Washington State Health Care Authority

Delivery System Reform Incentive Payment (DSRIP) Measurement Guide

How accountability is measured for Washington State, Medicaid managed care organizations (MCOs), and Accountable Communities of Health (ACHs) throughout the MTP Project (MTP)

Contents

Acronyms and initialisms

ACHs	Accountable Communities of Health
APM	Alternative payment model
AV	Achievement value
CMS	Centers for Medicare & Medicaid Services
DQA	Dental Quality Alliance
DSRIP	Delivery System Reform Incentive Payment
DY	Demonstration year
EQRO	External quality review organization
FE	Financial executor
GTG	Gap-to-goal
HCA	Health Care Authority
HCP-LAN	Health Care Payment Learning and Action Network
HEDIS	Healthcare Effectiveness Data and Information Set
IA	Independent assessor
IEE	Independent external evaluator
IHCP	Indian health care provider
IMC	Integrated managed care
IOS	Improvement-over-self
MACRA	Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act
MOUD	Medication for opioid use disorder
MCO	Managed care organization
MMIS	Medicaid Management Information System (also referred to as ProviderOne)
MTP	MTP Project
NCQA	National Committee for Quality Assurance
P4P	Pay-for-performance
P4R	Pay-for-reporting
PAV	Percentage achievement value
Q	Quarter
QI	Quality improvement
QIP	Quality improvement plan
QIS	Quality improvement score
SAR	Semi-annual report
WSCMS	Washington Statewide Common Measurement Set
SUD	Substance use disorder
SCHIP	State Children's Health Insurance Program
STCs	Special terms and conditions
TAV	Total achievement value
TPL	Third-party liability

VBP	Value-based purchasing
DSHS-RDA	Washington State Department of Social and Health Services, Research and Data Analysis Division

Change log

To request information about a prior version, contact medicaidtransformation@hca.wa.gov.

Chapter/Appendix	Last updated	Update history
General	Aug. 2019	• Aug. 2019: refreshed document to update formatting and non-substantive copy edits. Links updated throughout to reflect changes to Medicaid Transformation metrics page. • Aug. 7, 2018: corrections to formatting and web links. • Aug. 1, 2018: updated version posted. For a summary of changes from February version, refer to a summary of public comments and changes posted on Medicaid Transformation metrics page. • Feb. 2018: initial version posted online for public review.
Orientation to the DSRIP Measurement Guide	Aug. 2018	
Chapter 1: DSRIP program requirements and accountability	April 2022	• April 2022: added the extension of DSRIP to DY6 2022. • July 2020: updated DSRIP-incentive flow structure – statewide accountability chart.
Chapter 2: statewide accountability	May 2022	• May 2022: approved year-over-year baseline to performance period changes for the QIS component in statewide accountability. • April 2022: ○ Table 2: added DY6 at risk amount for statewide performance. ○ Table 8: added DY6 to statewide accountability measurement years. ○ VBP adoption updated to reflect DY6. ○ Table 9: updated with DY5 and DY6 targets and scoring weights. ○ Table 10: updated with statewide VBP adoption measurement years. • July 2021: ○ Equation 2: VBP improvement score revised with new methodology. ○ Metric: Child and Adolescent Well-Care Visits 3-11 Years of Age replaced Well-Child Visits 3-6 Years of Age ○ Updated Table 11. • July 2020: updated to reflect that statewide accountability has been waived for DY4. • July 2020: revised numerator statement in Equation 1 that states MCO payments to providers made through VBP arrangements qualify for inclusion in the numerator at or above Category 2C. • Aug. 2019: updated Table 7 to reflect metric change for DY4-DY5. • Sept. 2018: minor language edits for clarity and consistency with the updated Apple Health Appendix.
Chapter 3: MCO accountability	April 2022	• April 2022: ○ Table 12: added DY6 MCO incentives. ○ Table 15: MCO VBP adoption weights updated for DY5. ○ MCO incentives updated for DY6. • July 2021:

		○ Submitted request to CMS for revision to Table 14. ○ Submitted request to CMS for revision to Table 15. • Sept. 2018: minor language edits for clarity and consistency with the updated Apple Health Appendix. Corrected Table 13 to reflect the P4R/P4P split for relevant DYs. Narrative includes note to reflect that there were no MCO VBP incentives available for DY1.
Chapter 4: ACH incentives for value-based care	April 2022	• April 2022: ○ Table 18: updated with DY6 VBP incentives. ○ Table 19: update with DY6 potential incentives. ○ Table 20: updated with DY6 VBP milestone definition. ○ Table 23: updated with DY6 VBP targets. ○ Table 24: updated with DY4-DY6 scoring weights. ○ Table 26: updated with DY subtarget thresholds. • July 2021: ○ Submitted request to CMS for revision to Table 23. ○ Submitted request to CMS for revision to Table 24. • Sept. 2018: minor language edits for clarity and consistency with the updated Apple Health Appendix.
Chapter 5: ACH project incentives overall	April 2022	• April 2022: ○ Table 27: updated with DY6 P4P and P4R incentive weights
Chapter 6: ACH project incentives – P4R	April 2022	• April 2022: ○ Table 28: updated with DY6 P4R incentive weight ○ Table 30: updated with DY6 P4R deliverables milestones ○ Table 31: updated with DY6 P4R schedule for AVs • July 2021: SAR 4-8 made optional in Table 30. • Aug. 2019: ○ P4R milestones: footnote to clarify QIP is synonymous with the term "ACH Quality Improvement Strategy." ○ Table 30: added "Report on QIP" to reporting period Jan. 1–June 30, 2019 (per Project Toolkit). Updated deadline for QIP to July 31, 2019. ○ P4R metrics description updated to maintain consistency with current guidance for P4R metric reporting.
Chapter 7: ACH project incentives – P4P	April 2022	• April 2022: ○ Table 32: updated to reflect DY6 P4P incentive weight ○ Figure 26: updated to reflect DY5 and DY6 measurement years ○ Table 38: updated to reflect DY6 improvement target release schedule • July 2021: added Figure 27. • Aug. 2020: ○ Report time for data lag language updated.

		○ Table 34: updated to reflect dental sealants metric replaced. ○ Figure examples updated with more through explanations. ○ COVID-19-related P4P flexibility for AV calculations for DY4 added. • Aug. 2019: ○ Data collection and calculation: included additional information about data sources used for health care quality metrics. ○ Low count in numerator or denominator of P4P metrics: additional information about how low counts in the numerator and/or denominator will be handled for project P4P improvement targets and performance results. • Sept. 2018: IOS: in AV calculation example, the actual performance value was incorrectly stated as 77.38, when it should have been 77.30.
Chapter 8: ACH high performance	April 2022	• April 2022: ○ Table 41: updated HPP measurement years to include DY5 and DY6 changes. Changes include IOS and year-over-year baseline to performance periods. • July 2021: update and provided footnote on one high-performance pool measure in Table 39. • Aug. 2019: updated Table 41 to reflect metric change for DY4-5. • Aug. 2018: footnote updated to correct a typo. Figure 27 updated to clearly reflect the flow of incentives to high-performance incentives.
Appendix A: glossary of terms	April 2022	• April 2022: ○ Table 42: updated to include DY6.
Appendix B: resources for monitoring DSRIP progress	April 2022	• April 2022: ○ Table 43: updated tabs to reflect current sections in the Healthier Washington Dashboard.
Appendix C: DSRIP measurement and payment timing	April 2022	• April 2022: ○ Figure 29, 30, 31, 32 and 33: updated to include DY6 measurement years. • Aug. 2019: two timelines (Figures 28 and 30) updated to illustrate anticipated timing more accurately for distribution of earned ACH VBP incentives.
Appendix D: ACH VBP incentive calculation examples	April 2022	• April 2022: ○ Figure 35, 36, 37 and 38: updated to include DY5 VBP performance measurements. • July 2021: updated examples to show DY4 incentive calculations. • Aug. 2020: updated examples to show DY3 incentive calculations.
Appendix E: sample calculation of ACH high-performance	Aug. 2018	
Appendix F: DSRIP metric selection and alignment	Aug. 2018	
Appendix G: DSRIP quality and outcome metrics	April 2022	• April 2022: ○ Table 50 updated to reflect DY6 additions for measures comparison. ○ Table 50 updated to include updated performance methodology for DY5 and DY6,

		where all active measures will use the IOS method. • July 2021: Table 49 updated to reflect NCQA® measure changes: ○ Metric: Children's and Adolescent's Access to Primary Care Practitioners (CAP) was retired. ○ Metric: Child and Adolescent Well-Care Visits 3-21 Years of Age replaced CAP. ○ Metric: Well-Child Visits in the 3-6 Years of Age was retired. ○ Metric: Child and Adolescent Well-Care Visits 3-11 Years of Age replaced Well-Child Visits 3-6 Years of Age. ○ Metric: Well-Child Visits in the First 15 Months of Life was retired. ○ Metric: Well-Child Visits in the First 30 Months of life replaced Well-Child Visits in the First 15 Months of Life. ○ Metric: Comprehensive Diabetes Care: Medical Attention for Nephropathy retired. ○ Metric: Kidney Health Evaluation with Patients with Diabetes replaced CDC: Nephropathy. • Aug. 2020: updated Table 49 to integrate metric changes the state is implementing within the DSRIP program. A summary of changes is available on the MTP metrics page.
Appendix H: ACH project P4P improvement target and AV methodology	March 2022	• March 2022: sub-measures with 65+ age bands condensed to the larger sub-metric group. ○ All Cause Emergency Department Visits ○ Mental Health Treatment Penetration ○ Percent Homeless ○ Substance Use Disorder Treatment Penetration ○ Substance Use Disorder Treatment Penetration (Opioid) • July 2021: Table 49 updated to reflect NCQA® measure changes: ○ Metric: Children's and Adolescent's Access to Primary Care Practitioners (CAP) was retired. ○ Metric: Child and Adolescent Well-Care Visits 3-21 Years of Age replaced CAP. ○ Metric: Well-Child Visits in the 3-6 Years of Age was retired. ○ Metric: Child and Adolescent Well-Care Visits 3-11 Years of Age replaced Well-Child Visits 3-6 Years of Age. ○ Metric: Well-Child Visits in the First 15 Months of Life was retired. ○ Metric: Well-Child Visits in the First 30 Months of life replaced Well-Child Visits in the First 15 Months of Life. ○ Metric: Comprehensive Diabetes Care: Medical Attention for Nephropathy retired. ○ Metric: Kidney Health Evaluation with Patients with Diabetes replaced CDC: Nephropathy. • Aug. 2020: Table 50 updated to: ○ Include absolute benchmark values used to set improvement targets associated with DY5 performance. ○ Integrate metric changes the state is implementing within the DSRIP program. A summary of changes is available on the Medicaid Transformation metrics page.

Appendix I: ACH project P4P metrics – sample AV calculations	April 2022	• April 2022: ○ Figure 43: removed 65+ age band example. • Aug. 2019: sample calculations updated to use values that can be replicated using the rounded values for simplicity. • Sept. 2018: typo corrected. Updated Figure 42 to display the correct adjusted contribution value in the dark blue orb.
Appendix J: technical specifications (DSRIP quality and outcome metrics)	April 2022	• April 2022: ○ Figure 52: updated P4P benchmark periods and added DY6 benchmark periods. • Sept. 2018: modified to link to metrics page. Metric specifications moved to individual page links on the Medicaid Transformation metrics page. • Aug. 2018: corrected a formatting issue that caused some information to be hidden from the specification tables.
Appendix K: technical specifications (ACH project P4R metrics)	April 2022	• April 2022: ○ Figure 56: updated SAR submission periods of reporting to include P4R (DY6) sections • Aug. 2019: updated to reflect refinements in P4R metric reporting guidance to ACHs. • Sept. 2018: modified to link to metrics page. Metric specifications moved to individual page links on the Medicaid Transformation metric page.

Orientation to the DSRIP Measurement Guide

What is it?

The Delivery System Reform Incentive Payment (DSRIP) Measurement Guide describes how performance is measured for all accountable entities participating in Initiative 1 of the MTP Project (MTP): transformation through Accountable Communities of Health (ACHs).[1] Specifically, this guide describes:

- How participating entities are held accountable throughout the MTP period.
- How those entities can earn DSRIP program incentives.

Federal funding available under the DSRIP program is dependent upon successful achievement of MTP goals. These goals, or transformation targets, include value-based purchasing (VBP) adoption targets, and indicators of improvement and performance in clinical quality and outcome metrics.

Under the DSRIP program, Washington State, ACHs and Medicaid managed care organizations (MCOs) are all accountable for demonstrating improvement toward and attainment of transformation targets. Earning the maximum funding available requires that performance expectations be met at the state, MCO, and ACH level. Funding is tied to reporting activities, as well as improvement and achievement of transformation targets.

- **Washington State** is accountable for demonstrating to the Centers for Medicare & Medicaid Services (CMS) the attainment of transformation targets related to VBP, performance on quality and health outcome metrics, and implementing integrated managed care (IMC) statewide.
- **MCOs** are accountable for demonstrating to Health Care Authority (HCA) and the state-appointed independent assessor (IA) the achievement of transformation targets related to VBP.
- **ACHs** are accountable for demonstrating to HCA and the IA achievement of transformation targets related to VBP, completion of project milestones, and performance on quality and health outcome metrics.
- **Indian health care providers (IHCPs)** are accountable for demonstrating through achievement of collaborative Medicaid transformation, workforce capacity, and innovation and health systems.

Who is the intended audience of this guide?

The Measurement Guide is intended for interested and/or engaged partners in MTP efforts, including but not limited to ACHs, MCOs, MTP partners, state agencies, and legislative staff.

What information does this guide include?

This guide describes the levels of performance required to earn incentives, including for:

- Washington State accountability to CMS for improvement and performance.
- ACH and MCO accountability to the state for improvement and performance.

The guide also contains technical specifications for reporting and performance metrics, as well as the production and reporting procedures for assessing performance during the DSRIP program.

[1] This Measurement Guide does not apply to other key MTP initiatives. The information contained within this guide is specific to transformation through ACHs.

What information is not included in this guide?

The guide does not provide details for performance expectations between an ACH and its partnering providers, nor parameters for partnering providers to earn DSRIP incentives that have been earned by an ACH. This is because the ACH-provider relationship and DSRIP incentives distribution is determined at the regional level. **The ACH is accountable for its regional performance, not for any partnering provider's performance.**

How to read this guide

Many components of this guide are defined in CMS-approved MTP protocols and related documents. Key source documentation for MTP include the special terms and conditions (STCs), DSRIP planning protocol, DSRIP funding and mechanics protocol and the HCA Value-based Roadmap – Apple Health Appendix.

Some of the components of this document are also outlined in CMS-approved protocols, including key transformation targets, such as the Project Toolkit's ACH pay-for-performance (P4P) metrics, statewide accountability quality metrics, and annual VBP adoption targets.

This guide provides insight into how and when performance will be assessed, calculated, and reported; who is responsible for the assessment, calculation, and reporting of performance on behalf of accountable entities; and how performance is related to earning DSRIP incentives.

How this guide will change over time

At a minimum, this guide will be updated at least once a year. Beginning in 2019, a consistent annual refresh will be released. Updates may reflect retirement or adjustment of metrics, and any adjustments to the metric production process. Technical specification sheets will be reviewed to ensure calculation methods are standardized to the extent possible, with the measurement steward recommendations.

HCA may review and modify the contents of the guide as necessary over the course of the five-year MTP period. Changes will be clearly identified as the guide evolves over time.

Where can I reference this guide?

The guide is available on the Medicaid Transformation metrics page.

Questions

For questions about this guide or MTP, contact medicaidtransformation@hca.wa.gov

Chapter 1: DSRIP program requirements and accountability

MTP aims to transform the health care delivery system to address local health priorities, deliver high-quality, cost-effective care that treats the whole person, and create sustainable linkages between clinical and community-based services.

Figure 1: overarching goals of a healthier Washington

As part of MTP, the DSRIP program provides resources for regional, collaborative activities coordinated by the state's nine ACHs. ACHs are defined as self-governing organizations focused on improving health and transforming care delivery for the people who live within their region. Within the ACH, providers work together and with community-based organizations and local government entities to participate in delivery system reform efforts.

To support the goals of MTP, these partnering providers commit to implementing evidence-based interventions and promising practices that address the needs of Medicaid beneficiaries in their communities, according to the parameters defined in the DSRIP planning protocol.

As required by approved protocols, ACHs must select and implement at least four projects from the Project Toolkit. ACHs are eligible to earn incentive payments for completing project milestones, reporting on implementation metrics, and demonstrating improvement in health outcomes. Milestones and metrics are defined under each of the project areas in the Project Toolkit.

Shared concepts across DSRIP accountability framework

There are some concepts that repeat throughout this guide and apply across different accountable entities and funding sources. For example, P4R is an element of MCO, ACH, and IHCP accountability. P4R will trigger incentives from MCO VBP incentives, ACH project/VBP incentives, and IHCP incentives.

The table below provides a crosswalk of key concepts used throughout this guide. A full glossary of terms is included in Appendix A.

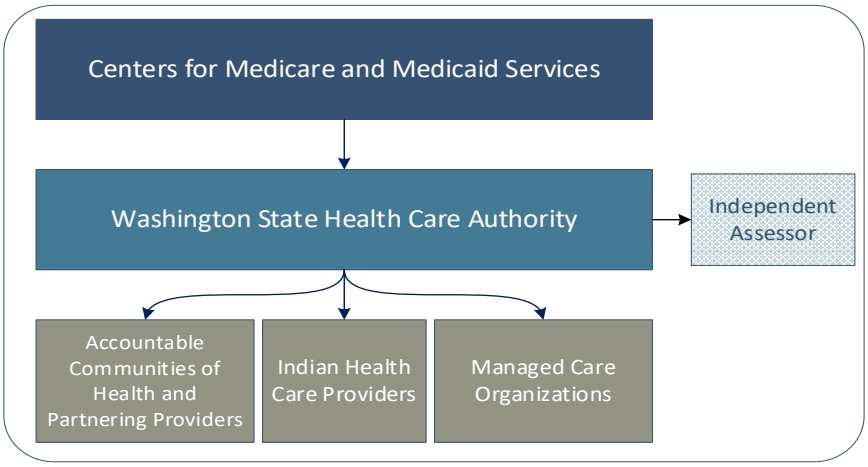
Table 1: DSRIP-shared concepts by entity and incentive source

Concept / term		Accountable entity				Funding source / incentive type			
		State	MCO	ACH	IHCP	Project	ACH VBP incentives	ACH high-performance	MCO VBP incentives
AV	AV	-	-	X	-	X	X	-	-
Attribution	-	X	X	X		X	X	X	X
Incentives	-		X	X	X	X	X	X	X
Measurement year	-	X	X	X	-	X	X	X	X
Pay-for-reporting	P4R		X	X	X	X	X	-	X
Pay-for-performance	P4P	X	X	X	-	X	X	X	X
Quality improvement composite score	QIS	X	X	X	-	-	-	X	X
Quality improvement model	QI	X	X	X	-	-	-	X	X

Overall DSRIP accountability framework

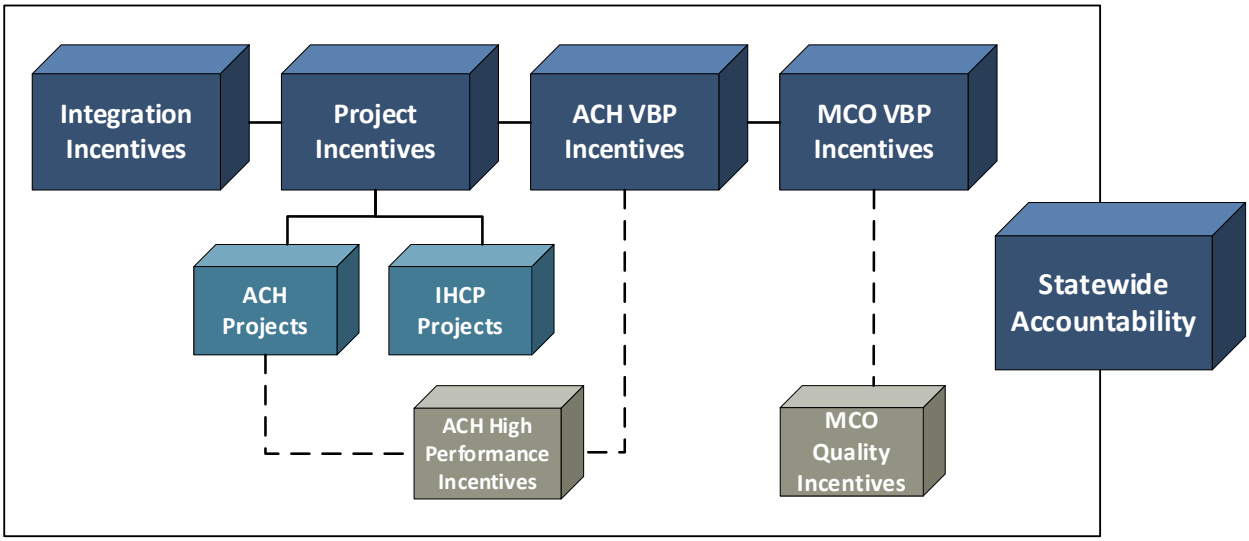
The scope of this document is focused on how the state is accountable to CMS, and how ACHs, IHCPs, and MCOs are accountable to and earn money from the state.

Figure 1: DSRIP accountability framework



There are several distinct "pools" of incentives that flow to different entities in the DSRIP program, each with different accountability and incentive payment structures. The following provides a snapshot of accountability and incentive payment structure by entity.

Figure 2: DSRIP incentive flow structure by incentive pool[2]



Once ACHs earn incentives through a given pool, each ACH will distribute earned incentives among partnering providers according to their own regionally-established performance and incentives framework. Regional performance and incentive frameworks are specific to each ACH's approach and not part of this guide.

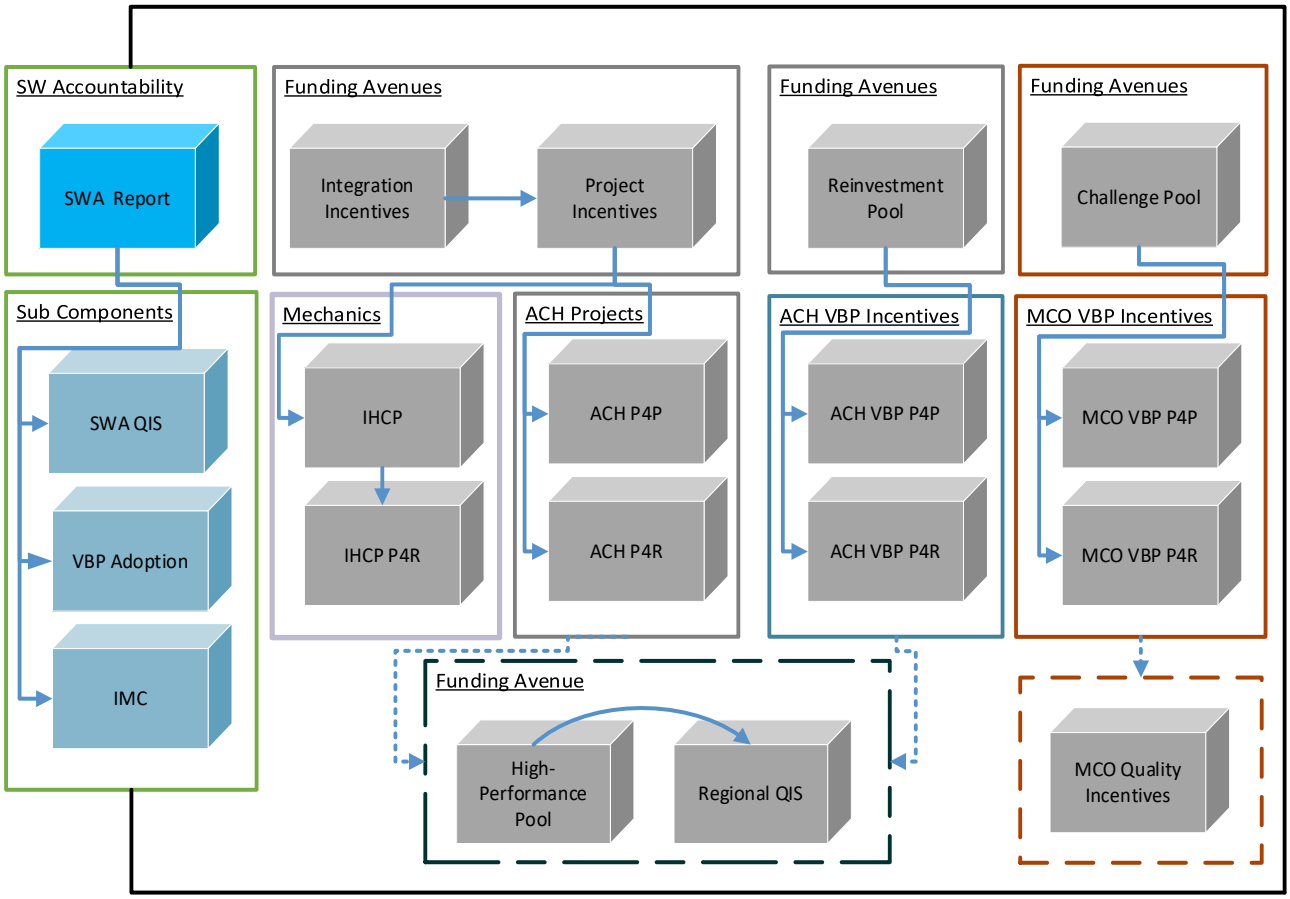
Washington State (Health Care Authority)

The state is accountable for demonstrating progress toward meeting the objectives of DSRIP. Funding may be reduced in DY3, DY4, DY5, and DY6 if the state fails to meet statewide accountability criteria set by CMS.

See the table on the following page.

[2] During DY1, ACHs earned design funds for successful completion of a two-phased certification process to demonstrate readiness to lead transformation projects. Design funds are not covered in the Measurement Guide.

Figure 3: DSRIP incentive flow structure – statewide accountability



The following table provides a snapshot of the key components of DSRIP statewide accountability.

Table 2: snapshot of statewide accountability parameters

Funding mechanics	
100 percent of total DSRIP incentives are at risk if the state fails to demonstrate statewide integration of physical and behavioral health managed care by January 2020.[3] • In DY3–6, a portion of DSRIP incentives will be at risk, depending on the state's advancement of quality and VBP goals, including: ○ Improvement and attainment of quality targets across a set of statewide metrics. ○ Improvement and attainment of defined statewide VBP adoption targets.	
Accountability components	**Criteria to earn full credit**
Statewide integration of physical and behavioral health. Medicaid managed care by January 1, 2020. Constitutes 100 percent of total DSRIP incentives conditioned on fulfillment of this component.	At least two contracts for integrated Medicaid managed care in each purchasing region must be effective and beneficiary enrollment initiated as of January 1, 2020.
Quality improvement. Demonstrate improvement and movement toward quality targets across 10 quality metrics. Constitutes 80 percent of statewide DSRIP withhold.	Composite statewide performance must meet or exceed the threshold QIS of 0.2 to receive full credit for the quality improvement portion of the statewide accountability withhold.
VBP adoption. Improvement toward and attainment of VBP adoption goals. Constitutes 20 percent of statewide DSRIP withhold.	If the state achieves the VBP adoption target, then the full VBP portion of the statewide accountability withhold is earned. If not, a partial amount of the VBP portion of the statewide accountability withhold may be earned based on improvement from baseline year.

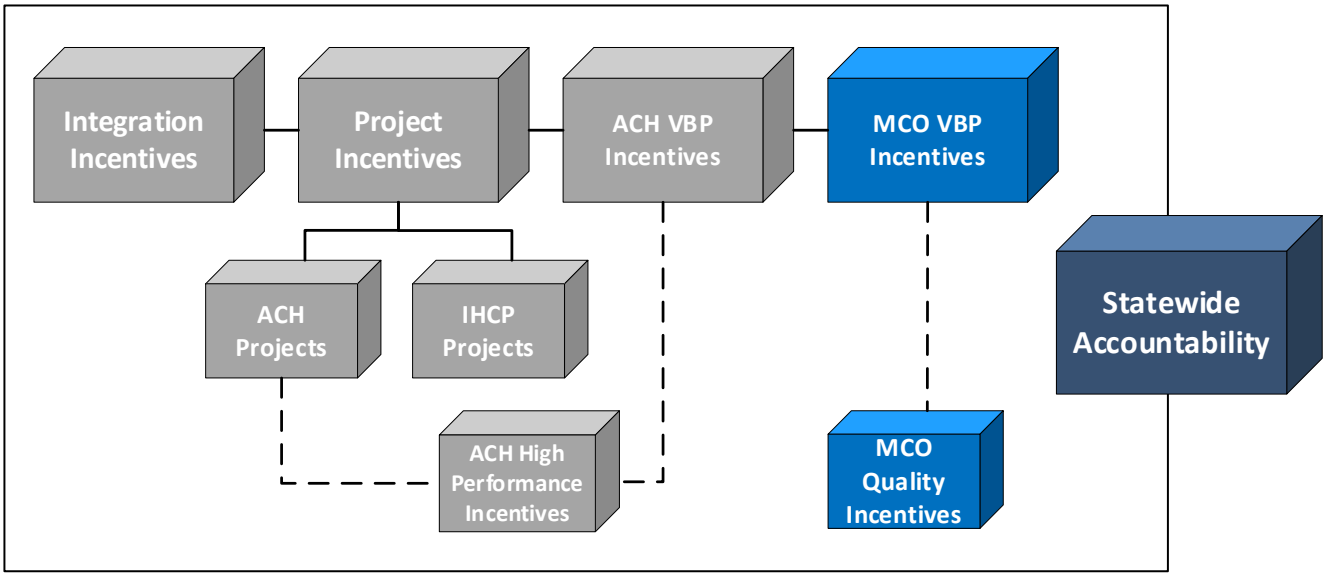
[3] This requirement was fulfilled as of January 2020 when the final regions moved to IMC.

Impact
If overall DSRIP funding is reduced because of underperformance for statewide targets, ACH project incentives will be reduced proportionately across all ACHs.

MCOs

A portion of DSRIP incentives is available to reward MCO adoption of VBP models. These incentives are referred to as MCO VBP incentives and are earned based on P4R and P4P. After incentives are distributed to reward MCO VBP adoption performance, any remaining incentives are redirected to reward MCO performance on a set of clinical quality metrics.

Figure 4: DSRIP incentive flow structure – MCO incentives



The following table provides a snapshot of the key components of DSRIP MCO accountability.

Table 3: snapshot of MCO accountability parameters

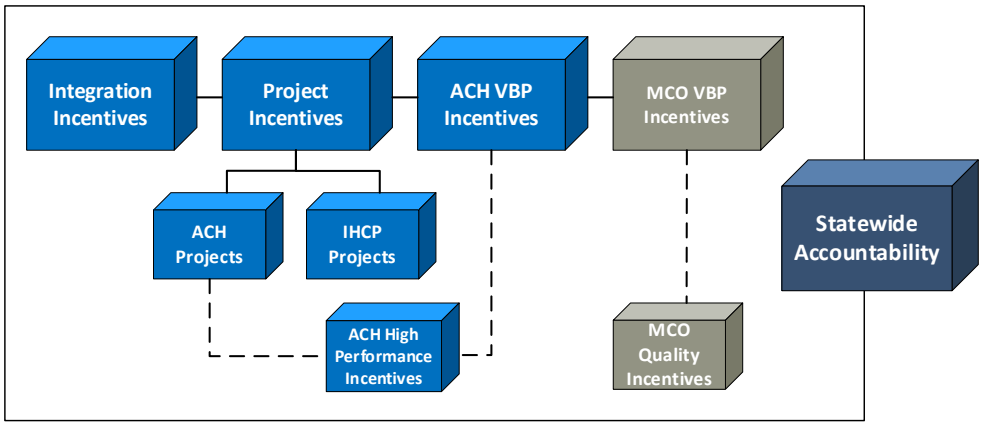
Funding mechanics	
MCO VBP incentives ("challenge pool"), not to exceed 5 percent of total available DSRIP funding, established to reward MCO progression towards achievement of VBP adoption targets. The potential earnable incentives for each MCO will be based on the MCO's share of the total Apple Health (Medicaid) managed care member months for the year.	
Accountability components	**Criteria**
VBP pay-for-reporting (P4R). Submission of information used to evaluate and validate degree of VBP adoption.	Full credit earned for the complete and timely reporting of data required to assess the MCO's progress toward meeting performance targets. An MCO must meet all requirements under MCO contract Exhibit: Challenge Pool – VBP incentives (subpart 2*)* to earn the P4R portion of incentives.
VBP pay-for-performance (P4P). Performance assessment consists of attainment of thresholds and targets, and improvement over the MCO's VBP adoption levels in the baseline year.	By meeting each of the VBP performance targets and thresholds associated with the performance year, the MCO can earn all or part of the P4P portion of the total earnable incentives available to the MCO.
Remaining incentives	
Each MCO is eligible to receive any remaining incentives according to two factors: • Attainment of established alternative payment model (APM) goal. • The relative magnitude of each MCO's QIS established under the terms in the contractual agreement between HCA and the MCO.	

ACHs

ACH progress toward achieving MTP goals are assessed on:

- Progression toward and achievement of regional VBP adoption targets.
- Successful reporting on project planning, implementation, and operation and timely achievement of milestones (P4R).
- Achievement of ACH-specific improvement targets for Project Toolkit P4P metrics.

Figure 5: DSRIP incentive flow structure – ACH incentives



The following table provides a snapshot of the key components of DSRIP ACH accountability.

