Hospital Transformation Program

Scoring Framework

January 29, 2026

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Contents

I. Introduction

Consistent with the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017, the Colorado Health Care Affordability and Sustainability Enterprise (CHASE), in concert with the state of Colorado Department of Health Care Policy & Financing (the Department or HCPF) sought and received approval from the federal Centers for Medicare & Medicaid Services (CMS) for the federal authority necessary through a state plan amendment to embark on a five-year program to implement hospital-led strategic initiatives through the establishment of a delivery system reform program. CHASE will seek additional Federal authority as necessary to continue implementing and overseeing the program.

The State leverages hospital supplemental payment funding generated through existing health care affordability and sustainability fees authorized under CHASE. These payments are used as incentives in a statewide Hospital Transformation Program (HTP) designed to improve patient outcomes through care redesign and integration with community-based providers, lower Medicaid costs through reductions in avoidable care, and prepare the state's hospitals for future value-based payment environments.

This document outlines the general framework for the HTP. The program includes significant collaboration with key stakeholders including the Department, CMS, the CHASE Board, the Colorado Hospital Association, participating hospitals, and broader stakeholders participating in the program.

A. Program Participation

To qualify for participation in HTP, a hospital must be state-licensed as a general or critical access hospital (CAH) participating in Colorado Medicaid. The hospital cannot be licensed as a Psychiatric Hospital, Rehabilitation Hospital, or Long-Term Care Hospital by the Colorado Department of Public Health & Environment. The hospital must submit an application for participation in the program.

B. New, Change in Enrollment, Change in Ownership Participation Requirement

New hospitals or hospitals with a change in enrollment or ownership and that subsequently meet program requirements are eligible to participate. Timelines for completing requirements will be adjusted accordingly, but will generally

follow the HTP schedule. For more information regarding HTP reporting requirements, timelines, and at-risk for new hospitals, the HTP Participation Procedures for New Hospitals onboarding packet may be provided upon request.

Any HTP-participating entity anticipating an acquisition, merger, closure, Medicaid enrollment change, state license change or other material change to its capacity, such as changes to licensed bed count, during the term of the HTP must inform the Department of those proposed changes. Notification of these changes must be made via email to COHTP@state.co.us at least 30 days in advance of the material change.

Any new HTP-participating hospital must inform the Department of its Medicaid provider enrollment application submission. HTP participation will begin the first day of the quarter following Medicaid enrollment approval if the approval is in the first or second quarter of the HTP program year. Hospitals that attain Medicaid enrollment approval during the third or fourth quarter of the HTP program year will begin the first day of the first quarter of the following program year. Medicaid enrollment notification must be made via email to COHTP@state.co.us at least 30 days in advance of the Medicaid enrollment submission date.

II. Overview

Colorado general and Critical Access Hospitals receive supplemental payments through CHASE. Participation in HTP is a condition to qualify for supplemental payments, with a portion of the payments at risk based on reporting activity, meeting major milestones, and performance on measures.

For each intervention, hospitals develop implementation plans with clear demonstrable milestones. Hospitals are measured on improved performance in years three through five across a series of measures important to improved processes of care, improved health outcomes, and reducing avoidable utilization and costs. In addition, hospitals produce a plan for sustainability of projects and performance in the final year of the demonstration.

During the pre-program period, referred to as program year (PY) 0, qualified hospitals conducted a Community and Health Neighborhood Engagement (CHNE)

process to inform the hospitals' HTP projects and cultivate the meaningful partnerships critical to the success of the overall program. Every hospital participating in the HTP must complete all components of the CHNE process.

Upon completion of PY0, the program was set to begin; however the start date was modified by the Department in light of the COVID-19 pandemic. As a result, a Program Application Period was added to the program.

Throughout the program, the Department will increase transparency through public reporting on quality measures and hospital utilization. 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.

As the program matures into the post-program time period, the Department anticipates efforts will be sustained or enhanced with the adoption of value-based and/or alternative payment methodologies, and efforts will be undertaken to define, evaluate, and identify centers of excellence.

III. Methodology

Colorado general and Critical Access Hospitals receive supplemental payments through CHASE. These supplemental payments include the Inpatient (IP) Supplemental Payment[1], Outpatient (OP) Supplemental Payment[2], Hospital Quality Incentive Payment (HQIP) Supplemental Payment, and the Disproportionate Share Hospital (DSH) Supplemental Payment.[3] The supplemental payments at risk for the HTP are the IP Supplemental Payment and the OP Supplemental Payment. If an eligible hospital does not participate in the HTP, the entirety of its IP Supplemental Payment and its OP Supplemental Payment will be withheld.

Each PY includes reporting activities that a qualified hospital is required to complete. A qualified hospital not completing a reporting activity shall have their IP/OP Supplemental Medicaid Payments reduced by a designated percent. The dollars not paid to those qualified hospitals shall be distributed to qualified

[1] The IP Supplemental Payment comprises any supplemental payment made by the CHASE through the IP upper payment limit (UPL) excluding the Hospital Quality Incentive Payment Supplemental Payment.
[2] The OP Supplemental Payment comprises any supplemental payment made by the CHASE through the OP UPL.
[3] The HQIP Supplemental Payment and the DSH Supplemental Payment are not part of HTP, will not be impacted by performance in HTP, and have their own eligibility criteria and payment methodologies.

hospitals completing the reporting activity. A qualified hospital's distribution shall equal their percentage of IP/OP Supplemental Medicaid Payment to the total IP/OP Supplemental Medicaid for all qualified hospitals completing the reporting activity, multiplied by the total reduced dollars for qualified hospitals not completing the reporting activity.

