Colorado Hospital Transformation Program

Quarterly Reporting Guide v6

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CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

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II. Introduction

The Colorado Department of Health Care Policy and Financing (Department or HCPF) administers the Hospital Transformation Program (HTP). Over the course of the HTP, the Department receives a variety of information from HTP participants through quarterly reports. This document is a comprehensive guide to the quarterly reporting process for hospitals that participate in the program and other stakeholders.

A. HTP Overview

The HTP is a five year program to implement hospital-led strategic initiatives through the establishment of an alternative payment incentive program. The HTP leverages supplemental payment funding generated through the existing healthcare affordability and sustainability fees. Payments are used as incentives in the HTP to improve patient outcomes through care redesign and integration with the community, optimize Medicaid costs through reductions in avoidable care, and prepare hospitals for future value-based care.

As part of the HTP, hospitals receive supplemental payments based on community health neighborhood engagement, performance on quality measures, and interventions implemented to impact those measures.

To qualify for the HTP, hospitals submitted HTP Applications containing interventions to be implemented or enhanced for the HTP to impact the hospital's selected performance measures. Upon Department approval of the HTP Application, participants prepared Implementation Plans for their HTP interventions with demonstrable milestones. Hospitals are measured on improved performance in years three through five of the program across a series of measures important to improved processes of care, improved health outcomes, and reducing avoidable utilization and costs. At the conclusion of the program, hospitals will be asked to produce a plan for sustainability of projects and performance.

B. Quarterly Reporting

Hospitals provide quarterly reports on intervention progress and milestones, as outlined in their approved HTP Implementation Plans, as well as ongoing community health neighborhood engagement (CHNE) activities. Once a year, hospitals also self-report data on their selected performance measures. All reports are reviewed by the

Department and are evaluated based on established scoring criteria described within this document to determine payment of at-risk dollars.

1. **Interim Activity and CHNE**

   Biannual interim activity reports indicate the hospitals' progress toward achieving the upcoming milestone for each intervention as established in the approved HTP Implementation Plan. This report also contains information about the hospital's CHNE activities during the quarter.

2. **Milestone Activity and CHNE**

   Biannual milestone reports determine whether the milestones established in the participant's Implementation Plan were met. As part of milestone reporting, hospitals submit the supporting documents specified in the Implementation Plan to verify milestone completion. This report also contains information about CHNE activities during the quarter.

   Hospitals subject to loss of at-risk dollars for missed (not completed) milestones may also submit a course correction plan (once per intervention) with the report during which the milestone was missed. Hospitals also have an opportunity to submit amendments of future milestones for Department review through the milestone report, if applicable.

3. **Performance Measures**

   Performance measures data is transmitted to the Department annually for the hospital-calculated measures selected in the HTP Application. Data for claims-based measures are not submitted by hospitals, rather claims-based measures are calculated on the hospitals' behalf by the Department.

The schedule below identifies the reporting periods and quarterly reporting due dates for the duration of the HTP. Quarterly reports are due the final calendar day of the month following the applicable quarter end. If the report due date falls on a weekend or Department holiday, reports may be submitted the following business day.

PY/Q	Quarter End Date	Required Report(s)	Report Due Date
PY1/Q1	12/31/2021	N/A	N/A
PY1/Q2	3/31/2022	Rehearsal Measure Data	3/31/2022
PY1/Q3	6/30/2022	Interim Activity & CHNE Report	7/31/2022
PY1/Q4	9/30/2022	Interim Activity & CHNE Report	10/31/2022
PY2/Q1	12/31/2022	Interim Activity & CHNE Report PY1 Performance Measure Data	1/31/2023
PY2/Q2	3/31/2023	Milestone & CHNE Report Milestone Course Correction (if applicable) Milestone Amendment (if applicable)	4/30/2023
PY2/Q3	6/30/2023	Interim Activity & CHNE Report	7/31/2023
PY2/Q4	9/30/2023	Milestone & CHNE Report Milestone Course Correction (if applicable) Milestone Amendment (if applicable)	10/31/2023
PY3/Q1	12/31/2023	Interim Activity & CHNE Report PY2 Performance Measure Data	1/31/2024
PY3/Q2	3/31/2024	Milestone & CHNE Report Milestone Course Correction (if applicable) Milestone Amendment (if applicable)	4/30/2024
PY3/Q3	6/30/2024	Interim Activity & CHNE Report	7/31/2024
PY3/Q4	9/30/2024	Milestone & CHNE Report Milestone Course Correction (if applicable) Milestone Amendment (if applicable)	10/31/2024
PY4/Q1	12/31/2024	Interim Activity & CHNE Report PY3 Performance Measure Data	1/31/2025
PY4/Q2	3/31/2025	Milestone & CHNE Report Milestone Course Correction (if applicable) Milestone Amendment (if applicable)	4/30/2025
PY4/Q3	6/30/2025	Interim Activity & CHNE Report	7/31/2025
PY4/Q4	9/30/2025	Milestone & CHNE Report Milestone Course Correction (if applicable) Milestone Amendment (if applicable)	10/31/2025
PY5/Q1	12/31/2025	Interim Activity & CHNE Report PY4 Performance Measure Data	1/31/2026
PY5/Q2	3/31/2026	Milestone & CHNE Report Milestone Course Correction (if applicable) Milestone Amendment (if applicable)	4/30/2026
PY5/Q3	6/30/2026	Interim Activity & CHNE Report	7/31/2026
PY5/Q4	9/30/2026	Milestone & CHNE Report	10/31/2026

PY/Q	Quarter End Date	Required Report(s)	Report Due Date
		Milestone Course Correction (if applicable) Milestone Amendment (if applicable)	
Payment Year Q1	12/31/2026	PY5 Performance Measure Data	1/31/2027

C. Review and Scoring of Quarterly Reports

Through the submission of quarterly reports, hospitals earn at-risk funds in three distinct areas: (1) Reporting, (2) Milestone completion, and (3) Measure performance.

1. Reporting Scores

The Department scores hospital reporting compliance based on both timeliness of the submission and whether the reporting provided is satisfactorily complete. If one, or both, of these scoring elements are not achieved, the hospital loses at-risk funds for reporting. Scores of "on time" and "complete" must be achieved for each reporting element to earn at-risk dollars for reporting for that quarter. Timeliness scores are based on submissions as of the due date. Reporting timeliness and completeness scores apply to the following submissions:

- ✓ Interim activity and CHNE reports
- ✓ Milestone and CHNE reports
- ✓ Performance measures data

2. Milestone Completion Scores

Distinct at-risk funds are earned for milestone completion, as documented in biannual milestone reports. In addition to scoring milestone reports for reporting compliance, a determination is made on whether the report demonstrates that the milestones established in the hospital's Implementation Plan were met. A score of "met" or "not met" is assigned, which translates to at-risk funding for milestone completion.

3. Performance Measure Scores

Distinct at-risk funds are earned for performance measures. In addition to scoring hospital self-reported performance measure submissions for

reporting compliance in PY1-PY5, a determination is made on whether the hospital meets or exceeds applicable measure benchmarks beginning in PY3. A portion of at-risk funds may be earned if the hospital does not meet the benchmark, but is able to meet the established achievement threshold. Further, additional at-risk funds may be earned if the hospital is considered "high performing" for performance measures. The Department will perform the applicable calculations to determine earned at-risk funds for measure performance, including benchmarks and achievement threshold attainment.

Scoring for the three categories of at-risk funds (reporting, milestone completion, and measure performance) are treated independently. If a hospital does not earn at-risk funds for one scoring category, at-risk funds may still be earned in other categories. For example, if a milestone completion score results in a "not met" score but the hospital provides complete and timely reporting, at-risk funds may be earned for reporting, and be unearned for milestone completion.

Report	At-Risk Category	Possible Scores
Interim Activity and CHNE	Reporting	Timeliness: On Time/Late Completeness: Complete/Incomplete
Milestones and CHNE	Reporting	Timeliness: On Time/Late Completeness: Complete/Incomplete
Milestones and CHNE	Milestone Completion	Milestone Completion: Met/Not Met
Milestone Course Correction	Milestone Completion[1]	Timeliness: On Time/Late Score: Approved/Approved with Modification/Rejected
Milestone Amendment	N/A[2]	Timeliness: On Time/Late Score: Approved / Rejected
Performance Measure Data	Reporting	Timeliness: On Time/Late Completeness: Complete/Incomplete

[1] If a hospital indicates a milestone is not completed in their milestone report, 50% of unearned at-risk dollars are earned back by submitting an accepted course correction plan. While the hospital's at-risk funds will not be negatively impacted for a course correction plan that is rejected, the hospital will not earn back 50% of unearned at-risk dollars for a missed milestone. For additional information, please refer to **Section IV.D. Course Correction Plan.**

[2] While there are no at-risk funds tied to receiving an approved or rejected milestone amendment, the hospital's future milestones will not be amended unless a score of "approved" is received. For additional information, please refer to **Section IV.E. Milestone Amendments.**

Report	At-Risk Category	Possible Scores
Performance Measure Data	Measures Performance	Benchmark: Met/Not Met Achievement Threshold: Met/Not Met/NA High Performing Hospital: Yes/No/NA

D. Scoring Review and Reconsideration Period

The Department has implemented a quarterly Scoring Review and Reconsideration Period (SRRP) as part of the process for finalizing hospitals' scores. The objective of the SRRP is to provide hospitals an opportunity to view their scores for reporting compliance, milestone completion (including milestone amendments and course corrections), and performance measure data accuracy after an initial review by the Department. As needed, hospitals may ask for a reconsideration of the score if they believe information has been scored in error.

Upon report submission, the Department will follow the timeline below to validate reports and finalize scoring. The SRRP begins when the Department notifies hospitals of initial scores available for viewing. Reporting and milestone completion scores are expected to be finalized within 45 business days from the report due date.

Validation Process Activity	Completion Date
Department completes initial review of quarterly reports	Within 20 business days of report due date
Department notifies participant of scores available for viewing and SRRP begins	Within 21 business days following the report due date
Hospital request for reconsideration due	Within 10 business days of release of initial scores.
Department issues final scores and SRRP reconsideration decisions	Within 14 business days of SRRP request period close.

On an annual basis, the Department will provide a quarterly reporting calendar, which will be made available on the CPAS portal. The calendar will include all key dates for quarterly reporting, such as the dates initial scores will be available, SRRP due dates, and scoring finalization dates.

1. Reviewing Hospital Scores

After the Department's initial review and scoring of quarterly reports, hospital contacts will receive email notification that scores are available for review on the CPAS portal. Hospitals follow the steps outlined below to view their scores:

- ✓ Log into the CPAS portal.
- ✓ Select Hospital Reporting Requirements dashboard to view the hospital's scores.
- ✓ Assess the current reporting quarter scores. Note: historic quarterly report scores will also be stored on the CPAS portal.
- ✓ A letter is provided in the CPAS portal document repository by the date hospitals are notified scores are available for viewing. If the hospital receives a score resulting in unearned funds, the letter explains the basis for unearned at-risk funds.

2. Requesting Reconsideration

Hospitals may request reconsideration of a scoring decision after receiving notification of initial scores. All requests for reconsideration must be submitted within 10 business days after notification that initial scores are available for viewing on the CPAS portal. No reconsideration requests received after 11:59 pm on the due date are considered.

To submit a request for reconsideration of the hospital's initial scores, follow the steps below:

- ✓ Download a blank HTP SRRP Form available in the CPAS portal.
- ✓ Complete the HTP SRRP Form to identify scoring elements the hospital would like reconsidered, and rationale for the reconsideration request.[3]
- ✓ Email the completed form to cohtp@mslc.com and copy cohtp@state.co.us.

