HTP Performance Measure Training

December 19, 2024

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Department of Health Care Policy & Financing

Agenda

- Department Updates
- PY4Q1 Reporting Overview
- Hospital Self-Reported Measure Overview
- Hospital Self-Reported Measure Workbook Demo
- Hospital-Reported Performance Measure Minimum Submission Review and SRRP Procedures
- Claims Based Measure Overview
- Performance Achievement
- Performance Measure Dashboards
- Wrap Up/Next Steps

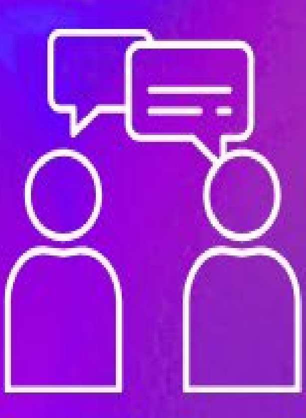
Department Updates

Save the Date

HTP Learning Symposium

When: June 11 & 12, 2025

Where: Auraria Campus – Tivoli Student Center



PY4Q1 Reporting Overview

PY4Q1 Reporting Overview

- The PY4Q1 Quarterly Reporting period opens on **January 2nd, 2025**. Hospitals are responsible for reporting the following components to earn a reporting score of **"complete"**:
  - ✓ **PY4Q1 Reporting Survey** (including Interim Activity and CHNE Reporting).
  - ✓ **PY3 Self-Reported Measure Workbook**
    - ➢ Measure documentation is not required upon submission, only self-reported measure data reporting; however, hospitals are encouraged to maintain accurate and thorough records to support the measure data reported.
- Quarterly Reports must be submitted by 11:59 PM MT **January 31st, 2025** to earn a reporting score of "timely".
- Quarterly Reports must be deemed complete and timely to earn the associated 0.5% at-risk.

PY4Q1 Interim Activity and CHNE Reminders

- As of PY3Q4, all hospital interventions were expected to be fully operational and have progressed into the continuous learning and improvement phase. Interim activity reported in the PY4Q1 Quarterly Report should be reflective of this shift.
- As a reminder, hospitals must report **at least one** CHNE activity per quarter in their PY4Q1 Quarterly Report.
- The PY4Q1 Reporting survey also includes a question related to self-reported measure workbook submission. In the survey, **Question Q17.3** asks whether the hospital's self-reported measure workbook has been uploaded to CPAS. The workbook is **not** required to be uploaded (i.e. a "yes" answer to this question) before the survey can be submitted, as long as it is submitted by the report due date.

PY4Q1 Reporting and Review Timeline

Hospital Self-Reported Measures Workbook	Date
MSLC to release hospital-specific workbooks	12/20/2024
Hospitals complete hospital self-reported measure workbooks and upload them to CPAS, as well as complete the PY4Q1 Interim/CHNE Quarterly Reporting Survey	1/2/2025 - 1/31/2025
PY4Q1 Quarterly Reviews	**Date**
MSLC to conduct Initial Reviews	2/1/2025 - 2/28/2025
MSLC to release notification to all hospitals that initial scores available on CPAS / SRRP begins	2/28/2025
MSLC to release claims-based measure files to hospitals	2/28/2025
Conduct SRRP Reviews	**Date**
SRRP Requests for Reconsideration due	2/28/2025 - 3/14/2025
MSLC to release notification to all hospitals that SRRP scores are available on CPAS / final scores are available	4/3/2025
Performance Measurement Results	**Date**
MSLC to release initial PY3 measure data to performance dashboards	2/28/2025
MSLC to release final PY3 measure results after SRRP to performance dashboards	4/3/2025

UPCOMING DUE DATE

Hospital Self-Reported Measure Overview

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_PY3 Self-Reported Measures_Blank

