Fentanyl Citrate
- Hydrocodone bitartrate
- Hydrocodone-Acetaminophen*
- Hydrocodone-Chlorpheniramine
- Hydrocodone-Cpm-Pseudoephed
- Hydrocodone-Homatropin*
- Hydromorphone
- Hydrocodone-Ibuprofen*
- Meperidine
- Morphine
- Morphine Sulfate
- Oxycodone
- Oxycodone-Acetaminophen*
- Oxycodone-Hydrochloride
- Oxymorphone-Hydrochloride
- Pseudoephedrine-Hydrocodone
- Tramadol

***IMPORTANT Note**: for combination Opioid ALTOs (i.e., Hydrocodone-Acetaminophen etc.), the data should reflect only the opioid administration and not be counted as an ALTO administration also.*

ALTO of Interest (all routes): Every medication has an approved name, which is a generic name. If a generic medication is made by several different pharmaceutical companies, it is given a brand or trade name. If your hospital policy does not require generic names be used throughout the facility, unless a brand name is required (e.g., those where the bioavailability may be different, such as Lithium), ensure these are captured but not counted twice.

- Aspirin
- Acetaminophen
- Amitriptyline
- Baclofen
- Bupivacaine (Marcaine)
- Camphor
- Capsaicin
- Celecoxib
- Cyclobenzaprine
- Desmopressin
- Diclofenac
- Dicyclomine

- Duloxetine
- Excedrin
- Famotidine
- Gabapentin
- Haloperidol
- Ibuprofen
- Indomethacin
- Ketamine
- Ketorolac
- Lidocaine
- Meloxicam
- Menthol
- Methocarbamol
- Methyl salicylate
- Metoclopramide
- Naproxen
- Nortriptyline
- Ondansetron
- Pregabalin
- Prochlorperazine
- Ropivacaine
- Simethicone
- Sucralfate
- Tamsulosin
- Tizanidine
- Venlafaxine

Inclusions:

- Include patients 18 years of age and older
- Include any ED visit where the patient was treated at some point in the ED, including patients admitted to inpatient, kept in observation, or discharged home
- Include the primary or secondary ICD-10-CM diagnosis codes listed in Table 1, Inclusion column

Exclusions:

- Exclude any ED visit with the following hospice and intensive care exclusion revenue codes – see Table 2
- Exclude the primary or secondary ICD-10-CM diagnosis codes listed in Table 1, Exclusion column
- Additional Exclusions**:** cases with age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)

Target Population Notes: Adult all payor patients 18 years of age and older

Risk Adjustment: Not applicable

Calculation Type:

- RATE: For Opioid Administrations – Total ED encounters in which medications listed in ***Opioids of Interest*** were administered per 1,000 ED visits among cases meeting the inclusion and exclusion criteria.
- RATE: For ALTO – Total ED encounters in which medications listed in ***ALTOs of Interest*** were administered per 1,000 ED visits among cases meeting the inclusion and exclusion criteria

Data Elements, Code Systems, Code Lists, Value Sets: See Table 1 – 2.

- For hospitals partnering with CHA to submit data, please reach out to ODHIN.Admin@cha.com.

TABLE 1: ICD-10-CM Primary and Secondary Diagnosis Code Ranges

Condition	Include	Exclude
Migraines and Headaches	Headache (R51), Migraine (G44), Other Headache Syndromes (G43), Benign Intracranial Hypertension (G93.2), Post Concussional Syndrome (F07.81)	Malignant neoplasms of eye, brain, and other parts of central nervous system (C69-72), Benign neoplasm of eye and adnexa, meninges, brain and other parts of central nervous system (D31-33), Transient cerebral ischemic attacks and related syndromes and

Condition	Include	Exclude
		Vascular syndromes of brain in cerebrovascular diseases (G45-46), Cerebrovascular diseases (I60-I69), Intracranial injury, Crushing injury of head, Avulsion and traumatic amputation of part of head, Other and unspecified injuries of head (S06-09)
Abdominal Pain	Abdominal and pelvic pain (R10), Abdominal rigidity (R19.3), Other chronic pain, not specified elsewhere (G89.29).	Malignant neoplasms of digestive organs (C15-26), Malignant neoplasm of retroperitoneum and peritoneum (C48), Carcinoma in situ of oral cavity, esophagus and stomach, other unspecified digestive organs (D00-01), Neoplasm of uncertain behavior of oral cavity and digestive organs (D37)
Back Pain	Other inflammatory spondylopathies(M46), Other spondylopathies (M48.00-08 and M48.30-38), Cervical disc disorders (M50), Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders (M51), Dorsalgia (M54), Biomechanical lesions, not elsewhere classified (M99), Muscle spasm of back (M62.830), Age-related osteoporosis with current pathological fracture, vertebra(e) (M80.08), Other osteoporosis with current pathological fracture, vertebra(e) (M80.88)	Disorder of continuity of bone (M84), Malignant neoplasm of peripheral nerves and autonomic nervous system (C47)
Chest Pain	Chest pain on breathing (R07.1), Precordial pain (R07.2), Other chest pain (R07.8), Chest pain unspecified, chest pain not cardiac related (R07.9), Pleurisy (R09.1)	Malignant neoplasm of bronchus and lung (C34), Malignant neoplasm of thymus (C37), Malignant neoplasm of heart, mediastinum, and pleura (C38), Malignant neoplasm of other and ill-defined sites in the respiratory system and intrathoracic organs (C39), Mesothelioma (C45), Kaposi's sarcoma (C46), Malignant neoplasm of breast (C50), Ischemic heart diseases (I20-25)
Dental Pain	Dentofacial anomalies [including malocclusion] and other disorders of jaw (M26-27), Jaw pain (R68.84), Necrotizing ulcerative stomatitis (A69.0), Herpes viral gingivostomatitis and pharyngotonsillitis (B00.2), Candidal stomatitis (B37.0), Candidal cheilitis (B37.83)	Codes beginning with C00-14, D00, Benign Neoplasm of mouth and pharynx (D10), Neoplasm of uncertain behavior of oral cavity and digestive organs (D37), Other disorders of teeth and supporting structures (K08), Benign neoplasm of lower jawbone (D16.5)
Extremity Pain	Infectious arthropathies (M00-02), Inflammatory polyarthropathies (M05-14), Osteoarthritis (M15-19), Other joint disorders (M20-25), Disorders of muscles (M60-M63), Disorders of synovium and tendon (M65-67), Other soft tissue disorders (M70-79)	Malignant neoplasms of bone and articular cartilage (C40-41), Malignant neoplasm of other connective and soft tissue (C49)
Fracture Injuries	Codes beginning with Fracture of skull and facial bones (S02), Fracture of lumbar spine and pelvis(S32), Fracture of shoulder and upper arm (S42), Other and unspecified injuries of shoulder and upper arm (S49), Fracture of forearm (S52), Other and unspecified injuries of elbow and forearm (S59), Fracture at wrist and hand level	Malignant neoplasms of bone and articular cartilage (C40-41), Malignant neoplasm of other connective and soft tissue (C49)