Table 4: snapshot of ACH accountability and incentive parameters

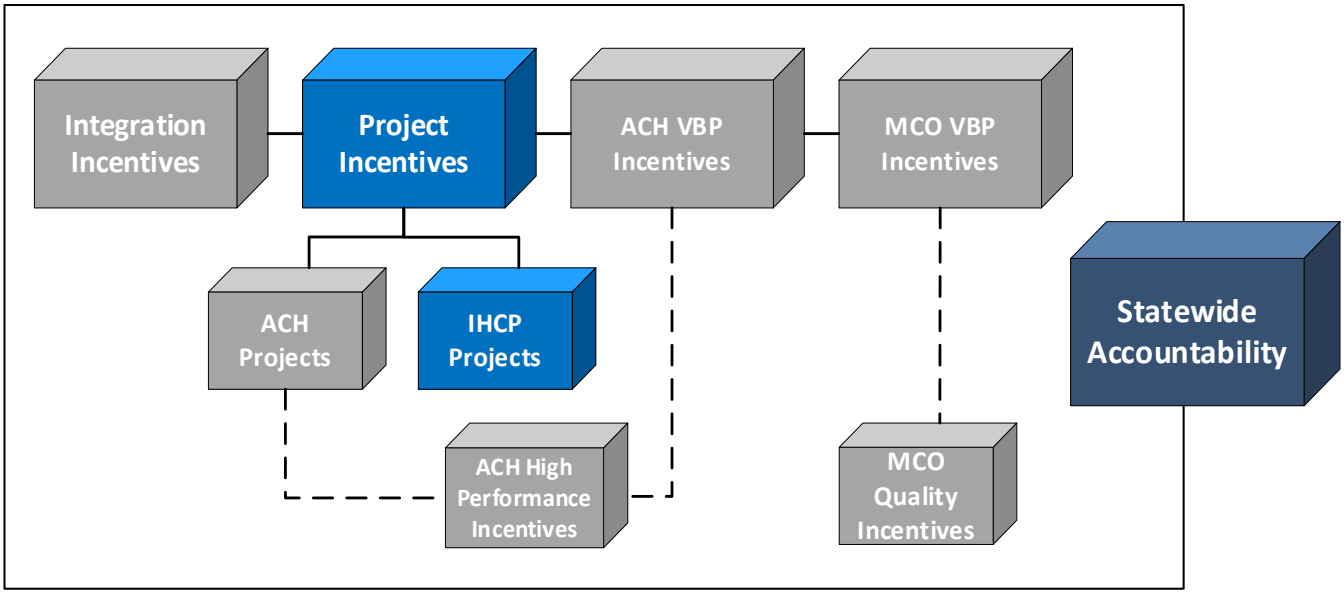
Funding mechanics	
ACHs can earn incentives from the following DSRIP funding sources: • **ACH project incentives** • **ACH VBP incentives ("reinvestment pool")** • **Integration incentives** **For both sources, the portion of incentives available for reporting is greater in the early MTP years, and gradually shifts to greater emphasis on performance in the later DSRIP years.** **Unearned incentives from both sources may be earned by ACHs as DSRIP high-performance incentives based on performance on select quality metrics.**	
Accountability components	Criteria
ACH project incentives. Completion of Project Toolkit activities and demonstrated improvements in outcomes for beneficiaries residing in the ACH.	• Pay-for-reporting. ACHs can earn incentive payments for submitting key P4R deliverables that contain required information within timeframes set forth by the state. P4R incentives are earned based on timely completion and reporting of milestones, timely and complete submission of recurrent deliverables, and timely and complete submission of "P4R metrics" collected for specific projects. • Pay-for-performance. Incentives earned for ACH improvement from baseline towards improvement targets and achievement of improvement targets.
ACH VBP incentives. Regional value-based payment adoption, rewarding improvement and target attainment.	• Pay-for-reporting. Credit received for complete and timely reporting that demonstrates timely achievement of VBP milestones as part of semi-annual reports. • Pay-for-performance. Performance assessment consists of attainment of VBP adoption (volume of qualifying payments through contracts between MCOs and providers) thresholds and targets, and improvement over the ACH region's VBP adoption levels in the baseline year.

Integration incentives. Achievement of regional milestones associated with transition to financial integration of behavioral health care.	Per legislation E2SSB 6312, all counties must operate in an integrated managed care model by January 1, 2020. This has been achieved as of January 1, 2020. Counties committed to implementing integrated managed care before 2020 and were eligible for incentives. Distribution of incentives related to integration is now complete. ACH regions are eligible to earn incentives for the achievement of milestones associated with the transition to financial integration of behavioral health care in their region. Integration incentives should be prioritized to support Medicaid behavioral health providers and the region with the process of transitioning to IMC. The expected use of integration incentives is to assist providers in the administrative and financial process steps required for successful transition, such as uptake of new billing or electronic record systems, technical assistance, or specialized provider training. Process and guidance for behavioral health integration incentives has been documented and is available online.
Remaining incentives	
Unearned ACH project and ACH VBP incentives that remain after each performance period are designated as ACH high-performance incentives. All ACHs are eligible to earn a portion of available ACH high-performance incentives. These incentives will be distributed based on regional ACH performance across nine metrics and adjusted for the relative proportion of Medicaid covered lives in each ACH.	

IHCPs engaged in tribal projects

To honor the government-to-government relationship between Tribes and Washington State, Tribes, IHCPs, or groups of tribes and IHCPs can work directly through HCA to receive MTP funds. The IHCP protocol outlines the parameters for earning these funds through IHCP-specific projects under DSRIP.

Figure 6: DSRIP incentive flow structure – IHCP incentives



The following table provides a snapshot of the key components of how IHCP incentives are earned.

Table 5: snapshot of IHCP incentive parameters

Funding mechanics	
Each IHCP, with support from the American Indian Health Commission (AIHC) and HCA will identify a project to improve the health of the population they serve. The projects are intended to meet the following core objectives of MTP: • **Integrate physical and behavioral health purchasing and service delivery to better meet whole-person needs.** • **Support provider capacity to adopt new payment and care models.** • **Implement population health strategies that improve health equity.** **The delegates of AIHC, as identified in the IHCP protocol, are the decision makers for the IHCP-specific incentives. They are responsible for approving all project plans and metrics as part of the IHCP-specific projects plan, due October 1, 2018.**	
Accountability components	Criteria
Achievement of IHCP-defined project milestones and metrics	All IHCP-specific projects will be pay-for-reporting (P4R) for the duration of MTP. Examples of potential projects and associated metrics could include: • Traditional medicine: number of integrated provider teams, which include a traditional healer. • Substance use disorder (SUD) response integrated into law enforcement: number of electronic referrals for SUD treatment made by law enforcement. • Telemedicine: percent increase in telemedicine appointments for specialty services received by the client within the clinic. Once the delegates approve the plans, each IHCP will report self-identified project milestones and metrics to HCA on a semi-annual basis to earn incentives.

Chapter 2: statewide accountability

Overview

Beginning in 2019 (DY3), a portion of statewide DSRIP funding will be at risk, depending on the state's advancement of VBP adoption and performance on a set of quality metrics. If the state does not achieve its targets, available DSRIP funding will be reduced in accordance with the STCs.

Table 6: annual percent of overall DSRIP incentives at risk for statewide performance[4]

	DY1 (2017)	DY2 (2018)	DY3 (2019)	DY4 (2020)	DY5 (2021)	DY6 (2022)
Percent of DSRIP	0%	0%	5%	10%[5]	20%[6]	20%

Statewide accountability components

For DY4, DY5, and DY6, the state is committed to achieving statewide integration of physical and behavioral health in managed care. In DY3–6, the state is committed to advancement of quality and VBP goals, including:

- Improvement and attainment of quality targets across a set of quality metrics.
- Improvement and attainment of defined statewide VBP adoption targets.

Integrated managed care

IMC is a foundational goal for MTP. It is characterized as a statewide accountability quality metric because all DSRIP incentives were at risk if statewide integration of physical and behavioral health did not occur by the January 2020 deadline.

Definition of achievement: At least two contracts for IMC in each purchasing region must be effective and beneficiary enrollment initiated as of January 1, 2020.

Data source: HCA will track and report on achievement of the metric based on effective dates of IMC contracts for each region.

Quality improvement

The 10 statewide accountability quality metrics were selected to align with other state measure sets and contracts, including Apple Health Managed Care contracts, Washington Statewide Common Measurement Set (WSCMS), and P4P metrics included in the transformation projects.

Table 7: statewide accountability quality metrics

Metric name
All-Cause Emergency Department Visits Per 1,000-Member Months
Antidepressant Medication Management
Asthma-related metric: • **DY3: Medication Management for People with Asthma: Medication Compliance** • **DY4/DY5: Asthma Medication Ratio**

[4] The dollar amounts at risk for performance are specified in the STCs.

[5] Because of the COVID-19 pandemic, statewide accountability has been waived for DY4. At-risk funding is therefore reduced from 10 percent to 0 percent for DY4.

[6] The percentages for DY4 and DY5 assume HCA demonstrates statewide integration of physical and behavioral health managed care by January 2020. 100 percent of total DSRIP funding is at risk in DY4 andDY5 if HCA fails to demonstrate this.

Comprehensive Diabetes Care: Blood Pressure Control
Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9%)
Controlling High Blood Pressure (<140/90)
Mental Health Treatment Penetration (Broad)
Plan All-Cause Readmission Rate (30 Days)
SUD Treatment Penetration
Child And Adolescent Well-Care Visits 3 – 11 Years of Age[7]

HCA will use a QI model to determine statewide performance across the quality metric set. At a high level, the following outlines how the QI model works in the context of statewide accountability.

Table 8: statewide accountability quality metrics – measurement years

DY	Performance year	Baseline year
3	2019	2017
4	Waived	Waived
5[8]	2021	2020
6	2022	2021

- Definition of achievement: A QIS of 0.2 is required to receive full credit for the quality component. This is the same threshold applied in the context of the QI model used in Apple Health Managed Care contracts.
- Data source: Performance results will be calculated from ProviderOne Medicaid claims and enrollment data. Measures that also require medical record data will be generated from MCO performance results reported to HCA's external quality review organization (EQRO), Qualis Health.
- Performance on each quality metric contributes equally to the statewide QI composite score, or statewide QIS.
- Each metric gets a metric-specific QI metric score. The QI metric score is a combination of an objective quality element (progress toward a defined target) and an annual improvement element (improvement from prior performance). The QI model will generate a statewide QIS, based on the weighted average of the combined metric quality scores and the metric improvement scores for the set of statewide accountability quality metrics.
- The QI model produces the following metric-specific output for each metric:
    - A metric quality score compares the statewide performance year result to the range defined by a quality score baseline and a metric target.
        - If NCQA data is available, the quality score baseline is the NCQA National Mean Medicaid result, and the metric target is the NCQA National 90th Medicaid Percentile.
        - If NCQA data is not available, the quality score baseline adopts the improvement score baseline value defined as the state baseline result, and the metric target is set to one percentage point improvement relative to the quality score baseline (in this case also the improvement score baseline).
    - A metric improvement score is calculated by comparing the performance year result to a range defined by state baseline performance (improvement score baseline) and the metric target.
- The metric quality score and metric improvement score are aggregated for each metric into a QI metric score with the use of a weighted average in which the metric quality score is increasingly weighted with higher performance.

[7] Child And Adolescent Well-Care Visits 3–11 Years of Age replaces the NCQA retired measure for Well-Child Visits in the 3rd, 4th, 5th, And 6th Years of Age.

[8] CMS approved on May 16th, 2022, a year-over-year baseline to performance period for DY5 and DY6 periods.

- QI metric scores are aggregated across all statewide accountability quality metrics to generate the statewide QIS.

VBP adoption

By the end of 2022 (DY6), 90 percent of total MCO payments to providers must be made through designated VBP arrangements for the state to secure maximum available DSRIP incentives.

Definition of achievement: Statewide VBP adoption targets are consistent with HCP-LAN APM Categories 2C and above. VBP adoption performance is measured by two factors: improvement toward and achievement of the annual target. If the VBP adoption target is achieved, then the full VBP portion of the statewide accountability withhold is earned. If the target is not achieved, a portion of the withhold can still be earned based on the state's improvement in VBP adoption from the prior year.

Table 9: annual statewide VBP adoption target and scoring weights

	VBP adoption target (HCP-LAN Category 2C or higher)	Scoring weights	
		Improvement	Achievement
DY3	75%	50%	50%
DY4[9]	85%	45%	55%
DY5	90%	75%	25%
DY6	90%	75%	25%

Table 10: statewide accountability VBP adoption – measurement years

DY	Performance year	Baseline year
3	2019	2018
4	Waived	Waived
5	2021	2020
6	2022	2021

Data source: Per their contract requirements with HCA, MCOs must attest to their VBP adoption levels annually by reporting total payments in each HCP-LAN category. The IA will calculate and validate statewide performance according to this annual data source. The statewide accountability VBP baseline year is the year prior to the performance year, in alignment with MCO VBP adoption assessment per the contractual agreement with HCA.

Payments to providers are defined as total Medicaid payments to providers (in dollars) for services, including inpatient, outpatient, physician/professional, and other health services, excluding any pass-through payments or other services carved out from MCO contracts. This amount excludes payments related to case payments, administrative dollars, Washington State Health Insurance Pool (WSHIP), premium tax, Safety Net Assessment Fund (SNAF), Provider Access Payment (PAP) or trauma funding.[10]

Calculating the level of VBP adoption: VBP adoption is calculated based on the share of MCO payments to providers that are made through VBP arrangements in HCP-LAN Category 2C or higher.[11]

[9] May 2021, HCA submitted a change request to CMS to revise the improvement and achievement weights to 75% and 25%. If the achievement is met, then all the incentive is earned. If not, then 75% can be earned.

[10] For CY2017, HCA included payments for pharmacy service in both the numerator and denominator when calculating the level of VBP adoption. However, starting in 2018, pharmacy has been removed from the MCO per member per month (PMPM). For CY2018, HCA will exclude all such payments in both the numerator and denominator when calculating the level of VBP adoption. See the model managed care contracts page for more information.

[11] Payments for behavioral health services are included when they are paid by a MCO, including integrated MCOs. Payments for behavioral health services paid by behavioral health organizations prior to integration are not included.

Equation 1: level of VBP adoption (percentage)

$$\text{Level of VBP adoption (percentage)} = \frac{\text{MCO payments to providers (in dollars) made through VBP arrangements at or above Category 2C}}{\text{Total MCO payments to providers (in dollars)}}$$

The state is measured on achievement of VBP adoption targets, as well as improvement over the state's prior year VBP adoption level. If the state meets the VBP adoption target for the performance year, then the **improvement score** is 100 percent. If the state does not meet the VBP adoption target for the performance year, then the **improvement score** is calculated as the percent change from the baseline year to the performance year.

Equation 2: VBP improvement score[12]

$$\text{Improvement Score} = \frac{\text{PY VBP adoption actual} - \text{Baseline}}{\text{PY VBP adoption target} - \text{Baseline}}$$

Where the calculation of the **improvement score** produces a negative percentage, the improvement score is zero (0) percent. The improvement score is capped at 75 percent.

Statewide accountability composite score

Each of the 10 quality measures contributes equal weight to the QI composite score (totaling 80 percent). VBP adoption is weighted at 20 percent in recognition of its importance in the overall MTP effort and statewide value-based goals.

The example illustrates the DSRIP incentives lost in DY4 if the state achieves full credit for QI but achieves only 50 percent credit for demonstrating improvement toward (but not achievement of) the state VBP adoption target.

Table 11: example DSRIP statewide accountability scenario – DY4 assessment

Statewide accountability components (DY3–6)	Weight	Total DSRIP dollars for year: $151,510,022 (10% of DSRIP funding at risk in DY4: $15,151,002)			
		Percent earned	Dollars at risk*	Dollars lost	Dollars earned
QIS	80%	100%	$12,120,802	$0	$12,120,802
VBP adoption score	20%	50%	$3,030,200	$1,515,100	$1,515,100
Total	100%		$15,151,002	$1,515,100	$13,635,902

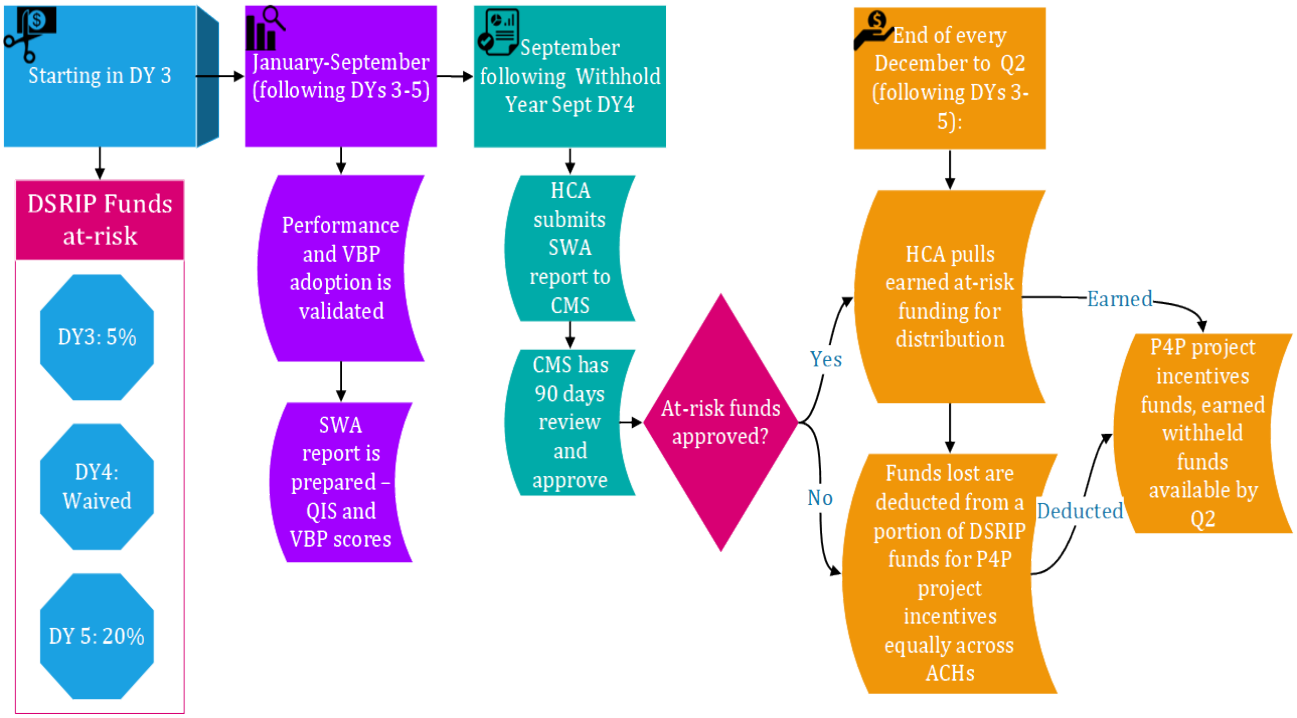
[12] VBP improvement score change is tentatively approved based on CMS verbal approve, April 2021. HCA is waiting on written confirmation of the approved changes.

Statewide accountability withhold approach

CMS will withhold the at-risk portion of DSRIP incentives in DY3 through DY5. HCA will submit a statewide accountability report and supporting documentation to CMS for review and approval. CMS will have 90 calendar days to review and approve the statewide accountability report.[13]

Once CMS approves the report, the state can access the earned withheld incentives, according to the statewide accountability QIS. An illustration of the withhold process steps is shown below. See Appendix C for detailed withhold process timeline.

Figure 7: validating statewide accountability scores and annual withhold amount (annual process for DY3–6)



Implications for DSRIP incentives

If overall DSRIP funding is reduced because of underperformance for statewide targets, ACH project incentives P4P will be reduced proportionately across all ACHs for the associated performance year. For example, should the state see a two percent reduction in incentives under the statewide accountability model, each ACH will see a two percent reduction in maximum, potential, earnable incentives for the performance year.

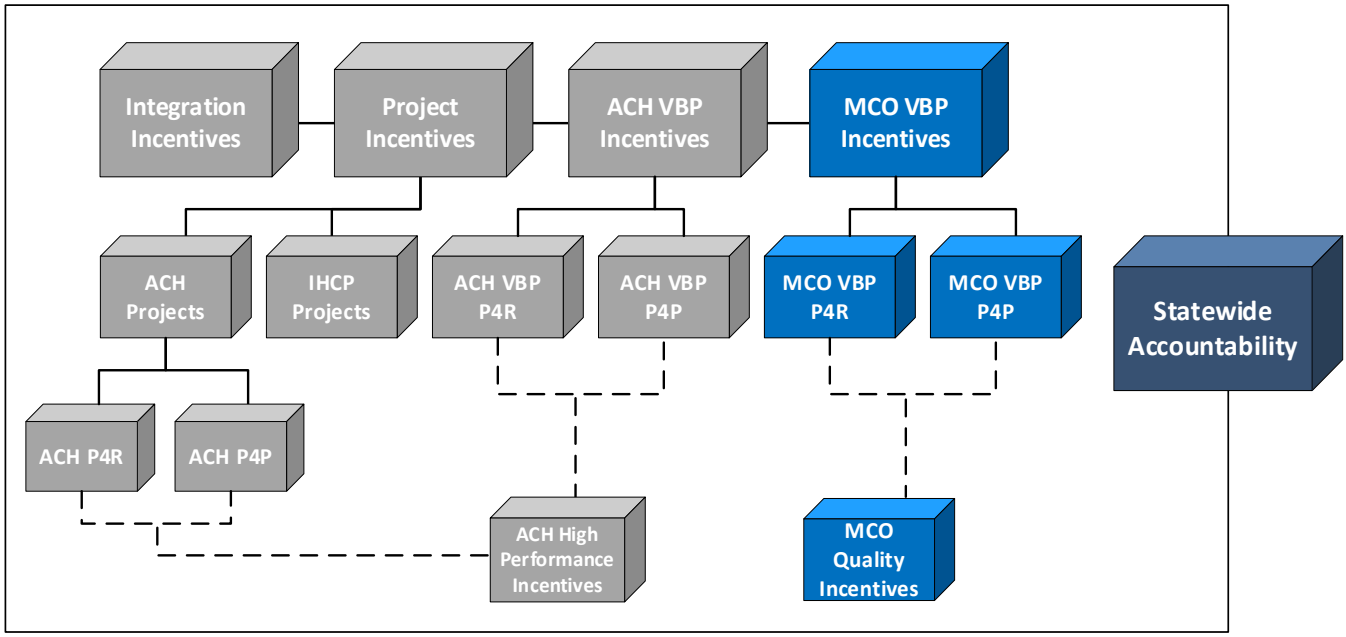
[13] View the DSRIP funding and mechanics protocol.

Chapter 3: MCO accountability

Overview

Washington's MCOs are critical partners in delivery system reform efforts, particularly to ensure the state's success in meeting its VBP goals. As stated in the STCs, MCOs are expected to serve in a leadership or supportive capacity in every ACH. This ensures that delivery system reform efforts are coordinated across all necessary sectors—those providing payment, delivering services, and providing critical, community-based supports.

Figure 8: DSRIP incentive flow structure – MCO incentives



In support of MTP, MCOs will demonstrate improvement toward, and achievement of the state's VBP targets and will play a critical role in the success and sustainability of Washington's DSRIP program.

Available incentives

MCOs are expected to participate in delivery system reform efforts as a matter of business interest and contractual obligation to the state. For this reason, they do not receive incentive payments for participation in ACH-led transformation projects. However, MCOs are eligible to earn MCO VBP incentives (through the challenge pool) for achieving annual MCO VBP targets.[14] The number of incentives available to an individual MCO is determined by the attributed statewide managed care member months undersigned Apple Health contracts for the performance year.[15]

Table 12: annual DSRIP funding available for MCO VBP incentives

DY1	DY2	DY3	DY4	DY5	DY6
N/A	$8,000,000	$8,000,000	$8,000,000	$8,000,000	$0[16]

[14] View the Managed care contracts page.

[15] Annual DSRIP incentives are based on best available information, and subject to change. In MCO contracts, these incentives are referred to as base earnable funds (BEF).

[16] For DY6, VBP targets are used as goal. Per STC 40, HCA has exercised the up-to option for incentives and set at 0%.HCA will still track VBP targets for DY6 as a measure of attainment/adoption.

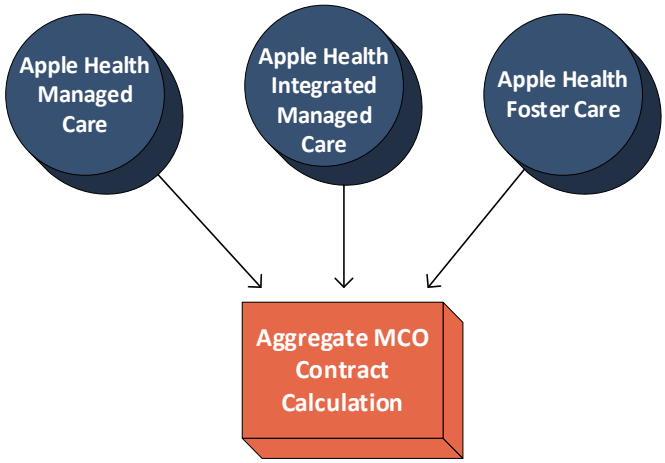
MCO VBP incentives are earned according to P4R and P4P expectations. Each year, MCOs have a defined portion of incentives available for achieving P4R criteria and P4P targets. The percent of available incentives split between P4R and P4P is defined in the STCs.

Table 13: annual percent of potential earnable MCO VBP incentives, by P4R and P4P

MCO VBP incentives	DY2	DY3	DY4	DY5
Pay-for-reporting (P4R)	50%	25%	0%	0%
Pay-for-performance (P4P)	50%	75%	100%	100%

The managed care contracts, including HCA's Apple Health Managed Care, Apple Health IMC, and Apple Health Foster Care, further specify how the incentives are distributed. If more than one of these contracts is effective between HCA and the MCO, the incentives earned will not be calculated separately for each contract. Instead, the incentives are calculated as a single payment, based on data aggregated from each of MCO's applicable Apple Health contract(s).

Figure 9: data aggregation across applicable MCO contracts



More information about MCO involvement in the transformation is available in the DSRIP planning protocol, DSRIP funding and mechanics protocol, and the HCA Value-based Roadmap - Apple Health Appendix.

Assessment of progress and performance

The performance year for determining whether MCOs have completed milestones in support of advancing VBP and achieved VBP targets is aligned with a given DY. The assessment period will occur during fall (October–December), after the performance year.

P4R

MCOs are eligible to earn MCO VBP incentives for P4R in DY2 and DY3 only (as no VBP incentive funds were available in DY1). These incentives are available to the MCOs for the complete and timely reporting of data required to assess the MCO progress toward meeting VBP adoption targets. The required data is specified in the contract between HCA and the MCO.

P4P

For DY2–5, the P4P portion of MCO VBP incentives are available for successful achievement of and improvement toward specified VBP adoption targets. Each MCO will be measured based on MCO-provided data (validated by the IA) and must meet performance expectations for the given year.

Performance targets, as well as improvement and achievement weighting for MCO VBP score determination, are outlined below.

Table 14: MCO VBP adoption targets

Year	Performance targets

	HCP-LAN 2C–4B performance target	HCP-LAN 3A–4B performance subtarget
DY1	30%	N/A
DY2	50%	10%
DY3	75%	20%
DY4	85%	30%
DY5[17]	90%	50%
DY6	90%	50%

MCO improvement and achievement are weighted differently throughout MTP. MCO improvement toward VBP adoption targets is more heavily weighted in the early years, while credit for full achievement of those targets is increasingly weighted in the later years.

Table 15: MCO VBP P4P score weights

Year	Calculation weight		
	Achievement score	Achievement subset score	Improvement score
DY1	40%	0%	60%
DY2	35%	5%	60%
DY3	45%	5%	50%
DY4[18]	50%	5%	45%
DY5	20%	5%	75%
DY6	20%	5%	75%

Based on performance, the MCO is eligible to earn all or part of the available MCO VBP incentives. HCA and the IA will use data, which the MCOs are contractually required to submit, to identify the following:

- **Achievement score:** An achievement score for each MCO is calculated annually. If the MCO has reached or exceeded the HCP-LAN Categories 2C–4B **performance target** for the performance year, then the **achievement score** will be 100 percent. If not, the **achievement score** is zero (0) percent.
- **Achievement subset score:** In DY2–6, the state will assess whether the MCO has met the annual achievement subset criteria. In DY3, the achievement subset criteria require MCOs have at least one VBP contract as a MACRA Advanced APM. In DY4 – 6, the achievement subset criteria require that the MCOs have at least one VBP contract in Category 3B or above and including at least one of the following features:
    - More than nominal risk for shared losses.
    - Payments tied to provider improvement or attainment on metrics from the WSCMS set using HCA QI model or similar tool.
    - Care transformation requirements including state-level best practices.
    - Use of certified electronic health record (EHR) technology in support of VBP methods

  If the achievement subset criteria are met, the achievement subset score will be 100 percent. If the achievement subset criteria are not met, the achievement subset score will be zero (0) percent.
- **Improvement score**: An improvement score for each MCO is calculated annually. If the MCO has met the performance target for the demonstration year, the improvement score is 100

[17] HCA submitted a revision to CMS to maintain the target score of 85% from DY4–5.
[18] HCA submitted a revision to CMS to update the achievement and improvement score weights for DY4 and 5. This was approved February 28, 2022. However, based on a delay in approval, MCOs will use the previously approved weights for DY4.

percent. If the MCO has not met the performance target for the performance year, the improvement score is calculated as the percent change from the baseline year to the performance year. See Figure 5. The improvement score is capped at 100 percent. Where the prior calculation produces a negative percentage, the improvement score is zero (0) percent.

- **Eligibility for MCO VBP incentives (performance subtarget):** MCOs must also meet a minimum threshold of VBP adoption in Category 3A and above (performance subtarget) to earn any MCO VBP incentives in DY4 and 5. The performance subtarget is also applied as a threshold for distribution of remaining funds only in DY2 and 3. This is described in the secondary process below.

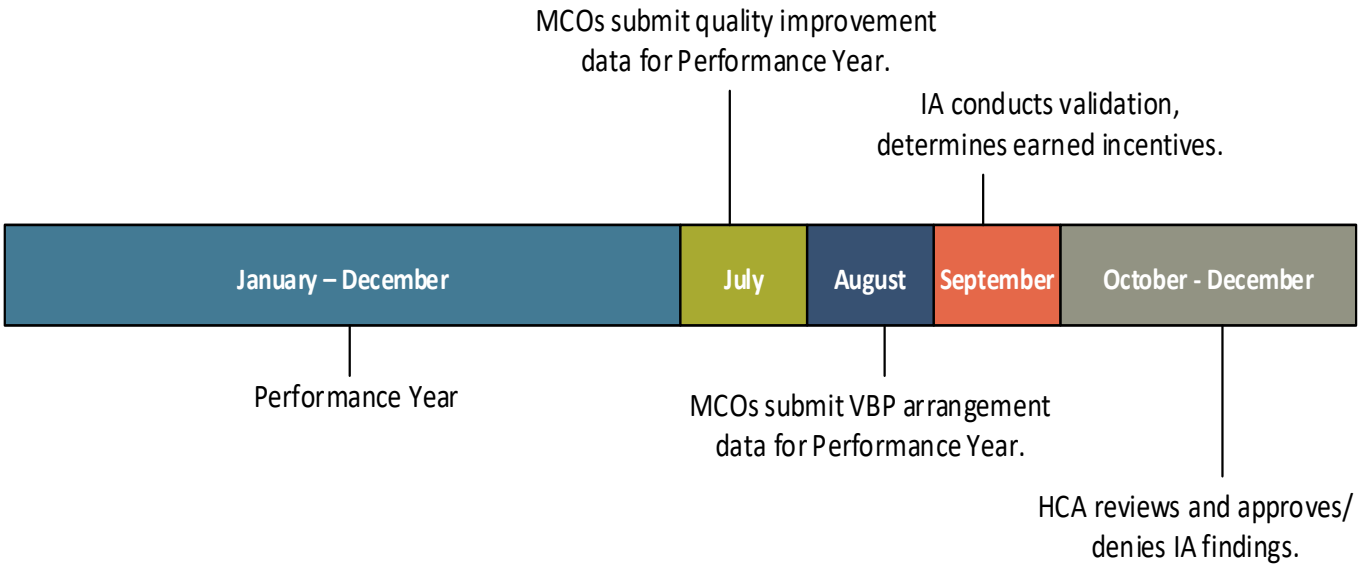
Table 16: annual HCP-LAN 3A–4B subtarget threshold for MCO VBP incentives

	DY1	DY2	DY3	DY4	DY5
HCP-LAN Categories 3A–4B performance subtarget	N/A	Eligibility: remaining funds Target = 10%	Eligibility: remaining funds Target = 20%	Eligibility: all funds Target = 30%	Eligibility: all funds Target = 50%

Incentive payment determination

The IA is responsible for determining whether reporting and performance expectations have been met.

Figure 10: assessment timeline for MCO VBP incentives



Distribution of remaining incentives

If there are any remaining MCO VBP incentives for a given performance year after initial allocation, a secondary process is initiated to allocate the unearned incentives. Each MCO is eligible to earn a share of any remaining incentives, based on achievement of the factors defined below.

Table 17: MCO eligibility to earn remaining MCO VBP incentives

HCP-LAN Categories 3A–4B performance subtarget	Relative QIS

The MCO must meet the HCP-LAN Categories 3A–4B performance subtarget for the performance year, set out in Table 14. • If the MCO has not met the annual performance subtarget, it will not be eligible for any of the remaining incentives. • If the MCO meets the annual performance subtarget, it is eligible for a percentage of remaining incentives. **Important:** MCOs must meet the HCP-LAN Categories 3A–3B performance subtarget during DY4 and 5 to be eligible for any MCO VBP incentives, as part of the primary VBP adoption assessment. This is in addition to any remaining incentives, as part of the secondary process.	If the MCO has met the HCP-LAN Categories 3A-4B performance subtarget, the MCO will receive a percentage of remaining MCO VBP incentives. This percentage is determined by the MCO's relative performance on the set of quality measures (as defined in MCO contracts for the associated performance year). MCO quality measure results are calculated in accordance with Washington Apple Health Managed Care contracts. The state and IA will use the quality measure results to determine the number of remaining incentives earned for eligible MCOs.

