Delivery System Reform Incentive Payment (DSRIP) Measurement Guide

How accountability is measured for Washington State, MCOs, and ACHs throughout Medicaid transformation

Version 1.0 [Last updated: February 7, 2018]

Contents

Orientation to Measurement Guide

What is the Measurement Guide?

The Measurement Guide defines in detail exactly how performance will be measured for accountable entities participating in the Healthier Washington Medicaid Transformation. In particular:

1) How participating entities are held accountable throughout the transformation, and
2) How those entities can earn Delivery System Reform Incentive Payment (DSRIP) incentive funds.

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

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

- *Washington state* is accountable for demonstrating to the Centers for Medicare and Medicaid Services (CMS) the attainment of transformation targets related to VBP, clinical quality outcomes, and achieving integrated managed care statewide.
- *ACHs* are accountable for demonstrating to the state and the Independent Assessor achievement of transformation targets related to VBP and performance on clinical quality outcomes.
- *MCOs* are accountable for demonstrating to the state and the Independent Assessor the achievement of transformation targets related to VBP.

Who is the intended audience of this guide?

This guide is intended for interested and/or engaged partners in Medicaid Transformation efforts, including but not limited to ACHs, MCOs, transformation partners, state agencies, and legislative staff.

What kind of information does this guide include?

The guide describes the different levels of performance that must occur to earn incentive funds: 1) Washington state accountability for improvement and performance to CMS; 2) ACH and MCO accountability to the state for improvement and performance.

In addition to how the various accountability levers coincide, the guide contains technical specifications for performance metrics, and the production and reporting procedures for assessing performance during the DSRIP program.

What kind of information is not included in this guide, and why?

This guide does not provide details for expected performance between an ACH and its partnering providers. This is because the ACH-provider relationship is not governed by the terms and conditions of the Medicaid Transformation. Rather, those arrangements will be decided at the regional level.

How to read this guide

Many components of this guide are defined in CMS-approved Medicaid Transformation protocols and documents submitted to CMS. Key source documentation can be found in the Special Terms and Conditions (STCs)[1], DSRIP Planning protocol[2], DSRIP Funding and Mechanics protocol [3]and the HCA Value-based Roadmap – Apple Health Appendix[4].

Therefore, there are components that are outlined in CMS-approved protocols, including key transformation targets, such as the Project Toolkit's ACH pay-for-performance metrics, statewide accountability quality metrics, and WA/MCO/ACH annual VBP adoption targets.

This guide aims to provide insight into how and when performance is assessed, calculated, and reported, as well as who is responsible for the assessment, calculation, and reporting of performance on behalf of accountable entities.

How this guide will change over time

This guide will be updated at least annually and evolve over time with additional information. Updates may reflect changes in specifications, retirement of measures, and any adjustments to the measure production process. Technical specification sheets will be reviewed to ensure calculation methods are standardized to the extent possible, with the measurement steward recommendations, and to maintain a robust approach to performance accountability for the DSRIP program.

The state preserves the flexibility to review and modify the contents of the guide as appropriate over the course of the five-year Medicaid Transformation period. Changes will be clearly identified as the guide evolves over time.

Where can I reference this guide?

This guide is posted on Healthier Washington's Medicaid Transformation webpage.[5]

[1] https://www.hca.wa.gov/assets/program/Medicaid-demonstration-terms-conditions.pdf
[2] https://www.hca.wa.gov/assets/program/dsrip-planning-protocol.pdf
[3] https://www.hca.wa.gov/assets/program/dsrip-funding-and-mechanics-protocol.pdf
[4] https://www.hca.wa.gov/assets/program/vbp_roadmapw-ah.pdf
[5] https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources

Chapter 1: DSRIP program requirements and accountability

The Healthier Washington Medicaid Transformation aims to transform the health care delivery system to address local health priorities, deliver high-quality, cost-effective care that treats the whole person, and create sustainable linkages between clinical and community-based services. As part of the Medicaid Transformation, the Delivery System Reform Incentive Payment (DSRIP) program provides resources for regional, collaborative activities coordinated by the state's nine Accountable Communities of Health (ACHs).

ACHs are defined as self-governing organizations focused on improving health and transforming care delivery for the people that live within their region. Within the ACH, providers work together and with community-based organizations and local government entities to participate in delivery system reform efforts. To support Medicaid Transformation, these partnering providers commit to implement evidence-based programs and promising practices that address the needs of Medicaid beneficiaries in their communities, according to the parameters defined in the DSRIP Planning protocol.[6] According to approved protocols, ACHs must select and implement at least four projects from the Project Toolkit.[7] ACHs are eligible to earn incentive payments for completing project milestones, reporting on implementation metrics, and demonstrating improvement in health outcomes. Milestones and metrics are defined under each of the project areas in the Project Toolkit.

DSRIP accountability framework

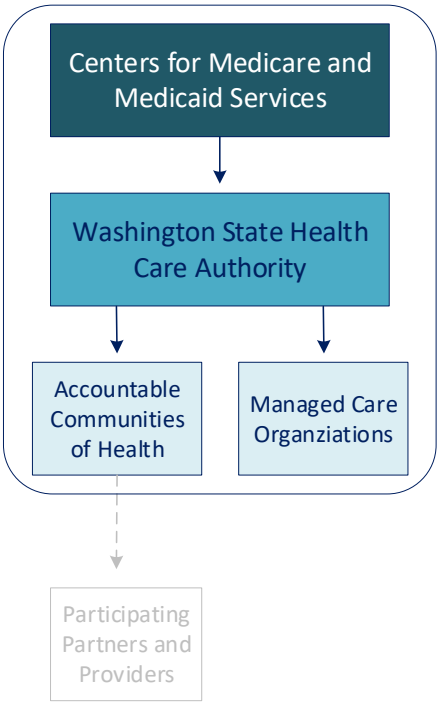
Overall progress under the DSRIP program will be monitored, assessed and incentivized for Washington State overall, at the level of the ACH region, and the Medicaid managed care organization (MCO).

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

Under the DSRIP program, Washington state, ACHs and MCOs are all accountable for demonstrating improvement toward and attainment of transformation targets. Earning the maximum funding available requires that performance expectations are met at the state level, at the MCO level, and at the ACH level. Funding is also tied to both reporting activities and performance. A summary of the accountability framework is as follows:

[6] https://www.hca.wa.gov/assets/program/dsrip-planning-protocol.pdf
[7] https://www.hca.wa.gov/assets/program/project-toolkit-draft.pdf

- *Washington state* is accountable for demonstrating to the Centers for Medicare and Medicaid Services (CMS) the attainment of transformation targets related to VBP, clinical quality outcomes and achieving integrated managed care statewide.
- *ACHs* are accountable for demonstrating to the state and the Independent Assessor achievement of transformation targets related to VBP and performance on clinical quality outcomes.
- *MCOs* are accountable for demonstrating to the state and the Independent Assessor the achievement of transformation targets related to VBP.



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

In turn, ACHs will distribute earned incentive funds among organizations in the region according to their own regionally established performance and funds flow framework. This step is specific to the individual ACH approach, and therefore is not part of this document.

Statewide accountability

Three key elements comprise the state's accountability for success: 1) improvement and attainment of quality targets across a set of 10 performance metrics; 2) improvement and attainment of defined statewide VBP targets; and 3) achievement of fully integrated managed care for all regions by January 2020 for physical and behavioral health services.

Statewide Accountability Components*

Quality metrics (10 total)
Mental Health Treatment Penetration
Substance Use Disorder Treatment Penetration
All Cause Emergency Department (ED) Visits per 1000 Member Months
Plan All-Cause Readmission Rate (30 days)
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
Antidepressant Medication Management (acute/continuation)
Medication Management for People with Asthma
Controlling High Blood Pressure
Comprehensive Diabetes Care: Blood Pressure Control
Comprehensive Diabetes Care: HbA1c Poor Control

+

Statewide VBP adoption goals (% of payments at or above HCP LAN 2C-4B)	
DY 3	75%
DY 4	85%
DY 5	90%

**Starting in demonstration year (DY) 4, 100% of DSRIP funding will be at risk if the state fails to demonstrate statewide integration of physical and behavioral health managed care by 2020.*

Beginning in DY 3 (2019), a percent of overall DSRIP funding is tied to statewide performance on statewide measures and VBP attainment; if the state does not achieve its targets, then available DSRIP funding will be reduced in accordance with the STCs (see STC 44). In DY 4 and DY 5, all DSRIP funds are tied to statewide achievement of fully integrated managed care for physical and behavioral health services by January 2020.

DSRIP funding at risk	DY 1	DY 2	DY 3	DY 4	DY 5
% of DSRIP funding at risk based on quality and VBP adoption performance	0%	0%	**5%**	**10%**	**20%**
% of DSRIP funding at risk based on managed care integration by January 2020	0%	0%	0%	100%	100%

The state is accountable for demonstrating improvement and attainment on a set of statewide quality measures. The state will adapt the Quality Improvement Score (QIS) methodology to determine statewide performance across the 10 quality metrics. The QIS model was originally developed by the Washington State Health Care Authority (HCA) for measuring Medicaid MCO performance and is used in other programs today, including in the Public Employee Benefits (PEB) Accountable Care Program (ACP). Using the QIS methodology, HCA will assess each of the 10 metrics for both quality and improvement on an annual basis beginning in DY 3. The weighted sum of all the individual measure quality improvement scores will contribute to the overall, composite QIS threshold that determines the percentage of funds earned. Pending CMS approval, the QIS threshold for receiving full funding for the quality metrics is set at the same level used for MCO contracting.

The other element of the statewide accountability framework is VBP adoption. HCA will assess VBP adoption based on improvement from the prior demonstration year and achievement of the target goal. Achievement goals for DY 3 – DY 5 are described below:

	DY 3	DY 4	DY 5
Statewide VBP adoption goals (HCP LAN categories 2C-4B)	75%	85%	90%

The final, overall statewide accountability score will account for both the composite QIS for quality metrics and the state's VBP adoption score. Statewide performance across the 10 quality metrics will determine 80 percent DSRIP funding at risk, and progress toward and attainment of statewide VBP targets will determine 20 percent DSRIP funding at risk. The statewide accountability score will be used to calculate whether DSRIP funding is reduced for DY 3, 4 and 5. Starting in DY 4, 100 percent of DSRIP funding will be at risk depending on whether the state demonstrates that at least two contracts for integrated managed care in each purchasing region are in effect and beneficiary enrollment has been

initiated as of January 1, 2020. More information can be found in the DSRIP Funding and Mechanics protocol[8].

The QIS methodology is currently under development by the state. A future update to the Measurement Guide will include additional detail about the statewide accountability assessment framework.

Medicaid managed care organization accountability

MCO role in DSRIP

As stated in STC 33, MCOs are expected to serve in leadership or supportive capacity in every ACH. This ensures that delivery system reform efforts funded under Medicaid Transformation are coordinated from the beginning across all necessary sectors – those providing payment, those delivering services, and those providing critical, community-based supports.

MCOs are accountable for demonstrating improvement toward and attainment of VBP targets, and play a critical role in the success and sustainability of Washington's DSRIP program.

DSRIP incentives available for MCO performance

MCOs are expected to participate in delivery system reform efforts as a matter of business interest and contractual obligation to the state, and for this reason, do not receive incentive payments for participation in ACH-led transformation projects.

However, a portion of DSRIP incentives is set aside to reward MCO attainment of value-based payment models, consistent with STC 42(a). These incentives are referred to as VBP incentives, and can be earned on the basis of pay for reporting, and pay for performance (P4P). After assessment of MCO VBP attainment performance, any remaining funds are be redirected to reward MCO performance on a set of clinical quality metrics.

More information about MCO involvement can be found in the DSRIP Planning protocol[9], DSRIP Funding and Mechanics protocol[10], and the HCA Value-based Roadmap - Apple Health Appendix[11].

A future update to this guide will include greater detail related to how any remaining MCO VBP incentive funds can be earned by MCOs on the basis of performance on clinical quality metrics.

Accountable Communities of Health accountability

ACH progress toward achieving the goals of Medicaid Transformation will be assessed based on 1) improvement toward and attainment of regional VBP adoption targets; 2) successful reporting on project planning and implementation milestones (pay for reporting); 3) achievement of ACH-specific improvement targets for Project Toolkit pay for performance metrics.

[8] https://www.hca.wa.gov/assets/program/dsrip-funding-and-mechanics-protocol.pdf
[9] https://www.hca.wa.gov/assets/program/dsrip-planning-protocol.pdf
[10] https://www.hca.wa.gov/assets/program/dsrip-funding-and-mechanics-protocol.pdf
[11] https://www.hca.wa.gov/assets/program/vbp_roadmapw-ah.pdf

Regional VBP target attainment

The success and sustainability of the state's DSRIP program is largely dependent on moving along the VBP continuum as a state and at the regional level. The STCs put forward annual VBP targets that ACHs are accountable for reaching.

More information about ACH VBP targets and how regional VBP performance is assessed can be found in the HCA Value-based Roadmap - Apple Health Appendix[7].

Pay for reporting (P4R)

Per STC 31, progress toward achieving the goals of Medicaid Transformation will be assessed based on achievement of specific milestones and measured by specific metrics that are defined in the DSRIP Planning Protocol. These milestones were developed by the state in consultation with stakeholders and members of the public and approved by CMS.

ACHs can earn incentive payments for successfully reporting on project planning and implementation milestones, and for ensuring complete and timely reporting of defined P4R metrics within the timeframes set forth by the state. P4R is designed to incentivize the collection of valuable and meaningful information that the ACH and participating providers are in the best position to collect, and that can support robust project monitoring and evaluation.

Examples of P4R metrics include:

- Of those providers at the clinic/site who are participating in the project, how many are trained in the appropriate evidence-based approach?
- At the clinic/site, are the providers who are trained actively implementing the evidence-based approach?

Through semi-annual reporting, ACHs will report on milestone achievement and information related to P4R metrics.

DSRIP incentives available for P4R completion

Reporting on milestone achievement and P4R metrics will determine the amount of Project Incentive funds earned by the ACH, as tied to the project and according to the P4R split for the given DY. Earned P4R payments are paid to the ACH account through the Financial Executor portal twice a year.

