DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

November 1, 2021

Dr. Charissa Fotinos
Acting Medicaid Director
Health Care Authority
626 8th Avenue SE
P.O. Box 45502
Olympia, Washington 98504-5010

Dear Dr. Fotinos:

Thank you for your request to modify the Attachments C and D in Washington's section 1115(a) demonstration, titled "Medicaid Transformation Project" ("MTP") (Project No. 11-W-00030/1). To align with the measure steward, NCQA, retiring and updating measures, Washington is making changes to four measures in its Delivery System Reform Incentive Program (DSRIP). The Projects Toolkit and Metrics Appendix, which is included in Attachment C, and the DSRIP Funding and Mechanics Protocol, Attachment D, are revised to reflect these changes in measures. These changes to pay-for-performance project and statewide accountability measures are effective for Demonstration Years 4 and 5.

If you have any questions, please contact your CMS project officer, Ms. Diona Kristian. Ms. Kristian is available to answer any questions concerning your section 1115(a) demonstration and his contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-6157
E-mail: Diona.Kristian@cms.hhs.gov

We look forward to our continued partnership on the MTP section 1115(a) demonstration.

Sincerely,

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: Nicole Lemmon, State Lead, Medicaid and Chip Operations Group

Washington State Health Care Authority

Medicaid Transformation Project (MTP) Toolkit

September 2021

Centers for Medicare and Medicaid Services (CMS) approved Washington's MTP Toolkit in June 2017 as part of the Delivery System Incentive Payment (DSRIP) planning protocol. The CMS-approved Project Toolkit contains the final projects, evidence-based approaches/strategies, and metrics for the Medicaid Transformation Project. (MTP) A timeline and summary of modifications made to this document (since CMS approval) are below.

- June 2017: approved by CMS as part of the DSRIP planning protocol.
- October 2017: revised to reflect the removal of five project pay-for-performance (P4P) metrics. The list of metrics and associated rationale and other resources are available on the MTP metrics page.
- July 2018: revised to streamline and clarify reporting requirements associated with achievement values (AVs), updated to reflect change in pay-for-reporting (P4R) metrics, minor change to one P4P metric (inpatient hospital utilization replaced by acute hospital utilization, per Healthcare Effectiveness Data and Information Set (HEDIS) 2018 recommendation).
- August 2019: the state adopted adjustments to the set of DSRIP accountability metrics associated with the Project Toolkit. More information is available on the MTP metrics page. The following P4P metric updates were incorporated into the Project Toolkit:
    - Metric: dental sealants for children at elevated risk: deactivate for ACH P4P accountability for demonstration year (DY)4. Assess activation for DY5 when revised specifications available. Applies to Project 3C.
    - Metric: medication management for people with asthma (National Quality Forum (NQF) 1799)): No change to DY3. In DY4, remove medication management for people with asthma and replace with asthma medication ratio (NQF 1800). Applies to Project 2A and 3D.
- September 2019: typos corrected in Appendix A: P4R and P4P AV association.
- June 2021: updated P4P metrics consisting with HEDIS changes for DY4 and DY5. The following measures were updated based on the 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 replaces 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 replaces 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 replaces 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 replaces CDC: Nephropathy.

Washington State Health Care Authority

Table of contents

Using the Project Toolkit: definitions

Project objective: aim the project is intended to achieve.

Target population: population the project is intended to address. For each project selected, the Accountable Community of Health (ACH) must define the target population, informed by regional needs, and based on the target population defined in the toolkit. ACHs may choose one or more target populations.

Evidence-based approach: menu of interventions available for the project. One or more evidence-based approaches are identified to serve as a menu of interventions for each project. ACHs may pursue one of the following approaches:

- Selecting one evidence-based approach for the entire project.
- Combining evidence-based approaches for the entire project.
- Applying different evidence-based approaches for different target populations/geographies for the project.

ACHs are required to implement one of the evidence-based approaches identified under the selected project or identify another, similar evidence-based approach. If selecting an alternative evidence-based approach, the ACH must demonstrate convincingly its equivalency to those in the toolkit, including the ability to achieve required project metrics.

Project stages and milestones: each project progresses from project planning, implementation, and sustainability. Each project is divided into three stages, which has defined milestones. ACHs must provide proof of completion of each milestone within a specified timeline to earn receive full project incentive funds from DY2 to DY4. To the extent possible, milestones, timeline, and proof of completion are standardized across projects. ACHs are awarded AVs for successful completion of project milestones according to the toolkit timeline.

P4R recurrent deliverables and P4P project metrics: in addition to milestones listed in the project stage, each ACH will be responsible for additional, recurrent P4R deliverables from DY2 to DY5. Each ACH will be held accountable and awarded incentive funds based on a P4P basis from DY3 through DY5 for the metrics listed in the toolkit. All P4P measurement and calculations will be produced by the state on an annual basis. Specifics on project performance measurement are further detailed in the DSRIP Measurement Guide.

Project incentive funds are earned on AVs for each specified item in the toolkit (project milestones, recurrent P4R deliverables, P4R metrics, and P4P metrics). See Appendix A: AV snapshot by project for a full schedule of AVs.

Project implementation guidelines: additional details on the project's core components, including health systems and community capacity building strategies and evidence-based approaches that are intended to guide ACHs' development of project implementation plans and quality improvement plans (QIPs).

Appendix A: P4R and P4P AV association: tables provide a quick reference for AVs for P4R and P4P funds by project by year.

Appendix B: Project Toolkit P4P metrics: ACHs are accountable for achieving targeted levels of improvement for project-specific outcome metrics. The tables provide a quick reference of the final project performance metrics used to measure ACH progress toward meeting project goals and targeted levels of improvement against outcome-based performance indicators.

Domain 1: health systems and community capacity building

This domain addresses the core health system capacities to be developed or enhanced to transition the delivery system under MTP. Domain 1 outlines three required focus areas: financial sustainability through value-based payment, workforce, and systems for population health management. Each of these areas will need to be addressed progressively throughout the five-year timeline to directly support Domain 2 and Domain 3 transformation project success.

Financial sustainability through value-based purchasing (VBP)

Overarching goal

Achieve the target of driving 90 percent of state-financed health care to value-based payment by the end of 2021.

The success and sustainability of the state's DSRIP program is largely dependent on moving along the value-based payment continuum as a state and at the regional level. ACHs may earn VBP incentives by reporting progress on VBP milestones (P4R), and improvement and attainment of VBP targets (P4P) in their region. ACHs will be primarily rewarded on progress in the early years, shifting to performance in later years.

VBP categories as defined by the Health Care Payment Learning Action Network (HCP-LAN) Framework will be used for calculating the annual targets below. Targets will be calculated by dividing the total Medicaid dollars spent in HCP-LAN categories 2C and higher by total Medicaid managed care organization (MCO) payments to providers.

Annual targets

Percentage of provider payments in HCP-LAN categories 2C or above required to earn VBP incentives.

Table 1: VBP targets

	DY1	DY2	DY3	DY4	DY5
HCP-LAN category 2C-4B	30%	50%	75%	85%	90%
Subset of goal above: HCP-LAN category 3A-4B	-	10%	20%	30%	50%
Payment in Advanced alternative payment methods (APMs)	-	-	TBD	TBD	TBD

Further information on regional, MCO, and statewide VBP targets, and how incentives are earned are available in the Apple Health Appendix and the DSRIP Measurement Guide.

Governance

HCA will create and facilitate a statewide Medicaid Value-based Payment (MVP) Action Team. The MVP Action Team will serve as a learning collaborative to support ACHs and MCOs in attainment of Medicaid VBP targets. It will serve as a forum to help prepare providers for value-based contract arrangements and to provide guidance on HCA's VBP definition (based on the HCP-LAN Framework). Representatives may include state, regional and local leaders, and stakeholders.

Project stages

Table 2: stage 1 – financial sustainability through VBP planning

Responsibility (regional/ statewide)	Activity	Timeline (complete no later than)
Statewide	The MVP Action Team will assist HCA in performing an assessment to capture or validate a baseline of the current VBP levels. To the extent assessments have already been conducted, the MVP Action Team will build from those assessments. Building from existing work when applicable, the MVP Action Team will: • Assist HCA in deploying survey/attestation assessments to facilitate the reporting of VBP levels to understand the current types of VBP arrangements across the provider spectrum. • Perform and/or review assessments of VBP readiness across regional provider systems. • Develop recommendations to improve VBP readiness across regional provider systems.	DY2, Q4

Regional	To support regional attainment of VBP targets, ACHs will achieve the following milestones:
	• Inform providers of VBP readiness tools to assist their move toward value-based care. Some viable tools may include:
	  ○ NACHC Payment Reform Readiness Toolkit
	  ○ AMA Steps Forward – preparing your practice for value-based care
	  ○ Rural Health Value Team's comprehensive Value-Based Care Strategic Planning Tool
	  ○ Assessments deployed by the Healthier Washington Collaboration Portal (WA Portal), formerly known as the Practice Transformation Support Hub, and the Transforming Clinical Practice Initiative (TCPI).
	  ○ Adoption of diagnostic coding in dental for bi-directional medical/dental data sharing and population health.
	• Connect providers to training and/or technical assistance offered through HCA, WA Portal, MCOs, and/or the ACH.
	• Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the annual Paying for Value provider survey.
	• Support providers in developing strategies to move toward value-based care.
		DY2, Q4

Table 3: stage 2 – financial sustainability through VBP implementation

Responsibility (regional/ statewide)		Timeline (complete no later than)
Statewide	Perform ongoing monitoring of regional, MCO, and statewide VBP attainment as described in the Apple Health Appendix.	DY5, Q4
Regional	To support regional attainment of VBP targets, ACHs will achieve the following milestones: • Identify providers who are struggling to implement practice transformation and move toward value-based care.	DY3, Q4

	• Support providers to implement strategies to move toward value-based care. • Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of the annual Paying for Value provider survey.	
	To support regional attainment of VBP targets, ACHs will achieve the following milestones: • Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of the annual Paying for Value provider survey. • Continued identification and support of providers struggling to implement practice transformation and move toward value-based care.	DY4, Q4

Workforce

Overarching goal

Promote a health workforce that supports comprehensive, coordinated, and timely access to care.

Governance

Throughout the design and implementation of transformation efforts, ACHs and partnering providers must consider workforce needs pertaining to selected projects and the broader objectives of MTP. There are several statewide taskforces and groups with expertise in identifying emerging health workforce needs and providing actionable information to inform the evolving workforce demands of a redesigned system of care. ACHs should leverage existing resources available to inform workforce strategies for the projects their region is implementing.

Project stages

Table 4: stage 1 – workforce planning

Responsibility (regional/ statewide)	Activity	Timeline (to complete no later than)
Statewide	• Based on identified regional workforce gaps and needs, provide recommendations and guidance to support and evolve the health care workforce consistent with MTP goals and objectives. • Identify existing educational and other resources available to educate, train, and re-train individuals to promote a workforce that supports and promotes evolving care models.	DY2, Q4

Regional	• Consider workforce implications as part of project implementation plans and identify strategies to prepare and support the state's health workforce for emerging models of care under MTP.
	• Develop workforce strategies to address gaps and training needs, and to make overall progress toward the future state of MTP:
	  ○ Identify regulatory barriers to effective team-based care and practice transformation.
	  ○ Incorporate strategies and approaches to cultural competency and health literacy trainings.
	  ○ Incorporate strategies to mitigate impact of health care redesign on workforce delivering services for which there is a decrease in demand.
		DY2, Q4

Table 5: stage 2 – workforce implementation

Responsibility (regional/statewide)		Timeline (complete no later than)
Statewide and regional	• Implement practice transformation and workforce strategies. • Administer necessary resources to support all efforts.	DY4, Q4

Systems for population health management

Overarching goal

Leverage and expand health information technology (HIT) and health information exchange (HIE) infrastructure and tools to capture, analyze, and share relevant data.

For the purposes of MTP, population health management is defined as:

- Data aggregation
- Data analysis
- Data-informed care delivery
- Data-enabled financial models

Governance

Governance is envisioned as a multi-tiered approach. Data and measurement activity in service of MTP will be facilitated by the Washington State Health Care Authority (HCA), in coordination with departments of Social and Health Services (DSHS) and Health (DOH).

- The Office of the National Coordinator develops policy and system standards for interoperability, which govern Certified Electronic Health Record Technology (CEHRT) and sets the national standards for how health information systems can collect, share, and use information. The use of interoperable HIT and HIE is expected to support care coordination and integration, quality improvement, and value-based payment.
- HCA will coordinate efforts among multiple state government agencies to link Medicaid claims, social services data, population health information, and social determinants of health data, as well as direct efforts to increase accessibility of data in line with current legislation.
- HCA will work with ACHs to ensure that:
    - Data products are developed that meet ACH project need.
    - Data are combined in ways that meet local needs.
    - Access to data accommodates different levels of IT sophistication, local use, and support improved care.

Project stages

Table 6: stage 1 – systems for population health management planning and implementation

Responsibility (regional/ statewide)	Activity	Timeline (complete no later than)

Statewide	• HCA will provide guidance to ACHs in assessing current population health management capacity in service of Domain 2 and Domain 3 projects.
	• HCA will Identify tools available for population health management, which may include:
	  ○ Agency for Healthcare Research and Quality's (AHRQ) Practice-Based Population Health.
	  ○ Office of the National Coordinator for Health IT's 2016 Interoperability Standards Advisory.
	  ○ SAMHSA-HRSA's Center for Integrated Health Solutions Population Health Management webinars.
	• The HCA will promote on-demand access to standard care summaries and medical records within the Clinical Data Repository (CDR) through the HIE and claims through the development of an integrated health information system.
	• To support the work, HCA will coordinate with the state-designated entity for HIE, OneHealthPort, which is responsible for building and implementing the infrastructure used for HIE and developing tools and services that support broader access and utilization of both HIE and clinical data. In addition, OneHealthPort works for and with the provider community to help develop community best practices for data exchange and use.
		DY4 Q2

Regional	To support transformation projects, ACHs will convene key providers and health system alliances to share information with the state on: • Provider needs to effectively access and use population health data. • Local health system stakeholder needs for population health, social service, and social determinants of health data. ACHs must address systems for population health management within their project implementation plans. This must include: • Identified work steps and deliverables to implement information exchange for community-based, integrated care. Implementation plans should be tailored based on regional providers' current state of readiness and the implementation strategies selected within Domains 2 and 3. • Actionable steps taken to develop or enhance information exchange between providers at points of care, which will allow for the ability to track and follow up on patients with target conditions. • Identified opportunities to leverage transformation incentives, resources, and activities to respond to needs and gaps identified in the current infrastructure and support statewide information exchange systems.	DY4 Q2

Domain 2: care delivery redesign

Transformation projects within this domain focus on innovative models of care that will improve the quality, efficiency, and effectiveness of care processes.

Project 2A: bi-directional integration of physical and behavioral health through care transformation

Project objective

This project uses a whole-person approach to care by addressing physical and behavioral health needs in one system through an integrated network of providers. This approach offers better coordinated care for patients and more seamless access to the services they need. This project will support and advance MTP and bring together the financing and delivery of physical and behavioral health services through MCOs for people enrolled in Medicaid.

Target population

All Medicaid beneficiaries (children and adults), particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD).

Guidelines

ACHs must implement a project that includes at least one approach from integrating:

- Behavioral health into primary care settings.
- Primary care into the behavioral health setting.

Evidence-based approaches for integrating behavioral health into a primary care setting:

- Bree Collaborative's Behavioral Health Integration Report and Recommendations
- Collaborative Care Model
    - The Collaborative Care Model is a team-based model that adds a behavioral health care manager and a psychiatric consultant to support the primary care provider's management of individual patients' behavioral health needs.
    - The model can be either practice-based or telehealth-based, so it can be used in both rural and urban areas.
    - The model can be used to treat a wide range of behavioral health conditions, including depression, SUD, bipolar disorder, post-traumatic stress disorder (PTSD), and other conditions.

Approaches based on emerging evidence for integrating primary care into behavioral health settings:

These approaches are described in the report "Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness."

For any approach, apply core principles of the Collaborative Care Model (see above) to integration into the behavioral health setting.

