HTP Performance Measure Training

December 11, 2025

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CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Agenda

- Hospital Self-Reported Measure Overview
- Hospital Self-Reported Measure Workbook Demo
- Performance Measure Minimum Submission Review and SRRP Procedures
- Claims Based Measure Overview
- Performance Measure At-Risk Calculation
- High Performing Hospital Determinations
- Performance Measure Dashboards
- Wrap Up/Next Steps

Hospital Self-Reported Measure Overview

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Hospital Self-Reported Measure Workbook: Introduction

- HTP measures are either calculated by HCPF using Medicaid **claims data** or are calculated and **"self-reported"** annually by HTP hospitals.
- Each hospital will have a customized workbook with their selected self-reported measures in which to report performance results.
- Workbooks have been uploaded to each hospital's CPAS account for the hospitals to download and complete. The file name appears as shown:

CHASE ID-Hospital Name_PY4 Self-Reported Measures_Blank

Hospital Self-Reported Measure Workbook: Introduction

- The Hospital Self-Reported Measure (HSRM) Workbook includes the following tabs:
  - ✓ Introduction
  - ✓ Overview
  - ✓ Data Entry
  - ✓ Data Information
  - ✓ Attestation
  - ✓ Validation Tool [NEW]
  - ✓ Measure Information

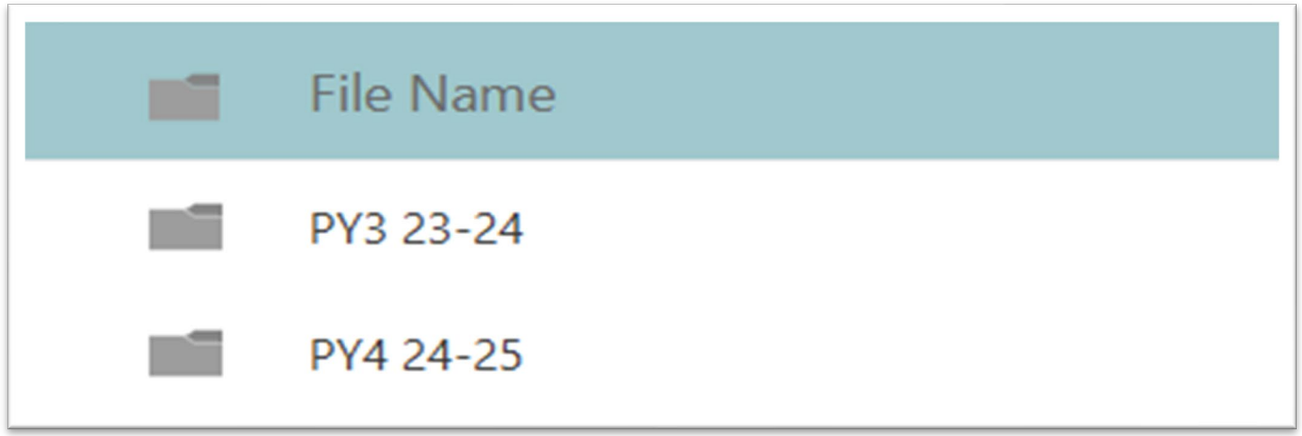
Accessing the Hospital Self-Reported Measure Workbook

To access your hospital's unique **HSRM workbook**:

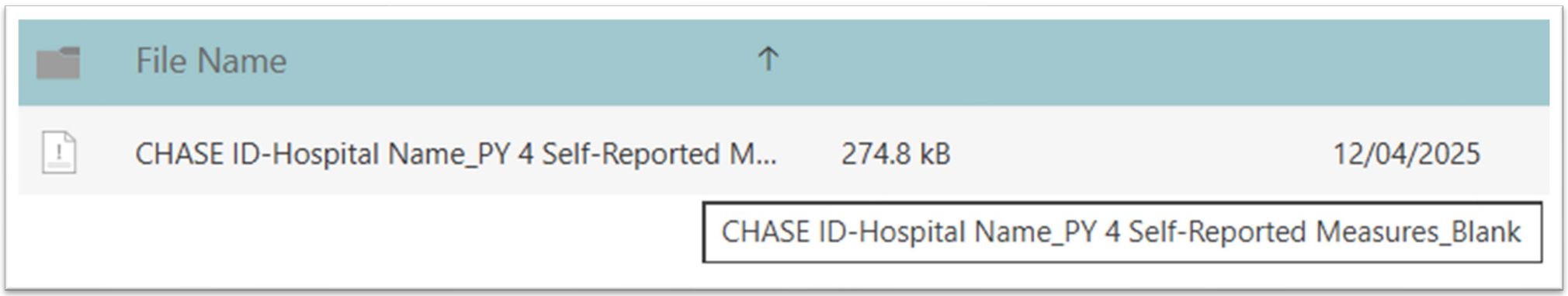
- ✓ Navigate to and login via https://cpasco.mslc.com/
- ✓ Navigate to your hospital's document repository.
- ✓ Navigate to the "**Performance Measure Submission**" folder.

Accessing the Hospital Self-Reported Measure Workbook

1. Navigate to the "**PY4 24-25**" subfolder.



2. Download the Excel file labeled with your hospital name and CHASE ID.



Submission and Next Steps

- Once the workbook is complete and accuracy is verified, hospitals will upload the completed workbook to CPAS in the same location where the blank copy was originally accessed and **notify** COHTP@mslc.com.
- When uploading the completed copy, change the file name from Blank to Complete:

  CHASE ID-Hospital Name_PY4 Self-Reported Measures_Complete

- Please note that hospitals should **not** move/add/delete rows or columns in the workbook. Further, the workbook should be submitted in **excel format.**
- Upon completion of an initial review, MSLC will upload the data to the data warehouse for use in program dashboards, and achievement calculations.

What's New?

The PY4 HSRM workbook includes a new Validation Tool.

1. The **Data Validation tool** allows hospitals the opportunity to check for validation flags that may result in an incomplete score during the Q1 performance measure review.
2. The accuracy of the flag is based on the hospital's own input of data on the Data Entry tab. Hospitals must manually enter their previous year's data (found on the CPAS performance measure detail dashboard) to check the year-over-year variance flag.
3. Any measure data that is confirmed accurate but **remains** flagged should be addressed on the **Data Information tab** prior to submission.
4. A detailed review of all hospital measure data submissions occurs following the close of the reporting period. That detailed review may warrant **additional follow up** from HCPF, even if there were no flags present in the Validation Tool.
5. The validation checks included in the workbook are standard checks performed each year; however, they are **subject to change** depending on data received, and new validation flags may be added at any point.