[3] Reminder that the SRRP accommodates additional supporting documentation in specific cases. Please refer to **Sections IV.F.3. Milestone Amendment** and **V.C.1. Hospital-calculated Measure Reporting Score** for additional information on applicable cases.

- ✓ In the subject line, enter "PY[x]Q[x]-SRRP-Hospital Name".

Do not attach documents other than the HTP SRRP Form to email requests for reconsideration, as all other quarterly report documents are managed within the CPAS portal. The goal of the process is to accommodate reconsideration of scoring decisions. Late report submissions and report revisions are not accepted as part of SRRP. Hospitals should follow the report-specific guidance contained in this document regarding whether additional documents will be accepted (via upload to the CPAS portal) during SRRP.

The hospital is notified via email when the Department has reached a decision on the hospital's reconsideration request. Using the same process to view initial scores, the hospital may view its final scores in the Hospital Reporting Requirements dashboard in the CPAS portal. Additionally, a letter will be provided in the CPAS portal document repository containing the Department's SRRP decision, if applicable.

3. Requesting Escalation

If the hospital disagrees with their reconsideration decision, they may request an escalation to Matt Haynes, Special Finance Projects Manager. If further escalation is necessary, hospitals may direct requests to Nancy Dolson, Special Financing Division Director (nancy.dolson@state.co.us). Escalations must be made within five business days of receiving a reconsideration response from the Department and requested as soon as possible to ensure timelines for finalizing HTP scores are maintained. If escalation is requested, please include Matt Haynes (matt.haynes@co.state.us) from the Department in the request and copy cohtp@state.co.us.

Escalation requests will not be considered if the hospital did not first raise the issue during the SRRP.

If escalation is requested, the Department will follow the timeline below to validate reports and adjudicate any escalation requests.

Escalation Process Activity	Completion Date
Hospital request for escalation to Matt Haynes, Special Finance Projects Manager	Within 5 business days of Department issuing SRRP determination
Department issues escalation request decision	Within 10 business days of Department issuing SRRP determination
Hospital request for additional escalation to Nancy Dolson, Special Financing Division Director.	Within 15 business days of Department issuing SRRP determination
Department issues escalation request decision	Within 20 business days of Department issuing SRRP determination

III. Guide to Interim Activity and CHNE Reporting

Interim Activity and CHNE reports document the hospitals' progress toward achieving the milestones established in the approved HTP Implementation Plan, and contain information about the hospital's CHNE activities.

A. Contents of Interim Activity and CHNE Report

The Interim Activity and CHNE Report Survey Template is included in Appendix B of this document.

B. Submission of Interim Activity and CHNE Report

The hospital's complete Interim Activity and CHNE report is included in the survey submission. Hospitals receive notification via email when the hospital's unique survey link is available to access on the CPAS portal. This notification will be sent to hospitals on the first business day following the close of the reporting quarter. To support hospital's timely submission of quarterly reports, a reminder email is sent to hospitals approximately five business days prior to the report due date.

Using the survey link, the hospital is guided through interim activity and CHNE reporting. Responses to all questions are required to advance through the survey. Upon submission of the survey, the report is transmitted to the Department. The survey automatically generates a confirmation page for the hospital's records after the survey has been successfully submitted. The survey responses are also

automatically emailed to the hospitals' contacts on file upon survey submission. After submission, additional revisions are not possible using the survey link provided.

1. **Report Revisions Prior to Due Date**

   The hospital may edit the survey on multiple occasions prior to the due date, and the hospital's changes are saved between sessions. However, submission of the survey prevents further edits. Hospitals are encouraged to carefully review their survey responses prior to submitting the report. If a hospital submitted their survey in error or notices material errors in the submission, they may notify cohtp@mslc.com **prior** to the report due date.

2. **Late Submissions Not Accepted**

   Late submission of interim activity and CHNE reports are not accepted. After the report due date, survey links are disabled and it is not possible for the hospital to submit a report for the quarter.

C. Scoring and Achievement Review Criteria

The Department scores Interim Activity and CHNE for reporting based on both timeliness of the submission and whether the reporting provided is satisfactorily complete. Hospital submissions must be scored "on time" and "complete" to earn at-risk dollars for reporting for the quarter. If one, or both, of these scoring elements is not achieved, the hospital loses one hundred percent of at-risk funds for reporting.

1. **Timeliness**

   Hospitals receive a score of "on time" or "late" for the interim activity and CHNE report based solely on the date the survey was submitted. Reports are due on the last calendar day of the month following quarter end, as shown in the above Quarterly Reporting Schedule section of this document. If the report due date falls on a weekend or Department holiday, reports may be submitted the following business day.

2. Completeness

Interim activity and CHNE reports receive a score of "complete" or "incomplete", based on the report's contents.

a. Interim Activity Completeness

To receive a score of "complete" for interim activity, the report must meet the criteria below:

- ✓ Is a response provided to each question in the survey?
- ✓ Is the response relevant to the intervention and upcoming milestone?
- ✓ Does the response describe interim activities the hospital has engaged in toward achievement of the upcoming milestone? Hospitals are able to address any future milestone(s) if they choose, but are required to minimally report progress on the upcoming milestone following the applicable interim activity report.

If the hospital is in the planning and implementation phase of the Implementation Plan and the upcoming milestone has multiple functional areas, it is not required for the hospital to report interim activity in every functional area of the upcoming milestone. Rather, the hospital may select one or more functional areas in which to report interim activity.

Regardless of Implementation Plan phase, hospitals indicate whether they are on target to complete the upcoming milestone. If the hospital indicates they are not on target for the upcoming milestone, responses are required regarding the challenges and risks and resulting mitigation strategies. The below scoring criteria is applicable if the hospital indicates they are not on target for an upcoming milestone:

- ✓ Does the response identify the challenges/risks?
- ✓ Does the response articulate planned and/or attempted mitigation strategies for the challenges/risks identified?

b. CHNE Completeness

To receive a score of "complete", the CHNE report must meet the criteria below:

- ✓ Is a response provided to each applicable question in the survey?
- ✓ Did the hospital perform CHNE activities during the quarter? Note, starting with PY1Q3, hospitals are required to report ongoing CHNE activities every quarter as part of quarterly HTP reporting. Each quarter a hospital must conduct **at least** one of the following: consultation with key stakeholders, community advisory meeting, and/or public input engagements. Details regarding the annual requirements for each program year are included below.

The following minimum annual CHNE requirements apply in PY1, as outlined in the Ongoing CHNE Requirements document:

- ✓ Hospitals must consult with key stakeholders in both PY1Q3 AND PY1Q4;
- ✓ Hospitals must host public engagements in either PY1Q3 OR PY1Q4

The following minimum annual CHNE requirements apply in PY2-5, as outlined in the Ongoing CHNE Requirements document:

- ✓ Hospitals must consult with key stakeholders outside of community advisory meetings at least two quarters each year;
- ✓ Hospitals must host or participate in community advisory meetings at least two quarters each year;
- ✓ Hospitals must host public engagements at least once annually (wherein members of the public are given the opportunity to learn about and provide feedback on the hospital's HTP interventions); and
- ✓ Hospitals must attend the annual Learning Symposium.

Learning Symposium attendance is collected by the Department. As a result, quarterly CHNE reports do not gather information about the hospital's Learning Symposium attendance.

On an annual basis following Q4, an expanded review of CHNE reports will be conducted to determine if the hospital has completed and documented the required engagements across the quarterly CHNE reports. The hospital will receive a Q4 reporting score of "incomplete" if the annual CHNE requirements are not met.

The Department's reporting scores interim activity and CHNE roll up to a single determination of whether the hospital earned at-risk for reporting for the quarter. Hospitals do not earn partial at-risk funds for reporting.

For example, a hospital could provide interim activity reporting that is "on time" and "complete", and report that no CHNE activities were completed during the quarter, resulting in a score of "on time" and "incomplete" for CHNE. This would result in the hospital losing one hundred percent of at-risk funds for reporting for the quarter, since the hospital did not meet all quarterly reporting requirements.

D. SRRP for Interim Activity and CHNE Reports

The Department's SRRP provides hospitals an opportunity to view the reporting scores received for interim activity and CHNE reports. If the hospital believes the report has been scored in error, they may ask for reconsideration of the Department's initial scores.

The process for viewing hospital scores and requesting reconsideration is described in the Introduction section of this document (see Scoring Review and Reconsideration Period subsection). These processes are consistent for all types of quarterly reports.

All scoring and reconsideration decisions are based solely on the interim activity and CHNE reports submitted by the due date. The only type of supporting documentation accepted during the SRRP for interim activity and CHNE reports are documents that illustrate why the hospital disagrees with the initial score. Late report submissions and report revisions are not accepted as part of the SRRP.

For example, if a hospital submitted their Interim Activity and CHNE report by the due date, but received an initial score of "late" due to Department error, the hospital may request reconsideration. In this case, the hospital could submit their dated survey confirmation page during SRRP to show timely submission. This document is permitted because it illustrates the basis for disagreement with the score. The confirmation page is not an item that should have been submitted as part of the hospital's quarterly report.

IV. Guide to Milestone and CHNE Reporting

Milestone reports document whether the intervention milestones established in the participant's Implementation Plan were met. As part of milestone reporting, hospitals submit via the CPAS portal the supporting documents specified in the Implementation Plan to verify milestone completion. This report contains a section to document the hospital's CHNE activities for the quarter. Milestone amendments and course correction plans may also be submitted, if applicable.

A. Contents of Milestone and CHNE Report

The Milestone and CHNE Report Survey Template is included in Appendix C of this document.

B. Milestone and CHNE Report Submission

A complete Milestone and CHNE report submission includes all of the following elements:

1. **Complete responses to all applicable survey questions**

   Hospitals receive notification via email when the hospital's unique survey link is available to access on the CPAS portal. This notification will be sent to hospitals on the first business day following the close of the reporting quarter. To support hospital's timely submission of quarterly reports, a reminder email is sent to hospitals approximately five business days prior to the report due date. Using the survey link, the hospital is guided through milestone and CHNE reporting. Responses to all questions are required to advance through the survey. Upon submission of the survey, the report is transmitted to the Department. The survey automatically generates a confirmation page for the

hospital's records after the survey has been successfully submitted. The survey responses are also automatically emailed to the hospitals' contacts on file upon survey submission. After submission, additional revisions are not possible using the survey link provided.

a. Report Revisions Prior to Due Date

The hospital may edit the survey on multiple occasions prior to the due date, and the hospital's changes are saved between sessions. However, submission of the survey prevents further edits. Hospitals are encouraged to carefully review their survey responses prior to submitting the report. If a hospital submitted their survey in error or notices material errors in the submission, they may notify cohtp@mslc.com **prior** to the report due date.

b. Late Submissions Not Accepted

Late submission of milestone and CHNE reports are not accepted. After the report due date, survey links are disabled and it is not possible for the hospital to submit a report for the quarter.

2. Milestone Supporting Documentation

Each hospital's Implementation Plan specifies supporting documentation to be submitted to verify milestone completion for each intervention in the applicable quarter. Supporting documentation must be uploaded to the CPAS portal document repository by the report due date. Folders in the document repository are labeled by program year and quarter to organize documentation submissions over the course of the program. The hospital is able to upload multiple documents to a single folder for the applicable quarter. Via the survey, it is required that the hospital properly name and catalogue the documents submitted, and utilize the document naming convention specified below.

a. Index of Supporting Documentation

In order for the Department to identify the specific milestone element the documentation corresponds to, hospitals will be asked

to provide an index of supporting documentation. The index of supporting documentation must use the following naming convention for each supporting document uploaded: **Milestone Code – Document Description.** Additionally, a space will be provided within the survey to indicate the page number of the supporting documentation that specifically supports completion of the milestone, if applicable. The supporting documentation uploaded to CPAS should be titled as indicated in the survey submission.