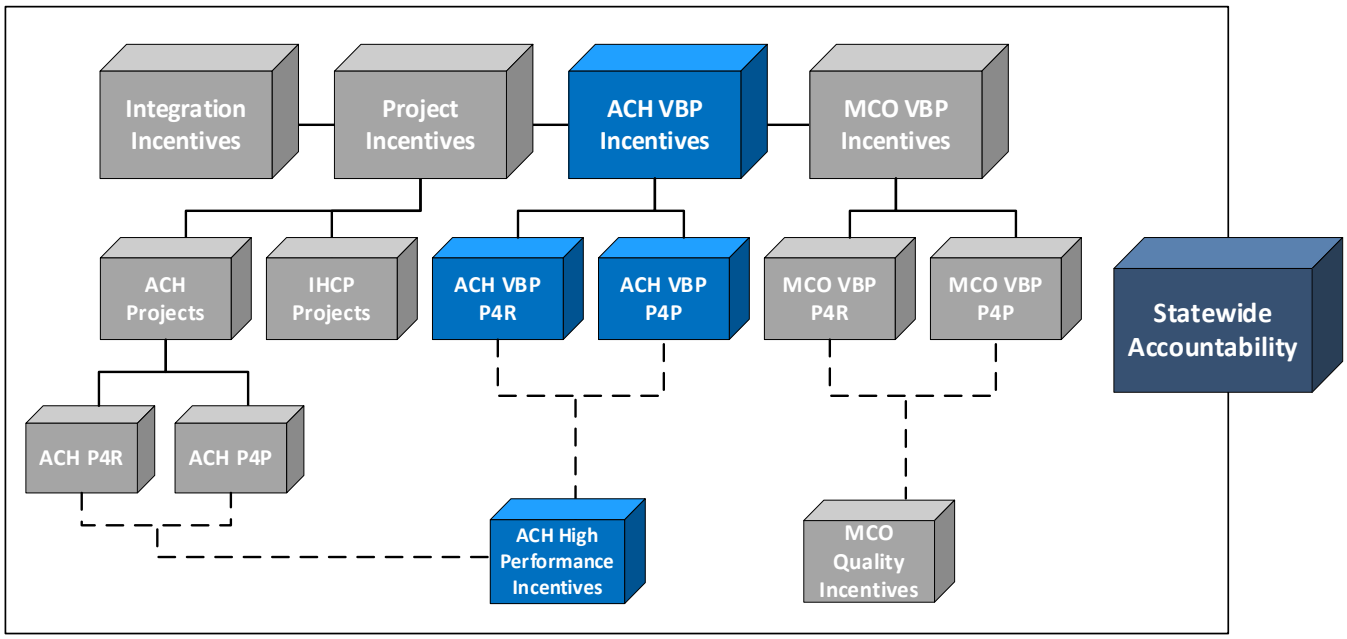
Chapter 4: ACH incentives for value-based care

Overview

The success and sustainability of the state's DSRIP program is dependent on moving along the VBP continuum, at both the state and regional level. ACHs are awarded incentives for demonstrated improvement and achievement of VBP adoption targets in their regions.[19] During DSRIP, ACHs are accountable for investing resources to support partnering providers.

For example, ACHs should be distributing earned incentives to support their partnering providers' needs in moving along the VBP continuum. ACHs support and assess provider VBP readiness and practice transformation and connect providers with training and resources.

Figure 11: ACH incentives – VBP



Available incentives

ACH can earn VBP incentives based on P4R and P4P. ACH VBP incentives are funded through the reinvestment pool. Potential earnable ACH VBP incentives are distributed evenly across all nine ACHs.

Table 18: annual DSRIP funding available for ACH VBP incentives[20]

DY1	DY2	DY3	DY4	DY5	DY6
N/A	$3,600,000	$4,500,000	$5,400,000	$6,300,000	$0[21]

[19] Regional VBP adoption targets are calculated based on MCO VBP adoption performance in the region. See Chapter 3.
[20] Annual DSRIP incentives are based on best available information and are subject to change.
[21] For DY6, VBP targets are used as goal. Per STC 40, HCA has exercised the up-to option for incentives and set at 0%. Those incentives will be placed back into the ACH P4R/P4P incentive pools. HCA will still track VBP targets for DY6 as a measure of attainment/adoption.

Note: Both ACH VBP and integration incentives are funded through the reinvestment pool. Earned incentives for ACHs that achieve key integration milestones may affect the amount of ACH VBP incentives available for a given year.

ACHs are eligible to earn VBP incentives through reported progress on VBP milestones (P4R), and improvement toward and achievement of VBP adoption targets (P4P) in their regions. Regarding VBP adoption, ACHs will be rewarded on reported progress in the early years, and increasingly on full attainment of targets in later years. The table below indicates the percent of VBP incentives available to ACHs for P4R and P4P throughout MTP.

Table 19: annual percent of potential earnable ACH VBP incentives, by P4R and P4P

ACH VBP incentives	DY1	DY2	DY3	DY4	DY5	DY6
Pay-for-reporting (P4R)	100%	75%	50%	25%	0%	N/A
Pay-for-performance (P4P)	0%	25%	50%	75%	100%	N/A

Assessment of progress and performance

P4R

ACHs report on VBP P4R milestones as part of their semi-annual reports. ACH VBP incentives for P4R are earned by providing complete and timely evidence of milestone completion for the annual reporting period. ACH VBP P4R milestones evolve as the transformation progresses. The table below outlines the milestones for each demonstration year.

Table 20: ACH VBP P4R milestones

Milestone	Reflective of activities that occurred during
• **N/A (none; no DSRIP funding allocated to VBP incentives for DY1)**	DY1 (2017)
• **Inform providers of VBP readiness tools to assist their move toward value-based care.** • **Connect providers to training and/or technical assistance offered through HCA, the Healthier Washington Collaboration Portal (WA Portal), MCOs, and/or the ACH.** • **Support assessments of regional VBP attainment by encouraging/incentivizing completion of the state provider survey.** • **Support providers to develop strategies to move toward value-based care.**	DY2 (2018)
• **Identification and support of providers struggling to implement practice transformation and move toward value-based care.** • **Support providers to implement strategies to move toward value-based care.** • **Continued support of regional VBP attainment assessments by encouraging/incentivizing completion of the state Paying for Value provider survey.**	DY3 (2019)
• **Continued support of regional VBP attainment assessments by encouraging/incentivizing completion of the state provider survey.** • **Continued identification and support of providers struggling to implement practice transformation and move toward value-based care.**	DY4 (2020)
• **N/A (all incentives reward performance; no incentives for reporting)**	DY5 (2021)
• **N/A (no incentives rewarded for performance; no incentives for reporting)**	DY6 (2022)

Incentive payment determination

The achievement of ACH VBP P4R milestones is assessed by the IA. Each VBP P4R milestone is associated with one (1.0) AV; the percentage of VBP P4R funds earned for the year is equal to the percent of VBP P4R AVs earned out of the total possible number of AVs. ACHs attest to milestones and provide evidence of completion (e.g., narrative responses, lists of activities), which are assessed on a binary (complete/incomplete) scale. The period for achieving P4R milestones is the corresponding DY.

Table 21: schedule of ACH VBP P4R milestone AVs

ACH VBP P4R milestones	DY2 Q1–Q4	DY3 Q1–Q4	DY4 Q1–Q4
Inform providers of VBP readiness tools to assist their move toward value-based care.	1.0	-	-
Connect providers to training and/or technical assistance offered through HCA, WA Portal, MCOs, and/or the ACH.	1.0	-	-
Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state's Paying for Value provider survey.	1.0	1.0	1.0
Support providers to develop strategies to move toward value-based care.	1.0	-	-
Identification and support of providers struggling to implement practice transformation and move toward value-based care.	-	1.0	-
Support providers to implement strategies to move toward value-based care.	-	1.0	-
Continued identification and support of providers struggling to implement practice transformation and move toward value-based care.	-	-	1.0
Total earnable P4R VBP AVs per reporting period	4.0	3.0	2.0

To identify the earned VBP P4R incentives for each ACH, the average AV for all P4R milestones that apply in the year (the percent AV completion) is multiplied by the ACH VBP incentives associated with P4R in the measurement year. In the example below, an ACH that earns three out of four possible AVs for the reporting period would earn 75 percent of available ACH VBP incentives associated with P4R.

Table 22: example ACH VBP P4R AV calculation (for reporting period DY2)

ACH VBP P4R milestones for reporting period: DY2 Q1–Q4	Earned AV	Possible AV
Inform providers of VBP readiness tools to assist their move toward value-based care.	0.0	1.00
Connect providers to training and/or technical assistance offered through HCA, WA Portal, MCOs, and/or the ACH.	1.0	1.00
Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state Paying for Value provider survey.	1.0	1.00
Support providers to develop strategies to move toward value-based care.	1.0	1.00
TAV	3.0	4.0
PAV	(3.0 / 4.0) = 75%	100%

Earned incentives are distributed annually to ACHs, aligned with the timing of P4P payment cycles for both ACH VBP and ACH project incentive payments.

P4P

The IA calculates VBP adoption by ACH region each year for the prior measurement year. The calculation is based on data provided by HCA's MCOs. HCA and IA obtain the data used to calculate regional ACH VBP achievement from annual MCO reporting on VBP adoption, both by region and by HCP-LAN category. The resulting data is validated by the IA and aggregated across all MCOs by region and HCP-LAN category. It is important to note that ACH achievement of regional VBP adoption targets is contingent on MCO VBP adoption performance. ACHs are expected to engage with MCOs and providers in their region to encourage VBP adoption but are not expected to be parties to VBP contracts themselves.

ACH VBP P4P incentives are associated with VBP adoption targets, as required by the STCs. Regional VBP adoption is calculated based on the share of MCO payments to providers that are made through VBP arrangements in the HCP-LAN Category 2C or higher.

Table 23: ACH VBP adoption targets

Year	Performance targets	
	HCP-LAN Category 2C and above option target	HCP-LAN Categories 3A–4B adoption subtarget

DY1	30%	N/A
DY2	50%	10%
DY3	75%	20%
DY4	85%	30%
DY5[22]	90%	50%
DY6	90%	50%

Achievement of annual ACH VBP P4P outcomes will consider the full achievement of VBP adoption targets and improvement from prior year performance toward VBP adoption targets.

Table 24: ACH VBP P4P score weights

Year	Calculation weight		
	Achievement score	Achievement subset score	Improvement score
DY1	N/A	N/A	N/A
DY2	35%	5%	60%
DY3	45%	5%	50%
DY4	20%	5%	70%
DY5	20%	5%	70%
DY6	20%	5%	70%

The amount of ACH VBP P4P incentives earned by the ACH based on performance will reflect the following components:

- Achievement of ACH VBP adoption target (HCP-LAN 2C or higher performance target).
- Achievement of defined subset criteria.
- Improvement from prior year VBP adoption.
- Minimum threshold for ACH VBP incentives (HCP-LAN 3A or higher performance subtarget).

Based on its performance, an ACH is eligible to earn all or part of the available incentives for ACH VBP P4P. HCA and IA will use data the MCOs are contractually required to submit to identify the following:

- **Achievement score:** An achievement score for each ACH region is calculated annually. If the ACH region has reached or exceeded the HCP-LAN 2C or above performance target for the performance year, the achievement score will be 100 percent. If not, the achievement score is zero (0) percent.
- **Achievement subset score:** In DY2–6, the state will assess whether the ACH region has met the annual achievement subset criteria. If the achievement subset criteria have been met, the achievement subset score will be 100 percent. If the achievement subset criteria have not been met, the achievement subset score will be zero (0) percent. In DY3, the achievement subset criteria require that ACHs have at least one VBP contract as a MACRA Advanced APM. In DY4 – 6, the achievement subset criteria require that the ACHs have at least one VBP contract in Category 3B or above and including at least one of the following features:
  - More than nominal risk for shared losses.
  - Payments tied to provider improvement or attainment on metrics from the WSCMS using HCA QI model or similar tool.
  - Care transformation requirements including state-level best practices.
  - Use of certified EHR technology in support of VBP methods.

[22] HCA submitted a revision to CMS to maintain the target score of 85% from DY4–5.

If the achievement subset criteria are met, the achievement subset score will be 100 percent. If the achievement subset criteria are not met, the achievement subset score will be zero (0) percent.

- **Improvement score:** Improvement scores for each ACH region is calculated annually. If the ACH region has met the performance target for the DY, then the improvement score is 100 percent. If the ACH region has not met the performance target for the performance year, then the improvement score is calculated as the percent change from baseline year to the performance year.
  The improvement score is capped at 100 percent. Where the prior calculation produces a negative percentage, the improvement score is zero (0) percent (see Figure 5). In addition, ACHs must also meet a minimum threshold of VBP adoption in Category 3A and above (performance subtarget) to earn any ACH VBP incentives in DY4 and 5.

Table 25: annual HCP-LAN Categories 3A–4B subtarget threshold for ACH VBP incentives

	DY1	DY2	DY3	DY4	DY5	DY6
HCP-LAN Categories 3A–4B subtarget	N/A	None	None	30%	50%	50%

Incentive payment determination

The IA calculates the final ACH VBP P4P score by adding the weighted scores for improvement, performance target and performance subset target achievement. The final score for all components will determine the proportion of potential ACH VBP P4P incentives earned by an ACH for a given performance year.

Full credit is earned by meeting or exceeding the defined target for the associated year. ACHs do not to earn additional incentives for exceeding improvement or performance expectations. Examples of ACH VBP incentive calculation are available in Appendix C.

ACHs earn VBP P4P incentives on an annual basis. Earned incentives are distributed in alignment with earned project P4P and VBP P4R incentive payments. Because of the data compilation and validation process, there is an approximate 18-month lag between the end of the performance year and when ACH VBP P4P incentives are paid.

Distribution of remaining incentives

If a region does not meet progress (P4R) or performance (P4P) expectations, the ACH's unearned VBP incentives will be used to fund ACH high-performance incentives.

Chapter 5: ACH project incentives overall

Overview

ACH project incentives are earned on a project-by-project basis. Each project in the ACH portfolio has an associated maximum total incentive for each performance period, with available incentives earned by meeting either reporting or performance targets. The DSRIP funding and mechanics protocol defines the project weights associated with maximum, available ACH project incentives.[23]

Maximum potential ACH project incentives

A point-in-time client enrollment count from November 2017 set the ACH population counts for the calculation of maximum potential ACH project and integration incentives. ACH population count included Medicaid and SCHIP beneficiaries with comprehensive physical and behavioral health care benefits—also referred to as full benefit Title XIX or Title XXI coverage—as of November 2017. Medicaid beneficiaries with both Medicaid and Medicare coverage (also referred to as dually eligible) were excluded from the ACH regional population counts.[24] This was the only exclusion criteria applied.

Table 26: November 2017 client enrollment count by ACH and county

Region/county	Total
Better Health Together	175,052
Adams	8,975
Ferry	2,115
Lincoln	2,823
Pend Oreille	3,868
Spokane	144,392
Stevens	12,879
Cascade Pacific Action Alliance	165,422
Cowlitz	33,418
Grays Harbor	23,894
Lewis	24,336
Mason	17,059
Pacific	5,907
Thurston	59,776
Wahkiakum	1,032
Greater Columbia ACH	227,331
Asotin	5,847
Benton	52,913
Columbia	1,015
Franklin	32,658
Garfield	545
Kittitas	9,018
Walla Walla	15,018
Whitman	7,432
Yakima	102,885
HealthierHere	358,022

[23] See section 3, subpart C of the DSRIP funding and mechanics protocol.
[24] ACH high-performance metrics will include dually eligible individuals in population counts and a subset of metric results (where full data is available). For more information, see Chapters 7 and 8.

King	358,022
North Central ACH	82,531
Chelan	22,313
Douglas	11,798
Grant	33,461
Okanogan	14,959
North Sound ACH	245,308
Island	13,292
San Juan	3,121
Skagit	32,542
Snohomish	147,092
Whatcom	49,261
Olympic Community of Health	73,719
Clallam	19,234
Jefferson	6,497
Kitsap	47,988
Pierce County ACH	203,383
Pierce	203,383
SWACH	115,708
Clark	107,777
Klickitat	5,851
Skamania	2,080
State total	**1,646,476**

The regional allocation was a one-time step. Maximum potential for ACH projects and integration incentives are now set for the duration of the MTP period and each annual performance period.

Annual allocation of ACH project incentives for reporting and performance

The state shifts accountability, moving from rewarding reporting (P4R) in the early years, to rewarding performance (P4P) in the later years. The table below outlines the percent of ACH project incentives available to ACHs for P4R and P4P throughout MTP.

Table 27: percent of annual ACH project incentives, by P4R and P4P

ACH project incentives	DY1	DY2	DY3	DY4	DY5	DY6
Pay-for-reporting (P4R)	100%	100%	75%	50%	25%	25%
Pay-for-performance (P4P)	0%	0%	25%	50%	75%	75%

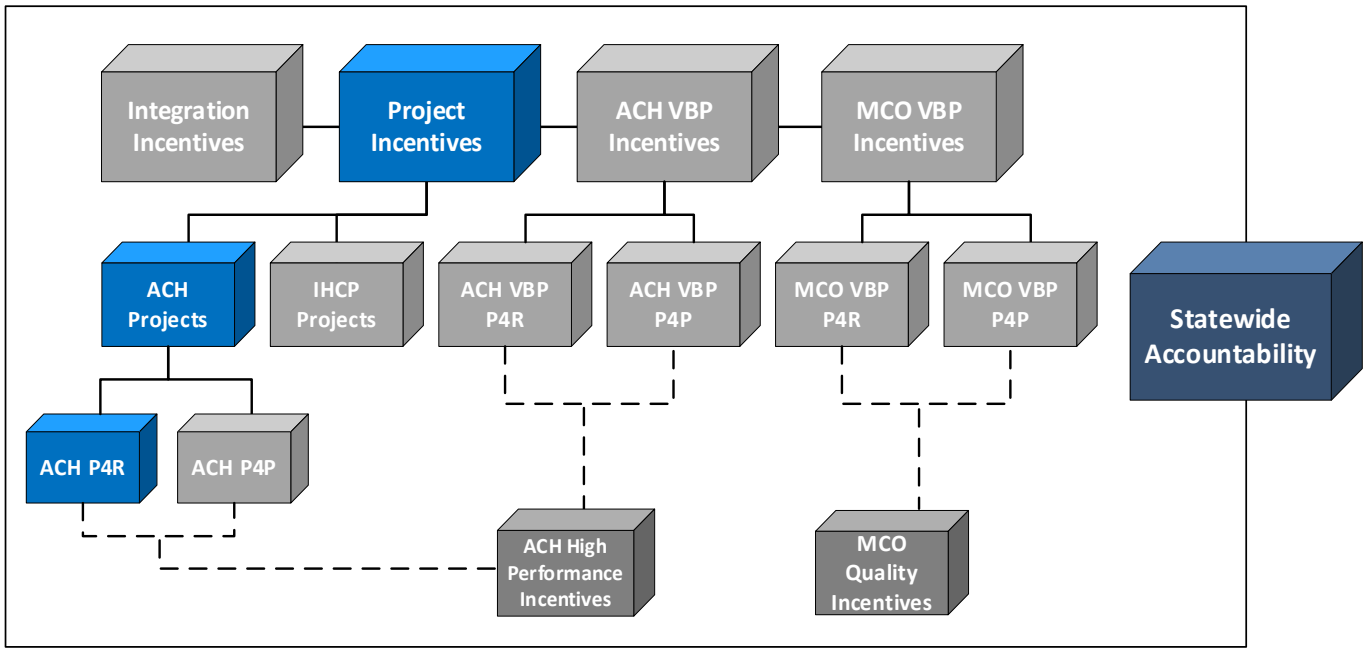
For more information, see Chapters 6 and 7.

Chapter 6: ACH project incentives – P4R

Overview

ACH project P4R is designed to incentivize the collection of valuable and actionable information the ACH and partnering providers are in the best position to collect. This information will support the IA, IEE, and the state in the monitoring and evaluation of MTP activities.

Figure 12: ACH accountability framework – project P4R



Available incentives

Incentives associated with P4R are earned from the ACH project incentives.

Table 28: percent of annual ACH project incentives associated with P4R

	DY1	DY2	DY3	DY4	DY5	DY6
ACH project incentives	100%	100%	75%	50%	25%	25%

ACH project P4R components

For each DY, a portion of annual ACH project incentives can be earned for:

- Reporting project implementation and operation information.
- Complete and timely submission of recurrent P4R deliverables.
- Completing defined milestones within the timeframes set by the state.

Achievement of P4R submission and milestone completion requirements are associated with AVs, which determine the amount of P4R project incentives earned for the reporting period. Successful completion of reporting requirements will require information from the ACH and ACH partnering providers. Each ACH is responsible for compiling information from partnering providers and submitting it to the state, on behalf of partnering providers, to meet the requirements of P4R.

As defined in the Project Toolkit, each ACH project is divided into three stages: planning, implementation, and sustainability. These project stages have defined milestones for which ACHs must provide proof of completion. In addition to reporting on the milestones for each project stage, ACHs are responsible for additional, recurrent P4R deliverables.

P4R milestones

P4R milestones are indicators of progress through the project planning, implementation, and scale/sustain stages, as defined in the Project Toolkit. Examples of milestones include:

- Completed current state assessment.
- Completed strategy development for Domain 1: health and community systems capacity building.
- Definition of evidence-based approaches or promising practices and target populations.
- Completion of initial partnering provider list.

Reporting on milestone completion will occur in SARs,[25] except for SAR 5, 6, 7, and 8, where these reporting requirements were made optional because of COVID-19 impacts. Milestones must be completed by the end of the reporting period in which they are associated. Milestones cannot be moved to earlier reporting periods, even if completed earlier. To see how milestones translate to AVs, see Table 31.

P4R recurrent deliverables

P4R recurring deliverables are the ACH's reporting mechanism for delivering project implementation and progress information to the state. A deliverable may include reporting on specific P4R milestones, P4R metrics, and ongoing project monitoring information. ACHs can earn P4R project incentives for timely completion and submission of P4R recurrent deliverables. Examples of deliverables include:

- Semi-annual reports
- Provider rosters
- P4R metrics
- Reporting on QIP

P4R metrics

P4R metrics are key deliverables, beginning in DY3 and continuing through DY5. They provide detailed information to HCA and ACHs about partnering provider implementation progress at a clinic/site level. Twice each year, ACHs will ask partnering providers to respond to a set of questions. This requirement became optional in DY4 through DY6. ACHs will report the responses to the state receive credit for timely reporting.

P4R metrics only pertain to project 2A or 3A. Only practice/clinic sites and community-based organizations (CBOs) affiliated with project 2A should respond to metric questions related to project 2A. Similarly, only practice/clinic sites and CBOs affiliated with project 3A should respond to metric questions related to project 3A.

Table 29: ACH project P4R metrics

Project	Site Type	Metric
2A	Practice/clinic	Level of physical and behavioral health integration at practice/clinic site (MeHAF site self-assessment survey).
3A	Practice/clinic	Provider use of guidelines for prescribing opioids for pain.
		Key clinical decision support features for opioid prescribing guidelines.
		Links to behavioral care and MOUD for people with opioid use disorders.
		Emergency department has protocols in place to initiate MOUD or offer take-home naloxone.
		CBO site is an access point in which persons can be referred for MOUD.

[25] View the Project Toolkit.

	Community-based organization (CBO)	CBO site provides services aimed at reducing transmission of infectious diseases to persons who use injection drugs.

Each P4R metric is specified for response at the level of the practice/clinic site or CBO. Some metrics, such as metrics related to improved opioid prescribing practices, may be important indicators of care transformation for practice/clinic sites but are not as applicable to the performance of CBOs. Similarly, some metrics address areas where CBOs have the potential to change outcomes for clients who have opioid use disorders or behavioral health needs but are outside the typical scope of practice/clinic sites that may focus on medical care.

P4R metrics have associated technical specifications for data collection. ACHs are not assessed on the responses provided by partnering providers, nor the response rate for the associated reporting period. Each metric specification includes a section of potential follow-up questions that reflect topics HCA would expect to pursue in such interviews. ACHs are welcome to use these questions in their internal data gathering as well. Technical specifications for the P4R metrics are available in Appendix K.

Assessment of progress and performance

With a few exceptions, ACHs will submit P4R deliverables semi-annually.[26] The table below illustrates the schedule of reporting periods and associated deadline for each deliverable. Recurring deliverables, such as the provider roster and P4R metrics, will be submitted to the IA on the same timeline as SARs.

Table 30: schedule of ACH project P4R reporting deliverables and associated reporting period

DY	Deliverable	Reporting period	ACH submission deadline
1 (2017)	• Project plan	N/A	Nov. 2017
2 (2018)	• SAR (#1) • Project milestone achievement • Standard SAR requirements	Jan. 1–June 30, 2018	July 31, 2018
2 (2018)	• Implementation plan	N/A	Oct. 1, 2018
2 (2018)	• SAR (#2) • Project milestone achievement • Standard SAR requirements • Provider roster	July 1–Dec. 31, 2018	Jan. 31, 2019
3 (2019)	• QIP (also known as ACH QIS)	N/A	July 31, 2019
3 (2019)	• SAR (#3) • Project milestone achievement • Standard SAR requirements • Provider roster • P4R metrics • Report on QIP	Jan. 1–June 30, 2019	July 31, 2019
3 (2019)	• SAR (#4) • Project milestone achievement • Standard SAR requirements • Provider roster • P4R metrics • Report on QIP	July 1–Dec. 31, 2019	Jan. 31, 2020
3 (2019)	• Mid-point assessment	Jan. 9, 2017–June 30, 2019	Dec. 31, 2019
4 (2020)	• SAR (#5) • Optional P4R metric reporting • Project milestone achievement • Standard SAR requirements • Provider roster	Jan. 1–June 30, 2020	July 31, 2020

[26] Implementation plans (DY2) are due outside the SAR schedule.

	• Optional P4R metric reporting • Report on QIP		
4 (2020)	• SAR (#6) • Optional P4R metric reporting • Project milestone achievement • Standard SAR requirements • Provider roster • P4R metrics • Report on QIP	July 1–Dec. 31, 2020	Jan. 31, 2021
5 (2021)	• SAR (#7) • Optional P4R metric reporting • Project milestone achievement • Standard SAR requirements • Provider roster • P4R metrics • Report on QIP	Jan. 1–June 30, 2021	July 31, 2022
5 (2021)	• SAR (#8) • Optional P4R metric reporting • Project milestone achievement • Standard SAR requirements • Provider roster • P4R metrics • Report on QIP	July 1–Dec. 31, 2021	Jan. 31, 2022
6 (2022)	• P4R (1) • Optional P4R metric reporting • Project milestone achievement • Standard SAR requirements • Provider roster	Jan. 1–June 30, 2022	April 2022
6 (2022)	• P4R (2) • Optional P4R metric reporting • Project milestone achievement • Standard SAR requirements • Provider roster	July 1–Dec. 31, 2022	Oct. 2022

AVs for P4R requirements

Each P4R reporting period is associated with a defined number of AVs. For example, milestones are outlined by demonstration year. For DY5, there are four milestones. Completion of SAR, completion/maintenance of partnering provider rosters, engagement or support in IEE activities, and report on QIP. Additionally, completing all SAR task earns an AV.

The average AVs for each project will be multiplied by the total P4R incentives associated with each project the ACH has chosen to pursue. Table 31 specifies the schedule and associated AVs for a given milestone or recurring deliverable.

Incentive payment determination

Starting in DY2, earned ACH project incentives for P4R are distributed semi-annually.

The IA is responsible for the review and assessment of all P4R components. The IA will calculate AVs based on meeting the reporting expectation during each six-month reporting period and use this to determine

earned ACH project incentive payment for P4R for the associated six-month reporting period. HCA has final approval authority.[27]

Table 31: sschedule of ACH project P4R Avs

Project P4R milestones, recurrent deliverables, and reporting components	Type	Reporting method	Project association	Potential earnable AVs									
				DY2 Q2	DY2 Q4	DY3 Q2	DY3 Q4	DY4 Q2	DY4 Q4	DY5 Q2	DY5 Q4	DY6 Q2	DY6 Q4
Completed current state assessment	Milestone	SAR	All	1									
Completed strategy development for Domain I (health and community systems capacity building)	Milestone	SAR	All	1									
Definition of evidence-based approaches or promising practices and target populations	Milestone	SAR	All	1									
Completion of initial partnering provider list	Milestone	SAR	All	1									
Completed implementation plan	Deliverable	IP	All		1								
Support regional transition to IMC (2020 regions only)	Milestone	SAR	2A		1								
Description of partnering provider progress in adoption of policies, procedures, and/or protocols	Milestone	SAR	All			1							
Completion and approval of QIP	Deliverable	QIP	All			1							
Description of training and implementation activities	Milestone	SAR	All				1						
Attestation of successfully integrating managed care (DY3 Q2 for early and mid-adopters; DY4 Q2 for 2020 regions)	Milestone	SAR	2A			1		1					
Description of scale and sustain transformation activities	Milestone	SAR	All						1				
Description of continuous quality improvement methods to refine/revise transformation activities	Milestone	SAR	All						1				
Demonstrate facilitation of ongoing supports for continuation and expansion	Milestone	SAR	All						1				
Demonstrate sustainability of transformation activities	Milestone	SAR	All						1				
Completion of semi-annual report	Recurrent deliverable	SAR	All	1	1	1	1	1	1	1	1		
P4R 1 - 2 report	Recurrent deliverable	SAR modified	All									1	1
Completion/maintenance of partnering provider roster	Recurrent deliverable	Provider roster	All		1	1	1	1	1	1	1	1	1

[27] The IA prepared a slide deck that describes the SAR review, implementation plans, and P4R AVs.

Identified HUB lead entity and description of qualifications	Milestone	SAR	2B		1								
Description of each pathway scheduled for initial implementation and expansion / partnering provider role and responsibilities to support pathways implementation	Milestone	SAR	2B				1						
Engagement/support of IEE activities	Milestone	SAR	All		1	1	1	1	1	1	1	1	1
Report on QIP	Recurrent deliverable	SAR	All			1	1	1	1	1	1	-	-
Address gaps in access and availability of providers offering recovery support services	Milestone	SAR	3A				1						
Completion of P4R metrics (All)	Recurrent deliverable	P4R metrics	2A, 3A			1	1	1	1	1	1	1	1

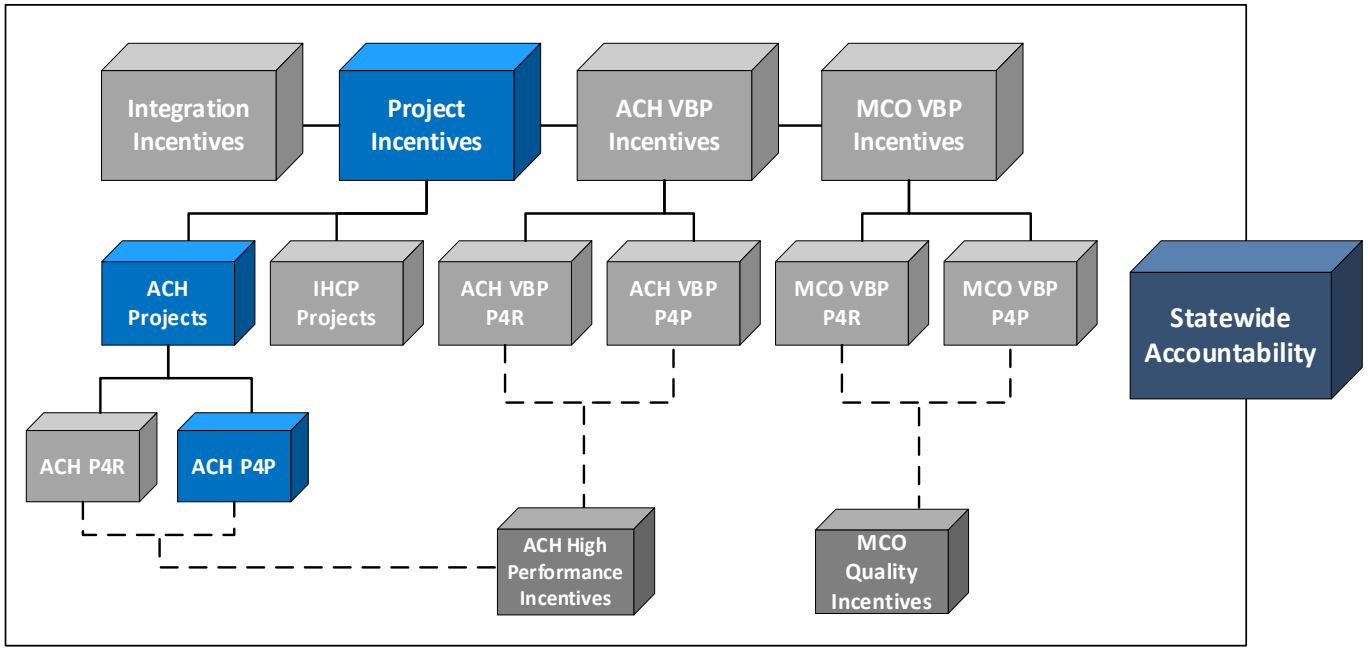
Chapter 7: ACH project incentives – P4P

Overview

ACHs are accountable for demonstrating improvements in outcomes for Medicaid beneficiaries residing in the ACH region. ACHs can earn P4P project incentives by demonstrating achievement and improvement toward ACH-specific improvement targets for project-specific metrics.

Improvement targets are determined based on prior ACH performance on the metric. The resulting ACH-level improvement and achievement are converted into AVs that determine what share of potential total P4P project incentives were earned for each project. ACH accountability for P4P metrics begins DY3, with some metrics added in DY4 and DY5.

Figure 13: ACH accountability framework – project P4P



Data required for ACH project P4P is collected, and results are calculated **by the state** for each ACH region. ACHs are accountable for all the Medicaid beneficiaries who reside in their region that meet the criteria of the P4P metrics (e.g., age, gender, and/or Medicaid coverage criteria) and regional attribution criteria. The calculation of P4P metrics is not limited to the Medicaid beneficiaries treated by partnering providers, nor is it limited to the scope of project activities ACHs implement within selected project areas.