Condition	Include	Exclude
	(S62), Fracture of femur (S72), Other and unspecified injuries of hip and thigh (S79), Fracture of lower leg, including ankle (S82), Other and unspecified injuries of lower leg (S89), Fracture of foot and toe, except ankle (S92), Osteoporosis with and without current pathological fracture (M80-81)	
Non-fracture Injuries	Dislocation and sprain of joints and ligaments of head (S03), Other and unspecified injuries of thorax (S29), Dislocation and sprain of joints and ligaments of lumbar spine and pelvis (S33), Other and unspecified injuries of abdomen, lower back, pelvis and external genitals (S39), Dislocation and sprain of joints and ligaments of shoulder girdle (S43), Injury of muscle, fascia and tendon at shoulder and upper arm level (S46), Dislocation and sprain of joints and ligaments of elbow (S53), Injury of muscle, fascia and tendon at forearm level (S56), Dislocation and sprain of joints and ligaments at wrist and hand level (S63), Other and unspecified injuries of wrist, hand and finger(s) (S69), Injury of muscle, fascia and tendon at hip and thigh level (S76), Dislocation and sprain of joints and ligaments of knee (S83), Injury of muscle, fascia and tendon at lower leg level (S86), Dislocation and sprain of joints and ligaments at ankle, foot and toe level (S93),Injury of muscle and tendon at ankle and foot level (S96); Temporomandibular joint disorder (M26.601-659)	Malignant neoplasms of bone and articular cartilage (C40-41), Malignant neoplasm of other connective and soft tissue (C49)
Urolithiasis (stone in the kidney, bladder, or urinary tract)	Urolithiasis (N20-N23), Hydronephrosis with renal and ureteral calculous obstruction (N13.2)	Malignant neoplasms of urinary tract (C64-68), Secondary malignant neoplasm of other and unspecified sites (C79), D09, D17, Benign neoplasm of urinary organs (D30), Neoplasm of uncertain behavior of urinary organs (D41), Neoplasms of unspecified behavior (D49)
Sickle Cell Anemia	None	Sickle-cell disorders, and other sickle-cell disorders (D57)

Table 2. Hospice and Intensive Care Exclusion Codes (REVENUE codes)

Code Type	Code	Description	Exclusion Reasoning
Revenue codes	020x*	ICU Revenue code	Identify those that were seen in the ED and then admitted to the ICU
Revenue codes	065x*	Hospice Revenue code	Identify those that were seen in the ED and then admitted to internal hospice
Revenue codes	0125	Routine Charges-Hospice	Identify those that were seen in the ED and then admitted to internal hospice
Revenue codes	0135	Routine Charges-Hospice	Identify those that were seen in the ED and then admitted to internal hospice

Code Type	Code	Description	Exclusion Reasoning
Revenue codes	0145	Routine Charges-Hospice	Identify those that were seen in the ED and then admitted to internal hospice
Revenue codes	0155	Routine Charges-Hospice	Identify those that were seen in the ED and then admitted to internal hospice
Revenue codes	0235	Routine Charges-Hospice	Identify those that were seen in the ED and then admitted to internal hospice
Revenue codes	0115	Routine Charges-Hospice	Identify those that were seen in the ED and then admitted to internal hospice
Revenue codes	0233	Routine Charges-ICU	Identify those that were seen in the ED and then admitted to the ICU
Patient Status/Discharge Disposition	50	Hospice – Home	Identify those that were admitted and then discharged to an external hospice facility
Patient Status/Discharge Disposition	51	Hospice – Medical facility (certified) providing hospice-level care	Identify those that were admitted and then discharged to an external hospice facility
CPT codes	99291	Critical Care CPT codes	Identify those that had received intensive/critical care in the ED
CPT codes	99292	Critical Care CPT codes	Identify those that had received intensive/critical care in the ED

** These fields represent parent codes for any revenue code beginning with the first three digits*

Additional Considerations: In terms of at-risk for the measure; 0% of the at-risk is related to reporting use of opioids and 100% of the at-risk is related to increasing ALTO use. Although measure performance will be based on increasing ALTO use alone, data related to use of opioids is still required to be reported. Additionally, note that the benchmark requires a 5% "improvement" on the prior year benchmark for years 4 and 5. For part one of the measure, reporting use of opioids, no benchmarks will be set and achievement will not be evaluated. For part two of the measure, increasing ALTO use, improvement is defined as an increase in the percentage.