The milestone code identifies the intervention number, program year, quarter, and milestone element (such as functional area), and is formatted as follows: INT[x] - PY[x]Q[x] - [x]. A best practice is to use the same milestone code as those in the CPAS Intervention/Milestone Detail Dashboard. Access the Intervention/Milestone Detail Dashboard using the following steps:

- Log in to CPAS
- Navigate to the "Reports" tab
- Click on Intervention/Milestone Detail
- The milestone code is present in the second column of the table for each intervention.

Example One: Milestone codes for a milestone in the planning and implementation phase with two functional areas:

- ✓ People Milestone Code – **INT3.PY2Q4.1**
- ✓ Technology Milestone Code - **INT3.PY2Q4.2**

  In this example, the second functional area is numbered "2", because there is more than one functional area associated with the milestone, and each functional area is identified by a different number.

Example Two: Milestone code for a continuous learning and improvement phase milestone:

- ✓ Milestone Code – **INT3.PY3Q4.1**

In this example, the milestone code ends with "1" because there are not multiple functional areas associated with continuous learning and improvement milestones. Thus, the final digit in the milestone code will always be "1" for continuous learning and improvement milestones.

An example of the full naming convention for supporting documentation is below.

- ✓ INT3.PY2Q4.1–Transitions of Care Meeting Minutes

For hospitals that submit multiple supporting documents to verify the same milestone, please separate document naming conventions by a semicolon. An example of the naming convention for 2 or more supporting documents for the same functional area is below:

- ✓ INT3.PY2Q2.1–Transitions of Care Meeting Minutes; INT3.PY2Q2.1–Transitions of Care Workbook

b. Supporting Documentation Submission

- Log into CPAS
- Navigate to the Document Repository
- Click on "Quarterly Reporting Submission"
- Click on Milestone Reporting for the appropriate quarter
- Upload all supporting documentation that verifies milestone completion utilizing the naming conventions indicated in the milestone reporting survey

C. Scoring and Achievement Review Criteria

Milestone and CHNE reports receive a score in two categories: (1) Reporting and (2) Milestone completion

1. Reporting Scores

The Department scores Milestone and CHNE for reporting compliance based on both timeliness of the submission and whether the reporting provided is satisfactorily complete. If one, or both, of these scoring elements is not achieved, the hospital loses one hundred percent of at-

risk funds for reporting. Hospital submissions must be scored "on time" and "complete" to earn at-risk dollars for reporting for that quarter.

a. Timeliness

Hospitals receive a score of "on time" or "late" for the milestone and CHNE report based solely on the date that the following items are submitted:

- ✓ Survey
- ✓ Milestone supporting documents

Reports are due on the last calendar day of the month following quarter end, as shown in the above Quarterly Reporting Schedule section of this document. If the report due date falls on a weekend or Department holiday, reports may be submitted the following business day.

b. Milestone Completeness

Milestone reports receive a score of "complete" or "incomplete", based on the report's contents, including supporting documentation.

The reporting score for completeness addresses whether minimum reporting criteria was attained. For the milestone report to be considered "complete", the below criteria must be met:

- ✓ Is a response provided to each applicable question in the survey?
- ✓ Do responses address the milestone (and associated functional areas) indicated in the Implementation Plan?
- ✓ Was documentation uploaded for each milestone the hospital met?

Documentation submission is required to achieve a score of "complete" for each milestone the hospital met during the quarter. If a hospital did not meet a milestone, the hospital may still achieve a reporting score of "complete". Documentation is not required for

the interventions where the hospital has indicated milestones were not met during the quarter.

Reporting "completeness" scores do not consider whether the milestone documentation submitted proves milestone completion. This is evaluated when determining if the milestone was met.

c. CHNE Completeness

To receive a score of "complete", the CHNE report must meet the criteria below:

- ✓ Is a response provided to each applicable question in the survey?
- ✓ Did the hospital perform CHNE activities during the quarter? Note, starting with PY1Q3, hospitals are required to report ongoing CHNE activity every quarter as part of quarterly HTP reporting. Each quarter a hospital must conduct **at least** one of the following: consultation with key stakeholders, community advisory meeting, and/or public input engagements. Details regarding the annual requirements for each program year are included below.

Annual CHNE requirements are applicable to the quarterly reporting process, as outlined in the Ongoing CHNE Requirements document. The following minimum CHNE requirements must be completed and demonstrated in the combined CHNE reports for each program year, beginning in program year two:

- ✓ Did hospital consult with key stakeholders outside of community advisory meetings at least two quarters each year?
- ✓ Did hospital host or participate in community advisory meetings at least two quarters each year?
- ✓ Did hospital host public engagements at least once annually?
- ✓ Did hospital attend the annual Learning Symposium annually?

As a reminder, there are no milestone reporting requirements in PY1; all CHNE reporting for PY1 happens during Interim Activity and CHNE reporting.

On an annual basis following Q4, an expanded review of CHNE reports will be conducted to determine if the hospital has completed and documented the above engagements in quarterly CHNE reports, with the exception of the annual Learning Symposium. Learning Symposium attendance will be collected by the Department. As a result, the hospital is not required to report on Learning Symposium attendance. The hospital will receive a Q4 reporting score of "incomplete" if the annual CHNE requirements are not met.

The reporting scores for milestones and CHNE roll up to a single determination of whether the hospital earned at-risk for reporting for the quarter. Hospitals do not earn partial at-risk funds for reporting.

2. Milestone Completion Scores

In addition to reporting, hospitals earn separate at-risk funds for meeting milestones. The Department scores milestones for each intervention as "met" or "not met", based on the responses to the survey, as well as the supporting documentation provided by the report due date.

For a milestone to be scored "met", the following scoring criteria will be applied, based on the survey submitted and documentation provided by the due date:

- ✓ Did hospital indicate in the survey that the milestone was completed by quarter-end?
- ✓ Did the hospital submit the supporting documentation specified in the Implementation Plan for the milestone?
- ✓ Does the supporting documentation provided demonstrate milestone completion (including all associated functional areas, if applicable)?
- ✓ If supporting documentation is dated, does documentation support milestone completion by quarter-end?

Each intervention receives a score of "met" or "not met", and the number of milestones met correlate to at-risk funds earned. The hospital does not have to meet all milestones to earn a portion of at-risk funds for meeting the remaining milestones.

D. Course Correction Plan

If a hospital indicates a milestone is not completed in their quarterly report, hospitals may submit a course correction plan with the report for the quarter during which the milestone was not met. For example, if a Q4 milestone is not completed, the course correction plan would be submitted as part of the Q4 milestone report. As a reminder, hospitals must submit course corrections during the initial quarterly report submission. No course corrections will be considered if submitted after the initial report due date. 50% of unearned at-risk dollars are earned back by submitting an accepted course correction plan. Course correction plans receive a score of "approved" or "rejected" based on whether the plan is satisfactorily complete, and whether the intervention is eligible for a course correction plan. Course correction plans may only be submitted once per intervention. An intervention would be ineligible for a course correction plan if a previous course correction plan was approved for the intervention.

"Course correction plans" must provide insights into the root causes of a missed milestone and detail the process the program participant intends to pursue to either complete the missed milestone as previously defined or provide insight as to why the missed milestone will not or should not be completed. Course correction plans must also provide operational insights into how future milestones associated with the intervention will be completed by their previously intended deadlines. Part of the hospitals' plan for correcting an intervention's course may involve amending future milestones. While the course correction plan could discuss amending future milestones as part of the way forward, the course correction plan is not the mechanism by which milestones are amended. All milestone amendments must be submitted as an official milestone amendment. As a result, if a course correction plan discusses milestone amendments which are not separately submitted as milestone amendments, no changes to the hospital's milestones will be recognized. As a reminder, milestones may be amended prospectively through reports for Q2 and Q4 and there is no limit to how often a hospital may prospectively amend milestones.

The below scoring criteria is applied to determine if the course correction plan is "approved" or "rejected":

- ✓ Did the hospital indicate the milestone for the current quarter was "not met"? (Note: If the milestone was met, the course correction plan will be rejected.)
- ✓ Is this the first course correction plan for the intervention? (Note: If a previous course correction plan was approved for the intervention, the intervention is ineligible for a course correction plan.)
- ✓ Did the hospital provide a complete response to each of the survey questions, including:
  - A summary of progress toward the milestone(s) to date, and current status of that progress?
  - A detailed description of the circumstances causing the milestone to be missed?
  - A description of intention to pursue milestone completion or insight on why milestone will not or should not be completed?
  - A description of how hospital will ensure future implementation activities and milestones are met?

Course correction plan scores are not viewable in the Hospital Reporting Requirements dashboard. As a result, the hospital will receive a letter uploaded to the CPAS portal to communicate the score. Communication of the score will be provided in a letter regardless of whether a score of "approved" or "rejected" is received.

E. Milestone Amendments

Throughout the HTP, various factors may require a participant to shift implementation strategies. New evidence-based models may emerge, or other key developments or operating characteristics of facilities may shift, requiring an amended approach to intervention completion. To allow for the flexibility to address unexpected barriers or outcomes, adopt new approaches and pursue innovative and emerging models of care, participants will be provided milestone amendment periods. This amendment process will occur as part of the reports for the second and fourth quarter of each program year. Note that only milestones due in future quarters may be amended.

To amend a single or multiple milestone(s), participants must record proposed milestone amendments that adequately address the following conditions for any proposed amended milestone:

- ✓ Milestone(s) for proposed amendment are clearly identified;
- ✓ Documentation to validate milestone completion is specified;
- ✓ Justification for amending the milestone(s) is provided;
- ✓ All the requirements outlined above regarding the development and submission of initial milestones have been satisfactorily met.

If in the survey the hospital indicates they would like to amend future milestones for an intervention, a hospital must also complete the Milestone Amendment Form available in CPAS and resubmit the form upon completion via CPAS. The amendment process is only available as part of milestone reports (in Q2 and Q4), and only milestones due in future quarters may be amended. Reminder that Milestone Amendment forms are also due with the submission of the milestone report. No milestone amendments will be considered if submitted after the initial report due date.

1. **Download and Complete the Milestone Amendment Form**

   To access the Milestone Amendment Form, hospitals may follow the steps outlined below to download the form from CPAS:

   - ✓ Log into CPAS
   - ✓ Navigate to the Document Repository
   - ✓ Click on the "Quarterly Reporting Submission" folder
   - ✓ Download the Milestone Amendment form
   - ✓ Follow the instructions on the tool to properly fill out the milestone amendment form
   - ✓ Upload milestone amendment form that corresponds to the amendments requested in this survey

2. **Submission of Milestone Amendment Form**
   - ✓ Log into CPAS

- ✓ Navigate to the Document Repository
- ✓ Click on "Quarterly Reporting Submission"
- ✓ Click on Milestone Reporting folder for the appropriate quarter
- ✓ Upload Milestone Amendment form that corresponds to the amendments requested in this survey
- ✓ Use the naming convention as follows: [CHASE ID] [Hospital Name] - [Submission Quarter] Milestone Amendment Form [Date]
- ✓ For example, 0 - CO Test Hospital - PY2Q2 Milestone Amendment Form 6.30.23

3. Milestone Amendment Scoring

Milestone amendment requests will receive a score of "approved", "approved with modification", or "rejected". All review criteria documented in the Implementation Plan Review Criteria is applicable to milestone amendments.

If a score of "approved with modifications" is received, a letter will be uploaded to the CPAS portal documenting the required modifications. In order to address the required modifications, the hospital must file a request for reconsideration by the SRRP due date with updated Implementation Plan language that meets Implementation Plan Review Criteria. If the updated language does not meet Implementation Plan Review Criteria, or if the hospital does not file a request for reconsideration, the hospital's score for the milestone amendment will revert to "rejected". While there is no at-risk funds tied to receiving an approved or rejected milestone amendment, the hospital's future milestones will not be amended unless a score of "approved" is received.