Unearned at-risk dollars will be calculated and redistributed in the fourth quarter following the PY in which the reporting activity or performance measure takes place. The supplemental payments used in the calculation of any unearned at-risk dollars also come from the PY in which the reporting activity or performance measure takes place. For example, any unearned at-risk dollars for the implementation plan and timely reporting in PY1 will be calculated using the supplemental payments a hospital is modeled to receive for PY1. The reconciliation of the unearned at-risk dollars and redistribution for the implementation plan and timely reporting in PY1 will take place in the fourth quarter of PY2.

A. Downside Risk - Pay for Reporting and Activity, Pay for Achievement, Performance and Improvement

There are six HTP reporting activities. Hospitals will be at-risk for a sequentially increasing percentage of their payments. The reporting activities are listed below, along with the total at-risk percent associated with each reporting activity.

- **Application (1.5% at-risk total)** – Qualified hospitals must provide interventions and measures they shall address which focus on improving processes of care and health outcomes and reducing avoidable utilization and cost. The percent at risk shall be scored on timely and satisfactory submission.
- **Implementation Plan (1.5% at-risk total) -** Qualified hospitals must submit a plan in PY1 to implement interventions with clear milestones that shall impact their measures. The percent at risk shall be scored on timely and satisfactory submission.
- **Quarterly Reporting (0.5% per quarter) -** Qualified hospitals must report quarterly on the activities that occurred in that quarter. For any given quarter, this includes interim activity reporting and CHNE reporting or

milestone activity reporting and CHNE reporting. The percent at risk shall be scored on timely and satisfactory submission.

- **Meeting Major Milestone (4.0% at-risk total in PY2, 8.0% at-risk total in PY3)** – Qualified hospitals must demonstrate completion of milestones, as previously determined in the hospital's approved Implementation Plan. The percent at risk shall be scored for achievement of milestones. Qualified hospitals that miss a milestone can have the reduction for the milestone reduced by 50% if they submit a course correction plan with the subsequent Milestone Report. A course correction reduction for a missed milestone can only be done once per intervention.
- **Performance Measure Reporting (5% at-risk total in PY3 (3% for CAHs), 18% at-risk total in PY4 (11% for CAHs), and 20% at-risk total in PY5 (12% for CAHs))** – In PY3 through PY5, qualified hospitals must report on established performance measures applicable to interventions implemented. Hospitals will earn an increasing percentage of at-risk dollars for meeting or exceeding performance measure benchmarks and achievement thresholds.
- **Sustainability Plan (8% at-risk total)** – As mentioned above, in PY5, qualified hospitals must submit a plan demonstrating how the transformation efforts will be maintained after the HTP is over. The percent at risk shall be scored on timely and satisfactory submission.

The schedule and at-risk percentages per program year for reportable activities are as follows:

- During the Program Application period, 1.5% of payments are at risk, contingent on the hospital application.
- In PY1, 2.5% of payments are at risk. 1.5% is at risk each for the implementation plan, and 1% at risk for timely reporting (.5% for two quarters).
- In PY2, 6% of payments are at risk. 2% is at risk for timely reporting (.5% for four quarters), and 4% at risk for meeting major project milestones. For hospitals who miss their milestones, 50% of the at-risk dollars can be earned back by submitting a course correction plan. Each hospital may submit a course correction plan once per intervention. Milestone amendments may

be submitted to amend single or multiple milestone(s), which could prevent the loss of at-risk dollars in subsequent PYs.

- In PY3, 15% of payments are at risk. 2% is at risk for timely reporting (.5% for four quarters), 8% is at risk for meeting major project milestones, and up to 5% at risk for not meeting or exceeding benchmarks or achievement thresholds (3% for CAHs). For hospitals who miss their milestones, 50% of the at-risk dollars can be earned back by submitting a course correction plan. Each hospital may submit a course correction plan once per intervention.
- In PY4, 20% of payments are at risk. 2% is at risk for timely reporting (.5% for four quarters), and up to 18% at risk for not meeting or exceeding benchmarks or achievement thresholds (11% for CAH).
- In PY5, 30% of payments will be at risk. 2% is at risk for timely reporting (.5% for four quarters), 8% at risk for submission and approval of the sustainability plan, and up to 20% at risk for not meeting or exceeding benchmarks or achievement thresholds (12% for CAH).

Please see *Appendix A: Financing Risk* and A*ppendix B: Financing Risk for Critical Access Hospitals* and *Appendix C: Measures Data and Reporting Timeline* for further information.

B. Upside Risk - Redistribution of Dollars, and Medicaid Savings Bonus

- **Redistribution of Dollars**

  While hospital payments will be at risk for certain activities, hospitals will also be able to receive an upside risk comprised of a redistribution of unearned at-risk dollars related to reportable activities.

  Unearned dollars for reporting requirements (application plan, implementation plan, and sustainability plan) and timely reporting will be pooled together when calculating redistribution for that program year.

  Unearned dollars for meeting major milestones will be pooled together when calculating redistribution for the applicable reporting quarter.

  Unearned dollars for performance measures will be distributed in the following manner when calculating redistribution:

For each statewide measure, unearned at-risk dollars will be redistributed to hospitals who scored in the top 10% on the measure.