Responsible entity for reporting

It is the ACH's responsibility to compile information from participating partners and submit to the state to meet the requirements of P4R milestones and metrics.

Source of P4R information

Successful reporting completion will require information from the ACH and ACH participating providers.

Measurement period for reporting

ACHs are expected to submit information to satisfy P4R reporting requirements twice per year. Reporting cycles span six-month periods and align with the calendar year. ACHs have 31 days after the close of the applicable reporting period to complete and submit P4R milestone and metric information to the IA. The IA assesses whether the ACH successfully reported complete and timely P4R milestone and/or P4R metric information in order to earn achievement values (AVs).

The IA will calculate AVs, based on meeting the reporting expectation during each 6-month reporting period, and use this to determine incentive payment adjustments for the associated 6-month reporting period.

Next steps for DY 2

The state is developing the P4R structure and expectations. One part of development is mapping Project Toolkit milestones to the relevant deliverable. This is to minimize the need for separate deliverables for each milestone, and instead incorporate reporting of milestone achievements within semi-annual reports.

A preliminary DY 2 P4R deliverable timeline is included below. All DY 2 deliverables will be submitted to the IA through the web-based document repository, the Washington Collaboration, Performance, and Analytics System (WA CPAS).

Table. DY 2 ACH Deliverable Schedule

Deliverable	Reporting period	HCA template release	ACH submission deadline
Semi-annual Report	01/01/2018 – 6/30/2018	March 2018	7/31/2018
Implementation Plan	N/A	April 2018	10/1/2018
Semi-annual Report	07/01/2018 – 12/31/2018	July 2018	1/31/2019

A future update to the Measurement Guide will include greater detail about P4R, including definitions, templates, expectations for P4R milestone and metric reporting, and how P4R milestones and metrics will translate to AVs.

Pay for performance metrics (P4P)

Pay for performance (P4P) is defined as the ability for ACHs to earn incentive funds by demonstrating achievement of and/or improvement toward ACH-specific performance goals. These goals are referred to as improvement targets. ACH-specific improvement targets are determined based on prior ACH performance for the metric, and final results will be mapped to achievement values (AV) to determine incentive funding earned. Accountability for P4P metrics begins DY 3 (2019). However, some metrics are not activated until DY 4 or DY 5.

P4P results are calculated for the entire ACH region and based on beneficiary place of residence. ACHs are accountable for the Medicaid lives that reside in their region that meet the criteria of the P4P measures, regardless of the scope of project activities within selected projects. The specific set of P4P metrics that ACHs are accountable for is based on the set of projects selected by the ACH. A summary of P4P metrics can be found in Appendix B and Appendix C of this document.

DSRIP incentives available for P4P performance

Performance on P4P metrics will determine the amount of Project Incentive funds earned by the ACH, as tied to the project and according to the P4P split for the given DY. Earned ACH P4P payments are paid to the ACH through the Financial Executor portal once a year.

Responsible entity for calculation and reporting

The state is responsible for annual P4P metric production on behalf of ACHs. The state will analyze the data and report P4P metric results to the IA. The IA translates P4P results to earned AVs. The IA will calculate AVs, based on performance during each 12-month measurement period, and use this to determine incentive payment adjustments for the associated 12-month measurement period.

Chapter 2 of the Measurement Guide describes the ACH P4P measurement process in detail and methodology for assessing performance and P4P AV calculation. Furthermore, metric definitions can be found in the Appendix.

Data sources used for P4P metric calculation

P4P metrics are calculated using various data sources. The primary source of information is HCA's Medicaid Management Information System (MMIS), ProviderOne. In addition to administrative claims and enrollment data, some metrics require supplementary data sources.

Table. Data source summary	
ProviderOne Medicaid claims and enrollment data	The data includes all health care claims and encounters for Medicaid members, enrollment periods, and demographic and address information. In order to represent the most complete data set for the performance period, the state will observe a six-month claims lag to account for processing time in the billing data. *Example of metrics: Antidepressant Medication Management; Comprehensive Diabetes Care: Hemoglobin A1c Testing.*
Vital statistics – birth and abortion data	Vital statistics[12] data come from Certificates of Live Birth, Certificates of Fetal Death, Certificates of Death, Certificates of Marriage, Certificates of Dissolution, and reports from abortion providers. The forms for certificates are provided by the Washington State Department of Health. The Center for Health Statistics registers only those vital events occurring in Washington State. Abortion reports are non-identified for both patient and facility and include only information on induced abortion. This includes all residents of Washington, and the data are updated annually. *Example of metrics: Timeliness of Prenatal Care; Contraceptive Care – Postpartum.*

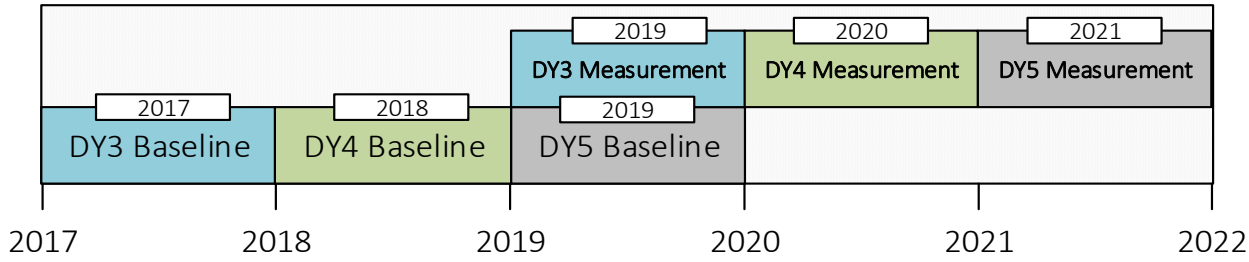
[12] http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/Birth

Table. Data source summary	
First Steps database	The First Steps Database (FSDB)[13] was designed to evaluate and monitor programs and services for low-income and other high-risk women and children in Washington state. Created and maintained by the Washington State Department of Social and Health Services – Research and Data Analysis (DSHS-RDA), the FSDB links vital statistics, Medicaid claims eligibility data, the Treatment and Report Generation Tool (TARGET), which is the management information system used by the Division of Alcohol and Substance Abuse, and the Case and Management Information System (CAMIS) files, which are maintained by Children's Administration of DSHS. The FSDB matches birth and death certificate information provided by the Department of Health Center for Health Statistics with the eligibility history and claims files from the Office of Financial Management and Health and Recovery Services Administration. *Example of metrics: Chlamydia Screening in Women Ages 16 to 24; Childhood Immunization Status (Combo 10).*
Washington State Identification System (WASIS) arrest database	The Washington State Identification System (WASIS) arrest database is maintained by the Washington State Patrol. The database is comprised of arrest charges for offenses resulting in fingerprint identification. The database provides a relatively complete record of felony and gross misdemeanor charges, but excludes some arrest charges for misdemeanor offenses that are not required to be reported. *Example of metric: Percent Arrested.*
Automated Client Eligibility System (ACES) data system	The DSHS Economic Services Administration's Automated Client Eligibility System (ACES) is used by caseworkers to record information about client self-reported living arrangements and shelter expenses. This information is used when determining eligibility for cash, food, and medical assistance. *Example of metric: Percent Homeless.*

Measurement period for performance assessment

P4P metrics are assessed using data over a 12-month period. This is referred to as a measurement year. The measurement year for P4P metrics is a 12-month timeframe that aligns with the demonstration year and calendar year. This will allow time for project implementation to take effect and for the measurement period to directly reflect the demonstration year for which the region is accountable for performance.

[13] https://www.dshs.wa.gov/sesa/research-and-data-analysis/first-steps-database



Regional ACH progress toward improvement targets will be assessed based on respective reference baseline years that are lagged by two years for the entire Medicaid Transformation effort. This allows for the improvement targets to be prospectively released prior to the start of the associated performance year.

Table. Anticipated improvement target release schedule	
Performance measurement year	**Improvement target available**
Demonstration Year 3 (2019)	Fall 2018
Demonstration Year 4 (2020)	Fall 2019
Demonstration Year 5 (2021)	Fall 2020

Therefore, ACHs and partnering providers will have the regional ACH improvement target expectations available prior to the start of the associated performance year.

Next steps in DY 2

Significant development by the state is required to produce the first reference baseline results and improvement targets, in addition to a six-month period post-measurement year to allow claims data maturation. The steps to ensuring consistency in how measures are calculated include:

- Finalization of measure specifications
- Standardization of broad inclusion criteria
- Consistent attribution logic to associate an individual or event to a region
- Method for linking P4P performance to respective achievement values (AV)

These components, as described in this guide, will be refined and finalized in the summer of DY2 (2018). The state will release official ACH baseline results and improvement targets for DY 3 in October 2018.

ACH high performance

ACHs are eligible to earn any leftover ACH Project Incentive and ACH VBP Incentive funds on an annual basis by demonstrating high performance on a sub-set of Project Toolkit P4P metrics.

A forthcoming update in DY 2 will include detail about how high performance will be measured, and how these funds will be distributed.

Chapter 2: P4P metrics

Improvement targets

ACHs will have a performance goal for each P4P metric, known as improvement target (IT). The first performance year is DY 3. On an annual basis starting with DY 3, the state will measure ACH progress toward improvement targets to evaluate performance. Each ACH will have their own baseline starting point. Improvement targets are reset for each performance year, according to the reference baseline year. Targets are established for each metric based on one of two methods: Gap to Goal (GTG), or Improvement Over Self (IOS).

Gap to Goal (GTG)

Metrics with available national Medicaid data[14] will be measured using a Gap to Goal closure methodology[15]. The gap is defined as the difference between ACH reference baseline year performance and the absolute benchmark. The absolute benchmark for GTG metrics are set at the national 90th percentile for Medicaid. The expectation for earning full achievement value (AV) credit will be equivalent to closing the gap between reference baseline year results and absolute benchmark value by 10 percent, relative to the size of the gap. Each performance year will have the improvement target set with respect to the reference baseline year results.

For each performance year, a summary of the various components and respective time periods/specifications can be found in the following table:

Table. Components for calculating annual GTG improvement targets

Performance year	Specifications for performance year[16]	Reference baseline year	Specifications for reference baseline year	Absolute benchmark year
DY 3 (2019)	HEDIS 2020	DY 1 (2017)	HEDIS 2018	NCQA Quality Compass 2017
DY 4 (2020)	HEDIS 2021	DY 2 (2018)	HEDIS 2019	NCQA Quality Compass 2018
DY 5 (2021)	HEDIS 2022	DY 3 (2019)	HEDIS 2020	NCQA Quality Compass 2019

As described in the DSRIP Funding and Mechanics protocol, if an ACH exceeds the absolute benchmark for a metric during the first baseline assessment, the metric will be dropped and the value of the

[14] NCQA Quality Compass: http://www.ncqa.org/hedis-quality-measurement/quality-measurement-products/quality-compass.

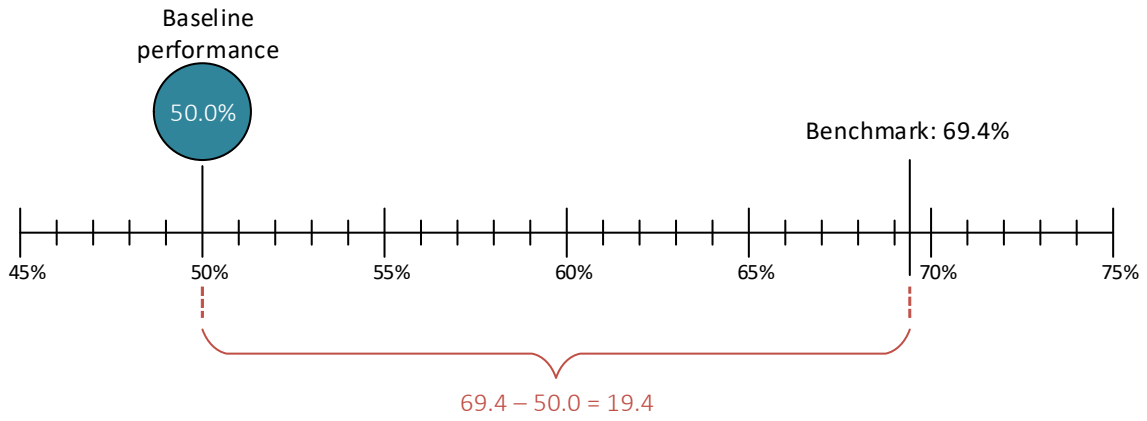
[15] Upon review of historical ACH/state performance data, some metrics with available national Medicaid data were placed in the Improvement Over Self category. This was done to more appropriately reflect the socioeconomic/demographic/geographic characteristics of the ACHs.

[16] Should the measure steward retire or modify specifications, the state may accept retirement or modifications to keep DSRIP measures relevant and meaningful. See Measurement Guide sub-section: *P4P measure retirement and specification modifications* for more detail.

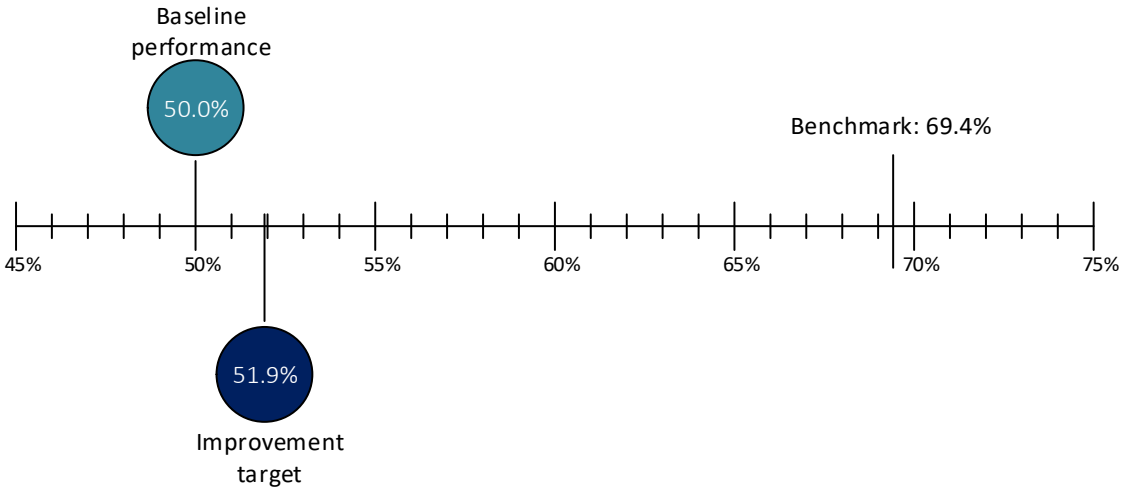
remaining measures redistributed. In cases where ACH performance meets or exceeds the absolute benchmark, the ACH will receive full credit for the AV tied to the metric for the associated performance period.