Overview Tab

- All measures that have been selected by the hospital are listed on the **overview tab.**
- Each measure is identified by whether the measure is calculated by the hospital or by HCPF.
- All required “hospital calculated” measures will auto-populate on the **"Data Entry" tab.**

Hospital Name:	Test Hospital
CHASE ID:	1

Measure ID	Measure Name	Reported Measure	Calculation Method
SW-RAH1	30-day All-Cause Risk Adjusted Hospital Readmission	**Yes**	HCPF Calculated
SW-RAH2	Pediatric All-Condition Readmission Measure	**Yes**	Hospital Calculated
RAH1	Follow up appointment with a clinician and notification to the Regional Accountable Entities (RAE) within one business day	**Yes**	Hospital Calculated
RAH2	Emergency Department (ED) Visits for Which the Member Received Follow-Up Within 30 Days of the ED Visit	**Yes**	HCPF Calculated
RAH3	Home Management Plan of Care (HMPC) Document Given to Pediatric Asthma Patient/Caregiver	**Yes**	Hospital Calculated
RAH4	Percentage of Patients with Ischemic Stroke who are Discharged on Statin Medication (Joint Commission STK-06)	**Yes**	Hospital Calculated
SW-CP1	Social Needs Screening and Notification	**Yes**	Hospital Calculated
CP1 (Ped)	Readmissions Rate Chronic Condition - 30 day pediatric	**Yes**	Hospital Calculated
CP1 (Adult)	Readmission Rate for a High Frequency Chronic Condition - 30 day adult	**Yes**	HCPF Calculated
CP2	Pediatric Bronchiolitis – Appropriate Use of Bronchodilators	**Yes**	Hospital Calculated

Data Entry Tab

- Hospitals will utilize the **Data Entry tab** to submit complete and accurate data to receive reporting scores of “complete” and to determine performance measure achievement.
- The Data Entry tab includes the following pre-populated columns: **Reported Measure, Measure ID, Measure Name, Measure Stratifications, Calculation Type and Benchmark Value**. Benchmark conclusion will calculate depending on the hospital’s data input as compared to the benchmark value.
- Hospitals will not be permitted to submit NDA (no data available) for the measure numerator without **loss of the applicable measure at-risk**.
- In instances when data is not provided (i.e. blank or "NDA") and/or the numerator value is 0, hospitals will be prompted to utilize the Data Information tab to explain the occurrence.

Data Entry Tab

- Hospitals must self-report measure data in the “Hospital Input” columns with the pale yellow fill color (with the exception of the pediatric readmission measures, which also require an input in the result column). Once data is entered, the fill color will change to green.
  - ✓ The type of calculation (percentage, rate, or count) impacts what data entry is required.
  - ✓ Hospitals must enter a numerical value greater than 0 in the numerator and denominator for hospital input sections. **The workbook will show an error message if a zero is entered (except for select count measures).**

Data Entry Tab: Percentage Measures

- **Percentage Measures:** Measure the number of a certain set of events that are proportional to one another. The numerator and denominator are the same unit of measurement and the numerator is a subset of the denominator.
  - ✓ Measures with a percentage calculation type require hospitals to enter a numerator and denominator. Hovering over the input cell will provide details on the requirements for that particular measure and data reporting element.
  - ✓ Data validation is built in to check for transposition errors in percentage measures.

PY4: Oct 2024-Sept 2025 (18% at risk, 11% for CAH)				*Hospital input - MUST be a numerical value to be accepted*	*Hospital input - MUST be a numerical value >0 to be accepted*	*Automatically calculated (unless otherwise indicated)*	*Automatically calculated*	*Automatically calculated*
Measure ID	Measure Name	Stratification	Calculation Type	Numerator	Denominator	Result	Benchmark Value	Benchmark Conclusion
RAH1								
RAH1	Follow up appointment with a clinician and notification to the Regional Accountable Entities (RAE) within one business day	N/A	%	492	598	0.823	0.800	Benchmark Met
RAH3								
RAH3	Home Management Plan of Care (HMPC) Document Given to Pediatric Asthma Patient/Caregiver	N/A	%	315	391	0.806	0.800	Benchmark Met
RAH4								
RAH4	Percentage of Patients with Ischemic Stroke who are Discharged on Statin Medication (Joint Commission STK-06)	N/A	%	388	444	0.874	0.950	Benchmark Not Met

Data Entry Tab: Rate Measures

- **Rate Measures:** A specific kind of ratio, in which two measurements are related to each other but do not utilize the same unit of measurement. The numerator is not a subset of the denominator when a rate is calculated. A rate measures the number of events compared to another unit of measurement.
  - ✓ Measures with a rate calculation type require hospitals to enter a numerator and denominator. Hovering over the input cell will provide details on the requirements for that particular measure and data reporting element.
  - ✓ Data validation is built in to check for transposition errors or when the result exceeds 1000 in measures where the rate is out of 1000 visits/patients.

Reporting period: **PY4: Oct 2024-Sept 2025 (18% at risk, 11% for CAH)**

					accepted	*accepted*	*(unless otherwise indicated)*	*Automatically calculated*	*Automatically calculated*
Reported Measure	Measure ID	Measure Name	Stratification	Calculation Type	Numerator	Denominator	Result	Benchmark Value	Benchmark Conclusion
Yes	**CP5**								
Yes	CP5.3	Reducing Neonatal Complications - Severe	Severe	Rate per 1000 live births	6	1000	6.00	N/A	N/A
Yes	CP5.2	Reducing Neonatal Complications - Moderate	Moderate	Rate per 1000 live births	19	1000	19.00	N/A	N/A
Yes	CP5	Reducing Neonatal Complications - Total	Total	Rate per 1000 live births	25	1000	25.00	25.720	Benchmark Met

Data Entry Tab: Count Measures

- **Count Measures:** A simple sum of the actions that qualify for inclusion. For HTP measures, this can be a count of patients, visits, or days, depending on the measure.
  - ✓ Measures with a count calculation type require hospitals to enter only one data point - a simple count. This data point is entered in the numerator column. Hovering over the input cell will provide details on the requirements for that particular measure and data reporting element.
  - ✓ Data validation is built in to ensure data is only entered in the numerator field.