Benchmark Information (for increasing ALTO use only):

- The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1, which is 545.47.
- The benchmark for PY4 will be equal to the PY3 benchmark, which is 545.47.
- The benchmark for PY5 will be equal to the PY3 benchmark, which is 545.47.

BH1 – Screening, Brief Intervention, and Referral to Treatment (SBIRT) in the ED

Definition: The percent of Medicaid ED patients age 12 years and older who are screened for alcohol or other substance use at the time of an ED visit and those who score positive have also received a brief intervention during the hospital visit.

Screening alone without a brief intervention for patients who score positive is not considered adequate for this measure. The measure is reported as one overall score counting in the numerator all patients who are screened and screen negative, and patients with positive screens only if there is a brief intervention.

Measure Steward: Oregon Health Authority

Data Source: Hospital self-report

Numerator: The numerator consists of the number of Medicaid patients screened at the time of an ED visit who do not have positive screen and the number of patients with positive screens only if they receive a brief intervention during the hospital visit. Patients who are screened at the time of the ED visit, and screen positive, but do not receive a brief intervention during the hospital visit, are excluded from the numerator.

Denominator: Number of ED visits for Medicaid patients age 12 years and older.

Exclusions:

Screening Rate: Any of the following criteria removes individuals from the denominator:

- Individual refuses to participate
- Situations where the individual's functional capacity or ability to communicate may impact the accuracy of results of standardized alcohol or drug use screening tools
- Medical stabilization is the primary function of the ED and treatment must be delivered to obtain that outcome. Therefore, the denominator should

exclude individuals where time is of the essence and to delay treatment would jeopardize the individual's health status.

Target Population Notes: Adult and Pediatric Medicaid (primary) patients

Data Elements, Code Systems, Code Lists, Value Sets: EMR or medical record documentation

Risk Adjustment: Not applicable

Calculation Type: Percentage

Additional Considerations: 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

Benchmark Information:

- The benchmark for PY3 will be 50%
- The benchmark for PY4 will be 55%
- The benchmark for PY5 will be 60%

BH2 – Initiation of Medication Assisted Treatment (MAT) in ED or Hospital Owned Certified Provider Based Rural Health Center

Definition: The percentage of ED visits where the patient diagnosed with an opioid use disorder (OUD) and who is in at least acute mild active opioid withdrawal for whom MAT with Buprenorphine is initiated during an emergency department visit or hospital-owned certified provider-based rural health center or through the provision/prescription of a home induction.

Measure Steward: Colorado Department of Health Care Policy and Financing, ACEP, SAMHSA

Data Source: Hospital self-report

Numerator: The number of ED visits where the patient diagnosed with an opioid use disorder (OUD) and who is in at least acute mild active opioid

withdrawal for whom MAT with Buprenorphine is initiated during an emergency department visit or hospital-owned certified provider-based rural health center through an on-site induction or through the provision/prescription of a home induction.

Denominator: The number of ED visits where the patient is diagnosed with an opioid use disorder (OUD) and who is in at least acute mild active opioid withdrawal.

Target Population Notes: All payor patients with an opioid use disorder diagnosis

Exclusions: Patients who are critically ill, unable to communicate due to dementia or psychosis, suicidal, unconscious, refused MAT, or left against medical advice (AMA). Patients where the induction of Buprenorphine is contraindicated.

Data Elements, Code Systems, Code Lists, Value Sets: Hospital self-report from visit note or claim

Risk Adjustment: Not applicable

Calculation Type: Rate

Additional Considerations: This measure is designed for hospitals who want to implement a program to train and certify providers and develop protocols to initiate MAT in the emergency department for appropriate patients. Patients will then be referred to outpatient providers for ongoing treatment. The measure will reflect the rate of OUD patients initiated with treatment annually post implementation. This metric definition is not intended to represent a practice guideline or to limit a hospital program's ability to initiate MAT to patients not identified within this measure specification. Providers are encouraged to consult with national best practices and national professional organization recommendations.

Resources: Substance Abuse and Mental Health Services Administration: Use of Medication-Assisted Treatment in Emergency Departments. HHS Publication No. PEP21-PL-Guide-5 Rockville, MD: National Mental Health and Substance Use

Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2021. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep21-pl-guide-5.pdf

Buprenorphine use in the Emergency Department Tool. https://www.acep.org/patient-care/bupe/

Benchmark Information:

- The benchmark for PY3 will be 70%
- The benchmark for PY4 will be 75%
- The benchmark for PY5 will be 80%

VI. Clinical and Operational Efficiencies

SW-COE1 – Hospital Index

Definition: A measure of avoidable care across procedural episodes. A hospital's index score will be compared to a baseline index score.

Measure Steward: Colorado Department of Health Care Policy and Financing utilizing the Prometheus tool

Data Source: Medicaid claims and Hospital Index Dashboards

Numerator: Not applicable

Denominator: Not applicable

Exclusions:
Per proprietary algorithm

Target Population Notes: Medicaid (primary) patients

Data Elements, Code Systems, Code Lists, Value Sets: Claims

The following procedures are used to calculate performance in the Hospital Index measure.