For local measures, unearned at-risk dollars will be pooled together and redistributed to hospitals whose average performance, as a percent of benchmark, for their local measures is in the top 10% of all hospitals. The percentage of benchmark that a hospital receives on each of its local measures will be calculated, and then the average percentage of benchmark across these measures will be determined. This average will be used to rank each hospital. Hospitals in the top 10% will be deemed a high performing hospital and awarded available redistributed at-risk dollars.

Example:

Hospital A
4 local measures
Measure 1 = 90% of benchmark = .9
Measure 2 = 110% of benchmark = 1.1
Measure 3 = 105% of benchmark = 1.05
Measure 4 = 120% of benchmark = 1.2
Average = 1.0625

Hospital B
2 local measures
Measure 1 = 120% of benchmark = 1.2
Measure 2 = 105% of benchmark = 1.05
Average = 1.125

Dollar distribution for each eligible hospital will be weighted by their total dollars at risk.

Please see *Appendix A: Financing Risk* and *Appendix B: Financing Risk for Critical Access Hospital*s for further information.

- **Medicaid Savings Bonus**

For PY3, PY4, and PY5, hospitals will be eligible for savings bonuses included in the upside opportunity.

The savings bonuses are comprised of dollars saved as a result of the program's hospitalization changes attributable to HTP efforts. A portion of the savings will be shared with all hospitals based on their relative proportion of Medicaid hospital utilization, adjusted by their average performance on HTP measures. Savings will be determined based on a comparison of actual hospital-based services payments to expected payments for the same period, adjusted for utilization. The pool of hospital savings will be capped by the lesser of hospital savings and total program payment savings, such that, if there is no overall savings, then there will be no savings bonuses. These savings will be evaluated for PY3, PY4, and PY5 with calculation at the end of each performance year and savings shared in the subsequent year in accordance with timely filing limits. For example, savings calculated in PY3 will be shared in PY4.

The 30% at-risk in PY5 will be reconciled along with the savings bonus for payment following the end of PY5. It is required to have a 6-month claims lag to produce the report for the last PY of the demonstration. The Department will have Q3 of payment year 5 to receive and accept sustainability plans and reconcile payments in Q4 of payment year 5.

Please see *Appendix C: Measures Data and Reporting Timeline* for an outline of the measures data and reporting timeline.

C. Pay for Reporting and Activity

Pay for reporting at-risk components include: the application, the implementation plan, each quarterly reporting and the sustainability as described above.

D. Pay for Achievement, Performance, and Improvement

Pay for achievement, performance and improvement at-risk components include achievement of project milestones and performance or improvement on outcome measures.

- **Achievement of Project Milestones.** At-risk percentages are tied to the successful completion of milestones. The percent of credit toward milestones will equal the number of milestones achieved, divided by the total number of milestones for the intervention. The at-risk percentage for each intervention will equal the at-risk percentage, divided by the number of interventions.
- **Performance or Improvement on Outcome Measures.** Hospitals are required to select measures as outlined in the Measurement Scoring section below. Beginning in PY3, an established at-risk percentage for a given PY is based on whether they:
    - ✓ Achieve or exceed the benchmarks for their measures; or,
    - ✓ Show marked improvement in their measures (i.e. meet achievement threshold).

  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, the following 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 according to the formula below:

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

  Those that fail to do either a. or b. for a measure will receive no points for that measure.

  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:

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

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

See *Appendix A: Financing Risk* and *Appendix B: Financing Risk for Critical Access Hospitals* for further information.

E. Benchmarking and Achievement Thresholds

After the baseline period of PY1, benchmarks will be set in PY2. Benchmarks will vary based on availability of data and type of measure.

Hospital Index Measure: The hospital index measure (SW-COE1) has a set benchmark for all hospitals.

- There is no benchmark for all hospitals for PY3 – at risk will be granted.
- The benchmark for all hospitals for PY4 will be performance against the Index benchmark of 100.
- The benchmark for all hospitals for PY5 will be performance against the Index benchmark of 100.
- The achievement threshold for hospital index measure will be set at the 50th percentile (median) performance of hospitals that did not meet the benchmark during the applicable performance year.

National or Statewide Standard Benchmark: For select measures, benchmarks will be based on national or statewide benchmarks per measure. The following benchmark and achievement threshold methodology will be implemented for applicable measures:

- The achievement threshold will be set at (individual) hospital's PY1 performance for all program years.
    - ✓ These measures include: SW-RAH2, CP1 (pediatric), CP2, and CP5

Fixed Benchmark: For select measures, there is a fixed benchmark. See Appendix D for benchmarks implemented for the following measures:

- BH1, COE1, CP6, SW-RAH1, RAH1, RAH4, SW-BH1, SW-CP1, SW-PH1[4], BH2, COE4, CP3, CP4, RAH3, and SW-BH2

The following achievement threshold methodology will be implemented for measures with fixed benchmarks.