If the milestone amendment is approved, an updated Implementation Plan will be available in the CPAS portal at the conclusion of the quarterly reporting process.

The following scoring criteria applies to milestone amendments:

- ✓ Did the hospital provide rationale for the milestone amendment?
- ✓ Does the revised milestone(s) meet all Implementation Plan Review Criteria for milestone descriptions?
- ✓ Does the revised supporting documentation meet all Implementation Plan Review Criteria for supporting documentation descriptions?

Milestone amendment scores are not viewable in the Hospital Reporting Requirements dashboard. As a result, the hospital will receive a letter uploaded to the CPAS portal to communicate the score. Communication of the score will be provided in a letter regardless of whether a score of "approved", "approved with modification" or "rejected" is received.

F. Scoring Review and Reconsideration Period

The Department's SRRP provides hospitals an opportunity to view the reporting scores received for milestone and CHNE reports. If the hospital believes the report has been scored in error, they may ask for reconsideration of the initial scores.

The process for viewing hospital scores and requesting reconsideration is described in the Introduction section of this document (see Scoring Review and Reconsideration Period subsection). These processes are consistent for all types of quarterly reports.

SRRP is available for scores received for any of the following: (1) Milestone and CHNE; (2) Course Correction Plan; and (3) Milestone Amendment.

1. Milestone and CHNE Scores

All scoring and reconsideration decisions for reporting and milestone attainment are based solely on the milestone and CHNE reports and documentation submitted by the due date. Late report submissions and report revisions are not accepted as part of the SRRP.

The only supporting documentation accepted during the SRRP for milestone and CHNE reports are documents that illustrate why the hospital disagrees with the initial score. Whereas, documents due as part of the report are not accepted during the SRRP.

If a hospital received a milestone or CHNE reporting score of "late" or "incomplete" the hospital may request SRRP to indicate why they believe the submission was scored in error. Additionally, if a hospital indicated a milestone was "met" in the milestone report submission and the milestone was scored "not met" by the Department due to insufficient/incomplete survey response or supporting documentation, the hospital may request SRRP to indicate why they believe the submission was scored in error.

2. Course Correction Plan

If the hospital believes the plan was scored in error, they may request reconsideration of the scoring decision during the SRRP. However, no additional documentation, nor course correction plan revisions are accepted during the SRRP. All scoring and reconsideration decisions are based solely on the plan originally submitted.

3. Milestone Amendment

If the hospital received a milestone amendment score of "rejected" and believes the milestone amendment was scored in error, they may request reconsideration of the scoring decision during the SRRP. For milestone amendments scored "approved with modification", the hospital is required to submit a request for reconsideration that contains revised milestone description(s) and/or revised documentation description(s), in order to improve the score to "approved". If a request for reconsideration, along with a modified milestone amendment form, is not filed to address the necessary modifications, the score will revert to "rejected", and no amendments to the Implementation Plan will be processed.

If the hospital's milestone amendment is revised during SRRP, the hospital should re-submit their milestone amendment form as instructed in the Submission of Milestone Amendment Form section above using the following naming convention: [CHASE ID] [Hospital Name] - [Submission Quarter] Milestone Amendment Form Revised [Revised Date]. Revised milestone and documentation descriptions for

the revised Implementation Plan must be provided during SRRP via the milestone amendment form.

The hospital must email both the completed SRRP form and modified milestone amendment form to cohtp@mslc.com and copy cohtp@state.co.us.

V. Guide to Performance Measure Reporting

Beginning in PY1, hospitals earn at-risk dollars for reporting on established performance measures applicable to each of their interventions. As the HTP evolves, the payment structure will shift from pay-for-reporting and pay-for-action in PY1 and PY2 to pay-for-quality and pay-for-performance beginning in PY3, with the percentage of hospital risk increasing incrementally each year through PY5.

A. Performance Measure Submission

Performance measure data is transmitted to the Department annually in January for the hospital-calculated measures selected in the HTP Application. Data for claims-based measures are not submitted by hospitals, rather claims-based measures are calculated on the hospitals' behalf by the Department.

Hospital-calculated measures are reported to the Department via the Hospital Self-Reported Measure Workbook. Beginning in PY2, Hospitals will indicate in their Q1 Interim Activity and CHNE reporting surveys whether the self-reported measure has been submitted.

1. Accessing the Hospital Self-Reported Measure Workbook

Hospitals receive notification via email when the hospital's unique workbook is available to access on the CPAS portal. This notification will be sent to hospitals on the first business day of January, annually. To support hospital's timely submission of performance measure data, a reminder email is sent to hospitals approximately five business days prior to the report due date, which is January 31st each year. To access the workbook, hospitals may follow the steps outlined below to download the workbook from CPAS:

- ✓ Log into CPAS

- ✓ Navigate to the Document Repository
- ✓ Click on the "Performance Measure Submission" folder
- ✓ Click on the appropriate folder for the current program year
- ✓ Download the hospital self-reported measure workbook
- ✓ The workbook will following this naming scheme: [CHASE ID]-[Hospital Name]_[PYx] Self-Reported Measures_Blank [Date]
- ✓ Follow the instructions in the workbook to properly fill out the workbook

2. Submitting the Hospital Self-Reported Measure Workbook

Once the hospital-self reported measure workbook is complete, hospitals are instructed to upload the completed workbook to CPAS.

- ✓ Log into CPAS
- ✓ Navigate to the Document Repository
- ✓ Click on the "Performance Measure Submission" folder
- ✓ Click on the appropriate folder for the current program year
- ✓ Upload the completed hospital self-reported measure workbook
- ✓ Hospitals should simply utilize the naming scheme already established in the blank workbook and replace "blank" with "complete". It is important the appropriate naming scheme is followed to ensure the system notifies the review team of the submission.
- ✓ For example, [CHASE ID]-[Hospital Name]_[PYx] Self-Reported Measures_Complete [Date]

a. Report Revisions Prior to Due Date

Hospitals are encouraged to carefully review their workbooks prior to submitting. If a hospital submitted their workbook in error or notices material errors in the submission, they may notify cohtp@mslc.com **prior** to the report due date.

b. Late Submissions Not Accepted

Late submission of performance measure data will be considered incomplete for the purposes of earning at-risk for timely reporting.

A. Scoring and Achievement Review Criteria

Performance measures receive a score in two categories: (1) Reporting and (2) Performance.

1. Reporting Scores

The Department scores performance measures for reporting compliance based on both timeliness of the submission and whether the reporting provided is satisfactorily complete. If one, or both, of these scoring elements is not achieved, the hospital loses one hundred percent of at-risk funds for reporting. Hospital submissions must be scored "on time" and "complete" to earn at-risk dollars for reporting for that quarter.

a. Timeliness

Hospitals receive a score of "on time" or "late" for the performance measure submission (hospital self-reported measure workbook) based solely on the date that the workbook is submitted.

Submissions are due annually on January 31st, as shown in the above Quarterly Reporting Schedule section of this document. If the report due date falls on a weekend or Department holiday, workbooks may be submitted the following business day.

b. Report Completeness

Hospitals receive a score of "complete" or "incomplete" for the performance measure submission (hospital self-reported measure workbook) based on the contents of the workbook.

The reporting score for completeness addresses whether minimum reporting criteria was attained. For the performance measure submission to be considered "complete", the below criteria must be met:

- ✓ Input numerical value into the "hospital input" columns of the Data Entry tab for all selected measures. For most measures, this is in the form of a numerator and denominator. In some cases, this is a single number that denotes a simple count of a certain defined action or population.
- ✓ Ensure workbook is free of data validation errors (i.e. data transposition errors)
- ✓ Ensure complete and accurate data is input for all measures. Numerator entries of NDA ("No Data Available") may be accepted as complete under certain circumstances. See Data Availability policy in section C below.
- ✓ List any limitations to reporting complete and accurate data on the Limitations tab.
- ✓ Complete all input fields on the Attestation tab, including checking the "Agree" box to accept all attestation statements.

Reporting "completeness" scores do not consider whether the performance measures meet established benchmarks or achievement thresholds. These factors are evaluated when determining performance scores. Reporting completeness only applies to hospital-calculated measures, as claims-based measures are calculated by the Department.

Measure documentation (i.e. EHR reports supporting the numerator and denominator) is not required with the performance measure submission. However, documentation should be maintained and may be requested in the event of data validation errors, discrepancies, or limitations are identified.

c. Data Availability Policy

As hospitals are working to operationalize their interventions and the associated performance measures, the Department recognizes there may be instances where hospitals do not have complete and accurate data to report for particular measures. Therefore, for hospital-calculated measures, there will be an option in the hospital-self reported measure workbook for hospitals to report a numerator of "NDA" (No Data Available). Hospitals should utilize this option if they are unable to report numerator data for the measure (for example, the

reporting mechanism is not operational) or the data they are able to report is incomplete or inaccurate (for example, data is only available for a portion of the year). Details of the impacts of NDA entries and other requirements and considerations are detailed below. It is important to note that these allowances are intended for PY1 and PY2 data submissions only. Complete and accurate data is expected in order for hospitals to receive reporting scores of "complete" and to determine performance measure achievement in PY3-PY5.

The section below outlines the considerations for PY1 and PY2 NDA entries for program benchmark setting and the impacts to performance year achievement thresholds:

NDA Entries for Measures with Fixed Benchmarks

In instances where incomplete performance measure data was anticipated and expected, fixed benchmarks were assigned, and accommodations will be made for "NDA" reporting without impact on at-risk. NDA entries will receive a reporting score of "complete" in PY1 and PY2 for measures with fixed benchmarks. If NDA is entered in PY3-PY5 for any measure, the measure will receive a reporting score of "incomplete". Hospital-calculated fixed benchmark measures include: RAH1, RAH3, RAH4, SW-CP1, CP2, CP3, CP4, CP5, CP6, SW-BH1, SW-BH2, BH1, BH2, COE1, and COE4.

Although these measures have fixed benchmarks, NDA entries may impact the measure's achievement threshold calculation.

The following hospital-calculated measures with fixed benchmarks have achievement thresholds based on the **median performance** of hospitals that did not meet the benchmark during the applicable performance year: RAH1, RAH4, SW-CP1, CP6, SW-BH1, BH1, BH2, and COE1.

- ✓ For these measures, if PY1 and/or PY2 data are not available by January of the applicable reporting year, hospitals will **not** be required to submit complete data for that year.

The following hospital-calculated measures with fixed benchmarks have achievement thresholds based on each hospital's **individual PY1 performance**: RAH3, CP2, CP3, CP4, CP5, SW-BH2, and COE4.

- ✓ For these measures, if a hospital submits an NDA in PY1 and/or PY2, hospitals will be required to submit complete data with the self-reported measure data submission in the following year. For instance, if a hospital reports NDA for applicable measures during the initial PY1 data submission period in January 2023, the hospital must submit complete and accurate PY1 data for applicable measures during the PY2 data submission in January 2024. While achievement thresholds will not be set based on PY2 data, hospitals that report NDA in PY2 are still required to submit complete data in the following year (during the initial data submission period in January 2025).
- ✓ If the data for these measures is not received during the data submission period in the following year, the reporting score for the following year will be deemed incomplete and the hospital will lose the associated at-risk. Additionally, if a hospital fails to submit PY1 data for any of these measures, the hospital will not have an achievement threshold established for measures where the achievement threshold is based on PY1 performance. This means hospitals will have to meet the established benchmark beginning in PY3 in order to earn any associated at-risk dollars for applicable measures.