Episode Description	Episode Type
Bariatric Surgery	Procedural
Breast Biopsy	Procedural
C-Section	Procedural
CABG &/or Valve Procedures	Procedural
Cataract Surgery	Procedural
Colonoscopy	Procedural
Colorectal Resection	Procedural
Coronary Angioplasty	Procedural
Gall Bladder Surgery	Procedural
Hip Replacement / Revision	Procedural
Hysterectomy	Procedural
Knee Arthroscopy	Procedural
Knee Replacement / Revision	Procedural
Lumbar Laminectomy	Procedural
Lumbar Spine Fusion	Procedural
Lung Resection	Procedural
Mastectomy	Procedural

Episode Description	Episode Type
Pacemaker / Defibrillator	Procedural
Prostatectomy	Procedural
Shoulder Replacement	Procedural
Tonsillectomy	Procedural
Transurethral Resection Prostate	Procedural
Upper GI Endoscopy	Procedural
Vaginal Delivery	Procedural

Risk Adjustment: No, but the index calculation is normalized

Calculation Type: Index score

Additional Considerations: Proprietary algorithm

citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.867.7869&rep=rep1&type=pdf

Benchmark Information:

- There will be no benchmark for PY3 and all at-risk will be granted.
- The benchmark for PY4 will be performance against the Index benchmark of 100.
- The benchmark for PY5 will be performance against the Index benchmark of 100.

COE1 – Increase the Successful Transmission of a Summary of Care Record to a Patient's Primary Care Physician (PCP) or Other Healthcare Professional within one Business Day of Discharge from an Inpatient Facility to home

Definition: Successful transmission of a summary of care record, as described in the intervention, to a Medicaid patient's PCP or other healthcare professional that is external to the hospital system within one business day of discharge from an inpatient facility to home.

Measure Steward: Colorado Department of Health Care Policy and Financing

Data Source: Hospital self-report

Numerator: The number of successful transmissions of a summary of care record via direct messaging or fax or via exchange facilitated by a Qualified Health Information Network to a Medicaid patient's PCP or other healthcare professional that is external to the hospital system within one business day of discharge from an inpatient facility to home.

Denominator: The number of Medicaid inpatient discharges to home for whom the patient's PCP or appropriate other health care professional is external to the hospital system.

Exclusions: Patients who choose to opt-out for the summary of care record transmission.

Target Population Notes: Adult and Pediatric Medicaid (primary) patients

Data Elements, Code Systems, Code Lists, Value Sets: EMR or patient record documentation

Summary of Care Record is defined in the "Medicaid Promoting Interoperability Program" by CMS[4] and has to include:

- Patient name
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Smoking status
- Current problem list (providers may also include historical problems at their discretion)[5]
- Current medication list[6]
- Laboratory test(s)
- Laboratory value(s)/result(s)
- Vital signs (height, weight, blood pressure, Body Mass Index (BMI))
- Procedures
- Care team member(s) including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider)[7]
- Immunizations
- Unique device identifier(s) for a patient's implantable device(s)

[4] www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MedicaidEP_2019_Obj7.pdf
[5] An eligible professional (EP) must verify that the fields for current problem list, current medication list, and current medication allergy list are not blank and include the most recent information known by the EP as of the time of generating the summary of care document or include a notation of no current problem, medication and/or medication allergies
[6] Ibid
[7] Ibid

- Care plan, including goals, health concerns, and assessment and plan of treatment
- Encounter diagnosis
- Functional status, including activities of daily living, cognitive and disability status

Risk Adjustment: Not applicable

Calculation Type: Percentage

Additional Considerations: If the patient cannot identify a PCP, the hospital should contact their primary RAE to determine the PCP assigned to the patient.

In cases where the hospital shares access to its EHR with the PCP, a transition may still count toward the measure if the hospital creates the summary of care document using the EHR and sends the summary of care document electronically.

Hospitals should define the best method for documenting receipt based on transmission type and their system capabilities.

Benchmark Information:

- The benchmark for PY3 will be 42%
- The benchmark for PY4 will be 50%
- The benchmark for PY5 will be 58%

COE2 – Implementation/expansion of Telemedicine Visits

Definition: The annual number of telemedicine visits supported through the hospital.

A telemedicine visit is an interactive telephone or video encounter between a clinician and a patient that meets the same standard or care as an in-person visit. This measure is intended for telehealth visits utilized to replace in-person inpatient or outpatient hospital visits between a patient and a clinician. This measure is not intended for remote patient monitoring.

Measure Steward: Colorado Department of Health Care Policy and Financing

Data Source: Hospital self-report

Numerator: This is a simple count of the number of telemedicine visits as described above.

Denominator: None

Exclusions: Patients receiving remote patient monitoring shall not be included in the count of telehealth visits.

Target Population Notes: Adult and Pediatric all payor patients

Data Elements, Code Systems, Code Lists, Value Sets: Visit counts from hospital systems or records

Risk Adjustment: Not applicable

Calculation Type: Visit count

Additional Considerations: This measure is appropriate for hospitals who want to implement or expand telemedicine programs on their own or in collaboration with a vendor or clinician group.

Only completed visits, not just scheduled, should be counted.

Hospital has to be the primary implementer of the telehealth visit process and system or have participated in significant collaborative planning and implementation with another hospital to enable these visits to occur. Hospital has to attest that the hospital facilitated the initiation of the visit as demonstrated through the intervention.

If system-level implementation, options for attributing the visits – all to one, nearest hospital to originating site, distribution of patients/adjusted charges.

Benchmark Information:

- The benchmark for PY3 will be 5% improvement of the hospital's PY1 (baseline) score
- The benchmark for PY4 will be 5% improvement of the PY3 benchmark
- The benchmark for PY5 will be 5% improvement of the PY4 benchmark

COE3 – Implementation/expansion of e-Consults

Definition: The annual number of e-Consults supported through the hospital.

e-Consults are a communication about a specific patient documented in the patient's medical record and conducted through a "web-based system that allows for an asynchronous exchange between clinicians to securely share health information and discuss patient care."