- The achievement threshold for measures where data is available from more than 10 hospitals will be set at the 50th percentile (median) performance of hospitals that did not meet the benchmark during the applicable performance year.
    - ✓ These measures include: BH1, COE1, CP6, SW-RAH1, RAH1, RAH4, SW-BH1, SW-CP1, and BH2
- The achievement threshold for measures where data is **not** available from more than 10 hospitals will be set at (individual) hospital's PY1 performance for all program years.
    - ✓ These measures include: COE4, CP3, CP4, RAH3, and SW-BH2

Average Performance Benchmark: For select measures, there is an average performance benchmark. The following benchmark and achievement threshold methodology will be implemented for applicable measures:

- The benchmark for all hospitals for PY3 will be the average performance of the top 75% of hospitals during PY1.
- The benchmark for all hospitals for PY4 will be a 5% improvement of PY3 benchmark.
- The benchmark for all hospitals for PY5 will be a 5% improvement of PY4 benchmark.
- The achievement threshold will be set at the 50th percentile (median) performance of hospitals that did not meet the benchmark during the applicable performance year.
    - ✓ These measures include: RAH2, SW-BH3, and CP1 (Adult)

[4] The PY4 and PY5 benchmarks for SW-PH1 are participation based; therefore, there will be no achievement threshold for the measure.

5% Year-over-Year Improvement Benchmark: For select measures, there is a 5% year-over-year improvement benchmark. The following benchmark and achievement threshold methodology will be implemented for applicable measures:

- The benchmark for PY3 will be 5% improvement of the PY1 (baseline) score.
- The benchmark for PY4 will be 5% improvement of the PY3 benchmark.
- The benchmark for PY5 will be 5% improvement of the PY4 benchmark.
- The achievement threshold will be set at (individual) hospital's PY1 performance for all program years.
    - ✓ These measures include: CP7, COE2, COE3, PH1, PH2, and PH3 (PY3 only)

Please see *Appendix D: Benchmark Methodologies* for the benchmark methodologies of each measure.

IV. Measurement Scoring

Data obtained from multiple sources to assess hospital performance was used to inform measure creation. Such sources of data include, but are not limited to: Medicaid claims data, hospital data self-reported to the Department on selected measures subject to review, and other public sources.

The proposal for calculating the total required effort for measures is that each hospital will be required to work on a set of measures equal to 100 points. Moreover, the number, mix, and points per measure will vary according to hospital size, defined by bed count, or specialty type. Hospitals have the option to work on local measures beyond the required minimum. This would spread the local measure risk by reducing the points per local measure.

A. Measurement Scoring by Hospital Size

Large hospitals (91-plus beds) will be accountable for six statewide measures, totaling 60 points and a minimum of four local measures, which will account for 40 points. Points per local measure will equal 40, divided by the number of local measures selected.

Medium hospitals (26 to 90 beds) will be accountable for six statewide measures and a minimum of two local measures. If two local measures are selected, statewide measures will total 75 points, and local measures will account for 25

points. If three local measures are selected, then statewide measures will total 67 points and local measures will account for 33 points. If four or more local measures are selected, then statewide measures will then total 60 points and local measures will account for 40 points. Points per local measure will equal 40, divided by the number of local measures selected for four or more local measures.

Small hospitals (<26 beds) excluding CAHs will be accountable for six measures (statewide or local) to account for 100 points. Points per each measure will equal 100 divided by the number of measures selected.

Similarly, CAHs will be accountable for six measures (statewide or local) to account for 100 points. Points per each measure will equal 100 divided by the number of measures selected. However, the risk for measures will be reduced by 40%.

Pediatric hospitals will be accountable for five statewide measures, totaling 50 points, and a minimum of five local measures, which will account for 50 points. Points per local measure will equal 50 divided by the number of local measures selected.

Respiratory specialty hospital(s) will be accountable for three statewide measures and a minimum of five local measures to account for 100 points. Points per each measure will equal 100 divided by the number of measures selected.

Orthopedic specialty hospital(s) will be accountable for six measures (statewide or local) to account for 100 points. Points per each measure will equal 100 divided by the number of measures selected.

As noted above, most hospitals will be accountable for certain statewide measures including at least one in each of the following areas:

- Reducing avoidable hospital utilization.
- Core populations.
- Behavioral health (BH) and substance use disorder (SUD).
- Clinical and operational efficiencies.
- Population health and total cost of care.

B. Rounding Methodology in Performance Measure Scoring

HCPF will apply rounding to performance-related calculations to ensure consistency and simplify data for ease of interpretation.

If a hospital's measure result is greater than one, the measure result will be rounded to the hundredth decimal place. If the measure result is less than one, the measure result will be rounded to the thousandth decimal place. There is an exception for the SW-RAH1 (30-day All Cause Risk Adjusted Hospital Readmission) measure which may have measure results greater than or less than one depending on the hospital. SW-RAH1 will always be rounded to the thousandth decimal place, as the measure's benchmark is less than one. The rounded measure result will be used in subsequent performance calculations and will be reflected in the CPAS Performance Measure Detail Dashboard. Rounding will only be applied to the measure result and not the measure numerator or denominator.

The rounding methodology described above has also been consistently applied across the following performance-related fields for PY3-PY5: benchmarks, achievement thresholds, improvement factors, and high performing hospital thresholds. This methodology has been defined to increase hospital visibility into performance calculations. The performance-related fields listed above will be displayed in the CPAS dashboards and/or written communications to hospitals as specified above.

All at-risk percentages will be displayed to the hundred-thousandths place (for example, 0.041234578 at-risk earned would be displayed to the fifth decimal place which is 0.04123 or 4.123%) in CPAS dashboards and determination letters; however, the at-risk percentages will not be rounded when applied to supplemental payment dollars for the sake of ensuring accurate financial calculations. Final dollars earned and unearned included in the hospital's annual CHASE payment letter will be rounded to the nearest whole dollar.