Available incentives

Incentives associated with P4P are earned from the ACH project incentives pool. Performance on P4P metrics will determine the amount of P4P project incentives earned by the ACH. Project incentives are allocated by project.

Table 32: percent of annual ACH project incentives associated with P4P

	DY1	DY2	DY3	DY4	DY5	DY6
ACH project incentives	0%	0%	25%	50%	75%	75%

Earned ACH P4P payments are paid to the ACH through the financial executor (FE) portal once a year.

Performance metric selection

CMS approved ACH performance metrics as part of the approved the DSRIP planning protocol, the funding and mechanics protocol, and the Project Toolkit. The state selected ACH project P4P metrics according to the following criteria:

- Relevance to project objectives and applicability to transformation activities.
- Reflect of progress that occurred during the pertinent performance year.
- Feasibility of state metric producers to calculate according to DSRIP measurement timelines and incentive payment cycles.

The state will not add additional metrics for purposes of MTP incentives. However, situations may arise when a measure steward may retire or alter metric specifications. The metric modifications may be incorporated in DSRIP.

Data collection and calculation

Type of data collection

A guiding principle for the selection of Project Toolkit P4P metrics was the feasibility of producing results at the level of the ACH on an annual basis by the state. This ensures that incentive payments can be earned and successfully disbursed to provide the resources and investment required to achieve delivery system transformation. This approach also allows the state to take the full responsibility to produce P4P metric results on behalf of the ACH, using pre-existing administrative data collection systems.

Administrative data is generated by organizations over the normal course of providing and paying for services, and includes data from claims, encounter, enrollment, and provider systems. At this time, the state does not have comprehensive access to data contained in the medical record. Therefore, the state prioritized metrics that can be calculated from existing administrative data sources and did not require supplementary information and/or development of procedures to conduct statistically valid sampling of beneficiary medical records at the regional level.

Exception to administrative data collection approach in DSRIP

Three metrics associated with DSRIP statewide accountability rely on hybrid data collection to produce results:[28]

- Comprehensive Diabetes Care: Blood Pressure Control
- Comprehensive Diabetes Care: Hemoglobin (Hba1c) Poor Control
- Controlling High Blood Pressure

The hybrid approach to data collection requires supplementary information collected through statistically valid sampling of carefully reviewed medical chart data, in addition to administrative data. Currently, data collection procedures for these three metrics yield results for the state overall, and at the MCO level. Data are generated via annual MCO reporting requirements per terms of their contracts with HCA. MCOs are not required to report results at the regional ACH level.

Though these metrics are not included in the required project P4P metrics listed in the Project Toolkit because of data collection limitations at the ACH level, it is possible to attain statewide performance under the current metric production methods. HCA included these metrics in the DSRIP statewide accountability framework to ensure the state is held accountable for these important clinical quality outcome measures.

Source of P4P metric data

The state uses existing administrative data sources to extract and analyze the data. A primary data source for P4P metrics is HCA's MMIS, known as ProviderOne. In addition to administrative claims and enrollment

[28] See Chapter 2.

information contained in ProviderOne, some metrics require supplementary data sources. A summary of key data sources is defined in the table below.

Table 33: primary data sources for ACH project P4P metrics

Title	Description
ProviderOne Medicaid claims and enrollment data (MMIS)	The MMIS data includes all health care claims and encounters for Medicaid beneficiaries, enrollment periods, demographic, and address information. To represent the most complete data set for the performance period, the state will observe a six-month claims lag to account for processing time and data maturity. Example of metrics that require MMIS data: antidepressant medication management, comprehensive diabetes care: hemoglobin a1c testing
Vital statistics – birth and abortion data	Vital statistics data come from certificates of live birth, certificates of fetal death, certificates of death, certificates of marriage, certificates of dissolution, and reports from abortion providers. The forms for certificates are provided by the Washington State Department of Health (DOH). DOH's Center for Health Statistics registers only those vital events occurring in Washington State. Abortion reports are non-identified for both patient and facility and include only information on induced abortion. This includes all residents of Washington, and the data are updated annually. Example of metrics that require vital statistics data: Timeliness of Prenatal Care, Contraceptive Care – Postpartum
First Steps database (FSDB)	FSDB was designed to evaluate and monitor programs and services for low-income and other high-risk women and children in Washington State. Created and maintained by the Washington State Department of Social and Health Services (DSHS), Research and Data Analysis (RDA), the FSDB links: • Vital statistics • Medicaid claims eligibility data • Treatment and Report Generation Tool (TARGET)—the management information system used by the Division of Alcohol and Substance Abuse Case and Management Information System (CAMIS) files—maintained by Washington State Department of Children, Youth, & Families FSDB matches birth and death certificate information provided by DOH's Center for Health Statistics with the eligibility history and claims files from the Office of Financial Management and Health and Recovery Services Administration. Birth certification information is updated annually by DOH's Center for Health Statistics. To represent the most complete data set for the performance period, the state will observe a six-month lag for claims data to account for processing time and data maturity. Example of metric that requires First FSDB data: Childhood Immunization Status (Combo 10)
Washington State Identification System (WASIS) arrest database	The WASIS arrest database is maintained by Washington State Patrol. The database comprises arrest charges for offenses resulting in fingerprint identification. The database provides a relatively complete record of felony and gross misdemeanor charges but excludes some arrest charges for misdemeanor offenses that are not required to be reported. Updated information from the WASIS arrest database will be available quarterly with a six-month reporting lag. Example of metric that requires WASIS data: Percent Arrested
Automated Client Eligibility System (ACES) data system	The DSHS Economic Services Administration's ACES is used by caseworkers to record information about client self-reported living arrangements and shelter expenses. This information is used when determining eligibility for cash, food, and medical assistance. Updated information from the ACES data system will be available quarterly. Example of metric that requires ACES data: Percent Homeless

Reporting lag of P4P metric data

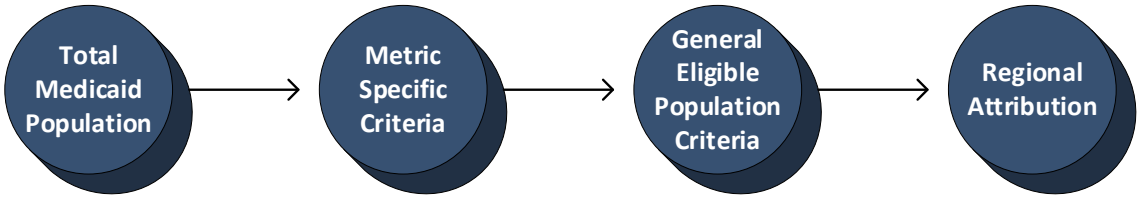
Under Washington State law (Washington Administrative Code (WAC) 182-502-0150(3)), providers have a year to submit initial claims for billing, with additional requirements outlined in MCO contracts (see ProviderOne Billing and Resource Guide). The state analyzed completion factors based on historical encounter data submitted to the MMIS. This completion factor analysis indicates that fewer than 90 percent of ultimately accepted encounters are uploaded and successfully accepted into the MMIS five months from the month the service was provided to the client.

Therefore, the state observes a six-month data lag before calculating P4P metrics to allow for reporting of information that is more complete. With additional processing time required to calculate the metrics and create the data products, the information in ACH data products tend to be nine to 12 months old. There are some exceptions to this around the P4P metrics reliant on the data from the FSDB.

P4P metric inclusion and exclusion criteria

Three types of criteria are applied in the metric production process. Metric specific criteria constrict the total Medicaid population to the specific subpopulation of focus for the metric. Eligible population criteria further narrow the population to the beneficiaries who meet project P4P Medicaid eligibility criteria. Finally, regional attribution identifies how to attribute a beneficiary to a single ACH for a given performance period.

Figure 14: application of P4P metric inclusion and exclusion criteria



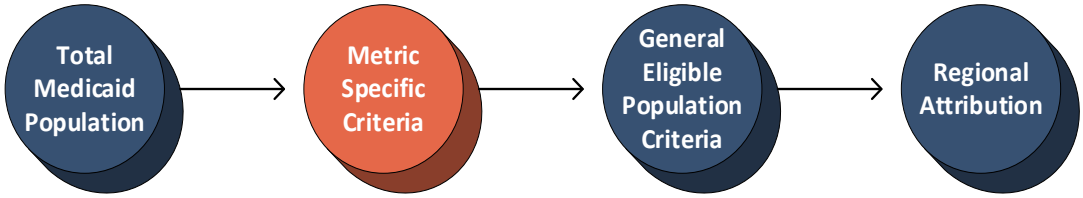
Technical specifications provide information about inclusion and exclusion criteria, as well as additional metric construction details for each P4P metric. Metric specifications are available on the Medicaid Transformation metrics page.

Metric-specific criteria

Metric specifications are developed by measure stewards to only include the population for which a particular service is recommended, or outcome is reported. To restrict measurement to this specific subpopulation, metrics specify inclusion or exclusion criteria. Some metrics are population-based, as it reports outcomes for all Medicaid beneficiaries who meet the basic eligibility criteria (e.g., **Percent Arrested** and **Percent Homeless**).

Other metrics may capture a more narrowly defined group within the ACH that meet additional criteria, such as diagnosis of a health condition (diagnosis-based, such as **Comprehensive Diabetes Care: Hba1c Testing**) or the occurrence of an event (episode-based, such as **Follow-Up After Hospitalization for Mental Illness**). Other metrics exclude beneficiaries who receive a particular set of services (such as excluding those in hospice care) or are only relevant metrics for one birth gender (e.g., **Timeliness of Prenatal Care**).

Figure 15: process for metric-specific criteria for calculation of ACH project P4P metrics



Age is another common inclusion or exclusion criteria that focuses metric results on the appropriate subpopulation for a given service or outcome. For example, for the metric **SUD Treatment Penetration**, information on SUD is not available for individuals under the age of 12. Therefore, the specification restricts the population to 12 years of age and older. In contrast, the **SUD Treatment Penetration – Opioid** metric is a modified version of the **SUD Treatment Penetration** metric.

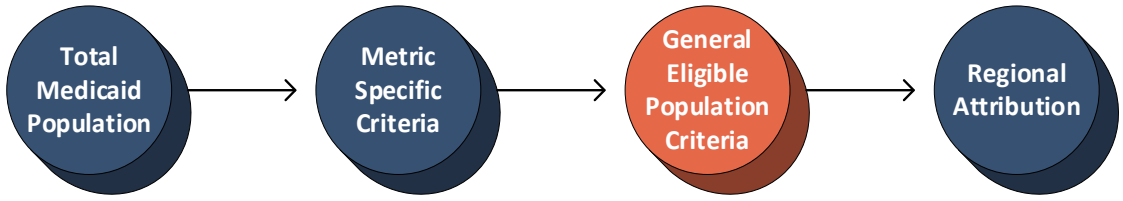
The opioid metric is tailored to measure experience of individuals with an identified opioid use disorder treatment need. The **SUD Treatment Penetration-Opioid** metric specifies 18 years of age and older criteria, as medication for opioid use disorder is not often prescribed to individuals under 18 years of age. By setting inclusion criteria at age 18 years and older (thereby excluding the 12-17-year-old subpopulation), the specification allows for more accurate measurement of treatment penetration.

Other metrics focus on services only available to children (e.g., Well-child Visits) or to adults (Statin Therapy) and the age restrictions ensure that the relevant population is being measured. Measure stewards may also specify the inclusion of individuals who are 65 years and older, but not dually eligible for Medicare and Medicaid. A large majority of individuals who make up this population are immigrants, as they are only eligible for Medicaid (new U.S. immigrants are not eligible for Medicare).

General eligible population criteria

There are three general eligible population criteria applied to all of project P4P metrics: (1) inclusion of Medicaid and SCHIP beneficiaries with comprehensive physical and behavioral health care benefits, (2) exclusion of beneficiaries who are dually eligible for Medicare and Medicaid and, (3) exclusion of beneficiaries with primary insurance other than Medicaid (TPL).

Figure 16: process for general eligible population criteria for calculation of ACH project P4P metrics



It is important to note the distinction between the eligible population criteria applied for the calculation of P4P metrics, compared to the ACH population counts used for the calculation of maximum potential ACH project incentives for all DYs. These are two separate methodologies. The ACH project incentives methodology is only used to set ACH project incentives thresholds by DY, whereas the eligible population criteria are used when calculating P4P metrics for each performance period.[29]

In addition, the general eligible population criteria used to calculate P4P metrics explains the difference in client counts that may be available on Apple Health enrollment reports, the Healthier Washington Dashboard, and other data resources.[30]

Inclusion of Medicaid and SCHIP beneficiaries

All P4P metrics include Medicaid and SCHIP beneficiaries with comprehensive physical and behavioral health care benefits, also referred to as full benefit Title XIX or Title XXI coverage. Four P4P metrics associated with **Project 3B: reproductive, maternal and child health** also include those who only qualify for the Family Planning Only Program (also known as Take Charge).

The Family Planning Only Program provides family planning services to men and women at or below 260 percent of the Federal Poverty Limit who are either uninsured and not eligible for Medicaid coverage or insured and seeking confidential family planning services.[31]

Because of the possibility of disruption in Medicaid coverage, most metrics have an "allowable gap" in coverage. This means that individuals who experience a lapse in Medicaid coverage (typically a short period, such as one month) may still be eligible for inclusion in metric results. Technical specifications define the allowable gap for each metric.

Exclusion of dual-eligible beneficiaries

For P4P metric calculation, individuals who are dually eligible for more than the metric specific allowable gap in enrollment will be excluded. The experience of dually eligible individuals cannot be fully accounted for because not all P4P metric producers have complete Medicare data available for ACH project incentive P4P

[29] See Chapter 5.
[30] See Appendix B.
[31] Visit the Take Charge page.

metric analysis.[32] Excluding duals from P4P metrics supports a consistent measurement approach that will ensure robust regional estimates over the MTP period.

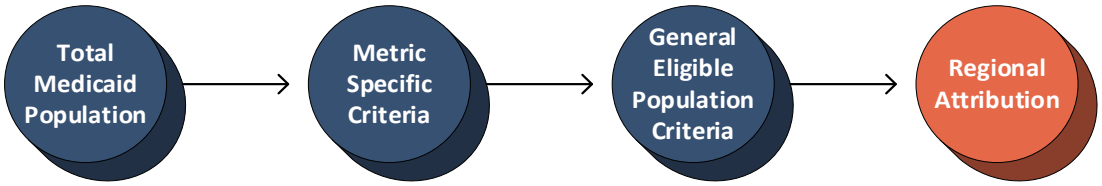
Exclusion of beneficiaries with primary insurance other than Medicaid (TPL)

Individuals with primary TPL (other primary health care coverage) for more than the metric specific allowable gap in enrollment will be excluded from P4P metric calculation.33 Mixed coverage affects the accuracy of metric reporting because it results in a non-comprehensive picture of health care encounters for an individual.

ACH regional attribution

For performance measurement, ACHs are accountable for individuals enrolled in Medicaid who reside in their ACH regions. The eligible population is not limited to people receiving care from partnering providers or service sites that are participating in project activities. Beneficiaries are included in P4P metric results according to ACH geographic boundaries and derived from residential addresses included in the Medicaid enrollment files. The physical address available in the measurement window is used to map a given beneficiary's address to a single ZIP code, county, and ACH.[34]

Figure 17: process for regional attribution for calculation of ACH project P4P metrics



For a Medicaid beneficiary to be attributed to an ACH P4P result, the residential address (or addresses) on file in the Medicaid enrollment files must consistently be within the ACH's geographic boundaries for the relevant measurement period. This methodology attributes a Medicaid beneficiary experience to a single ACH for a given measurement period.

This limits the population for performance measurement purposes to a relatively stable group of beneficiaries. This approach ensures the ACH is accountable for a population that was likely living in the region for much of the measurement period, based on the best available data, and likely to experience impacts from project activities. The objective is to establish an accountability structure that is fair and sets a reasonable performance expectation.

For most metrics, the residential address on file is required to be within the ACH geographic boundaries for 11 out of 12 months of the measurement period. Some of the metrics, however, measure a generally less residentially stable population and therefore have a lower residency requirement to prevent a substantial portion (greater than 15 percent) of beneficiaries from being unattributed to any ACH. Therefore, a subset of P4P metrics will use the less restrictive seven out of 12 months.

Table 34: ACH project P4P metrics with ACH regional attribution criteria of 7 out of 12 months

Metric name
All Cause Emergency Department (ED) Visits Per 1000-Member Months
Contraceptive Care – Postpartum
Percent Arrested

[32] See Chapter 8.
[33] TPL refers to the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all the expenditures for medical assistance furnished under a Medicaid state plan. Visit the Medicaid website for more information.
[34] Because people enrolled in the Address Confidentiality Program cannot be attributed to a county of residence, Medicaid beneficiaries enrolled in this program are excluded from the calculation of performance measures.

Percent Homeless (Narrow Definition)35
Periodontal Evaluation in Adults with Chronic Periodontitis
Primary Caries Prevention Intervention as Offered by Medical Provider
Timeliness Of Prenatal Care
Utilization Of Dental Services

Technical specifications for each metric are available on the Medicaid Transformation metrics page.

Calculating ACH improvement targets

The state is also responsible for calculating ACH-specific performance goals for each P4P metric, known as an improvement target. Improvement targets are reset for each performance year, according to the ACH's performance in the reference baseline year. Improvement targets are established for each of the metrics based on one of two methods: GTG or IOS. Visual representations of the ACH project P4P production, metric results and improvement target release cycle is available in Appendix C.

GTG

Metrics with available national Medicaid data (most NCQA metrics) will be measured using a GTG methodology.[36] The gap is defined as the difference between ACH reference baseline year performance and an absolute benchmark. The absolute benchmark for GTG metrics are set at the national 90th Percentile for Medicaid (based on administrative data only method of data collection), as calculated annually by NCQA Quality Compass. The expectation for earning full AV credit will be equivalent to closing the gap between reference baseline year results and absolute benchmark value by 10 percent, relative to the size of the gap.

Baseline GTG performance that exceeds absolute benchmark

At time of baseline and improvement target calculation, and in the rare case where an ACH is found to achieve the absolute benchmark, the metric will be dropped from associated projects for the performance cycle to further incentivize improvement in the remaining metrics. This is a DSRIP requirement, as defined in the DSRIP funding and mechanics protocol.

The state will assess results for the reference baseline year and determine whether any results for GTG metrics are above associated absolute benchmark. For example, if an ACH exceeds the target goal the absolute benchmark when the 2017 baseline is calculated, the ACH will not be accountable for that measure for the 2019 performance year. If the same ACH's 2018 baseline result does not exceed the associated absolute benchmark, the ACH will be accountable for that metric for 2020 performance assessment.

The value of the available incentives for the performance period are redistributed across the remaining metrics within a given project. The state will communicate any need to adjust the P4P metrics for which an ACH is accountable prior to the start of the associated performance measurement year when baseline results and improvement targets are released. Regardless of specification changes that may occur during the performance cycle, the notification of a dropped metric is final. A dropped metric will not be reintroduced for that performance period.

If an ACH exceeds performance on a submetric (but not all the submetrics) during baseline calculation, neither the parent metric nor the submetric is dropped. The ACH is eligible for full credit for the contribution by the high-performing submetric by sustaining high performance during the performance period. The approach avoids undue emphasis on the remaining age groups or treatment category when determining overall performance. AV calculations will proceed as specified in Appendix H.

[35] Beneficiary location information gathered during the eligibility determination process is sufficient to attribute most Medicaid beneficiaries who are homeless to a county for purposes of ACH regional attribution.

[36] Upon review of historical ACH/state performance data, some metrics with available national Medicaid data were placed in the IOS category to reflect the socioeconomic, demographic, and geographic characteristics of the ACHs.

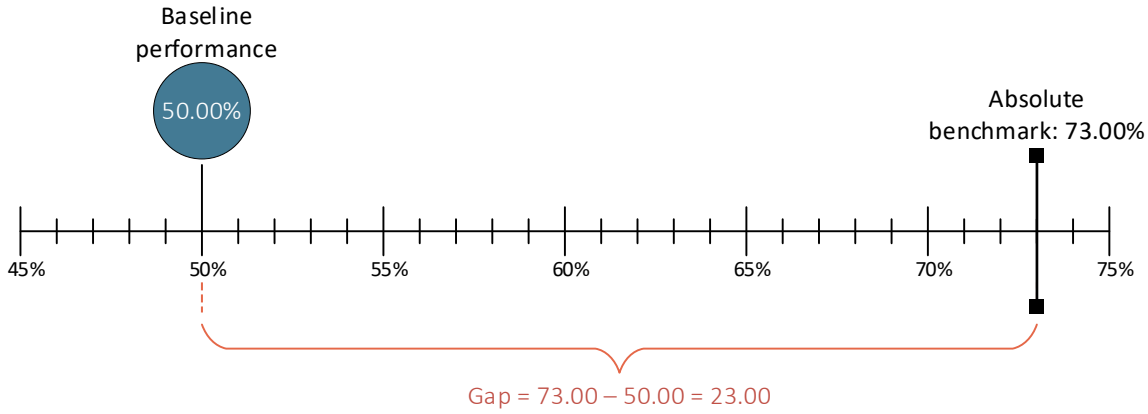
If a situation arises where **all** submetric results for a given GTG metric are above the associated absolute benchmarks at the time of initial baseline calculation, the entire metric is dropped for that performance cycle. Therefore, incentives for the associated payment period are redistributed across remaining metrics.

Significant modifications in specifications may occur for GTG metrics, thus requiring a recalculation of baseline results to ensure consistency in measurement (an "apples to apples" comparison of baseline and performance results). The extent of the specification changes is not known until **after** the associated performance year ends. Thus, if the ACH exceeds the final absolute benchmark after a re-run of baseline results, **the metric will not be dropped.** The ACH will receive full credit for demonstrating high performance during the performance period. Additional information can be found in the section: Continuous quality improvement and monitoring of ACH project P4P metrics.

Step-by-step: setting the improvement target using GTG

To illustrate the concept, suppose an ACH baseline performance for a given metric is 50 percent. If the absolute benchmark value for the metric is 73 percent, the gap is (73-50), or 23 percentage points.[37]

Figure 18: calculating the gap between ACH baseline performance and absolute benchmark



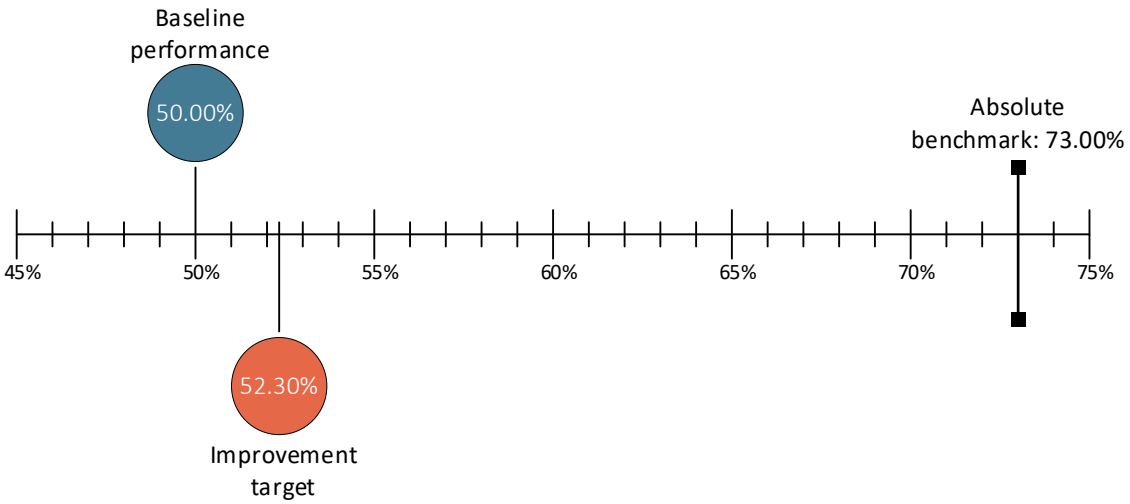
Ten percent of that gap is 2.30 percentage points. Therefore, the ACH would need to improve 2.30 percentage points to achieve the improvement target and receive full credit, as measured during the performance year.

Table 35: example: calculation steps to set improvement target using GTG

Determine ACH – specific improvement target	Description	Example
Establish gap amount	Gap = Absolute benchmark - ACH baseline result	73.00 - 50.00 = 23.00
Calculate 10% of the gap	Gap times .10 = gap reduction to meet improvement target	23.00 x 0.10 = 2.30
IT established by adding percentage point-gap reduction to ACH baseline result	Gap reduction + ACH baseline = improvement target	50.00 + 2.30 = 52.30

[37] The numbers used in these illustrations are examples only. No rounding will occur in any step of the calculation and the full, non-truncated result will be used to determine AV threshold performance.

Figure 19: setting the improvement target using GTG



The example above illustrates how to calculate the improvement target for GTG metrics where a higher value is better. The same methodology applies for metrics where a lower value signals improvement.

IOS

For other metrics, improvement targets will be set by IOS, a standard percent improvement relative to the ACH's reference baseline year results. Rationale for the inclusion of metrics in this category include a lack of available national and/or state Medicaid benchmark data, the metric was recently developed, and/or to account for regional variation in results beyond the ACH control (e.g., geography).

Improvement targets for IOS metrics are set to be consistent with the magnitude of change required to meet targets in the GTG methodology metrics. To assess the magnitude of improvement required to successfully close the gap by 10 percent (GTG performance expectation to earn full credit), the state evaluated historical ACH performance for the GTG metrics with available data.

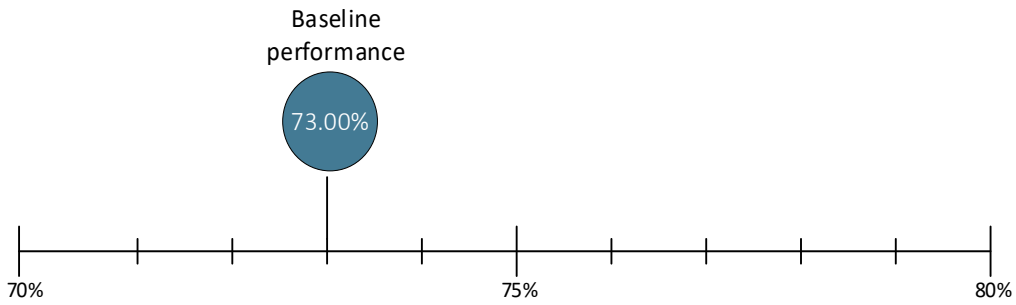
Based on the analysis, the median magnitude of change required to receive full credit for GTG metrics was 1.9 percent improvement over reference baseline performance. Therefore, the improvement expectation for DSRIP IOS metrics is set at 1.9 percent improvement over performance in the reference baseline year. The expectation for improvement is standard across all IOS metrics and will be consistently applied for all years of MTP.

Step by step: setting the improvement target using IOS

To illustrate, suppose an ACH's baseline result for a given metric is 73 percent.[38]

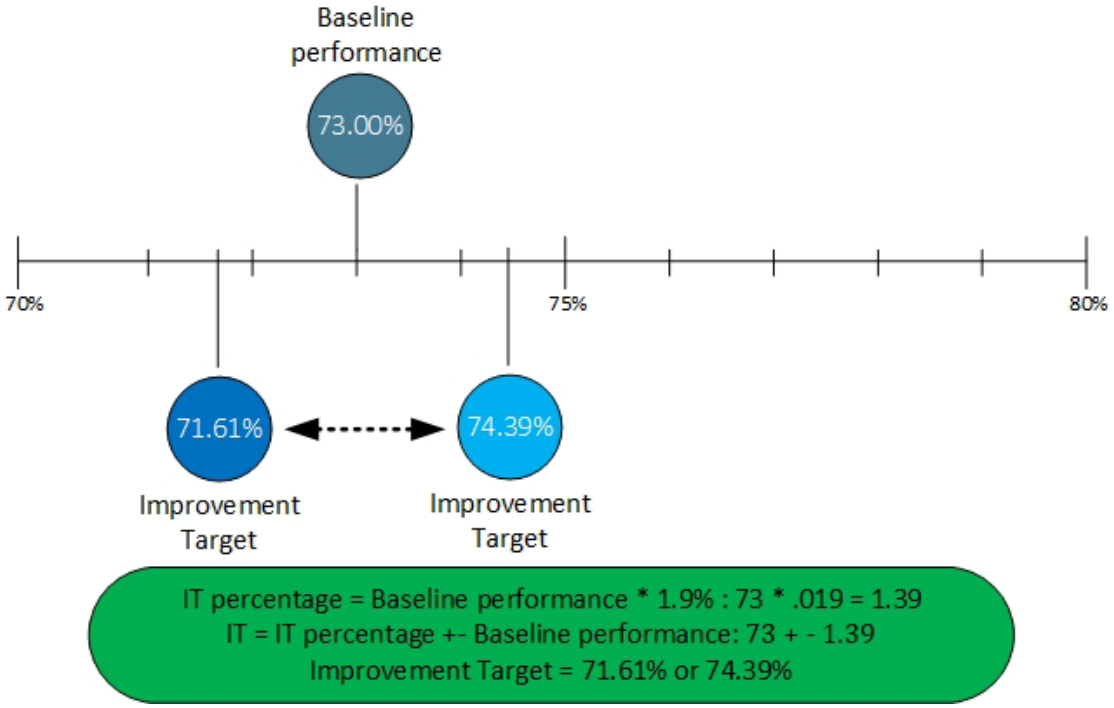
[38] The numbers used in these illustrations are examples only. No rounding will occur in any step of the calculation and the full, non-truncated result will be used to determine AV threshold performance.

Figure 20: example: improvement target set using IOS – establish baseline



The performance expectation is set by finding the equivalent of a 1.90 percent change over the reference baseline result. The improvement target is then established by adjusting the baseline result up or down by the percentage point change, depending on the directionality of quality improvement.

Figure 21: example: improvement target set using IOS – improvement target



For metrics where higher values demonstrate improvement, percentage point change is added to the reference baseline result. For metrics where lower values are better, the percentage point change is subtracted from the reference baseline result. In the example above, the improvement target for the performance period is 74.39 percent.

Table 36: example: calculation steps to set improvement target using IOS

Determine ACH – specific improvement target	Description	Example
Establish performance expectation according to the magnitude of improvement required, based on reference baseline year results	ACH baseline result times 0.019 = percentage point change required	73.00 x 0.019 = 1.39
Improvement target established by adjusting the baseline result by the percentage point change	For metric where higher value is better: ACH baseline result + percentage point change = improvement target For metric where lower value is better:	73.00 + 1.39 = 74.39 or 73.00 - 1.39 = 71.61

	ACH baseline result – percentage point change = improvement target	

Rounding P4P metric improvement targets and official results

The state will apply the following principles when producing P4P metric results and improvement targets:

- Performance determination – no rounding will occur in any step of the calculation and the full, non-truncated result will be used to determine AV threshold performance.
- Reporting – for public reporting and other data products, the state may apply rounding (e.g., visualization of results in publicly available dashboard) for readability.

Low count in numerator or denominator of P4P metrics

A guiding principle for the selection of Project Toolkit metrics was that the number of beneficiaries who met inclusion criteria for the measurement period (or the denominator) for the overall metric would be large enough to yield stable, robust estimates of performance.39 This principle minimizes the risk of results being subject to random variability over time. If a candidate metric could not reliably be assumed to hit a statistically valid threshold (n>=30) for the denominator at the regional level, then it was not considered a suitable metric to include in the ACH accountability framework.[40]

However, some metrics are comprised of submetrics. Metrics with age groups, for example, are most likely to encounter a low count in the denominator. To mitigate the risk of a low count in the denominator for a submetric, performance is determined by a weighted average of each submetric result, and weighting is determined by the number of Medicaid beneficiaries the ACH has in the denominator for each submetric. This approach ensures that having few or no members in the denominator does not disproportionally affect the overall P4P metric result and attainment of the associated AV.[41]

The numerator count is representative of the number of beneficiaries out of the total metric population who received or experienced the metric-specific qualifying event, service, or treatment. In the case where there is a zero (0) count in the numerator of a metric or submetric, the following process will be applied to determine the improvement target:

- The improvement target will be calculated per the method specified for that metric (GTG, IOS).
    - If the metric uses an **IOS** method, the zero (0) percent rate on the baseline will result in an improvement target of zero (0) percent (0 * 1.9 percent = 0 percent).
    - If the metric uses a **GTG** method, the improvement target will be to close 10 percent of the gap between the zero (0) percent baseline and the 90th National Percentile goal.
- For purposes of public reporting, suppression requirements will ultimately determine how results are presented for situations where there is a low count in the numerator or the denominator.

Translating P4P results to AVs

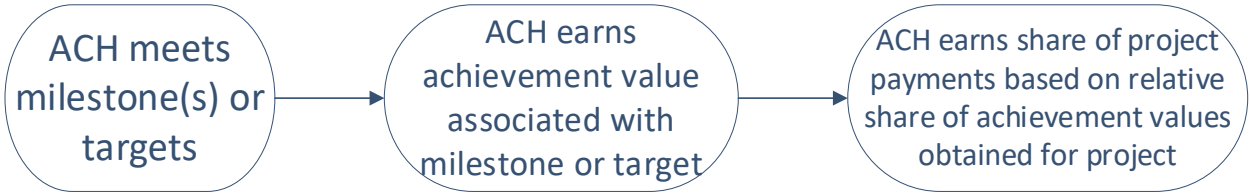
The state entities responsible for metric production will calculate results and submit to the IA for compilation into a single report. The performance results for the measurement period will be sent to the IA to assess earned AVs and to make final incentive payment determination.

[39] See Measurement Guide subsection reporting lag of P4P metric data.
[40] For the DSRIP program, the state determined a statistically valid threshold of a count of 30 to align with New York's DSRIP and California's PRIME program measurement approach.
[41] See Appendix I.

AV calculation for incentive payment adjustments

Within each performance cycle, an AV is calculated for each ACH for each metric. AVs drive payments from ACH project incentives. In the context of P4P, the maximum value of an AV is one (1.0), in the instance in which an ACH meets the designated improvement target. The amount of ACH project incentive P4P funding paid to an ACH will be based on the amount of progress made toward achieving its improvement target on each P4P metric.