Measure Steward: Colorado Department of Health Care Policy and Financing

Data Source: Hospital self-report

Numerator: This is a simple count of the number of e-Consults as described above.

Denominator: None

Exclusions: None

Target Population Notes: Adult and Pediatric all payor patients

Data Elements, Code Systems, Code Lists, Value Sets: Visit counts from hospital systems or records

Risk Adjustment: Not applicable

Calculation Type: Visit count

Additional Considerations: This measure is appropriate for hospitals who want to implement or expand e-Consults on their own or in collaboration with a vendor or clinician group.

Benchmark Information:

- The benchmark for PY3 will be 5% improvement of the hospital's PY1 (baseline) score
- The benchmark for PY4 will be 5% improvement of PY3 benchmark
- The benchmark for PY5 will be 5% improvement of PY4 benchmark

COE4 – Energy Star Certification Achievement and Score Improvement for Hospitals

Definition: The ENERGY STAR Score for Hospitals applies to general medical and surgical hospitals, including critical access hospitals and children's hospitals. The objective of the ENERGY STAR score is to provide a fair

assessment of the energy performance of a property relative to its peers, taking into account the climate, weather, and business activities at the property. To identify the aspects of building activity that are significant drivers of energy use and then normalize for those factors, a statistical analysis of the peer building population is performed. The result of this analysis is an equation that will predict the energy use of a property, based on its experienced business activities. The energy use prediction for a building is compared to its actual energy use to yield a 1 to 100 percentile ranking of performance, relative to the national population. The reference data used to establish the peer building population for hospital ENERGY STAR scores in the United States is based on data from an industry survey conducted by the American Society for Healthcare Engineering (ASHE), a personal membership society of the American Hospital Association (AHA).

Measure Steward: U.S. Department of Environmental Protection and U.S. Department of Energy

Data Source: Hospital self-report

Numerator: ENERGY STAR Score

Denominator: None

Exclusions: None

Target Population Notes: All payor patients

Data Elements, Code Systems, Code Lists, Value Sets: Per ENERGY STAR program

Risk Adjustment: Yes, the analysis includes adjustments for the following

- Building size
- Number of Full-Time Equivalent Workers
- Number of Staffed Beds
- Number of MRI Machines
- Weather and Climate (using Cooling Degree Days, retrieved based on Zip code)

Calculation Type: Description available at: www.energystar.gov/sites/default/files/tools/Hospital_August_2018_EN_508.pdf

Additional Considerations: The ENERGY STAR score for hospitals is updated historically every ten years to establish the peer building population (most recent update in November 2021). In the event of an update to the ENERGY STAR certification algorithm from the Environmental Protection Agency (EPA) during the Colorado HTP timeline, the benchmark score will be adjusted or normalized as appropriate to recognize methodological adjustments resulting in a rebasing to the hospital's ENERGY STAR rating.

Benchmark Information:

10 or less hospitals selected this measure:

- The benchmark for PY3 will be an ENERGY STAR Score of 80
- The benchmark for PY4 will be an ENERGY STAR Score of 85
- The benchmark for PY5 will be an ENERGY STAR Score of 90

VII. Population Health/Total Cost of Care

SW-PH1 – Inpatient Hospital Transitions (IHT)

Definition: For Medicaid patients with complex inpatient hospital transitions, care coordination notifications are sent to the RAE to request RAE support in discharge planning.

Inpatient Hospital Transitions are:

- Not associated with authorization for inpatient stay or provider reimbursement.
- A mechanism for hospitals to share focused member-specific information with the RAEs to ensure successful discharge planning.
- The first step in the official communication from hospitals to the RAEs when the hospitals need assistance for a member discharge or transition.
- Focused on complex inpatient hospital transitions from one level of care to another.

All hospitals that selected SW-PH1 must participate in the Inpatient Hospital Transitions (IHT) program and make at least one IHT referral, in accordance with the IHT guidelines. An IHT referral must be made for every IHT qualified stay occurrence at each 30-day interval (exception NICU) to earn the associated at-risk.

Additional information on the IHT program is located on the HCPF website: https://hcpf.colorado.gov/iht

Measure Steward: Colorado Department of Health Care Policy and Financing

Data Source: Medicaid Claims and Atrezzo Provider Portal

Numerator: IHT referrals.

Denominator: Number of IHT qualified hospital stay occurrences.

Exclusions:

- Inpatient Behavioral Health Units
- Long Term Acute Care Hospitals and Specialty hospitals

- Behavioral Health Hospitals
- NICU
    - NICU Level I: Well Newborn Nursery
    - NICU Level II: Special Care Nursery

Target Population Notes: Adult and Pediatric Medicaid (primary)

Data Elements, Code Systems, Code Lists, Value Sets:

Inpatient Hospital Transitions Components:

- Hospitals will follow the current process of submitting the request for RAE assistance as part of the newly designed "IHT Questionnaire" housed in Acentra's PAR Platform (Atrezzo).
- Non-NICU Patients
    - Hospitals will determine which patients engage in IHT.
    - Includes all hospitalized non- Neonatal Intensive Care Unit (NICU) patients, in which the hospital determines to have a complex discharge plan, rather than a subset of select diagnosis.
    - Submit referral for ALL inpatients (non-NICU) at hospital day 30 and every 30-day interval till discharge
    - Refer to IHT Non-NICU Spec Doc for more information.
- NICU members only:
    - Only need to submit one notification, unless hospital identifies care coordination needs help prior to discharge
    - Do **not** need to submit at inpatient length of stay day 30 and every 30 - day interval till discharge
    - NICU Level I: Well Newborn Nursery and NICU Level II: Special Care Nursery are exempt.