PY4: Oct 2024-Sept 2025 (18% at risk, 11% for CAH)

Measure ID	Measure Name	Stratification	Calculation Type	Numerator *Hospital input - MUST be a numerical value to be accepted*	Denominator *Hospital input - MUST be a numerical value >0 to be accepted*	Result *Automatically calculated (unless otherwise indicated)*	Benchmark Value *Automatically calculated*	Benchmark Conclusion *Automatically calculated*
COE2								
COE2	Implementation/Expansion of Telemedicine Visits	N/A	Count	200	N/A	N/A	198.450	Benchmark Met
COE3								
COE3	Implementation/Expansion of e-Consults	N/A	Count	4391	N/A	N/A	6690.600	Benchmark Not Met

Data Entry Tab: Benchmarks

- The **Benchmark Value** column will display what the benchmark is for the specified hospital and measure.
- The **Benchmark Conclusion** column will calculate whether the hospital has met or not met the benchmark once all required fields are completed.
  - ✓ The benchmarks have been calculated for PY3-PY5 and are also available for hospitals to view on the CPAS Performance Measure Detail dashboards.
  - ✓ If the benchmark is not met, hospitals will be prompted to provide more information on the **data information** tab.

PY4: Oct 2024-Sept 2025 (18% at risk, 11% for CAH)				*Hospital input - MUST be a numerical value to be accepted*	*Hospital input - MUST be a numerical value >0 to be accepted*	*Automatically calculated (unless otherwise indicated)*	*Automatically calculated*	*Automatically calculated*
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Data Information Tab

- The **Data Information tab** provides hospitals an opportunity to communicate reporting concerns and/or supplemental information to the Department with their submission. Entry on the Data Information tab is required when a numerator of 0 or NDA is entered for select measures, and optional for all others.
- If a measure is **flagged** on the validation tool tab, but the hospital asserts that the data entry is accurate, the hospital should explain their reasoning here.

Auto-populate OR Hospital Input	*Auto-populate OR Hospital Input*	*Automatically calculated*	*Hospital Input*
Measure ID	Measure Name	Achievement/ Reporting Impact	Measure Data Information
Example: SW-CP1	*Social needs screening and notification - Total*	**Benchmark Not Met; Reporting Incomplete**	*Example: The identification of the Medicaid population was previously inaccurate. Our hospital has improved our identification method in our EHR, and have been able to pull the correct numerator/denominator for this measure in the current program year.*
Enter measure ID here.	Enter measure name here		
Enter measure ID here.	Enter measure name here		

Data Validation Tool Tab ***[NEW]***

- The **Data Validation Tool** provides an opportunity for hospitals to proactively address validation flags that may otherwise constitute an incomplete score during the Q1 performance measure review.

Measure ID	Measure Name	Program Year	Numerator/Count	Denominator (If applicable)	
Select Measure ID		PY4 (Current Program Year)			<--- *Will auto-populate based the measure ID selected*
		PY3 (Previous Program Year)			<--- *manual entry from CPAS Performance Measure Detail Dashboard*

Measure-Specific Validations (Based on measure input populated in table above)

Validation Criteria	Criteria Definition	Validation Check
Data Information Tab Incomplete	The input columns on the Data Information tab are not fully completed for all measures where a numerator of zero or "NDA" was entered.	
Invalid Numerator	The numerator value is blank or an invalid.	
Invalid Denominator	The denominator value is blank or an invalid.	

Attestation Tab

- **IMPORTANT NOTE:** Hospitals **must** conduct internal quality control reviews of the data input before submission.
- The hospital will be asked to read and review the following attestation statements.
- Check the "Agree" box to acknowledge the hospital's agreement. The workbook will **not** be accepted as complete if this tab is not completed.

Attestation

On behalf of my organization, I have reviewed the data that is being submitted and certify that the foregoing information is true, accurate and complete. Internal validation checks and quality control reviews have been completed. I agree to notify HCPF if I believe that the data reported contains errors.

I further attest that my organization is aware of the following:

• The Colorado Hospital Transformation Program payment will be paid from State and Federal funds, and that by filing this attestation a claim is being submitted for State and Federal funds, and that the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain a Colorado Hospital Transformation Program payment, may be prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.

• HCPF reserves the right to perform an audit of this information. The audit may include an on-site visit by HCPF staff or designee to gather data to support the measures reported. Pursuant to the Code of Colorado Regulations, 10 CCR 2505-10, Section 8.130.2D, records necessary to support Hospital Transformation Program requirements, including calculation of performance measures will be maintained for **six years** unless an additional retention period is required elsewhere in 10 C.C.R. 2505-10. Documentation will be available for review upon request.

By clicking on this checkbox, I agree to the above attestation. ☐ Agree

Measure Information Tab

- Reference information about all program performance measures can be found on the **Measure Information tab**.
- This information will align with the current HTP measure specifications document but should not be used in place of the measure specifications.
- The measure specifications provides more detail regarding inclusions, exclusions, and other important parameters. For full updated measure specifications, visit the CO HTP website.

Hospital Self-Reported Measure Workbook Live Demo

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Hospital-Reported Performance Measure Minimum Submission Review and SRRP Procedures

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Minimum Submission Review

- Annually, a **Minimum Submission Review** (MSR) process is conducted on the hospital self-reported measure workbook as a way to evaluate hospital self-reported data for completeness and timeliness.
  - ✓ A **series of validation tests** will check for outliers or red flags that may indicate erroneous data and may require further investigation.
  - ✓ The review is meant for the purpose of verifying performance measure data accuracy to support calculating achievement.
- Hospitals can utilize the **Data Validation Tool** to check for any data validation flags in their data.
- Use of the **Data Validation Tool** and **Data Information** tabs may proactively address and resolve any data flags a hospital would have otherwise received in their initial determination letter.