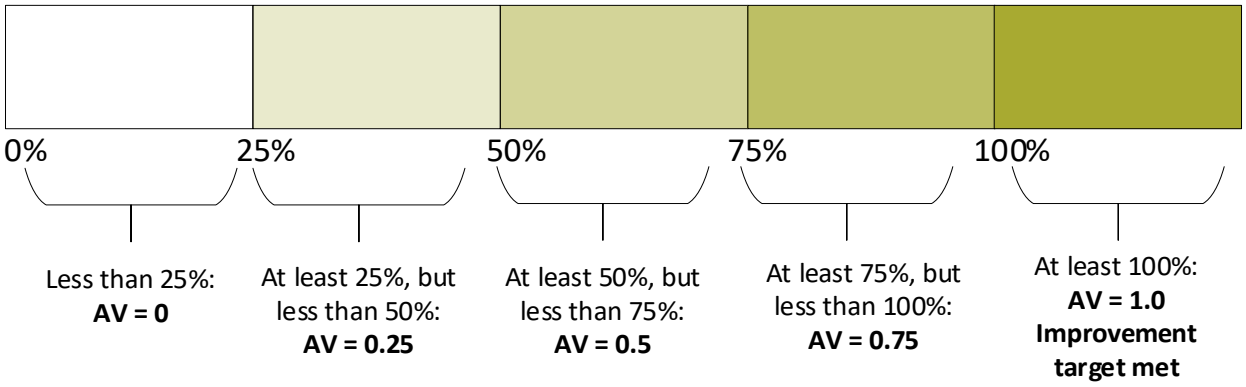
Figure 22: ACH project P4P incentive payment process



For P4P metrics, an ACH may earn AVs at various magnitudes based on meeting a minimum threshold of 25 percent of its improvement target in the performance year. If this performance threshold is not achieved, an ACH will forfeit the ACH project incentive P4P payment associated with that metric. Project P4P incentives that go unearned during the performance period can then be earned through the ACH high-performance incentive process.[42]

Enhanced AV valuation can be achieved if the ACH realizes a higher percentage of the improvement target, beyond the 25 percent threshold.

Figure 23: AV performance thresholds



Step by step: sample AV calculations

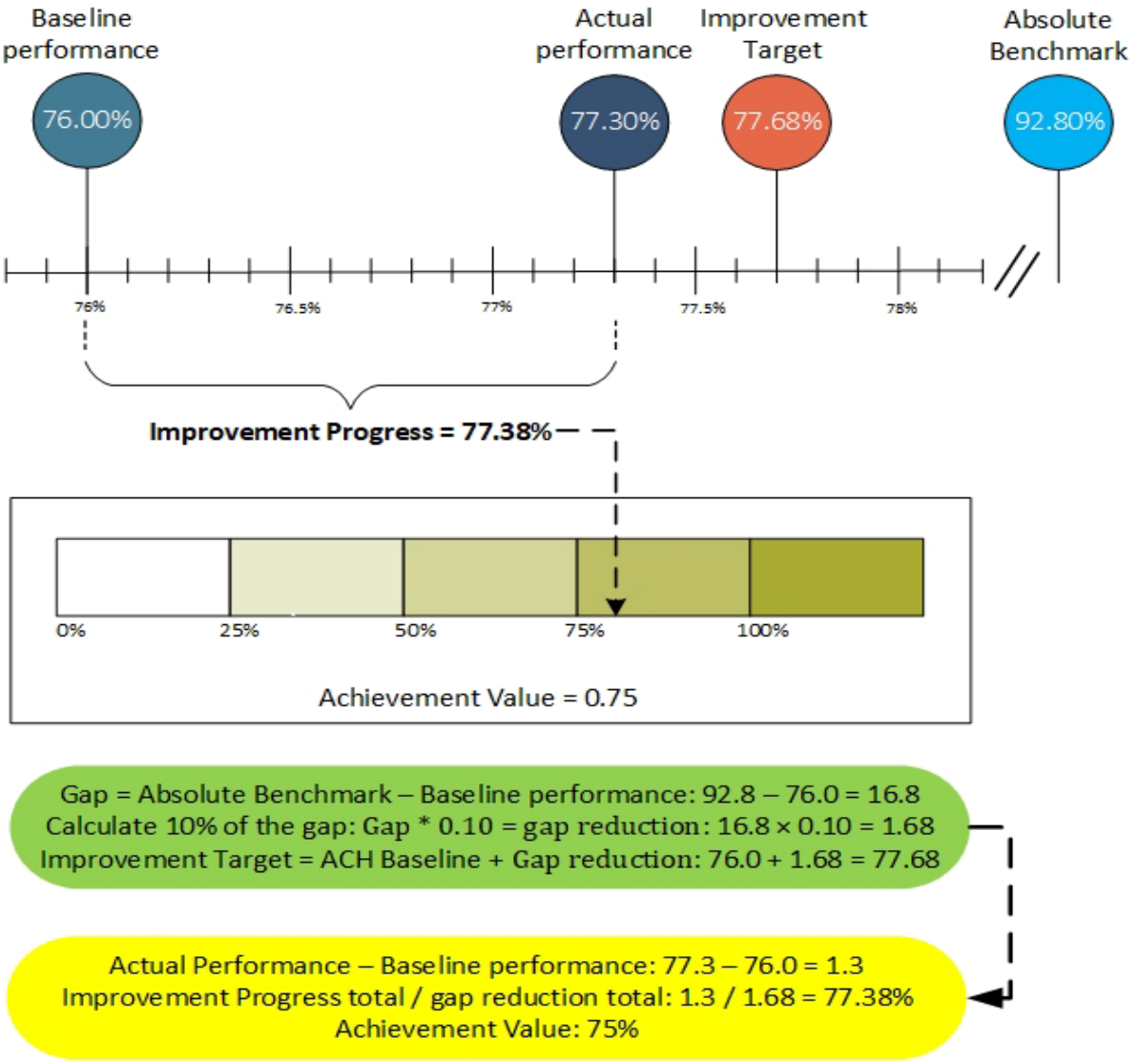
For a metric with a single rate, the results for that rate determine the AV for that metric. The following example uses a hypothetical P4P metric that uses the GTG method to set the improvement target (or, the performance expectation).

In the example, the ACH's baseline performance is 76 percent, and the improvement target is 77.68 percent (based on the metric absolute benchmark of 92.80). The ACH's actual performance is 77.30 percent, an improvement of 1.30 percentage points of the 1.68 percentage point improvement target.

The resulting 77.38 percent progress toward the improvement target from the baseline is between 75 percent and 100 percent, so it earns a 0.75 AV for that metric for each associated selected project.

Figure 24: example of translating performance for single metric result to AV

[42] See Chapter 8.



Additional examples of AV calculation are available in Appendix I.

TAV calculation by project

To determine TAV for each project in a payment period, the AVs earned within the project by the ACH are summed. From there, the PAV is calculated by dividing the TAV by the total of possible AVs for the project in that payment period. The purpose of the PAV is to represent the proportion of metrics an ACH has achieved for each project in each payment period and will be used to determine the distribution of dollars earned out of the maximum annual ACH project funding.

Step by step: sample TAV calculation for one project

The table below provides an example of how individual metric AVs contribute to the TAV for a given project area. In this instance, the ACH earned 84 percent of their total possible ACH project P4P incentives associated with Project 3A in this performance year.

Table 37: example TAV calculation (Project 3D)

Metric	Earned AV	Possible AV
Acute Hospital Utilization	0.75	1.00
All Cause Emergency Department (ED) Visits Per 1000-Member Months	0.75	1.00
Children's And Adolescents' Access to Primary Care Practitioners	1.00	1.00

Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	0.50	1.00
Comprehensive Diabetes Care: Hemoglobin A1c Testing	1.00	1.00
Comprehensive Diabetes Care: Medical Attention for Nephropathy	0.75	1.00
Medication Management for People with Asthma	1.00	1.00
Statin Therapy for Patients with Cardiovascular Disease	1.00	1.00
TAV	6.75	8.00
PAV	(6.75 / 8.0) = 84%	100%

P4P metric production cycle

Responsible entity for P4P metric calculation

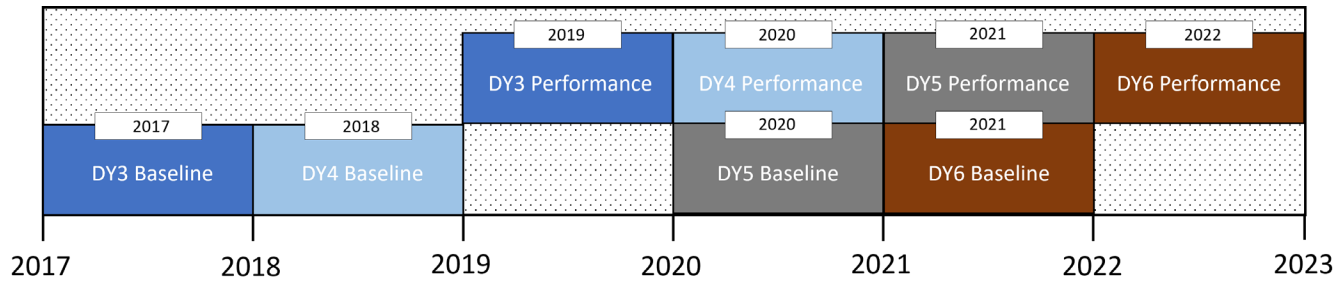
The state is responsible for annual P4P metric production on behalf of ACHs. HCA executed a contract with Providence Center for Outcomes Research and Education (Providence CORE) between October 2017 and June 2020 for DSRIP measurement support. As of July 2020, P4P metric production responsibilities are shared between HCA and RDA. ACHs are not responsible for and will not be collecting or reporting to the state on any data for P4P purposes.

Baseline results (including improvement targets) are released in the quarter prior to the beginning of the relevant measurement year (see Appendix C). For each performance cycle, HCA will report P4P metric results for a given performance period to the IA. The IA will calculate AVs for each project for each ACH, based on performance during the DY, and use this to determine earned ACH project incentive P4P payments for the associated DY for each ACH and project.

Measurement years for P4P metrics

P4P metric specifications require a 12-month performance period. For the purposes of ACH performance, the performance period will align with the DY. ACH progress toward improvement targets will be assessed based on reference baseline years that are separated by two years for the MTP period. This gap between baseline and performance measurement years is intended to allow time for project implementation to take effect.

Figure 25: ACH project P4P metric measurement years



Because of COVID-19, a modified approach will be taken for assessing DY4 performance. In July 2020, CMS approved flexibility for 2020 P4P AV calculations. The flexibility allows the state to compare results by metric (CY2019 regional results, CY2019 statewide average, or the CY2020 regional results). The IA will apply whichever result provides the greatest AV calculation.

Unofficial or example CY2019 and CY2020 data used and does not reflect actual or anticipated results.

Figure 26: P4P DY4 measurement flexibility

ACH	Metric	CY2018 baseline	Improvement target	CY2019 performance	CY2019 statewide avg.	CY2020 performance
ACH A	Antidepressant Medication Management: Acute	51.36%	52.69%	52.1%	51.3%	52.8%
ACH B	Antidepressant Medication Management: Acute	50.38%	51.82%	51.0%	51.3%	52.1%

ACH C	Antidepressant Medication Management: Acute	55.25%	56.20%	56.5%	51.3%	56.1%
ACH D	Plan All-Cause Hospital Readmission Rate	10.95	10.74	10.7	10.6	11.9
ACH E	Plan All-Cause Hospital Readmission Rate	8.47	8.3	8.5	11.9	10.1
ACH F	Plan All-Cause Hospital Readmission Rate	11.54	11.32	12.6	12.1	12.0

Improvement targets will be prospectively released prior to the start of the associated performance year.

Table 38: ACH Project P4P metric improvement target release schedule

Performance year	Improvement target available
DY3 (2019)	Fall 2018
DY4 (2020)	Fall 2019
DY5 (2021)	Fall 2020
DY6 (2022)	Fall 2022[43]

The following table outlines production cycle dependencies and associated timing for ACH P4P incentive payment, using DY3 performance measurement as an example. For each metric, assuming no major changes or updates in specifications, the improvement target (as calculated fall of 2018 (for baseline year 2017 data)) will be used to compare 2019 performance (calculated in the fall of 2020). The state, however, will continuously monitor for changes in specifications that may affect the comparability of the baseline and improvement target results to 2019 performance results.

Under Washington State law (WAC 182-502-0150(3)), providers have a year to submit initial claims for billing, with additional requirements outlined in MCO contracts. (Additional information is available in the ProviderOne Billing and Resource Guide. The state analyzed completion factors based on historical encounter data submitted to the MMIS.

This completion factor analysis indicates that fewer than 90 percent of ultimately accepted encounters are uploaded and successfully accepted into the MMIS five months from when the service was provided to the client. Therefore, the state observers a six-month data lag before calculating P4P metrics to allow for reporting of information that is more complete.

Visual representations of the P4P metric production cycle, including the metric results and improvement target release cycle, are available in Appendix C.

Table 39: summary of ACH project P4P metric production cycle (using DY3 performance cycle)

Year	Month	Task
DY1 (2017)	January–December	Baseline measurement year for DY3 P4P
DY2 (2018)	September–November	ACHs receive: • Baseline results • ACH-specific improvement targets • Notification of any dropped metrics because of baseline result that exceeds absolute benchmark
DY3 (2019)	January–December	• DY3 (2019) = performance measurement year • State monitors for changes in metric specifications by measure stewards
DY4 (2020)	January–June	• 6-month claims data lag for measurement year 2019 • State monitors for changes in metric specifications by measure stewards.
	July–August	1-2 months for data processing, verification, and validation

[43] HCA elected to wait for official approval of measurement periods from CMS. Approval was granted in March 2022. HCA will maintain refreshed data timelines for official baseline and performance updates in the fall of 2022 for DY5 and DY6.

	September	• Calculation of results for DY3 performance on P4P metrics completed • 1 month to run QI model on statewide accountability quality metrics and draft supporting documentation for CMS • State will submit statewide accountability report to CMS
	October–November	IA will score P4P AVs used to determine earned P4P project incentives and calculate ACH quality improvement QIS to determine eligibility for ACH high-performance incentives
	October–December	90-day review period for CMS review and approval of statewide accountability report findings[44]
	December	Calculation of final DY3 P4P total incentives completed, based on amount of statewide accountability withheld incentives earned per CMS.
DY5 (2021)	January–April	Up to 4 months to: • Adjust total ACH project incentives based on statewide performance • Apply AVs to determine earned P4P project incentives ACH incentives • Identify total unearned incentives • Apply ACH QI model to identify ACH-level DSRIP high-performance incentives • Payments made in Q2 to align payment timing with second DY4 project P4R payment

Validation

Validation is an integral component of measurement production. The goal of validation is to ensure the type of measure and what it is intended to measure across contexts (e.g., different geographic areas) and time-periods. Validation steps include:

- Subject matter expert review of metric specifications.
- Peer and/or supervisory review of code.
- Replication of results by another metric producer.[45]
- Comparison of results to another metric producer's results.
- Comparison of results to previous years/quarters.
- Comparison to similar metrics in another context.

Validation is an ongoing process, and each metric production cycle will include some of these validation activities. The extent of validation activities each production cycle is dependent on what has occurred since the previous production cycle. For example, the validation that occurs for the addition of new medications in a metric specification will be different from the validation that occurs if a substantial change to a metric specification is needed.

Continuous quality improvement and monitoring of ACH project P4P metrics

Situations may arise when the measure stewards retire or alter metric specifications to reflect changes in clinical care guidelines, treatment recommendations, or current health care practices. To align with changes, such metric modifications may also be incorporated in DSRIP. The following sections describe the steps the state will take to monitor for changes with potential impacts in the context of ACH project P4P measurement.

[44] This step only applies to statewide accountability; it does not pertain to ACH project P4P metric results.
[45] Threshold for concluding replication activities is 0.1% unresolved difference between measure producers. Validation via replication is not possible for all measures because of restrictions on sharing maternal/child health data and some behavioral health data.

Metric retirement and specification modification

Should the measure steward retire or substantially modify the specifications, the state may accept retirement or modifications to keep DSRIP metrics relevant and meaningful. To that end, the guiding principles for the incorporation in DSRIP metrics are as follows:

- Clinically relevant and meaningful quality metrics reflecting recommended care and current health care practices.
- Alignment and consistent use of metric specifications for DSRIP and core sets used by other programs or initiatives in Washington when applicable.

Based on the situation, notification of CMS, stakeholders, and partners will depend on the scope of impacts and dependencies of the decision. For example, the decision to adopt changes in a few codes in a value set to calculate a metric may be reflected in routine updates of the Measurement Guide. If, however, a metric change has substantial effects on performance goals based on national standards, notification of CMS prior to implementation may be required and will be considered on a case-by-case basis.

The method of implementing the change and its effects on the absolute benchmark and improvement target may be dependent on the following factors:

- Necessity of implementation (concordance with clinical guidelines and/or benefit structure).
- Availability of a replacement metric for retired metric.
- Ability to compare results based on the revised specification to previous results, or to re-calculate previous results with the modified specification.

Monitoring for potential impacts of specification updates for ACH P4P production cycle

Two years separate the baseline DY and performance DY for each ACH P4P cycle. While the two-year gap allows time for transformation activities to take effect, there is risk that performance metric specifications may change during the period between baseline and performance years.

Metric specifications can change yearly, and changes may be substantial over a two-year period. Changes in metric specification generally represent improvements in measurement. These changes may include the addition of newly created or required procedure codes, new approved medications for the treatment of conditions, or may reflect changes in Medicaid billing practice. Such changes may also reflect wholesale changes in how a measure steward defines a particular measurement concept.

A substantial change could have a large effect on the numerator, denominator, and/or metric result. Substantial changes in metric specifications have occurred in the past and it is possible that they may occur during MTP.

To ensure consistency when comparing baseline and performance year results, the state will use information from measure stewards to evaluate the degree of change. For HEDIS™ metrics, NCQA evaluates and releases information about impacts on benchmarks.[46] They identify four possible scenarios when comparing metrics across years:

- **No trending impact:** no measure specification changes or insignificant change.
- **Caution flag:** slight measure specification change, but not significant enough to effect trends (and thus year over year comparison).
- **Break in trending:** measure specification changes greatly and an impact to benchmark trending is expected.
- **First-year status:** measure specification changes so much that NCQA treats the measure as a new measure and no trend data is reported (and previous benchmarks are not comparable).

If metrics are identified as **no trending impact** or **caution flag**, the benchmarks and improvement targets set during the baseline year will not change. If a metric is identified as a **break in trending** or **first-year status**,

[46] For more information, visit the NCQA website.

the state will evaluate the appropriateness of the metric. If the metric is deemed to be inappropriate for comparing to the previously calculated baseline, the state will determine if the baseline and associated benchmarks and improvement targets need to be recalculated using the updated specifications. **Note**: substantial changes are expected to be the exception to the norm.

For non-NCQA stewarded metrics, a similar process will be completed. Non-NCQA measure stewards include RDA, HCA, the Bree Collaborative, and DQA. HCA will release a summary of DSRIP metric changes and projected impacts each year.

As part of the ongoing monitoring process, P4P metric producers will be re-calculating all P4P metrics with the most recent specifications each year. Thus, longitudinal data will be available for comparison. The state will use this trend data to monitor the impact of specification updates and help inform decisions about updating previously set baselines, benchmarks, and improvement targets.

Chapter 8: ACH high-performance incentives

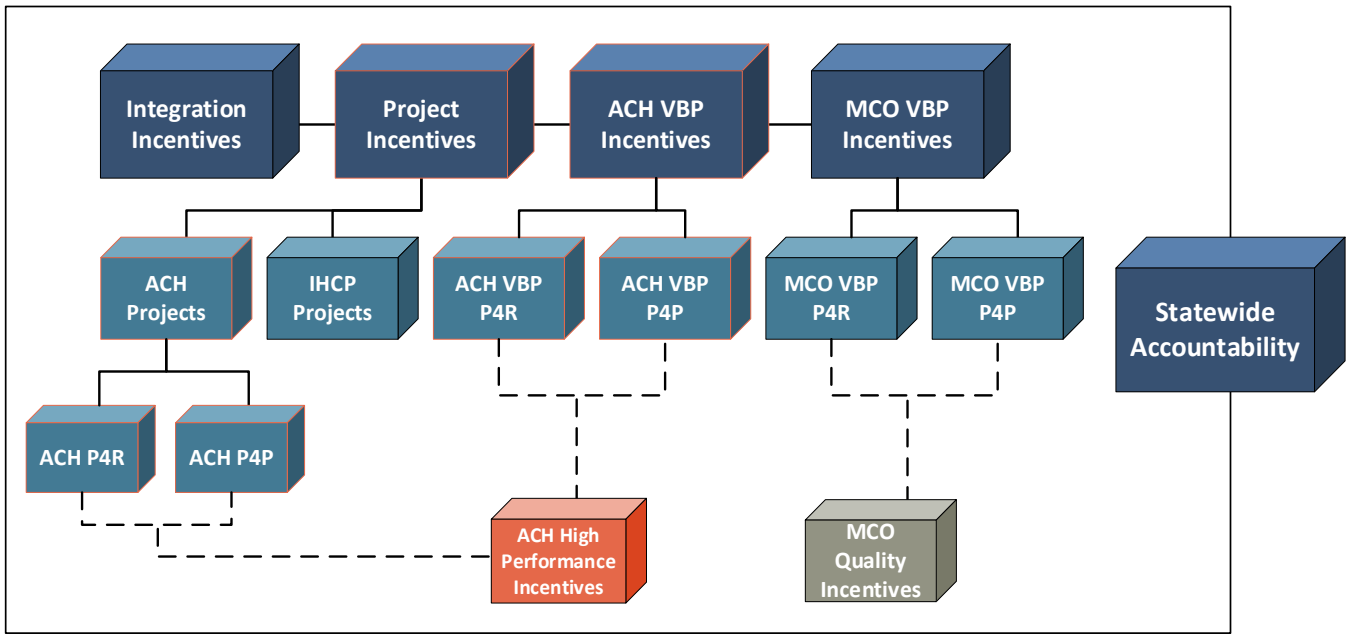
COVID-19 impacts

As of August 2020, no changes have been made to the ACH high-performance incentives approach because of the pandemic. This is subject to change in future years.

Overview

ACH high-performance incentives serve as an opportunity to reward high-performing ACHs with a chance to earn additional DSRIP incentives. Starting in DY2, incentives may be available for ACH high-performance incentives based on total incentives unearned through ACH VBP incentives (reinvestment pool) and ACH project incentives (both P4R and P4P).

Figure 27: ACH accountability framework – high-performance



A guiding principle for rewarding high-performing ACHs is to incentivize meaningful improvement across a set of health outcome metrics, while not disadvantaging those regions that may be starting from a lower baseline level of performance. The ACH high-performance incentive methodology rewards both attainment of quality targets and improvement in quality metrics. The underlying rationale includes:

- Consistency in use of QI model across incentive payment contexts.
  - Similar models are used in MCO contract quality withholds, MCO VBP incentives (challenge pool) unearned incentives distribution based on quality metric performance, and DSRIP statewide accountability.
  - Consistency with MTP STCs and protocols.
- Incentivizing high-performance and on-going improvement on P4P metrics that overlap with statewide accountability quality metrics.
- An opportunity for ACHs to earn otherwise unearned ACH project and VBP incentives.

Available incentives

The amount of available incentive funding depends on the extent to which ACHs earn available ACH project incentives and ACH VBP incentives. ACH high-performance incentives are only available if at least one ACH does not meet the criteria for full credit for one of these sets of incentives.

Methodology

Metrics

The state defined a set list of nine high-performance metrics that will apply to all ACHs for all years of MTP. The metrics overlap with ACH project incentive P4P metrics and reinforce statewide accountability objectives. The rationale for metric selection includes:

- Seven of nine metrics overlap with DSRIP statewide accountability quality metrics.
- Six of nine metrics are associated with at least one of the required projects all ACHs implement.
- Two metrics reinforce the importance of social determinants of health in the Medicaid population.

Table 40: ACH high-performance metrics

Metric name
All-Cause Emergency Department Visits Per 1,000-Member Months*
Antidepressant Medication Management
Asthma: • **DY3: Medication Management for People with Asthma** • **DY4 – DY6: Asthma Medication Ratio**
Mental Health Treatment Penetration (Broad Definition) *
Percent Arrested*
Percent Homeless (Narrow Definition) *
Plan All-Cause Readmission Rate (30 Days) *
SUD Treatment Penetration*
Child And Adolescents Well-Care Visits 3-11 Years of Age

In general, the metric specifications and inclusion and exclusion criteria will be consistent with those used for ACH project incentives P4P. For six of the nine metrics, however, (those marked with an asterisk in above table) the metric specifications will include individuals who are dually eligible for Medicaid and Medicare for the purposes of ACH high-performance incentives.

The state is monitoring the dual experience and to make sure the program has no adverse effect on duals. The state will include the dually eligible population for metrics for which full Medicare and Medicaid data are available.

Definition of measurement years

The performance year is compared to a baseline year of two years prior, in line with the measurement approach for ACH project incentive P4P metrics.

Table 41: ACH high-performance measurement years

DY	Performance year	Baseline year
2	2018	2016
3	2019	2017

4[47]	2020	2018
5[48]	2021	2020
6	2022	2021

QI model

To calculate relative high performance among ACHs, the state will use a model that evaluates quality improvement across the set of high-performance metrics. The parameters of the model are defined to account for variability in ACH baseline performance. At a high level, the following outlines how the QI model works in the context of ACH high-performance assessment:

- The QI model measures both quality attainment and degree of improvement for each metric.
- ACHs will be evaluated across the full set of high-performance metrics for each assessment, regardless of baseline performance results.[49]
- ACH performance across the nine metrics will be used to generate a QI composite score, or QIS, with each metric weighted equally.
- The QI model produces the following metric-specific output for each metric:
    - A metric quality score compares the performance year result to a range set by the lowest performing ACH result during the baseline measurement year (quality score baseline) and a metric target.
        - If NCQA data is available, then the metric target is defined as the NCQA national 90th Medicaid Percentile.
        - If NCQA data is not available, then the metric target is set at 10 percent improvement relative to the metric statewide result at baseline.
    - A metric improvement score compares the performance year result to the range bounded by the ACH's baseline performance (improvement score baseline) and the metric target.
    - The metric quality score and metric improvement score are aggregated into a QI metric score with the use of a weighted average in which the metric quality score is increasingly weighted with higher performance.
- The aggregated QI metric scores are then aggregated across all high-performance metrics to generate a QIS that reflects the ACH region's performance across the set of high-performance metrics.

Calculating results

The state will use the same production processes as performed for ACH project incentive P4P metric results. The results generated though P4P production will be used as inputs for the QI model, except for the six metrics specified to include dually eligible individuals. The IA will receive metric results and calculate the high-performance QIS for each ACH.

Eligibility for incentives and allocation methodology

A guiding principle for incentives allocation was to incentivize relative high performance using a QIS that reflects a range of health outcomes, while allowing lower performing ACHs to earn at least a portion of incentives that they may need to make the investments necessary to improve performance.

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[47] The state will compare results for DY4 by metric (CY2019 regional results, CY2019 statewide average, or the CY2020 regional results). The IA will apply whichever result provides the greatest AV calculation.

[48] CMS approved a year-over-year baseline to performance outcome for DY5 and DY6. This is support of continued efforts to stabilize performance measurement after COVID-19.

[49] Metrics will not be removed from the high-performance set if an ACH is above the absolute benchmark at baseline for project P4P, nor if the metric result is above the metric target in the QI model at baseline. All ACHs are assessed on the same nine high-performance metrics for each performance period.

For each performance period where ACH high-performance incentives are available, all ACHs are eligible to earn a portion of incentives, regardless of ACH performance on project P4P metrics. There is no performance threshold for eligibility.

Incentives are distributed according to the ACH's relative QIS and adjusted for regional population size. If underlying performance is similar across regions, then the population adjustment has the effect of allocating incentives proportionate to the covered lives in the ACH region. To see how this works, see Appendix E.

Relative regional population proportions will be calculated for each performance year. Population adjustment will reflect the balance of covered lives in the region, based on the November client-by-month file during the performance measurement year.[50] Regional population proportions will reflect:

- Medicaid and SCHIP beneficiaries with comprehensive physical and behavioral health care benefits, also referred to as full benefit Title XIX or Title XXI coverage.
- Medicaid beneficiaries with both Medicaid and Medicare coverage (those who are dually eligible).

Timing of earned incentives and disbursement

First, the state and IA complete the assessment of ACH project incentive P4R/P4P and ACH VBP incentive (reinvestment pool) P4R/P4P attainment to determine the amount, if any, of unearned incentives available for ACH high-performance incentives for a given DY.

ACH high-performance incentives are awarded based on performance in the same DY. Therefore, ACH high-performance incentives follow a similar lag as the ACH project incentive P4P results to allow time for the data to mature and calculation to occur. For example, incentives that are unearned in DY2 are available to be earned for DY2, with payment transfers from HCA to the FE in Q2, DY4. For information about measurement and payment timelines, see Appendix C.

[50] This is like how regional attribution was defined for maximum ACH project incentives, although in that case the populations are not updated after November 2017 and exclude dually eligible individuals. For more information, see Chapter 5.

Appendix A: glossary of terms

Table 42: DSRIP accountability and measurement – glossary of terms

Term	Acronym	Definition
Accountable Communities of Health	ACHs	ACHs are independent, regional organizations. They work with their communities on specific health care and social needs-related projects and activities. This work seeks to improve the health of people in Washington State. ACHs play an integral role in Washington's MTP efforts. Although MTP is Medicaid-focused, ACHs are working in many ways to improve the health of their communities. There are nine ACHs in Washington State.
ACH high-performance metrics	-	The subset of project P4P metrics that ACHs can earn unearned DSRIP project incentives for high performance.
Achievement value	AV	Point values assigned to each P4R and P4P milestone, deliverable, and metric that drive incentive payment calculations. Maximum value of one (1.0).
Attribution	-	Assignment of Medicaid beneficiaries to an ACH, MCO, and/or performance metric.
Baseline year	-	Indicates the measurement year in which baseline performance is assessed, and from which improvement is measured for the associated performance year.
Centers for Medicare & Medicaid Services	CMS	The federal authorizing agency for Washington's MTP.
Delivery System Reform Incentive Payment	DSRIP	DSRIP is a strategy to accomplish delivery system reform. The term "DSRIP incentives" refers to the type of money available to pay for regional transformation projects. These incentives are a vital tool to transform the Medicaid delivery system to care for the whole person and use resources more wisely. DSRIP is not a grant. It is a time-limited performance-based incentive program for earning incentives through achievement of milestones and outcomes.
Demonstration year	**DY**	Refers to a year within the MTP period. DY1 was the first year of MTP, which began January 2017. DY6, the last year of MTP, ends December 31, 2022. **DY1: 2017** / **DY2: 2018** / **DY3: 2019** / **DY4: 2020** / **DY5: 2021** / **DY6: 2022**
DSRIP funding and mechanics protocol	-	Describes the role and function of standardized ACH reports to be submitted quarterly to the state, allocation formula and parameters for incentive payments, the state's process to develop an evaluation plan, and incentive contingencies.
DSRIP planning protocol	-	Describes the ACH project plans, the set of outcome metrics that must be reported, transformation projects eligible for DSRIP incentives, and timelines for meeting associated metrics.
Eligible population	-	All beneficiaries attributed to the ACH, according to record of residence, who qualify for the metric (not limited to partnering providers or service sites).
Gap-to-goal	GTG	Performance expectations based on the difference between ACH reference baseline year performance and the absolute benchmark (set at the national 90th Percentile for Medicaid).
Healthcare effectiveness data and information set	HEDIS	A tool used by more than 90% of United States health plans to measure performance on important dimensions of care and service.
Improvement-over-self	IOS	The percentage improvement expectation for metrics not measured through GTG in which the percent improvement relative to the ACH's reference baseline year results.
Improvement target	-	ACH-specific improvement expectation, based on prior ACH performance for the metric.
Incentives	-	Incentives available to be earned for achieving required performance.

Independent assessor	IA	State-contracted entity that monitors ACH projects and milestone achievement, calculates AVs, and determines incentive payment amounts earned for each reporting period.
Managed care organization	MCO	State-contracted organizations that provide health care services for Medicaid beneficiaries.
MCO quality metrics	-	Seven metrics that MCOs can earn challenge pool incentives based on quality and improvement. See HCA's managed care page for more information.
Medicaid Transformation Project	MTP	Aims to transform the health care delivery system to address local health priorities, deliver high-quality, cost-effective care that treats the whole person, and create sustainable links between clinical and community-based services.
NCQA quality compass	-	A tool used for examining quality improvement and benchmarking plan performance using HEDIS data.
Pay-for-performance	P4P	State-calculated achievement and/or improvement on quality or VBP performance measures.
Pay-for-reporting	P4R	Entity-reported information and progress on key process milestones.
Percentage AV	PAV	Represents the proportion of total available AVs earned for the relevant payment period for the project or VBP by an ACH or MCO, used to determine the incentives earned out of the maximum possible funding. Calculated by dividing the weighted total of possible AVs for the project in a payment year.
Performance year	-	Indicates the measurement year in which performance is measured and for which incentives are being earned.
Project Toolkit	-	Provides additional details and requirements related to ACH projects and assists ACHs in developing their project plans.
Quality improvement composite score	QIS	A composite score representing quality attainment and improvement on measures.
Quality improvement model	-	The methodology to generate a QIS based on the weighted average of a set of measures.
Special terms and conditions	STCs	Details the nature, character, and extent of federal involvement in MTP, the state's implementation of expenditure authorities, and the state's obligations to CMS during the MTP.
Statewide accountability components	-	Ten quality metrics defined in the DSRIP funding and mechanics protocol, VBP attainment targets, and integration requirement.
Total AV	TAV	Total of the summed AVs for an ACH for a given performance period.
Value-based purchasing	VBP	VBP is a strategy used to improve the quality and value of health care services a person receives. VBP ensures health plans and health care providers are accountable for providing high-quality, high-value care and a satisfying patient experience. This strategy is consistent with the HCP-LAN APM Framework and MACRA, aligned with broader U.S. Department of Health and Human Services' delivery system reform goals.
VBP attainment targets	-	Targets based on the percentage of Apple Health MCO payments to providers that fall into Categories 2C-4B of the HCP-LAN APM Framework, starting in DY1, with progressive targets throughout MTP.
VBP Roadmap – Apple Health Appendix	-	• Reflects specific initiatives and changes to the Medicaid program. • Describes how managed care is aligning with MTP. • Establishes targets for VBP attainment and related incentives under the DSRIP program for MCOs and ACHs.