- Refer to the IHT NICU Spec Doc for more information.

Risk Adjustment: Not applicable

Calculation Type: Met/Not Met

Additional Considerations:

- All hospitals that selected SW-PH1 must participate in the Inpatient Hospital Transitions (IHT) program and make at least one IHT referral in both PYs 4 and 5.
- HCPF will examine the 30 day stay occurrences in order to have a claims record to reference for accountability.
  - Any hospitals that do not have a corresponding IHT referral to the RAE for every 30-day stay (and every 30th day thereafter) will not earn associated at-risk dollars.
  - Referrals for a particular 30-day stay occurrence must be made within +/- 7 days of the stay occurrence. For example, a referral for a 30-day stay must be received between day 23 and day 37.
- Redistribution of any unearned at-risk will go proportionally to all hospitals that did not lose at-risk.
- Patient-level data regarding each hospital's complex discharges and IHT referrals will be provided to hospitals annually, aligning with the provision of other claims-based measure results. As this measure is evaluated on a met/not met basis for HTP, CPAS dashboards will only display whether the measure benchmark has been met or not met. The claims-based measure detail files provided will include a numerator and denominator value for this measure.

Benchmark Information:

- There will be no benchmark for PY3 and all at-risk will be granted.
- The benchmark for PY4 will be met if all qualifying IHT stays have received a referral.

- The benchmark for PY5 will be met if all qualifying IHT stays have received a referral.

PH1 – Increase the Percentage of Patients who had a Well Visit within a Rolling 12-month period

Definition: The percentage of Medicaid patients who had a well visit within a rolling 12-month period.

Measure Steward: Colorado Department of Health Care Policy and Financing

Data Source: Medicaid claims

Numerator: Patients who received a well visit within a rolling 12-month period.

Denominator: Patients with an (any) outpatient or inpatient claim.

Exclusions:

- Patients not continuously enrolled in Medicaid throughout the measurement year with no more than 45 days total gap.
- Patients with Medicare enrollment at any point during the measurement year
- Patients with third party insurance at any point during the measurement year
- Patients with Managed Care at any point during the measurement year
- Patients with Emergency Medicaid at any point during the measurement year

Target Population Notes:

- Adult and Pediatric Medicaid (primary)

Data Elements, Code Systems, Code Lists, Value Sets: For well visits, the ACC KPI definition was utilized, as well as, additional E and M procedure codes added by the Department.

Risk Adjustment: Not applicable

Calculation Type: Percentage

Additional Considerations:

- Claims with the listed diagnosis codes and billing provider types 32, 45, and 61 were included to capture FQHC, RHC, and IHS visits
- Additional denominator claim type definition:
    - ✓ Claim Type Code used include Inpatient crossover Claims (A), Inpatient Claims (I), Outpatient crossover Claims (C), Outpatient Claims (O) to retrieve all/any outpatient and inpatient claims.
- Additional numerator claim type definition:
    - ✓ Claim Type Code used include Professional crossover Claims (B), Professional Claims (M), Outpatient crossover Claims (C), Outpatient Claims (O), along with any of three following conditions
        - To retrieve well visit using E and M procedure code: Procedure code in ('99381','99382','99383','99384','99385','99386','99387','99391','99392','99393','99394','99395', '99396', '99397', '99460','99461','99463')
        - To retrieve well visit using diagnosis code and additional procedure code to match the ACC KPI definition:

          Diagnosis code in ('Z762','Z0000','Z0001','Z00110','Z00111','Z00121','Z00129','Z005','Z006','Z0070','Z0071','Z008','Z020','Z021','Z022','Z023','Z024','Z025','Z026','Z0281','Z0282','Z0283','Z0289')

          AND

          Procedure code (between '99201' and '99205') or procedure code (between '99211' and '99215') or procedure code in ('99304','99305','99306','99307','99308','99309','99310','99311','99312','99313','99315','99316','99318','99341','99342','99343','99344','99345','99347','99348','99349','99350','99406','99407','99408','99409','99415','99416','99420','99429','99401','99402','99403','99404','99411','99412')
        - To retrieve well visit using diagnosis code and billing provider type:

          Diagnosis code in ('Z762','Z0000','Z0001','Z00110','Z00111','Z00121','Z00129','Z0

05','Z006','Z0070','Z0071','Z008','Z020','Z021','Z022','Z023','Z024','Z025','Z026','Z0281','Z0282','Z0283','Z0289')

AND

Billing provider type in ('32', '45', '61') which are FQHC, RHC, and IHS, respectively

- Eligibility
    - ✓ Health Program Code used include 'MEDA', 'MEDB' for Medicare exclusion
    - ✓ Excluded Title XIX Aid Codes are F3 and F4 (QMB/SLMB)
    - ✓ Excluded Aid Codes include 'N1', 'N2', 'N4', 'K2', 'K7', 'F3', 'F4'

Benchmark Information:

10 or less hospitals selected this measure:

- The benchmark for PY3 will be 5% improvement of the hospital's PY1(baseline) score
- The benchmark for PY4 will be 5% improvement of the PY3 benchmark
- The benchmark for PY5 will be 5% improvement of the PY4 benchmark

PH2 – Increase the Number of Patients Seen by Co-Responder Hospital Staff

Definition: Increase the number of patients seen by Co-Responder hospital staff. Program description at: https://bha.colorado.gov/behavioral-health/co-responder

Measure Steward: Colorado Department of Health Care Policy and Financing

Data Source: Hospital self-report

Numerator: Simple count of number of patient contacts by hospital supported Co-Responder staff.

