Hospital Transformation Program

Scoring Framework

February 17,2021

CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

Contents

I. Background

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) will seek approval from the federal Centers for Medicare and 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.

The state will leverage hospital supplemental payment funding generated through existing healthcare affordability and sustainability fees authorized under CHASE. These payments will be 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 a proposal for a general framework for how hospitals will be evaluated on identified measures for the HTP. The recommendations contained within this report are intended to guide and inform the decision-making process to finalize the program framework. The decision-making process for finalizing this proposal will include significant collaboration with key stakeholders including the Department, the CMS, the CHASE Board, the Colorado Hospital Association, participating hospitals, and broader stakeholders participating in the program.

Any HTP participating entity anticipating an acquisition, merger, closure, Medicaid License change or other material change to its capacity, such as changes to licensed beds during the term of the HTP, is obligated to alert the Department of those proposed changes. Such notification must occur in a timely manner upon the approval by the hospital's Board of Directors regarding the transaction's proposed effective date, as well as any potential implications regarding all applicable entities participating in HTP.

At that point, the Department would then trigger a process to review the facilities' eligibility and determine the most appropriate path forward. The state retains the discretion to require or allow an adjustment to a hospital's application and will be determined on a case-by-case basis.

II. Overview

As part of the HTP, hospitals will receive supplemental payments based on their activity and performance on measures, and the interventions implemented to impact those measures.

For each intervention, hospitals will be asked to develop implementation plans with clear demonstrable milestones. Hospitals will be 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 will be asked to produce a plan for sustainability of projects and performance in the final year of the demonstration.

The Department is recommending measure scoring for the HTP that includes a combination of measures for all hospitals statewide and local measures selected by each individual hospital to align with their improvement priorities and community needs.

III. HTP Evolution

During the pre-program period, referred to as program year 0 (PY0), qualified hospitals were tasked with conducting a Community and Health Neighborhood Engagement (CHNE) process to inform the hospitals' HTP projects and cultivate the meaningful partnerships that will be critical to the success of the overall program. It is mandatory every hospital participating in the HTP complete all components of the CHNE process.

In light of the COVID-19 pandemic, the Department modified the program start date. As a result, hospital applications will be due April 30th, 2020 and approvals issued in July.

The first year of the HTP—referred to as PY1—will be the first of five years of the program. Throughout the program period, the Department seeks to

continue its efforts to 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.

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

Hospitals will be at-risk for a sequentially increasing percentage of their payments. The schedule for at-risk dollars is as follows:

- During the **Program Application** period, 1.5% of payments will be at-risk contingent on the hospital application.
- In **PY1**, 2.5% of payments will be at-risk, with 1.5% at risk each for the implementation plan and 1% at risk for timely reporting.
- In **PY2**, 6% of payments will be at-risk, with 2% at risk for timely reporting, 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 in Q3. Each hospital may submit a course correction plan once per intervention.
- In **PY3**, 15% of payments will be at-risk, with 2% at risk for timely reporting, 8% at risk for meeting major project milestones, and up to 5% at risk for not meeting or exceeding benchmarks or achievement thresholds (3% for critical access hospitals (CAH)). For hospitals who miss their milestones, 50% of the at-risk dollars can be earned back by submitting a course correction plan in Q1 or Q3. Each hospital may submit a course correction plan once per intervention.

- In **PY4**, 20% of payments will be at-risk, with 2% at risk for timely reporting 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, with 2% at risk for timely reporting, 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 Appendices A and B for further information.

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

While hospital payments will be at-risk for certain activities, high performing hospitals, defined as those in the top 10%, will also be able to receive an upside risk comprised of a redistribution of at-risk dollars. For PY1 through PY3, this upside risk will comprise only a redistribution of at-risk dollars. For each statewide measure, unearned at-risk dollars for that measure will be distributed to hospitals who scored in the top 10% on the measure.

Unearned at-risk dollars for local measures will be pooled together and distributed 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 and the distribution will be awarded to the top 10%.

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 Appendices A and B for further information.

In addition, in PY4 and 5 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 program year 5. It is required to have a 6-month lag to produce the report for the last program year 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 for an outline of the measures data and reporting timeline.