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

To illustrate the concept, suppose an ACH baseline performance for a given metric is 50.0 percent. If the absolute benchmark value for the metric is 69.4 percent, then the gap is (69.4-50.0), or 19.4 percentage points.



Ten percent of that gap is 1.9 percentage points. Therefore, the ACH would need to improve 1.9 percentage points to achieve the improvement target and receive full credit, as measured during the performance year.



The following table summarizes the calculation steps for the above example:

Table. Sample calculation: Gap to Goal		
Determine improvement target	Description	Example
Establish gap amount	Gap = Absolute benchmark – ACH baseline result	69.4 – 50.0 = 19.4
Calculate 10% of the gap	Gap * 0.10 = gap reduction to meet IT	19.4 * 0.10 = 1.9
IT established by adding percentage point gap reduction to ACH baseline result	Gap reduction + ACH baseline = IT	50.0 + 1.9 = 51.9

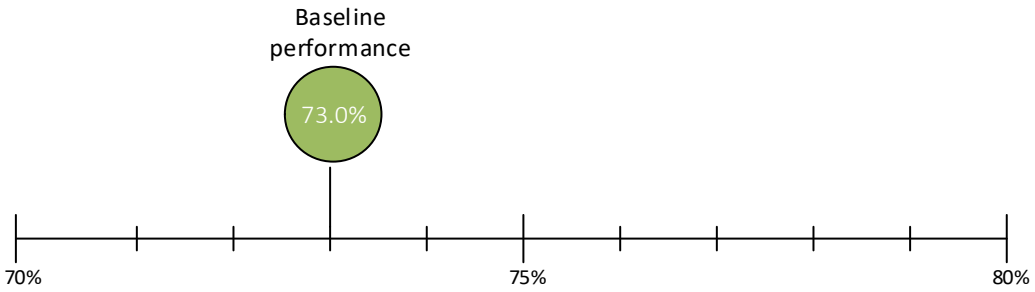
Improvement Over Self (IOS)

For the remaining metrics, improvement targets will be set by a standard percent improvement relative to the ACH's reference baseline year results. This concept is referred to as Improvement Over Self (IOS). Rationale for the inclusion of metrics in this category include lack of available national/state Medicaid benchmark data, and/or metric recently developed.

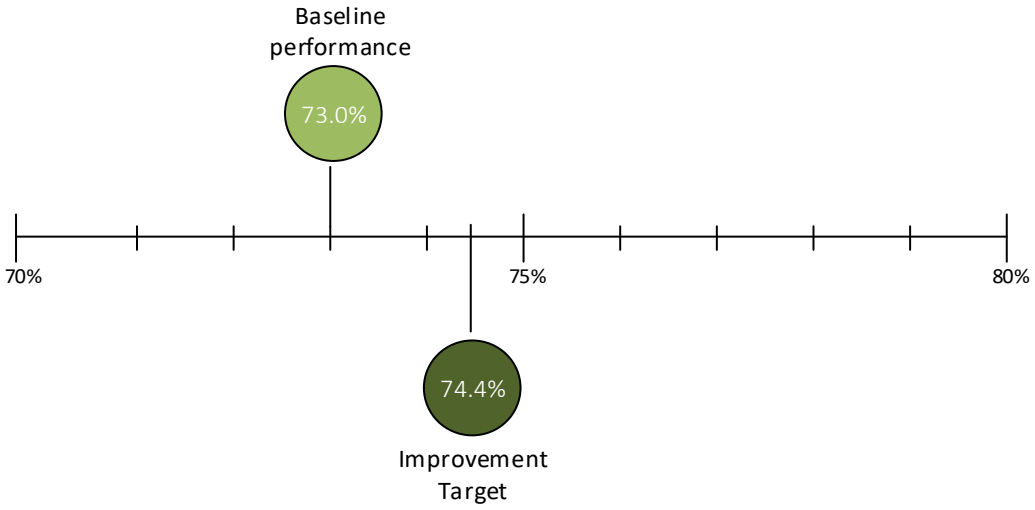
Improvement targets for IOS metrics will be set to be consistent with the magnitude of change required to meet targets in the GTG methodology metrics. To assess the magnitude of improvement required to successfully close the gap by 10 percent (GTG performance expectation to earn full credit), the state evaluated historical ACH performance for the GTG metrics with available data. Based on the analysis, the median magnitude of change required to receive full credit for GTG metrics was 1.9 percent improvement over reference baseline performance. Therefore, the improvement expectation for DSRIP IOS metrics is set at 1.9 percent improvement over performance in the reference baseline year. The expectation for improvement is standard across all IOS metrics, and will be consistently applied for all years of Medicaid Transformation.

Step by step: setting the improvement target using IOS

To illustrate, suppose an ACH's baseline result for a given metric is 73.0 percent.



The performance expectation is set by finding the equivalent of a 1.9 percent change over the reference baseline result. The improvement target is then established by adjusting the baseline result up or down by the percentage point change, depending on the directionality of quality improvement.



For metrics where higher values are better, percentage point change is added to the reference baseline result; for metrics where lower values are better, the percentage point change is subtracted from the reference baseline result. In the example above, the improvement target for the performance period is 74.4 percent.

The following table summarizes the calculation steps for the above example:

Table. Sample calculation: Improvement Over Self		
Determine improvement target (IT)	Description	Example
Establish performance expectation according to the magnitude of improvement required, based on reference baseline year results	ACH baseline result * 0.019 = percentage point change required	73.0 * 0.019 = 1.387
IT established by adjusting the baseline result by the percentage point change	*For metric where higher value is better:* ACH baseline result + percentage point change = IT *For metric where lower value is better:* ACH baseline result – percentage point change = IT	73.0 + 1.387 = 74.4

Rounding P4P metric components and results

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

- Rounding of results will not occur until the final step of the calculation
- Results will be carried out to one decimal point beyond the level of precision indicated by the detailed measure specifications
- Numbers 0 to 4 are rounded down, and numbers 5 to 9 are rounded up
- For HEDIS measures, the state will follow the standard specifications related to rounding during the calculation and level of detail for reporting of metric results

- For non-HEDIS measures, the state will report results to the first decimal point, or to the tenth place

In addition to standard rounding conventions, the state's approach to ensuring consistency in P4P measurement is described in Measurement Guide sub-section: Standard population inclusion and regional attribution measurement concepts.

Standard population inclusion and regional attribution measurement concepts

Per the parameters of CMS-approved DSRIP programs, the key mechanism to drive incentive payments to ACHs and participating providers is the measurement of the health and wellness of individuals with Medicaid benefits. P4P metrics, which include clinical and outcome metrics, are measured at the level of the ACH and calculated using a standard and consistent approach by the state. From the entire population of individuals enrolled in Medicaid at any given time, performance measurement requires additional considerations related to data source, coverage group, and other inclusion criteria in order to ensure standardized reporting of P4P results accurately and fairly reflects beneficiary experience and ACH accountability.

There is an important distinction between the ACH regional population counts used for calculating maximum, up-to ACH Project Incentives, compared to the standard population criteria applied to the calculation of P4P metrics.

As background, for the purpose of determining regional attribution for maximum potential ACH Project Incentives and ACH Integration Incentives, a point-in-time client enrollment count was used. The client count for the month of November 2017 was used as the point-in-time enrollment snapshot to determine ACH attribution for incentives for the duration of the Medicaid Transformation period. This was a one-time step; maximum potential ACH Project and Integration Incentives are now set for each annual performance period. This includes all individuals with Medicaid coverage on record as of November 2017, including both Title XIX and XXI. However, Medicaid beneficiaries with both Medicaid and Medicare coverage were excluded from the final ACH attribution. This difference in methodology used to calculate regional population counts explains the difference in client counts that may be found on Apple Health enrollment reports, HW Dashboard, and other sources.

Defining the eligible population for P4P measurement

ACHs are accountable for all individuals enrolled in Medicaid who reside in the ACH regional boundaries. The eligible population is not limited to individuals accessing care at partnering provider or service sites that are participating in project activities. Medicaid eligibility information is evaluated for the measurement window, per metric specifications, or to specific regions within the ACHs geographic boundaries.

After identifying all individuals enrolled in Medicaid who are geographically eligible for inclusion in an ACH's P4P measurement, the state will then determine which individuals should be included in P4P measurement on the basis of Medicaid eligibility.

Some individuals are screened out of the population prior to analysis because they have mixed insurance coverage. Mixed coverage impacts the accuracy of measure reporting because either have a non-comprehensive picture of health care encounters for an individual. Two groups that fall into this

category are individuals eligible for both Medicare and Medicaid, and individuals with primary Third Party Liability (TPL)[17].

For the purpose of P4P metric calculation, individuals that are full dual eligible beneficiaries of both Medicare and Medicaid, as well as those individuals with primary TPL, will be prospectively excluded from P4P metric calculation. These individuals cannot be completely accounted in measurement due to lack of data availability. These exclusions are intended to support robust results and accuracy in defining, tracking, and measuring Medicaid beneficiary experience for the DSRIP program.

Eligible population per measure specification

The population included in P4P analysis begins with the same exclusion criteria outlined above, then applies any additional criteria as defined in the measure specifications. Measures are developed to capture the population for which a particular service is recommended; this is called the eligible population. To define the eligible population, measures often apply criteria such as age or diagnosis of a health condition to identify members in the eligible population.

While some measures may apply to everyone in the ACH (population-based), others may capture a smaller group within the ACH membership that meet added measure-specific criteria such as diagnosis of a health condition (diagnosis-based) or the occurrence of an event such as hospitalization (episode-based). In addition, many health care quality measures impose additional "continual coverage" requirements, or continuous eligibility, that would further exclude people with coverage gaps.

Age groups

Calculation of P4P metrics will follow the specifications as defined by the measure steward. However, performance may not be assessed for every age group specified. If a measure has a single, overall age group specified, then this is used to determine performance. If a measure has separate, stratified age groups and not one, overall rate, then the stratified age groups are calculated and assessed for improvement toward and achievement of ACH-specific improvement targets.

Individuals who are 65 years and older, but not dually eligible for Medicare and Medicaid, are included in P4P calculation when specified by the measure steward. Accordingly, 14 of the 31 Transformation Project Toolkit P4P metrics specify the inclusion of individuals 65 years and older. From the other side of the life course, 24 of the 31 P4P metrics specify the inclusion of pediatric and young adult beneficiaries.

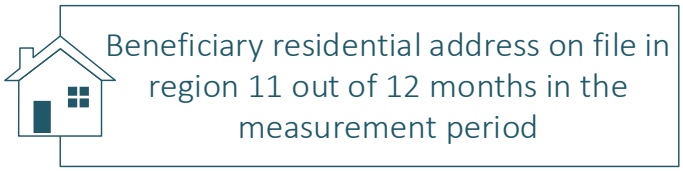
The state is committed to a DSRIP program design that accounts for all Medicaid lives for which the state can reliably and consistently measure improvement. A full description of the age groups by metric are defined in Appendix C.

Attributing P4P results to the ACH

Members are included in P4P metrics according to geographic ACH boundaries, and derived from residential addresses included in the Medicaid enrollment files. The physical address available in the measurement window is used to map a given member's address to a single ZIP code, county, and ACH.

[17] Third Party Liability (TPL) refers to the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan. Visit the Medicaid.gov website for more information about TPL: https://www.medicaid.gov/medicaid/eligibility/tpl-cob/index.html

To be attributed to an ACH, the residential address on file in the Medicaid enrollment files is required to be consistently within the boundaries of the ACH for 11 out of 12 months of the measurement period.



This methodology will be applied broadly to all P4P metrics in order to attribute a Medicaid beneficiary experience to a single ACH for a given measurement period. In effect, assignment based on 11 out of 12 months residential address within the ACH region limits the population to a relatively stable group of beneficiaries. This ensures the ACH is accountable for a population that was likely living in the region for the majority of the measurement period, based on the best available data, and likely to experience impacts from project activities. The objective is to establish an accountability structure that is fair and sets a reasonable performance expectation.

P4P metric production and reporting cycle

One guiding principle for the selection of Project Toolkit P4P metrics was the feasibility of producing results at the level of the ACH on an annual basis by the state. Specifically, the state prioritized those metrics for which the state was in the best position to reliably calculate according to the parameters and required timelines. This ensures that incentive payments can be earned and successfully disbursed to provide the resources and investment required to achieve a transformed health delivery system. To that end, metrics that can be produced solely from administrative data sources were prioritized.

This also allows the state to take the responsibility of producing P4P metric results on behalf of the ACH, thereby eliminating the need for partnering providers to report P4P metric data to the state. The state is committed to the production and reporting of the P4P metrics in the Transformation Project Toolkit.

P4P metric production cycle

P4P metric calculation will be the responsibility of the state and a third-party contracted support. HCA executed a contract with Providence Center for Outcomes Research and Education (CORE) beginning in October 2017 for DSRIP measurement support. P4P metric production responsibilities will be shared between HCA, DSHS-RDA and Providence CORE. Programs used to calculate measure results will be developed using the measure steward specifications. Internal review procedures for these programs include:

- External review of measure logic by other measure producer entity
- Parallel development of measures
- Code comparison and external review
- Member level validation of results, accounting for all differences in results as either differences in logic or data to within 0.02 percent
- Reconciling all differences in results attributed to logic or implementation differences to within 0.02 percent
- Comparison to previously computed results and results from external sources

- Periodic review of alignment and repeating any required steps of validation in order to maintain alignment

Medicaid claims and encounter data for the measurement year will be considered finalized with the inclusion of the current year June billing information in the transaction systems, allowing a six-month run-out of claims data. A six-month paid-date run-out will be consistently applied for all P4P metric calculations.