- Off-site, enhanced collaboration
- Co-located, enhanced collaboration

- Co-located, integrated

Project stages

Table 7: stage 1 – bi-directional integration planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity of integrated care model adoption: describe the level of integrated care model adoption among the target providers/organizations serving Medicaid beneficiaries. Explain which integrated models or practices are currently in place and describe where each target provider/organization currently falls in the levels of collaboration as outlined in the Standard Framework for Integrated Care.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity building • **Identify how strategies for health systems/community capacity building focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Define target population(s) and evidence-based approach(es)/promising practices informed by regional health needs.**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify and engage initial partnering providers, including behavioral and physical health providers, organizations, and relevant committees or councils.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2
Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.** • **For 2020 adopters of integrated managed care: ensure planning reflects timeline and process to transition to integration of physical and behavioral health, including engaging and convening county commissioners, Tribal Governments, MCOs, behavioral health and primary care providers, and other critical partners.**	Timely submission of implementation plan	DY2, Q3
Support regional transition to integrated managed care (2020 regions only) • **Note: This milestone only applies to those ACH regions that were not early or mid-adopters for integrated managed care.** • **Engage and convene county commissioners, Tribal Governments, MCOs, behavioral health and primary care providers, and other critical partners to develop a plan and description of a process to transition to integrated managed care.**	Report milestone completion in semi-annual report	DY2, Q4

Table 8: stage 2 – bi-directional integration implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures, and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches.**	Timely submission of QIP	DY3, Q2
Description of training and implementation activities • **Ensure each partnering provider and/or organization is provided with, or has secured, the training and technical assistance resources and HIT/HIE tools necessary to perform their role in the integrated care activities.** • **Obtain technology tools needed to create, transmit, and download shared care plans and other HIE technology tools to support integrated care activities.** • **Provide participating providers and organizations with financial resources to offset the costs of infrastructure necessary to support integrated care activities.**	Demonstrate progress in semi-annual report	DY3, Q4
Attestation of successfully integrating managed care • **Implementation of integrated managed care (applicable to mid-adopter regions).**	Report milestone completion in semi-annual report	

Table 9: stage 3 – bi-directional integration scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase use of technology tools to support integrated care activities by additional providers/organizations.** • **Identify new, additional target providers/organizations.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model and adopting guidelines, policies, and procedures as required.**		
Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.** • **Leverage regional champions and implement a train-the-trainer approach to support the spread of best practices.**		
Demonstrate sustainability of transformation activities		

• **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 10: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 (2018)	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of independent external evaluator (IEE) activities	DY2, Q4
DY3 (2019)	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Maine Health Access Foundation (MeHAF) Site Self-Assessment Survey))	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (MeHAF Site Self-Assessment Survey)	DY3, Q4
	P4P: state-produced	• All-Cause Emergency Department (ED) Visits per 1000 Member Months • Antidepressant Medication Management • Children's and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Medication Management for People with Asthma (5 – 64 Years) • Mental Health Treatment Penetration (Broad Version) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual
DY4 (2020)	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (MeHAF Site Self-Assessment Survey)	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (MeHAF Site Self-Assessment Survey)	DY4, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months	Annual

		• Antidepressant Medication Management • Asthma Medication Ratio • Child and Adolescent Well-Care Visits (3-21 Years of Age) • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Kidney Health Evaluation with Patients with Diabetes • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	
DY5 (2021)	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (MeHAF Site Self-Assessment Survey)	DY5, Q2
		• Completion of semi-annual report (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (MeHAF Site Self-Assessment Survey)	DY5, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Antidepressant Medication Management • Asthma Medication Ratio • Child and Adolescent Well-Care Visits (3-21 Years of Age) • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Kidney Health Evaluation with Patients with Diabetes • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual

Project implementation guidelines

This section provides additional details on the project's core components and should guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems community and capacity building strategies

- **Population health management/HIT:** current level of adoption of electronic health records (EHRs) and other systems that support relevant bi-directional data sharing, clinical-community linkages,

timely communication among care team members, care coordination and management processes, information to enable population health management and quality improvement processes, and provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.

- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Shortage of mental health providers, SUD providers, social workers, nurse practitioners, primary care providers, care coordinators and care managers.
    - Opportunities for use of telehealth and integration into work streams.
    - Workflow changes to support integration of new screening and care processes, care integration, and communication.
    - Cultural and linguistic competency and health literacy deficiencies.
- **Financial sustainability:** alignment between current payment structures and guidelines for physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Guidance for evidence-based approaches

Integrating behavioral health into primary care setting

Standards adopted by the Bree Collaborative in the Behavioral Health Integration Report and Recommendations (As part of this option, regions will implement the core components that are consistent with the standards adopted by the Bree Collaborative).

Summary of core elements and minimum standards for integrated care element specifications under consideration by the Bree Collaborative:

- Integrated Care Team: each member of the integrated care team has clearly defined roles for both physical and behavioral health services. Team members, including clinicians and non-licensed staff, may participate in team activities, either in person or virtually.
- Routine access to integrated services: access to behavioral health and primary care services are available routinely as part of the care team's daily workflow and on the same day as patient needs are identified, as feasible. Patients can be engaged and receive treatment in person or by phone or videoconferencing, as convenient for the patient.
- Accessibility and sharing of patient information: the integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care. All clinicians work together to jointly support their roles in the patient's shared care plan.
- Access to psychiatry services: access to psychiatry consultation services is available in a systematic manner to assist the care team in developing a treatment plan and to advise the team on adjusting treatments for patients who are not improving as expected.
- Operational systems and workflows support population-based care: a structured method is in place for proactive identification and stratification of patients for behavioral health conditions. The care team

tracks patients to make sure each patient is engaged and treated-to-target (i.e., to remission or other appropriate individual improvement goals).

- Evidence-based treatments: age-appropriate, measurement-based interventions for physical and behavioral health interventions are adapted to the specific needs of the practice setting. Integrated practice teams use behavioral health symptom rating scales in a systematic and quantifiable way to determine whether their patients are improving.
- Patient involvement in care: the patient's goals are incorporated into the care plan. The team communicates effectively with the patient about their treatment options and asks for patient input and feedback into care planning.

Collaborative Care Model

As part of this option, regions can choose to focus initially on depression screening and treatment program (such as tested in the IMPACT model). Many successful Collaborative Care pilot programs begin with an initial focus on depression and later expand to treat other behavioral health conditions, including SUD.

Implement the core components and tasks for effective integrated behavioral health care, as defined by the Advancing Integrated Mental Health Solutions (AIMS) Center of the University of Washington and shown here:

- Patient identification and diagnosis:
    - Screen for behavioral health problems using valid instruments.
    - Diagnose behavioral health problems and related conditions.
    - Use valid measurement tools to assess and document baseline symptom severity.
- Engagement in integrated care program:
    - Introduce collaborative care team and engage patient in integrated care program.
    - Initiate patient tracking in population-based registry.
- Evidence-based treatment:
    - Develop and regularly update a biopsychosocial treatment plan.
    - Provide patient and family education about symptoms, treatments, and self-management skills.
    - Provide evidence-based counseling (e.g., motivational interviewing, behavioral activation).
    - Provide evidence-based psychotherapy (e.g., problem-solving treatment, cognitive behavioral therapy, interpersonal therapy).
    - Prescribe and manage psychotropic medications as clinically indicated.
    - Change or adjust treatments if patients do not meet treatment targets.
- Systematic follow-up, treatment adjustment, and relapse prevention:
    - Use population-based registry to systematically follow all patients.
    - Proactively reach out to patients who do not follow-up.
    - Monitor treatment response at each contact with valid outcome metrics.
    - Monitor treatment side effects and complications.
    - Identify patients who are not improving to target them for psychiatric consultation and treatment adjustment.
    - Create and support relapse prevention plan when patients are substantially improved.

- Communication and care coordination:
    - Coordinate and facilitate effective communication among all providers on the treatment team, regardless of clinic affiliation or location.
    - Engage and support family and significant others as clinically appropriate.
    - Facilitate and track referrals to specialty care, social services, and community-based resources.
- Systematic psychiatric case review and consultation (in-person or via telemedicine):
    - Conduct regular (e.g., weekly) psychiatric caseload review on patients who are not improving.
    - Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals.
    - Provide psychiatric assessments for challenging patients, either in-person or via telemedicine.
- Program oversight and quality improvement:
    - Provide administrative support and supervision for program.
    - Provide clinical support and supervision for program.
    - Routinely examine provider- and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use this information for quality improvement.

Integrating primary care into behavioral health setting

Offsite enhanced collaboration

Primary care and behavioral health providers located at a distance from one another will move beyond basic collaboration (in which providers make referrals, do not share any communication systems, but may or may not have periodic non-face-to-face communication, including sending reports), to enhanced collaboration that includes tracking physical health outcomes, with the following core components:

- Providers have regular contact and view each other as an interdisciplinary team, working together in a client-centered model of care.
- A process for bi-directional information sharing, including shared treatment planning, is in place and is used consistently.
- Providers may maintain separate care plans and information systems, but regular communication and systematic information sharing results in alignment of treatment plans, and effective medication adjustments and reconciliation to effectively treat beneficiaries to achieve improved outcomes.
- Care managers and/or coordinators are in place to facilitate effective and efficient collaboration across settings ensuring that beneficiaries do not experience poorly coordinated services or fall through the cracks between providers.
- Care managers and/or coordinators track and monitor physical health outcomes over time using registry tools, facilitate communication across settings, and follow up with patients and care team members across sites.

Co-located, enhanced collaboration or co-located, integrated

Apply and implement the core principles of the Collaborative Care Model to the integration of primary care; implement the core components and tasks for effective integration of physical health care into the behavioral health setting.

- Patient identification and diagnosis:
    - Screen for and document chronic diseases and conditions, such as obesity, diabetes, heart disease and others.
    - Diagnose chronic diseases and conditions.
    - Assess chronic disease management practices and control status.
- Engagement in integrated care program:
    - Introduce collaborative care team and engage patient in integrated care program.
    - Initiate patient tracking in population-based registry.
- Evidence-based treatment:
    - Develop and regularly update a biopsychosocial treatment plan.
    - Provide patient and family education about symptoms, treatments, and self-management skills.
    - Provide evidence-based self-management education.
    - Provide routine immunizations according to Advisory Committee on Immunization Practices (ACIP) recommendations as needed.
    - Provide the U.S. Preventive Services Task Force screenings graded A and B as needed.
    - Prescribe and manage medications as clinically indicated.
    - Change or adjust treatments if patients do not meet treatment targets, refer to specialists as needed.
- Systematic follow-up, treatment adjustment:
    - Use population-based registry to systematically follow identified patients.
    - Proactively reach out to patients who have difficulty following up.
    - Monitor treatment response at each contact with valid outcome metrics.
    - Monitor treatment side effects and complications.
    - Identify patients who are not improving and identify them for specialist evaluation or connection to increased primary care access/utilization.
- Communication and care coordination:
    - Coordinate and facilitate effective communication among all providers on the treatment team, regardless of clinic affiliation or location.
    - Engage and support family and significant others as clinically appropriate.
    - Facilitate and track referrals to specialty care, social services, and community-based resources.
- Systematic case review and consultation (in person or via telemedicine):
    - Conduct regular (e.g., weekly) chronic disease and condition caseload review on patients who are not improving.
    - Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals.
- Program oversight and quality improvement:

- Provide administrative support and supervision to support an integrated team.
- Provide clinical support and supervision for care team members who are co-located.
- Routinely examine provider-level and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use to inform quality improvement processes and activities.

Project 2B: community-based care coordination

Project objective

Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.

Target population

Medicaid beneficiaries (adults and children) with one or more chronic disease or condition (such as arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity, and stroke), or mental illness/depressive disorders, or moderate to severe SUD and at least one risk factor (e.g., unstable housing, food insecurity, high emergency management services (EMS) utilization).

Evidence-based approach

Pathways Community HUB

Project stages

Table 11: stage 1 – community-based care coordination planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively focus on the need for regional community-based care coordination.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for health systems community and capacity building focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Define target population(s) and evidence-based approach(es)/promising practices informed by regional health needs.**	Report milestone completion in semi-annual report	DY2, Q2

Completion of initial partnering provider list
• **Identify and engage project implementation partnering provider organizations, including:**
  ○ **Review national HUB standards and provide training on the HUB model to stakeholders.**
  ○ **Identify, recruit, and secure formal commitments for participation from all implementation partners, including patient-centered medical homes, health homes, care coordination service providers, and other community-based service organizations, with a written agreement specific to the role each will perform in the HUB.**
  ○ **Determine how to fill gaps in resources, including augmenting resources within existing organizations and/or hiring at the HUB lead entity.**
  ○ **Execute Master Services Agreement for partnering providers receiving funds through the financial executor (FE) portal.**
	Report milestone completion in semi-annual report	DY2, Q2

Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3
Identified HUB lead entity and description of qualifications • **Identify project lead entity, including:** ○ **Establishing HUB planning group, including payers.**	Report milestone completion in semi-annual report	DY2, Q4

Table 12: stage 2 – community-based care coordination implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways.**	Timely submission of QIP	DY3, Q2
Description of training and implementation activities **Implement project, which includes the Phase 2 (creating tools and resources) and 3 (launching the HUB) elements specified by AHRQ:** • **Create and implement checklists and related documents for care coordinators.** • **Implement selected pathways from the Pathways Community HUB Certification Program or implement care coordination evidence-based protocols adopted as standard under a similar approach.** • **Develop systems to track and evaluate performance.** • **Hire and train staff.** • **Implement technology-enabled care coordination tools and enable the appropriate integration of information captured by care coordinators with clinical information captured through statewide HIE.**	Demonstrate progress in semi-annual report	DY3, Q4
Description of each pathway scheduled for initial implementation and expansion/partnering provider roles and responsibilities to support Pathways implementation.	Demonstrate progress in semi-annual report	DY3, Q4

Table 13: stage 3 – community-based care coordination scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Expand the use of care coordination technology tools to additional providers and/or patient populations.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model, and adopting guidelines, policies, and procedures as required.**		
Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 14: community-based care coordination P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Mental Health Treatment Penetration (Broad Version) • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q2

		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Mental Health Treatment Penetration (Broad Version) • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • SUD Treatment Penetration	Annual

Project implementation guidelines

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of electronic health records (EHRs) and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, information to enable population health management and quality improvement processes, and provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:

    - Shortage of mental health providers, SUD providers, social workers, nurse practitioners, primary care providers, care coordinators and care managers.
    - Opportunities for use of telehealth and integration into work streams.
    - Workflow changes to support integration of new screening and care processes, care integration, and communication.
    - Cultural and linguistic competency and health literacy deficiencies.
- **Financial sustainability:** alignment between current payment structures and guidelines for physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Project 2C: transitional care

Project objective

Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.

Target population

Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home or to supportive housing, and beneficiaries with serious mental illness (SMI) discharged from inpatient care, or client returning to the community from prison or jail.

Evidence-based approaches for care management and transitional care:

1) Interventions to Reduce Acute Care Transfers, INTERACT™4.0: a quality improvement program that focuses on the management of acute change in resident condition.
2) Transitional Care Model: a nurse-led model of transitional care for high-risk older adults that provides comprehensive in-hospital planning and home follow-up.
3) The Care Transitions Intervention® (CTI): a multi-disciplinary approach toward system redesign incorporating physical, behavioral, and social health needs and perspectives. Note: the CTI is also known as the Skill Transfer Model™, the Coleman Transitions Intervention Model®, and the Coleman Model®.
4) Care Transitions Interventions in Mental Health provides a set of components of effective transitional care that can be adapted for managing transitions among persons with SMI.