Hospital Self-Reported Measure Workbook: Introduction

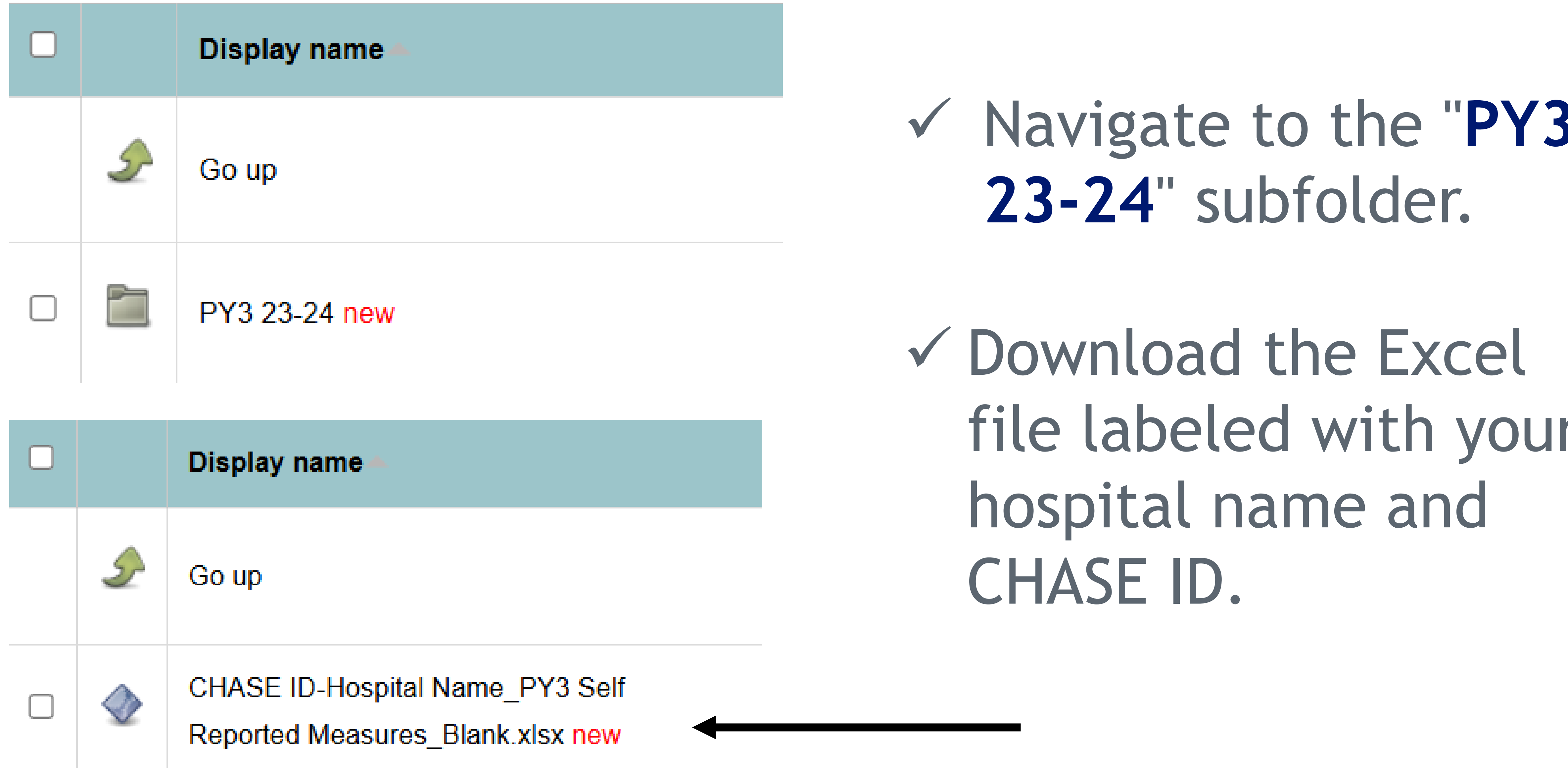
- The Hospital Self-Reported Measure Workbook includes the following tabs:
  - ✓ **Introduction Tab**
  - ✓ **Overview Tab**
  - ✓ **Data Entry Tab**
  - ✓ **Data Information Tab**
  - ✓ **Attestation Tab**
  - ✓ **Measure Information_ALL Tab**

Accessing the Hospital Self-Reported Measure Workbook

To access your hospital's unique **SRMW**:

- ✓ 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



- ✓ Navigate to the "**PY3 23-24**" subfolder.
- ✓ 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_PY3 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 PY3 Hospital SRMW includes some new features:

1. Starting with PY3, benchmarks will be included on the Data Entry tab. The **Benchmark Value** column will display what the benchmark is for the specified hospital and measure.
   - ✓ As some Achievement Thresholds calculations are based on performance of all hospitals in that measure during the applicable performance year, **AT's will not be available in hospital SRMW**.
2. The **Benchmark Conclusion** column will calculate whether the hospital has met or not met the benchmark once all required fields are completed.