C. Pay for Reporting and Activity

Hospitals will be asked to implement interventions that will impact HTP measures. In the Program Application period and PY1, the timely approval of the application and the implementation plans for the interventions each carry a 1.5% downside risk.

Throughout the HTP, hospitals will be asked to document and report on the activities they are undertaking with the implementation, management, execution, and monitoring of the interventions they have committed to in their applications. Failure to report completely and on time for any quarter will result in complete forfeiture of at-risk reporting funds for that quarter. These quarterly reporting requirements and associated at-risk funds will begin in Q3 of PY1 and continue through the entirety of the program.

Additionally, hospitals will be asked to report on ongoing community engagement activities. This information, along with any self-reported data associated with HTP measures as a requirement of the program each year, carries a .5% risk for failure to report in a timely and complete fashion according to established reporting deadlines. For PY1 this will be total of 1% and will be 2% risk for all subsequent years.

Hospitals will have the opportunity to earn back 50% of milestone penalties for an intervention by submitting a course correction plan. Each hospital may submit a course correction plan once per intervention. Course correction plans may be submitted as part of quarterly reporting in the third quarter of PY2 as well as the first or third quarter of PY3.

After the completion of the program, hospitals will be required to submit a sustainability plan demonstrating how the transformation efforts will be maintained after the five-year demonstration period. Failure to submit and gain approval of sustainability plans will result in complete forfeiture of the associated at-risk funds.

D. Pay for Achievement, Performance, and Improvement

There are two areas of accomplishment within the HTP:

- **Achievement of Project Milestones**. Hospitals will be asked to establish milestones associated with each implemented intervention and the

measures they are impacting. These are process measures essential to achieving successful outcomes they will be held to as they implement and execute on their plans. The at-risk percentage will be tied to the successful completion of milestones. The percent of credit toward milestones for each measure will equal the number of milestones achieved divided by the total number of milestones for the measure. 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 will be asked to select measures as outlined in the Measurement Scoring section below. Beginning in PY3, hospitals will have an established percentage at risk for a given program year based on whether they:

  a. Achieve or exceed the benchmarks for their measures; or,

  b. Show marked improvement in their measures.

If a hospital achieves or exceeds the benchmark for a measure, the full point value for that measure is earned.

If a hospital performs at or above the achievement threshold on a measure, but does not meet the benchmark, 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:

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

Example: Medium Size Hospital working on 6 statewide measures each 12.5 points and 2 local measures each 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 Appendices A and B for further information.

E. Benchmarking and Achievement Thresholds

After the baseline period of PY1, benchmarks and achievement thresholds will be set in PY2 based on the prior year's performance. In the case of select measures that will require new interventions, and as such will not have data available for baselining, baseline data may be captured in PY2 and submitted concurrently with PY2 data.

Benchmarks will vary based on availability of data and type of measure.

Where benchmarks are available either nationally or statewide, the benchmark may be set consistent with that benchmark.

Where data is available from more than ten hospitals and no standard benchmark is used:

- The benchmark for all hospitals for PY3 will be the average performance of the top 75% of hospitals during PY1

For all measures with more than ten hospitals:

- 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) of hospital's performance during PY1

For select process rate measures where there is **not** data available nationally, statewide, or from ten or more hospitals the expectation is that the process will be implemented across all eligible patients:

- The benchmark for all hospitals for PY3 will be 80%
- The benchmark for all hospitals for PY4 will be 85%
- The benchmark for all hospitals for PY5 will be 90%
- The achievement threshold will be set at (individual) hospital's performance from the prior year

For all other measures where there are less than ten hospitals:

- The benchmark for PY3 will be baseline score in PY1 plus 5%
- The benchmark for PY4 will be PY3 benchmark plus 5%
- The benchmark PY5 will be PY4 benchmark plus 5%
- The achievement threshold will be set at (individual) hospital's PY1 performance

Please see Appendix D for benchmark methodologies of each measure.

IV. Measurement Scoring

Data obtained from multiple sources to assess hospital performance were 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.

Large hospitals (91+ 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 (26-90 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 critical access hospitals 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.