NDA Entries for Measures without Fixed Benchmarks

There may be instances where hospitals are unable to provide complete and accurate data for hospital-calculated measures without fixed benchmarks. NDA entries will receive a reporting score of "incomplete" for hospital-calculated measures without fixed benchmarks in all program years. These measures include: SW-RAH2, CP1 (Ped), CP7, SW-BH3, COE2, COE3, PH2, and PH3.

- ✓ For these measures, hospitals will be required to submit complete data with the self-reported measure data submission in the following year. For instance, if a hospital reports NDA for applicable measures during the initial PY1 data submission

period in January 2023, the hospital will receive an incomplete reporting score for PY1. Also, the hospital is required to submit complete and accurate PY1 data for applicable measures during the PY2 data submission in January 2024.

- ✓ If complete PY1 data is not received, there are multiple implications in addition to impacting the hospital's reporting completeness score.
  1. The reporting score for the following year will also be deemed incomplete and the hospital will lose the associated at-risk for reporting.
  2. The hospital will not have a benchmark established for measures with year-over-year improvement benchmarks, which include: CP7, COE2, COE3, PH2, and PH3. Therefore, the hospital will not be able to earn at-risk associated with performance measure achievement.
  3. The hospital will be excluded from benchmark calculations for measures with average performance benchmark methodologies, which includes SW-BH3.

Regardless of the benchmark and achievement threshold methodology, Hospitals will be required to explain their data reporting limitations on the "Data Limitations" tab of the hospital self-reported workbook when a numerator of zero or NDA is entered. Further, valid denominator entries are still required when NDA is entered as the numerator in order for the hospital to earn a reporting score of complete. Additional information or clarification may be requested during the Scoring Review and Reconsideration Period.

Various scenarios to illustrate NDA entries for PY1 and their impact depending on the benchmark and achievement threshold type are modeled below.

Measure	Benchmark Methodology	Achievement Threshold Methodology	PY1 Reporting Score Impact	Data Submission Required in PY2	PY2 Reporting Score Impact
RAH1	Fixed	Median Performance	Complete	Not Required	N/A

Measure	Benchmark Methodology	Achievement Threshold Methodology	PY1 Reporting Score Impact	Data Submission Required in PY2	PY2 Reporting Score Impact
CP4	Fixed	Individual PY1 Performance	Complete	Required in PY2	Complete/ Incomplete depending on data submission
SW-BH3	Average Performance	Median Performance	Incomplete	Required in PY2	Complete/ Incomplete depending on data submission
CP7	Year-Over-Year Improvement	Individual PY1 Performance	Incomplete	Required in PY2	Complete/ Incomplete depending on data submission

2. Performance Scores

In addition to reporting, an established at-risk percentage is earned beginning in PY3 based on whether the hospitals:

- ✓ Achieve or exceed the benchmarks for their measures; or,
- ✓ Show marked improvement in their measures.

If a hospital achieves or exceeds the benchmark for a measure, the full point value for that measure is earned. If a hospital performs at or above the achievement threshold on a measure, but does not meet the benchmark, an improvement factor will be applied to the hospital's possible points for the given measure based on the relative percentage of improvement towards the benchmark. Those that fail to meet the benchmark or achievement threshold for a measure will receive no points for that measure.

In addition, hospitals had the option to select a statewide priority as one of their measures during the application process. Statewide priority measures do not have associated benchmarks or achievement thresholds. Instead, performance for these measures is based on successful implementation of the applicable interventions. Once the PY5Q4 milestone report is submitted, the review team will conduct a reconciliation of all milestone report scores throughout the program related to the statewide priority interventions. If all milestones

outlined in the hospital's approved Implementation Plan have not been met, the hospital will lose the associated at-risk for the statewide priority measures.

For additional details on performance measure scoring and at-risk calculations, please refer to the Scoring Framework on the CO HTP website.

B. Scoring Review and Reconsideration Period

The Department's SRRP provides hospitals an opportunity to view the measure reporting and performance scores received. If the hospital believes a measure has been scored in error, they may ask for reconsideration of the initial scores.

The process for viewing hospital scores and requesting reconsideration is described in the Introduction section of this document (see Scoring Review and Reconsideration Period subsection). These processes are consistent for all types of quarterly reports.

SRRP is available for scores received for any of the following: (1) hospital-calculated measure reporting score; (2) performance scores for hospital-calculated and claims-based measures.

1. Hospital-calculated Measure Reporting Score

All scoring and reconsideration decisions for reporting are based solely on the hospital self-reported measure workbook content and timeliness. The Department will review all submissions to ensure data is complete and accurate by running a series of validation tests (please note these tests are separate from the data validation flags built within the self-reported measure workbook). If data is flagged as incomplete or potentially inaccurate, an initial reporting score of "incomplete" will be given. Hospitals will have the opportunity to work through any data flags during the SRRP process by either correcting data submissions or confirming the accuracy of what was previously submitted, which may involve submission of additional documentation/explanations to support reported measure results. As a result, the initial reporting score may be modified and will be finalized at the completion of the SRRP.

If the hospital self-reported measure workbook is revised during SRRP, the hospital should re-submit their workbook as instructed in the *Submitting the Hospital Self-Reported Measure Workbook* section above using the following naming convention: [CHASE ID]-[Hospital Name]_[PYx] Self-Reported Measures_SRRP_Date.

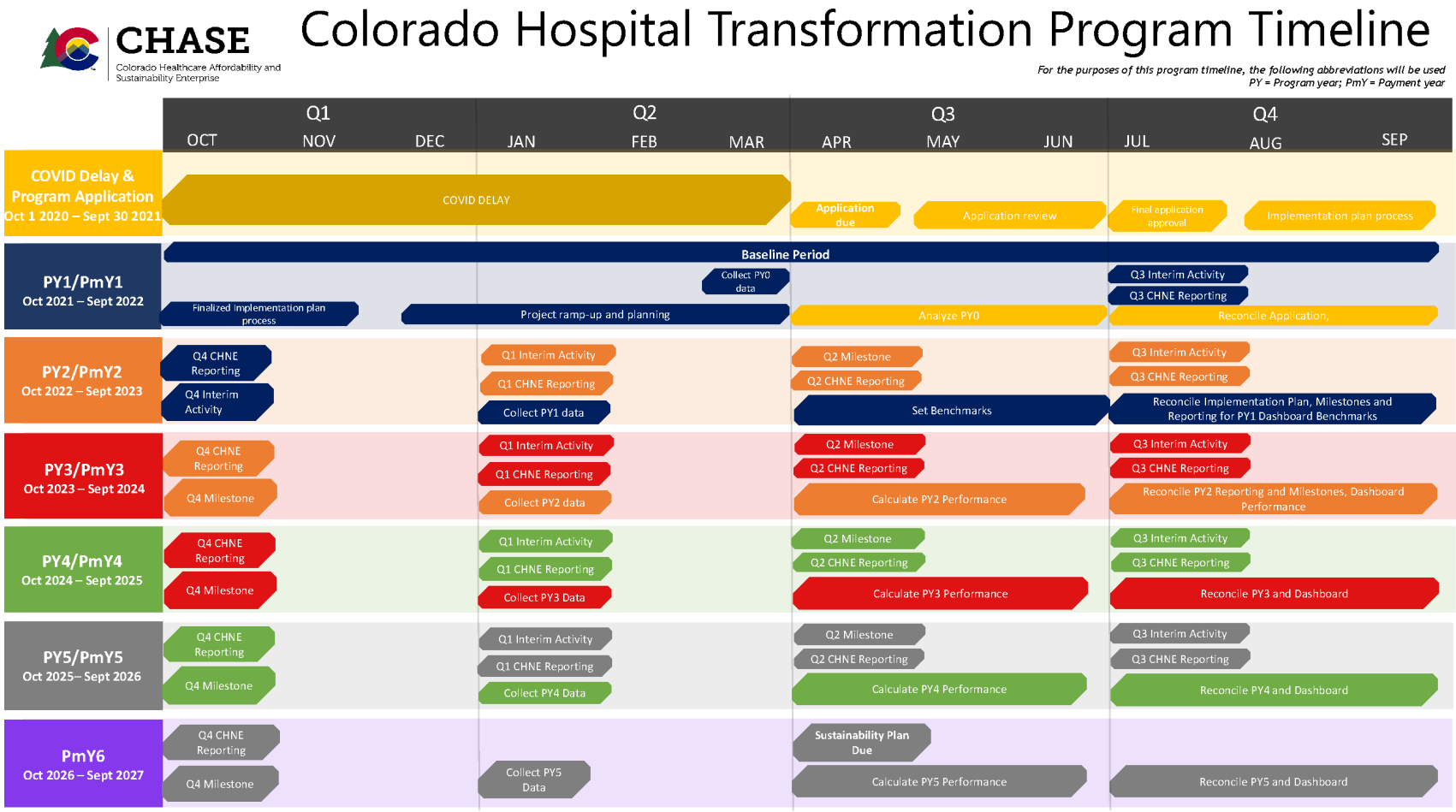
If the hospital would like to submit additional documentation to support their performance measure data, please upload the documentation to the hospital's Document Repository in CPAS and utilize the SRRP form to describe the documentation submitted. **As a reminder, documentation containing PHI should not be uploaded to CPAS.**

2. Performance Scores

All scoring and reconsideration decisions for measure performance are based on hospital-calculated measure data submissions and claims-based measure data as provided by the Department.

Hospitals may opt to provide additional documentation/explanations to support why they believe their measure performance to have been scored incorrectly.

VI. Appendix A: Program Timeline



VII. Appendix B: Interim Activity and CHNE Report Survey Template

A. Colorado HTP Quarterly Report

Welcome to the Hospital Transformation Program (HTP) Quarterly Reporting Survey. This tool can be used to report on the hospital's interim activities related to HTP interventions and ongoing CHNE activities. Please follow section-specific instructions and answer each question completely.

B. Interim Activity Reporting

Reporting Hospital: CO HTP Test Hospital

Intervention: Intervention Name

Reporting Period: Program Year (PY) 1, Quarter (Q) 3

Upcoming Milestone: PY2Q2

This section will be used to report interim activities that are in support of completing the upcoming milestone for each intervention. Hospitals may review the latest submission of their Implementation Plan CPAS on the Intervention/Milestone Detail reporting dashboard, along with the hospital's reported interventions and milestone activities.

II.1. Indicate the phase to which the hospital attributes the interim activities for this intervention.

Planning and Implementation Phase
Continuous Learning and Improvement Phase

If **Planning and Implementation Phase** is selected for Question II.1, the below survey questions will follow:

II.2.a. Indicate the functional area(s) to which the hospital attributes the interim activities for this intervention. Select all that apply.

People

Process
Technology
Patient Engagement/ Target Population

II.2.b. Explain the interim activities related to the [People, Process, Technology, Patient Engagement/Target Population] functional area that the hospital has engaged in. The hospital may also include details of planning activities related to completion of the milestone activities for this intervention by next milestone reporting quarter (please limit responses to 250 words).

Note: The above prompt will repeat for each functional area selected.

II.2.c. Does the hospital consider its activities as on target for completing the upcoming milestone by its intended deadline?

Yes
No

Note: The next three prompts will only be included if "No" is selected above.

II.2.d. If not, what challenges and/or risks are present that may prevent the successful completion of the milestone in the functional areas (People, Process, Technology, Patient Engagement/Target Population)?

II.2.e. Indicate the functional area(s) to which the hospital attributes the challenges and/or risks. Select all that apply.

People
Process
Technology

Patient Engagement/ Target Population

II.2.f. What efforts does the hospital have planned, or has it attempted, to mitigate any challenges or risks identified above?