Appendix B: resources for monitoring DSRIP progress

The performance metrics selected for the DSRIP program are not intended to include all social and health indicators that show progress or improvement resulting from transformation activities. For DSRIP, the state prioritized metrics based on:

- Their relevance to MTP goals.
- The state's ability to calculate results of activities during the associated measurement period.
- The time required to distribute performance-based incentive payments.

The state will monitor transformation progress not only as it relates to the broad accountability metrics, but also across sub-populations, and in conjunction with existing measurement efforts. The following efforts illustrate the mechanisms by which the state and partners will track and assess DSRIP.

Healthier Washington Dashboard

The Healthier Washington Dashboard is a publicly available data resource that allows users to explore data on populations, health indicators and HEDIS measures for Washington State. The information can aid MTP partners in conducting regional health assessments, planning for health improvement and measure health outcomes among the individuals in regional communities.

The dashboard supports ACHs and partnering providers by providing actionable data on population health and social determinants of health. Where possible, the state will make available data that can help clarify why there may be disparities in health outcomes within and across ACH regions.

To support DSRIP project activities, the state invested in enhanced dashboard functionalities: the inclusion of all DSRIP ACH project P4P metric results. The expansion of the dashboard coincided with the release of the first set of baseline project P4P results and associated improvement targets in October 2018. ACHs, partnering providers, other stakeholders, and the public can view annual ACH P4P results for each baseline and performance year cycle.

In addition, interim unofficial results for P4P metrics and related sub-metrics will be updated on a quarterly basis. The enhanced dashboard also shows ACH project P4P metric results for Medicaid beneficiaries by geographic region (e.g., ACH region, county) and demographics (e.g., age group, gender, race, ethnicity). Users can combine filters to see metric results for specific populations for a more in-depth exploration of the demographic dimensions and geography, where there is sufficient data to do so. The table below outlines the different options for viewing population health data.

Table 43: summary of Healthier Washington Dashboard information

Dashboard	Purpose	Refresh cycle	Description of info/filters
Measure explorer & trend	Displays rates for Medicaid claims-based measures, with the ability to combine filters for multiple dimensions	Annually	• Demographics: gender, race/ethnicity, age group, language • Geography: state, ACH, county
Transformation measures	• ACH project P4P metric results • Tracks progress toward improvement targets	Quarterly	• Demographics: gender, race/ethnicity, age group, language • Geography: state, ACH, county

Although not part of the formal P4P accountability structure, the state will monitor broad Medicaid beneficiary outcomes, regardless of ifr they fit the "eligible population" criteria for P4P measurement. The state will ensure information about the unattributed beneficiary population and dually eligible individuals are available to ACHs and engaged partners through supplemental data products.

Other publicly available data resources

Beyond the Healthier Washington Dashboard, there are several data resources available that report various measures, health status, and other related indicators. The following table provides a starter set of potential sources of interest, though it is not a full list.

Table 44: examples of publicly available data sources

Data Source		Population		Granularity			Data categories							
		Total	Medicaid	State	ACH	County	Demographic characteristics	Social determinants	Provider access	Health status	Utilization	Service costs	Provider network	Workforce
Source	Title													
DOH	Washington Tracking Network (WTN) WTN Health Data Visualization	x		x	Lim.	x	x	x		x	x			
DOH	WA DOH, Comprehensive Hospital Abstract Reporting System (CHARS)			x		Zip	x			x	x			
DOH	WA DOH, Hospital Financial Data			x										
DOH	WA DOH, Vital Statistics	x		x		x				x				
DOH	WA DOH, Communicable Diseases and Chronic Conditions	x		x		x				x				
DOH	WA DOH, Maternal and Child Care	x		x		x				x	x			
DOH	WA DOH, Health Behaviors	x		x	Lim.	Lim.		x		x				

DOH	WA DOH, Rural Health, Medically Underserved Area Designations	x				x			x				x	x
DOH	Washington State Health Assessment	x		x		x	x	x	x	x				
DOH	DOH, Washington State Drug Overdose Quarterly Report	x		x	x	x				x				
DSHS	WA DSHS RDA, Community Risk Profiles	x		x	x	x		x						
DSHS	WA DSHS RDA, Client Data	x		x		x		x						
DSHS	WA DSHS RDA, Profiles of Persons Served by DSHS & WA Housing Authority	x	x	x		x		x		x				
DSHS	WA DSHS RDA, Outcome Measures for Adults Enrolled in Medicaid		x	x	x		x	x			x			
DSHS	WA DSHS, Long-Term Residential Options	x		x		x							x	
DSHS	WA DSHS, Nursing Facility Rates and Reports	x		x		x						x	x	
HCA	Healthier Washington Dashboard, measure explorer		x	x	x	x				x	x		x	

HCA	Healthier Washington Dashboard, population explorer		x	x	x	x	x							
HCA	Healthier Washington Dashboard, Statewide Measure Browser		x	x	x	x		x		x				
HCA	Healthier Washington Dashboard, measure maps			x	x	x				x	x			
HCA	HCA, Analytics Research and Measurement (ARM) Data Dashboard Suite	x	x	x	x	x	x		x		x		x	
HCA	HCA Data & Reports, Reproductive Health	x	x	x		x				x	x			
HCA	HCA, Data & Reports, Apple Health (Medicaid) reports		x	x		x	x			x	x			
HCA	HCA, Data & Reports, Dental Data	x		x		x	x				x	x	x	
WHA	Washington Health Alliance, WA Community Checkup, Scores	x	x	x	x	x				x	x		x	
WHA	Washington Health Alliance WA Community Checkup, Reports	x	x	x	x	x								

Appendix C: DSRIP measurement and payment timing

Figure 28: measurement and payment timing: ACH project, VBP, and high-performance incentives

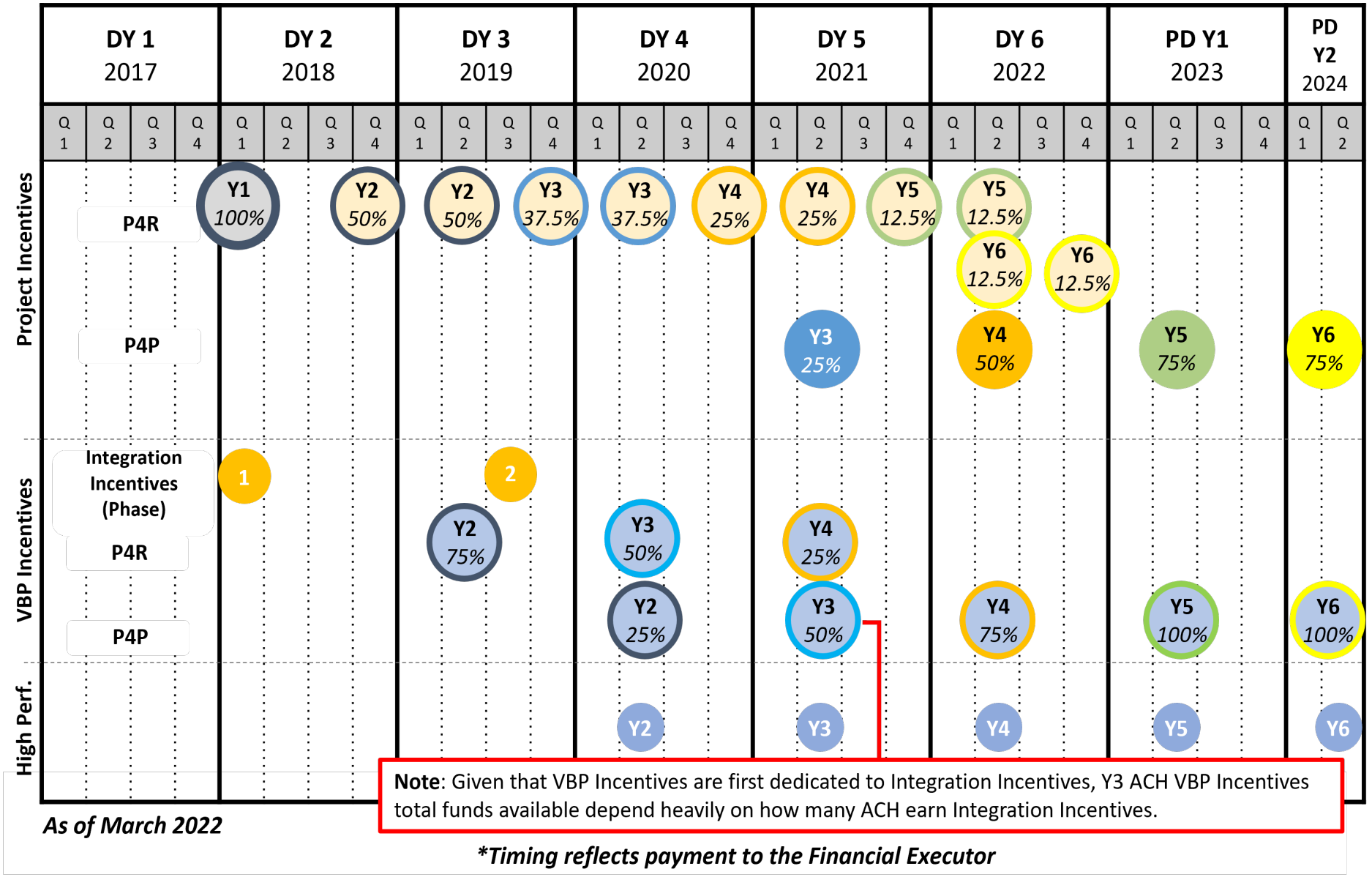


Figure 29: measurement and payment timing: ACH project incentives

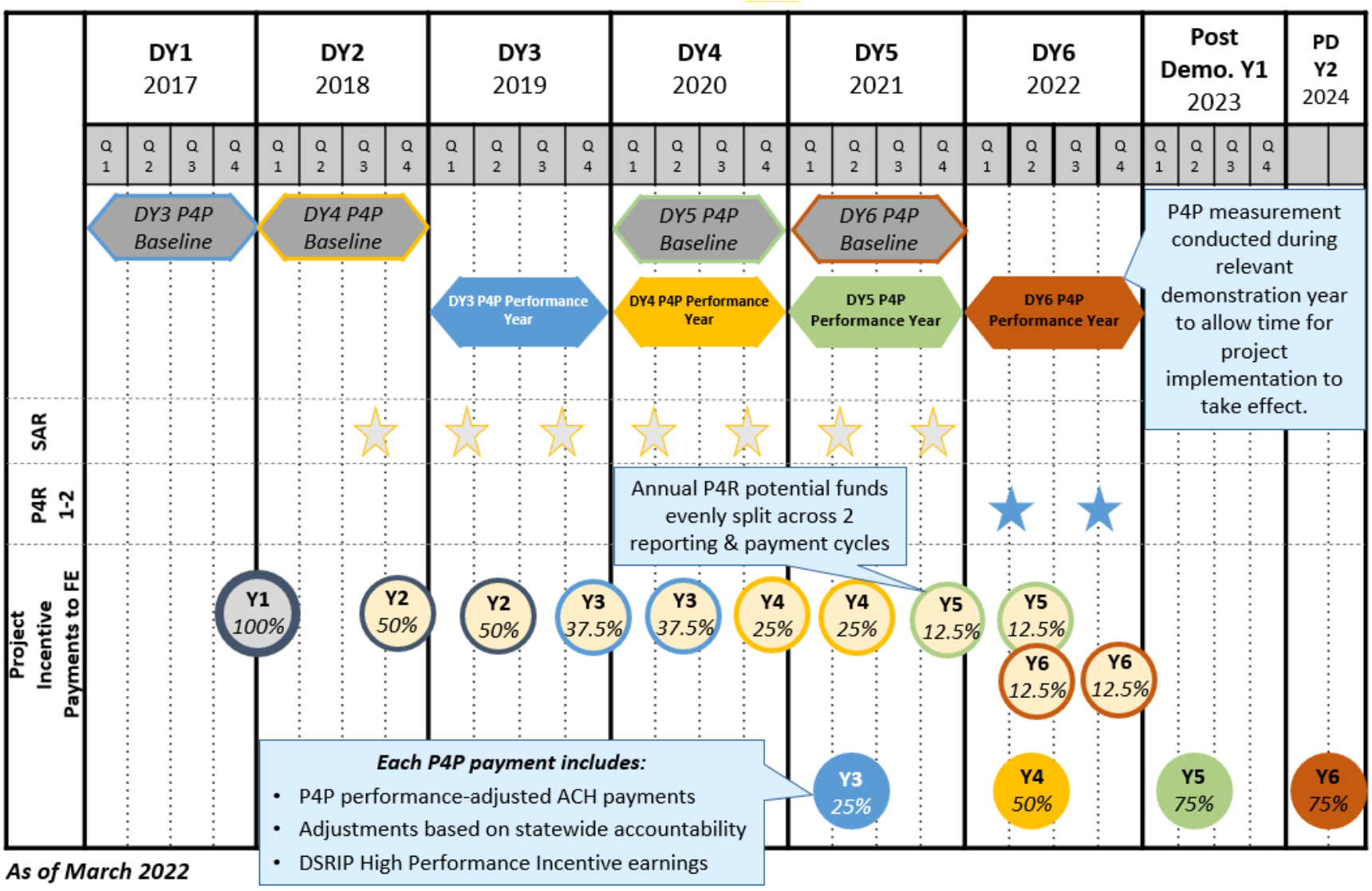
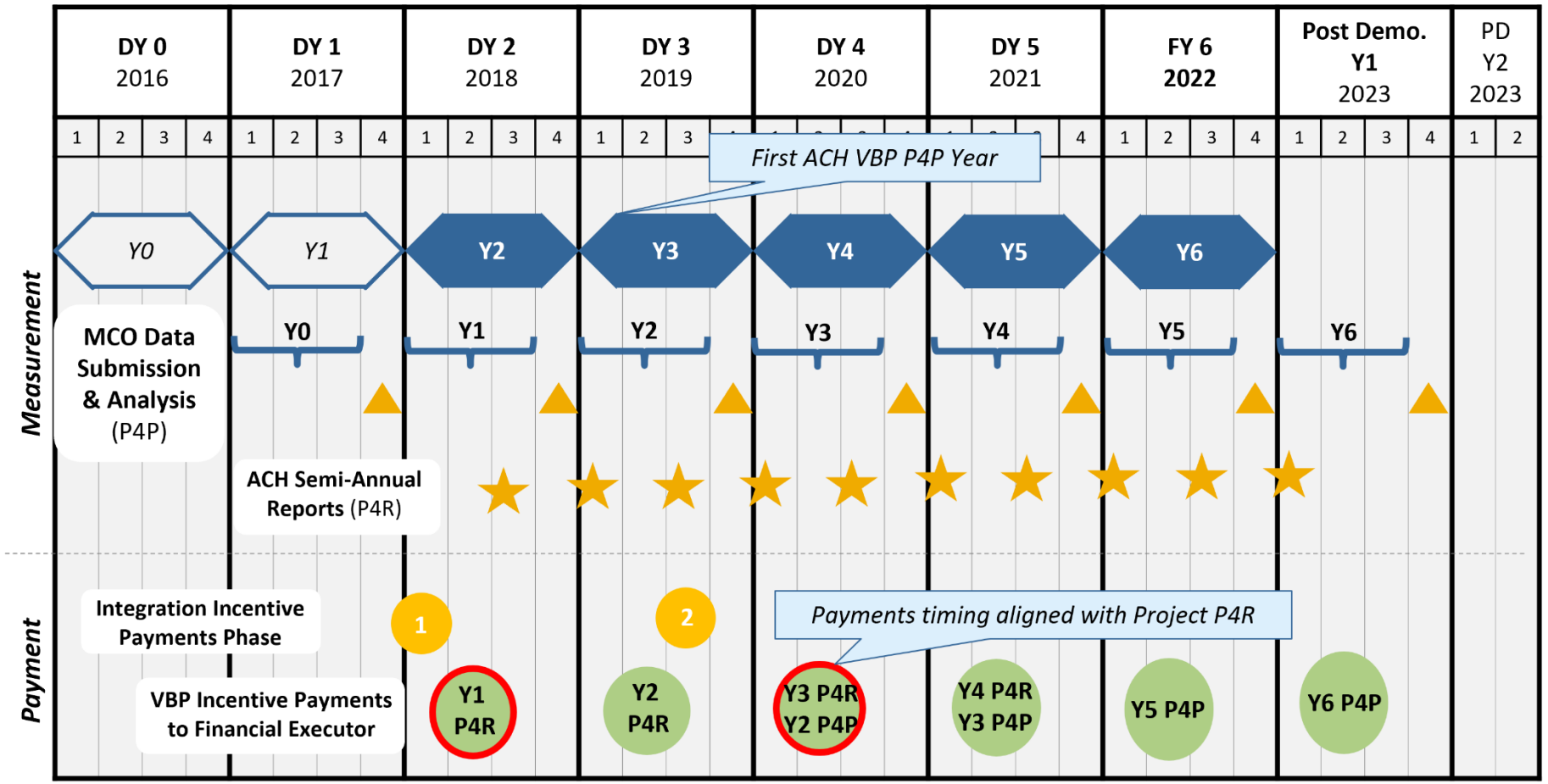


Figure 30: measurement and payment timing: ACH VBP incentives

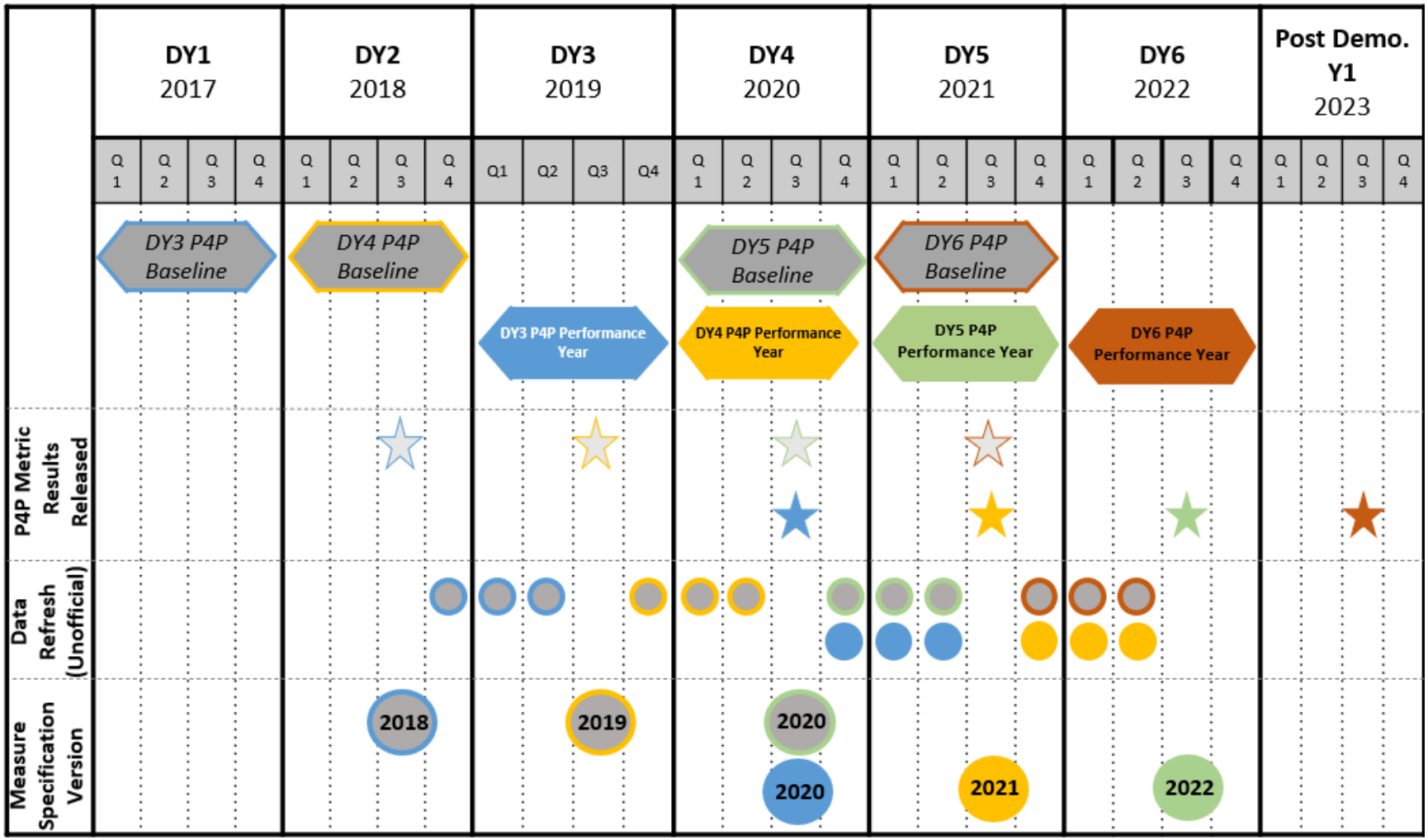


Note: *Given that VBP Incentives are first dedicated to Integration Incentives, Y1 and Y3 ACH VBP Incentives total funds available depend heavily on how many ACHs earn Integration Incentives.*

As of April 2022

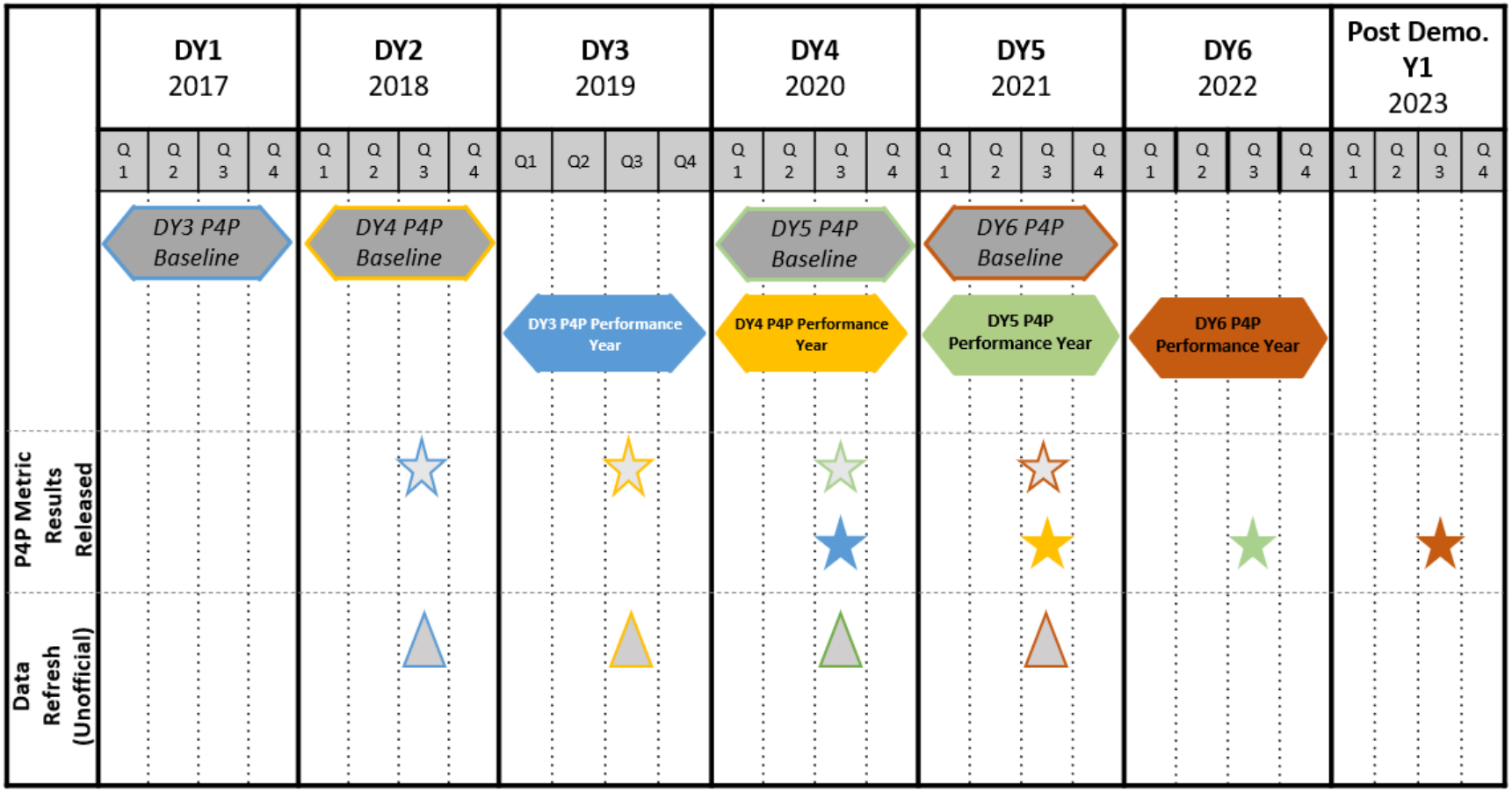
Legend
Release of survey data
Due date for ACH Semi-Annual Reports (P4R)

Figure 31: ACH project P4P metric production cycle



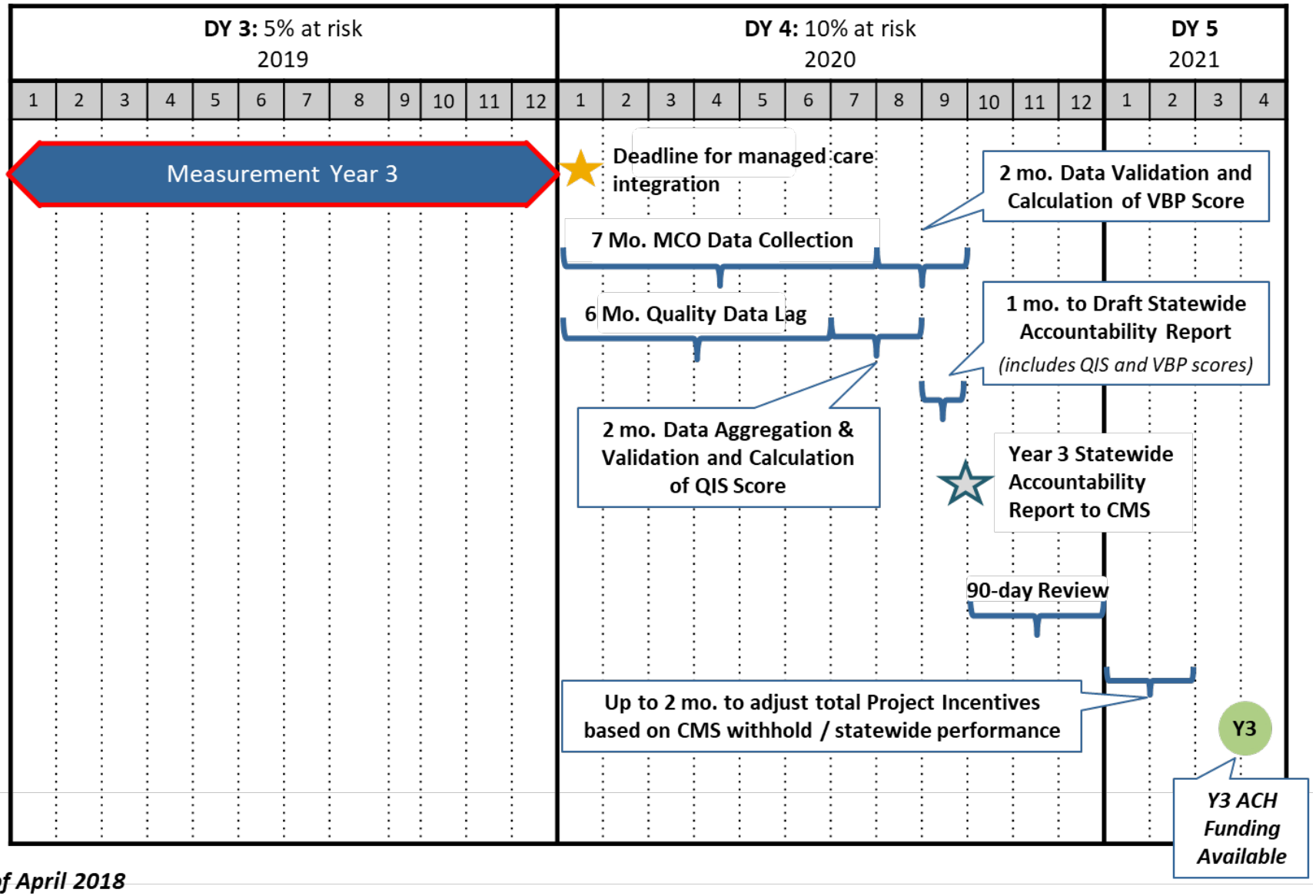
As of March 2022

Figure 32: ACH P4P metric results and improvement target release cycle



As of March 2022

Figure 33: measurement and availability of at-risk incentives: statewide accountability



As of April 2018

Appendix D: ACH VBP incentive calculation examples

This appendix provides example scenarios of ACH P4R and P4P reporting and performance to calculate earned ACH VBP incentives.

Figure 34: example scenarios of ACH VBP incentives calculation (using DY4 parameters)

Example Scenarios – DY 5

- Up to $6.3 million available for ACH VBP Incentives in DY 5, divided equally among 9 ACHs → **$700k per ACH** maximum potential VBP Incentives for DY 5
    - *Note: Both ACH VBP and Integration Incentives are funded through the Reinvestment Pool. Earned incentives for ACHs that achieve key integration milestones may impact the amount of VBP incentives available for a given year.*
- DY 5 ACH P4R / P4P split: **0% P4R** ($0k) & **100% P4P** ($700k)
- DY 5 **P4R includes 4 milestones** (4 in Domain 1 from Project Toolkit)
- DY 5 **VBP P4P Score Weighting**: 75% Improvement Score / 20% Achievement Score / 5% Achievement Sub-Set Score
- Achievement Score is based on DY 5 **VBP Target is 90%** HCP LAN 2C – 4B, with no threshold requirement related to higher-level VBP adoption
    - The **Achievement Sub-Set criteria** for full credit for the Achievement Sub-Set Score in DY 5 requires that the ACH region have at least one MCO with at least one VBP contract in HCP LAN category 3B or above and must also have 50% of all contracts in the HCP LAN category.