Critical access hospitals will be accountable for six measures (statewide or local) and will have their risk for measures 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 four statewide measures and a minimum of four local measures. If four measures are selected, then statewide measures will total 56 points and local measures will account for 44 points. If five or more measures are selected, then statewide measures will total 50 points and local measures will total 50 points. Points per local measure will equal 50 divided by the number of local 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 and substance use disorder
- Clinical and operational efficiencies
- Population health and total cost of care

As noted in Section III.A, above, the projects and measures will be risk-scored as follows based on the relative points corresponding to milestones and achievement:

- **PY1:** 1.5% at risk for performance-improvement plan with milestones in year 2 and 3 and outcome improvement in years 3 to 5
- **PY2:** 4% risk for milestones
- **PY3:** 8% risk for milestones and 5% risk for measures (3% for CAH)
- **PY4:** 18% risk for measures (11% for CAH)
- **PY5:** 20% risk for measures (12% for CAH) and 8% risk for sustainability plan

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
  - ✓ Adult 30-day all cause risk adjusted readmission rate.
  - ✓ Pediatric all condition readmission measure.
- Core Populations
  - ✓ Social needs screening and notification.
- Behavioral Health and Substance Use Disorder

- ✓ 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 emergency department.
- ✓ Pediatric screening for depression in inpatient and emergency department (ED) including suicide risk.
- ✓ Using alternatives to opioids (ALTO's) in hospital ED's – Decrease opioid use and increase use of ALTO's.

- Clinical and Operational Efficiencies
  - ✓ Hospital Index.

- Population Health and Total Cost of Care
  - ✓ Severity adjusted length of stay (LOS).

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 Community and Health Neighborhood Engagement (CHNE) process. The Department has worked with quality measures workgroups to identify local measures for the program. These measures include:

- Reducing Avoidable Hospitalizations:
  - ✓ Follow up appointment with a clinician made prior to discharge and notification to the Regional Accountable Entities (RAE) within one business day.
  - ✓ Emergency department (ED) visits for which the member received follow up within 30 days of the ED visit.
  - ✓ Home management plan of care (HMPC) Document given to pediatric asthma patient/caregiver.
  - ✓ Percentage of patients with ischemic stroke who are discharged on statin medication.

- Core Populations:
  - ✓ Readmission rate for a high frequency chronic condition – 30-day adult/30 day pediatric.
  - ✓ Pediatric Bronchiolitis – Appropriate use of bronchodilators.
  - ✓ Pediatric Sepsis – Timely antibiotics.

- ✓ Screening for transitions of care supports in adults with disabilities.
- ✓ Reducing neonatal complications.
- ✓ Screening and referral for perinatal and post-partum depression, and anxiety and notification of positive screens to the RAE.
- ✓ Increase access to specialty care.

- Behavioral Health/Substance Use Disorder:
  - ✓ Screening, Brief Intervention and Referral to Treatment (SBIRT) in the ED.
  - ✓ Initiation of Medication Assisted Treatment (MAT) the ED or hospital owned certified provider based rural health center.

- Clinical and Operating Efficiencies:
  - ✓ 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.
  - ✓ Implementation/expansion of telemedicine visits.
  - ✓ Implementation/expansion of e-Consults.
  - ✓ Energy Star Certification Achievement and Score Improvement for Hospitals.

- Population Health and Total Cost of Care:
  - ✓ Increase the percentage of patients who had a well visit within a rolling 12-month period.
  - ✓ Increase the number of patients seen by Co-Responder hospital staff.
  - ✓ Improve leadership diversity.

C. State 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:

- Conversion of hospital-owned FSED to address community needs.
- The creation of dual-track emergency departments.

D. Complementary Statewide Efforts

Within certain focus areas, there will be some complementary statewide efforts HTP participating hospitals will be asked to align with or engage in along with HTP efforts. These complementary efforts will correspond with the Community and Health Neighborhood Engagement (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 (APM) 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 ADT 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.