If **Continuous Learning and Improvement Phase** is selected for Question II.1, the below survey questions will follow:

II.3.a. Explain the interim activities related to this milestone activity that the hospital has engaged in. The hospital may also include details of planning activities related to completion of the milestone activities by next milestone reporting quarter (please limit responses to 250 words).

II.3.b. Does the hospital consider its activities as on target for completing the upcoming milestone by its intended deadline?

Yes
No

Note: The next two prompts will only be included if "No" is selected above.

II.3.c. If not, what challenges and/or risks are present that may prevent the successful completion of the milestone?

II.3.d. What efforts does the hospital have planned, or has attempted, to mitigate any challenges or risks identified above?

C. Ongoing Community Health Neighborhood Engagement Reporting

Reporting Hospital: CO HTP Test Hospital

Reporting Period: PY1Q3

As part of their participation in the HTP, hospitals must continue to facilitate a Community and Health Neighborhood Engagement (CHNE) process by which they collaborate with local community organizations and other external stakeholders to ensure hospitals and their interventions continue to be responsive to the community. Hospitals are required to complete CHNE activities in all quarters throughout the year, including consulting with key stakeholders, participating in community advisory meetings, and engaging with the public. Unlike interim activity and milestone reporting, ongoing CHNE reporting will be addressed on a hospital level rather than per intervention.

Hospitals must keep the Department of Health Care Policy and Financing (Department) informed of their ongoing CHNE as part of their regular HTP reporting obligations. Starting with PY1Q3, hospitals are required to report some type of ongoing CHNE activities every quarter as part of quarterly HTP reporting (whether key stakeholder engagements, community advisory meetings, and/or public engagements). This includes the following activities every PY, at a minimum:

- Hospitals must consult with key stakeholders outside of community advisory meetings at least **two** quarters each year.
- Hospitals must host or participate in community advisory meetings at least **two** quarters each year.
- Hospitals must host a public engagement at least **once** annually.
- Hospitals must attend the annual Learning Symposium.

If stakeholder consultation happened only through community advisory meetings, please report engagement via the Community Advisory Meeting section rather than the Consultation with Key Stakeholders section. As a reminder, hospitals must consult key stakeholder outside of community advisory meetings in at least two quarters.

Hospitals do not report Learning Symposium attendance through quarterly CHNE reporting. The Department collects attendance records for the Learning Symposium, and these records are used to evaluate compliance with this requirement.

For PY1, quarterly reporting will only occur in PY1Q3 and PY1Q4. For PY1, hospitals are required to report two quarters of consultations with key stakeholders and at least one quarter of Public Engagement.

Hospitals should consult the Ongoing CHNE Requirements document for more information about these requirements. Please use the following section to report on these activities.

III.1.a. Select any of the following that the hospital completed this quarter. Depending on which CHNE activities are selected, the following screens will populate accordingly.

Consultation with Key Stakeholders
Community Advisory Meetings
Public Engagements
None of the above

D. Ongoing CHNE Reporting: Consultation with Key Stakeholders

Reporting Hospital: CO HTP Test Hospital

Reporting Period: PY1Q3

Please use the next screens to report on the hospital's consultation with key stakeholders this quarter. As a reminder, if the consultation occurred through community advisory meetings, please report that engagement in the Community Advisory Meeting section instead. Hospitals must consult key stakeholders outside of community advisory meetings in at least two quarters, at a minimum.

Hospitals determine the key stakeholders specific to their community and community needs, local conditions and their HTP initiatives. However, the Department expects that key stakeholders for all hospitals will include at least one representative from most, if not all, of the following stakeholder categories:

- Regional Accountable Entities (RAEs).
- Local Public Health Agencies (LPHAs).
- Mental Health Centers.
- Community Health Centers, including Federally Qualified Health Centers (FQHCs) and rural health centers (RHCs).
- Primary Care Medical Providers (PCMPs).
- Regional Emergency Medical and Trauma Services Advisory Councils (RETACs).
- Long Term Service and Support (LTSS) Providers.
- Consumer advocates or advocacy organizations.
- Health Alliances.
- Community organizations addressing social determinants of health.

Key stakeholders should also include representatives of any stakeholder categories that are impacted by, or particularly relevant to, any of the hospital's HTP initiatives.

III.2.a. Please list all the names of the organizations you consulted with this quarter below. You may repeat and/or add any stakeholder organizations the hospital consulted with in previous quarters.

Organization Name:	

Note: The next two prompts will be repeated for each organization name entered by the hospital in this section. Engagement with up to 20 key stakeholders (outside community advisory meetings) may be reported for each quarter.

Please update the table below for your consultation(s) with the indicated stakeholder this quarter. Include all dates of engagement with the stakeholder outside of community advisory meetings, and all topics covered throughout the engagement(s). If consultation happened through community advisory meetings, please report so in that section instead of this section.

III.2.b. Organization Name [prepopulated] – Details of Consultation

Name of Organization	Type of Organization (RAE, Mental Health Center, Health Alliance, etc.)	Name of Primary Point of Contact at Organization	Title of Primary Point of Contact	Date(s) of Engagement (mm/dd/yyyy)
[Prepopulated organization name]				

III.2.c. Organization Name [prepopulated] – Overview of HTP Topics Discussed

Measures
Interventions
Partners
Data Sharing / Technology
Data Reporting
General HTP Updates and Information
Other (Please Specify):

E. Ongoing CHNE Reporting: Community Advisory Meetings

Reporting Hospital: CO HTP Test Hospital

Reporting Period: PY1Q3

The Department expects that hospitals will also engage key stakeholders in a group setting through either convening of community advisory meetings or continued participation in existing advisory committees. The hospital should determine the most appropriate manner of convening meetings and who should be recruited to participate based on local conditions and existing relationships and collaborations. This includes whether the hospital will be able to engage existing committees or will choose to convene its own meetings. Key stakeholder groups must also be identified for inclusion in these meetings. The stakeholders who should be consulted are similar to those outlined in the Consultation with Key Stakeholders section above.

Hospitals may be able to meet this requirement through participation with health alliances. Likewise, the Accountable Care Collaboratives (ACC's) statewide and regional Program Improvement Advisory Committees (PIAC) may be an appropriate venue. PIACs were formed in July 2018 to engage stakeholders and provide guidance on how to improve health, access, cost, and satisfaction of Medicaid members and providers. If a hospital is unable to leverage its local health alliance, Regional PIAC or another similar existing convening, or if these convenings will not meet the hospital's needs for informing its ongoing HTP implementation, the hospital will be expected to convene meetings for its continued CHNE.

Hospitals should convene or engage in community advisory meetings at least semi-annually. This requirement can be satisfied by convening two or more different groups that meet the above requirements at least once each per year.

Please use the next screens to report on the hospital's community advisory meetings (if any) this quarter. As a reminder, hospitals are required to engage or participate in community advisory meetings at least twice (in two different quarters).

III.3.a. Name of Community Advisory Meeting

III.3.b. Date of Meeting (mm/dd/yyyy)

III.3.c. Information about Participating Organizations formatted as follows:

- Organization Name, Organization Type (RAE, Mental Health Center, Health Alliance, etc.)

III.3.d. Information about Meeting Organizer formatted as follows:

- Organization, Individual Name, Individual Title

III.3.e. Overview of HTP Topics Discussed

Measures
Interventions
Partners
Data Sharing / Technology

Data Reporting
General HTP Updates and Information
Other (Please Specify):

III.3.f. Please provide a brief overview of the feedback received.

III.3.g. Please briefly explain how the feedback received has informed the hospital's efforts going forward.

III.3.h. Would the hospital like to report another community advisory meeting?

Yes
No

Note: Up to 10 community advisory meetings may be reported for each quarter.

F. Ongoing CHNE Reporting: Public Engagement

Reporting Hospital: CO HTP Test Hospital

Reporting Period: PY1Q3

Continued CHNE should include periodic engagement with the public more broadly. This could be achieved via public forum, focus groups and / or online or paper surveys. Hospitals are permitted to leverage the public meeting pursuant to Colorado Revised Statutes Title 25.5, Article 1, Part 7 to meet this requirement as long as members of the public are given a specific opportunity during that hearing to learn about and provide feedback on the hospitals' HTP initiatives. Hospitals may also convene public engagement opportunities jointly with other hospitals as long as there are specific opportunities for members of the public to learn about and provide

feedback on each hospital's HTP initiatives. Hospitals should facilitate public engagement at least once per year.

Please use the next screens to report on the hospital's public engagement activities (if any) this quarter.

III.4.a. Type of Venue (public forum, focus group, etc.)

III.4.b. Date or Time Span of the Activity (mm/dd/yyyy)

III.4.c. Number of People that Participated

<25
25-50
51-100
>100

III.4.c. Was this a joint activity with other hospitals?

Yes
No

III.4.d. Was this event combined with other topics?

Yes, with the Community Benefit meeting
Yes, combined with another topic: [enter here]
No

III.4.e. Did the public engagement provide members of the public an opportunity to learn AND provide feedback on the hospital's HTP interventions?

Yes
No

III.4.f. Please provide a brief overview of the feedback received.

III.4.g. Please briefly explain how the feedback received has informed the hospital's efforts going forward.

III.4.h. Would the hospital like to report another public engagement?

Yes
No

Note: Up to 5 public engagements may be reported for each quarter.

G. Self-Reported Measure Workbook (If Applicable)

Reporting Hospital: CO HTP Test Hospital

Reporting Period: PY2Q1

IV.1. The hospital's self-reported measure workbook is due this quarter. Please confirm the hospital has uploaded or will upload the completed self-reported measure workbook on the CPAS portal prior to the report due date.

☐ Agree

H. Survey Conclusion

V.1. Thank you for filling out this quarterly report. By completing this form, the individual identified attests that they are authorized to complete this quarterly report on behalf of the hospital indicated and that the quarterly report has been completed truthfully and accurately. Please sign your name and include your title and the date to verify the accuracy of this information.

Please ensure all responses are complete before you submit this report.

VIII. Appendix C: Milestone and CHNE Report Survey Template

A. Colorado HTP Quarterly Report

Welcome to the Hospital Transformation Program (HTP) Quarterly Reporting Tool. This tool can be used to report information related to in-progress program intervention implementation, milestone completion, milestone amendments, course corrections, and ongoing CHNE activities. Please follow section-specific instructions and answer each question completely.

B. Milestone Reporting

Reporting Hospital: Test Hospital A

Intervention #: Intervention Name

Reporting Quarter: PY2Q2

Hospitals may review the latest submission of their Implementation Plan on CPAS on the Intervention/Milestone Detail reporting dashboard, along with the hospital's reported interventions and milestone activities below. This field will be prepopulated with information from the hospital's Implementation Plan for the upcoming milestone for the hospital to reference:

Intervention #: Intervention Name

Milestone Reporting Quarter	PY2Q2
Milestone Phase	Planning and Implementation
Impact Milestone	No
People (Milestone Code)	Functional Area Description
Supporting Documentation for the People Functional Area	Description
Process (Milestone Code)	Functional Area Description

Supporting Documentation for the Process Functional Area	Description
Technology (Milestone Code)	Functional Area Description
Supporting Documentation for the Technology Functional Area	Description
Patient Engagement (Milestone Code)	Functional Area Description
Supporting Documentation for the Patient Engagement Functional Area	Description
Continuous Learning and Improvement Milestone (Milestone Code)	Milestone Description
Supporting Documentation	Description
Has a Course Correction Plan Been Submitted for this Milestone?	No

[The survey questions below will be prepopulated based on phase and functional area.]

Reporting Hospital: Test Hospital A

Intervention #: Intervention Name

Reporting Quarter: PY2Q2

Milestone Code: INT1.PY2Q2.1

I.4.a.1. People Functional Area - Is the hospital reporting this milestone as complete relative to the **People** functional area? (A milestone will only be considered fully complete if all activities of all applicable functional area(s) have been completed.)