Minimum Submission Review

- Once the MSR process is complete, hospitals will receive their **initial measure reporting and measure achievement scores** via PY5Q1 initial determination letters uploaded to CPAS. Initial scores will also be available in each hospital's CPAS dashboards.
- Common issues discovered in previous years during the MSR process include:
  - ✓ Incomplete attestation tab
  - ✓ Invalid Numerator/Denominator
  - ✓ Transposition of measure data for measures with multiple parts (for example, entering data for reporting Opioid use in the space for ALTO and vice versa)
  - ✓ Invalid numerator or denominator values (i.e. blanks, text, or 0)
  - ✓ Large variations from the hospital's prior year denominator data
  - ✓ >2 standard deviations from the measure average for all hospitals reporting
- Hospitals that have advanced knowledge of potential data flags are encouraged to utilize the **Data Information tab** to communicate possible variances/incomplete reports to the review team.

Scoring Review and Reconsideration Period (SRRP)

- The SRRP Request Form is located in the **Scoring Review and Reconsideration Period (SRRP)** folder in the CPAS document repository.
- If the SRRP request is related to self-reported performance measures, the hospital will select **"Performance Measures"** in the Hospital Information portion of the form and follow the written instructions.
- SRRP is available for scores received for any of the following areas of the PY5Q1 Quarterly Report:
  1. Interim activity reporting completeness/timeliness
  2. CHNE reporting completeness/timeliness
  3. Hospital self-reported measure workbook completeness/timeliness
  4. Hospital self-reported measure achievement
- SRRP requests should be sent via email to cohtp@mslc.com and cohtp@state.co.us and will be reviewed within 10 business days of submission.

Scoring Review and Reconsideration Period (SRRP)

- Hospitals will receive two types of scores based on their measure submissions in PY4 – Measure Reporting Scores and Measure Performance Scores.
  - ✓ If the reported data is **flagged** as potentially incomplete or inaccurate, the hospital will receive an initial determination score of **"incomplete".**
  - ✓ Further, hospitals will also **receive measure achievement scores** based on whether they achieve or exceed the benchmarks for their measures.
- Hospitals will have the opportunity to **work through any data flags** and/or submit **reconsiderations of measure achievement results** during the **SRRP process.** As always, hospitals may do so 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.
  - ✓ For this particular type of SRRP request, hospitals are invited to submit additional information for consideration, **if necessary.**
- As a result, the **initial reporting score may be modified** and **will be finalized** at the completion of the SRRP.

SRRP For Performance Measures

Section II. HOSPITAL INFORMATION

Hospital CHASE ID - Name: Select Hospital

Program Year and Quarter: Select Program Year and Quarter

Submitted By: Enter Responsible Person for SRRP Contact Information: Enter Email Address

Submission Date: Enter a date

Scoring Reconsideration Requested: (*select all that apply based on applicable quarter*)

☐ Interim Activity Reporting – *Complete table 1*

☐ CHNE Reporting – *Complete table 2*

☐ Milestone Reporting (late and/or incomplete submission) – *Complete table 1*

☐ Milestone Achievement (unmet milestones) – *Complete table 3*

☐ Milestone Amendment Modification Required (milestone amendment received 'approved with modification' or 'rejected' score) – *Provide updated Milestone Amendment form*

☐ Milestone Course Correction (milestone course correction received 'rejected' score) – *Complete table 4*

☐ Performance Measures – *Complete table 5, and provide updated Self-Reported Hospital Workbook if necessary*

SRRP For Performance Measures

Table 5: Performance Measure Data Reconsideration Request: ☐ Yes ☐ No

(Note: Hospitals review state calculated measure results and hospital-self reported measure data flags and may request reconsideration if the data requires revision.)

PERFORMANCE MEASURE RECONSIDERATION REQUESTS		
Measure	Detailed Rationale for Scoring Reconsideration Request	Documents Uploaded? (Y/N)

Claims Based Measure Overview

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Claims Based Measures

- Performance Measures that are not hospital-reported will be calculated using **state claims data.**
- Claims-based measures are calculated by the state and transmitted to hospitals through the **Secure File Transfer Protocol (SFTP).**
  - ✓ The PY4 claims-based measure files will be available to hospitals by **February 27, 2026.**
  - ✓ Starting with **PY4**, data for SW-PH1 (Inpatient Hospital Transitions) will now be included in the claims-based measure summaries.
    - ➢ Reminder: This benchmark has been updated and is now based on participation in the program. The benchmark for PY4 and PY5 will be met if the hospital is actively participating and has submitted at least one referral.

Claims Based Measures: SFTP

- Hospitals can access the new SFTP via: https://secure.mslc.com/
- As a reminder, **new SFTP accounts** were created for each hospital's listed **primary and secondary** HTP contacts.
  - ✓ Account holders should have accepted a new **Terms of Use (TOU)** agreement and accessed the new site to complete their account creation.
- If there have been changes to your hospital's primary and secondary contacts, please email cohtp@mslc.com for an updated contact list form.

Performance Measure At-Risk Calculation

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Performance Measure At-Risk Calculation: Overview

- Starting with **PY3**, hospitals will earn **performance achievement at-risk** for meeting their pre-established benchmarks.
- Similar to milestone achievement, performance achievement at-risk is calculated on a **per-measure basis**.
- Hospitals can earn performance achievement at-risk in one of two ways:
  - ✓ Achieve or exceed the measure **benchmark.**
    - ➢ If a hospital achieves or exceeds the benchmark for a measure, the **full at-risk** allocated to that measure is earned.
  - ✓ Show marked improvement in their measures (i.e. meet **achievement threshold**).
    - ➢ If a hospital does **not meet the benchmark** but meets or exceeds the **achievement threshold** for the measure, **partial at-risk** may be earned.

At-Risk Earned Calculation Components

There are several components needed to calculate performance at-risk earned and unearned.

Hospital Performance on All Measures

Measure Benchmarks and Achievement Thresholds

Benchmark Value for Each Measure

AT Value for Each Measure

Total At-Risk based on Performance Year

At-Risk Earned for Measure

At-Risk Unearned for Measure

Hospital Category

Hospital Measure Counts

Number of Statewide Measures

Number of Local Measures

Points per Measure

Total Statewide Measure Points

Total Local Measure Points

Points per Local Measure

Points per Statewide Measure

Reference Slide: Accessing PY4 Measure Results

During PY5Q1, the Performance Measure Detail Dashboard will be updated during **initial** and **final** determination periods. The dashboard will display hospital annual performance measure result information, measure benchmarks, achievement/scoring status, and high performing hospital status.