The production cycle allows the state to collect all required data for ACH and state accountability metrics. Therefore, annual ACH P4P payment will include: P4P performance-adjusted ACH payments, adjustments based on statewide accountability, and DSRIP High Performance incentive earnings.

To illustrate, the following table outlines production cycle dependencies and associated impacts to the timing of final ACH P4P incentive payment:

Table. Demonstration year 3: P4P metric production cycle

Year	Month	Task
2017		
	January-December	Measurement year for **reference baseline year**
2018		
	October	Official baseline results and improvement targets available
2019		
	January-December	Demonstration year 3 = **performance measurement year**
2020		
	January-June	6-month claims data lag
	July-August	1-2 months for data processing, verification and validation
	September	• P4P results are known • 1 month to (1) run QIS model on statewide accountability measures; (2) draft supporting documentation for CMS. • State will submit Statewide Accountability Report to CMS
	October-November	• Independent Assessor will: (1) score P4P achievement values (AV); (2) calculate ACH QIS model to determine eligibility for High Performance funds. • ACH P4P AV results known by end of November
	October-December	90-day review period for CMS review and approval of Statewide Accountability Report findings
	December	Final DY 3 P4P total funds known
2021		
	January-April	Up to 4 months to: (1) Adjust total Project Incentives based on statewide performance (2) apply AVs to adjust ACH funds (3) identify total unearned funds (4) apply ACH QIS to identify ACH-level DSRIP High Performance Incentives (5) Align payment timing with second DY4 P4R payment

Next steps

The P4P production process is in development. A future update to this guide will include additional detail about the timing and process for public dissemination of annual P4P results, and additional detail for P4P metric production and reporting.

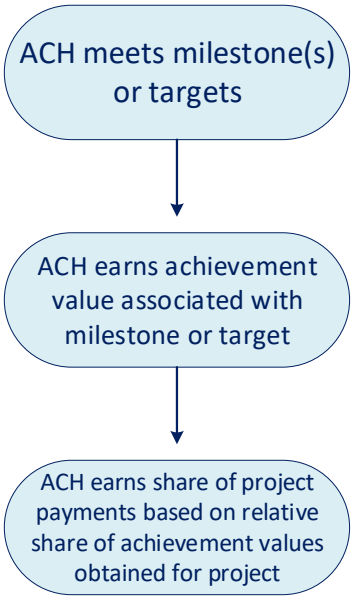
Translating P4P results to achievement values

Process for translating P4P results to achievement values

The state entities responsible for metric production will calculate results, and submit to state-contracted third party vendor (the Independent Assessor, or IA) for compilation into a single report. The performance results for the measurement period will be sent to the IA to assess earned Achievement Values and to make final incentive payment determination.

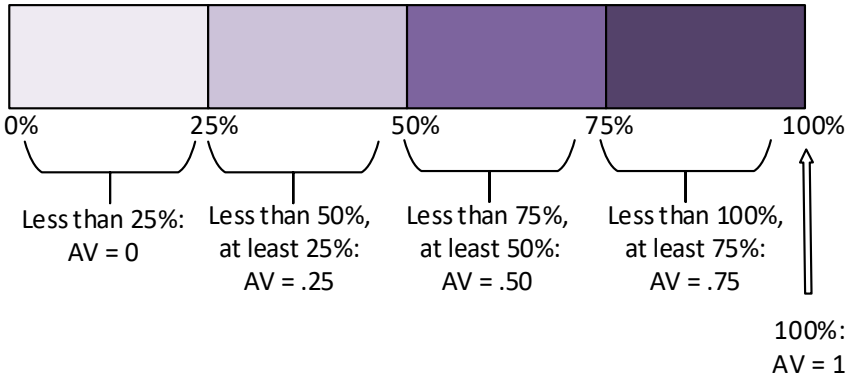
Achievement value calculation for incentive payment adjustments

Within each payment period, ACHs are evaluated against the 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 (1.0), 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 P4P metric.



For P4P metrics, an ACH may achieve an AV based on meeting a minimum threshold of 25 percent of its improvement target in the performance year. If this performance threshold is not achieved, an ACH would forfeit the Project Incentive payment associated with that metric.

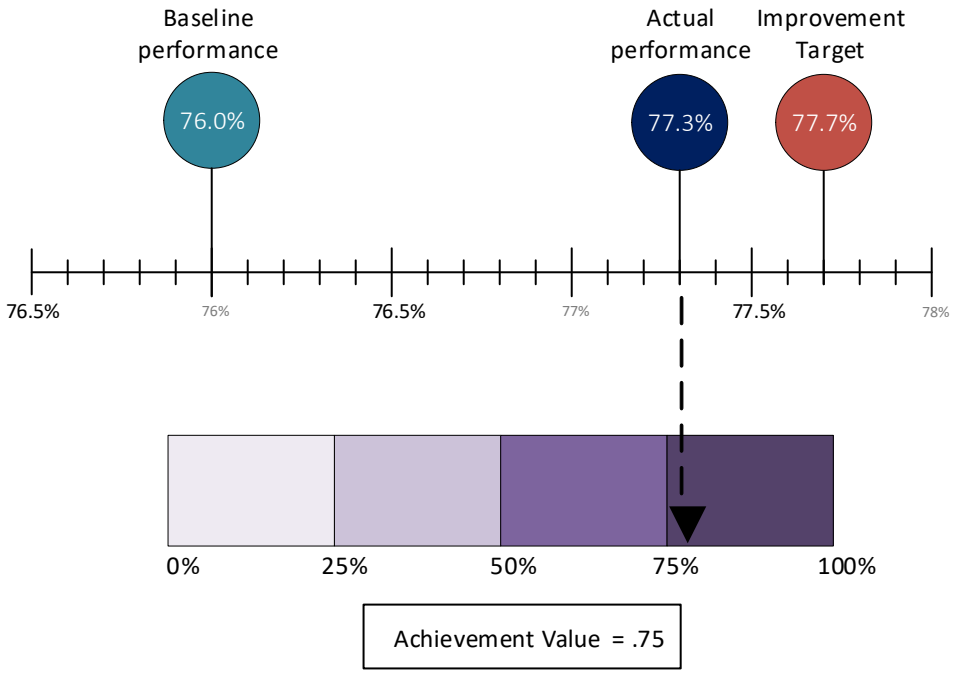
Enhanced AV valuation can be achieved if the ACH realizes a higher percentage of the improvement target, beyond the 25 percent threshold:



Sample AV calculations

For a metric with single rate, the results for that rate determine the AV for that metric. Using the Comprehensive Diabetes Care: Hemoglobin A1c Testing metric (Gap to Goal) as an example: the ACH's baseline performance is 76.0 percent, and the improvement target is 77.7 percent. The ACH's actual performance is 77.3 percent, which results in 77.0 percent progress toward the improvement target. The 77.0 percent maps to a 0.75 achievement value.

Note: the absolute benchmark for this metric is 92.8 percent, per the metric's technical specification (see Appendix E).



Additional examples of achievement value calculation can be found in Appendix D.

Total achievement value calculation by project

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

Sample total achievement value calculation for one project

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

Project 3A: Chronic Disease Prevention and Control		
Metric	Earned AV	*Possible AV*
All Cause Emergency Department (ED) Visits per 1000 Member Months	0.75	*1.00*
Child and Adolescents' Access to Primary Care Practitioners	1.00	*1.00*
Comprehensive Diabetes Care: Eye Exam (retinal) performed	0.50	*1.00*
Comprehensive Diabetes Care: Hemoglobin A1c Testing	1.00	*1.00*
Comprehensive Diabetes Care: Medical Attention for Nephropathy	0.75	*1.00*
Inpatient Hospital Utilization	0.75	*1.00*
Medication Management for People with Asthma	1.00	*1.00*
Statin Therapy for Patients with Cardiovascular Disease	1.00	*1.00*
Total Achievement Value (TAV)	**6.75**	*8.00*
Percentage Achievement Value (PAV)	**(6.75 / 8.0) = 84%**	*100%*

P4P measure retirement and specification modifications

The objective is to maintain consistency for measures associated with projects throughout the Medicaid Transformation. The measures associated with the Project Toolkit will be collected for all five years and specifications will be held consistent to the extent possible. Many of the measures used in DSRIP are currently used in CMS Medicaid quality core sets, as well as health plan reporting, and the measure steward is often a national organization. Situations may arise when the measure stewards retire or alter measure specifications to reflect changes in clinical care guidelines, treatment recommendations, or current health care practices. To align collection of data from all health care providers, the measure modifications may also be incorporated in DSRIP.

Guiding principles

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

1. Clinically relevant and meaningful quality measures reflecting recommended care and current health care practices; and
2. Alignment and consistent use of measure specifications for DSRIP and core sets used by other programs or initiatives in Washington when appropriate.

Based on the issue/decision, notification of CMS, stakeholders, and partners will depend on the scope of impacts and dependencies of the decision. For example, changes in a few codes in a value set to calculate a metric may be adopted in routine updates of the Measurement Guide; however, if a metric change has potential impacts to performance goals, annual improvement targets, and achievement values, then notification of CMS prior to implementation may be required.

The decision to retire a measure or to implement a modification with a measure, the method of implementing the change and its impact to the absolute benchmark and improvement target may be dependent on the following factors:

- Necessity of implementation (concordance with clinical guidelines and/or benefit structure)
- Availability of replacement measure for retired measure
- Ability to compare results with modification to previous results or to re-calculate previous results with modification

Adjusting annual improvement targets and achievement values

Given the two-year separation between reference baseline measurement year and the performance year, it is critical that the state monitor impacts of changes to specifications that may occur over time. While year-over-year changes may be minor, some may not be, and changes may have a cumulative effect. The state will develop procedures to address situations where the performance year and baseline year specifications are significantly different and any changes in performance are more likely driven by specification differences rather than ACH performance.

The Measurement Guide will be updated to reflect applicable procedures at a later date.

State contact for more information

For questions related to the content of this document or the Healthier Washington Medicaid Transformation, please contact medicaidtransformation@hca.wa.gov.

Appendix A: Glossary of terms

Term	Acronym	Definition
Accountable Communities of Health	ACH	An Accountable Community of Health is a group of people and organizations from a variety of sectors in a given region with a common interest in improving health. With support from the state, they are voluntarily organizing to make community-based decisions on health needs and priorities, and how best to address those priorities without duplicating services. ACHs develop, implement, and monitor transformation projects under Initiative 1 of the Medicaid Transformation, Transformation through ACHs. There are nine ACHs in Washington State.
ACH High Performance Metrics	-	The subset of statewide accountability metrics that ACHs can earn unearned DSRIP Project Incentive funds for high performance.
Achievement Value	AV	Point values assigned to each metrics that is payment-driven, maximum value of one (1.0).
Centers for Medicare and Medicaid Services	CMS	The federal authorizing agency for Washington's Medicaid Transformation Project.
Delivery System Reform Incentive Payment	DSRIP	DSRIP is a strategy to accomplish delivery system reform. The term "DSRIP funds" refers to the type of money available to pay for regional transformation projects. These funds are a vital tool to transform the Medicaid delivery system to care for the whole person, and use resources more wisely. The funds will be administered by ACHs. DSRIP is not a grant. It is a performance-based incentive program for earning funds through achievement of milestones and outcomes. These projects must be self-sustaining by the end of the Medicaid Transformation in 2021.
Demonstration Year	DY	Aligned with CMS approval of the transformation, the Healthier Washington Medicaid Transformation demonstration years begin January 9, 2017 and continue through December 31, 2021. For example, DY 1 runs from January 9, 2017 through December 31, 2017. DYs 2-5 align exactly with the calendar year.
DSRIP Funding and Mechanics protocol	-	Describes the role and function of standardized ACH reports to be submitted quarterly to the state, allocation formula and parameters for incentive payments, the state's process to develop an evaluation plan, and incentive contingencies. Link: https://www.hca.wa.gov/assets/program/dsrip-planning-protocol.pdf
DSRIP Planning Protocol	-	Describes the ACH Project Plans, the set of outcome measures that must be reported, transformation projects eligible for DSRIP funds, and timelines for meeting associated metrics. Link: https://www.hca.wa.gov/assets/program/dsrip-funding-and-mechanics-protocol.pdf

Term	Acronym	Definition
Eligible Population	-	All members attributed to the ACH, according to record of residence, who qualify for the measure, not limited to partnering providers or service sites.
Gap to Goal	GTG	Performance expectations based on the difference between ACH reference baseline year performance and the absolute benchmark (set at the national 90th percentile for Medicaid).
Healthcare Effectiveness Data and Information Set	HEDIS	A tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.
Improvement Over Self	IOS	The percentage improvement expectation for metrics not measured through Gap to Goal, in which the percent improvement relative to the ACH's reference baseline year results.
Improvement Target	IT	Improvement expectation toward ACH-specific performance goals, based on prior ACH performance for the metric.
Independent Assessor	-	State-contracted entity that participates in ongoing monitoring of ACH projects and milestone achievement, calculates Achievement Values, and determines incentive payment adjustments for each reporting period.
Managed Care Organization	MCO	State-contracted organizations that provide access to health care services for Medicaid beneficiaries.
MCO Quality Metrics	-	Seven metrics that MCOs may earn Challenge Pool funds based on quality and improvement.
Medicaid Transformation Project	MTP	Aims to transform the health care delivery system to address local health priorities, deliver high-quality, cost-effective care that treats the whole person, and create sustainable linkages between clinical and community-based services.
NCQA Quality Compass	-	A tool used for examining quality improvement and benchmarking plan performance, using HEDIS data.
Pay-for-Performance	P4P	Defined as the ability for ACHs to earn incentive funds by demonstrating achievement of and/or improvement toward ACH-specific performance goals.
Pay-for-Reporting	P4R	Defined as the ACH successfully reporting the project milestone or metric within the specified reporting timeframe.
Percentage Achievement Value	PAV	Represents the proportion of metrics an ACH has achieved for each project in each payment period, used to determine the distribution of dollars earned out of the maximum annual ACH project funding. Calculated by dividing the weighted total of possible Achievement Values for the project in a payment year.
Project Toolkit	-	Provides additional details and requirements related to ACH projects and assists ACHs in developing their Project Plans. Link: https://www.hca.wa.gov/assets/program/project-toolkit-approved.pdf
Quality Improvement Score	QIS	A composite score that takes into account quality attainment, as well as quality improvement.