V. Statewide Measures, Local Measures, State Priorities, and Complementary Efforts

A. Statewide Measures

For each focus area, there will be at least one statewide measure required for most HTP-participating hospitals. The focus area related to Behavioral Health and Substance Use Disorder is the only area that will have more than one measure considered statewide. Below are the statewide measures for the program.

- Reducing Avoidable Hospital Utilization
  - ✓ SW-RAH1 - 30-day All Cause Risk Adjusted Readmission.
  - ✓ SW-RAH2 - Pediatric All-Condition Readmission Measure.
- Core Populations
  - ✓ SW-CP1 - Social Needs Screening and Notification.
- Behavioral Health and Substance Use Disorder
  - ✓ SW-BH1 - Collaboratively develop and implement a mutually agreed upon discharge planning and notification process with the appropriate RAE's for eligible patients with a diagnosis of mental illness or substance use disorder (SUD) discharged from the hospital or ED.
  - ✓ SW-BH2 - Pediatric Screening for Depression in Inpatient and ED including Suicide Risk.
  - ✓ SW-BH3 - Using Alternatives to Opioids (ALTO) in Hospital Emergency Departments (ED): 1) Report use of Opioids 2) Increase use of ALTO
- Clinical and Operational Efficiencies
  - ✓ SW-COE1 - Hospital Index.
- Population Health and Total Cost of Care
  - ✓ SW-PH1 - Inpatient Hospital Transitions (IHT).

B. Local Measure

Hospitals will be asked to select from a list of local measures to comprise the remainder of their measurement score. The combination of local measures selected should be reflective of the community needs identified in the CHNE process. The Department has worked with quality measures workgroups to identify local measures for the program. These measures include:

- Reducing Avoidable Hospitalizations

- ✓ RAH1 - Follow up appointment with a clinician and notification to the Regional Accountable Entities (RAE) within one business day.
- ✓ RAH2 - Emergency Department (ED) visits for which the member received follow up within 30 days of the ED visit.
- ✓ RAH3 - Home Management Plan of Care (HMPC) Document Given to Pediatric Asthma Patient/Caregiver.
- ✓ RAH4 - Percentage of Patients with Ischemic Stroke who are Discharged on Statin Medication (eCQM).

- Core Populations
  - ✓ CP1 - Readmission Rate for a High Frequency Chronic Condition – 30-day (Adult)
  - ✓ CP1 – Pediatric readmissions rate chronic condition 30 day.
  - ✓ CP2 - Pediatric bronchiolitis appropriate use of bronchodilators.
  - ✓ CP3 - Pediatric sepsis timely antibiotics.
  - ✓ CP4 - Screening for transitions of care supports in adults with disabilities.
  - ✓ CP5 - Reducing neonatal complications.
  - ✓ CP6 - Screening and referral for perinatal and post-partum depression and anxiety and notification of positive screens to the RAE.
  - ✓ CP7 - Increase access to specialty care.
- Behavioral Health/Substance Use Disorder
  - ✓ BH1 - Screening, Brief Intervention, and Referral to Treatment (SBIRT) in the ED.
  - ✓ BH2 - Initiation of Medication Assisted Treatment (MAT) in ED or Hospital Owned Certified Provider Based Rural Health Center
- Clinical and Operating Efficiencies
  - ✓ COE1 - Increase the successful transmission of a summary of care record to a patient's primary care physician (PCP) or other health care professional within one business day of discharge from an inpatient facility to home.
  - ✓ COE2 - Implementation/expansion of Telemedicine Visits.
  - ✓ COE3 - Implementation/expansion of e-Consults.

- ✓ COE4 - Energy star certification achievement and score improvement for hospitals.

- Population Health and Total Cost of Care
  - ✓ PH1 - Increase the percentage of patients who had a well visit within a rolling 12-month period.
  - ✓ PH2 - Increase the number of patients seen by co-responder hospital staff.
  - ✓ PH3 - Improve leadership diversity. (measure suspended effective in PY4)

C. Statewide Priorities

In addition, hospitals have the option to replace a local measure with a statewide priority. Each statewide priority will be worth 20 points, and if selected the points for each remaining local measure will be equal to the remaining total required local measure points divided by the number of local measures, greatly reducing the risk associated with those measures. Statewide priorities in the program are:

- SP-PH1 - Conversion of Freestanding EDs to Address Community Needs.
- SP-PH2 - Creation of Dual Track ED.

Performance for these measures is based on successful implementation of the applicable interventions. In PY3-PY4, the at-risk associated to statewide priorities will be granted. By PY5, if all milestones outlined in the hospital's approved Implementation Plan have not been met, the hospital will lose the 20 points in PY5, which is equal to the at-risk reduction associated to statewide priority measures. There are no benchmarks or achievement thresholds associated with the statewide priority measures. For additional details on the review criteria for statewide priority measures, please refer to the HTP Quarterly Reporting Guide on the CO HTP website.

D. Complementary Statewide Efforts

Within certain focus areas, there are complementary statewide efforts HTP-participating hospitals are asked to align with or engage in along with HTP efforts. These complementary efforts correspond with the CHNE process, core populations, and BH and SUD coordination.

- A discussion of hospital inventory and capacity will be a part of the CHNE.