Evidence-informed approaches to transitional care for people with health and behavioral health needs leaving incarceration

Despite the relative dearth of specific, outcomes-focused research on effective integrated health and behavioral health programs for people leaving incarceration, considerable evidence on effective integrated care models, prison/jail reentry, and transitional programming has paved the way for increased understanding of critical components of an integrated transitional care approach. See the following:

- American Association of Community Psychiatrists' Principles for Managing Transitions in Behavioral Health Services

Project stages

Table 15: transitional care planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively deliver care transition services.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for Health systems/community capacity • **Identify how strategies for health systems community and capacity building focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Define target population(s) and evidence-based approach(es)/promising practices informed by regional health needs.**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify, recruit, and secure formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.** • **For projects targeting people transitioning from incarceration: identify and secure formal partnerships with relevant criminal justice agencies (including but not limited to correctional health, local releasing, and community supervision authorities), health care and behavioral health care service providers, and reentry-involved community-based organizations, including state and local reentry councils.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2
Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3

Table 16: transitional care implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways.**	Timely submission of QIP	DY3, Q2

Description of training and implementation activities • **Implement project, including the following core components across each approach selected:** • **Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.** • **Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure care team members, including client and family/caregivers, have access to the electronic shared care plan).** • **Establish mechanisms for coordinating care management and transitional care plans with related community-based services and supports, such as those provided through supported housing programs.** • **Incorporate activities that increase the availability of POLST forms across communities/agencies, where appropriate.** • **Develop systems to monitor and track performance.**	Demonstrate progress in semi-annual report	DY3, Q4

Table 17: transitional care scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model, and adopting guidelines, policies, and procedures as required.**		
Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 18: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018)	DY2, Q4

		• Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days)	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Submission of QIP • Metric reporting	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Percent Homeless (Narrow Definition) • Plan All-Cause Readmission Rate (30 Days)	Annual
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2

		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After ED Visit for Mental Illness • Follow-up After Hospitalization for Mental Illness • Percent Homeless (Narrow Definition) • Plan All-Cause Readmission Rate (30 Days)	Annual

Project implementation guidelines

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of electronic health records (EHRs) and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, information to enable population health management and quality improvement processes, and provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Shortage of mental health providers, SUD providers, social workers, nurse practitioners, primary care providers, care coordinators and care managers.
    - Opportunities for use of telehealth and integration into work streams.
    - Workflow changes to support integration of new screening and care processes, care integration, and communication.
    - Cultural and linguistic competency and health literacy deficiencies.
- **Financial sustainability:** alignment between current payment structures and guidelines for physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Guidance for evidence-based approaches

Evidence-based approaches for care management and transitional care

INTERACT™4.0

The skilled nursing facility (SNF) and the project implementation team will utilize INTERACT™4.0 toolkit and resources and implement the following core components:

- Educate leadership in the INTERACT™ principles.
- Identify a facility champion who can engage other staff and serve as a coach.
- Develop care pathways and other clinical tools for monitoring patients that lead to early identification of potential instability and allow intervention to avoid hospital transfer.
- Provide all staff with education and training to fill their role in the INTERACT™ model.
- Educate patients and families and provide support that facilitates their active participation in care planning.
- Establish enhanced communication with acute care hospitals, relying on technology where appropriate.
- Establish quality improvement process, including root cause analysis of transfers and identification and testing of interventions.
- Demonstrate cultural competence and client engagement in the design and implementation of the project.

Transitional Care Model

Implement the essential elements of this model:

- Use of advanced knowledge and skills by a transitional care nurse (TCN) to deliver and coordinate care of high-risk older adults within and across all health care settings. The TCN is primary coordinator of care throughout potential or actual episodes of acute illness.
- Comprehensive, holistic assessment of each older adult's priority needs, goals, and preferences.
- Collaboration with older adults, family caregivers, and team members in implementation of a streamlined, evidenced-based plan of care designed to promote positive health and cost outcomes.
- Regular home visits by the TCN with available, ongoing telephone support (seven days per week) through an average of two months.
- Continuity of health care between hospital, post-acute, and primary care clinicians facilitated by the TCN by accompanying patients to visits to prevent or follow-up on an acute illness care management.
- Active engagement of patients and family caregivers with a focus on meeting their goals.
- Emphasis on patients' early identification and response to health care risks and symptoms to achieve longer-term positive outcomes and avoid adverse and untoward events that lead to acute care service use (e.g., ED visits, re-hospitalizations).
- Multidisciplinary approach that includes the patient, family caregivers, and health care providers as members of a team.
- Strong collaboration and communication between older adults, family caregivers, and health care team members across episodes of acute care and in planning for future transitions (e.g., palliative care).
- Ongoing investment in optimizing transitional care via performance monitoring and improvement.

Care Transitions Intervention®

Implementation guidance:

- A meeting with a Transitions coach in the hospital (where possible, as this is desirable but not essential) to discuss concerns and to engage patients and their family caregivers.
- Set up the Transitions coach in home follow-up visit and accompanying phone calls designed to increase self-management skills, personal goal attainment, and provide continuity across the transition.

Care transitions interventions in mental health

Set of components of effective transitional care that can be adapted for managing transitions among persons with serious mental illness:

- Adapt components of care transitions interventions to focus on points of transition for the SMI population, including discharge from intensive behavioral health care, and discharge from emergency room (ER) for mental health, alcohol, or other drug dependence.
- Prospective modeling: employ prospective modeling to identify who is at greatest risk. Consider different patterns of morbid conditions within and among mental illnesses, SUDs, and general medical/surgical conditions that might require modifications.
- Patient and family engagement: create culturally competent engagement strategies to drive authentic inclusion of patient and/or family in treatment/transitional care plan. Adapt engagement strategies for individuals with SMI.
- Transition planning: establish an appropriate client-specific plan for transition to the next point of care. Consider how to utilize step-down mental health services, such as day treatment and intensive outpatient care. Consider trade-offs between length of stay for stabilization and risk of rehospitalization. Include assessment of need of primary care planning as well as substance abuse and dual disorders. An assessment and specific plan for housing and other social services should be included.
- Information transfer/personal health record: ensure all information is communicated, understood, and managed, and links patients, caregivers, and providers. Establish protocols to ensure privacy and other regulations are followed. Establish pathways for information flow among providers and clinics.
- Transition coaches/agents: define transition coach role, tasks, competencies, training, and supervision requirements. Consider the need for mental health providers, such as social workers, to serve as transition agents or to train other personnel in mental health tools and techniques. Consider use of health information technology to augment/assist coaches.
- Provider engagement: providers at each level of care should have clear responsibility and plan for implementing all transition procedures/interventions. Communication and hand-off arrangements should be pre-specified in a formal way.
- Quality metrics and feedback: gather metrics on follow-up post-hospitalization, rehospitalization and other feedback on process and outcomes and consumer/family perspective. Utilize metrics in quality improvement and accountability.

- Shared accountability: all providers share in expectations for quality as well as rewards/penalties. Accountability mechanisms may include financial mechanisms and public reporting about quality and value. Consumers/families share in accountability as well.

Evidence-informed approaches to transitional care for people with health and behavioral health needs leaving incarceration

For projects targeting people transitioning from incarceration, include in the implementation plan at a minimum:

- Strategy to increase Medicaid enrollment, including:
    - Process for identifying (1) individuals who are covered under Medicaid and whose benefits will not be terminated because of incarceration, (2) individuals whose Medicaid eligibility will terminate because of incarceration, and (3) individuals who will likely be Medicaid-eligible at release, regardless of current or prior beneficiary status.
    - Process for completing and submitting Medicaid applications for individuals (2) and (3) above, timed appropriately such that their status moves from suspended to active at release.
    - Agreements in place with relevant criminal justice agencies to ensure individuals (1) above receive community-based, Medicaid-reimbursable care in a timely matter when clinically appropriate (with a focus on populations "at risk," such as the elderly, LGBTQ, chronically ill, those with serious mental illness and/or SUD, and more).
- Strategy for beginning care planning and transition planning prior to release, including:
    - A process for conducting in-reach to prison/jails and correctional facilities, which leverages and contemplates resources, strengths, and relationships of all partners.
    - A strategy for engaging individuals in transitional care planning as a one component to a larger reentry transition plan.
    - A strategy for ensuring care planning is conducted in a culturally competent manner and contemplates social determinants of health, barriers to accessing services or staying healthy, as well as barriers to meeting conditions of release or staying crime-free.

Project 2D: diversion interventions

Project objective

Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations.

Target population

Medicaid beneficiaries presenting at the ED for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.

Evidence-supported diversion strategies

- ED diversion: a systematic approach to re-directing and managing persons who present at the ED for non-emergency conditions, which may be oral health, general physical health, and/or behavioral health conditions.
    - ER is for emergencies
    - Non–ED Interventions to Reduce ED Utilization: A Systematic Review
- Community Paramedicine Model: an evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations. Additional resources include:
    - communityparamedic.org
    - Community paramedicine evaluation tool
    - RHI Hub
- Law Enforcement Assisted Diversion (LEAD®): a community-based diversion approach with the goals of improving public safety and public order and reducing the criminal behavior of people who participate in the program.

Project stages

Table 19: stage 1 – diversion interventions planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively deliver diversion services.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for Domain I focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2

Definition of evidence-based approaches or promising practices and target populations • **Select target population and evidence-supported approach informed by regional health needs.** • **If applicable: determine which non-emergent condition(s) should be the focus of ED diversion and/or community paramedicine (oral health, general physical health, and/or behavioral health conditions).**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify, recruit, and secure formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.** • **For lead: establish a community advisory group that includes representation from community members, health care and social services, law enforcement and community public safety leaders.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2
Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3

Table 20: stage 2 – diversion interventions implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures, and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways.**	Timely submission of QIP	DY3, Q2

Description of training and implementation activities
• **Implement project, including the following core components across each approach selected:**
  ○ **Ensure participating partners are provided with, or have access to, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.**
  ○ **Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure team members, including client, have access to the information appropriate to their role in the team).**
  ○ **Establish mechanisms for coordinating care management plans with related community-based services and supports, such as those provided through supported housing programs.**
	Demonstrate progress in semi-annual report	DY3, Q4

Table 21: stage 3 – diversion interventions scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Expand the model to additional communities and/or partner organizations.**	Demonstrate progress in semi-annual report.	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model, and adopting guidelines, policies, and procedures as required.**		
Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 22: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Percent Homeless (Narrow Definition)	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4

	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Percent Arrested • Percent Homeless (Narrow Definition)	Annual
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Percent Arrested • Percent Homeless (Narrow Definition)	Annual

Project implementation guidance

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of electronic health records (EHRs) and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, information to enable population health management and quality improvement processes, and provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Shortage of mental health providers, SUD providers, social workers, nurse practitioners, primary care providers, care coordinators and care managers.
    - Opportunities for use of telehealth and integration into work streams.
    - Workflow changes to support integration of new screening and care processes, care integration, and communication.
    - Cultural and linguistic competency and health literacy deficiencies.
- **Financial sustainability:** alignment between current payment structures and guidelines for physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Guidance for evidence-based approaches

ED diversion

While there is no single model for effective ED diversion, a variety of examples can be found that share common elements. The following elements must be reflected in the implementation, unless noted otherwise:

- ED will establish linkages to community primary care provider(s) to connect beneficiaries without a primary care provider to one, or for the purpose of notifying the current primary care provider of the ED presentation and coordinating a care plan. Where available, care coordinators can facilitate this process.
- ED will establish policies and procedures for identifying beneficiaries with minor illnesses who do not have a primary care provider. After completing appropriate screenings validating a non-emergency need, will assist the patient in receiving a timely appointment with a primary care provider.

Community Paramedicine Model

This is an evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations

Approved medical program directors (MPDs), working with first responders, ED practitioners, and primary care providers to develop protocols, which may include transporting beneficiaries with non-emergency needs to alternate (non-ED) care sites, such as urgent care centers and/or patient-centered medical homes. Providers may collaborate to develop community paramedicine programs. Core issues to be addressed in the design of a community paramedicine program should include:

- A detailed explanation about how the community paramedics would be trained and would maintain their skills.
- A description of how appropriate medical supervision would be ensured.
- A description of how data to evaluate quality assurance and quality improvement activities would be obtained and monitored.
- An evaluation plan for assessing the impacts on quality and cost of care, and how the local EMS agency will ensure that all patients are treated equally regardless of insurance status and health condition, among other factors.
- A plan for integrating the community paramedicine program with other community-based health care and social service programs and for analyzing the potential impacts of the community paramedicine program on these providers, including safety-net providers.
- How to leverage the potential of EHRs and HIE to facilitate communication between community paramedics and other health care providers.

Law Enforcement Assisted Diversion, LEAD®

LEAD is a community-based diversion approach with the goals of improving public safety and public order and reducing the criminal behavior of people who participate in the program.

Review resources and assistance available from the LEAD® National Support Bureau. Many components of LEAD® can be adapted to fit local needs and circumstances, however, the following core principles must be built into the implementation:

- Establish the LEAD® program as a voluntary agreement among independent decision-makers.
- Engage law enforcement and generate buy-in, including obtaining commander-level support.
- Identify a dedicated project manager.
- Tailor the LEAD® intervention to the community.
- Provide intensive case management – to link diverted individuals to housing, vocational and educational opportunities, treatment, and community services. Participants may need access to medication-assisted therapy and other drug treatment options; they may also need access to food, housing, legal advocacy, job training, and other services.
    - Apply a harm reduction/housing first approach – develop individual plans that address the problematic behavior as well as the factors driving that behavior.
    - Consider the use of peer supports.
- Provide training in the areas of trauma-informed care and cultural competencies.
- Prepare an evaluation plan.

Domain 3: prevention and health promotion

Transformation projects within this domain focus on prevention and health promotion to eliminate disparities and achieve health equity across regions and populations. Domain 3 includes one required project and three optional projects.

Project 3A: addressing the opioid use public health crisis (required)

Project objective

Support the achievement of the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.

Target population

Medicaid beneficiaries, including youth, who use, misuse, or abuse prescription opioids and/or heroin.

Recommended resources for identifying promising practices/evidence-supported strategies

Clinical guidelines

- AMDG's Interagency Guideline on Prescribing Opioids for Pain
- CDC Guideline for Prescribing Opioids for Chronic Pain (United States, 2016)
- Substance Use during Pregnancy: Guidelines for Screening and Management

Statewide plans

- 2016 Washington State Interagency Opioid Working Plan
- Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan

Implementation plans must demonstrate a multi-pronged approach that includes strategies targeting the following essential components:

- Prevention: prevent opioid use and misuse
- Treatment: link individuals with OUD with treatment services
- Overdose prevention: intervene in opioid overdoses to prevent death
- Recovery: promote long-term stabilization and whole-person care

Project stages

Table 23: stage 1 – prevention and health promotion planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess the current regional capacity to effectively impact the opioid crisis and include strategies to leverage current capacity and address identified gaps.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for health systems/community capacity focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Select target population and evidence-based approach informed by regional health needs. (Consider areas with limited access to treatment for opioid disorder, and rates of opioid use, misuse, and abuse.)**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify and engage project implementation partnering provider organizations.** • **Identify established local partnerships that are addressing the opioid crisis in their communities and establish new partnerships where none exist.** • **Identify, recruit, and secure formal commitments for participation in project implementation including professional associations, physical, mental health and SUD providers and teaching institutions.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2
Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3

Table 24: stage 2 – prevention and health promotion implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches.**	Timely submission of QIP	DY3, Q2

Description of training and implementation activities
• **Implement selected strategies/approaches across the core components:**
  ○ **Prevention**
  ○ **Treatment**
  ○ **Overdose prevention**
  ○ **Recovery supports**
• **Monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines and incorporate any changes into project implementation plan.**
• **Convene or leverage existing local partnerships to implement project; one or more such partnerships may be convened:**
  ○ **Each partnership should include health care services, including mental health and SUD providers, community-based service providers, executive and clinical leadership, consumer representatives, law enforcement, criminal justice, emergency medical services, and elected officials; identify partnership leaders and champions. Consider identifying a clinical champion and one or more community champions.**
  ○ **Establish a structure that allows for efficient implementation of the project and provides mechanisms for any workgroups or subgroups to share across teams, including implementation successes, challenges, and overall progress.**
  ○ **Continue to convene the partnership(s) and any necessary workgroups on a regular basis throughout implementation phase.**
	Demonstrate progress in semi-annual report	DY3, Q2

Address gaps in access and availability of providers offering recovery support services • **Develop a plan to address gaps in the number or locations of providers offering recovery support services, (this may include the use of peer support workers).**	Demonstrate progress in semi-annual report	DY3, Q4

Table 25: stage 3 - prevention and health promotion scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase scale of activities by adding partners and/or reaching new communities under the current initiative (e.g., to cover additional high-needs geographic areas), as well as defining a path forward to deploy the partnership's expertise, structures, and capabilities to address other yet-to-emerge public health challenges.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Review and apply data to inform decisions regarding specific strategies and action to be spread to additional settings or geographical areas.**		

Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide or support ongoing training, technical assistance, and community partnerships to support spread and continuation of the selected strategies/approaches.** • **Convene and support platforms to facilitate shared learning and exchange of best practices and results to date (e.g., the use of interoperable HIE by additional providers providing treatment of persons with OUD).**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 26: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • P4R metrics (Project 3A P4R metrics)	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Project 3A P4R metrics)	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Patients prescribed chronic concurrent opioids and sedatives prescriptions • Patients prescribed high-dose chronic opioid therapy	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Project 3A P4R metrics)	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Project 3A P4R metrics)	DY4, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months	Annual

		• Patients prescribed chronic concurrent opioids and sedatives prescriptions • Patients prescribed high-dose chronic opioid therapy • SUD Treatment Penetration (Opioid)	
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Project 3A P4R metrics)	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP • Collection and reporting of provider-level P4R metrics (Project 3A P4R metrics)	DY5, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Patients prescribed chronic concurrent opioids and sedatives prescriptions • Patients prescribed high-dose chronic opioid therapy • SUD Treatment Penetration (Opioid)	Annual

Project implementation guidance

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management systems/HIT:** adoption of technology with the capability to support identification of persons at high-risk for opioid overdose, notifications to health care providers of opioid overdose events, monitoring of prescribing practices, and implementation of quality improvement processes; a plan to build enhancements in EHRs and other systems to support clinical decisions in accordance with guidelines; an assessment of the current level of use of the PDMP and ED Information Exchange; and strategies to increase use of PDMP and interoperability with EHRs. Overall, in line with Goal 4 of the State Interagency Opioid Working Plan; develop a plan to use data and information to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Efforts to enhance medical, nursing, and physician assistant school curricula on pain management, the PDMP, and recognition and treatment of opioid use disorder (OUD).
    - Partnering with professional associations and teaching institutions to educate dentists, osteopaths, nurses, and podiatrists on current opioid prescribing guidelines.
    - Encouraging licensing boards of authorized prescribers to mandate continuing education credits (CEUs) on opiate prescribing and pain management guidelines.
    - Encouraging family medicine, internal medicine, obstetrics/gynecology (OB/GYN) residency programs to train residents on care standards/medications for OUD.