Term	Acronym	Definition
Special Terms and Conditions	STC	Set forth in detail the nature, character, and extent of federal involvement in the Healthier Washington Medicaid Transformation, the state's implementation of expenditure authorities, and the state's obligations to CMS during the five-year period. Link: https://www.hca.wa.gov/assets/program/Medicaid-demonstration-terms-conditions.pdf
Statewide Accountability Metrics	-	Ten metrics defined in the DSRIP Funding and Mechanics protocol.
Total Achievement Value	TAV	Total of the summed Achievement Values according to their relative weighting.
Value-based Payment	VBP	State-established goals consistent with the Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Models (APM) Framework 2 and MACRA (Medicare Access and CHIP Reauthorization Act), aligned with broader U.S. Department of Health and Human Services' delivery system reform goals.
VBP Attainment Targets	-	Targets based on the percentage of payments to providers that fall into categories 2C through 4B of the HCP-LAN APM Framework, starting in Demonstration Year (DY) 1, with progressive targets throughout the demonstration.
VBP Roadmap – Apple Health Appendix	-	Reflects specific initiatives and changes pertaining to the Apple Health (Medicaid) program; describes how managed care is transforming in alignment with the MTP demonstration, and establishes targets for VBP attainment and related incentives under the DSRIP program for MCOs and ACHs.

Appendix B: Project Toolkit P4P metrics – description

TABLE. Project Toolkit P4P Metrics - Description Name of Metric	NQF#	Measure Steward	Measure Description	ACH High Performance metric	Statewide Accountability metric	Associated Toolkit Projects
All Cause Emergency Department (ED) Visits per 1000 Member Months	N/A	RDA	The rate of Medicaid beneficiary visits to emergency department per 1000 member months, including visits related to mental health and substance use disorder.	Y	Y	2.a, 2.b, 2.c, 2.d, 3.a, 3.b 3.c, 3.d
Antidepressant Medication Management	0105	NCQA	Percent of Medicaid beneficiaries 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment.	Y	Y	2.a
Child and Adolescents' Access to Primary Care Practitioners	N/A	NCQA	Percent of children and adolescents enrolled in Medicaid who had a visit with a primary care provider.	N	N	2.a, 3.d
Childhood Immunization Status (Combo 10)	0038	HEDIS	Percent of children 2 years of age enrolled in Medicaid who received the combo 10 HEDIS vaccine series (4DTaP/DT/Td, 3 Hib, 3 polio, 3 Hep B, 1 MMR, 1 Varicella, 2 Hep A, 2 flu, 4 PCV, 2 rotavirus) during the measurement period.	N	N	3.b
Chlamydia Screening in Women Ages 16 to 24	0033	NCQA	Percent of female Medicaid beneficiaries 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	N	N	3.b
Comprehensive Diabetes Care: Eye Exam (retinal) performed	0055	NCQA	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 period, or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	N	N	2.a, 3.d

TABLE. Project Toolkit P4P Metrics - Description Name of Metric	NQF#	Measure Steward	Measure Description	ACH High Performance metric	Statewide Accountability metric	Associated Toolkit Projects
Comprehensive Diabetes Care: Hemoglobin A1c Testing	0057	NCQA	Percent of Medicaid beneficiaries 18–75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	N	N	2.a, 3.d
Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062	NCQA	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 period.	N	N	2.a, 3.d
Contraceptive Care – Most & Moderately Effective Methods	2903	US Office of Population Affairs	Percent of female Medicaid beneficiaries 15-44 years of age at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved method of contraception.	N	N	3.b
Contraceptive Care – Postpartum	2902	US Office of Population Affairs	Among female Medicaid beneficiaries age 15 through 44 years who had a live birth, the percent that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery.	N	N	3.b
Dental Sealants for Children at Elevated Caries Risk	2508, 2509	DQA	Percent of children enrolled in Medicaid at elevated risk of dental caries (i.e., “moderate” or “high”) who received a sealant on a permanent first molar tooth within the reporting year.	N	N	3.c
Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence	2605	NCQA	The percent of discharges for Medicaid beneficiaries 18 years of age and older who had a visit to the emergency department with a primary diagnosis alcohol or other drug dependence during the measurement year AND who had a follow-up visit within 30 days of discharge with any provider with a corresponding primary diagnosis of alcohol or other drug dependence. Two rates are reported: (1) The percentage of discharges for beneficiaries who received follow-up within 30 days of discharge; (2) The percentage of discharges for beneficiaries who received follow-up within 7 days of discharge.	N	N	2.a, 2.b, 2.c

TABLE. Project Toolkit P4P Metrics - Description Name of Metric	NQF#	Measure Steward	Measure Description	ACH High Performance metric	Statewide Accountability metric	Associated Toolkit Projects
Follow-up After Emergency Department Visit for Mental Health	2605	NCQA	The percent of discharges for Medicaid beneficiaries 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health during the measurement year AND who had a follow-up visit within 30 days of discharge with any provider with a corresponding primary diagnosis of alcohol or other drug dependence. Two rates are reported: (1) The percentage of discharges for beneficiaries who received follow-up within 30 days of discharge; (2) The percentage of discharges for beneficiaries who received follow-up within 7 days of discharge.	N	N	2.a, 2.b, 2.c
Follow-up After Hospitalization for Mental Illness	0576	NCQA	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 an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: (1) The percentage of discharges for beneficiaries who received follow-up within 30 days of discharge; (2) The percentage of discharges the beneficiaries who received follow-up within 7 days of discharge.	N	N	2.a, 2.b, 2.c
Inpatient Hospital Utilization	N/A	NCQA	For Medicaid beneficiaries 18 years and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year.	N	N	2.a, 2.b, 2.c, 3.a, 3.d
Medication Management for People with Asthma: Medication Compliance 75%	1799	NCQA	The percent of Medicaid beneficiaries who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.	Y	Y	2.a, 3.d
Mental Health Treatment Penetration (Broad Version)	N/A	RDA	Percent of Medicaid beneficiaries with a mental health service need who received at least one qualifying service during the measurement year.	Y	Y	2.a, 2.b, 3.b
Patients on high-dose chronic opioid therapy by varying thresholds	N/A	Bree Collaborative	Percent of Medicaid beneficiaries prescribed chronic opioid therapy according to the following thresholds: 1.) Doses >50 mg morphine equivalent dosage (MED) in a quarter; 2.) Doses >90 mg MED in a quarter. Bree Collaborative specifies for quarterly counts; all qualifying observations for a given quarter will count towards the overall, annual estimate required for DSRIP performance measurement.	N	N	3.a

TABLE. Project Toolkit P4P Metrics - Description Name of Metric	NQF#	Measure Steward	Measure Description	ACH High Performance metric	Statewide Accountability metric	Associated Toolkit Projects
Patients with concurrent sedatives prescriptions	N/A	Bree Collaborative	Among Medicaid beneficiaries receiving chronic opioid therapy ≥60 days, the percent that had ≥60 days of sedative hypnotics, benzodiazepines, carisoprodol, and/or barbiturates in the same calendar quarter. Bree Collaborative specifies for quarterly counts; all qualifying observations for a given quarter will count towards the overall, annual estimate required for DSRIP performance measurement.	N	N	3.a
Percent Arrested	N/A	RDA	Percent of Medicaid beneficiaries who were arrested at least once during the measurement year.	N	N	2.d
Percent Homeless (Narrow Definition)	N/A	RDA	Percent of Medicaid beneficiaries who were homeless in at least one month in the measurement year. Excludes "homeless with housing" ACES living arrangement code.	N	N	2.b, 2.c, 2.d
Periodontal Evaluation in Adults with Chronic Periodontitis	N/A	DQA	Percent of Medicaid beneficiaries age 30 years and older with chronic periodontitis who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the measurement year.	N	N	3.c
Plan All-Cause Readmission Rate (30 Days)	1768	NCQA	Among Medicaid beneficiaries age 18-64 years old, the percent of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days.	Y	Y	2.a, 2.b, 2.c
Primary Caries Prevention Intervention by Primary Care Medical Providers	1419	DQA	Measure is a modification of the State Common Measure Set measure. Among eligible Medicaid beneficiaries, the measure quantifies all fluoride varnish applications provided by professional providers (non-dental primary care medical provider) during a child's primary care medical visit. In contrast to previously endorsed NQF 1419 and the SCMS measure, the current measure calculation does not limit the data filter in the Medicaid Claims to EPSDT claims type.	N	N	3.c
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	N/A	NCQA	Percent of Medicaid beneficiaries 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.	N	N	3.d

TABLE. Project Toolkit P4P Metrics - Description Name of Metric	NQF#	Measure Steward	Measure Description	ACH High Performance metric	Statewide Accountability metric	Associated Toolkit Projects
Substance Use Disorder Treatment Penetration	N/A	RDA	The percentage of Medicaid beneficiaries with a substance use disorder treatment need who received substance use disorder treatment in the measurement year.	Y	Y	2.a, 2.b, 3.b
Substance Use Disorder Treatment Penetration (Opioid)	N/A	RDA	The percent of Medicaid beneficiaries with an identified opioid use disorder treatment need who received medication assisted treatment (MAT) or medication-only treatment for opioid use disorder in the measurement year.	N	N	3.a
Timeliness of Prenatal Care	N/A	NCQA	The percent of all live birth deliveries for Medicaid beneficiaries that received a prenatal care visit in the first trimester of pregnancy, or within 42 days of enrollment.	N	N	3.b
Utilization of Dental Services by Medicaid Beneficiaries	N/A	HCA	Dental service utilization among Medicaid beneficiaries.	N	N	3.c
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	1516	NCQA	The percent of children 3-6 years of age enrolled in Medicaid who had one or more well-child visits with a primary care provider during the measurement year.	Y	Y	3.b
Well-Child Visits in the First 15 Months of Life	1392	NCQA	The percent of children 15 months old enrolled in Medicaid who had the recommended number of well-child visits with a primary care provider during their first 15 months of life. For the purpose of performance measurement, the rate of children receiving 6 or more visits is used.	N	N	3.b

Appendix C: Project Toolkit P4P Metrics - Metric criteria, improvement target methodology and AV determination

TABLE. Project Toolkit P4P Metrics - Measure criteria, improvement target methodology and AV determination.	NQF #	Measure Steward	Metric age criteria	Associated Toolkit Projects	P4P IT Methodology	Achievement Value (AV) calculation, based on metric/submetric results	
Name of Metric					Gap to goal (GTG); Improvement over self (IOS)	Submetrics used to determine AV for Associated Metric	AV Determination for Metrics with Multiple Component Rates
All Cause Emergency Department (ED) Visits per 1000 Member Months	N/A	RDA	10+ years. Reported separately for three age bands: 10 – 17 years; 18 – 64 years; 65+ years.	2.a, 2.b, 2.c, 2.d, 3.a, 3.b 3.c, 3.d	IOS	• 0 – 17 years • 18 – 64 years • Age 65+	Weighted average of performance for each submetric is used to calculate overall AV; determined by number of Medicaid beneficiaries the ACH has in each submetric.
Antidepressant Medication Management	0105	NCQA	18+ years	2.a	GTG	• Acute Phase Treatment • Continuation Phase Treatment	Each submetric contributes equal weight in the final AV calculation for the overall metric.
Child and Adolescents' Access to Primary Care Practitioners	N/A	NCQA	Age 12 months - 19 years. Reported separately for the following age bands: 12-24 months; 2-6 years; 7-11 years; 12-19 years.	2.a, 3.d	GTG	• Age 12-24 months • Age 25 months - 6 years • Age 7-11 years • Age 12-19 years	Weighted average of performance for each submetric is used to calculate overall AV; determined by number of Medicaid beneficiaries the ACH has in each submetric.
Childhood Immunization Status (Combo 10)	0038	HEDIS	As of 2 years of age	3.b	GTG	N/A; Single metric result	

TABLE. Project Toolkit P4P Metrics - Measure criteria, improvement target methodology and AV determination.	NQF #	Measure Steward	Metric age criteria	Associated Toolkit Projects	P4P IT Methodology	Achievement Value (AV) calculation, based on metric/submetric results	
Name of Metric					Gap to goal (GTG); Improvement over self (IOS)	Submetrics used to determine AV for Associated Metric	AV Determination for Metrics with Multiple Component Rates
Chlamydia Screening in Women Ages 16 to 24	0033	NCQA	16-24 years	3.b	GTG	N/A; Single metric result	
Comprehensive Diabetes Care: Eye Exam (retinal) performed	0055	NCQA	18-75 years	2.a, 3.d	GTG	N/A; Single metric result	
Comprehensive Diabetes Care: Hemoglobin A1c Testing	0057	NCQA	18-75 years	2.a, 3.d	GTG	N/A; Single metric result	
Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062	NCQA	18-75 years	2.a, 3.d	GTG	N/A; Single metric result	
Contraceptive Care – Most & Moderately Effective Methods	2903	US Office of Population Affairs	Age 15 - 44 years. Reported separately for two age bands: 15 - 20 years; 21 - 44 years.	3.b	IOS	• 15 - 20 years • 21 - 44 years [part of Contraceptive Care bundle]	Assess all submetric rates of the Contraceptive Care bundle. The submetric with the most progress towards the improvement target will determine the final AV value for the "Contraceptive Care" bundle.
Contraceptive Care – Postpartum	2902	US Office of Population Affairs	Age 15 - 44 years. Reported separately for two age bands: 15 - 20 years; 21 - 44 years.	3.b	IOS	• 15 - 20 years • 21 - 44 years [part of Contraceptive Care bundle]	Assess all submetric rates of the Contraceptive Care bundle. The submetric with the most progress towards the improvement target will determine the final AV value for the "Contraceptive Care" bundle.