In the event of a missed milestone, participating hospitals may file for an intervention course correction. If you select **No** below, you will be prompted on a later page to complete questions regarding course correction for this milestone. As a reminder, hospitals can only file one course correction plan per intervention over the course of the program.

Yes
No

I.4.b.1. People Functional Area - Did the hospital upload the supporting documentation file identified at the beginning of this report and in the Implementation Plan to CPAS?

Yes
No

I.4.c.1. People Functional Area - Index of Supporting Documentation formatted as below (separated by semi-colons):

- ✓ INT1.PY2Q2.1 - [Name of Document 1]; INT1.PY2Q2.1 - [Name of Document 2]

I.4.d.1. People Functional Area – Documentation notes for reviewer, if applicable (page number, tab reference, or other clarifying information).

I.4.a.2 Process Functional Area - Is the hospital reporting this milestone as complete relative to the **Process** functional area? (A milestone will only be considered fully complete if all activities of all applicable functional area(s) have been completed.)

In the event of a missed milestone, participating hospitals may file for an intervention course correction. If you select "No" below, you will be prompted on a later page to complete questions regarding course correction for this milestone. As a reminder,

hospitals can only file one course correction plan per intervention over the course of the program.

Yes
No

Reporting Hospital: Test Hospital A

Intervention #: Intervention Name

Reporting Quarter: PY2Q2

Milestone Code: INT1.PY2Q2.2

I.4.b.2. Process Functional Area - Did the hospital upload the supporting documentation file identified at the beginning of this report and in the Implementation Plan to CPAS?

Yes
No

I.4.c.2. Process Functional Area - Index of Supporting Documentation formatted as below (separated by semi-colons):

- ✓ INT1.PY2Q2.2 - [Name of Document 1]; INT1.PY2Q2.2 - [Name of Document 2]

I.4.d.2. Process Functional Area - Documentation notes for reviewer, if applicable (page number, tab reference, or other clarifying information).

Reporting Hospital: Test Hospital A

Intervention #: Intervention Name

Reporting Quarter: PY2Q2

Milestone Code: INT1.PY2Q2.3

I.4.a.3. Technology Functional Area - Is the hospital reporting this milestone as complete relative to the **Technology** functional area? (A milestone will only be considered fully complete if all activities of all applicable functional area(s) have been completed.)

In the event of a missed milestone, participating hospitals may file for an intervention course correction. If you select "No" below, you will be prompted on a later page to complete questions regarding course correction for this milestone. As a reminder, hospitals can only file one course correction plan per intervention over the course of the program.

Yes
No

I.4.b.3. Technology Functional Area - Did the hospital upload the supporting documentation file identified at the beginning of this report and in the Implementation Plan to CPAS?

Yes
No

I.4.c.3. Technology Functional Area - Index of Supporting Documentation formatted as below (separated by semi-colons):

- ✓ INT1.PY2Q2.3 - [Name of Document 1]; INT1.PY2Q2.3 - [Name of Document 2]

I.4.d.3. Technology Functional Area - Documentation notes for reviewer, if applicable (page number, tab reference, or other clarifying information).

Reporting Hospital: Test Hospital A

Intervention #: Intervention Name

Reporting Quarter: PY2Q2

Milestone Code: INT1.PY2Q2.4

I.4.a.4. Patient Engagement Functional Area - Is the hospital reporting this milestone as complete relative to the **Patient Engagement** functional area? (A milestone will only be considered fully complete if all activities of all applicable functional area(s) have been completed.)

In the event of a missed milestone, participating hospitals may file for an intervention course correction. If you select "No" below, you will be prompted on a later page to complete questions regarding course correction for this milestone. As a reminder, hospitals can only file one course correction plan per intervention over the course of the program.

Yes
No

I.4.b.4. Patient Engagement Functional Area - Did the hospital upload the supporting documentation file identified at the beginning of this report and in the Implementation Plan to CPAS?

Yes
No

I.4.c.4. Patient Engagement Functional Area - Index of Supporting Documentation formatted as below (separated by semi-colons):

- ✓ INT1.PY2Q2.4 - [Name of Document 1]; INT1.PY2Q2.4 - [Name of Document 2]

I.4.d.4. Patient Engagement Functional Area - Documentation notes for reviewer, if applicable (page number, tab reference, or other clarifying information).

Reporting Hospital: Test Hospital A

Intervention #: Intervention Name

Reporting Quarter: PY2Q2

Milestone Code: INT1.PY2Q2.1

I.4.a.5. **Continuous Learning and Improvement** - Is the hospital reporting this continuous learning and improvement milestone as complete?

In the event of a missed milestone, participating hospitals may file for an intervention course correction. If you select "No" below, you will be prompted on a later page to complete questions regarding course correction for this milestone. As a reminder, hospitals can only file one course correction plan per intervention.

Yes
No

I.4.b.5. Continuous Learning and Improvement - Did the hospital upload the supporting documentation file identified at the beginning of this report and in the Implementation Plan to CPAS?

Yes
No

I.4.c.5. Continuous Learning and Improvement - Index of Supporting Documentation formatted as below (separated by semi-colons):

- ✓ INT1.PY2Q2.1 - [Name of Document 1]; INT1.PY2Q2.1 - [Name of Document 2]

I.4.d.5. Continuous Learning and Improvement - Documentation notes for reviewer, if applicable (page number, tab reference, or other clarifying information).

C. Milestone Course Correction Reporting

If a hospital indicates a milestone is not completed, hospitals may submit a course correction plan with the report for the quarter during which the milestone was not met. For example, if a Q4 milestone is not completed, the course correction plan would be submitted as part of the Q4 milestone report. 50% of unearned at-risk dollars are earned back by submitting an accepted course correction plan. Course correction plans receive a score of "approved" or "rejected" based on whether the plan is satisfactorily complete, and whether the intervention is eligible a course correction plan. Course correction plans may only be submitted once per intervention. An intervention would be ineligible for another course correction plan if a previous course correction plan was approved the intervention.

"Course correction plans" must provide insights into the root causes of a missed milestone and detail the process the program participant intends to pursue to either complete the missed milestone as previously defined or provide insight as to why the missed milestone will not or should not be completed. Course correction plans must also provide operational insights into how future milestones associated with the intervention will be completed by their previously intended deadlines. Part of the hospitals' plan for correcting an intervention's course may involve amending future milestones. While the course correction plan could discuss amending future milestones as part of the way forward, the course correction plan is not the mechanism by which milestones are amended. All milestone amendments must be submitted as an official milestone amendment, which will be completed in a later portion of this survey. As a result, if a course correction plan discusses milestone amendments which are not separately submitted as milestone amendments, no

changes to the hospital's milestones will be recognized. As a reminder, as outlined above, milestones may also be amended prospectively through reports for Q2 and Q4 and there is no limit to how often a hospital may prospectively amend milestones.

The below scoring criteria is applied to determine if the course correction plan is "approved" or "rejected":

- ✓ Did the hospital indicate the milestone for the current quarter was "not met"? (Note: If the milestone was met, the course correction plan will be rejected.)
- ✓ Is this the first course correction plan for the intervention? (Note: If a previous course correction plan was approved for the intervention, the intervention is ineligible for a course correction plan.)
- ✓ Did the hospital provide a complete response to each of the survey questions, including:
  - A summary of progress toward the milestone(s) to date, and current status of that progress?
  - A detailed description of the circumstances causing the milestone to be missed?
  - A description of intention to pursue milestone completion or insight on why milestone will not or should not be completed?
  - A description of how hospital will ensure future implementation activities and milestones are met?

Course correction plan scores are not viewable in the Hospital Reporting Requirements dashboard. As a result, the hospital will receive a letter uploaded to the CPAS portal to communicate the score. Communication of the score will be provided in a letter regardless of whether a score of "approved" or "rejected" is received.

Reporting Hospital: Test Hospital A

Intervention #: Intervention Name

Milestone Code:

Milestone: PY2Q2

In the event of a missed milestone, participating hospitals may file for an intervention course correction. Please indicate below whether the hospital intends to file a course correction for this intervention. As a reminder, hospitals can only file one course correction plan per intervention.

If **No** is selected for Question I.4.a., the below survey questions will follow for each intervention:

I.5.a. [FUNCTIONAL AREA] - Does the hospital wish to file a course correction for this intervention?

Yes
No

If **Yes** is selected for Question I.5.a, the below survey questions will follow.

I.5.b. [FUNCTIONAL AREA] - Please summarize the progress toward the milestone to date and the current status of that progress.

I.5.c. [FUNCTIONAL AREA] - Provide a detailed description of the circumstances that have caused the hospital to be unable to complete the milestone. The description should provide insights into the root causes of the missed or incomplete milestone.

I.5.d. [FUNCTIONAL AREA] - Detail the process the program participant intends to pursue to either complete the missed milestone as previously defined or provide insight as to why the missed milestone will not or should not be completed.

I.5.e. [FUNCTIONAL AREA] - Describe how the hospital will ensure that implementation activities for the submitted intervention are completed under this course correction plan.

I.5.f. [FUNCTIONAL AREA] - Provide operational insights into how future milestones associated with the intervention will be completed by their previously intended deadlines.

D. Milestone Amendment Reporting

Throughout the HTP, various factors may require a participant to shift its implementation strategies. New evidence-based models may emerge, or other key developments or operating characteristics of facilities may shift, requiring an amended approach to intervention completion. To allow for the flexibility to address unexpected barriers or outcomes, adopt new approaches and pursue innovative and emerging models of care, participants will be provided milestone amendment periods. This amendment process will occur as part of the reports for the second and fourth quarter of each program year. Note that only milestones due in future quarters may be amended.

To amend a single or multiple milestone(s), participants must record proposed milestone amendments along with reports for Q2 and / or Q4 that adequately address the following conditions for any proposed amended milestone:

- ✓ Milestone(s) for proposed amendment are clearly identified;
- ✓ Documentation to validate milestone completion is specified;
- ✓ Justification for amending the milestone(s) is provided;
- ✓ All the requirements outlined above regarding the development and submission of initial milestones have been satisfactorily met.

The milestone amendment request process is incorporated into quarterly milestone reporting. If in the survey the hospital indicates they would like to amend future milestones for an intervention, a hospital must also complete the Milestone Amendment Form available in CPAS and resubmit the form upon completion via CPAS. The amendment process is only available as part of milestone reports, and only milestones due in future quarters may be amended. Reminder that Milestone Amendment forms are also due with the submission of the milestone report. Please refer to the Quarterly Reporting Guide for review and scoring criteria details for amended milestones.

Following the submission of amended milestones, the Department will initiate a review and approval process in parallel with quarterly report filing review timelines.

1. **Download and Complete the Milestone Amendment Form**

   To access the Milestone Amendment Form, hospitals may follow the steps outlined below to download the form from CPAS:

   - Log into CPAS
   - Navigate to the Document Repository
   - Click on the "Quarterly Reporting Submission" folder
   - Download the Milestone Amendment form
   - Follow the instructions on the tool to properly fill out the milestone amendment form
   - Upload milestone amendment form that corresponds to the amendments requested in this survey

   A copy of the milestone amendment form can also be downloaded below:

2. **Submission of Milestone Amendment Form**
   - Log into CPAS
   - Navigate to the Document Repository
   - Click on "Quarterly Reporting Submission"

- Click on Milestone Reporting folder for the appropriate quarter
- Upload Milestone Amendment form that corresponds to the amendments requested in this survey
- Use the naming convention as follows: [CHASE ID] [Hospital Name] - [Submission Quarter] Milestone Amendment Form [Date]
- For example, 0 - CO Test Hospital - PY2Q2 Milestone Amendment Form

The next section gives hospitals the opportunity to amend milestones prospectively. Please indicate whether the participating hospital wishes to amend any upcoming milestones for this intervention.