- Identifying critical workforce gaps in the substance use treatment system and develop initiatives to attract and retain skilled professionals in the field.

- **Financial sustainability:** alignment between current payment structures and guidelines for care about opioid prescribing; and evidence-supported treatments and recovery supports for OUDs that incorporate current state and anticipated future state of VBP arrangements to support opioid abuse prevention and control efforts into the regional VBP transition plan.

Guidance for evidence-based approaches

Implementation plan

Each region will develop a plan that provides a detailed description of how the ACH will implement selected strategies and activities that together create a comprehensive strategy addressing prevention, treatment, overdose prevention, and recovery supports aimed at supporting whole-person health.

Prevention: prevent opioid misuse and abuse

- Promote use of best practices among health care providers for prescribing opioids for acute and chronic pain:
    - Promote the use of the prescription drug monitoring plan (PDMP) and its linkage into EHR systems to increase the number of providers regularly using the PDMP and the timely input of prescription medication data into the PDMP.
    - Train, coach, and offer consultation with providers on opioid prescribing and pain management.
    - Promote the integration of telehealth and telephonic approaches.
    - Support innovative telehealth in rural and underserved areas to increase capacity of communities to support OUD prevention and treatment.
- Together, with the Center for Opioid Safety Education and other partners like statewide associations, raise awareness and knowledge of the possible adverse effects of opioid use, including overdose, among opioid users:
    - Promote accurate and consistent messaging about opioid safety and to address the stigma of addiction by public health, health care providers, law enforcement, community coalitions, and others specific to the region and local communities.
- Prevent opioid initiation and misuse in communities, particularly among youth:
    - Build awareness and identify gaps as they relate to ongoing prevention efforts (e.g., school-based programs); connect with local health jurisdictions and DOH and HCA's Department of Behavioral Health and Recovery (DBHR) to understand the efforts currently underway in the region.
- Promote safe home storage and appropriate disposal of prescription pain medication to prevent misuse:
    - Identify and map drug take back programs to highlight where additional programs could be implemented or expanded to meet community need.
    - Promote the use of home lock boxes to prevent unintended access to medication.

Treatment: link individuals with OUD to treatment services

- Build capacity of health care providers to recognize signs of possible opioid misuse, effectively identify OUD, and link patients to appropriate treatment resources:
    - Effective treatment of OUD includes medication and psychosocial supports. Conduct inventory of existing treatment resources in the community (e.g., formal treatment programs and practices/providers providing medications for opioid use disorder (MOUD)(methadone, buprenorphine, naltrexone)).
    - Educate providers across all health professions on how to recognize signs of opioid misuse and OUD among patients and how to use appropriate tools to identify OUD.
    - Offer patients brief interventions and referrals to MOUD and psychosocial support services, if needed.
    - Build skills of health care providers to have supportive patient conversations about problematic opioid use and treatment options.
    - Give pharmacists tools on where to refer patients who may be misusing prescription pain medication.
- Expand access to, and utilization of, clinically appropriate evidence-based practices for OUD treatment in communities, particularly MOUD:
    - Increase the number of providers certified to prescribe OUD medications in the region; promote the application and receipt of physician, Advanced Registered Nurse Practitioner (ARNP), and physician assistant waivers for providers in a variety of settings, such as hospitals, primary care clinics, correctional facilities, mental health and SUD treatment agencies, methadone clinics, and other community-based sites.
    - Together with HCA identify policy gaps and barriers that limit availability and utilization of buprenorphine, methadone, and naltrexone and contribute to the development of policy solutions to expand capacity.
    - Build structural supports (e.g., case management capacity, nurse care managers, integration with SUD providers) to support medical providers and staff to implement and sustain MOUD, such as methadone and buprenorphine. Examples of evidence-based models include the hub and spoke and nurse care manager models.
    - Promote and support pilot projects that offer low barrier access to buprenorphine in efforts to reach persons at high risk of overdose. For example, in EDs, correctional facilities, syringe exchange programs, and SUD and mental health programs.
    - Build linkages/communication pathways between those providers providing medication and those providing psychosocial therapies.
- Expand access to and utilization of OUD medications in the criminal justice system:
    - Train and provide technical assistance to criminal justice professionals to endorse and promote agonist therapies for people under criminal sanctions.
    - Optimize access to chemical dependency treatment services for offenders who have been released from correctional facilities into the community and for offenders living in the community under correctional supervision, through effective care coordination and engagement in transitional services.

    - Ensure continuity of treatment for persons with an identified OUD need upon exiting correctional facilities by providing direct linkage to community providers for ongoing care.
- Increase capacity of syringe exchange programs to effectively provide overdose prevention and engage beneficiaries in support services, including housing.
    - Provide technical assistance to local health jurisdictions and community-based service organizations to organize or expand syringe exchange and drug user health services.
    - Develop/support linkages between syringe exchange programs and physical health providers to treat any medical needs that require referral.
- Identify and treat OUD among pregnant and parenting women (PPW) and Neonatal Abstinence Syndrome (NAS) among newborns:
    - Disseminate the guideline Substance Abuse during Pregnancy: Guidelines for Screening and Management.
    - Disseminate the Washington State Hospital Association Safe Deliveries Roadmap standards to health care providers.
    - Educate pediatric and family medicine providers to recognize and appropriately manage newborns with NAS.
    - Increase the number of obstetric and maternal health care providers permitted to dispense and prescribe MOUD through the application and receipt of Drug Enforcement Administration (DEA)-approved waivers.
    - Establish or enhance community pathways to support PPW with connecting to care services that address whole-person health, including physical, mental, and SUD treatment needs during, through and after pregnancy.

Overdose prevention: intervene in opioid overdoses to prevent death

- Educate individuals who use heroin and/or prescription opioids, and those who may witness an overdose, on how to recognize and appropriately respond to an overdose.
    - Provide technical assistance to first responders, chemical dependency counselors, and law enforcement on opioid overdose response training and naloxone programs.
    - Assist EDs to develop and implement protocols on providing overdose education and take-home naloxone to individuals seen for opioid overdose.
- Make system-level improvements to increase availability and use of naloxone.
    - Establish standing orders in all counties and all opioid treatment programs to authorize community-based naloxone distribution and lay administration.
    - Promote co-prescribing of naloxone for pain patients as best practice, per Agency Medical Director's Group (AMDG) guidelines.
- Together with the Center for Opioid Safety Education, promote awareness and understanding of Washington State's Good Samaritan Law.
    - Educate law enforcement, prosecutors, and the public about the Good Samaritan Response Law.

Recovery: promote long-term stabilization and whole-person care

- Enhance/develop or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery.
- Establish or enhance community-based recovery support systems, networks, and organizations to develop capacity at the local level to design and implement peer and other recovery support services as vital components of recovery-oriented continuum of care.
- Support whole person health in recovery:

Connect SUD providers with primary care, behavioral health, social service, and peer recovery support providers to address access, referral, and follow up for services.

Project 3B: reproductive and maternal/child health

Project objective

Ensure that people have access to high-quality reproductive health care throughout their lives and promote the health safety of Washington's children.

Target population

Medicaid beneficiaries who are people of reproductive age, pregnant persons, parents of children ages 0-3, and children ages 0-17.

Evidence-based approach

- Strategies to improve adult health to ensure families have intended and healthy pregnancies that lead to healthy children. The Centers for Disease Control and Prevention (CDC) has provided 10 recommendations that aim to improve a person's health before conception, whether before a first or a subsequent pregnancy.
- Evidence-based home visiting model for pregnant high-risk persons, including high-risk, first-time parents. Potential approaches can include Nurse Family Partnership (NFP) or other federally recognized evidence-based home visiting model currently operating in Washington State.

Evidence-based model or promising practice to improve regional well-child visit rates and childhood immunization rates. Project stages

Table 27: stage 1 – reproductive and maternal/child health planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively focus on the need for high-quality reproductive and maternal and child health care.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for Domain I focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Select evidence-based approach(es) and specific target population(s) informed by regional health needs.**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify, recruit, and secure formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2

Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3

Table 28: stage 2 – reproductive and maternal/child health implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures, and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches.**	Timely submission of QIP	DY3, Q2

Description of training and implementation activities
• **Implement project, including the following core components across each approach selected:**
  ○ **Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.**
  ○ **Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure care team members, including client and family/caregivers, have access to the care plan).**
  ○ **Establish mechanisms, including technology enabled, interoperable care coordination tools, for coordinating care management and transitional care plans with related community-based services and supports, such as those provided through supported housing programs.**
  ○ **Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes, and tracking outcomes.**
	Demonstrate progress in semi-annual report	DY3, Q4

Table 29: stage 3 – reproductive and maternal/child health scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model and adopting guidelines, policies, and procedures as required.**		

Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of transformation activities post-DSRIP.**		

Table 30: project metrics and recurrent deliverables associated with AVs

Year	Type	Metric/deliverable	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Chlamydia Screening in Women • Mental Health Treatment Penetration (Broad Version) • SUD Treatment Penetration • Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Age	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Childhood Immunization Status (Combo 10) • Chlamydia Screening in Women • Contraceptive Care – Access Measures (NQF# 2903, 2902) • Performance assessed by annual improvement on at least one of the Contraceptive Care Access measures. • Mental Health Treatment Penetration (Broad Version) • Timeliness of Prenatal Care • SUD Treatment Penetration	Annual

		• Well-Care Visits (3-11 Years of Age) • Well-Child Visits in the First 30 Months of Life	
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Childhood Immunization Status (Combo 10) • Chlamydia Screening in Women • Contraceptive Care – Access Measures (NQF# 2903, 2902) • Performance assessed by annual improvement on at least one of the Contraceptive Care Access measures. • Mental Health Treatment Penetration (Broad Version) • Timeliness of Prenatal Care • SUD Treatment Penetration • Well-Care Visits (3-11 Years of Age) • Well-Child Visits in the First 30 Months of Life	Annual

Project implementation guidelines

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Shortage of mental health providers, SUD providers, social workers, nurse practitioners, primary care providers, care coordinators and care managers.
    - Opportunities for use of telehealth and integration into work streams.
    - Workflow changes to support integration of new screening and care processes, care integration, communication.
    - Cultural and linguistic competency, health literacy deficiencies.
- **Financial sustainability:** alignment between current payment structures and guidelines for reproductive, maternal and child health care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support improvement of reproductive, maternal and child health efforts into the regional VBP transition plan. Development of model benefit(s) to cover reproductive, maternal and child health services.

Guidance for evidence-based approaches

Approaches to improve reproductive, maternal, and children's health

Implementation of evidence-based and emerging strategies to improve reproductive health

The CDC provided 10 recommendations that aim to improve a person's health before conception, whether before a first or a subsequent pregnancy. The recommendations fall into 10 areas: 1) individual responsibility across the lifespan, 2) consumer awareness, 3) preventive visits, 4) interventions for identified risks, 5) interconception care, 6) pre-pregnancy checkup, 7) health insurance coverage for people with low incomes, 8) public health programs and strategies, 9) research, and 10) monitoring improvements.

Strategies to improve adult health to ensure families have intended and healthy pregnancies that lead to healthy children. Specifically, ACHs should consider evidence-based models to improve utilization of effective reproductive health strategies, including pregnancy intention counseling, healthy behaviors and risk reduction, effective contraceptive use, safe and quality perinatal care, interconception care, and general preventive care.

- Washington State acted on these recommendations by providing a program for uninsured people to obtain basic family planning services (Take Charge and working with providers to improve obstetric outcomes) and grants (Personal Responsibility and Education Plan), and through other actions.

- This project builds on current efforts and provides a mechanism for communities to further the implementation of the recommendations.

Implementation for a home-visiting model should follow evidence-based practice standards.

- Evidence-based home visiting model for pregnant, high-risk people, including high-risk, first-time people. Potential approaches can include NFP or other federally recognized evidence-based home visiting model currently operating in Washington State. If chosen, implementing agencies must meet all fidelity, essential requirements, and/or program standard requirements as defined by the model developer. The project must demonstrate a valid need for home-visiting service expansion and that services will be coordinated. The following models are currently operating in Washington State:
    - NFP provides first-time, low-income persons and their children with nurse-led, home-based support and care.
    - Early Head Start Home-Based Model (EHS) works with parents to improve child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness.
    - Parents as Teachers (PAT) promotes optimal early development, learning and health of children by supporting and engaging their parents and caregivers.
    - Family Spirit offers culturally tailored home-visiting to promote the optimal health and wellbeing of American Indian parents and their children.

Implementation of an evidence-based model or promising practice to improve regional well-child visit rates (for ages 3-6) and childhood immunization rates.

If chosen, implementing agencies must meet all fidelity, essential requirements and/or program standard requirements as defined by the model developer. Possible approaches include:

- Bright Futures
- Stony Brook Children's Hospital Enriched Medical Home Intervention (EMHI)

Project 3C: access to oral health services

Project objective

Increase access oral health services to prevent or control the progression of oral disease and ensure that oral health is recognized as a fundamental component of whole-person care.

Target population

All Medicaid beneficiaries, especially adults.

Evidence-based approach

- Oral Health in Primary Care: integrating oral health screening, assessment, intervention, and referral into the primary care setting.
- Mobile/Portable Dental Care: national maternal and child health resource center providers a manual to guide planning and implementation of mobile dental units and portable dental care equipment for school-age children, which could be adapted for adults.

Project stages

Table 31: stage 1- access to oral health services planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively impact access to oral health services**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for health systems/community capacity focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Select target population and evidence-based approach informed by regional health needs.** ○ **Identify communities or sub-regions with demonstrated shortages of dental providers or otherwise limited access to oral health services.**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify, recruit, and secure formal commitments for participation from implementation partners, to include, at minimum, primary care providers and dentists, via a written agreement.** ○ **Must demonstrate sufficient initial engagement to implement the approach in a timely manner. (Include dentists/dental practices and periodontists who will serve as referral sources.)**	Report milestone completion in semi-annual report	DY2, Q2
Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building**	Timely submission of implementation plan	DY2, Q3

(HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.		

Table 32: stage 2- access to oral health services implementation

Project milestone	Proof of completion required	Due
Description of partnering provider progress in adoption of policies, procedures and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches.**	Timely submission of QIP	DY3, Q2
Description of training and implementation activities • **Implement project, including the following core components across each approach selected:** ○ **Implement bi-directional communications strategies/interoperable HIE tools to support the care model.** ○ **Establish mechanisms for coordinating care with related community-based services and supports.** ○ **Develop workflows to operationalize the protocol, specifying which member of the care performs each function, inclusive of when referral to dentist or periodontist is needed.** ○ **Establish referral relationships with dentists and other specialists, such as ear, nose, and throat specialists (ENTs) and periodontists.** ○ **Ensure each member of the care team receives the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.** ○ **Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes.** ○ **Engage with payers in discussion of payment approaches to support access to oral health services.**	Demonstrate progress in semi-annual report	DY3, Q4

Table 33: stage 3- access to oral health services scale and sustain

Project Milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase scope and scale, expand to serve additional high-risk populations, and add partners or service sites to spread approach to additional communities.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model, and adopting guidelines, policies, and procedures as required.**		
Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 34: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Application Delivered by Non-Dental Health Professional • Utilization of Dental Services	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q2

		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Periodontal Evaluation in Adults with Chronic Periodontitis • Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Application Delivered by Non-Dental Health Professional • Utilization of Dental Services	Annual
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Dental Sealants for Children at Elevated Caries Risk • Periodontal Evaluation in Adults with Chronic Periodontitis • Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Applications Delivered by Non-Dental Health Professional • Utilization of Dental Services	Annual

Project implementation guidelines

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Shortage of dentist, hygienist, and other dental care providers, and primary care providers.
    - Access to periodontal services.
    - Training and technical assistance to ensure cultural and linguistic competency, health literacy needs.
- **Financial sustainability:** alignment between current payment structures and integration of oral health services; incorporate current state and anticipated future state of value-based payment arrangements to support access to oral health efforts into the regional VBP transition plan; promote VBP readiness

tools and resources, such as the adoption of diagnostic coding in dental for bi-directional medical/dental data sharing and population health.