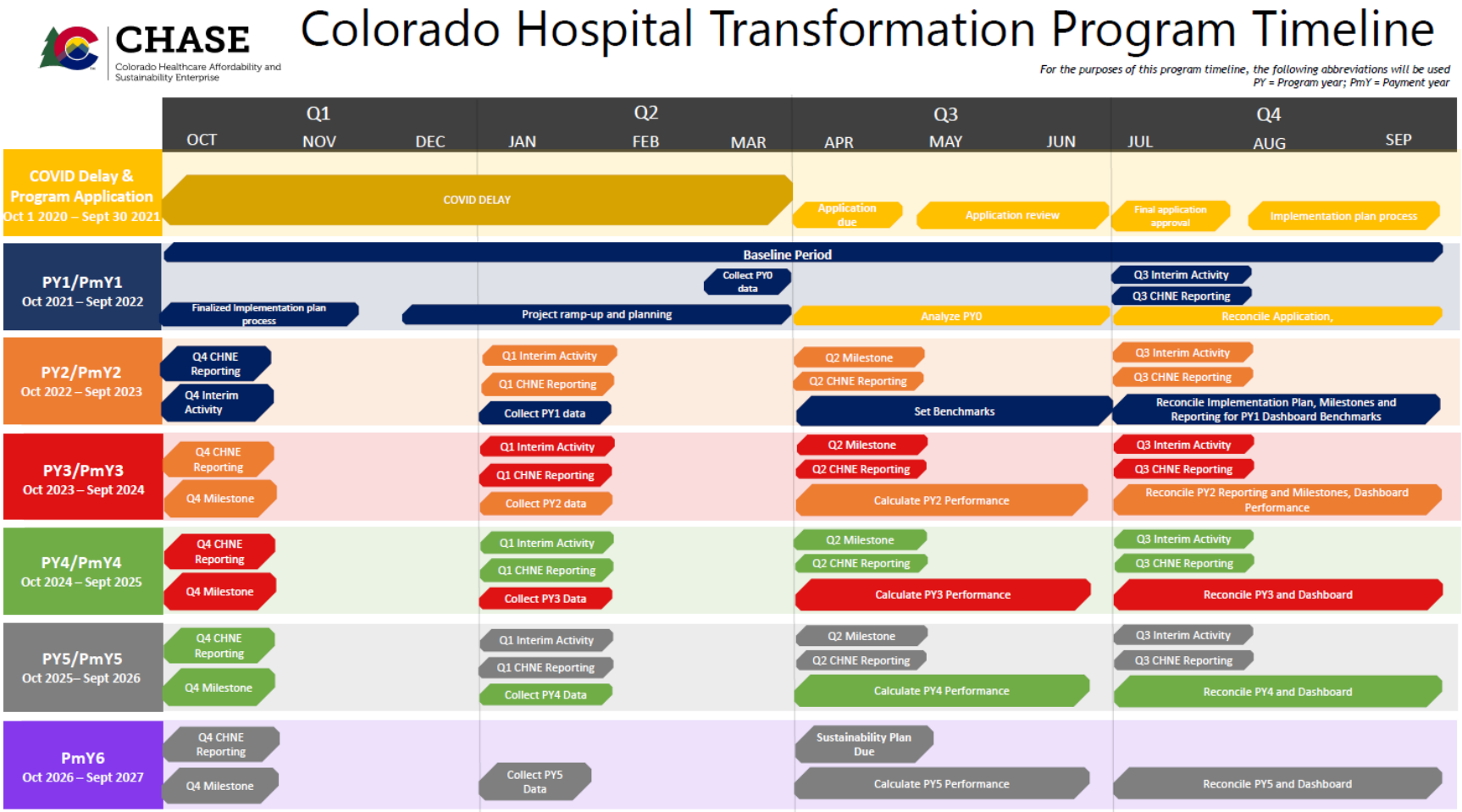
VI. Appendix A – Financing Risk

HTP Year	Total % At-Risk (Downside)	Upside Risk	Description of Activities At-Risk	% At-Risk by Activity
Program Application Period *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 2021 – Sept 2022*	2.5	Redistribution of unearned at-risk dollars for PY1	Implementation Plan with Milestones Approved Q1	1.5
			Timely Reporting	1
Year 2 *Oct 2022 – Sept 2023*	6	Redistribution of unearned at-risk dollars for PY2	Timely Reporting	2
			Meeting Major Milestones	4
Year 3 *Oct 2023 – Sept 2024*	15	Redistribution of unearned at-risk dollars for PY3 and savings bonuses	Timely Reporting	2
			Meeting Major Milestones	8
			Meet or Exceed Benchmark or Achievement Threshold	5
Year 4 *Oct 2024 – Sept 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 2025 – Sept 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 Period *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 2021 – Sept 2022*	2.5	Redistribution of unearned at-risk dollars for PY1	Implementation Plan with Milestones Approved Q1	1.5
			Timely Reporting	1
Year 2 *Oct 2022 – Sept 2023*	6	Redistribution of unearned at-risk dollars for PY2	Timely Reporting	2
			Meeting Major Milestones	4
Year 3 *Oct 2023 – Sept 2024*	13	Redistribution of unearned at-risk dollars for PY3 and savings bonuses	Timely Reporting	2
			Meeting Major Milestones	8
			Meet or Exceed Benchmark or Achievement Threshold	3
Year 4 *Oct 2024 – Sept 2025*	23	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 2025 – Sept 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 the average performance of the top 75% of hospitals in the state during PY1
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark
- **SW-RAH2 - Pediatric All-Condition Readmission Measure**
  - ✓ The benchmark will be the national benchmark

  If the national benchmark is not available:
  - ✓ The benchmark for PY3 will be baseline score in PY1 plus 5%
  - ✓ The benchmark for PY4 will be PY3 benchmark plus 5%
  - ✓ The benchmark for PY5 will be PY4 benchmark plus 5%
- **RAH1 - Follow up appointment with a clinician made prior to discharge and notification to the Regional Accountable Entities (RAE) within one business day**

  If greater than 10 hospitals select this measure:
  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark

  If 10 or less hospitals select this measure:
  - ✓ The benchmark for PY3 will be 80%
  - ✓ The benchmark for PY4 will be 85%
  - ✓ The benchmark for PY5 will be 90%
- **RAH2 - Emergency Department (ED) visits for which the member received follow-up within 30 days of the ED visit**

  If greater than 10 hospitals select this measure:
  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1

- ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
- ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark

If 10 or less hospitals select this measure:

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

- **RAH3 - Home Management Plan of Care (HMPC) document given to pediatric asthma patient/caregiver**

If greater than 10 hospitals select this measure:

- ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1
- ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
- ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark

If 10 or less hospitals select 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**

If greater than 10 hospitals select this measure:

- ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1
- ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
- ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark

If 10 or less hospitals select this measure:

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

B. Core Populations

- **SW-CP1 - Social needs screening and notification**

- ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1
- ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
- ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark

- **CP1 – Readmission rate for a high frequency chronic condition 30-day**

  If greater than 10 hospitals select this measure:
  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark

  If 10 or less hospitals select this measure:
  - ✓ The benchmark for PY3 will be baseline score in PY1 plus 5%
  - ✓ The benchmark for PY4 will be PY3 benchmark plus 5%
  - ✓ The benchmark for PY5 will be PY4 benchmark plus 5%
- **CP2 - Pediatric Bronchiolitis - Appropriate use of bronchodilators**
  - ✓ The benchmark for PY3 will be 80%
  - ✓ The benchmark for PY4 will be 85%
  - ✓ The benchmark for PY5 will be 90%
- **CP3 - Pediatric Sepsis – Timely antibiotics**
  - ✓ The benchmark for PY3 will be baseline score in PY1 plus 5%
  - ✓ The benchmark for PY4 will be PY3 benchmark plus 5%
  - ✓ The benchmark for PY5 will be PY4 benchmark plus 5%
- **CP4 - Screening for transitions of care supports in adults with disabilities**

  If greater than 10 hospitals select this measure:
  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark

  If 10 or less hospitals select this measure:

- ✓ 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**

  If greater than 10 hospitals select this measure:

  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark

  If 10 or less hospitals select this measure:

  - ✓ The benchmark for PY3 will be baseline score in PY1 plus 5%
  - ✓ The benchmark for PY4 will be PY3 benchmark plus 5%
  - ✓ The benchmark for PY5 will be PY4 benchmark plus 5%

- **CP6 – Screening and Referral for Perinatal and Post-Partum Depression and Anxiety and notification of positive screens to the Regional Accountable Entities (RAE)**

  If greater than 10 hospitals select this measure:

  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark

  If 10 or less hospitals select this measure:

  - ✓ 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 baseline score in PY1 plus 5%
  - ✓ The benchmark for PY4 will be PY3 benchmark plus 5%
  - ✓ The benchmark for PY5 will be PY4 benchmark plus 5%

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 the average performance of the top 75% of hospitals in the state during PY1
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark
- **SW-BH2 - Pediatric screening for depression in inpatient and ED including suicide risk**
  - ✓ The benchmark for PY3 will be baseline score in PY1 plus 5%
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark
- **SW-BH3 - Using Alternatives to Opioids (ALTO's) in hospital emergency departments (ED's); Decrease use of opioids and Increase ALTO's**
  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark
- **BH1 – Screening, Brief Intervention, Referral and Treatment (SBIRT) in the emergency department**

  If greater than 10 hospitals select this measure:
  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark

  If 10 or less hospitals select this measure:

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

- **BH2 - Initiation of Medication Assisted Treatment (MAT) in emergency department (ED) or hospital owned certified provider based rural health center**
  - ✓ The benchmark for PY3 will be baseline score in PY1 plus 5%
  - ✓ The benchmark for PY4 will be PY3 benchmark plus 5%
  - ✓ The benchmark for PY5 will be PY4 benchmark plus 5%

D. Clinical and Operational Efficiencies

- **SW-COE1 - Hospital index**
  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark
- **COE1 - Increase the successful transmission of a transition record, such as an ADT notification, to a patient's primary care physician (PCP) or other healthcare professional within 24 hours of discharge from an inpatient facility to home**

  If greater than 10 hospitals select this measure:
  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark

  If 10 or less hospitals select this measure:
  - ✓ The benchmark for PY3 will be 80%
  - ✓ The benchmark for PY4 will be 85%
  - ✓ The benchmark for PY5 will be 90%
- **COE2 - Implementation/expansion of telemedicine visits**
  - ✓ The benchmark for PY3 will be baseline score in PY1 plus 5%
  - ✓ The benchmark for PY4 will be PY3 benchmark plus 5%

- ✓ The benchmark for PY5 will be PY4 benchmark plus 5%

- **COE3 - Implementation/expansion of e-Consults**
  - ✓ The benchmark for PY3 will be baseline score in PY1 plus 5%
  - ✓ The benchmark for PY4 will be PY3 benchmark plus 5%
  - ✓ The benchmark for PY5 will be PY4 benchmark plus 5%
- **COE4 – Energy star certification achievement and score improvement for hospitals**

  If greater than 10 hospitals select this measure:
  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark

  If 10 or less hospitals select this measure:
  - ✓ The benchmark for PY3 will be 80%
  - ✓ The benchmark for PY4 will be 85%
  - ✓ The benchmark for PY5 will be 90%

E. Population Health/Total Cost of Care

- **SW-PH1 - Severity Adjusted Length of Stay (LOS)**
  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark
- **PH1 - Increase the percentage of patients who had a well visit within a rolling 12-month period**

  If greater than 10 hospitals select this measure:
  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark

If 10 or less hospitals select this measure:

- ✓ The benchmark for PY3 will be baseline score in PY1 plus 5%
- ✓ The benchmark for PY4 will be PY3 benchmark plus 5%
- ✓ The benchmark for PY5 will be PY4 benchmark plus 5%

- **PH2 – Increase the number of patients seen by Co-Responder hospital staff**

  - ✓ The benchmark for PY3 will be baseline score in PY1 plus 5%
  - ✓ The benchmark for PY4 will be PY3 benchmark plus 5%
  - ✓ The benchmark for PY5 will be PY4 benchmark plus 5%

- **PH3 – Improve leadership diversity**

  If greater than 10 hospitals select this measure:

  - ✓ The benchmark for PY3 will be the average performance of the top 75% of hospitals in the state during PY1
  - ✓ The benchmark for PY4 will be 5% improvement of the PY3 benchmark
  - ✓ The benchmark for PY5 will be 5% improvement of the PY4 benchmark

  If 10 or less hospitals select this measure:

  - ✓ The benchmark for PY3 will be baseline score in PY1 plus 5%
  - ✓ The benchmark for PY4 will be PY3 benchmark plus 5%
  - ✓ The benchmark for PY5 will be PY4 benchmark plus 5%