Denominator: None

Exclusions: None

Target Population Notes: Adult all payor

Data Elements, Code Systems, Code Lists, Value Sets: Patient count

Risk Adjustment: Not applicable

Calculation Type: Patient count

Additional Considerations: Hospital diversion rate should be tracked and reported.

Benchmark Information:

- The benchmark for PY3 will be 5% improvement of the hospital's PY1(baseline) score
- The benchmark for PY4 will be 5% improvement of the PY3 benchmark
- The benchmark for PY5 will be 5% improvement of the PY4 benchmark

PH3 – Improve Leadership Diversity

Definition: Increase the percentage of management staff from underrepresented groups.

Management staff are defined as hospital employees who manage a department or have a title of director or above.

Measure Steward: Colorado Department of Health Care Policy and Financing

Data Source: Hospital self-report

Numerator: Number of hospital employed staff who manage a department or have a title of director or above and who are from underrepresented groups.

Denominator: Number of hospital employed staff who manage a department or have a title of director or above.

Exclusions: None

Target Population Notes: Hospitals will submit titles, position descriptions and numbers of management staff for consideration for inclusion in this metric.

Data Elements, Code Systems, Code Lists, Value Sets: Employee types

Risk Adjustment: Not applicable

Calculation Type: Percentage

Additional Considerations: This will be a year over year improvement over hospital baseline.

Benchmark Information:

10 or less hospitals selected this measure:

- The benchmark for PY3 will be 5% improvement of the hospital's PY1 (baseline) score
- The benchmark for PY4 will be 5% improvement of the PY3 benchmark
- The benchmark for PY5 will be 5% improvement of the PY4 benchmark

VIII. Statewide Priorities – Optional Choices Below

SP-PH1 – Conversion of Freestanding EDs to Address Community Needs

Conditions to Qualify for Freestanding ED (FSED) conversion credit:

- Identify Hospital affiliated FSEDs
    - ✓ Which hospital billing IDs were the FSEDs using?
    - ✓ Mid-point report review
- Efforts beginning October 2018 and after will be eligible
- Priorities are that FSEDs are:
    - ✓ Converted to primary care with after hours
    - ✓ Converted to BH or SUD treatment
    - ✓ Closed
- For each FSED identify:
    - ✓ Is it being converted or closed? Yes/No
    - ✓ If converted, to what?
    - ✓ If closing, why closing instead of converting?
    - ✓ If not converting or closing all the affiliated FSEDs, why are the remaining ones staying in place?

SP-PH2 – Creation of Dual Track ED

A separate process for lower acuity patients presenting to the emergency room department with less serious conditions who can be treated more quickly and then released consisting of the following:

- Dedicated space part of or adjacent to the emergency room
- Dedicated staffing
- Explicit triage criteria
- Open a minimum of 8 hours a day
- Average wait time less than regular emergency department
- Protocols for most common conditions expected to be treated
    - ✓ Minimum of 12 protocols

IX. Appendix

Version Control Inventory

8.24.2021

- SW3-ED ALTO Measure updated.
- BH2 – Initiation of MAT updated.
- COE1 – Summary of Care updated.
- COE2 – Implementation/expansion of Telemedicine Visits updated.
- RAH4 – Statin Medication updated to match eCQM documentation and added link.
- SW-CP1 – Added patient refusal to the exclusion list.
- CP4 - Added patient refusal to the exclusion list.
- CP6 - Added patient refusal to the exclusion list.
- Removed Attachment A Colorado Hospital Specification Detail.
- Added Benchmarks to all measures based on measure selection.

8.30.2021

- RAH1- Numerator exclusion updated.

9.23.2021

- BH1- Added SBIRT link.
- COE1 – Added opt-out for the summary of care record transmission to exclusion list.
- SW-BH3 – Added note about combination Opioid-ALTOs. Edited codes in Table 1 under inclusions. Edited Table 1 under exclusions. Added Table 2 under exclusions. Clarified Table 3. Added CHA contact email.
- Clarified Benchmarks.

10.26.2021

- Added General Guidance section.
- Added Measure Field Definitions section.
- Made general updates throughout for consistency and clarity.
- Added stratifications for applicable measures.

1.14.2022

- SW-CP1 Social Needs Screening Measure updated.
- CP2 – Exclusions and benchmarks updated.
- CP3 - Benchmarks updated.
- CP5 - Benchmarks updated.

1.21.2022

- General Guidance
    - ✓ Clarification added regarding Medicaid target populations.
    - ✓ Added patient age calculation
- Removed Data Collection Methodology from all measures.
- Updated measure title of RAH1.
- Added clarity to SW-CP1.
- CP6 – Added note about hospitals reporting count of total positive screens separately from numerator and denominator.

2.2.2022

- Updated Hospital Index benchmarks
- Time intervals - Removed from all measures except CP2 because the measure is reported December to April.
- Added wording in additional considerations to RAH1, RAH2, SW-CP1, CP6, COE1, SW-BH1 and PH1 regarding the intent for hospitals to work with the primary RAE.
- Added clarity to exclusion criteria for SW-CP1.

6.10.2022

- RAH1 - Updated exclusions in RAH1 for clarity
- RAH4 - Updated measure steward to Joint Commission.
- SW-CP1 – Updated measure definition, numerator criteria, and added clarity to additional considerations.
- CP5 – Specified ICD-10 code tables.
- CP6 - Updated screenings and encounters to include IP, ED, and Observation.
- COE1 – Updated language to specify SOC record transmission must be "external to the hospital system" and updated benchmarks.
- COE4 – Added clarification to definition, numerator, and benchmark. Included additional considerations related to future adjustments to score.