Guidance for evidence-based approaches

Oral health in primary care

Planning:

For oral health in primary care, consider a phased approach to implementation, such as:

- Begin with screening patients for signs and symptoms of early disease and develop a structured referral process for dentistry.
- Offer fluoride varnish for pediatric patients per the USPSTF61 and AAP guidelines; consider indications for fluoride varnish for high-risk adults.
- Focus on patient/caregiver risk assessment and risk reduction through patient education, dietary counseling, and oral hygiene training.
- Identify a particular high-risk patient population (e.g., adult patients with diabetes, pregnant persons) and begin with a pilot before expanding population/practice wide.
- Articulate the activities in each phase, and the associated timeline.

Implementation:

- Establish and implement clinical guideline or protocol that incorporates the following five elements of the Oral Health Delivery Framework:
    - Ask about symptoms that suggest oral disease and factors that place patients at increased risk for oral disease. Two or three simple questions can be asked to elicit symptoms of oral dryness, pain or bleeding in the mouth, oral hygiene and dietary habits, and length of time since the patient last saw a dentist. These questions can be asked verbally or included in a written health risk assessment.
    - Look for signs that indicate oral health risk or active oral disease. Assess the adequacy of salivary flow; look for signs of poor oral hygiene, white spots or cavities, gum recession, or periodontal inflammation; and conduct examination for signs of disease. During a well-visit or complete physical exam, this activity could be included as a component of the standard Head, Ears, Eyes, Neck, and Throat Exam (HEENT exam) resulting in a comprehensive assessment that includes the oral cavity—a "HEENOT" exam.
    - Decide on the most appropriate response. Review information gathered and share results with patients and families. Determine a course of action using standardized criteria based on the answers to the screening and risk assessment questions; findings of the oral exam; and the values, preferences, and goals of the patient and family.
    - Act by delivering preventive interventions and/or placing an order for a referral to a dentist or medical specialist. Preventive interventions delivered in the primary care setting may include: 1) changes in the medication list to protect the saliva, teeth, and gums, 2) fluoride therapy, 3) dietary counseling to protect the teeth and gums, and to promote glycemic

control for patients with diabetes, 4) oral hygiene training 5) therapy for tobacco, alcohol, or SUD and 6) referrals to dental.
    - Document the findings as structured data to organize information for decision support, measure care processes, and monitor clinical outcomes so that quality of care can be managed.
- Establish and implement workflows to operationalize the protocol, specifying which member of the care performs each function, inclusive of when referral to dentist or periodontist is needed.
- Ensure each member of the care team receives the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner.
- Establish referral relationships with dentists and other specialists, such as ENTs and periodontists.
- Engage with payers in discussion of payment approaches to support the model.

Mobile/portable dental care:

The national maternal and child health resource center provides a manual to guide planning and implementation of mobile dental units and portable dental care equipment for school-age children, which could be adapted for adults.

Planning:

- Specify where the mobile units and/or portable equipment will be deployed. Consider locations where Medicaid beneficiaries access housing, transportation, or other community-based supports, as well as rural communities, migrant worker locations, and American Indian reservations.
- Secure commitments from potential sites and develop a list of potential future sites.
- Specify the scope of services to be provided, hours of operation, and staffing plan.
- Include steps to show how ACH will research, and comply with, laws, regulations, and codes that may impact the design or implementation of the mobile unit and/or portable equipment.
- Include the timeline for educating providers, beneficiaries, and communities about the new service.

Implementation will include the following core components:

- Establish guidelines, policies, protocols, and/or procedures as necessary to support the full scope of services being provided.
- Secure necessary permits and licenses required by the state or locality.
- Establish referral relationships with primary care providers, dental providers, and other specialists, e.g., ENTs and periodontists, as needed.
- Acquire mobile unit and/or portable equipment and other supplies.
- Recruit, hire, and train staff.
- Implement the provider, client, and community education campaign to raise awareness of the new service.

Project 3D: chronic disease prevention and control

Project objective

Integrate health system and community approaches to improve chronic disease management and control.

Target population

Medicaid beneficiaries (adults and children) with or at risk for arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity, and stroke, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region.

Evidence-based approach:

Chronic Care Model

Project stages

Table 35: stage 1 – chronic disease prevention and control planning

Project milestone	Proof of completion required	Due
Completed current state assessment • **Assess current state capacity to effectively impact chronic disease.**	Report milestone completion in semi-annual report	DY2, Q2
Completed strategy development for health systems/community capacity • **Identify how strategies for health systems/community capacity focus areas (systems for population health management, workforce, value-based payment) will support project.**	Report milestone completion in semi-annual report	DY2, Q2
Definition of evidence-based approaches or promising practices and target populations • **Select specific target population(s), guided by disease burden and overall community needs, ACHs will identify the population demographic and disease area(s) of focus, ensuring focus on population(s) experiencing the highest level of disease burden.** • **Select evidence-based guidelines and best practices for chronic disease care and management using the Chronic Care Model approach to improve asthma, diabetes, and/or heart disease control, and address obesity in their region.** • **Region may pursue multiple target chronic conditions and/or population-specific strategies in their overall approach.**	Report milestone completion in semi-annual report	DY2, Q2
Completion of initial partnering provider list • **Identify, recruit, and secure formal commitments for participation from all implementation partners, including health care providers (must include primary care providers) and relevant community-based service organizations.** • **Form partnerships with community organizations to support and develop interventions that fill gaps in needed services.** • **Execute Master Services Agreement for partnering providers receiving funds through the FE portal.**	Report milestone completion in semi-annual report	DY2, Q2

Completed implementation plan • **Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment) and health equity.**	Timely submission of implementation plan	DY2, Q3

Table 36: stage 2 – chronic disease prevention and control implementation

Project milestone	Proof of completion	Due
Description of partnering provider progress in adoption of policies, procedures, and/or protocols • **Develop guidelines, policies, procedures, and protocols.**	Demonstrate progress in semi-annual report	DY3, Q2
Completion and approval of QIP • **Develop continuous quality improvement strategies, measures, and targets to support the selected approaches.**	Timely submission of QIP	DY3, Q2

Description of training and implementation activities
• **Implement disease/population-specific Chronic Care Implementation Plan for identified populations within identified geographic areas, inclusive of identified change strategies to develop and/or improve:**
  ○ **Self-management support**
  ○ **Delivery system design**
  ○ **Decision support**
  ○ **Clinical information systems (including interoperable systems)**
  ○ **Community-based resources and policy**
  ○ **Health care organization**
• **Implementation should ensure integration of clinical and community-based strategies through communication, referral, and data-sharing strategies.**
	Demonstrate progress in semi-annual report	DY3, Q4

Table 37: stage 3 – chronic disease prevention and control scale and sustain

Project milestone	Proof of completion required	Due
Description of scale and sustain transformation activities • **Increase scale of approach, expand to serve additional high-risk populations, include additional providers and/or cover additional high-needs geographic areas, to disseminate and increase adoption of change strategies that result in improved care processes and health outcomes.**	Demonstrate progress in semi-annual report	DY4, Q4
Description of continuous quality improvement methods to refine/revise transformation activities • **Employ continuous quality improvement methods to refine the model, updating model, and adopting guidelines, policies, and procedures as required.**		

Demonstrate facilitation of ongoing supports for continuation and expansion • **Provide or support ongoing training, technical assistance, learning collaborative platforms, to support shared learning, spread and continuation, and expansion of successful change strategies (e.g., the use of interoperable clinical information systems by additional providers, additional populations, or types of information exchanged).**		
Demonstrate sustainability of transformation activities • **Identify and encourage arrangements between providers and MCOs that can support continued implementation of the project beyond DY5.** • **Identify and resolve barriers to financial sustainability of project activities post-DSRIP.**		

Table 38: P4R recurrent deliverables and P4P project metrics

Year	Type	Recurrent deliverable or metric	Due
DY2 – 2018	P4R: ACH-reported	• Completion of semi-annual report 1 (template available March 2018)	DY2, Q2
		• Completion of semi-annual report 2 (template available July 2018) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities	DY2, Q4
DY3 – 2019	P4R: ACH-reported	• Completion of semi-annual report 3 (template available January 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q2
		• Completion of semi-annual report 4 (template available July 2019) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY3, Q4
	P4P: state-produced	• All-Cause ED Visits per 1000 Member Months • Children's and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Medication Management for People with Asthma (5 – 64 Years)	Annual
DY4 – 2020	P4R: ACH-reported	• Completion of semi-annual report 5 (template available January 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q2
		• Completion of semi-annual report 6 (template available July 2020) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY4, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Asthma Medication Ratio • Child and Adolescent Well-Care Visits (3-21 Years of Age) • Comprehensive Diabetes Care: Eye Exam (retinal) performed	Annual

		• Comprehensive Diabetes Care: Hemoglobin A1c Testing • Kidney Health Evaluation with Patients with Diabetes • Statin Therapy for Patients with Cardiovascular Disease (Prescribed) • Well Child Visit in the first 30 months of Life	
DY5 – 2021	P4R: ACH-reported	• Completion of semi-annual report 7 (template available January 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q2
		• Completion of semi-annual report 8 (template available July 2021) • Completion/maintenance of partnering provider roster • Engagement/support of IEE activities • Report on QIP	DY5, Q4
	P4P: state-produced	• Acute Hospital Utilization • All-Cause ED Visits per 1000 Member Months • Asthma Medication Ratio • Child and Adolescent Well-Care Visits (3-21 Years of Age) • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Kidney Health Evaluation with Patients with Diabetes • Statin Therapy for Patients with Cardiovascular Disease (Prescribed) • Well Child Visits in the first 30 months of Life	Annual

Project implementation guidelines

This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and QIPs.

Guidance for project-specific health systems/community capacity strategies

- **Population health management/HIT:** current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable chronic disease population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs, such as:
    - Shortage of community health workers, certified asthma educators, certified diabetes educators, home health care providers.
    - Access to specialty care, opportunities for telehealth integration.
    - Workflow changes to support registered nurses and other clinical staff to be working to the top of professional licensure. Training and technical assistance to ensure a prepared, proactive practice team and prepared, proactive community partners.
    - Cultural and linguistic competency, health literacy needs.
- **Financial sustainability:** alignment between current payment structures and guidelines are, inclusive of community-based services (such as home-based asthma visits, diabetes self-management education,

and home-based blood pressure monitoring); incorporate current state and anticipated future state of VBP arrangements to support chronic disease control efforts into the regional VBP transition plan. Consider inclusion of the following within reimbursement models: bundled services, group visits, once-daily medication regimens, community-based self-management support services.

Guidance for evidence-based approaches

Chronic Care Model

Regions are encouraged to focus on more than one chronic condition under the Chronic Care Model approach.

Examples of specific strategies to consider within Chronic Care Model approach:

- The Community Guide
- Million Hearts Campaign
- CDC-recognized National Diabetes Prevention Programs (NDPP)
- Community Paramedicine model: locally designed, community-based, collaborative model of care that leverages the skills of paramedics and EMS systems to address care gaps identified through a community specific health care needs assessment.

Specific change strategies to be implemented across elements of the Chronic Care Model: self-management support, delivery system design, decision support, clinical information systems, community-based resources and policy, and health care organization.

- **Self-management support strategies and resources** to empower and prepare patients to manage their health and health care, such as: incorporate the 5As (assess, advise, agree, assist, arrange) into regular care, such as:
    - Completing and update asthma action plans
    - Providing access to asthma self-management education, diabetes self-management education, and Stanford Chronic Disease Management Program
    - Supporting home-based blood pressure monitoring
    - Providing motivational interviewing
    - Ensuring cultural and linguistic appropriateness
- **Delivery system design strategies** to support effective, efficient care, such as implementing and supporting team-based care strategies; increasing the presence and clinical role of non-physician members of the care team; increasing frequency and improving processes of planned care visits and follow-up; referral processes to care management and specialty care.
- **Decision support strategies** to support clinical care that is consistent with scientific evidence and patient preference, such as development and/or provision of decision support tools (guideline summaries, flow sheets, etc.); embed evidence-based guidelines and prompts into EHRs; provide education as needed on evidence-based guidelines via case-based learning, academic detailing, or modeling by expert providers; establish collaborative management practices and communication with specialty providers; incorporate patient education and engagement strategies.

- **Clinical information systems strategies** to organize patient and population data to facilitate efficient and effective care, such as utilization of patient registries; automated appointment reminder systems; bi-directional data sharing and encounter alert systems; provider performance reporting.
- **Community-based resources and policy strategies** to activate the community, increase community-based supports for disease management and prevention, and development of local collaborations to address structural barriers to care such as community paramedicine; tobacco-free policy expansion; tobacco cessation assistance; nutritional food access policies; National Diabetes Prevention Program; home-based and school-based asthma services; worksite nutritional and physical activity programs; and behavioral screen time interventions.
- **Health care organization strategies** that ensure high-quality care, such as engagement of executive and clinical leadership; support for quality improvement processes; shared learning structures; intersection with care coordination efforts; and financial strategies to align payment with performance.

Appendix A: P4R and P4P AV association

By project and reporting period

AV snapshot: Project 2A - bi-directional integration of physical and behavioral health through care transformation

Table 39: P4R AV earning potential (Project 2A)

P4R milestones and recurrent deliverables	Schedule of AVs							
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0							
Completed strategy development for Domain I (health and community systems capacity building)	1.0							
Definition of evidence-based approaches or promising practices and target populations	1.0							
Completion of initial partnering provider list	1.0							
Completed implementation plan		1.0						
Support regional transition to integrated managed care (2020 regions only)		1.0						
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0					
Completion and approval of QIP			1.0					
Description of training and implementation activities				1.0				
Attestation of successfully integrating managed care			1.0		1.0			
Description of scale and sustain transformation activities						1.0		
Description of continuous quality improvement methods to refine/revise transformation activities						1.0		
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0		
Demonstrate sustainability of transformation activities						1.0		
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0
Collection and reporting of provider-level P4R metrics			1.0	1.0	1.0	1.0	1.0	1.0
Total earnable P4R AVs per reporting period	5.0	5.0	8.0	6.0	6.0	9.0	5.0	5.0

Table 40: P4P AV earning potential (Project 2A)

P4P project metric	Schedule of AVs		
	DY3 (2019) Q1-Q4	DY4 (2020) Q1-Q4	DY5 (2021) Q1-Q4
Acute Hospital Utilization	Inactive	1.0	1.0
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0
Antidepressant Medication Management	1.0	1.0	1.0
Asthma Medication Ratio	Inactive	1.0	1.0
Children's and Adolescents' Access to Primary Care Practitioners	1.0	Inactive	Inactive
Child and Adolescent Well-Care Visits (3-21 Years of Age)	Inactive	1.0	1.0
Comprehensive Diabetes Care: Eye Exam (retinal) performed	Inactive	1.0	1.0
Comprehensive Diabetes Care: Hemoglobin A1c Testing	1.0	1.0	1.0
Comprehensive Diabetes Care: Medical Attention for Nephropathy	1.0	Inactive	Inactive
Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence	Inactive	1.0	1.0
Follow-up After ED Visit for Mental Illness	Inactive	1.0	1.0
Follow-up After Hospitalization for Mental Illness	Inactive	1.0	1.0
Kidney health Evaluation for Patients with Diabetes	Inactive	1.0	1.0
Medication Management for People with Asthma: Medication Compliance 75%	1.0	Inactive	Inactive
Mental Health Treatment Penetration (Broad Version)	1.0	1.0	1.0
Plan All-Cause Readmission Rate (30 Days)	1.0	1.0	1.0
SUD Treatment Penetration	1.0	1.0	1.0
Total earnable P4P AV per performance period	9.0	14.0	14.0

AV snapshot: Project 2B - community-based care coordination

Table 41: P4R AV earning potential (Project 2B)

P4R milestones and recurrent deliverables	Schedule of AVs							
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0							
Completed strategy development for Domain I (health and community systems capacity building)	1.0							
Definition of evidence-based approaches or promising practices and target populations	1.0							
Completion of initial partnering provider list	1.0							
Completed implementation plan		1.0						
Project 2B: Identified HUB lead entity and description of qualifications		1.0						
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0					
Completion and approval of QIP			1.0					
Description of training and implementation activities				1.0				
Project 2B: Description of each pathway scheduled for initial implementation and expansion / partnering provider role & responsibilities to support Pathways implementation				1.0				
Description of scale and sustain transformation activities						1.0		
Description of continuous quality improvement methods to refine/revise transformation activities						1.0		
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0		
Demonstrate sustainability of transformation activities						1.0		
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0
Total earnable P4R AVs per reporting period	5.0	5.0	6.0	6.0	4.0	8.0	4.0	4.0