Measure identifying information

Program Year	Hospital Name	CHASE ID	Measure ID
PY3	[redacted]		SW-RAH1
PY3			SW-CP1
PY3			CP1.1
PY3			CP6
PY3			SW-BH1
PY3			SW-BH3.1
PY3			SW-BH3.2
PY3			SW-COE1
PY3			COE1
PY3			SW-PH1

Measure results

Numerator	Denominator	Result
0.093	0.083	1.111
481.00	560.00	0.859
3.00	25.00	0.120
247.00	264.00	0.936
1048.00	1048.00	1.000
1699.00	7425.00	228.82
3865.00	7425.00	520.54
N/A	N/A	77.70
523.00	879.00	0.595
N/A for PY3	N/A for PY3	N/A for PY3

Benchmark, achievement threshold, and high performing hospital status

Benchmark Method	Benchmark Value	Benchmark: Met / Not Met	Achievement Threshold Method	Achievement Threshold Value	Achievement Threshold: Met / Not Met	High Performing Hospital
Fixed Benchmark	0.850	Not Met	Median Performance	1.096	Not Met	No
Fixed Benchmark	0.800	Met	Median Performance	0.650	N/A	No
Average Performance	0.066	Not Met	Median Performance	0.107	Not Met	No
Fixed Benchmark	0.800	Met	Median Performance	0.652	N/A	No
Fixed Benchmark	0.800	Met	Median Performance	0.740	N/A	Yes
Average Performance	203.80	Not Met	Median Performance	251.89	Met	No
Average Performance	545.47	Not Met	Median Performance	468.66	Met	No
Hospital Index Measure	Benchmark Met	Met	Median Performance	N/A	N/A	No
Fixed Benchmark	0.420	Met	Median Performance	0.247	N/A	No
Fixed Benchmark	Benchmark Met	Met	Median Performance	N/A	N/A	No

Reference Slide: Benchmark and Achievement Threshold Methodologies

Benchmark Type	Associated Measures	Achievement Threshold
Set Benchmark	SW-COE1	50th percentile (median) performance of hospitals that **did not meet** the benchmark.
Average Performance Benchmark	RAH2, SW-BH3, and CP1 (Adult)	
Fixed Benchmark	BH1, COE1, CP6, SW-RAH1, RAH1, RAH4, SW-BH1, SW-CP1, SW-PH1, BH2	
	COE4, CP3, CP4, RAH3, SW-BH2	Individual hospital's PY1 performance for all program years.
National or Statewide Standard Measures	SW-RAH2, CP1 (pediatric), CP2, CP5	
5% Year-over-Year Improvement Benchmark	CP7, COE2, COE3, PH1, PH2	
Active Participation	SW-PH1	No Achievement Threshold

Reference Slide: Hospital Size Requirements

Hospital Type	Statewide Measure Count	Local Measure Count	Total Points
Respiratory Hospital	3	Minimum of 5	100
Pediatric Hospital	5	Minimum of 5	100
Critical Access Hospital	6 statewide or local measures		100
Orthopedic Specialty Hospital	6 statewide or local measures		100
Small Hospital	6 statewide or local measures		100
Medium Hospital	6	Minimum of 2	100
Large Hospital	6	Minimum of 4	100

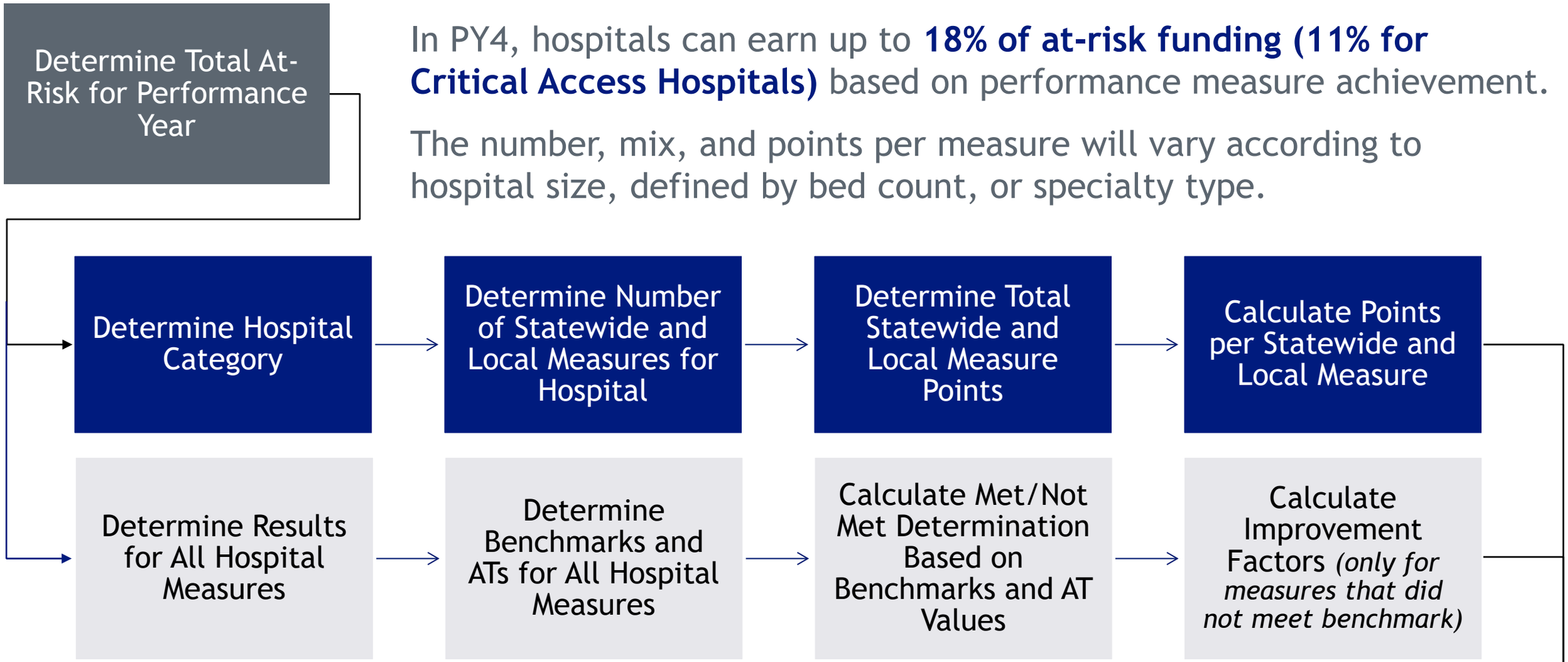
Reference Slide: Total Points Available by Measure Type and Hospital Size