11.9.2022

- SW-RAH1 –
    - ✓ Updated numerator/denominator wording
    - ✓ Updated exclusions to include patients with Medicare enrollment, third party insurance, managed care, and EMS

- ✓ Added definitions of Medicaid readmission, Medicaid index admission, and actual/expected readmission
- ✓ Updated exclusions
- ✓ Updated target population notes
- ✓ Updated additional considerations
- ✓ Updated risk adjustment steps
- ✓ Updated risk adjustment tables link

- SW-RAH2 –
  - ✓ Updated definition, numerator and denominator wording
  - ✓ Updated exclusion detail to include patients who were in an observation stay
  - ✓ Expanded wording on target population, risk adjustment and calculation type
  - ✓ Removed Eligibility guidelines in additional considerations
  - ✓ Benchmark updated
- RAH2 –
  - ✓ Updated exclusion criteria
  - ✓ Added procedure codes/billing provider information
- CP1 Adult -
  - ✓ Expanded wording in definition
  - ✓ Updated numerator/denominator
  - ✓ Updated exclusions
  - ✓ Included discharge status codes to be excluded
  - ✓ Updates to target population notes
  - ✓ Updated benchmark methodology to average performance
- CP1 Pediatric -
  - ✓ Updated definition, numerator and denominator wording
  - ✓ Updated Data Source, Risk adjustment, Target Population
  - ✓ Removed “Patients discharged AMA” from exclusions
  - ✓ Benchmark updated
- CP6 -

- ✓ Updated wording in additional considerations

- SW-BH1 -
  - ✓ Updated wording in definition, numerator and denominator
  - ✓ Removed ICD code ranges
  - ✓ Updated additional considerations
- SW-BH2 -
  - ✓ Updated definition wording
  - ✓ Added patient refusal exclusion
  - ✓ Updated target population wording
  - ✓ Added additional consideration
- SW-PH1 -
  - ✓ Updated exclusions
  - ✓ Expanded risk adjustment and additional considerations wording
- PH1 -
  - ✓ Updated numerator and denominator wording
  - ✓ Updated exclusions to include patients with Medicare enrollment, third party insurance, managed care, and EMS
  - ✓ Added claim type codes

12.15.2022

- SW-RAH2 –
  - ✓ Benchmark updated based on data from PHIS
- CP1 Pediatric -
  - ✓ Benchmark updated based on data from PHIS
- CP2 –
  - ✓ Added observation place of service
  - ✓ Updated target population to specify age as of admission date
- CP3 -
  - ✓ Added observation place of service
  - ✓ Updated target population to specify age as of date of diagnosis of suspected sepsis

- SW-BH3 -
    - ✓ Updated measure definition, numerator, and denominator wording
    - ✓ Removed MME table as it is no longer relevant
    - ✓ Updated calculation type to align with revised definition
    - ✓ Updated additional considerations
    - ✓ Added Ropivacaine and Bupivacaine (Marcaine) to ALTOs of Interest

7.24.2023

- COE3 -
    - ✓ Updated measure definition to remove the references to primary care clinicians/providers and specialists.
- SW-BH1 -
    - ✓ Added 2023 diagnoses codes.
    - ✓ Updated exclusions to include hospice.
- SW-RAH1 -
    - ✓ Updated Benchmarks for PY3-PY5.
- RAH1 -
    - ✓ Updated exclusions to include inpatient hospice.
- RAH4 -
    - ✓ Updated Benchmarks for PY3-PY5.
- SW-CP1 -
    - ✓ Updated exclusions to include hospice.
- CP5 -
    - ✓ Added the date of the data referenced in PY3 and PY5 benchmarks.
- CP6 -
    - ✓ Updated exclusions to include hospice.
- SW-PH1 -
    - ✓ Updated language to clarify measure specifications.
    - ✓ Updated Benchmarks for PY4 and PY5.

10.4.2023

- SW-RAH1 -
    - ✓ Updated Benchmarks for PY3-PY5.
- SW-PH1 -
    - ✓ Updated Benchmarks for PY3-PY5.

- BH1 -
    - ✓ Updated measure definition and numerator definition to indicate the brief intervention after a positive screen in the ED may occur at any point during the hospital visit.

11.15.2023

- SW-RAH2 -
    - ✓ Added content to additional considerations regarding inclusion of out-of-state Medicaid
- SW-BH3 -
    - ✓ Modified select terminology in measure title, definition, and numerator/denominator.

03.12.2024

- RAH4
    - ✓ Updated exclusion criteria to align with Joint Commission Specifications Manual.

05.22.2024

- SW-BH3.2 (Increase use of ALTO)
    - ✓ Updated Benchmarks for PY3-PY5.
- Average performance benchmarks
    - ✓ Added benchmark calculated based on PY1 data for all average performance benchmark measures.

10.1.2024

- SW-PH1
    - ✓ Removed all Specifications for Severity Length of Stay (LOS) measure.
    - ✓ Added new Specifications for SW-PH1 (Inpatient Hospital Transitions (IHT)).

11.5.2024

- BH1
    - ✓ Updated benchmark values for PY3-PY5.

1.7.2025

- COE1
    - ✓ Updated numerator definition to specify summary of care exchange may be facilitated by a Qualified Health Information Network

1.8.2025

- SW-PH1

- ✓ Updated Additional Considerations to include that referrals for a particular 30-day stay occurrence must be made within +/- 7 days of the stay occurrence.