Table 42: P4P AV earning potential (Project 2B)

P4P project metric	Schedule of AVs		
	DY3 (2019) Q1-Q4	DY4 (2020) Q1-Q4	DY5 (2021) Q1-Q4
Acute Hospital Utilization	Inactive	1.0	1.0
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0
Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence	Inactive	1.0	1.0
Follow-up After ED Visit for Mental Illness	Inactive	1.0	1.0
Follow-up After Hospitalization for Mental Illness	Inactive	1.0	1.0
Mental Health Treatment Penetration (Broad Version)	1.0	1.0	1.0
Percent Homeless (Narrow Definition)	1.0	1.0	1.0
Plan All-Cause Readmission Rate (30 Days)	1.0	1.0	1.0
SUD Treatment Penetration	1.0	1.0	1.0
Total earnable P4P AV per performance period	5.0	9.0	9.0

AV snapshot: Project 2C -transitional care

Table 43: P4R AV earning potential (Project 2C)

P4R milestones and recurrent deliverables	Schedule of AVs							
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0							
Completed strategy development for Domain I (health and community systems capacity building)	1.0							
Definition of evidence-based approaches or promising practices and target populations	1.0							
Completion of initial partnering provider list	1.0							
Completed implementation plan		1.0						
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0					
Completion and approval of QIP			1.0					
Description of training and implementation activities				1.0				
Description of scale and sustain transformation activities						1.0		
Description of continuous quality improvement methods to refine/revise transformation activities						1.0		
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0		
Demonstrate sustainability of transformation activities						1.0		
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0
Total earnable P4R AVs per reporting period	5.0	4.0	6.0	5.0	4.0	8.0	4.0	4.0

Table 44: P4P AV earning potential (Project 2C)

P4P project metric	Schedule of AVs, by year		
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4
Acute Hospital Utilization	Inactive	1.0	1.0
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0
Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence	Inactive	1.0	1.0
Follow-up After ED Visit for Mental Illness	Inactive	1.0	1.0
Follow-up After Hospitalization for Mental Illness	Inactive	1.0	1.0
Percent Homeless (Narrow Definition)	1.0	1.0	1.0
Plan All-Cause Readmission Rate (30 Days)	1.0	1.0	1.0
Total earnable P4P AV per performance period	3.0	7.0	7.0

AV snapshot: Project 2D - diversion interventions

Table 45: P4R AV earning potential (Project 2D)

P4R milestones and recurrent deliverables	Schedule of AVs							
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0							
Completed strategy development for Domain I (health and community systems capacity building)	1.0							
Definition of evidence-based approaches or promising practices and target populations	1.0							
Completion of initial partnering provider list	1.0							
Completed implementation plan		1.0						
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0					
Completion and approval of QIP			1.0					
Description of training and implementation activities				1.0				
Description of scale and sustain transformation activities						1.0		
Description of continuous quality improvement methods to refine/revise transformation activities						1.0		
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0		
Demonstrate sustainability of transformation activities						1.0		
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0
Total earnable P4R AVs per reporting period	5.0	4.0	6.0	5.0	4.0	8.0	4.0	4.0

Table 46: P4P AV earning potential (Project 2D)

P4P project metric	Schedule of AVs, by year		
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0
Percent Arrested	Inactive	1.0	1.0
Percent Homeless (Narrow Definition)	1.0	1.0	1.0
Total earnable P4P AV per performance period	2.0	3.0	3.0

AV snapshot: Project 3A - addressing the opioid use public health crisis

Table 47: P4R AV earning potential (Project 3A)

P4R milestones and recurrent deliverables	Schedule of AVs							
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0							
Completed strategy development for Domain I (health and community systems capacity building)	1.0							
Definition of evidence-based approaches or promising practices and target populations	1.0							
Completion of initial partnering provider list	1.0							
Completed implementation plan		1.0						
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0					
Completion and approval of QIP			1.0					
Description of training and implementation activities				1.0				
Address gaps in access & availability of providers offering recovery support services				1.0				
Description of scale and sustain transformation activities						1.0		
Description of continuous quality improvement methods to refine/revise transformation activities						1.0		
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0		
Demonstrate sustainability of transformation activities						1.0		
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0
Collection and reporting of provider-level P4R metrics			1.0	1.0	1.0	1.0	1.0	1.0
Total earnable P4R AVs per reporting period	5.0	4.0	7.0	7.0	5.0	9.0	5.0	5.0

Table 48: P4P AV earning potential (Project 3A)

P4P project metric	Schedule of AVs, by year		
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4
Acute Hospital Utilization	Inactive	1.0	1.0
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0
Patients prescribed chronic concurrent opioids and sedatives prescriptions	1.0	1.0	1.0
Patients prescribed high-dose chronic opioid therapy	1.0	1.0	1.0
SUD Treatment Penetration (Opioid)	Inactive	1.0	1.0
Total earnable P4P AV per performance period	3.0	5.0	5.0

AV snapshot: Project 3B - reproductive and maternal/child health

Table 49: P4R AV earning potential (Project 3B)

P4R milestones and recurrent deliverables	Schedule of AVs							
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0							
Completed strategy development for Domain I (health and community systems capacity building)	1.0							
Definition of evidence-based approaches or promising practices and target populations	1.0							
Completion of initial partnering provider list	1.0							
Completed implementation plan		1.0						
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0					
Completion and approval of QIP			1.0					
Description of training and implementation activities				1.0				
Description of scale and sustain transformation activities						1.0		
Description of continuous quality improvement methods to refine/revise transformation activities						1.0		
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0		
Demonstrate sustainability of transformation activities						1.0		
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0
Total earnable P4R AVs per reporting period	5.0	4.0	6.0	5.0	4.0	8.0	4.0	4.0

Table 50: P4P AV earning potential (Project 3B)

P4P project metric	Schedule of AVs, by year		
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0
Childhood Immunization Status (Combo 10)	Inactive	1.0	1.0
Chlamydia Screening in Women	1.0	1.0	1.0
Child and Adolescents Well-Child Visits (3-11 Years of Age)	Inactive	1.0	1.0
Contraceptive Care – Most & Moderately Effective Methods	Inactive	1.0	1.0
Contraceptive Care – Postpartum	Inactive	1.0	1.0
Mental Health Treatment Penetration (Broad Version)	1.0	1.0	1.0
SUD Treatment Penetration	1.0	1.0	1.0
Timeliness of Prenatal Care	Inactive	1.0	1.0
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Age	1.0	Inactive	Inactive
Well-Child Visits in the First 15 Months of Life	Inactive	Inactive	Inactive
Well-Child Visits in the First 30 Months of Life	Inactive	1.0	1.0
Total earnable P4P AV per performance period	5.0	10.0	10.0

AV snapshot: Project 3C - access to oral health services

Table 51: P4R AV earning potential (Project 3C)

P4R milestones and recurrent deliverables	Schedule of AVs							
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0							
Completed strategy development for Domain I (health and community systems capacity building)	1.0							
Definition of evidence-based approaches or promising practices and target populations	1.0							
Completion of initial partnering provider list	1.0							
Completed implementation plan		1.0						
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0					
Completion and approval of QIP			1.0					
Description of training and implementation activities				1.0				
Description of scale and sustain transformation activities						1.0		
Description of continuous quality improvement methods to refine/revise transformation activities						1.0		
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0		
Demonstrate sustainability of transformation activities						1.0		
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0
Total earnable P4R AVs per reporting period	5.0	4.0	6.0	5.0	4.0	8.0	4.0	4.0

Table 52: P4P AV earning potential (Project 3C)

P4P project metric	Schedule of AVs, by year		
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0
Dental Sealants for Children at Elevated Caries Risk	Inactive	Inactive	1.0
Periodontal Evaluation in Adults with Chronic Periodontitis	Inactive	1.0	1.0
Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Application Delivered by Non-Dental Health Professional	1.0	1.0	1.0
Utilization of Dental Services	1.0	1.0	1.0
Total earnable P4P AV per performance period	3.0	4.0	5.0

AV snapshot: Project 3D - chronic disease prevention and control

Table 53: P4R AV earning potential (Project 3D)

P4R milestones and recurrent deliverables	Schedule of AVs							
	DY2 (2018)		DY3 (2019)		DY4 (2020)		DY5 (2021)	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
Completed current state assessment	1.0							
Completed strategy development for Domain I (health and community systems capacity building)	1.0							
Definition of evidence-based approaches or promising practices and target populations	1.0							
Completion of initial partnering provider list	1.0							
Completed implementation plan		1.0						
Description of partnering provider progress in adoption of policies, procedures and/or protocols			1.0					
Completion and approval of QIP			1.0					
Description of training and implementation activities				1.0				
Description of scale and sustain transformation activities						1.0		
Description of continuous quality improvement methods to refine/revise transformation activities						1.0		
Demonstrate facilitation of ongoing supports for continuation and expansion						1.0		
Demonstrate sustainability of transformation activities						1.0		
Completion of semi-annual report	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Completion/maintenance of partnering provider roster		1.0	1.0	1.0	1.0	1.0	1.0	1.0
Engagement/support of IEE activities		1.0	1.0	1.0	1.0	1.0	1.0	1.0
Report on QIP			1.0	1.0	1.0	1.0	1.0	1.0
Total earnable P4R AVs per reporting period	5.0	4.0	6.0	5.0	4.0	8.0	4.0	4.0

Table 54: P4P AV earning potential (Project 3D)

P4P project metric	Schedule of AVs, by year		
	DY3 (2019) Q1- Q4	DY4 (2020) Q1- Q4	DY5 (2021) Q1-Q4
Acute Hospital Utilization	Inactive	1.0	1.0
All-Cause ED Visits per 1000 Member Months	1.0	1.0	1.0
Asthma Medication Ratio	Inactive	1.0	1.0
Children's and Adolescents' Access to Primary Care Practitioners	1.0	Inactive	Inactive
Child and Adolescent Well-Care Visits (3-21 Years of Age)	Inactive	1.0	1.0
Comprehensive Diabetes Care: Eye Exam (retinal) performed	Inactive	1.0	1.0
Comprehensive Diabetes Care: Hemoglobin A1c Testing	1.0	1.0	1.0
Comprehensive Diabetes Care: Medical Attention for Nephropathy	1.0	Inactive	Inactive
Kidney Health Evaluation for Patients with Diabetes	Inactive	1.0	1.0
Medication Management for People with Asthma: Medication Compliance 75%	1.0	Inactive	Inactive
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	Inactive	1.0	1.0
Total earnable P4P AV per performance period	5.0	8.0	8.0

Appendix B: Project Toolkit for P4P metrics

The following table provides a high-level description for the Project Toolkit P4P metrics. Full measure specifications and measure production information can be referenced in the DSRIP Measurement Guide.

Table 55: Project Toolkit P4P metrics

Name of measure	Term used to reference the measure
National Quality Forum (NQF)#	Measures endorsed by NQF will have an identification number. A full list of NQF-endorsed measures are available through the Quality Positioning System (QPS).
Measure steward	An individual or organization that owns a measure is responsible for maintaining the measure. Measure stewards are often the same as measure developers, but not always. Measure stewards are also an ongoing point of contact for people interested in a measure.
Measure description	Summary information to provide high-level understanding of measure intent.
ACH P4P metrics for project incentives, by year	Outlines the DYs when the measure is "activated" or associated with project P4P incentives. P4P begins DY3; however, not all measures are "activated" at the same time.
Associated toolkit projects	Indicates the projects for which the metric is associated with project P4P incentives.
ACH high-performance metric	Indicates whether the metric is associated with earning incentives from the ACH high-performance pool.

Table 56: ACH project P4P metrics

Name of metric	NQF#	Measure steward	Measure description	ACH P4P metrics for project incentives, by year			Associated toolkit projects	ACH high-performance metric
				DY3 (2019)	DY4 (2020)	DY5 (2021)		
Acute Hospital Utilization	N/A	NCQA (HEDIS)	The rate of acute inpatient discharges among Medicaid beneficiaries, 18 years of age and older, during the measurement year. Measure is expressed as a rate per 1,000 denominator member months.	Inactive	P4P	P4P	2A, 2B, 2C, 3A, 3D	N
All-Cause ED Visits per 1000 Member Months	N/A	DSHS (Research and Data Analysis (RDA) Division)	The rate of Medicaid beneficiary visits to an ED during the measurement year, including visits related to mental health and SUD. Measure is expressed as a rate per 1,000 denominator member months.	P4P	P4P	P4P	2A, 2B, 2C, 2D, 3A, 3B 3C, 3D	Y
Antidepressant Medication Management	0105	NCQA (HEDIS)	The percentage of Medicaid beneficiaries, 18 years of age and older, who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment during the measurement year.	P4P	P4P	P4P	2A	Y
Asthma Medication Ratio	1800	NCQA (HEDIS)	The percentage of Medicaid beneficiaries, 5-64 years of age, who were identified as having persistent asthma and had a ratio of controller medication to total asthma	Inactive	P4P	P4P	2A, 3D	Y (DY4, DY5)

			medications of 0.50 or greater during the measurement year.					
Children's and Adolescents' Access to Primary Care Practitioners	N/A	NCQA (HEDIS - modified)	The percentage of Medicaid beneficiaries, 12 months-19 years of age, who had an ambulatory or preventive care visit during the measurement year.	P4P	Inactive	Inactive	2A, 3D	N
Child and Adolescent Well-Care Visits	N/A	NCQA (HEDIS - modified)	The percentage of Medicaid beneficiaries, 3-21 years of age, who had at least one comprehensive well-care visit during the measurement year.	N/A	P4P	P4P	2A, 3D	N
Child and Adolescent Well-Care Visits	N/A	NCQA (HEDIS - Modified)	The percentage of Medicaid beneficiaries, 3-11 years of age, who had at least one comprehensive well-care visit during the measurement year.	N/A	P4P	P4P	3B	Y
Childhood Immunization Status (Combo 10)	0038	NCQA (HEDIS)	The percentage of Medicaid beneficiaries who turned 2 years of age during the measurement year who, by their second birthday, received all vaccinations in the Combo 10 vaccination set.	Inactive	P4P	P4P	3B	N
Chlamydia Screening in Women	0033	NCQA (HEDIS)	The percentage of female Medicaid beneficiaries, 16-24 years of age, identified as sexually active and who had at least one test for chlamydia during the measurement year.	P4P	P4P	P4P	3B	N
Comprehensive Diabetes Care: Eye Exam (retinal) Performed	0055	NCQA (HEDIS)	The percent of Medicaid beneficiaries, 18-75 years of age, with diabetes (type 1 and type 2) who had a retinal or dilated eye exam by an eye care professional during the measurement year, or a	Inactive	P4P	P4P	2A, 3D	N

			negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement year.					
Comprehensive Diabetes Care: Hemoglobin A1c Testing	0057	NCQA (HEDIS)	The percent of Medicaid beneficiaries, 18-75 years of age, with diabetes (type 1 and type 2) who received a Hemoglobin A1c (HbA1c) test during the measurement year.	P4P	P4P	P4P	2A, 3D	N
Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062	NCQA (HEDIS)	The percent of Medicaid beneficiaries, 18-75 years of age, with diabetes (type 1 and type 2) who had a nephropathy screening test or evidence of nephropathy during the measurement year.	P4P	Inactive	Inactive	2A, 3D	N
Contraceptive Care – Most and Moderately Effective Methods	2903	US Office of Population Affairs	The percent of female Medicaid beneficiaries, 15-44 years of age, at risk of unintended pregnancy that are provided a most effective (i.e., sterilization, implants, intrauterine devices, or systems (IntraUterine Device (IUD) or IntraUterine System (IUS) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved method of contraception during the measurement year.	Inactive	P4P	P4P	3B	N
Contraceptive Care – Postpartum	2902	U.S. Office of Population Affairs	The percent of female Medicaid beneficiaries, 15-44 years of age, who had a live birth that are provided a most effective (i.e., sterilization, implants, intrauterine devices, or systems [IUD/IUS]) or	Inactive	P4P	P4P	3B	N

			moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved method of contraception within 3 and 60 days of delivery during the measurement year.					
Dental Sealants for Children at Elevated Caries Risk	2508, 2509	Dental Quality Alliance (DQA)	The percent of Medicaid beneficiaries, 6-14 years of age, at elevated risk of dental caries who received a sealant on a permanent first molar tooth (age 6-9 years) or a sealant on a permanent second molar tooth (age 10-14 years) during the measurement year.	Inactive	Inactive	P4P	3C	N
Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence	2605	NCQA (HEDIS)	The percent of ED visits for Medicaid beneficiaries, 13 years of age and older, with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit. 2. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. ED visit and follow-up must occur during the measurement year.	Inactive	P4P	P4P	2A, 2B, 2C	N