Figure 35: example scenario 1: ACH with low level of VBP adoption, moderate improvement

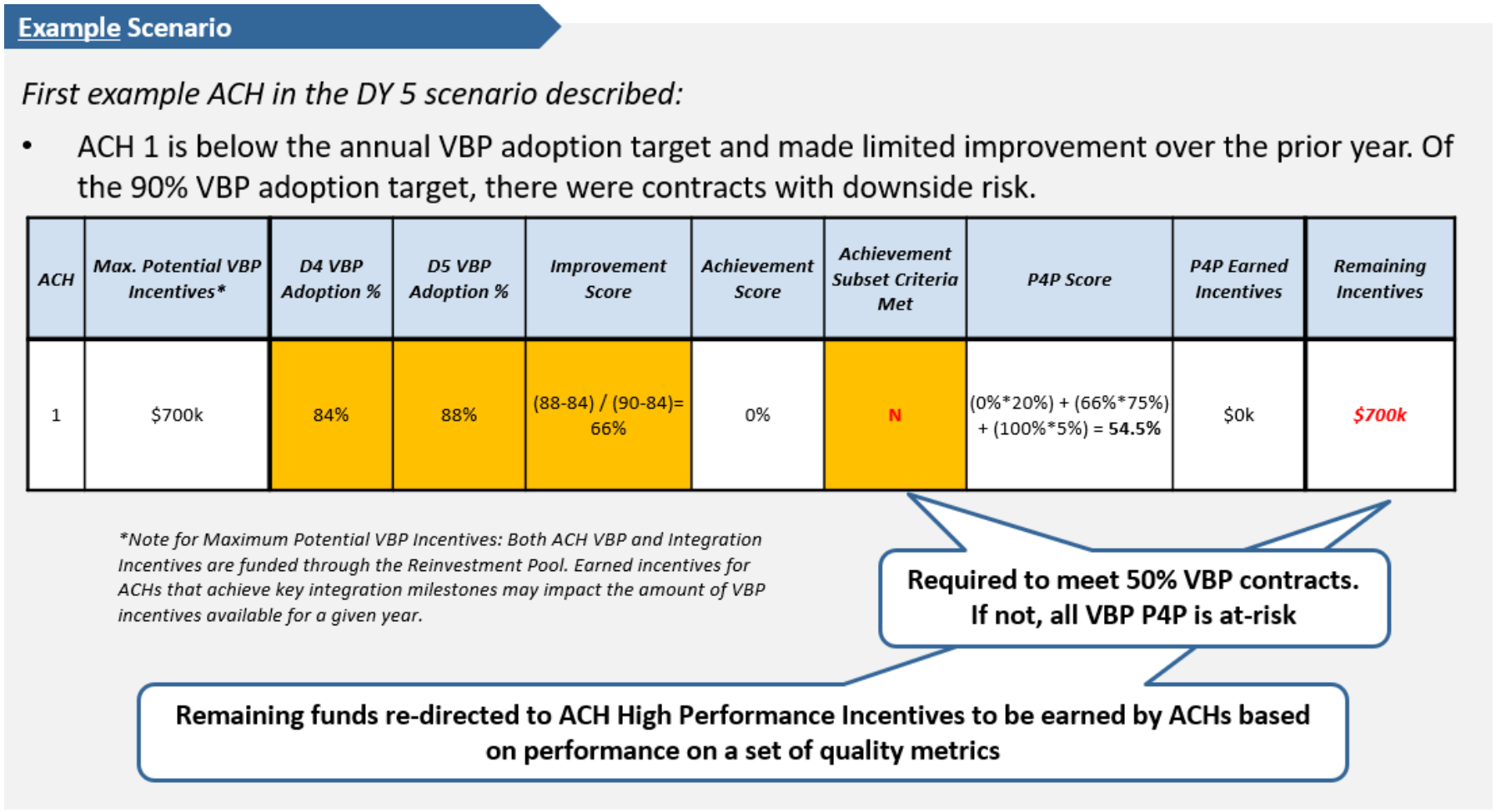


Figure 36: example scenario 2: ACH that missed VBP adoption target, but made significant improvement

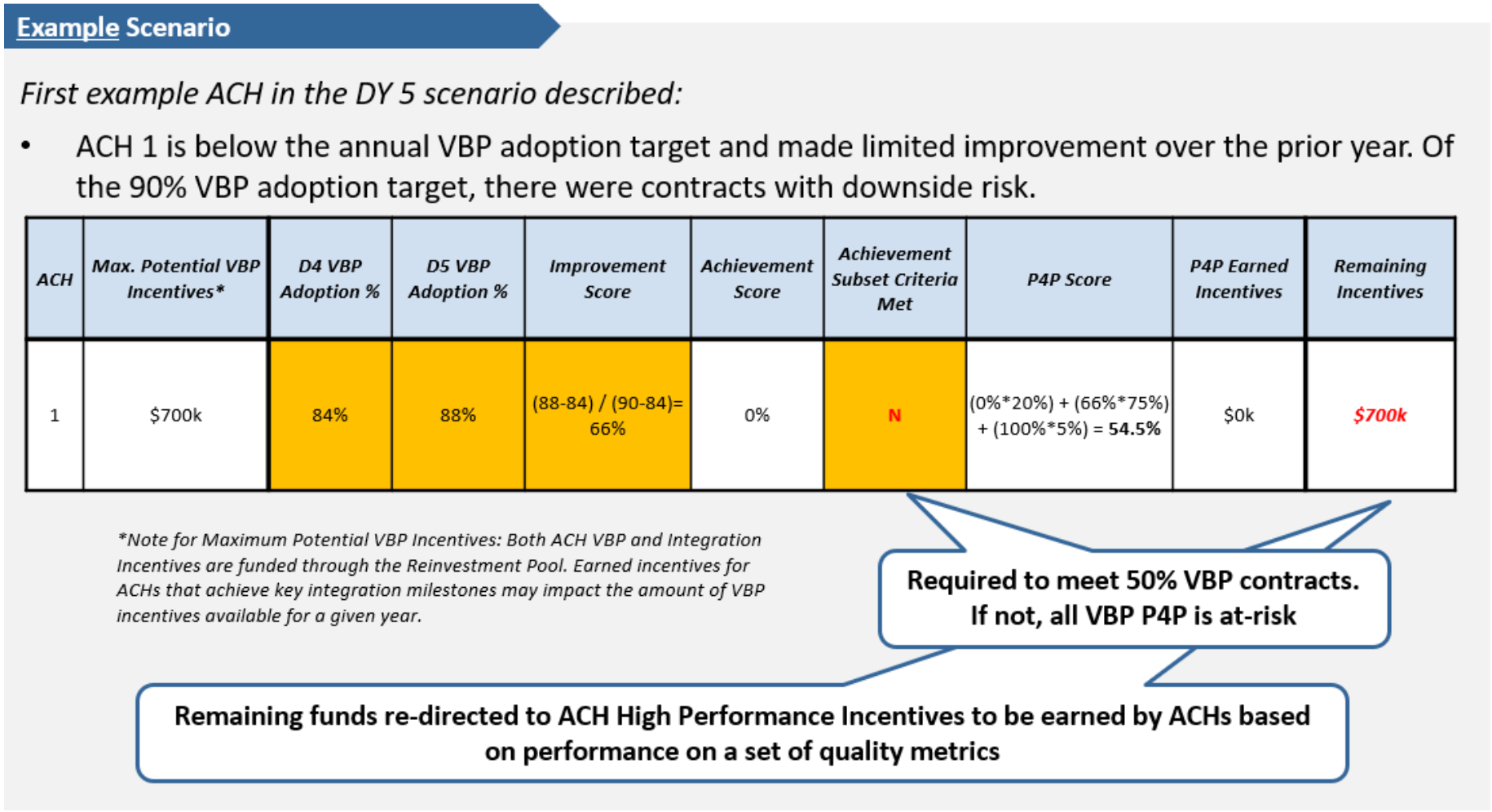


Figure 37: example scenario 3: ACH that exceeded VBP adoption target

Example Scenario

Third example ACH in the DY 5 scenario described:

- ACH 3 has a high VBP attainment and had already met the Year 5 VBP goal in Year 4. The region maintained the level of VBP adoption in DY 5 and had downside risk contracts.

ACH	*Max. Potential VBP Incentives**	*D3 VBP Adoption %*	*D4 VBP Adoption %*	*Improvement Score*	*Achievement Score*	*Achievement Subset Criteria Met*	*P4P Score*	*P4P Earned Incentives*	*Remaining Incentives*
3	$700k	85%	90%	*100% (VBP adoption target met. Full credit for Improvement Score.)*	100%	Y	(100%*20%) + (100%*75%) + (100%*5%) = **100%**	$700k	***$0k***

**Note for Maximum Potential VBP Incentives: Both ACH VBP and Integration Incentives are funded through the Reinvestment Pool. Earned incentives for ACHs that achieve key integration milestones may impact the amount of VBP incentives available for a given year.*

Remaining funds re-directed to ACH High Performance Incentives to be earned by ACHs based on performance on a set of quality metrics

Appendix E: sample calculation of ACH high-performance incentives

This appendix provides sample calculations to show how ACH high-performance incentive payments are determined once regional ACH QIS are known. The two examples illustrate how the ACH QIS is adjusted by the ACH population weight (population size) to yield the final earned percentage of available ACH high-performance incentives for the performance year (total incentives earned). For a description of ACH high-performance incentives methodology, see Chapter 8.

Important caveats to note for the following examples*:*

- Values under QI composite score and population size are hypothetical, and do not reflect actual ACH performance or population proportions.
- The dollar value used in the examples below (available ACH high-performance incentives) is also hypothetical and for illustration purposes only. The true value will depend on ACH earning of project and VBP incentives for the associated performance period.
- Color key:

- Identifies an input from the performance period
- Calculation occurs within the table per description of the formula

Table 45: interpreting ACH high-performance incentive distribution examples

FIELD LABEL	Description
QIS	The **ACH QIS** reflects the ACH region's performance across the set of high-performance metrics.
Relative QIS percentage	Each **ACH QIS** is divided by the sum of all ACH QIS for the performance period to yield the **relative QIS percentage**.
Percent of population	Of statewide Medicaid and SCHIP beneficiaries with comprehensive physical and behavioral health care benefits (also referred to as full-benefit Title XIX or Title XXI coverage), the **percent of population** is the percent residing in the ACH region during the performance period.
Population index	The **population size** is converted to a ratio that represents the relative Medicaid and SCHIP population in the ACH, compared to the percent of population in the other ACHs. An index of 1.00 is average. Figures higher or lower than 1.00 represent a population larger or smaller, relative to the average. The population index helps determine the **population-adjusted relative QIS percentage.**
Population-adjusted relative QIS percentage	The **population index** for each region is multiplied by the **relative QIS percentage** to determine the **population-adjusted relative QIS percentage.**
Percent of incentives	For each ACH, the **population-adjusted relative QIS percentage** is divided by the sum of all ACH population-adjusted relative QIS percentages for the performance period to yield the **percent of incentives** that will be awarded to the ACH. This step ensures that the percent for all regions adds up to 100 percent.

Example 1. This table illustrates the distribution of available ACH high-performance incentive for a performance period where ACHs demonstrated a range of ACH QIS for a given performance period. All values in the example below are for illustration purposes only.

Available ACH high-performance incentives: $1,000,000

Table 46: example: distribution of ACH high-performance incentives, range of ACH QIS

ACH region	ACH QI composite score (QIS)	Relative QIS percentage	Percent of population	Population index	Population-adjusted relative QIS percentage	Percent of incentives	Total high-performance incentives earned
ACH A	1.22	11.6%	10.2%	0.92	10.7%	10.7%	$ 107,054
ACH B	1.31	12.5%	11.1%	1.00	12.5%	12.5%	$ 125,095
ACH C	1.49	14.2%	14.3%	1.29	18.3%	18.3%	$ 183,302
ACH D	1.51	14.4%	4.2%	0.38	5.4%	5.5%	$ 54,560
ACH E	1.43	13.6%	7.8%	0.70	9.6%	9.6%	$ 95,957
ACH F	0.70	6.7%	8.2%	0.74	4.9%	4.9%	$ 49,381
ACH G	1.11	10.6%	25.2%	2.27	24.0%	24.1%	$ 240,640
ACH H	0.90	8.6%	15.0%	1.35	11.6%	11.6%	$ 116,139
ACH I	0.81	7.7%	4.0%	0.36	2.8%	2.8%	$ 27,873
Sum:	**10.48**	**100.0%**	**100.0%**		**99.8%**	**100.0%**	**$1,000,000**

Example 2: this table illustrates the distribution of available ACH high-performance incentive for a performance period where every ACH achieved the same ACH QIS. All values in the example below are for illustration purposes only.

Available ACH high-performance incentives: $1,000,000

Table 47: example: distribution of ACH high-performance incentives, all ACH QIS equal

ACH region	ACH QIS	Relative QIS percentage	Percent of population	Population index	Population-adjusted relative QIS percentage	Percent of incentives	Total high-performance incentives earned
ACH A	**1.10**	10.5%	10.2%	0.92	9.6%	10.2%	$ 102,000
ACH B	**1.10**	10.5%	11.1%	1.00	10.5%	11.1%	$ 111,000
ACH C	**1.10**	10.5%	14.3%	1.29	13.5%	14.3%	$ 143,000
ACH D	**1.10**	10.5%	4.2%	0.38	4.0%	4.2%	$ 42,000
ACH E	**1.10**	10.5%	7.8%	0.70	7.4%	7.8%	$ 78,000
ACH F	**1.10**	10.5%	8.2%	0.74	7.7%	8.2%	$ 82,000
ACH G	**1.10**	10.5%	25.2%	2.27	23.8%	25.2%	$ 252,000
ACH H	**1.10**	10.5%	15.0%	1.35	14.2%	15.0%	$ 150,000
ACH I	**1.10**	10.5%	4.0%	0.36	3.8%	4.0%	$ 40,000
Sum:	**9.90**	**94.5%**	**100.0%**		**94.5%**	**100.0%**	**$1,000,000**

Appendix F: DSRIP metric selection and alignment

This appendix identifies the state's selection and approval process for quality and outcome metrics used to determine performance and accountability for the DSRIP program. The following information applies to three components of the DSRIP accountability framework:

Figure 38: DSRIP accountability framework – components with quality and outcome metrics

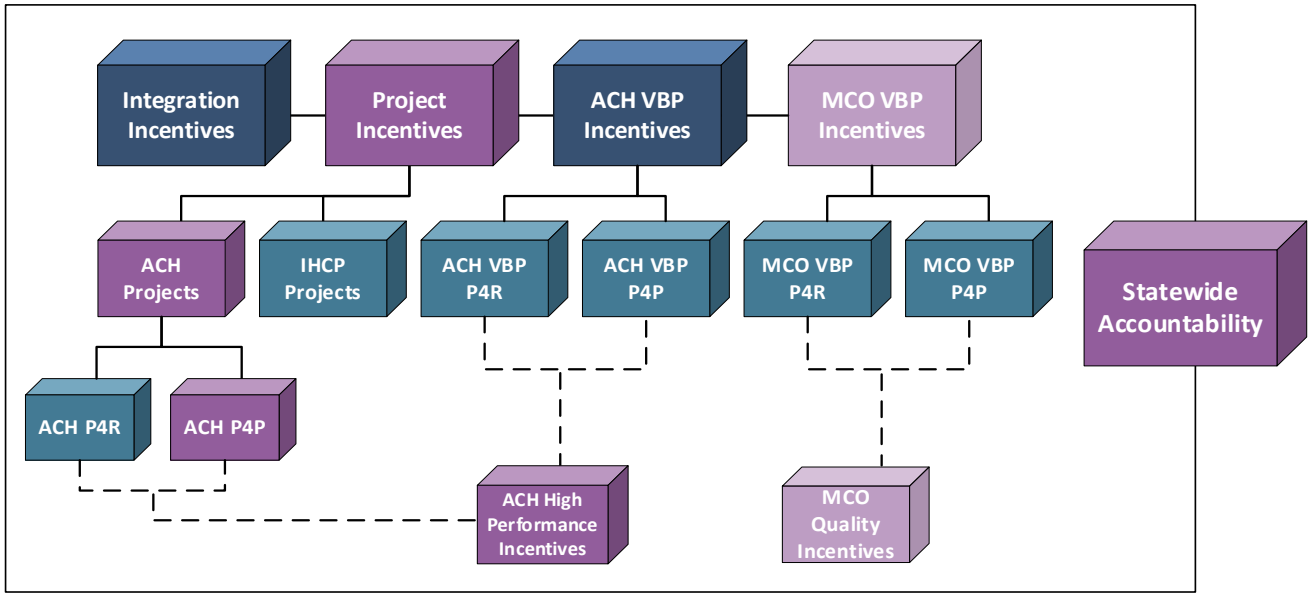


Table 48: metric category and associated incentives

Metric category	Associated incentives
ACH project P4P metrics	ACH project incentives
ACH high performance	Unearned project and ACH VBP incentives
Statewide accountability quality metrics	Quality component of the overall DSRIP program incentives at risk DY3-DY6

MCO clinical quality metrics are not reflected in this appendix, as these metrics are included in MCO contracts and are subject to change year over year.[51] However, the metrics listed here are aligned with MCO metrics to the extent possible.

Metric selection criteria

The state selected DSRIP quality and outcome metrics according to the following criteria:

- Relevance to project objectives and applicability to transformation activities
- Reflect progress that occurred during the pertinent performance year
- Feasibility of state metric producers to calculate according to DSRIP measurement timelines and incentive payment cycles

[51] See managed care contracts page.

Additionally, the state prioritized alignment with established statewide measurement initiatives and efforts, such as:

- The Washinton State Common Measure Set (WSCMS), which provides the foundation for health care accountability and measuring performance. Mandated by House Bill 2572, it is foundational to ensuring the ability to measure progress toward achieving healthier outcomes for all residents in Washington.
- Cross-System Outcome Measures for Adults Enrolled in Medicaid. Performance measure development process conducted by DSHS, in collaboration with Medicaid delivery system stakeholders, as part of the 2013 House Bill 1519 (Chapter 320, Laws of 2013) and Senate Bill 5732 (Chapter 338, Laws of 2013).
- The Bree Collaborative, which was established in 2011 by the Washington State Legislature, so that public and private health care stakeholders can work together to improve quality, health outcomes, and the cost effectiveness of care. In 2016, the Bree Collaborative endorsed the 2015 agency medical directors group guidelines on prescribing opioids for pain, convened a workgroup to develop implementation strategies, and elected to develop opioid prescribing metrics aligned with both the Washington State and Centers for Disease Control and Prevention (CDC) guidelines. HCA adopted the recommended opioid prescribing metrics July 2017.
- Results Washington, established under Executive Order 13-04, Results Washington, is an innovative, data-driven performance management initiative with five core goal areas, including healthy and safe communities.
- Existing HCA reporting efforts, such as annual data and reports related to Medicaid dental and oral health service utilization.

Process for finalization of DSRIP metrics

The state facilitated multiple opportunities for feedback from stakeholders and partners throughout the development of the MTP protocols and the Project Toolkit from October 2016 to June 2017.The state received CMS approval for metrics as part of the approved DSRIP planning protocol, funding and mechanics protocol, and the Project Toolkit. The objective is to maintain project metric consistency throughout the MTP period. However, situations may arise when a measure steward may retire or alter metric specifications. The metric modifications may be incorporated in DSRIP.[52]

Alignment of DSRIP metrics

As of spring 2018, **22 of the 34 CMS-approved DSRIP quality and outcome metrics** overlap with the WSCMS. For the list of the DSRIP quality and outcome metrics, see Appendix G.

However, the state identified relevant metrics that connect to project objectives for those project areas that did not have metrics available in the WSCMS. The table below describes the rationale for metrics that do not overlap with the WSCMS and where there is alignment with other existing state measurement initiatives.

[52] See Chapter 7.

Table 49: description of ACH project P4P metrics not in WSCMS

Description of metrics not in WSCMS (as of spring 2018)	
Metric	**Description of origin/rationale for selection**
• **All- Cause Emergency Department Visits Per 1,000-Member Months** • **Percent Arrested** • **Percent Homeless (Narrow Definition)** • **SUD Treatment Penetration (Opioid)**	• Aligned with or a variant of the Cross-System Outcome Measures for Adults Enrolled in Medicaid (5732/1519 measure set). • All cause ED metric: variant that includes visits related to mental health and SUD. • SUD treatment penetration (opioid): variant of general SUD treatment penetration metric specific to individuals with an identified opioid use disorder treatment need.
• **Patients Prescribed Chronic Concurrent Opioids and Sedatives Prescriptions**	• Selected from the approved Bree Collaborative opioid prescribing metrics.
• **Timeliness of Prenatal Care**	• Directly aligned with the Results Washington, Healthy People, Healthy Babies Goal Map objective (increase rate of infants whose mothers receive prenatal care in the first trimester of pregnancy). The metric for MTP is calculated using standard NCQA HEDIS specifications to yield a Medicaid-only result. In contrast, Results Washington is a measure of total population, and uses DOH specifications.
• **Contraceptive Care – Most and Moderately Effective Methods** • **Contraceptive Care – Postpartum**	• Metrics came forward during the stakeholder review and comment period to promote access to contraceptive care and support pregnancy intention under Project 3B: reproductive, maternal and child health. The National Quality Forum endorsed the clinical performance metrics for contraceptive care in November 2016.
• **Children Preventive Services** • **Periodontal Evaluation in Adults with Chronic Periodontitis** • **Use of Dental Services**	• Because of the lack of oral health-related metrics in the WSCMS, the state needs to identify additional metrics that were relevant to project objectives and target populations. The state looked to DQA-endorsed metrics. One metric targeted to adult access to dental service was prioritized, as well a measure of dental service use.
• **Acute Hospital Utilization**	• A core objective of MTP is to reduce unnecessary use of intensive services and settings. In addition to a performance measure of emergency department use, the state sought to complement this by a measure of inpatient hospital utilization.

Appendix G: DSRIP quality and outcome metrics

Purpose: the following table defines the metrics used to determine performance and accountability for the DSRIP program. The table includes indicator columns to categorize the metrics by DSRIP program utility:

- Statewide accountability quality metrics (associated with the quality component of the overall DSRIP program incentives at risk DY3-DY6)
- ACH project P4P metrics (associated with ACH project incentives)
- ACH high-performance metrics (associated with unearned project and ACH VBP incentives)

Table 50: DSRIP quality and outcome metrics

Name of metric	NQF#	Measure steward	Statewide accountability metric (quality component)	ACH project P4P metrics for project incentives, by year				Associated Project Toolkit projects	ACH high-performance metric
				DY3 (2019)	DY4 (2020)	DY5 (2021)	DY6 (2022)		
Acute Hospital Utilization	N/A	NCQA (HEDIS)	N	Inactive	P4P	P4P IOS only	P4P IOS only	2A, 2B, 2C, 3A, 3D	N
All Cause Emergency Department Visits	N/A	DSHS-RDA	Y	P4P	P4P	P4P IOS only	P4P IOS only	2A, 2B, 2C, 2D, 3A, 3B 3C, 3D	Y
Antidepressant Medication Management	0105	NCQA (HEDIS)	Y	P4P	P4P	P4P IOS only	P4P IOS only	2A	Y
Asthma Medication Ratio	1800	NCQA (HEDIS)	Y (DY4, DY5)	Inactive	P4P	P4P IOS only	P4P IOS only	2A, 3D	Y (DY4, DY5)
Children's and Adolescents' Access to Primary Care Practitioners	N/A	NCQA (HEDIS - modified)	N	P4P	Inactive	Inactive	Inactive	2A, 3D	N
Child And Adolescent Well-Care Visits		NCQA (HEDIS - modified)	N	N/A	P4P	P4P IOS only	P4P IOS only	2A, 3D	N

Child and Adolescent Well-Care Visits		NCQA (HEDIS - Modified)	Y	N/A	P4P	P4P IOS only	P4P IOS only	3B	Y
Childhood Immunization Status (Combo 10)	0038	NCQA (HEDIS)	N	Inactive	P4P	P4P IOS only	P4P IOS only	3B	N
Chlamydia Screening in Women	0033	NCQA (HEDIS)	N	P4P	P4P	P4P IOS only	P4P IOS only	3B	N
Comprehensive Diabetes Care: Blood Pressure Control	0061	NCQA (HEDIS)	Y	NA	NA	NA	NA	NA	N
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	0055	NCQA (HEDIS)	N	Inactive	P4P	P4P IOS only	P4P IOS only	2A, 3D	N
Comprehensive Diabetes Care: Hemoglobin A1c Poor Control	0059	NCQA (HEDIS)	Y	NA	NA	P4P IOS only	P4P IOS only	NA	N
Comprehensive Diabetes Care: Hemoglobin A1c Testing	0057	NCQA (HEDIS)	N	P4P	P4P	P4P IOS only	P4P IOS only	2A, 3D	N
Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062	NCQA (HEDIS)	N	P4P	Inactive	Inactive	Inactive	2A, 3D	N
Contraceptive Care – Most and Moderately Effective Methods	2903	U.S. Office of Population Affairs	N	Inactive	P4P	P4P IOS only	P4P IOS only	3B	N
Contraceptive Care – Postpartum	2902	U.S. Office of Population Affairs	N	Inactive	P4P	P4P IOS only	P4P IOS only	3B	N
Controlling High Blood Pressure	0018	NCQA (HEDIS)	Y	NA	NA	NA	NA	NA	N
Dental Sealants for Children at Elevated Caries Risk (Metric Replaced by Preventive Services for Children at Elevated Caries Risk, Dental or Oral Health Services)	2508, 2509	DQA	N	Inactive	Inactive	Inactive	Inactive	3C	N

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	2605	NCQA (HEDIS)	N	Inactive	P4P	P4P IOS only	P4P IOS only	2A, 2B, 2C	N
Follow-Up After Emergency Department Visit for Mental Illness	2605	NCQA (HEDIS)	N	Inactive	P4P	P4P IOS only	P4P IOS only	2A, 2B, 2C	N
Follow-Up After Hospitalization for Mental Illness	0576	NCQA (HEDIS)	N	Inactive	P4P	P4P IOS only	P4P IOS only	2A, 2B, 2C	N
Kidney Health Evaluation for Patients with Diabetes		NCQA (HEDIS)	N	Inactive	P4P	P4P IOS only	P4P IOS only	2A, 3D	N
Medication Management for People with Asthma: Medication Compliance 75%	1799	NCQA (HEDIS)	Y (DY3)	P4P	Inactive	Inactive	Inactive	2A, 3D	Y (DY3)
Mental Health Treatment Penetration (Broad Version)	N/A	DSHS-RDA	Y	P4P	P4P	P4P IOS only	P4P IOS only	2A, 2B, 3B	Y
Patients Prescribed Chronic Concurrent Opioids and Sedatives Prescriptions	N/A	Bree Collaborative	N	P4P	P4P	P4P IOS only	P4P IOS only	3A	N
Patients Prescribed High-Dose Chronic Opioid Therapy	N/A	Bree Collaborative	N	P4P	P4P	P4P IOS only	P4P IOS only	3A	N
Percent Arrested	N/A	DSHS-RDA	N	Inactive	P4P	P4P IOS only	P4P IOS only	2D	Y

Percent Homeless (Narrow Definition)	N/A	WA DSHS-RDA	N	P4P	P4P	P4P IOS only	P4P IOS only	2B, 2C, 2D	Y
Periodontal Evaluation in Adults with Chronic Periodontitis	N/A	DQA	N	Inactive	P4P	P4P IOS only	P4P IOS only	3C	N
Plan All-Cause Readmission Rate (30 Days)	1768	NCQA (HEDIS)	Y	P4P	P4P	P4P IOS only	P4P IOS only	2A, 2B, 2C	Y
Preventive Services for Children at Elevated Caries Risk, Dental or Oral Health Services	N/A	DQA	N	Inactive	Inactive	P4P IOS only	P4P IOS only	3C	N
Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Application Delivered by Non-Dental Health Professional	N/A	WA HCA-ARM	N	P4P	P4P	P4P IOS only	P4P IOS only	3C	N
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	N/A	NCQA (HEDIS)	N	Inactive	P4P	P4P IOS only	P4P IOS only	3D	N
Substance Use Disorder Treatment Penetration	N/A	DSHS-RDA	Y	P4P	P4P	P4P IOS only	P4P IOS only	2A, 2B, 3B	Y
Substance Use Disorder Treatment Penetration (Opioid)	N/A	DSHS-RDA	N	Inactive	P4P	P4P IOS only	P4P IOS only	3A	N
Timeliness of Prenatal Care	N/A	NCQA (HEDIS)	N	Inactive	P4P	P4P IOS only	P4P IOS only	3B	N
Utilization of Dental Services	N/A	DQA	N	P4P	P4P	P4P IOS only	P4P IOS only	3C	N
Well-Child Visits in the 3rd, 4th, 5th, And 6th Years of Age	1516	NCQA (HEDIS - modified)	Y	P4P	Inactive	Inactive	Inactive	3B	Y
Well-Child Visits in the First 30 Months of Life		NCQA (HEDIS - modified)	N	Inactive	P4P	P4P IOS only	P4P IOS only	3B	N

Appendix H: ACH project P4P improvement target and AV methodology

The following table is focused on ACH P4P metrics associated with projects in the Project Toolkit. The purpose of this table is to outline the methodology used to set improvement targets for the associated performance year. ACH progress toward the improvement target will determine the portion of ACH project incentives earned for each activated metric in the ACH project portfolio. Unless otherwise specified, GTG benchmarks are the NCQA Quality Compass National Medicaid 90th Percentile rates for the respective year (2017, 2018, 2019).

Table 51: ACH project P4P metric improvement target and AV methodology

Name Of Metric	NQF#	ACH P4P improvement target methodology					ACH P4P AV methodology	
		Method (GTG, IOS)	Absolute benchmark value (GTG only)				Metric/submetric results used to determine AV	AV determination
			2020 benchmark (for DY6 performance)	2019 benchmark (for DY5 performance)	2018 benchmark (for DY4 performance)	2017 benchmark (for DY3 performance)		
Acute Hospital Utilization	N/A	IOS	N/A	N/A	N/A	N/A	Single metric result (18+ years)	Single metric result
All Cause Emergency Department Visits	N/A	IOS	N/A	N/A	N/A	N/A	• 0 – 17 years • 18+ years	Weighted average of performance for each submetric is used to calculate overall AV. This is determined by number of Medicaid beneficiaries the ACH has in each submetric.
Antidepressant Medication Management	0105	GTG (DY5/6 IOS)	Acute phase treatment (XX.XX); continuation phase treatment (XX.XX)	Acute phase treatment (64.29%); continuation phase treatment (49.37%)	Acute phase treatment (64.72%); continuation phase treatment (49.24%)	Acute Phase treatment (63.6%); continuation phase treatment (49.1%)	• Acute Phase Treatment • Continuation Phase Treatment	Each submetric contributes equal weight in the final AV calculation for the overall metric.
Asthma Medication Ratio	1800	GTG (DY5/6 IOS)	Pending	73.38%	71.93%	N/A	Single metric result (5-64 years)	Single metric result

Children's And Adolescents' Access to Primary Care Practitioners	N/A	GTG (DY5/6 IOS)		Age 12-24 months (97.97%); age 2-6 years (93.3%); age 7-11 years (96.08%); age 12-19 years (95.2%)	Age 12-24 months (97.71%); age 2-6 years (92.88%); age 7-11 years (96.18%); age 12-19 years (94.75%)	Age 12-24 months (97.89%); age 2-6 years (93.16%); age 7-11 years (96.1%); age 12-19 years (96.09%)	• Age 12-24 months • Age 25 months - 6 years • Age 7-11 years • Age 12-19 years	Weighted average of performance for each submetric is used to calculate overall AV. This is determined by number of Medicaid beneficiaries the ACH has in each submetric.
Child And Adolescents Well-Care Visits		IOS	Pending	Pending	Pending	N/A	• Age 3-11 years of age • Age 12-17 years of age • Age 18-21 years of age	Weighted average of performance for each submetric is used to calculate overall AV. This is determined by number of Medicaid beneficiaries the ACH has in each submetric.
Child And Adolescents Well-Care Visits		IOS	Pending	Pending	Pending	N/A	Single metric result (age 3-11 years of age)	Single metric result
Childhood Immunization Status (Combo 10)	0038	GTG (DY5/6 IOS)	Pending	45.06%	50.21%	Inactive for DY3. Benchmark value provided for information only: 62.16%	Single metric result (reported for those 2 years of age during the measurement year)	Single metric result
Chlamydia Screening in Women	0033	GTG (DY5/6 IOS)	Pending	71.42%	71.33%	71.50%	Single metric result (16-24 years)	Single metric result
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	0055	GTG (DY5/6 IOS)	Pending	82.51%	75.11%	Inactive for DY3. Benchmark value provided for information only: 73.08%	Single metric result (age 18-75 years)	Single metric result
Comprehensive Diabetes Care: Hemoglobin A1c Testing	0057	GTG (DY5/6 IOS)	Pending	94.59%	95.19%	95.36%	Single metric result (age 18-75 years)	Single metric result
Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062	GTG (DY5/6 IOS)	Pending	93.63%	94.42%	94.91%	Single metric result (age 18-75 years)	Single metric result

Contraceptive Care – Most & Moderately Effective Methods	2903	IOS	N/A	N/A	N/A	N/A	• 15-20 years • 21-44 years	Assess all submetric rates of the Contraceptive Care bundle. The submetric with the most progress toward the improvement target will determine the final AV value for the Contraceptive Care bundle.
Contraceptive Care – Postpartum	2902	IOS	N/A	N/A	N/A	N/A	• 15-20 years • 21-44 years	
Dental Sealants for Children at Elevated Caries Risk	2508, 2509	IOS	Inactive for DY6	Inactive for DY5	Inactive for DY4	Inactive for DY5	• Age 6-9 years • Age 10 years-14 years	Weighted average of performance for each submetric is used to calculate overall AV. This is determined by number of Medicaid beneficiaries the ACH has in each submetric.
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	2605	IOS	N/A	N/A	N/A	N/A	• 30 days • 7 days	Each submetric contributes equal weight in the final AV calculation for the overall metric.
Follow-Up After Emergency Department Visit for Mental Illness	2605	IOS	N/A	N/A	N/A	N/A	• 30 days • 7 days	Each submetric contributes equal weight in the final AV calculation for the overall metric.
Follow-Up After Hospitalization for Mental Illness	0576	IOS	N/A	N/A	N/A	N/A	• 30 days • 7 days	Each submetric contributes equal weight in the final AV calculation for the overall metric.
Kidney Health Evaluation for Patients with Diabetes		IOS	Pending	Pending	Pending	N/A	Single metric result (18-85 years)	Single metric results
Medication Management for People with Asthma: Medication Compliance 75%	1799	GTG	Inactive for DY 6	Inactive for DY5	Inactive for DY4	50%	Single metric result (5-64 years)	Single metric result

Mental Health Treatment Penetration (Broad Version)	N/A	IOS	N/A	N/A	N/A	N/A	• Age 6-17 years • Age 18+ years	Weighted average of performance for each submetric is used to calculate overall AV. This is determined by number of Medicaid beneficiaries the ACH has in each submetric.
Patients Prescribed Chronic Concurrent Opioids and Sedatives Prescriptions	N/A	IOS	N/A	N/A	N/A	N/A	Single metric result (all ages).	Single metric result
Patients Prescribed High-Dose Chronic Opioid Therapy	N/A	IOS	N/A	N/A	N/A	N/A	• Percentage of chronic opioid therapy patients receiving doses ≥50 mg. Morphine Equivalent Dose "MED" in a calendar quarter • Percentage of chronic opioid therapy patients receiving doses ≥90 mg. MED in a calendar quarter.	Each submetric contributes equal weight in the final AV calculation for the overall metric.
Percent Arrested	N/A	IOS	N/A	N/A	N/A	N/A	Single metric result (18-64 years)	Single metric result
Percent Homeless (Narrow Definition)	N/A	IOS	N/A	N/A	N/A	N/A	• 0-17 years • 18+ years	Weighted average of performance for each submetric is used to calculate overall AV. This is determined by number of Medicaid

								beneficiaries the ACH has in each submetric.
Periodontal Evaluation in Adults with Chronic Periodontitis	N/A	IOS	N/A	N/A	N/A	N/A	Single metric result (≥30 years)	Single metric result
Plan All-Cause Readmission Rate (30 Days)	1768	IOS	N/A	N/A	N/A	N/A	Single metric result (18-64 years)	Single metric result
Preventive Services for Children at Elevated Caries Risk, Dental or Oral Health Services	N/A	IOS	N/A	N/A	N/A	N/A	• Age 6-9 years • Age 10-14 years	Weighted average of performance for each submetric is used to calculate overall AV. This is determined by number of Medicaid beneficiaries the ACH has in each submetric.
Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Application Delivered by Non-Dental Health Professional	N/A	IOS	N/A	N/A	N/A	N/A	Single metric result (0-5 years)	Single metric result
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	N/A	IOS	N/A	N/A	N/A	N/A	Single metric result (comprised of males 21 to 75 years of age; females 40 to 75 years of age)	Single metric result
Substance Use Disorder Treatment Penetration	N/A	IOS	N/A	N/A	N/A	N/A	• Age 12-17 years • Age 18+ years	Weighted average of performance for each submetric is used to calculate overall AV. This is determined by number of Medicaid beneficiaries the ACH has in each submetric.