TABLE. Project Toolkit P4P Metrics - Measure criteria, improvement target methodology and AV determination.	NQF #	Measure Steward	Metric age criteria	Associated Toolkit Projects	P4P IT Methodology	Achievement Value (AV) calculation, based on metric/submetric results	
Name of Metric					Gap to goal (GTG); Improvement over self (IOS)	Submetrics used to determine AV for Associated Metric	AV Determination for Metrics with Multiple Component Rates
Dental Sealants for Children at Elevated Caries Risk	2508, 2509	DQA	Age 6-14 years. Reported separately for two age bands: 6 – 9 years; 10 – 14 years	3.c	IOS	• Age 6 years – 9 years • Age 10 years – 14 years	Weighted average of performance for each submetric is used to calculate overall AV; determined by number of Medicaid beneficiaries the ACH has in each submetric.
Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence	2605	NCQA	18+ years	2.a, 2.b, 2.c	IOS	• 30 days • 7 days	Each submetric contributes equal weight in the final AV calculation for the overall metric.
Follow-up After Emergency Department Visit for Mental Health	2605	NCQA	18+ years	2.a, 2.b, 2.c	IOS	• 30 days • 7 days	Each submetric contributes equal weight in the final AV calculation for the overall metric.
Follow-up After Hospitalization for Mental Illness	0576	NCQA	6+ years	2.a, 2.b, 2.c	IOS	• 30 days • 7 days	Each submetric contributes equal weight in the final AV calculation for the overall metric.
Inpatient Hospital Utilization	N/A	NCQA	18+ years	2.a, 2.b, 2.c, 3.a, 3.d	IOS	N/A; Single metric result	
Medication Management for People with Asthma: Medication Compliance 75%	1799	NCQA	5-64 years	2.a, 3.d	GTG	N/A; Single metric result	
Mental Health Treatment Penetration (Broad Version)	N/A	RDA	6+ years. Separate reporting for three age bands: 6 – 17 years; 18 – 64 years; 65+ years.	2.a, 2.b, 3.b	IOS	• Age 6 years – 17 years • Age 18 years – 64 years • Age 65+	Weighted average of performance for each submetric is used to calculate overall AV; determined by number of Medicaid beneficiaries the ACH has in each submetric.

TABLE. Project Toolkit P4P Metrics - Measure criteria, improvement target methodology and AV determination.	NQF #	Measure Steward	Metric age criteria	Associated Toolkit Projects	P4P IT Methodology	Achievement Value (AV) calculation, based on metric/submetric results	
Name of Metric					Gap to goal (GTG); Improvement over self (IOS)	Submetrics used to determine AV for Associated Metric	AV Determination for Metrics with Multiple Component Rates
Patients on high-dose chronic opioid therapy by varying thresholds	N/A	Bree Collaborative	All ages	3.a	IOS	• Percentage of chronic opioid therapy patients receiving doses >50 mg. MED in a calendar quarter; • Percentage of chronic opioid therapy patients receiving doses >90 mg. MED in a calendar quarter. *Metric Note:* Submetrics will be calculated by quarter, following the Bree Collaborative specifications. The quarterly results will then be combined and reported as an annual value to determine ACH performance.	Each submetric contributes equal weight in the final AV calculation for the overall metric.
Patients with concurrent sedatives prescriptions	N/A	Bree Collaborative	All ages	3.a	IOS	N/A; Single metric result. *Metric Note:* Metric will be calculated by quarter, following the Bree Collaborative specifications. The quarterly results will then be combined and reported as an annual value to determine ACH performance.	

TABLE. Project Toolkit P4P Metrics - Measure criteria, improvement target methodology and AV determination.	NQF #	Measure Steward	Metric age criteria	Associated Toolkit Projects	P4P IT Methodology	Achievement Value (AV) calculation, based on metric/submetric results	
Name of Metric					Gap to goal (GTG); Improvement over self (IOS)	Submetrics used to determine AV for Associated Metric	AV Determination for Metrics with Multiple Component Rates
Percent Arrested	N/A	RDA	18-64 years	2.d	IOS	N/A; Single metric result	
Percent Homeless (Narrow Definition)	N/A	RDA	All ages. Separate reporting for three age bands: 0-17 years; 18 – 64 years; 65+ years.	2.b, 2.c, 2.d	IOS	• 0-17 years • 18 – 64 years • 65+ years	
Periodontal Evaluation in Adults with Chronic Periodontitis	N/A	DQA	30+ years	3.c	IOS	N/A; Single metric result	
Plan All-Cause Readmission Rate (30 Days)	1768	NCQA	18+ years	2.a, 2.b, 2.c	IOS	N/A; Single metric result	
Primary Caries Prevention Intervention by Primary Care Medical Providers	1419	DQA	Under 21 years of age.	3.c	IOS	N/A; Single metric result	
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	N/A	NCQA	Rate comprised of: • Males 21 to 75 years of age • Females 40 to 75 years of age	3.d	IOS	N/A; Single metric result	

TABLE. Project Toolkit P4P Metrics - Measure criteria, improvement target methodology and AV determination.	NQF #	Measure Steward	Metric age criteria	Associated Toolkit Projects	P4P IT Methodology	Achievement Value (AV) calculation, based on metric/submetric results	
Name of Metric					Gap to goal (GTG); Improvement over self (IOS)	Submetrics used to determine AV for Associated Metric	AV Determination for Metrics with Multiple Component Rates
Substance Use Disorder Treatment Penetration	N/A	RDA	Age 12+ years. Separate reporting by three age bands: 12 years – 17 years; 18 – 64 years; 65+ years.	2.a, 2.b, 3.b	IOS	• Age 12 years – 17 years • Age 18 years – 64 years • Age 65+	Weighted average of performance for each submetric is used to calculate overall AV; determined by number of Medicaid beneficiaries the ACH has in each submetric.
Substance Use Disorder Treatment Penetration (Opioid)	N/A	RDA	Age 12+ years. Separate reporting by three age bands: 12 years – 17 years; 18 – 64 years; 65+ years.	3.a	IOS	• Age 12 years – 17 years • Age 18 years – 64 years • Age 65+	Weighted average of performance for each submetric is used to calculate overall AV; determined by number of Medicaid beneficiaries the ACH has in each submetric.
Timeliness of Prenatal Care	N/A	NCQA	None specified; no age restriction.	3.b	GTG	N/A; Single metric result	
Utilization of Dental Services by Medicaid Beneficiaries	N/A	HCA	All ages. Two age stratifications are used: •20 years and under •21 years and above	3.c	IOS	Service Category: Overall (Includes preventative and restorative) Age Groups: • Children Ages 20 and under • Adults Age 21 and above	Accountability linked to performance on the broad service category “Overall." The AV is determined by the age band submetric that shows the greatest progress towards its respective improvement target.

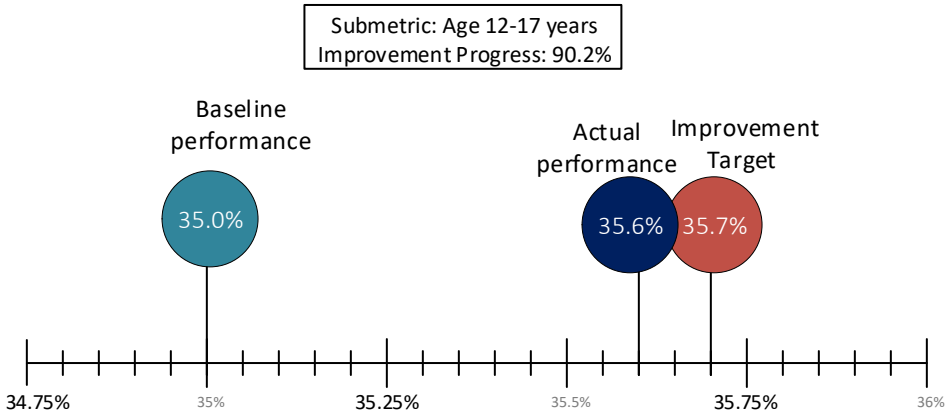
TABLE. Project Toolkit P4P Metrics - Measure criteria, improvement target methodology and AV determination.	NQF #	Measure Steward	Metric age criteria	Associated Toolkit Projects	P4P IT Methodology	Achievement Value (AV) calculation, based on metric/submetric results	
Name of Metric					Gap to goal (GTG); Improvement over self (IOS)	Submetrics used to determine AV for Associated Metric	AV Determination for Metrics with Multiple Component Rates
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	1516	NCQA	3-6 years.	3.b	GTG	N/A; Single metric result	
Well-Child Visits in the First 15 Months of Life	1392	NCQA	15 months of age during the measurement period.	3.b	GTG	N/A; Single metric result	

Appendix D: Sample Achievement Value Calculations

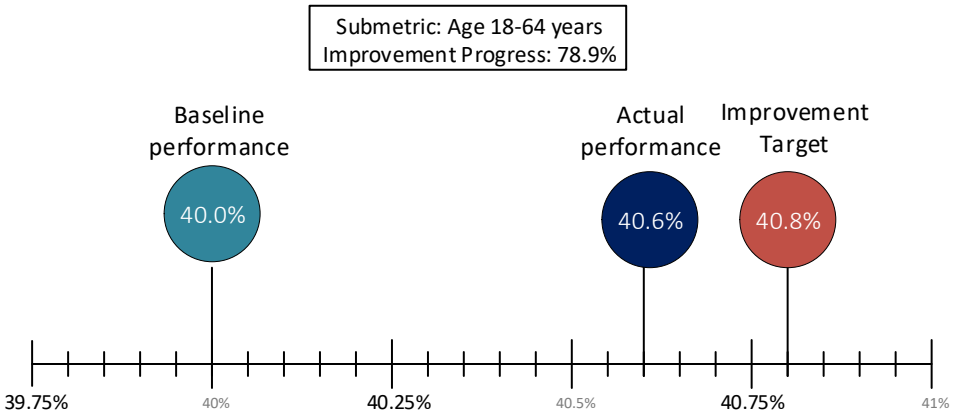
AV Calculation for Metric with Multiple Age Groups

For metric with multiple age groups, the weighted average of performance for each submetric is used to calculate overall AV. This is determined by number of Medicaid beneficiaries the ACH has in each submetric. There is no minimum threshold for the denominator for the inclusion of the submetric in the AV calculation.

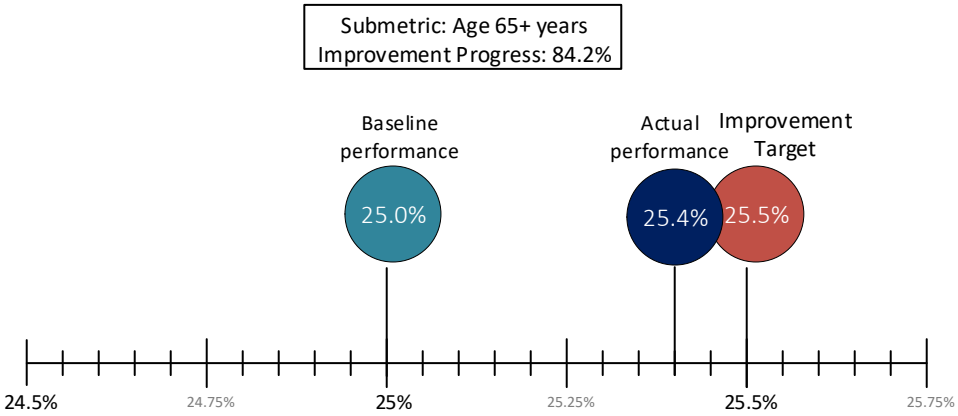
As an example, the Substance Use Disorder metric (Improvement Over Self) has three submetrics: age 12-17 years, age 18-64 years, and age 65+ years. The ACH has a baseline performance, improvement target, and actual performance for each submetric.



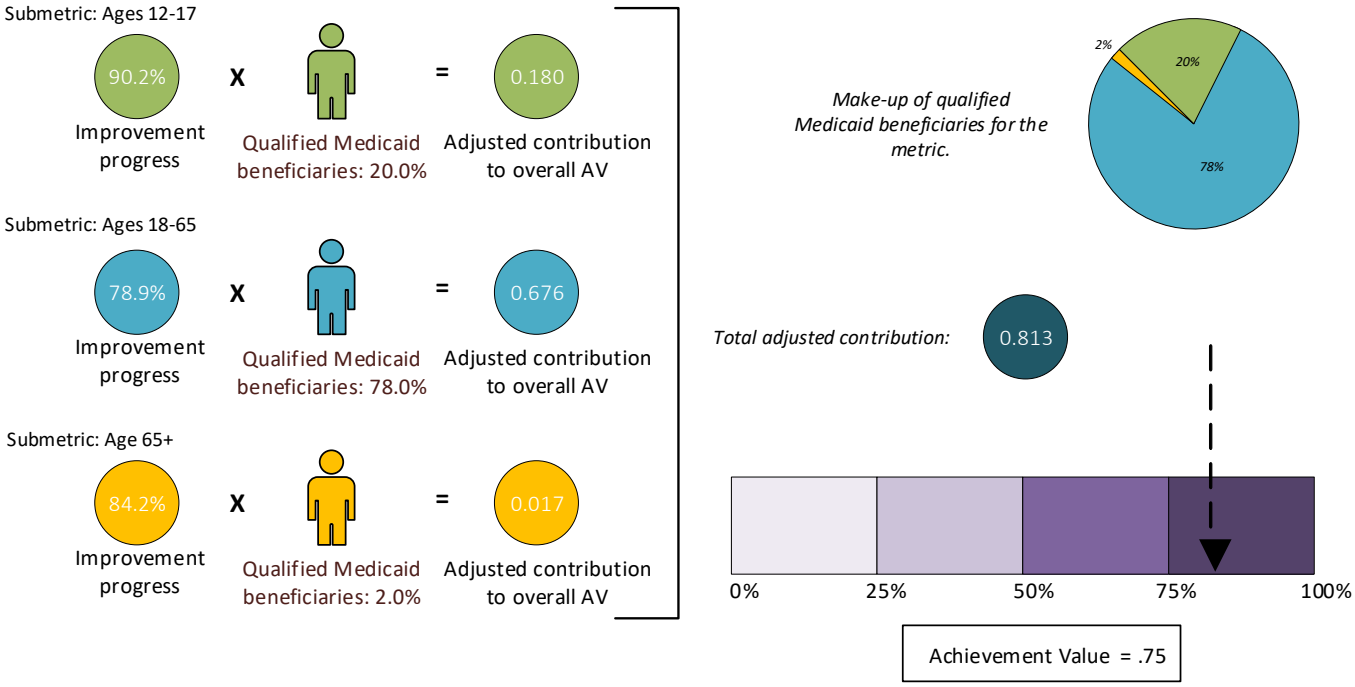
For the age 12-17 years submetric, the ACH's actual performance was 35.6 percent, resulting in 90.2 percent progress toward the improvement target (35.7 percent).