Follow-up After ED Visit for Mental Illness	2605	NCQA (HEDIS)	The percent of ED visits for Medicaid beneficiaries, 6 years of age and older, with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit. 2. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. ED visit and follow-up must occur during the measurement year.	Inactive	P4P	P4P	2A, 2B, 2C	N
Follow-up After Hospitalization for Mental Illness	0576	NCQA (HEDIS)	The percent of discharges for Medicaid beneficiaries, 6 years of age and older, who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: 1. The percentage of discharges for which the member received follow-up within 7 days after discharge. 2. The percentage of discharges for which the member received follow-up within 30 days after discharge. Hospitalization discharge and follow-up must occur during the measurement year.	Inactive	P4P	P4P	2A, 2B, 2C	N

Kidney Health Evaluation for Patients with Diabetes		NCQA (HEDIS)		Inactive	P4P	P4P	2A, 3D	N
Medication Management for People with Asthma: Medication Compliance 75%	1799	NCQA (HEDIS)	The percent of Medicaid beneficiaries, 5-64 years of age, who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for the treatment period during the measurement year. Rate are reported for the percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.	P4P	Inactive	Inactive	2A, 3D	Y (DY3 only)
Mental Health Treatment Penetration (Broad Version)	N/A	WA DSHS (RDA)	The percent of Medicaid beneficiaries, 6 years of age and older, with a mental health service need identified within the past two years, who received at least one qualifying service during the measurement year.	P4P	P4P	P4P	2A, 2B, 3B	Y
Patients Prescribed Chronic Concurrent Opioids and Sedatives Prescriptions	N/A	Bree Collaborative	The percent of Medicaid beneficiaries prescribed opioids and a concurrent sedative prescription, among beneficiaries prescribed chronic opioids.	P4P	P4P	P4P	3A	N

Patients Prescribed High-dose Chronic Opioid Therapy	N/A	Bree Collaborative	The percent of Medicaid beneficiaries prescribed chronic opioid therapy. Two rates reported according to dosage threshold: 1. Greater than or equal to 50mg morphine equivalent dosage in a quarter. 2. Greater than or equal to 90mg morphine equivalent dosage in a quarter.	P4P	P4P	P4P	3A	N
Percent Arrested	N/A	WA DSHS (RDA)	The percent of Medicaid beneficiaries, aged 18 and older, who were arrested at least once during the measurement year.	Inactive	P4P	P4P	2D	Y
Percent Homeless (Narrow Definition)	N/A	WA DSHS (RDA)	The percent of Medicaid beneficiaries who were homeless in at least one month during the measurement year. Narrow definition excludes "homeless with housing" living arrangement code from the Automated Client Eligibility System (ACES).	P4P	P4P	P4P	2B, 2C, 2D	Y
Periodontal Evaluation in Adults with Chronic Periodontitis	N/A	Dental Quality Alliance (DQA)	The percent of Medicaid beneficiaries, ages 30 years and older, with history of periodontitis who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the measurement year.	Inactive	P4P	P4P	3C	N
Plan All-Cause Readmission Rate (30 Days)	1768	NCQA (HEDIS)	The percent of acute inpatient stays among Medicaid beneficiaries, 18 years of age and older, during the measurement year that were followed by an unplanned	P4P	P4P	P4P	2A, 2B, 2C	Y

			acute readmission for any diagnosis within 30 days.					
Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Application Delivered by Non-Dental Health Professional	N/A	HCA	The percent of Medicaid beneficiaries, 0-5 years of age, who received a topical fluoride application from a professional provider (non-dental medical provider) during any medical visit during the measurement year.	P4P	P4P	P4P	3C	N
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	N/A	NCQA (HEDIS)	The percent of Medicaid beneficiaries, male 21-75 years of age and females 40-75 years of age, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) who were dispensed at least one high- or moderate-intensity statin medication during the measurement year.	Inactive	P4P	P4P	3D	N
SUD Treatment Penetration	N/A	DSHS (RDA)	The percent of Medicaid beneficiaries 12 years of age and older with an SUD treatment need identified within the past two years, and who received at least one qualifying SUD treatment during the measurement year.	P4P	P4P	P4P	2A, 2B, 3B	Y
SUD Treatment Penetration (Opioid)	N/A	DSHS (RDA)	The percent of Medicaid beneficiaries, 18 years of age and older, with an opioid used disorder treatment need identified within the past two years, who received medication assisted treatment (MAT) or medication-only	Inactive	P4P	P4P	3A	N

			treatment for OUD during the measurement year.					
Timeliness of Prenatal Care	N/A	NCQA (HEDIS)	The percent of live birth deliveries that received a prenatal care visit in the first trimester, on the enrollment start date or within 42 days of enrollment during the measurement year.	Inactive	P4P	P4P	3B	N
Utilization of Dental Services	N/A	DQA	The percent of Medicaid beneficiaries who received preventative or restorative dental services in the measurement year.	P4P	P4P	P4P	3C	N
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Age	1516	NCQA (HEDIS - modified)	The percent of Medicaid beneficiaries 3–6 years of age who had one or more well-child visits during the measurement year.	P4P	Inactive	Inactive	3B	Y
Well-Child Visits in the First 30 Months of Life		NCQA (HEDIS - modified)	The percent of Medicaid beneficiaries who turned 30 months old during the measurement year and who had six or more well-child visits during their first 15 months of life and two or more visits between 15 to 30 months.	Inactive	P4P	P4P	3B	N

ATTACHMENT D: DSRIP FUNDING AND MECHANICS PROTOCOL

I. Accountable Communities of Health

a. Introduction

This demonstration aims to transform the health care delivery system through regional, collaborative efforts led by ACHs. ACHs are self-governing organizations with multiple community representatives that are focused on improving health and transforming care delivery for the populations that live within the region. Providers within ACH regions will partner to implement evidence-based programs and emerging innovations, as defined in the DSRIP Planning Protocol (Attachment C), that address the needs of Medicaid beneficiaries. ACHs, through their governing bodies, are responsible for managing and coordinating the projects undertaken with partnering providers as well as state reporting.

This protocol provides detail and criteria that ACHs and their partnering providers must meet in order to receive DSRIP funding and the process that the state will follow to ensure that ACHs will meet these standards.

b. ACH Service Regions

There are nine ACHs that cover the entire state, with the boundaries of each aligned with the state's Medicaid Regional Service Areas (RSA). The RSAs were designated in 2014 through legislation that required the state to continue regionalizing its Medicaid purchasing approach. The RSA geographic boundaries were designated by assessing the degree to which they:

- Support naturally occurring health care delivery system and community service referral patterns across contiguous counties;
- Reflect active collaboration with community planning that prioritizes the health and well-being of residents;
- Include a minimum number of beneficiaries (at least 60,000 covered Medicaid lives) to ensure active and sustainable participation by health insurance companies that serve whole region; and
- Ensure access to adequate provider networks, consider typical utilization and travel patterns, and consider the availability of specialty services and the continuity of care.

ACH Name	Counties in RSA
Better Health Together	Adams, Ferry, Lincoln, Pend Oreille, Spokane Stevens
Greater Columbia ACH	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, Yakima
SWACH	Clark, Klickitat, Skamania
Cascade Pacific Action Alliance	Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, Wahkiakum
Olympic Community of Health	Clallam, Kitsap, Jefferson
Healthier Here	King

Elevate Health	Pierce
North Sound ACH	Island, San Juan, Skagit, Snohomish Whatcom
North Central ACH	Chelan, Douglas, Grant, Okanogan

c. ACH Composition and Partnering Provider Guidelines

Each ACH consists of partnering providers. The commitment to serving Medicaid beneficiaries, as well as the diversity and expertise of those providers and social service organizations, is important in evaluating Project Plan applications.

d. The ACH serves as the lead for the projects with partnering providers that are participating in Medicaid transformation projects. The ACH must submit a single Project Plan application on behalf of the partnering providers, and serve as the single point of performance accountability in the Independent Assessor's evaluation of projects and metrics. *ACH Governance and Management*

Each ACH must describe its primary decision-making process, process for conflict resolution, and its structure (e.g., a Board or Steering Committee) that is subject to composition and participation guidelines as outlined in STC 23. Each ACH's primary decision-making body will be responsible for approving the selection of transformation projects. Each ACH will comply with STCs 22 and 23 in its decision-making structure, which compliance the state will review and approve as part of ACH certification. .

The overall organizational structure of the ACH must reflect the capability to make decisions and oversee regional efforts in alignment with the following five domains, at a minimum:

- Financial
- Clinical
- Community
- Data and Performance Monitoring
- Program management and strategy development

The ACH's responsibilities include engaging stakeholders region-wide; supporting partnering providers in planning and implementing projects in accordance with requirements of the demonstration; developing budget plans for the distribution of DSRIP funds to partnering providers in accordance with the funding methodology provided in this protocol; collaborating with partnering providers in ACH leadership and oversight; and leading and complying with all state and CMS reporting requirements.

II. Projects, Metrics and Metric Targets

a. Overview of Projects

ACHs must select and implement at least four Transformation projects from the Project Toolkit (described in the DSRIP Planning Protocol [Attachment C]). ACHs must provide project details in the Project Plan application and describe how selected projects are directly responsive to the needs and characteristics of the Medicaid populations served in the region.

Projects described in the DSRIP Planning Protocol (Attachment C) are grouped into three domains: Health Systems and Community Capacity, Care Delivery Redesign, and Prevention and Health Promotion. The ACHs are responsible for demonstrating progress in relation to progress milestones and outcome metrics for each project.

b. Project Metrics

As part of their Project Plans, ACHs must develop timelines for implementation of projects, in alignment with state-specified process milestones included in Attachment C. Metrics that track progress in project planning, implementation, and efforts to scale and sustain project activities will be used to evaluate ACH milestone achievement.

ACHs must report on these metrics in their semi-annual reports (described in Section V). For each reporting period, ACHs are eligible to receive incentive payments for progress milestones and improvement toward performance metric targets. For designated performance metrics, ACHs will be awarded Achievement Values (AV), based on the mechanism described in Section IV of this protocol.

c. Outcome Metric Goals and Improvement Target

ACHs will have a performance goal for each outcome metric. On an annual basis, the state will measure ACH improvement from a baseline toward this goal to evaluate whether or not the ACH has achieved the metric improvement target. Each ACH will have its own baseline starting point. Both existing and new measures' baselines will be set based on performance during Demonstration Year (DY) 1.

Annual improvement targets for ACH outcome metrics will be established using one of two methodologies:

(1) Gap to Goal Closure: This methodology will be used for metrics that have available state or national Medicaid, or other comparable populations, 90th percentile benchmarks. Outcome targets will be based on these state or national performance benchmarks, whenever available, but adjustments may be made to reflect the socioeconomic and demographic characteristics of the populations serviced by ACHs, where possible.

The "gap" in this methodology is defined as the difference between the baseline (or end of prior DY) performance and the 90th percentile benchmark. Annual improvement targets will be an up to 10 percent closure of the gap year over year.

An example to illustrate the gap to goal methodology: If the baseline data for a measure is 52 percent and the goal is 90 percent, the gap to the goal is 38. The target for the project's first year of performance would be 38 times 10 percent, equaling a 3.8 percent increase in the result (target 55.8%). Each subsequent year would continue to be set with a target using the most recent year's data. For example, should an ACH meet or exceed the first year's target of 55.8 percent, the next annual target would be up to 10 percent of the new gap to the goal. This will account for smaller gains in subsequent years as performance improves toward the goal or measurement ceiling.

In cases where ACH performance meets or exceeds the performance goal (i.e., the 90 percent performance in the example above), incentives are earned based on continued

performance above the goal. If an ACH has already surpassed the goal in the baseline year, the measure will be dropped and value of the remaining measures rebased.
(2) Improvement-Over-Self: For those metrics without a state or national Medicaid benchmark available, including innovative metrics, the state will set a standard percent improvement relative to each ACH's previous DY performance. This percent improvement target will be determined on a metric-by-metric basis based on available evidence of a reasonable expectation for magnitude of change. Improvement targets for these metrics will be set to be consistent with the magnitude of change required to meet targets in the gap-to-goal methodology measures. The improvement-over-self-target for each metric will be consistent across each ACH.

III. Incentive Funding Formula and Project Design Funds

a. Demonstration Year 1 (DY1)

i. Project Design Funds

In accordance with STCs 35(i) and 45, during DY1, the state will provide project design funds to ACHs for completing the designated certification process. The design funds are a fixed component distributed equally across ACHs for completing the certification process described in Attachment C and can be used to develop specific and comprehensive Project Plans. This funding allows ACHs to begin to develop the technology, tools, and human resources to support the necessary capacity ACHs need to pursue demonstration goals in accordance with community-based priorities.

Design funds payments will total up to 25 percent of allowable expenditures in DY1 with payments distributed in two phases between June and September 2017. As described in the DSRIP Planning Protocol (Attachment C), ACHs are required to complete the two-phase certification process for receipt of design funds. In order to be eligible for incentive payments, beyond design funds, an ACH must submit and receive state approval of a Project Plan.

ii. Project Funding

The state will distribute the remaining DY1 DSRIP funding (excluding state administrative expenses) to certified ACHs upon approval of the Project Plan application. The amount of DSRIP funding available for each ACH will be scaled based on application scoring by the Independent Assessor as outlined in STC 36.

b. Demonstration Years 2 through 5 Funding and Project Valuation

In accordance with STC 35(h), the state has developed criteria and methodology for project valuation by which ACHs will continue to earn incentive payments in DY 2 through 5 by reporting on and achieving progress measures and performance-based outcome metrics. Project valuation is calculated during DY1 once each certified ACH

submits a Project Plan application detailing project selection and implementation strategies. Based on this content, the state determines maximum incentive payments allotted to each ACH, by project, which will be available for distribution to partnering providers. As described in STC 35, the annual maximum project valuation is determined based on the attributed number of Medicaid beneficiaries residing in the ACH RSA(s) and on the Project Plan application scores.

The maximum amount of ACH incentive funding is determined according to the methodology described in (c) below. Once each project is assigned a maximum valuation, the project's corresponding, individual progress measures and outcome metrics are valued according to the methodology described in (d) below.

Maximum ACH and project valuations are subject to monitoring by the state and CMS. In the event that an ACH does not meet the expected targets for each project's reporting-based progress measures and performance-based outcome metrics, the ACH's project valuation may be commensurately reduced from the maximum available project valuation. In addition, ACHs may receive less than their maximum available project valuation if DSRIP funding is reduced based on performance of the statewide measure bundle described in Section VII.

c. Calculating Maximum ACH Project Valuation

Each DY, a maximum statewide amount of DSRIP project funding will be identified. For approved tribal specific projects, a percentage of annual DSRIP funding will be allocated to tribal-specific projects in a manner consistent with this Protocol and the Tribal Protocol, which describes tribal projects and funds flow. Remaining project funds will be available to ACHs based on the methodology outlined below.

Step 1: Assigning Project Weighting

The state has weighed the projects in the Transformation Project Toolkit (Attachment C) relative to one another as a percentage of the total annual DSRIP project funding available, known as the project weight. ACHs must select at least four projects, including Project 2A (Bi-Directional Integration of Physical and Behavioral Health through Care Transformation), Project 3A (Addressing the Opioid Use Public Health Crisis) and least two additional projects, one from Domain 2 and one from Domain 3.

Each project has associated metrics that ACHs must achieve to earn funding tied to the project. An ACH's payment for project implementation is based on pay-for-reporting (P4R) in DY1 and DY2 and based on both P4R and pay-for-performance (P4P) in DY3, DY4[1] and DY5. The maximum amount of incentive funding that an ACH can earn is determined based on the ACH's project selection, the value of the projects selected, the quality and score of Project Plan applications, and the number of Medicaid beneficiaries attributed to the ACH. Project weights outlined in Table 1 were assigned with consideration of the following factors:

[1] Due to COVID-19 and related performance impacts in CY 2020, CMS approved flexibility for 2020 P4P achievement value calculations. The flexibility allows the state to compare results by metric (2019 regional results, 2019 statewide average, or the 2020 regional results). The Independent Assessor will apply whichever result provides the greatest AV calculation.

- Alignment with statewide measures to better incentivize the achievement of statewide objectives.
- Number of Medicaid beneficiaries within scope and capacity of projects to address population need and improve population health.
- Potential cost-savings to ensure that the state's Medicaid per-capita cost is below national trends.
- Existence of evidence-based strategies to ensure a reduction in avoidable use of intensive services.
- Focus on quality of services, rather than quantity, to accelerate transition to value-based payment.