PY3: Oct 2023-Sept 2024 (5% at risk, 3% for CAH)

				Hospital input – MUST be a numerical	*Hospital input – MUST be a numerical value*	*Automatically calculated*	*Automatically calculated*	*Automatically calculated*	*Autom...*
Measure ID	Measure Name	Stratification	Calculation Type	Numerator	Denominator	Result	Benchmark Value	Benchmark Conclusion	Da...
RAH1	Follow up appointment with a clinician and notification to the Regional Accountable Entities (RAE) within one business day	N/A	%	492	598	82.27%	80.00%	Benchmark Met	Clear of data entr...
RAH3									
RAH3	Home Management Plan of Care (HMPC) Document Given to Pediatric Asthma	N/A	%	NDA	1000	Inconclusive	80.00%	Benchmark Not Met	Please complete...
RAH4									
RAH4	Percentage of Patients with Ischemic Stroke who are Discharged on Statin Medication (Joint Commission STK-06)	N/A	%	564	590	95.59%	95.00%	Benchmark Met	Clear of data entr...
SW-CP1									

What's New?

3. Starting with PY3, the Hospital SRMW will also include a **Data Information tab,** which provides hospitals an opportunity to communicate reporting concerns and/or supplemental information to the Department.
    - This tab has replaced the **Data Limitations tab**, on which hospitals previously provided clarity and mitigation strategies solely related to incomplete data (0/NDA submissions). The information included on this tab can now be provided more **broadly** to provide helpful **context** around the hospital's measure submission.
    - Examples of scenarios that warrant completion of this tab may include:
        - ✓ Incomplete and/or missing data
        - ✓ Data that has not met the benchmark
        - ✓ Large variances from prior years (PY1 and PY2)
    - The Data Information tab is not required for the Hospital SRMW to be deemed complete unless the measure data is not available (i.e. numerator is 0 or NDA).

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

- Starting in PY3, hospitals will utilize the **Data Entry tab** to submit complete and accurate data in order 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, and Calculation Type**.
- 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).**
- The Result, Benchmark, Benchmark Conclusion, and Data Validation columns are automatically calculated based on the Hospital Input columns.

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.

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.

PY3: Oct 2023-Sept 2024 (5% at risk, 3% for CAH)				*Hospital input - MUST be a numerical*	*Hospital input - MUST be a numerical value*	*Automatically calculated*	*Automatically calculated*	*Automatically calculated*	*Automatically calculated*
Measure ID	Measure Name	Stratification	Calculation Type	Numerator	Denominator	Result	Benchmark Value	Benchmark Conclusion	Data Validation
CP5									
CP5	Reducing Neonatal Complications - Severe	Severe	Rate per 1000 live	NDA	1000	Inconclusive	N/A	N/A	Please complete the Data Information tab.
CP5	Reducing Neonatal Complications - Moderate	Moderate	Rate per 1000 live	500	1000	500.00	N/A	N/A	Clear of data entry validation errors.
CP5	Reducing Neonatal Complications - Total	Total	Rate per 1000 live births	25	2000	12.50	25.72	Benchmark Met	Clear of data entry validation errors.

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.

PY3: Oct 2023-Sept 2024 (5% at risk, 3% for CAH)

				Hospital input – MUST be a numerical	*Hospital input – MUST be a numerical value*	*Automatically calculated*	*Automatically calculated*	*Automatically calculated*	*Automatically calculated*
Measure ID	Measure Name	Stratification	Calculation Type	Numerator	Denominator	Result	Benchmark Value	Benchmark Conclusion	Data Validation
COE2									
COE2	Implementation/Expansion of Telemedicine Visits	N/A	Count	200	N/A	N/A	198.45	Benchmark Met	Clear of data entry validation errors.
COE3									
COE3	Implementation/Expansion of e-Consults	N/A	Count	4391	N/A	N/A	6690.6	Benchmark Not Met	If the hospital would like to provide additional context around data submission, please complete the Data Information tab.
COE4									

Data Entry Tab: Benchmarks

- Starting in PY3, benchmarks will be included on the Data Entry tab.
- 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.

Reporting period: PY3: Oct 2023-Sept 2024 (5% at risk, 3% 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*	*Automatically calculated*	*Automatically calculated*	*Automatically calculated*
Reported Measure	Measure ID	Measure Name	Stratification	Calculation Type	Numerator	Denominator	Result	Benchmark Value	Benchmark Conclusion	Data Validation
Yes	RAH1									
Yes	RAH1	Follow up appointment with a clinician and notification to the Regional Accountable Entities (RAE) within one business day	N/A	%	492	598	82.27%	80.00%	Benchmark Met	Clear of data entry validation errors.
Yes	RAH3									
Yes	RAH3	Home Management Plan of Care (HMPC) Document Given to Pediatric Asthma Patient/Caregiver	N/A	%	315	391	80.56%	80.00%	Benchmark Met	Clear of data entry validation errors.
Yes	RAH4									
Yes	RAH4	Percentage of Patients with Ischemic Stroke who are Discharged on Statin Medication (Joint Commission STK-06)	N/A	%	388	444	87.39%	95.00%	Benchmark Not Met	If the hospital would like to provide additional context around data submission, please complete the Data Information tab.