For the 18-64 years submetric, the ACH's actual performance was 40.6 percent, resulting in 78.9 percent progress toward the improvement target (40.8 percent).



For the age 65+ years submetric, the ACH's actual performance was 25.4 percent, resulting in 84.2 percent progress toward the improvement target (25.5 percent).

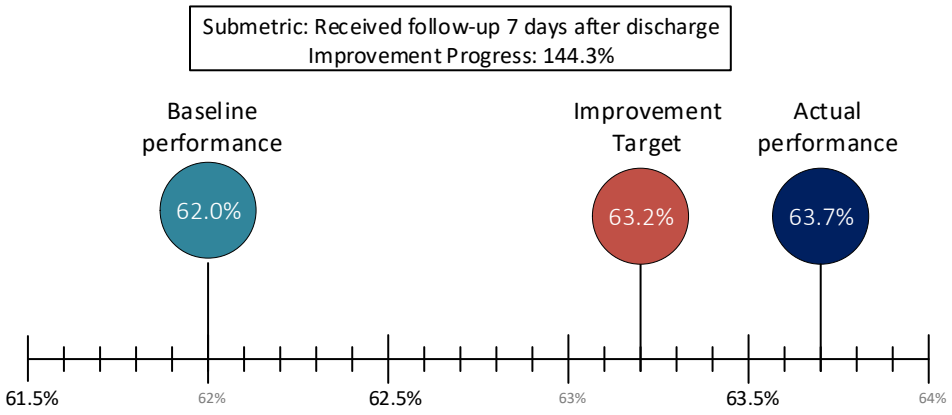


The weighted average of the three submetrics is used to calculate the total adjusted contribution of the achievement value. In this example, the weight of each submetric maps to the makeup of qualified Medicaid beneficiaries for that submetric. The ages 12-17, 18-64, and 65+ submetrics make up 20 percent, 78 percent, and 2 percent of the total Medicaid beneficiaries for this metric, respectively.

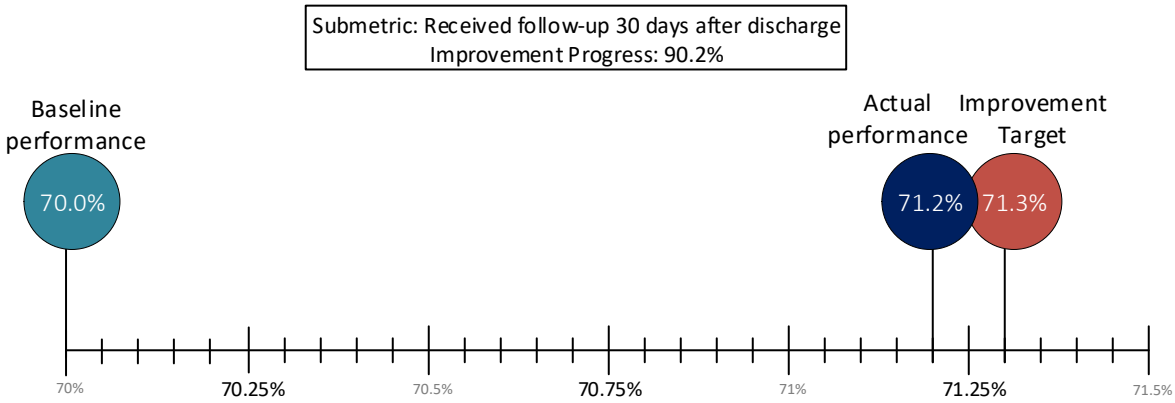
The total adjusted contribution toward the achievement value in this example equals 0.813, mapping to a .75 achievement value.

AV Calculation for Metric with Multiple Components, Equally Weighted

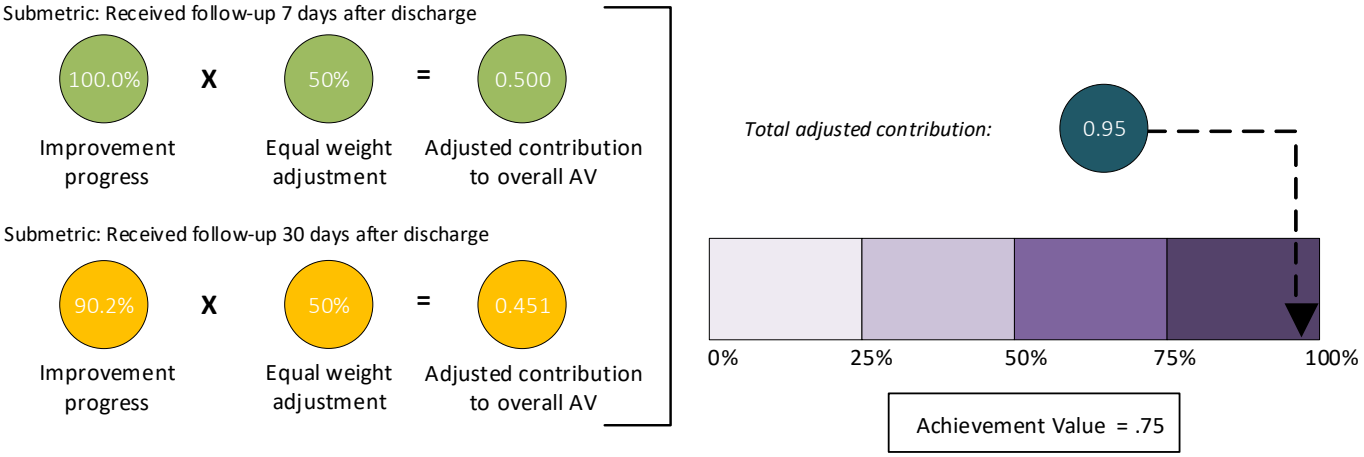
For applicable metrics with multiple submetrics that do not relate to age groups, each submetric contributes equal weight in the final AV calculation for the overall metric. There is no minimum threshold for the denominator for the inclusion of the submetric in the AV calculation. The Follow-up After Hospitalization for Mental Illness metric (Improvement Over Self), as an example, has two submetrics: Received follow-up 7 days after discharge, and Received follow-up 30 days after discharge.



For this submetric, the ACH's baseline performance was 63.7 percent, and the improvement target was 63.2 percent. The ACH's actual performance surpassed the improvement target, resulting in 144.3 percent progress.



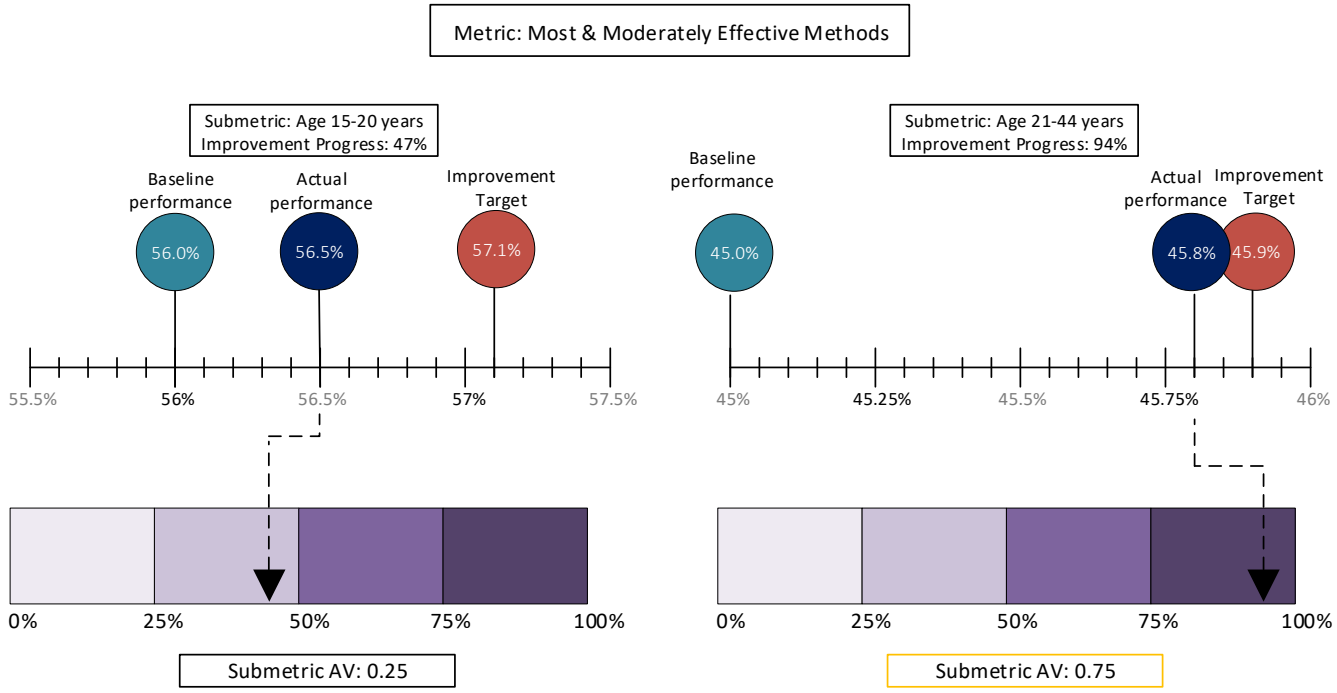
For this submetric, the ACH's baseline performance was 70.0 percent, and the improvement target was 71.3 percent. The ACH's actual performance was 71.2 percent, resulting in 90.2 percent progress toward the improvement target.

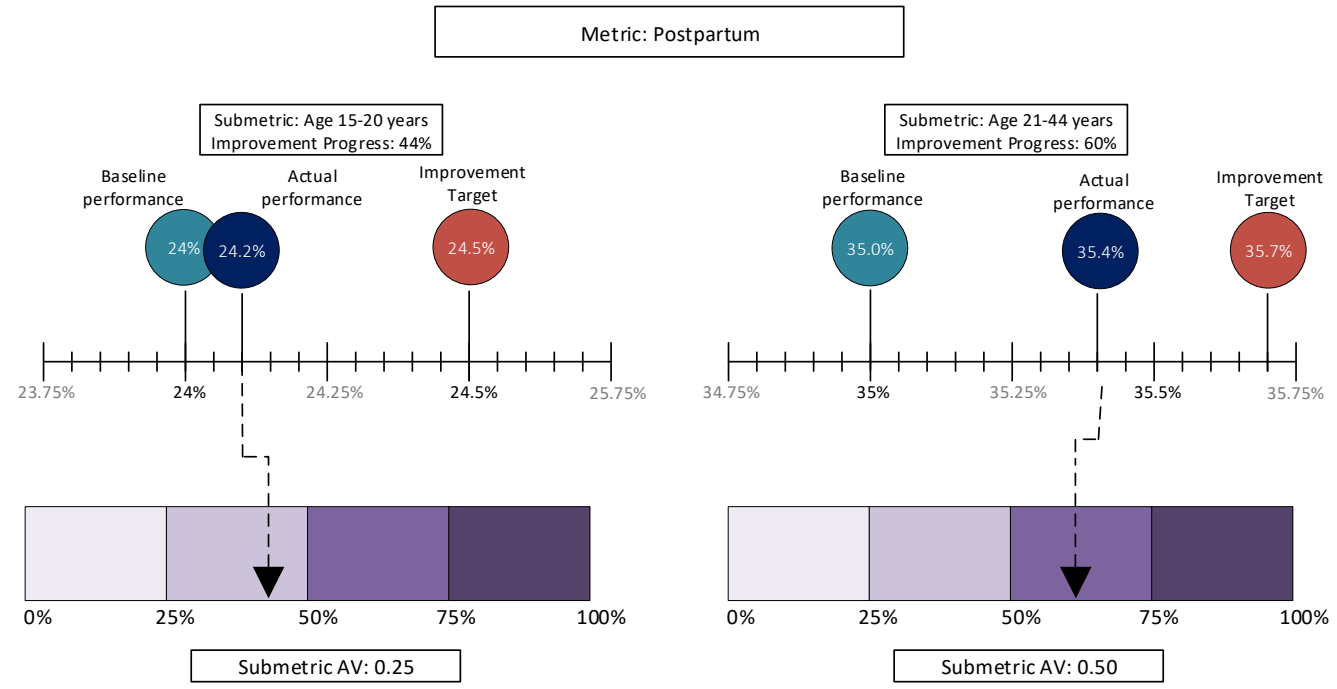


These two submetrics contribute equal weight toward the final achievement value calculation. In this example, the ACH's equal-weighted performance on each submetric results in a total adjusted contribution of 0.95, which maps to a 0.75 achievement value. Note: the improvement progress cannot measure over 100 percent.

AV Calculation for Bundle of Metrics

To calculate the achievement value for a bundle of metrics, all submetrics are assessed, and the submetric with the greatest progress toward the improvement target will determine the final achievement value bundle or metric. This calculation method applies to the Contraceptive Care metric bundle and Utilization of Dental Services metric. See the graphics below for an example of the Contraceptive Care (Improvement Over Self) calculations.





In these example calculations, the better performing submetric achievement value (0.75) determines the final metric achievement value.

Appendix E: Technical specification sheets

The specifications used to produce baseline 2017 results are available below. Measures are produced using national and standardized specifications. Variations from standard specifications are noted in the documents.

Situations may arise when the measure stewards retire or alter measure specifications to reflect changes in clinical care guidelines, treatment recommendations, or current health care practices. To align collection of data from all health care providers, the measure modifications may also be incorporated in DSRIP. If changes are adopted, specification sheets will be updated to reflect this and annotated to indicate the measurement years impacted.

For HEDIS metrics, additional detail and value sets can be found in the HEDIS Manual.

All Cause Emergency Department (ED) Visits per 1000 Member Months

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: The rate of Medicaid beneficiary visits to emergency department per 1000 member months, including visits related to mental health and substance use disorder.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 2013 Engrossed House Bill 1519 (Chapter 320, Laws of 2013) and Second Substitute Senate Bill 5732 (Chapter 338, Laws of 2013) performance measure development process.