Table 1. Transformation Project Weighting

Project Weighting	
Project	Weight
2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation	32%
2B: Community-Based Care Coordination	22%
2C: Transitional Care	13%
2D: Diversions Interventions	13%
3A: Addressing the Opioid Use Public Health Crisis	4%
3B: Reproductive and Maternal and Child Health	5%
3C: Access to Oral Health Services	3%
3D: Chronic Disease Prevention and Control	8%

Projects listed in order of Project Weighting

Project 2A (Bi-Directional Integration of Care and Primary Care Transformation) represents the state's primary objective under Initiative 1 of the demonstration. Project 2A requires the highest level of integration of all other projects and, therefore, houses the largest corresponding set of P4P metrics. Furthermore, Project 2A has the potential to yield the greatest achievement of value for Medicaid members through an evidence-based approach—and is likely to result in significant cost-savings for both the state and federal government. Regions that have implemented fully integrated managed care are be better positioned to scale project 2A and are eligible for an enhanced DY1 valuation based on project plan scoring methodology.

Project 2B (Community-Based Care Coordination) has the potential to realize significant healthcare spending reductions while providing local services to many of the state's most vulnerable Medicaid beneficiaries. To earn payments for this project, an ACH must transition early in the demonstration to P4P.

The project weights of Project 2C (Transitional Care) and Project 2D (Diversion Interventions) are each 13 percent. Both projects allow ACHs to select one or more evidence-based approaches to result in cost-savings for a smaller population of Medicaid beneficiaries compared to Projects 2A and 2B. In addition, these two projects have a smaller number of measures moving to P4P throughout the demonstration period compared to other Domain 2 projects.

Project 3D (Chronic Disease Prevention and Control) has the greatest project weighting in Domain 3s, at 8 percent. Project 3D has the potential to yield significant results for a large population of Medicaid beneficiaries by including multiple chronic diseases within the project. By affecting a large population through an evidence-based model, Project 3D has the potential to result in significant cost savings.

Project 3B (Reproductive and Maternal and Child Health) impacts a large subpopulation of Medicaid beneficiaries. This project offers several optional evidence-based approaches to drive success and a suitable number of metrics to measure performance.

Project 3A (Addressing the Opioid Use Public Health Crisis) will affect a subset of the state's substance use disorder (SUD) population of Medicaid beneficiaries, anticipated to be proportionally smaller than most other Domain 3 projects, by aligning with Governor Inslee's Executive Order 16-09.[1] Based on public comments and feedback to the Project Toolkit (Attachment C), Project 3A has now been escalated as a required project for all ACHs.

Project 3C (Access to Oral Health Services) is primarily targeted at the adult population, who will benefit from the evidence-based approach selected by the ACH, and there is a defined number of P4R metrics that will be used to measure an ACH's performance.

Step 2: Calculating Maximum ACH Project Funding

In accordance with STC 28 and STC 35(b), the state developed an allocation methodology for maximum ACH project funding based on project selection, transformation impact of projects, and attribution based on residence. The state will use the defined RSA boundaries to determine beneficiary attribution for the funding methodology using the November 2017 client-by-month file. The relative level of Medicaid attribution determined at that time will determine maximum DSRIP funds per ACH throughout the demonstration, as outlined below. Maximum funding by project is calculated by multiplying the total state ACH project funds available by the respective project weight (see Table 1 for project weighting).

Maximum Statewide Funding by Project = [Total Annual Statewide ACH Project Funds Available by DY] x [Project Weight]

In order to determine the maximum annual ACH funding by project, the maximum annual statewide funding by project is multiplied by total Medicaid beneficiaries residing in the ACH RSA.

Maximum ACH Funding by Project = [Maximum Annual Statewide Funding by Project] x [Percent of Total Attributed Medicaid Beneficiaries

This formula will be repeated for all selected projects, and the sum of selected project valuations equals the maximum amount of financial incentive payments each ACH can earn for successful project implementation over the course of the demonstration. Each ACH is required to select at least four projects, including Project 2A and Project 3A. If ACHs choose

[1] Available at http://www.governor.wa.gov/sites/default/files/exe_order/eo_16-09.pdf.

fewer than the total eight projects, project weights will be rebased proportionately for DY2 through DY5. This maximum ACH valuation will be earned upon achieving defined reporting-based progress measures and performance-based outcome metrics and may be reduced based on application of the statewide penalty described in Section VII.

For DY1, the maximum ACH Funding by Project will be adjusted based on Project Plan scores. Each ACH Project Plan will be scored by the Independent Assessor. The scoring criteria will be developed in conjunction with the Project Plan template (see DSRIP Planning Protocol).

d. Earning Incentive Payments

In DY2 through DY5, ACHs earn incentive payments for successful implementation and reporting of selected projects. Successful implementation is defined for each project as meeting the associated reporting-based progress measures and performance-based outcome metrics.

Within each payment period, ACHs are evaluated against these designated metrics and awarded Achievement Values (AV), which are point values assigned to each metric that is payment-driving. The maximum value of an AV is one (1) in the instance in which an ACH meets the designated metric.

The amount of incentive funding paid to an ACH will be based on the amount of progress made toward achieving its improvement target on each outcome metric. An ACH may achieve an AV based on meeting a minimum threshold of 25% of its gap-to-goal target in the year. If this performance threshold is not achieved, and ACH would forfeit the project incentive payment associated with that metric.

Enhanced AV valuation can be achieved if the ACH realizes a higher percentage of the gap-to-goal performance target, beyond the 25% threshold:

- 100 percent achievement of performance goal (achievement value = 1)
- Less than 100 percent achievement of performance goal and at least 75 percent achievement of performance goal (achievement value = .75)
- Less than 75 percent achievement of performance goal and at least 50 percent achievement of performance goal (achievement value = .50)
- Less than 50 percent achievement of performance goal and at least 25 percent achievement of performance goal (achievement value = .25)
- Less than 25 percent threshold achievement (achievement value = 0)

To determine Total Achievement Value (TAV) for each project in a given payment period, the AVs earned within the project are summed according to their relative weighting as illustrated in Table 2. From there, the Percentage Achievement Value (PAV) is calculated by dividing the TAV by the weighted 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 as follows:

Table 2. Example Calculation of Achievement Values

Measure/Metric	Achievement Value
Outcome Metric 1	0
Outcome Metric 2	1
Outcome Metric 3	0.5
TAV	**1.5**
PAV	**50.0%**

To support the expected outcomes from successful project implementation, ACHs are solely responsible for P4R progress measures in DY1 and DY2. The state will transition a robust set of outcome metrics to be P4P, meaning a portion of project funds are dependent on ACH demonstrating improvement toward performance targets in the out years. Table 3 illustrates the timing and distribution of transition to P4P:

Table 3. Transition to Pay-for-Performance, Percentage of Annual DSRIP Incentive Payment Allocation

Metric Type	DY1	DY2	DY3	DY4	DY5
P4R	100%	100%	75%	50%	25%
P4P	0%	0%	25%	50%	75%

e. Managed Care Integration

A primary goal of the demonstration is to support implementation of a fully integrated physical health and behavioral health managed care system. Although there are RSAs that have made progress toward integration, a majority of the state requires significant investments to achieve statewide integration of physical and behavioral health services by January 2020.

Regions that implement fully integrated managed care prior to 2020 are eligible to earn incentive payments above the maximum valuation for project 2A. To earn incentives above the maximum valuation for project 2A, regions must submit binding letters of intent to implement full integration. This will be reported in Project Plan submissions. The incentive payment is calculated using a base rate of up to $2 million and a per member rate based on total attributed Medicaid beneficiaries, with payments distributed to the ACH in the calendar year of completion.

> **Integration Incentive** = [Base Rate] + [Member Adjustment x Total Attributed Medicaid Beneficiaries] x [Phase Weight]

The incentives for fully integrated managed care will be distributed in two phases associated with reporting on progress measures: binding letter(s) of intent, and implementation. These phases represent two key activities towards integration. ACHs and partnering providers are eligible for an incentive payment for reporting on the completion of each phase.

Table 4. Weighting of Integration Progress Measures by Phase

Phase Weights	
Phase 1: Binding Letter(s) of Intent	40%
Phase 2: Implementation	60%

f. Value-based Payment Incentives

In accordance with STCs 41 and 42 and the state's Value-based Roadmap (Attachment F), the state will set aside no more than 15 percent of annually available DSRIP funds to reward MCO and ACH partnering providers for provider-level attainment of VBP targets as well as progression from baseline as described in STCs 41 and 42. VBP targets reflect goal levels of adoption of Alternative Payment Models (APM) and Advanced APMs in managed care contracting.

IV. ACH Reporting Requirements

These activities are detailed below.

a. Semi-Annual Reporting for ACH Project Achievement

Two times per year, ACHs seeking payment under the demonstration shall submit reports that include the information and data necessary to evaluate ACH projects using a standardized reporting form developed by the state. ACHs must use the document to report on their progress against the milestones and metrics described in their approved Project Plans. Based on these reports, as well as data generated by the state on performance metrics, the state will calculate aggregate incentive payments in accordance with this protocol. The ACH reports will be reviewed by state and the Independent Assessor. Upon request, ACHs will provide back-up documentation in support of their progress. These reports will be due as indicated below after the end of each reporting period:

- For the reporting period encompassing January 1 through June 30 of each year; the semi-annual report and the corresponding request for payment must be submitted by the ACH to the state before July 31.
- For the reporting period encompassing July 1 through December 31 of each year; the semi-annual report and the corresponding request for payment must be submitted by the ACH to the state before January 31.

The state shall have 30 calendar days after these reporting deadlines to review and approve or request additional information regarding the data reported for each milestones/metric and measure. If additional information is requested, the ACH shall respond to the request within 15 calendar days and the state shall have an additional 15 calendar days to review, approve, or deny the request for payment, based on the additional information provided. The state shall schedule the payment transaction for each ACH within 30 calendar days following state approval of the semi-annual report. Approved payments will be transferred to the Financial Executor until the ACH provides direction for payment distribution to partnering providers.

The state must use this documentation in support of claims made on the MBES/CBES 64.9 Waiver form, and this documentation must be made available to CMS upon request.

V. State Oversight Activities

The state will provide oversight to ensure accountability for the demonstration funds being invested in Washington State, as well as to promote learning with the state and across the

country from the work being done under the MTP demonstration. Throughout the demonstration, the state and/or its designee will oversee the activities of ACHs and submit regular reports to CMS pursuant to STC 37.

Each ACH must enter into a contract with the Washington State Health Care Authority (HCA) to be eligible to receive project design funds, as well as other incentive funding under the demonstration. This contract sets forth the requirements and obligations of the ACHs as the leads for DSRIP and other partnering providers. The contract addresses reporting requirements, data sharing agreements, performance standards, compliance with the STCs of the demonstration, and the ACH's agreement to participate in state oversight and audit activity to ensure program integrity of the demonstration. In the contract, HCA requires ACHs to participate in semi-annual reporting outlined in this protocol as a condition for qualifying for demonstration funds.

The state will support ACHs by providing guidance and support on the state's expectations and requirements. Additionally, state activities designed to ensure program integrity are detailed below:

a. Quarterly Operational Reports

The state will submit progress reports on a quarterly basis to CMS. The reports will present the state's analysis of the status of implementation; identify challenges and effective strategies for overcoming them; review any available data on progress toward meeting metrics; describe upcoming activities; and include a payment summary by ACH as available. The reports will provide sufficient information for CMS to maintain awareness regarding progress of the demonstration.

b. Learning Collaboratives

Annual learning collaboratives will be sponsored by the state to support an environment of learning and sharing among ACHs. Specifically, the collaboratives will promote the exchange of strategies for effectively implementing projects and addressing operational and administrative challenges. ACHs will be required to participate and contribute to learning collaboratives as specified in STCs 37(c) and 45(a)(v).

c. Program Evaluation

In accordance with STCs 35 and 107, the state will develop an evaluation plan for the DSRIP component of the draft evaluation design. The state will contract with an independent evaluator to evaluate the demonstration. The evaluator will be selected after a formal bidding process that will include consideration of the applicant's qualifications, experience, neutrality, and proposed budget. Evaluation drafts and reports will be submitted in accordance with deadlines in section 7 of the STCs.

VI. Statewide Performance and Unearned DSRIP Funding

a. Accountability for State Performance

The state is accountable for demonstrating progress toward meeting the demonstration's objectives. Funding for ACHs and partnering providers may be reduced in DY3, DY4[2], and DY5 if the state fails to demonstrate quality and improvement on the statewide measures listed below. STC 44 specifies the amount of annual DSRIP funding at risk based on statewide performance on these measures. The funding reductions will be applied proportionally to all ACHs based on their maximum Project Funding amount.

A statewide performance goal will be established for the statewide metrics. The state will be accountable for achieving these goals by the end of the demonstration period. During DY3 and DY4[2], annual assessment of quality and improvement from a defined baseline toward these goals will be used to measure and evaluate whether or not the statewide metric improvement target has been achieved.

Statewide Accountability Metrics

1. Mental Health Treatment Penetration
2. Substance Use Disorder Treatment Penetration
3. Outpatient Emergency Department Visits per 1000 Member Months
4. Plan All-Cause Readmission Rate (30 days)
5. ~~Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life~~[3]
5. Child and Adolescents Well-Care Visits 3-11 Years of Age
6. Antidepressant Medication Management
7. Medication Management for People with Asthma (5 – 64 Years)
8. Controlling High Blood Pressure[4]
9. Comprehensive Diabetes Care - Blood Pressure Control
10. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control

The state will establish a baseline performance for each measure. The state will adapt the Quality Improvement Score (QIS) methodology, originally developed by HCA for measuring MCO performance, to determine statewide performance across the statewide accountability measures for the demonstration. Each measure is assessed for both achievement of quality and improvement on an annual basis beginning DY3. The weighted sum of all the individual measure quality improvement scores will yield the overall QIS.

The overall QIS is then used to indicate whether a reduction of funding is warranted, and to calculate the percentage of funding at risk that should be reduced for that demonstration year. Annual improvement will reflect closing of the relative gap between prior performance year and the goal by up to 10 percent each year, as described in Attachment C, Section III(c). Quality will be assessed based on existing national benchmark standards where possible. For newer, innovative measures that do not have

[2] Due to COVID-19 impacts, Statewide accountability has been waived for DY 4. At-risk funding is therefore reduced from 10% to 0% for DY4.
[3] In 2021, NCQA Hedis® retired Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life. This measure was replaced with Child and Adolescents Well-Care visits 3 – 11 Years of Age. This change will apply to DY 4 and DY 5 results.
[4] Controlling high blood pressure has been removed from Statewide accountability QIS counts. The measure is inactive for DY3-DY5.

established national estimates, quality will be determined based on available evidence of reasonable expectation for magnitude of change.

If the state fails to achieve its annual quality improvement score on a given statewide accountability metric, funding will be reduced by the amount tied to the QIS.

The draw of the FFP match for all at-risk funds under statewide accountability metrics, or reporting of payments on the CMS-64 form, will not occur until the QIS have been approved by the state and CMS. The state will submit the QIS and supporting documentation to CMS for review and approval. CMS will have 90 calendar days to review and approve the QIS. Once the at-risk payments are approved, the state will disburse the portion of the withheld at-risk funds that were earned, and the state will report such expenditures on the CMS 64 form and draw down FFP accordingly. The state may not claim FFP for any at-risk expenditures until CMS has issued formal approval.

a. Reinvestment of Unearned DSRIP Funding

DSRIP funding that is unearned because the ACH failed to achieve certain performance metrics for a given reporting period may be directed toward DSRIP High Performance incentives. Unearned project funds directed to high performers will be used to support the scope of the statewide DSRIP program or to reward ACHs whose performance substantively and consistently exceeds their targets as measured according to a modified version of the QIS described above. The state does not plan to withhold any amounts to subsidize this reinvestment pool.

VII. Demonstration Mid-point Assessment

In accordance with STC 21, a mid-point assessment will be conducted by the Independent Assessor in DY3. Based on qualitative and quantitative information, and stakeholder and community input, the mid-point assessment will be used to systematically identify recommendations for improving individual ACHs and implementation of their Project Plans. If the state decides to discontinue specific projects that do not merit continued funding, the project funds may be made available for expanding successful project plans in DY 4 and DY5.

ACHs will be required to participate in the mid-point assessment and adopt recommendations that emerge from the review. The state may withhold a percentage or all future DSRIP incentive funds if the ACH fails to adopt recommended changes, even if all other requirements for DSRIP payment are met.