- Engagement with a multi-provider consensus quality measure and alternative payment methodology collaborative.
- Use of the advanced care plan repository and education tools.
- Use of the Medication (Rx) Prescribing Tool (which is being expanded to include health improvement program and opioid addiction prevention insights for prescribers).
- Real-time data sharing and admission, transfer, and discharge standards.
- Defining and identifying Centers of Excellence.
- Where capacity and need align, obtain necessary enrollment to provide beds for residential and inpatient substance use disorder (SUD) services following approval of the Department's SUD Waiver.
- Participation in a rural hospital support program for certain qualified hospitals.

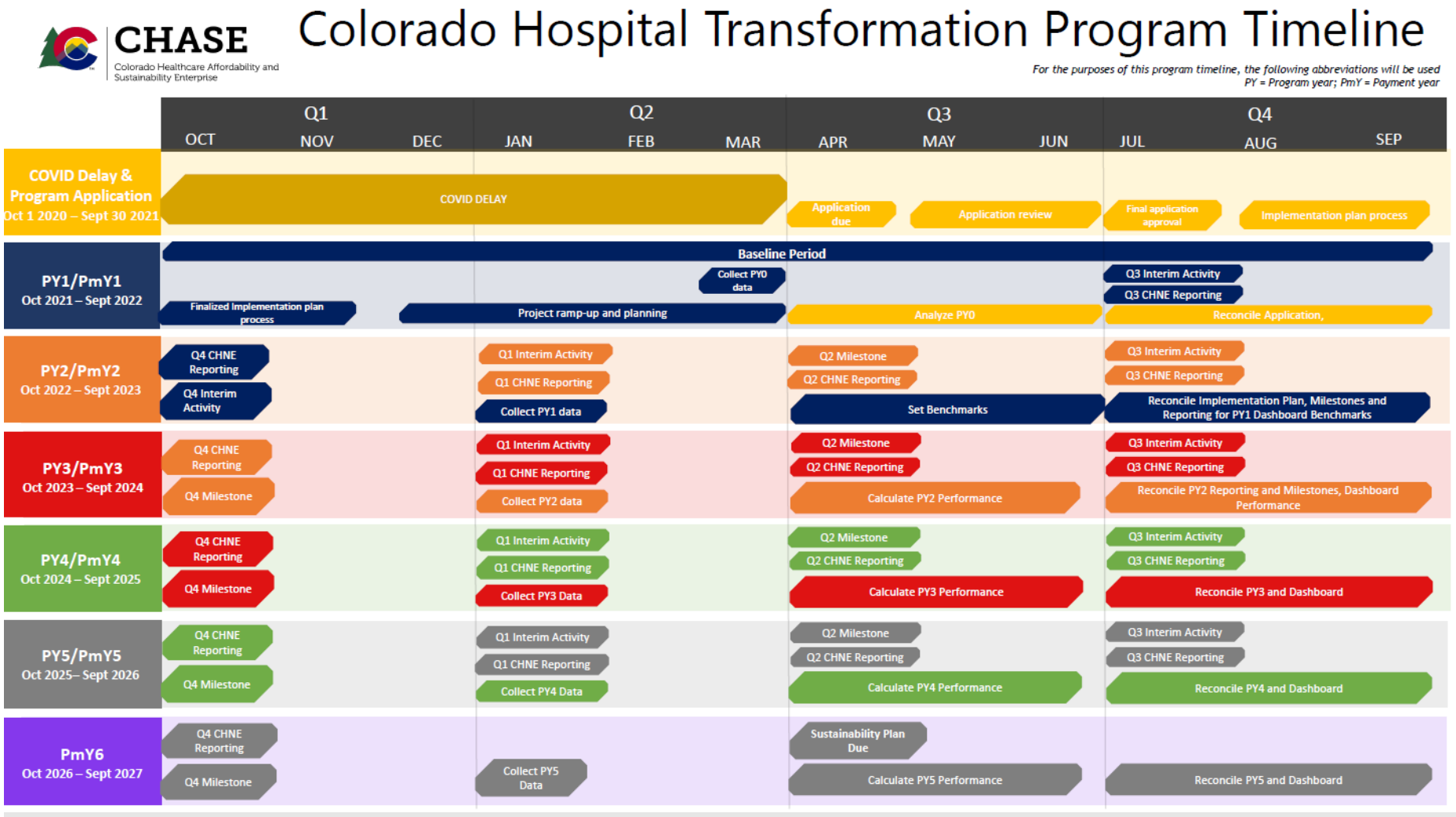
VI. Appendix A: Financing Risk

HTP Year	Total % At-Risk (Downside)	Upside Risk	Description of Activities At-Risk	% At-Risk by Activity
Program Application Oct 1, 2020 - Sept 30, 2021	1.5	Redistribution of unearned at-risk dollars for the Program Application Period	Community and Health Neighborhood Engagement Reporting	0
			Application Approved Q4	1.5
Year 1 Oct 1, 2021 - Sept 30, 2022	2.5	Redistribution unearned at-risk dollars for PY1	Timely Reporting of Implementation Plan with Milestones Approved Q1	1.5
			Timely Quarterly Reporting	1
Year 2 Oct 1, 2022 - Sept 30, 2023	6	Redistribution of unearned at-risk dollars for PY2	Timely Reporting	2
			Meeting Major Milestones	4
Year 3 Oct 1, 2023 - Sept 30, 2024	15	Redistribution of unearned at-risk dollars for PY3	Timely Reporting	2
			Meeting Major Milestones	8
			Meet or Exceed Benchmark or Achievement Threshold	5
Year 4 Oct 1, 2024 - Sept 30, 2025	20	Redistribution of unearned at-risk dollars for PY4 and savings bonuses	Timely Reporting	2
			Meet or Exceed Benchmark or Achievement Threshold	18
Year 5 Oct 1, 2025 - Sept 30, 2026	30	Redistribution of unearned at-risk dollars for PY5 and savings bonuses	Timely Reporting	2
			Sustainability Plan	8
			Meet or Exceed Benchmark or Achievement Threshold	20