II.4.a. Does the participating hospital wish to amend any upcoming milestones for any of the following interventions? Select all that apply.

	PY2Q4	PY3Q2	PY3Q4	PY4Q2	PY4Q4	PY5Q2	PY5Q4
Intervention 1: *Intervention Name*	☐	☐	☐	☐	☐	☐	☐
Intervention 2: Intervention Name	☐	☐	☐	☐	☐	☐	☐
Intervention 3: Intervention Name	☐	☐	☐	☐	☐	☐	☐
Intervention 4: Intervention Name	☐	☐	☐	☐	☐	☐	☐
Intervention 5: Intervention Name	☐	☐	☐	☐	☐	☐	☐
Intervention 6: Intervention Name	☐	☐	☐	☐	☐	☐	☐
Intervention 7: Intervention Name	☐	☐	☐	☐	☐	☐	☐

	PY2Q4	PY3Q2	PY3Q4	PY4Q2	PY4Q4	PY5Q2	PY5Q4
Intervention 8: Intervention Name	☐	☐	☐	☐	☐	☐	☐
Intervention 9: Intervention Name	☐	☐	☐	☐	☐	☐	☐
Intervention 10: NA	☐	☐	☐	☐	☐	☐	☐
Intervention 11: NA	☐	☐	☐	☐	☐	☐	☐

If **any of the above are** selected for Question II.4.a, the below question II.5.a will follow and prepopulate based on selection from Question II.4.a:

II.5.a. Has the hospital uploaded the updated Milestone Amendment form to CPAS? As a reminder, the Milestone Amendment form is due with the submission of this milestone reporting survey.

- ✓ Log into CPAS
- ✓ Navigate to the Document Repository
- ✓ Click on "Quarterly Reporting Submission"
- ✓ Click on Milestone Reporting for the appropriate quarter (PY2Q4)
- ✓ Upload milestone amendment form that corresponds to the amendments requested in this survey
  - Use the appropriate naming convention: [CHASE ID] [Hospital Name] - [Submission Quarter] Milestone Amendment Form [Date]
  - For example, 0 - CO Test Hospital - PY2Q2 Milestone Amendment Form 10.31.22

The milestone amendment form allows for amendments to be made to multiple interventions, as well as, multiple quarters for each intervention within one form. It is important for the hospital to track each milestone the hospital is requesting to amend.

Please check each of the following boxes to confirm you have appropriately filled out the Milestone Amendment form to include each intervention and quarter listed AND the Milestone Amendment form has been uploaded to the appropriate folder in CPAS. Select all that apply.

	Milestone Amendment Form Uploaded to CPAS Includes All of the Following (check the box to confirm):
Intervention 1: Intervention Name - PY2Q4	☐
Intervention 1: Intervention Name - PY3Q2	☐
Intervention 7: Intervention Name - PY2Q4	☐

E. Ongoing Community Health Neighborhood Engagement Reporting

Ongoing Community Health Neighborhood Engagement Reporting Overview

As part of their participation in the HTP, hospitals must continue to facilitate a Community and Health Neighborhood Engagement (CHNE) process by which they collaborate with local community organizations and other external stakeholders to ensure hospitals and their interventions continue to be responsive to the community. Hospitals are required to complete CHNE activities in all quarters throughout the year, including consulting with key stakeholders, participating in community advisory meetings, and engaging with the public. Unlike interim activity and milestone reporting, ongoing CHNE reporting will be addressed on a hospital level rather than per intervention.

Hospitals must keep the Department of Health Care Policy and Financing (Department) informed of their ongoing CHNE as part of their regular HTP reporting obligations. Starting with PY1Q3, hospitals are required to report some type of ongoing CHNE activities every quarter as part of quarterly HTP reporting (whether key stakeholder engagements, community advisory meetings, and/or public engagements).

Starting in PY2, the following activities are required every PY at a minimum:

- Hospitals must consult with key stakeholders outside of community advisory meetings at least **two** quarters each year.
- Hospitals must host or participate in community advisory meetings at least **two** quarters each year.
- Hospitals must host a public engagement at least **once** annually.
- Hospitals must attend the annual Learning Symposium.

If stakeholder consultation happened only through community advisory meetings, please report engagement via the Community Advisory Meeting section rather than the Consultation with Key Stakeholders section. As a reminder, hospitals must consult key stakeholder outside of community advisory meetings in at least two quarters.

Hospitals do not report Learning Symposium attendance through quarterly CHNE reporting. The Department collects attendance records for the Learning Symposium, and these records are used to evaluate compliance with this requirement.

Hospitals should consult the Ongoing CHNE Requirements document for more information about these requirements. Please use the following section to report on these activities.

III.1.a. Select any of the following that the hospital completed this quarter. Depending on which CHNE activities are selected, the following screens will populate accordingly.

Consultation with Key Stakeholders
Community Advisory Meetings
Public Engagements
None of the above

F. Ongoing CHNE Reporting: Consultation with Key Stakeholders

Reporting Hospital: CO HTP Test Hospital

Reporting Period: PY2Q2

Please use the next screens to report on the hospital's consultation with key stakeholders this quarter. As a reminder, if the consultation occurred through

community advisory meetings, please report that engagement in the Community Advisory Meeting section instead. Hospitals must consult key stakeholders outside of community advisory meetings in at least two quarters, at a minimum.

Hospitals determine the key stakeholders specific to their community and community needs, local conditions and their HTP initiatives. However, the Department expects that key stakeholders for all hospitals will include at least one representative from most, if not all, of the following stakeholder categories:

- Regional Accountable Entities (RAEs).
- Local Public Health Agencies (LPHAs).
- Mental Health Centers.
- Community Health Centers, including Federally Qualified Health Centers (FQHCs) and rural health centers (RHCs).
- Primary Care Medical Providers (PCMPs).
- Regional Emergency Medical and Trauma Services Advisory Councils (RETACs).
- Long Term Service and Support (LTSS) Providers.
- Consumer advocates or advocacy organizations.
- Health Alliances.
- Community organizations addressing social determinants of health.

Key stakeholders should also include representatives of any stakeholder categories that are impacted by, or particularly relevant to, any of the hospital's HTP initiatives.

III.2.a. Please list all the names of the organizations you consulted with this quarter below. You may repeat and/or add any stakeholder organizations the hospital consulted with in previous quarters.

Organization Name:	

Note: The next two prompts will be repeated for each organization name entered by the hospital in this section. Engagement with up to 20 key stakeholders (outside community advisory meetings) may be reported for each quarter.

Please update the table below for your consultation(s) with the indicated stakeholder this quarter. Include all dates of engagement with the stakeholder outside of community advisory meetings, and all topics covered throughout the engagement(s). If consultation happened through community advisory meetings, please report so in that section instead of this section.

III.2.b. Organization Name [prepopulated] – Details of Consultation

Name of Organization	Type of Organization (RAE, Mental Health Center, Health Alliance, etc.)	Name of Primary Point of Contact at Organization	Title of Primary Point of Contact	Date(s) of Engagement (mm/dd/yyyy)
[Prepopulated organization name]				

III.2.c. Organization Name [prepopulated] – Overview of HTP Topics Discussed

Measures
Interventions
Partners
Data Sharing / Technology
Data Reporting
General HTP Updates and Information
Other (Please Specify):

G. Ongoing CHNE Reporting: Community Advisory Meetings

Reporting Hospital: CO HTP Test Hospital

Reporting Period: PY2Q2

The Department expects that hospitals will also engage key stakeholders in a group setting through either convening of community advisory meetings or continued participation in existing advisory committees. The hospital should determine the most appropriate manner of convening meetings and who should be recruited to participate based on local conditions and existing relationships and collaborations. This includes whether the hospital will be able to engage existing committees or will choose to convene its own meetings. Key stakeholder groups must also be identified for

inclusion in these meetings. The stakeholders who should be consulted are similar to those outlined in the Consultation with Key Stakeholders section above.

Hospitals may be able to meet this requirement through participation with health alliances. Likewise, the Accountable Care Collaboratives (ACC's) statewide and regional Program Improvement Advisory Committees (PIAC) may be an appropriate venue. PIACs were formed in July 2018 to engage stakeholders and provide guidance on how to improve health, access, cost, and satisfaction of Medicaid members and providers. If a hospital is unable to leverage its local health alliance, Regional PIAC or another similar existing convening, or if these convenings will not meet the hospital's needs for informing its ongoing HTP implementation, the hospital will be expected to convene meetings for its continued CHNE.

Hospitals should convene or engage in community advisory meetings at least semi-annually. This requirement can be satisfied by convening two or more different groups that meet the above requirements at least once each per year.

Please use the next screens to report on the hospital's community advisory meetings (if any) this quarter. As a reminder, hospitals are required to engage or participate in community advisory meetings at least twice (in two different quarters).

III.3.a. Name of Community Advisory Meeting

III.3.b. Date of Meeting (mm/dd/yyyy)

III.3.c. Information about Participating Organizations formatted as follows:

- Organization Name, Organization Type (RAE, Mental Health Center, Health Alliance, etc.)

III.3.d. Information about Meeting Organizer formatted as follows:

- Organization, Individual Name, Individual Title

III.3.e. Overview of HTP Topics Discussed

Measures
Interventions
Partners
Data Sharing / Technology
Data Reporting
General HTP Updates and Information
Other (Please Specify):

III.3.f. Please provide a brief overview of the feedback received.

III.3.g. Please briefly explain how the feedback received has informed the hospital's efforts going forward.

III.3.h. Would the hospital like to report another community advisory meeting?

Yes
No

Note: Up to 10 community advisory meetings may be reported for each quarter.

H. Ongoing CHNE Reporting: Public Engagement

Reporting Hospital: CO HTP Test Hospital

Reporting Period: PY2Q2

Continued CHNE should include periodic engagement with the public more broadly. This could be achieved via public forum, focus groups and / or online or paper surveys. Hospitals are permitted to leverage the public meeting pursuant to Colorado Revised Statutes Title 25.5, Article 1, Part 7 to meet this requirement as long as members of the public are given a specific opportunity during that hearing to learn about and provide feedback on the hospitals' HTP initiatives. Hospitals may also convene public engagement opportunities jointly with other hospitals as long as there are specific opportunities for members of the public to learn about and provide feedback on each hospital's HTP initiatives. Hospitals should facilitate public engagement at least once per year.

Please use the next screens to report on the hospital's public engagement activities (if any) this quarter.

III.4.a. Type of Venue (public forum, focus group, etc.)

III.4.b. Date or Time Span of the Activity (mm/dd/yyyy)

III.4.c. Number of People that Participated

<25
25-50
51-100
>100

III.4.c. Was this a joint activity with other hospitals?

Yes
No

III.4.d. Was this event combined with other topics?

Yes, with the Community Benefit meeting
Yes, combined with another topic: [enter here]
No

III.4.e. Did the public engagement provide members of the public an opportunity to learn AND provide feedback on the hospital's HTP interventions?

Yes
No

III.4.f. Please provide a brief overview of the feedback received.

III.4.g. Please briefly explain how the feedback received has informed the hospital's efforts going forward.

III.4.h. Would the hospital like to report another public engagement?

Yes
No

Note: Up to 5 public engagements may be reported for each quarter.

I. Survey Conclusion

IV.1. Thank you for filling out this quarterly report. By completing this form, the individual identified attests that they are authorized to complete this quarterly report on behalf of the hospital indicated and that the quarterly report has been completed truthfully and accurately. Please sign your name and include your title and the date to verify the accuracy of this information.

Please ensure all responses are complete before you submit this report.