Hospital Size	Number of Local Measures	Statewide Measure Total Points	Local Measure Total Points
Respiratory Hospital	5+ measures	100 points total spread equally across number of statewide or local measures	
Pediatric Hospital	5+ measures	50 points	50 points
Orthopedic Specialty Hospital	100 points total spread equally across 6 statewide or local measures		
Small Hospital	100 points total spread equally across 6 statewide or local measures		
Critical Access Hospital	100 points total spread equally across 6 statewide or local measures		
Medium Hospital	2 measures	75 points	25 points
	3 measures	67 points	33 points
	4+ measures	60 points	40 points
Large Hospital	4+ measures	60 points	40 points

At-Risk Earned Calculation Methodology

In PY4, hospitals can earn up to **18% of at-risk funding (11% for Critical Access Hospitals)** based on performance measure achievement.

The number, mix, and points per measure will vary according to hospital size, defined by bed count, or specialty type.



The percent earned of the total at-risk for measure performance for each hospital will be based on the **sum of the total points earned** for the measures they are working on. That total will be divided by the total possible measure points (100) to determine the percent earned of at-risk dollars

Performance Measure At-Risk Calculation: Improvement Factor

- If the hospital performance is greater than the benchmark, then the hospital will earn their full points associated to the measure.
- If the hospital performance is less than the achievement threshold, then the hospital will earn 0 points for the measure.
- 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:

$$Improvement\ Factor = \frac{(\text{Hospital Performance} - \text{Achievement Threshold})}{(\text{Benchmark} - \text{Achievement Threshold})}$$

Performance Measure At-Risk Calculation: Total At-risk Earned

- The percent earned of the **total at-risk** for measure performance for each hospital will be based on the sum of the total points earned for the measures they are working on.
- That total will be divided by the total possible measure points (100) to determine the percent earned of at-risk dollars as below:

$$\textit{Percent earned of at-risk dollars} = \frac{\text{Measure Points Achieved}}{100}$$

- Points per measure vary depending on measure type and number of measures selected.
- Hospitals should review the HTP Scoring Framework for additional details.

Performance Measure At-Risk Calculation - Case Study 1

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Case Study: Hospital A, Medium Hospital

Example: Medium sized hospital (Hospital A) working on six statewide measures each worth 12.5 points, and two local measures each worth 12.5 points. The total performance at-risk is 18%.

		Benchmarks		Achievement Thresholds	
	Measure Points	**Met Count**	**Not Met Count**	**Met Count**	**Not Met Count**
Statewide Measures 6 total measures	75 points total 12.5 points each measure	4 Met	2 Not Met	2 Met	0 Not Met
Local Measures 2 total measures	25 points total 12.5 points each measure	1 Met	1 Not Met	1 Met	0 Not Met

Case Study: Hospital A, Medium Hospital

Hospital A performed at or above the achievement threshold, but does not meet the benchmark, for 2 statewide measures and 1 local measure. As a result, an **improvement factor** will be applied to the hospital's possible points for the applicable measures based on the relative percentage of improvement towards the benchmark.

$$Improvement\ Factor = \frac{(\text{Hospital Performance} - \text{Achievement Threshold})}{(\text{Benchmark} - \text{Achievement Threshold})}$$

	Measure Result	Benchmark Value	Achievement Threshold Value	Improvement Factor
Statewide Measure 1	0.66	0.70	0.50	80%
Statewide Measure 2	0.07	0.08	0.06	50%
Local Measure 1	510	650	450	30%

Case Study: Hospital A, Medium Hospital

- Step 1: Calculate earned points due to measures that met the benchmark
  - ✓ Four statewide measures and one local measure better than benchmark:

$$(4 \text{ measures } \times 12.5 \text{ points}) + (1 \text{ measure } \times 12.5 \text{ points}) = 62.5 \text{ points earned}$$

- Step 2: Calculate earned points due to measure meeting achievement threshold but not benchmark.
  - ✓ Two statewide and one local measure above achievement threshold. (Improvement factor formula found on Slide 35)

$$(0.8 \text{ factor} \times 12.5 \text{ points}) + (0.5 \text{ factor } \times 12.5 \text{ points}) + (0.3 \text{ factor } \times 12.5 \text{ points}) = 20 \text{ points earned}$$

- Step 3: Calculate total at-risk earned (formula found on Slide 36)

$$\frac{\text{Measure points earned}}{100 \text{ points}} = \frac{62.5 \text{ points} + 20 \text{ points}}{100 \text{ points}} = 82.5\% \text{ of total at risk earned}$$

Performance Measure At-Risk Calculation - Case Study 2

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Case Study: Hospital B, Critical Access Hospital

Example: Critical Access hospital (Hospital B) working on six total measures, four local and two statewide measures worth 16.7 points each. The total performance at-risk is 11%.

		Benchmarks		Achievement Thresholds	
	Measure Points	**Met Count**	**Not Met Count**	**Met Count**	**Not Met Count**
Statewide Measures 2 total measures	33.4 points total 16.7 points each measure	2 Met	0 Not Met	N/A	N/A
Local Measures 4 total measures	66.8 points total 16.7 points each measure	2 Met	2 Not Met	1 Met	1 Not Met

Case Study: Hospital B, Critical Access Hospital

Hospital B **did not meet the benchmark** for one local, but they did meet the achievement threshold for that local measure.
As a result, an **improvement factor** will be applied to the hospital's possible points for the applicable measures based on the relative percentage of improvement towards the benchmark.

$$\textit{Improvement Factor} = \frac{(\text{Hospital Performance} - \text{Achievement Threshold})}{(\text{Benchmark} - \text{Achievement Threshold})}$$

	Measure Result	Benchmark Value	Achievement Threshold Value	Improvement Factor
Local Measure 1	5.50	6.50	2.50	75%