VII. Appendix B: Financing Risk for Critical Access Hospitals

HTP Year	Total % At-Risk (Downside)	Upside Risk	Description of Activities At-Risk	% At-Risk by Activity
Program Application Oct 1, 2020 - Sept 30, 2021	1.5	Redistribution of unearned at-risk dollars for the Program Application Period	Community and Health Neighborhood Engagement Reporting	0
			Application Approved Q4	1.5
Year 1 Oct 1, 2021 - Sept 30, 2022	2.5	Redistribution unearned at-risk dollars for PY1	Timely Reporting of Implementation Plan with Milestones Approved Q1	1.5
			Timely Quarterly Reporting	1
Year 2 Oct 1, 2022 - Sept 30, 2023	6	Redistribution of unearned at-risk dollars for PY2	Timely Reporting	2
			Meeting Major Milestones	4
Year 3 Oct 1, 2023 - Sept 30, 2024	13	Redistribution of unearned at-risk dollars for PY3	Timely Reporting	2
			Meeting Major Milestones	8
			Meet or Exceed Benchmark or Achievement Threshold	3
Year 4 Oct 1, 2024 - Sept 30, 2025	13	Redistribution of unearned at-risk dollars for PY4 and savings bonuses	Timely Reporting	2
			Meet or Exceed Benchmark or Achievement Threshold	11
Year 5 Oct 1, 2025 - Sept 30, 2026	22	Redistribution of unearned at-risk dollars for PY5 and savings bonuses	Timely Reporting	2
			Sustainability Plan	8
			Meet or Exceed Benchmark or Achievement Threshold	12

VIII. Appendix C: Measures Data and Reporting Timeline



IX. Appendix D: Benchmark Methodologies

A. Reducing Avoidable Hospitalization Utilization

- SW-RAH1 - 30-day all-cause risk adjusted hospital readmission.
  - ✓ The benchmark for PY3 will be .85.
  - ✓ The benchmark for PY4 will be .96.
  - ✓ The benchmark for PY5 will be .96.
- SW-RAH2 - Pediatric all-condition readmission measure.

  The benchmark will be set from the national PHIS data set for the HTP baseline period Oct. 1, 2021 – Sept. 30, 2022.
  - ✓ The benchmark for PY3 will be the mean of the national data set which is 6.36%
  - ✓ The benchmark for PY4 will be the mid-point between the mean and the top quartile of the national data set which is 6.07%
  - ✓ The benchmark for PY5 will be the top quartile of the national data set which is 5.77%
- RAH1 - Follow up appointment with a clinician and notification to the Regional Accountable Entities (RAE) within one business day.
  - ✓ The benchmark for PY3 will be 80%.
  - ✓ The benchmark for PY4 will be 82%.
  - ✓ The benchmark for PY5 will be 85%.
- RAH2 - Emergency Department (ED) visits for which the member received follow-up within 30 days of the ED visit.

  Greater than 10 hospitals selected this measure:
  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1 (baseline), which is 67.2%.
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark, which is 70.5%.
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark, which is 74%.
- RAH3 - Home Management Plan of Care (HMPC) document given to pediatric asthma patient/caregiver.

10 or less hospitals selected this measure:

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

- RAH4 - Percentage of patients with ischemic stroke who are discharged on statin medication.
  - ✓ The benchmark for PY3 will be 95%.
  - ✓ The benchmark for PY4 will be 95%.
  - ✓ The benchmark for PY5 will be 95%.

B. Core Populations

- SW-CP1 - Social needs screening and notification.
  - ✓ The benchmark for PY3 will be 80%.
  - ✓ The benchmark for PY4 will be 85%.
  - ✓ The benchmark for PY5 will be 90%.
- CP1 (Adult) – Readmission rate for a high frequency chronic condition 30 day (adult).

  Greater than 10 hospitals selected this measure:
  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1 which is .066.
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark which is .062.
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark which is .059.
- CP1 (Ped) – Pediatric readmission rate chronic condition 30 day.

  The benchmark will be set from the national PHIS data set for the HTP baseline period Oct. 1, 2021 – Sept. 30, 2022.
  - ✓ The benchmark for PY3 will be the mean of the national data set which is 5.92%
  - ✓ The benchmark for PY4 will be the mid-point between the mean and the top quartile of the national data set which is 5.87%
  - ✓ The benchmark for PY5 will be the top quartile of the national data set which is 5.81%