Data Information Tab

- Starting with PY3, the Hospital SRMW will also include a **Data Information tab**, which provides hospitals an opportunity to communicate reporting concerns and/or supplemental information to the Department.

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: 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*	**Benchmark Not Met**	*Example: No summaries of care were able to be transmitted in the previous program year as our hospital was in the process of connecting to an EHR. Now that we have completed the implementation, summaries of care have been reported. For this reason, we expect a large variance between the past and current program years.*
Enter measure ID here.	Enter measure name here.		
Enter measure ID here.	Enter measure name here.		

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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:

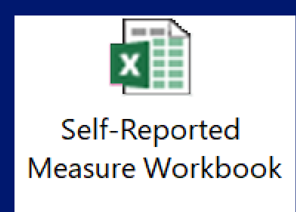
- The Colorado Hospital Transformation Program payment will be paid from State and Federal funds, and that by filing this attestation a claim is being submitted for State and Federal funds, and that the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain 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.

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



Hospital-Reported Performance Measure Minimum Submission Review and SRRP Procedures

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.
- Use of the **Data Information** tab may proactively address data validation flags.

Minimum Submission Review

- Once the MSR process is complete, hospitals will receive their **initial measure reporting and measure achievement scores** via PY4Q1 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
  - ✓ Numerator/Denominator transposition
  - ✓ 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 PY4Q1 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 PY3 – 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*

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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

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 PY3 claims-based measure files will be available to hospitals by **February 28, 2025.**
  - ✓ The files will **not** include data for SW-PH1 (Inpatient Hospital Transitions) for PY3 as all associated at-risk is being **automatically awarded**. The data for this measure will be included in the claims-based measure summaries starting with **PY4**.

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 Achievement

Performance Achievement: Overview

- Beginning with **PY3**, hospitals will earn **performance achievement at-risk.**
- 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**, **partial at-risk** may be earned.

Achievement Threshold: Improvement Factor

- 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:

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

- Each measure's benchmark and achievement threshold type is included in the HTP Scoring Framework and CPAS **Performance Measure Detail dashboard.**

Performance Achievement: Total At-risk Earned

- The percent earned of the **total at-risk** dollars 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. See HTP Scoring Framework for details.

Performance Achievement: Total At-risk Earned

- Example: Medium sized hospital working on six statewide measures each worth 12.5 points, and two local measures each worth 12.5 points:
  - ✓ Four statewide measures and one local measure better than benchmark = (4 x 12.5) + (1 x 12.5) = 62.5 points
  - ✓ Two statewide and one local measure above achievement threshold at 80% improvement (improvement factor = 0.8) = (2 x .8 x 12.5) + (1 x .8 x 12.5) = 30 points

Total Points = 92.5 = 92.5% earned of at-risk dollars

Benchmark and Achievement Threshold Methodologies: PY3

Benchmark Type	Associated Measures	Achievement Threshold
No PY3 Benchmark	SW-COE1, SW-PH1	50th percentile (median) performance of hospitals that did not meet the benchmark.
Fixed Benchmark	BH1, COE1, CP6, SW-RAH1, RAH1, RAH4, SW-BH1, SW-CP1, BH2, COE4, CP3, CP4, RAH3, SW-BH2	
National or Statewide Standard Measures	SW-RAH2, CP1 (pediatric), CP2, CP5	Individual hospital's PY1 performance for all program years.
Average Performance Benchmark	RAH2, SW-BH3, and CP1 (Adult)	
5% Year-over-Year Improvement Benchmark	CP7, COE2, COE3, PH1, PH2, PH3	

Performance Measure Dashboards

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

Prograı 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. This dashboard will be populated starting in PY3.

Measure Peformance - Summary

Annual performance achievement

At-risk earned / unearned

Excel Export

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

Next Steps

- Hospitals should review Measure Specifications, Scoring Framework, and Quarterly Reporting Guide as needed before completing all required reporting for the PY4Q1 quarterly report.
- 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 PY4Q1 quarterly reporting survey, opening on January 2nd, 2025.
- Submit both the PY4Q1 Quarterly Reporting survey and the self-reported measure workbook by **January 31st, 2025**.
- Email cohtp@mslc.com with any questions.

Thank You