Substance Use Disorder Treatment Penetration (Opioid)	N/A	IOS	N/A	N/A	N/A	N/A	• Age 18+ years	Weighted average of performance for each submetric is used to calculate overall AV. This is determined by number of Medicaid beneficiaries the ACH has in each submetric.
Timeliness Of Prenatal Care	N/A	GTG (DY5/6 IOS)	Pending	92.35 %	92.63%	Inactive for DY3. Benchmark value provided for information only: 92.89%	Single metric result (no age restriction specified)	Single metric result
Utilization Of Dental Services	N/A	IOS	N/A	N/A	N/A	N/A	• Age 20 and under • Age 21 and above	The AV is determined by the age band submetric that shows the greatest progress towards its respective improvement target.
Well-Child Visits in The Third, Fourth, Fifth, And Sixth Years of Life	1516	GTG (DY5/6 IOS)	Pending	86.28%	86.24%	85.04%	Single metric result (age 3-6 years)	Single metric result
Well-Child Visits in The First 30 Months of Life	1392	IOS	Pending	70.49%	71.38%	Inactive for DY3. Benchmark value provided for information only: 67.83%	• 30 months of age • 15 months of age during measurement period	Weighted average of performance for each submetric is used to calculate overall AV. This is determined by number of Medicaid beneficiaries the ACH has in each submetric.

Appendix I: ACH project P4P metrics - sample AV calculations

The examples contained in this appendix illustrate how to determine earned AV for ACH project P4P metrics comprised of more than one result (also referred to as those that have submetrics).

- Each submetric has its own improvement target (set using baseline results).
- There may be a situation where an ACH's performance surpasses the improvement target for a metric or submetric. For the purposes of translating a result that is equal to or exceeds the improvement target, improvement progress is capped at 100 percent.
- For a comprehensive list of the ACH project P4P metrics and the associated AV determination methodology, see Appendix H.
- Chapter 7 sets the improvement target for both GTG metrics and IOS metrics. There is also an example of how to translate a single metric result (for a metric that does not have any submetrics) to the earned AV.

Summary of examples in this appendix:

- **Example 1:** the AV is determined by the weighted average of performance for each submetric. Weighting is determined by number of Medicaid beneficiaries the ACH has in the denominator of each submetric. Example 1 uses a project P4P metric with multiple age group submetrics.
- **Example 2:** each submetric contributes equal weight in the final AV calculation for the overall metric. Example 2 uses a project P4P metric with two submetrics that each can contribute up to half of the overall metric AV.
- **Example 3:** results for each submetric is assessed for improvement progress. The submetric with the most progress toward its submetric specific improvement target will determine the final, overall AV value for the metric (or, in the case of the "contraceptive care access" metrics, for the bundle).

Example 1

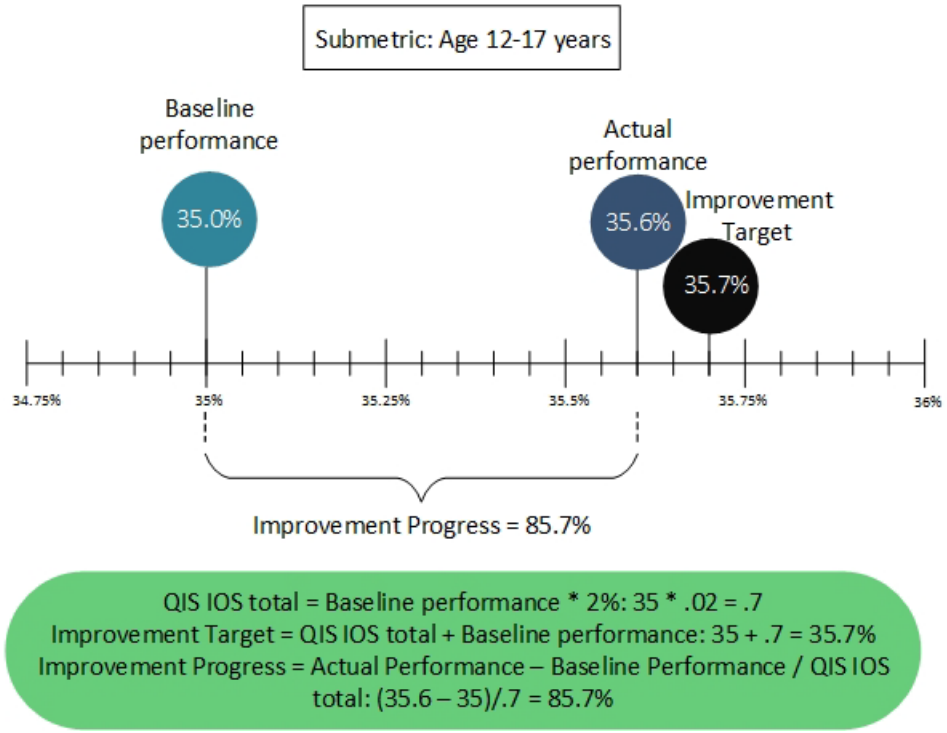
The AV is determined by the weighted average of performance for each submetric. Weighting is determined by the number of Medicaid beneficiaries the ACH has in the denominator of each submetric. Example 1 uses a project P4P metric with multiple age group submetrics.

As an example, the **SUD Treatment Penetration** metric (**IOS**) as well as a statewide accountability metric, which uses the QIS formula of 0.2 improvement has two submetrics: age 12-17 years and age 18-64+ years. There is no minimum threshold for the denominator for the inclusion of the submetric in the AV calculation. The ACH has a baseline performance, improvement target, and actual performance for each submetric.

Figure 40: submetric process

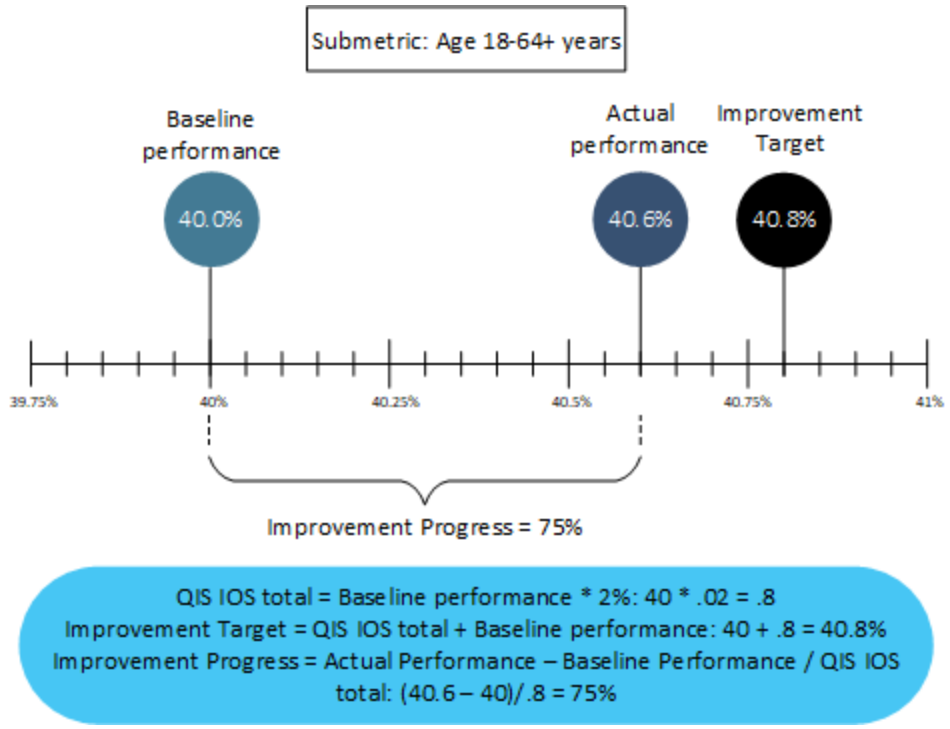
For the age 12-17 years submetric, the ACH's actual performance was 35.6 percent, resulting in 85.7 percent progress toward the submetric improvement target (35.7 percent).

Figure 41: example submetric calculation: SUD treatment penetration, age 12-17 years



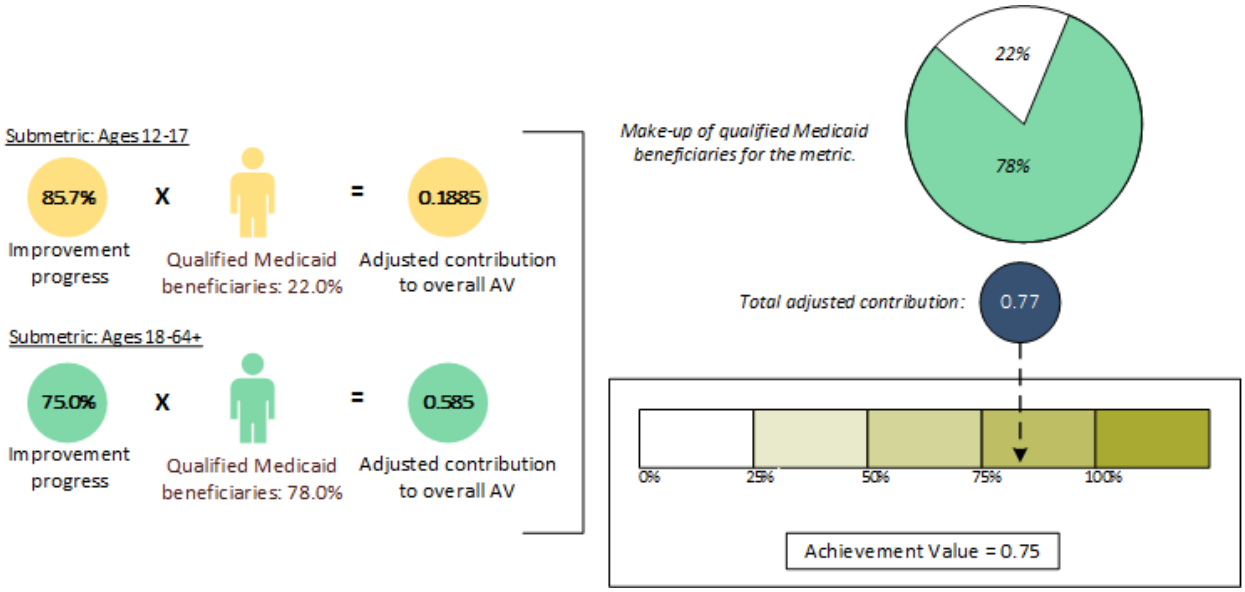
For the 18-64 years submetric, the ACH's actual performance was 40.6 percent, resulting in 75.0 percent progress toward the improvement target (40.8 percent).

Figure 392: example submetric calculation: SUD treatment penetration, age 18-64+ years



For the age 65+ years submetric, the ACH's actual performance was 25.4 percent, resulting in 80.0 percent progress toward the improvement target (25.5 percent).

Figure 43: example AV calculation: SUD treatment penetration, all submetrics



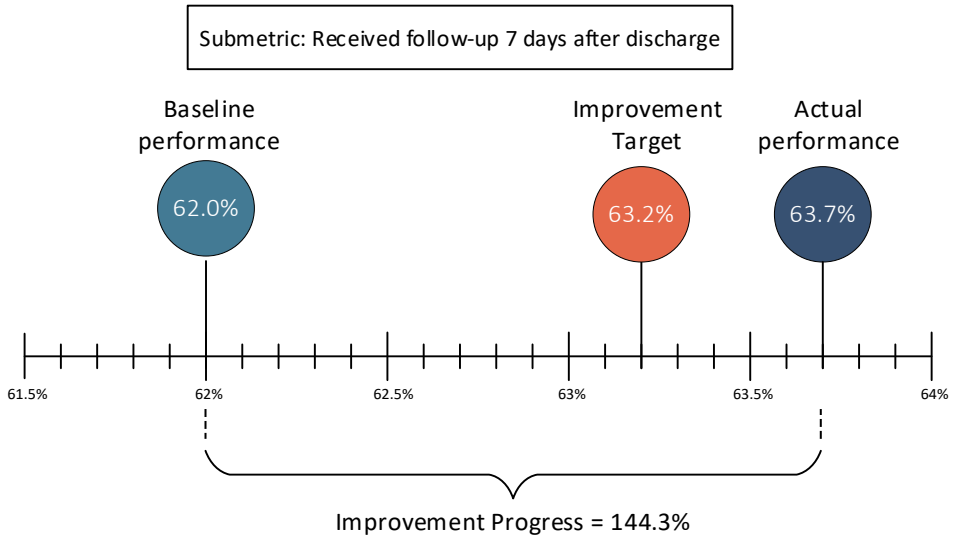
The total adjusted contribution toward the AV in this example equals 0.77, mapping to a 0.75 AV.

Example 2

Each submetric contributes equal weight in the final AV calculation for the overall metric. Example 2 uses a project P4P metric with two submetrics that each can contribute up to half of the overall metric AV.

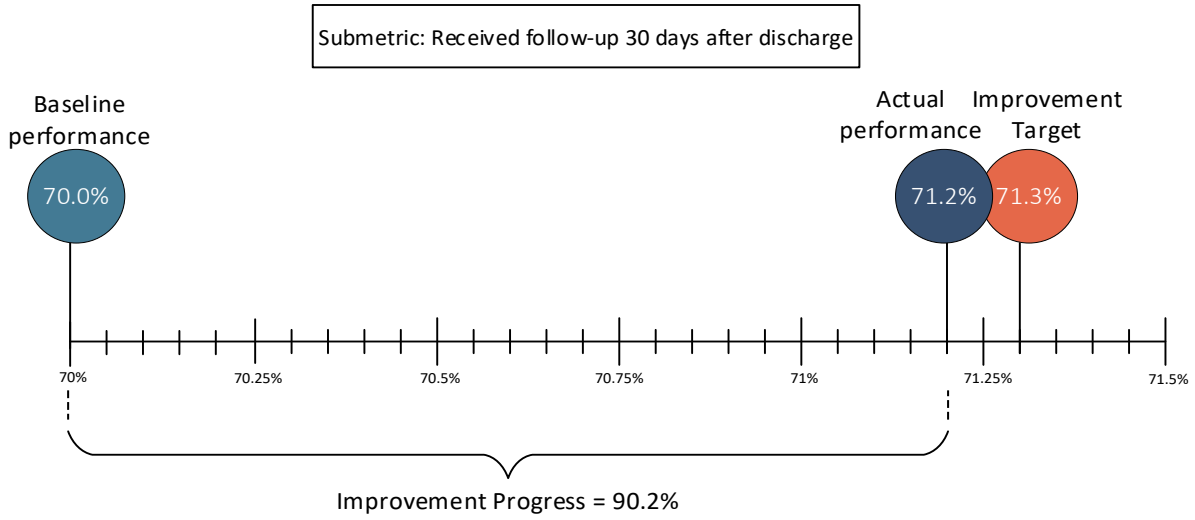
The **Follow-Up After Hospitalization for Mental Illness** metric (**IOS**), as an example, has two submetrics: received follow-up seven days after discharge, and received follow-up 30 days after discharge. There is no minimum threshold for the denominator for the inclusion of the submetric in the AV calculation.

Figure 44: example submetric calculation: Follow-Up After Hospitalization for Mental Illness, 7 days



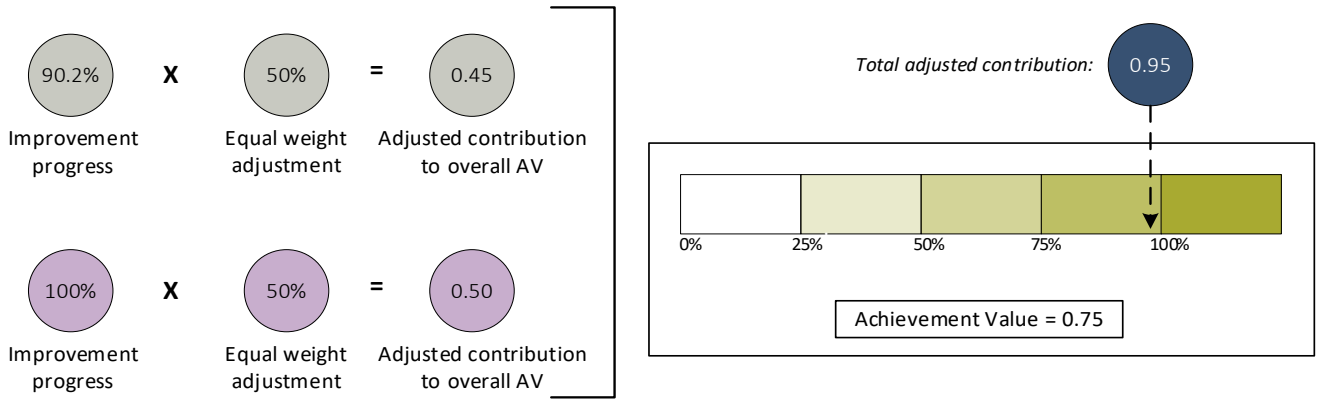
For this submetric, the ACH's baseline performance was 62.0 percent, and the improvement target was 63.2 percent. The ACH's actual performance surpassed the improvement target, resulting in 144.3 percent progress, which equates to full credit for this submetric (100 percent).

Figure 405: example submetric calculation: Follow-Up After Hospitalization for Mental Illness, 30 days



For this submetric, the ACH's baseline performance was 70.0 percent, and the improvement target was 71.3 percent. The ACH's actual performance was 71.2 percent, resulting in 90.2 percent progress toward the improvement target.

Figure 46: example AV calculation: Follow-Up After Hospitalization for Mental Illness



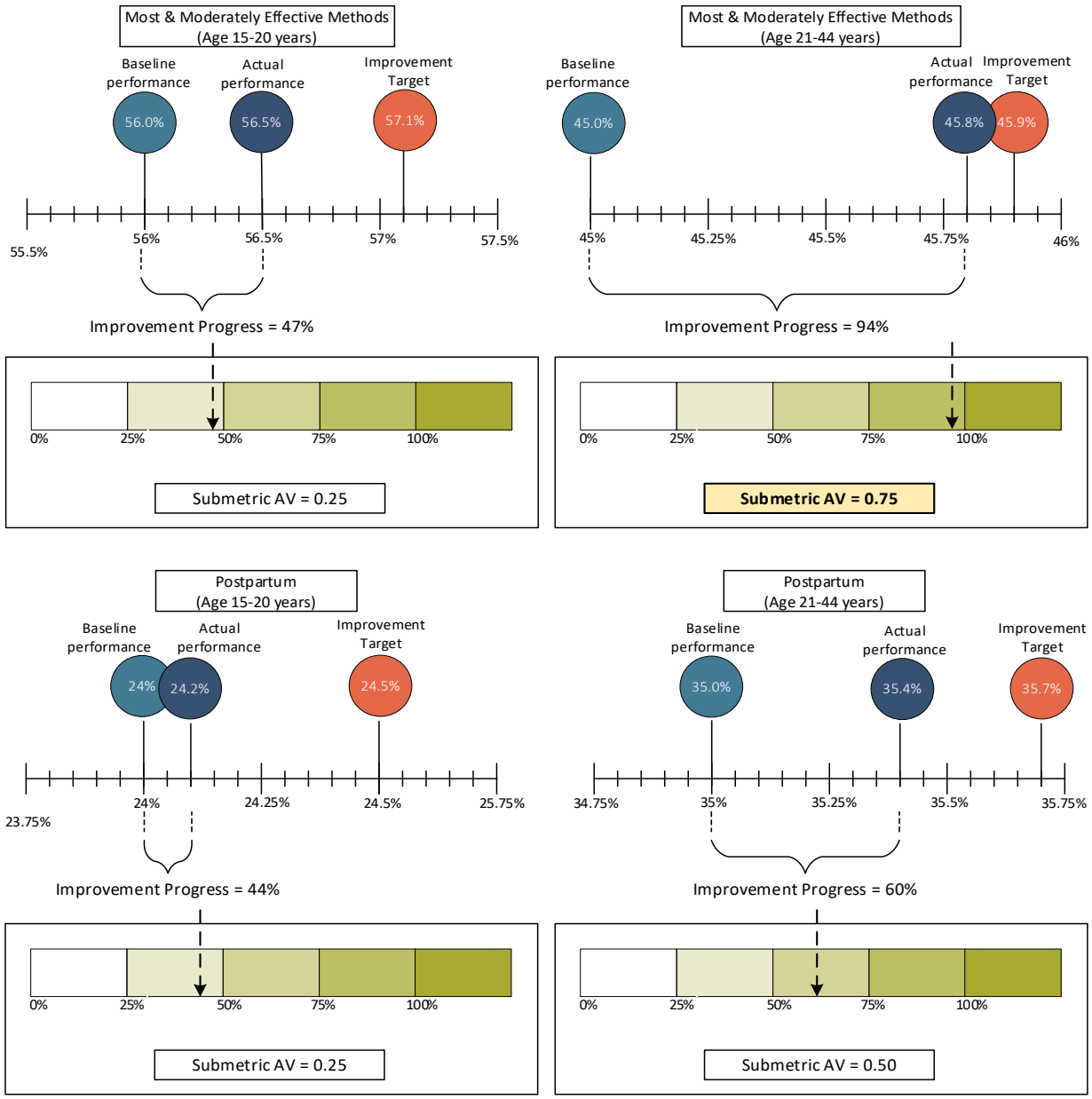
These two submetrics contribute equal weight toward the final AV calculation. In this example, the ACH's equal-weighted performance on each submetric results in a total adjusted contribution of 0.95, which maps to a 0.75 AV.

Example 3

Results for each submetric are assessed for improvement progress. The submetric with the most progress toward its submetric specific improvement target will determine the final, overall AV value for the metric (or, in the case of the "contraceptive care access metrics," for the bundle).

To calculate the AV for a bundle of metrics, all submetrics are assessed, and the submetric with the greatest progress toward the improvement target will determine the final AV bundle or metric. This calculation method applies to the **Contraceptive Care** metric bundle and **Utilization of Dental Services** metric. See the graphics on next page for an example of the **Contraceptive Care (IOS)** calculations.

Figure 47: example AV calculation: contraceptive care bundle



In these submetric calculations, the best performing submetric AV (0.75) determines the final metric AV.

Appendix J: technical specifications (DSRIP quality and outcome metrics)

Technical specifications are provided for ACH project incentive P4P metrics, ACH high-performance metrics, and DSRIP statewide accountability quality metrics. Each technical specification sheet notes the utility of each metric, and some metrics have multiple utilities. Technical specification for all accountability metrics are available on the Medicaid Transformation metrics page.

Metrics use national and/or state standard specifications. Variations from these standards are noted in the specification sheets. These variations are generally because of national standards that do not accurately reflect Washington Medicaid context.

Situations may arise when the measure stewards retire or alter metric specification to reflect changes in clinical care guidelines, treatment recommendations, or current health care practices. If metric modifications are adopted, specifications will be updated to reflect any changes, and annotated to include the affected measurement year(s).

Before using the technical specification, review the How to read DSRIP metric technical specification on the next page. If there are any questions about the metric specifications, contact medicaidtransformation@hca.wa.gov.

How to read DSRIP metric technical specifications

Metric name

- **Metric description** provides a brief description that includes definitions and additional detail needed to understand the metric.
- **Metric specification version** identifies the measure steward and version of specification used for the current specification sheet.
- **Data collection method** defines the method of data collection. Some metrics use only administrative data sources, while other metrics may use a hybrid data collection. An administrative collection method relies solely on clinical information collected from the electronic records generated in the normal course of business, such as claims, registration systems, or encounters. If a hybrid approach is used, a valid sample of carefully reviewed chart data will supplement the administrative data.
- **Data source** identifies all data sources required to generate the metric (e.g., ProviderOne).
- **Claim status** is for metrics that require claims and encounter data, identifies the status of the claims, and/or encounters eligible for inclusion in the metric calculation. For the purposes of DSRIP measurement, metrics only include final paid claims or accepted encounters.
- **Identification window** is relevant measurement timeframe. This generally aligns with the measurement year, but some metrics require previous year information to establish metric eligibility.
- **Direction of quality improvement** defines direction (higher or lower), representing improvement in the metric result.
- **URL of specifications:** if available, website for current specification version.

DSRIP program summary

- **Metric utility** defines metric association with DSRIP measurement and accountability. Metrics land in at least one of the following: ACH P4P (for ACH project incentives), ACH high-performance (for ACH high-performance incentives), and/or DSRIP statewide accountability (to determine at-risk overall DSRIP incentives in DY3-5).
- **ACH project P4P – metric results used for AV** defines metric result or submetric results used to determine earned AV for associated measurement period. See Appendix I.

- **ACH project P4P – improvement target methodology** defines whether the metric uses GTG or IOS methodology to set associated improvement targets. A full description of the methodology is available in Chapter 7. A full list of metrics and improvement target methodology used to set improvement targets is available in Appendix H.
- **ACH project P4P GTG - absolute benchmark value:** if metric uses GTG-based achievement, current, and past national benchmark will be set at the NCQA Quality Compass National Medicaid, 90th Percentile from the baseline year used and the benchmark for the performance year.

Table 52: P4P benchmark periods

DY3/performance year 1 (2019)	2017 NCQA Quality Compass National Medicaid, 90th Percentile
DY4/performance year 2 (2020)	2018 NCQA Quality Compass National Medicaid, 90th Percentile
DY5/performance year 4 (2021)	2020 IOS benchmarks, 1.9% improvement over baseline
DY6/performance year 5 (2022)	2021 IOS benchmarks, 1.9% improvement over baseline

- If metrics use IOS, no benchmark is listed. A full list of metrics and improvement target methodology used to set improvement targets is available in Appendix H. ACH regional attribution: for most metrics to be attributed to an ACH, the residential address(es) on file in the Medicaid enrollment files is/are required to be consistently within the boundaries of the ACH for 11 out of 12 months in the measurement year. A subset of metrics will use the less-restrictive seven out of 12 months in the measurement year.
- **Statewide attribution:** for DSRIP statewide accountability metrics, statewide attribution requirements are also included. For nine of the 10 statewide accountability quality metrics, to be included in attribution to the state, the residential address on file in the Medicaid enrollment files is required to be consistently within Washington State's boundary for 11 out of 12 months in the measurement year. One statewide accountability quality metric uses the less-restrictive seven out of 12 months in the measurement year.

DSRIP metric details

Eligible population: metric specific criteria for inclusion in the denominator of the metric.

Note: depending on the metric utility for DSRIP, distinct population eligibility criteria may apply (and are shown in different tables).

Table 53: ages included in the metric and indication of age

Age	Ages included in the metric; also includes indication of when age is determined
Gender	Indication of any gender-based exclusions.
Minimum Medicaid enrollment	Minimum Medicaid enrollment for metric inclusion. Enrollment criteria is either continuous or non-continuous in the measurement year.
Allowable gap in Medicaid enrollment	Description of any gaps allowed in enrollment to meet Medicaid enrollment criteria.
Medicaid enrollment anchor date	Defines the anchor date required for Medicaid enrollment, if applicable. If a specific anchor date is listed, an individual must be enrolled in Medicaid on that date to be included in the metric.
Medicaid benefit and eligibility	Description of Medicaid eligibility criteria for inclusion or exclusion in metric.

Denominator

Data elements required for denominator: description of data components used to calculate the denominator. Where possible, relevant value sets of current procedural terminology (CPT), code on dental procedures and nomenclature (CDT), and other values are listed. These value sets are used to identify relevant claim, encounter, or pharmacy data. HEDIS metrics are copyright protected and specific instructions and detailed value sets cannot be provided. In such cases, the name of the relevant values set(s) is referenced.

- Claim/encounter data.

- Description of any claim and encounter data used to determine inclusion in the denominator pharmacy data.
- Description of any pharmacy data used to determine inclusion in the denominator.

Value sets required for denominator: list of value sets referenced in calculation of the denominator.

Table 54: denominator value set

Name	Value set
Name of value sets required for metric construction	Includes specific codes, taxonomies, and other information required for the value set if possible

Required exclusions for denominator

Eligible population exclusions are listed in the eligible population in table 53 above.

- Metric specific exclusions: description of any metric specific exclusions required to be in the denominator.
- Deviations from cited specifications for denominator: description of any deviations from the measure steward's specification version cited in the metric information section, including the use of optional criteria.

Beneficiaries must qualify for inclusion in the denominator to be eligible for inclusion in the numerator.

Numerator

Data elements required for numerator: description of data components used to calculate the numerator. HEDIS metrics are copyright-protected and specific instructions and CPT code sets cannot be provided. Where possible, relevant sets of CPT or CDT are listed. The value sets are used to identify relevant claim, encounter, or pharmacy data. HEDIS value set are proprietary and specific lists of CPT or CDT codes cannot be provided. In such cases, the name of the relevant values sets is referenced.

- Claim/encounter data: description of any claim and encounter data used to determine inclusion in the numerator.
- Pharmacy data: description of any pharmacy data used to determine inclusion in the numerator.

Value sets required for numerator: list of value sets referenced in calculation of the numerator.

Table 55: numerator value set

Name	Value set
Name of value sets required for metric construction	Includes specific codes, taxonomies, and other information required for the value set if possible

Required exclusions for numerator

- Metric specific exclusions: description of any metric specific exclusions required to be in the numerator.
- Deviations from cited specifications for numerator.
- Description of any deviations from the measure steward's specification version cited in the metric Information section, including the use of optional criteria.

Version control

Record of any changes to the metric specifications from previous releases of the Measurement Guide.

Appendix K: technical specifications (ACH project P4R metrics)

Technical specification sheets for ACH project P4R metrics are available on the Medicaid Transformation metrics page.

A few important points on the technical specifications:

- **Each metric is identified as related to Project 2A or Project 3A.** Only practice/clinic sites and CBOs affiliated with Project 2A should respond to metric questions related to Project 2A. Similarly, only practice/clinic sites and CBOs affiliated with Project 3A should respond to metric questions related to Project 3A. For measures related to prescribing, only consider providers with prescribing privileges in determining the appropriate response.
- **Each metric is specified for response at the level of the practice/clinic site or CBO.** Some metrics, such as metrics related to improved opioid prescribing practices, may be important indicators of care transformation for practice/clinic sites but are not as applicable to the performance of CBOs. Similarly, some metrics address areas where CBOs have the potential to transform outcomes for clients who have opioid use disorders or behavioral health needs but are outside the typical scope of practice/clinic sites that may focus on medical care.
- **Respondents may interpret some questions in different ways.** HCA has sought to balance the goals of obtaining important information with offering ACHs flexibility and minimizing ACH burden. HCA encourages respondents to interpret questions in the manner most appropriate to their practice or organization's unique situation, and to retain any records they used to generate responses based on their interpretation to facilitate future compliance and evaluation activities.
- **As an option, ACHs may follow-up with selected respondents to learn more about their progress through a structured interview.** Each metric specifications includes a section of potential follow-up questions that reflect topics HCA would expect to ACHs to pursue in such interviews. ACHs are welcome to use these questions in their internal data-gathering as well.
- **ACHs will receive credit for reporting the responses received, based on their P4R metric collection efforts for the reporting period.** These metrics provide additional important information on implementation progress. While there is not a specified minimum response rate, it is HCA's expectation that ACHs will facilitate participation of practice/clinic sites and CBOs and strive for as much participation as possible of practice/clinic sites and CBOs.

Before using the technical specification sheets, review the How to read the ACH project P4R metric specification sheets guideline on the next page. If there are any questions about the metric specifications, contact meadicaidtransformation@hca.wa.gov.

How to read the ACH project P4R specifications

Metric information

Metric description provides a brief description that includes definitions and additional detail needed to understand the metric.

Reporting period and deadline:

- Reporting period references the interval for which providers should consider their performance for the associated reporting period when responding.
- Reporting deadline references the due date for ACHs to submit P4R metric information to the IA.
- It is at the ACHs discretion as to how and when to request the P4R metric information from relevant partnering providers. For example, an ACH may ask partnering providers for their P4R metric information between April to June. This encourages responses that are likely to reflect the

associated reporting period and ensure that information is collected in time for submission to the IA by the reporting deadline.

Table 56: SAR submission, reporting period, and deadline

SAR submission	Reporting period	Reporting deadline
3	January–June 2019	07/31/2019
4	July–December 2019	01/31/2020
5	January–June 2020	07/3/020
6	July–December 2020	01/31/2021
7	January–June 2021	07/31/2021
8	July–December 2021	01/31/2022
P4R – 1	January – March 2022	04/10/2022
P4R – 2	July – September 2022	10/9/2022

DSRIP program summary

Project affiliation identifies whether the metric addresses Project 2A or Project 3A.

Metric respondent criteria define the attributes of partnering providers for which metric questions are applicable and constitute the potential respondent pool from which responses could be fielded. The ACH-maintained partnering provider roster will serve as a primary source that lists potential respondents. However, not all metrics are applicable to all partnering providers affiliated with a particular project.

For example, metrics may be relevant only to providers in a particular specialty or providers who are able to prescribe medications. In cases where the partnering provider roster does not provide the fields necessary to identify the providers eligible to respond to a particular metric, ACHs may use discretion in identifying appropriate respondents.

DSRIP metric details

Table 57: question and response format

Question	Response format
Question text	Response options (e.g., yes/no, select the option that applies, and select all options that apply.

Practice/clinic/CBO sites are not required to provide detailed information when responding to question prompts. The ACH may be asked to share additional information that supports the responses submitted at any subsequent time for purposes of monitoring and auditing, or general follow-up and learning discussions with the state. If the ACH to is unable to share requested information in a timely manner, it may result in a loss of ACH project incentives or other actions, as deemed appropriate by HCA.

Potential follow-up questions

Follow-up questions are included for some metrics. The IA and/or IEE may use these questions in follow-up conversations with partnering provider sites (practice/clinic, CBOs) and ACHs. ACHs may elect to use them for their own follow-up activities with partnering provider sites.

Version control

Record of any changes to the metric specifications from prior releases.