- CP2 - Pediatric bronchiolitis appropriate use of bronchodilators.
    - ✓ The benchmark for PY3 will be 46%.
    - ✓ The benchmark for PY4 will be 40%.
    - ✓ The benchmark for PY5 will be 35%.
- CP3 - Pediatric sepsis timely antibiotics.
    - ✓ The benchmark for PY3 will be 80%.
    - ✓ The benchmark for PY4 will be 85%.
    - ✓ The benchmark for PY5 will be 90%.
- CP4 - Screening for transitions of care supports in adults with disabilities.
    - ✓ The benchmark for PY3 will be 80%.
    - ✓ The benchmark for PY4 will be 85%.
    - ✓ The benchmark for PY5 will be 90%.
- CP5 - Reducing neonatal complications.
    - ✓ The benchmark for PY3 is the median for Colorado calculated from the Joint Commission 2020 Health Care Quality data download, which is 25.72.
    - ✓ The benchmark for PY4 is the mid-point between the benchmarks for PY3 and PY5, which is 21.88.
    - ✓ The benchmark for PY5 is the top quartile (top 25%) for Colorado calculated from the Joint Commission 2020 Health Care Quality data download, which is 18.04.
- CP6 – Screening and referral for perinatal and post-partum depression and anxiety and notification of positive screens to the RAE.
    - ✓ The benchmark for PY3 will be 80%.
    - ✓ The benchmark for PY4 will be 85%.
    - ✓ The benchmark for PY5 will be 90%.
- CP7 – Increase access to specialty care.
    - ✓ The benchmark for PY3 will be 5% improvement of the hospital's PY1 (baseline) score.
    - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark.

- ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark.

C. Behavioral Health/Substance Use Disorder

- SW-BH1 - Collaboratively develop and implement a mutually agreed upon discharge planning and notification process with the appropriate RAE's for eligible patients with a diagnosis of mental illness or substance use disorder (SUD) discharged from the hospital or ED.
  - ✓ The benchmark for PY3 will be 80%.
  - ✓ The benchmark for PY4 will be 85%.
  - ✓ The benchmark for PY5 will be 90%.
- SW-BH2 - Pediatric screening for depression in Inpatient and ED including suicide risk.
  - ✓ The benchmark for PY3 will be 80%.
  - ✓ The benchmark for PY4 will be 85%.
  - ✓ The benchmark for PY5 will be 90%.
- SW-BH3 - Using Alternatives to Opioids (ALTO) in Hospital Emergency Departments (ED): Increase use of ALTO.
  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1, which is 545.47.
  - ✓ The benchmark for PY4 will be equal to the PY3 benchmark, which is 545.47.
  - ✓ The benchmark for PY5 will be equal to the PY3 benchmark, which is 545.47.
- BH1 – Screening, Brief Intervention, Referral and Treatment (SBIRT) in the ED.
  - ✓ The benchmark for PY3 will be 50%.
  - ✓ The benchmark for PY4 will be 55%.
  - ✓ The benchmark for PY5 will be 60%.
- BH2 - Initiation of Medication Assisted Treatment (MAT) in ED or hospital owned certified provider based rural health center.
  - ✓ The benchmark for PY3 will be 70%.
  - ✓ The benchmark for PY4 will be 75%.

- ✓ The benchmark for PY5 will be 80%.

D. Clinical and Operational Efficiencies

- SW-COE1 - Hospital index.
  - ✓ There is no benchmark for all hospitals for PY3 – at risk will be granted.
  - ✓ The benchmark for all hospitals for PY4 will be performance against the Index benchmark of 100.
  - ✓ The benchmark for all hospitals for PY5 will be performance against the Index benchmark of 100.
- COE1 - Increase the successful transmission of a transition record to a patient's primary care physician (PCP) or other health care professional within 24 hours of discharge from an inpatient facility to home
  - ✓ The benchmark for PY3 will be 42%.
  - ✓ The benchmark for PY4 will be 50%.
  - ✓ The benchmark for PY5 will be 58%.
- COE2 - Implementation/expansion of Telemedicine Visits.
  - ✓ The benchmark for PY3 will be 5% improvement of the hospital's PY1 (baseline) score.
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark.
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark.
- COE3 - Implementation/expansion of e-Consults.
  - ✓ The benchmark for PY3 will be 5% improvement of the hospital's PY1 (baseline) score.
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark.
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark.
- COE4 – Energy star certification achievement and score improvement for hospitals.

  10 or less hospitals selected this measure:

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

E. Population Health/Total Cost of Care

- SW-PH1 - Inpatient Hospital Transitions (IHT)
  - ✓ There will be no benchmark for PY3 and all at-risk will be granted.
  - ✓ The benchmark for PY4 will be met if the hospital is actively participating and has submitted at least one referral.
  - ✓ The benchmark for PY5 will be met if the hospital is actively participating and has submitted at least one referral.
- PH1 - Increase the percentage of patients who had a well visit within a rolling 12-month period.

  10 or less hospitals selected this measure:
  - ✓ The benchmark for PY3 will be 5% improvement of the hospital's PY1 (baseline) score.
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark.
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark.
- PH2 – Increase the number of patients seen by co-responder hospital staff.
  - ✓ The benchmark for PY3 will be 5% improvement of the hospital's PY1 (baseline) score.
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark.
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark.
- PH3 – Improve leadership diversity[5].

[5] The measure was suspended beginning in PY4. Hospitals have been instructed not to report interim activity, milestone completion, or performance measure data for this measure or its associated intervention. There will be no performance achievement benchmark for the measure in PY4-PY5 and at-risk will be granted.

- ✓ The benchmark for PY3 will be 5% improvement of the hospital's PY1 (baseline) score.
- ✓ There will be no benchmark for PY4 and all at-risk will be granted.
- ✓ There will be no benchmark for PY5 and all at-risk will be granted.