Case Study: Hospital B, Critical Access Hospital

- Step 1: Calculate earned points due to measures that met the benchmark
  - ✓ Two statewide measures and two local measures better than benchmark:

$$(2 \text{ measures } \times 16.7 \text{ points}) + (2 \text{ measures } \times 16.7 \text{ points}) = 66.8 \text{ points earned}$$

- Step 2: Calculate earned points due to measure meeting achievement threshold but not benchmark.
  - ✓ One local measure above achievement threshold. (Improvement factor for Local Measure found on Slide 43). Hospital B did not meet the benchmark OR the achievement threshold for another local measure, resulting in 0 points.

$$(0.75 \text{ factor} \times 16.7 \text{ points}) + 0 \text{ points} = 12.53 \text{ points earned}$$

- Step 3: Calculate total at-risk earned (formula found on Slide 36).

$$\frac{\text{Measure points earned}}{100 \text{ points}} = \frac{66.8 \text{ points} + 12.53 \text{ points}}{100 \text{ points}} = 79.3\% \text{ of total at risk earned}$$

High Performing Hospital Determination

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High Performing Hospital Determination Overview

- While hospital payments will be at-risk for certain activities, a portion of each hospital's supplemental payment is at-risk based on performance on **selected quality measures**.
- Upside risk is available through redistribution of **unearned at-risk dollars** from other hospitals related to performance achievement.
- **Redistribution** of unearned at-risk dollars for performance achievement is evaluated on a per-measure basis for **statewide measures** and **pooled together for local measures.**

High Performing Hospital Determination Overview

- Unearned dollars for performance measures will be redistributed to **"high performing hospitals"** as defined below:
  - ✓ **Statewide Measures**: Hospitals that scored in the top 10% of the measure.
  - ✓ **Local Measures:** Unearned at-risk dollars will be pooled together and redistributed to hospitals whose **average performance**, is in the top 10% of all hospitals.
    - ➢ This average is used to rank each hospital.

High Performing Hospital Determination for Statewide Measure(s)

Example: Hospital A has selected three statewide measures that carry at-risk. One of these measures, SW-RAH1, is a negative directionality measure, while the other two are positive directionality measures. Reminder that determination of high performing hospitals for statewide measures are calculated on a per-measure basis.

Measure ID	Measure Direction	Measure Result	Benchmark Value
SW-BH1	Positive	0.76	0.80
SW-BH3.2	Positive	448.08	545.47
SW-RAH1	Negative	0.55	0.85

High Performing Hospital Determination for Statewide Measure(s)

- Step 1: Determine the statewide measure result.
- Step 2: The **high-performance threshold** is determined by the 90th percentile (top 10% performer) of the selected measure.
- Step 3: Compare the statewide measure result to the high-performance threshold. If the hospital's statewide measure result is **greater than or equal to** the threshold, the hospital is determined to be a **high performing hospital.** If the hospital's statewide measure result is **less than** the threshold, the hospital is **not determined to be a high performing hospital** for that measure.

High Performing Hospital Determination for Statewide Measure(s)

Example: Hospital A has selected three statewide measures that carry at-risk. Below shows the results of the high performing hospital determination calculations for those measures.

Measure ID	Measure Direction	Measure Result	Benchmark Value	High Performance Threshold	PY3 High Performing Hospital
SW-BH1	Positive	0.76	0.80	0.79	No
SW-BH3.2	Positive	448.08	545.47	664.06	No
SW-RAH1	Negative	0.55	0.85	0.56	High Performing Hospital

Components for Calculating High Performing Hospitals for Local Measures

- The percentage of benchmark and local measure factor is only applicable to **local measures.**
- The **percentage of benchmark** that a hospital receives on each of its local measures will be calculated, and then the average percentage of benchmarks across these measures will be determined.

$$Positive\ Directionality\ Percentage\ of\ Benchmark = \frac{Measure\ Result}{Benchmark}$$

$$Negative\ Directionality\ Percentage\ of\ Benchmark = \frac{Benchmark\ Value\ - Measure\ Result}{Benchmark\ Value} + 1$$

- The **local measure factor** is calculated by the average of the percentage of benchmark for every local measure the hospital chose.

$$Local\ Measure\ Factor = \frac{Sum\ of\ Percentage\ Benchmarks}{Number\ of\ Measures}$$

High Performing Hospital Determination for Local Measure(s)

Example: Hospital A has also selected three local measures. One of these measures, CP1.1, is a negative directionality measure, while the other two are positive directionality measures.

Measure ID	Measure Direction	Measure Result	Benchmark Value
COE2	Positive	266.00	198.45
CP1.1	Negative	0.05	0.062
PH1	Positive	0.24	0.29

To further assess whether a hospital is a high performing hospital for local measures, it will be necessary to calculate the percentage of benchmark for each local measure and hospital's overall local measure factor.

High Performing Hospital Determination for Local Measure(s)

- Step 1: Calculate the **percentage of benchmark** for each local measure.

  - ✓ $COE2 = 266.0/198.45 = 1.34\ percentage\ of\ benchmark$
  - ✓ $CP1.1 = ((0.07 - 0.05)/0.07)) + 1 = 1.29\ percentage\ of\ benchmark$
  - ✓ $PH1 = 0.24/0.29 = 0.83\ percentage\ of\ benchmark$

- Step 2: Calculate the **local measure factor** for the hospital.

$$\frac{1.34 + 1.29 + 0.83}{3} = 1.15\ local\ measure\ factor$$

Measure ID	Measure Direction	Measure Result	Benchmark Value	Percentage of Benchmark	Local Measure Factor
COE2	Positive	266.00	198.45	1.34	1.15
CP1.1	Negative	0.05	0.07	1.29	
PH1	Positive	0.24	0.29	0.83	

High Performing Hospital Determination for Local Measure(s)

- Step 3: The **high-performance threshold** is determined by the 90th percentile (top 10% performer) of the average of the local measures.
- Step 4: Compare the local measure factor to the threshold. If the hospital's local measure factor is **greater than or equal to the threshold,** the hospital is determined to be a **high performing hospital.** If the local factor measure is **less than the threshold**, the hospital is not determined to be a high performing hospital across local measures.
- Reminder, for local measures, high performing hospital determinations are based on the hospital's aggregate local measure performance – this is different than determinations for statewide measures.

Hospital Name	Local Measure Factor	High Performance Threshold	PY3 High Performing Hospital
Hospital A	1.15	1.58	No

High Performing Hospital – Final Determination Letter

- The **High Performing Hospital Appendix** outlines the hospital's performance redistribution for both local and statewide measures.
- Reminder, hospitals can receive an **upside risk** comprised of a redistribution of unearned at-risk dollars from other hospitals. Unearned at-risk dollars are redistributed based on those determined to be high performing hospitals.
- Hospitals will be able to view measures results, benchmarks, percentage of benchmark, local measure factor, high performance threshold, and high performing hospital determinations in this Appendix in final determinations letters.

Measure ID	Local/ Statewide	PY4 Measure Result	PY4 Benchmark	Percentage of Benchmark	Local Measure Factor	High Performance Threshold	PY4 High Performing Hospital
BH1	Local	0.430	0.500	0.860	1.245	1.581	No
COE1	Local	1.000	0.420	2.381	1.245	1.581	No
RAH1	Local	0.630	0.800	0.788	1.245	1.581	No
RAH2	Local	0.640	0.672	0.953	1.245	1.581	No
SW-BH1	Statewide	1.000	0.800	N/A	N/A	1.000	High Performing Hospital
SW-CP1	Statewide	1.000	0.800	N/A	N/A	1.000	High Performing Hospital

Performance Measure Dashboards

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Performance Measure Detail Dashboard

- The **Performance Measure Detail Dashboard** displays hospital annual performance measure result information, measure benchmarks, achievement/scoring status, and high performing hospital status.
- The dashboard displays measure information for both **self-reported measures** and **claims measures**.

Measure Peformance - Detail

Measure identifying information | **Measure results** | **Benchmark, achievement threshold, and high performing hospital status**

Progra Year	Hospita Name	CHA ID	Measur ID	Reporting Method	Local vs Statewi	Numera	Denom	Result	Benchmark Method	Benchmark Value	Benchmark Met / Not Met	Achieveme Threshold Method	Achieveme Threshold Value	Achieveme Threshold: Met / Not Met	High Performing Hospital
PY1			SW-RAH1	Claims-Based Measure	Statewide	0.022	0.095	0.225	Fixed Benchmark	N/A	N/A	Median Performance	N/A	N/A	N/A
PY1			SW-CP1	Hospital Reported	Statewide	NDA	646.00	NDA	Fixed Benchmark	N/A	N/A	Median Performance	N/A	N/A	N/A
PY1			SW-BH1	Hospital Reported	Statewide	NDA	2423.00	NDA	Fixed Benchmark	N/A	N/A	Median Performance	N/A	N/A	N/A
PY1			SW-BH3.1	Hospital Reported	Statewide	658.00	2603.00	252.79	Average Performance	N/A	N/A	Median Performance	N/A	N/A	N/A

Performance Measure Detail Dashboard

- Hospitals may also view the **Benchmark and Achievement Threshold Methodology Descriptions**, which is a reference table that provides measure description and benchmark information.

Benchmark and Achievement Threshold Methodology Descriptions

Measure ID	Measure Description	Benchmark Type	PY3 Benchmark Method	PY4 Benchmark Method	PY5 Benchmark Method	Achievement Threshold Method
BH1	Screening, Brief Intervention, and Referral to Treatment (SBIRT) in the Emergency Department	Fixed Benchmark	0.500	0.550	0.600	Median (50th percentile) performance of hospitals that did not meet the benchmark during the applicable performance year.
BH2	Initiation of Medication Assisted Treatment (MAT) in Emergency Department or Hospital Owned Certified Provider Based Rural Health Center	Fixed Benchmark	0.700	0.750	0.800	Median (50th percentile) performance of hospitals that did not meet the benchmark during the applicable performance year.
COE1	Increase the successful transmission of a summary of care record to a patient's primary care physician or other healthcare professional within one business day of discharge from an inpatient facility to home	Fixed Benchmark	0.420	0.500	0.580	Median (50th percentile) performance of hospitals that did not meet the benchmark during the applicable performance year.
COE2	Implementation/Expansion of Telemedicine Visits	Year Over Year Improvement	5% improvement of hospital's baseline score	5% improvement of hospital's PY3 benchmark	5% improvement of hospital's PY4 benchmark	Individual hospital's baseline year performance for all program years.
COE3	Implementation/Expansion of e-Consults	Year Over Year Improvement	5% improvement of hospital's baseline score	5% improvement of hospital's PY3 benchmark	5% improvement of hospital's PY4 benchmark	Individual hospital's baseline year performance for all program years.

Performance Measure Summary Dashboard

- The **Performance Measure Summary Dashboard** summarizes annual performance achievement information, high-performing hospital status information, and earned/unearned percentage outcomes.

Measure Peformance - Summary

Excel Export

Annual performance achievement

At-risk earned / unearned

Hospital Name	CHASE ID	Program Year	Measure Total	Count of Measures that Met Benchmark	Count of Measures that Did Not Meet Benchmark	Count of Measures that Met Achievement Threshold (Where Benchmark was Not Met)	Count of Measures that Did Not Meet Benchmark and Achievement Threshold	Count of Measures Where Hospital Was Considered a High Performing Hospital	At Risk %	Earned %	Unearned %
		PY3	7	0	7	0	7	0	0.0 %	0.0 %	0.0 %
		PY4	7	0	7	0	7	0	0.0 %	0.0 %	0.0 %
		PY5	7	0	7	0	7	0	0.0 %	0.0 %	0.0 %
		PY3	7	0	7	0	7	0	0.0 %	0.0 %	0.0 %

Next Steps

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Next Steps

- Hospitals should review Measure Specifications, Scoring Framework, and Quarterly Reporting Guide as needed before completing all required reporting for the PY5Q1 quarterly report.
- Once available, download the unique **Hospital Self-Reported Measure Workbook** from your hospital's CPAS document repository.
- Confirm SFTP access for both primary and secondary contacts.
- Complete the P5Q1 quarterly reporting survey, opening on January 2nd, 2026.
- Submit both the PY5Q1 Quarterly Reporting survey and the self-reported measure workbook by **February 2nd, 2026**.
- Email cohtp@mslc.com with any questions.

Thank You

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