Name and date of specification used: Specifications are a variant of the DSHS(RDA)Cross-System Outcome Measures for Adults Enrolled in Medicaid - "Emergency Department Utilization (July 2016, v 1.1)."

Measure type: Other

If other, specify: Developed by DSHS (RDA).

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data; RSN/BHO encounter data and DBHR-paid behavioral health services; CARE assessment diagnoses for identification of mental illness and substance use disorder.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Lower is better.

URL of specifications: Modified version of DSHS(RDA) measure; link to original: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/cross-system/ED-Utilization.pdf

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance ■ DSRIP Statewide Accountability ■

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	All ages. Three age stratifications used: 0-17 years; 18 – 64 years; 65 years and older

All Cause Emergency Department (ED) Visits per 1000 Member Months

Continuous Medicaid enrollment criteria	At least one month
Allowable gap in enrollment	Any
Anchor date	None
Measurement period	The measurement year.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	Outpatient ED visits meeting the numerator criteria defined below.
Identification window	N/A

Denominator:

Population meeting eligible population criteria.

Numerator:

Outpatient ED visits during medical coverage months in the eligible population in the measurement year.

ED visits are defined by the following criteria:

- Claim or encounter is a hospital outpatient claim type AND
- One or more of the following criteria is met:
    - Revenue code in the set ('0450', '0451', '0452', '0456', '0459')
    - Procedure code in the set ('99281' ,'99282' ,'99283' ,'99284' ,'99285', '99288')
    - Place of service code = Emergency Department AND Procedure codes in the set 10021 to 69990.
        - AND ED Visit did not convert to an inpatient admission.

Measure is expressed as a rate per 1,000 denominator member months in the measurement year.

Antidepressant Medication Management

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Percent of Medicaid beneficiaries 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Reported separately for: Acute Phase Treatment, and Continuation Phase Treatment.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance ■ DSRIP Statewide Accountability ■

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019):
- Acute Phase Treatment (63.6%); 2017 NCQA Quality Compass National Medicaid 90th Percentile
- Continuation Phase Treatment (49.1%); 2017 NCQA Quality Compass National Medicaid 90th Percentile

Eligible Population:

Ages	18 years and older; age as of last day of the fourth month of the measurement year.
Continuous Medicaid enrollment criteria	105 days prior to the Index Prescription Start Date (IPSD) through 231 days after the IPSD.

Antidepressant Medication Management

Allowable gap in enrollment	1 month
Anchor date	Index Prescription Start Date: The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.
Measurement period	105 days prior to the Index Prescription Start Date (IPSD) through 231 days after the IPSD.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the Intake Period. Exclude members who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population: • An outpatient visit, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria: – AMM Stand Alone Visits Value Set with Major Depression Value Set. – AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set. • An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set). • An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient stays: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria. Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 105 days prior to the IPSD. Calculate continuous enrollment. Members must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.
Identification window	N/A

Antidepressant Medication Management

Denominator:

Population meeting eligible population criteria.

Numerator:

Effective Acute Phase Treatment: At least 84 days (12 weeks) of treatment with antidepressant medication (Table AMM-C), beginning on the IPSD through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Continuation Phase Treatment: At least 180 days (6 months) of treatment with antidepressant medication (Table AMM-C) beginning on the IPSD through 231 days after the IPSD (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Child and Adolescents' Access to Primary Care Practitioners

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Percent of children and adolescents enrolled in Medicaid who had a visit with a primary care provider. Reported separately for the following age groups: 12-24 months, 2-6 years, 7-11 years, and 12-19 years.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019):
- Age 12-24 months (97.89%); 2017 NCQA Quality Compass National Medicaid 90th Percentile
- Age 2-6 years (93.16%); 2017 NCQA Quality Compass National Medicaid 90th Percentile
- Age 7-11 years (96.1%); 2017 NCQA Quality Compass National Medicaid 90th Percentile
- Age 12-19 years (96.09%); 2017 NCQA Quality Compass National Medicaid 90th Percentile

Eligible Population:

Ages	12 months–19 years as of last day of the measurement year. Four age stratifications are used, according to the age on the last day of the measurement year: • 12–24 months • 25 months–6 years • 7-11 years • 12-19 years

Child and Adolescents' Access to Primary Care Practitioners

Continuous Medicaid enrollment criteria	• For 12–24 months, 25 months–6 years: the measurement year. • For 7–11 years, 12–19 years: the measurement year and the year prior to the measurement year.
Allowable gap in enrollment	1 month per year
Anchor date	Last day of measurement year.
Measurement period	• For 12–24 months, 25 months–6 years: the measurement year • For 7–11 years, 12–19 years: the measurement year and the year prior to the measurement year
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	None.
Identification window	N/A

Denominator:

Population meeting eligible population criteria.

Numerator:

• For 12–24 months, 25 months–6 years: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement year.

• For 7–11 years, 12–19 years: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement year or the year prior to the measurement year.

Count all members who had an ambulatory or preventive care visit to any PCP. Exclude specialist visits.

Childhood Immunization Status (Combo 10)

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Percent of children 2 years of age enrolled in Medicaid who received the combo 10 HEDIS vaccine series (4DTaP/DT/Td, 3 Hib, 3 polio, 3 Hep B, 1 MMR, 1 Varicella, 2 Hep A, 2 flu, 4 PCV, 2 rotavirus) during the measurement period.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data; Washington Immunization Information System.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): 48.5%; 2017 NCQA Quality Compass National Medicaid 90th Percentile

Eligible Population:

Ages	Children who turn 2 years of age during the measurement year.
Continuous Medicaid enrollment criteria	12 months prior to the child's second birthday.
Allowable gap in enrollment	1 month
Anchor date	Enrolled on the child's second birthday.
Measurement period	2 years

Childhood Immunization Status (Combo 10)

Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	None.
Identification window	N/A

Denominator:

The eligible population.

Numerator:

Children 2 years of age who had the following by their second birthday:

- Four diphtheria, tetanus and acellular pertussis (DTaP)
- Three polio (IPV)
- One measles, mumps and rubella (MMR)
- Two H influenza type B (HiB)
- Three hepatitis B (HepB)
- One chicken pox (VZV)
- Four pneumococcal conjugate (PCV)
- Two hepatitis A (HepA)
- Two or three rotavirus (RV)
- Two influenza (flu) vaccines

For MMR, hepatitis B, VZV and hepatitis A, count any of the following:

- Evidence of the antigen or combination vaccine; or
- Documented history of the illness; or
- A seropositive test result for each antigen.

Chlamydia Screening in Women Ages 16 to 24

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Percent of female Medicaid beneficiaries 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): 71.5%; 2017 NCQA Quality Compass National Medicaid 90th Percentile

Eligible Population:

Ages	16-24 years; age as of last day of the measurement year.
Continuous Medicaid enrollment criteria	The measurement year.
Allowable gap in enrollment	No more than one gap of 1 month during the measurement year.
Anchor date	Last day of measurement year.
Measurement period	1 year

Chlamydia Screening in Women Ages 16 to 24

Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits, and individuals with family planning only services. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	Women who are identified as 'sexually active' using either the claim/encounter data or the pharmacy data: • From claim/encounter data during the measurement year – a code from either the 'Pregnancy Value Set,' 'Sexual Activity Value Set,' or 'Pregnancy Tests Value Set.' • Dispensed prescription contraceptives (Table CHL-A1) during the measurement year.
Identification window	N/A

Denominator:

Population meeting eligible population criteria.

Numerator:

At least one chlamydia test (Chlamydia Tests Value Set) during the measurement year.

Comprehensive Diabetes Care: Eye Exam (retinal) performed

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: 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 period, or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): 68.3%; 2017 NCQA Quality Compass National Medicaid 90th Percentile

Eligible Population:

Ages	18–75 years; age as of last day of the measurement year.
Continuous Medicaid enrollment criteria	The measurement year.
Allowable gap in enrollment	1 month
Anchor date	Last day of measurement year.
Measurement period	The measurement year.

Comprehensive Diabetes Care: Eye Exam (retinal) performed

Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years): • At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits. • At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set). Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CDC-A).
Identification window	N/A

Denominator:

Population meeting eligible population criteria.

Numerator:

Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

• A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.

• A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

Any of the following meet criteria:

Comprehensive Diabetes Care: Eye Exam (retinal) performed

• Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.

• Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a negative result (negative for retinopathy).

• Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set). All codes must be on the same claim.

• Any code in the Diabetic Retinal Screening With Eye Care Professional Value Set billed by any provider type during the measurement year.

• Any code in the Diabetic Retinal Screening With Eye Care Professional Value Set billed by any provider type during the year prior to the measurement year, with a negative result (negative for retinopathy).

• Any code in the Diabetic Retinal Screening Negative Value Set billed by any provider type during the measurement year.

Comprehensive Diabetes Care: Hemoglobin A1c Testing

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Percent of Medicaid beneficiaries 18–75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): 92.8%; 2017 NCQA Quality Compass National Medicaid 90th Percentile

Eligible Population:

Ages	18–75 years; age as of last day of the measurement year.
Continuous Medicaid enrollment criteria	The measurement year.
Allowable gap in enrollment	1 month
Anchor date	Last day of measurement year.
Measurement period	The measurement year.

Comprehensive Diabetes Care: Hemoglobin A1c Testing

Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. Claim/encounter data: Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years): • At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits. • At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set). Pharmacy data: Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CDC-A).
Identification window	N/A

Denominator:

Population meeting eligible population criteria.

Numerator:

An HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

Comprehensive Diabetes Care: Medical Attention for Nephropathy

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: 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 period.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): 93.3%; 2017 NCQA Quality Compass National Medicaid 90th Percentile

Eligible Population:

Ages	18–75 years; age as of last day of the measurement year.
Continuous Medicaid enrollment criteria	The measurement year.
Allowable gap in enrollment	1 month
Anchor date	Last day of measurement year.
Measurement period	The measurement year.

Comprehensive Diabetes Care: Medical Attention for Nephropathy

Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years): • At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits. • At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set). Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CDC-A).
Identification window	N/A

Denominator:

Population meeting eligible population criteria.

Numerator:

A nephropathy screening or monitoring test or evidence of nephropathy, as documented through administrative data. This includes diabetics who had one of the following during the measurement year:

• A nephropathy screening or monitoring test (Urine Protein Tests Value Set).

• Evidence of treatment for nephropathy or ACE/ARB therapy (Nephropathy Treatment Value Set).

• Evidence of stage 4 chronic kidney disease (CKD Stage 4 Value Set).

• Evidence of ESRD (ESRD Value Set).

• Evidence of kidney transplant (Kidney Transplant Value Set).

Comprehensive Diabetes Care: Medical Attention for Nephropathy

• A visit with a nephrologist, as identified by the organization's specialty provider codes (no restriction on the diagnosis or procedure code submitted).

• At least one ACE inhibitor or ARB dispensing event (Table CDC-L).

Contraceptive Care – Most & Moderately Effective Methods

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Percent of female Medicaid beneficiaries 15-44 years of age at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved method of contraception.

Name and date of specification used: U.S. Department of Health & Human Services, Office of Population Affairs 2017 Specifications.

Measure type: Other

If other, specify: Developed by U.S. Office of Population Affairs.

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: https://www.hhs.gov/opa/performance-measures/most-or-moderately-effective-contraceptive-methods/index.html

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	15-44 years. Two age stratifications used: 15-20 years; 21-44 years.
Continuous Medicaid enrollment criteria	The measurement year.
Allowable gap in enrollment	No more than one gap of 1 month during the measurement year.
Anchor date	Last day of measurement year.

Contraceptive Care – Most & Moderately Effective Methods

Measurement period	1 year
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits, and individuals with family planning only services. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	Provision of contraception.
Identification window	N/A

Denominator:

In addition to the eligible population criteria above, define the denominator by excluding women not at risk of unintended pregnancy because they:

• Were infecund due to non-contraceptive reasons such as natural menopause or oophorectomy.

• Had a live birth in the last 2 months of the measurement year because there may not have been an opportunity to provide them with contraception. A two-month period was selected because the American College of Obstetricians and Gynecologists (ACOG) recommends having a postpartum visit by 6 weeks, and an additional 2 weeks was added to allow for reasonable delays in attending the postpartum visit.

• Were still pregnant at the end of the year because they were pregnant but did not have a pregnancy outcome code indicating a non-live birth or a live birth.

Once the exclusions are applied, the denominator includes women who were:

• Not pregnant at any point in the measurement year.

• Pregnant during the measurement year but whose pregnancy ended in the first 10 months of the measurement year, since there was adequate time to provide contraception in the postpartum period.

• Pregnant during the measurement year but whose pregnancy ended in an ectopic pregnancy, stillbirth, miscarriage, or induced abortion.

Numerator:

• Define the numerator by identifying women who used a most (sterilization, IUD, implant) or moderately (injection, oral pills, patch, ring, or diaphragm) effective method of contraception in the measurement year.

• Adjust for LARC removals and re-insertions. The LARC methods can be removed at the woman's request so adjustments must be made to reflect this.

Contraceptive Care – Most & Moderately Effective Methods

• Calculate the rates by dividing the number of women who used a most or moderately effective method of contraception by the number of women in the denominator.

Contraceptive Care – Postpartum

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Among female Medicaid beneficiaries age 15 through 44 years who had a live birth, the percent that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery.

Name and date of specification used: U.S. Department of Health & Human Services, Office of Population Affairs 2017 Specifications.

Measure type: Other

If other, specify: Developed by U.S. Office of Population Affairs.

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data; Vital statistics - birth certificate data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: https://www.hhs.gov/opa/performance-measures/postpartum-most-or-moderately-effective-contraceptive-methods/index.html

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	15-44 years. Two age stratifications used: 15-20 years; 21-44 years.
Continuous Medicaid enrollment criteria	Within the measurement year, women enrolled from the date of delivery to 60 days postpartum.
Allowable gap in enrollment	No allowable gap during the continuous enrollment period.
Anchor date	The date of delivery.

Contraceptive Care – Postpartum

Measurement period	60 days
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits, and individuals with family planning only services. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	Provision of contraception.
Identification window	N/A

Denominator:

The eligible population includes women ages 15 through 44 years who had a live birth in the measurement year. Women will be excluded from the denominator if they did not have an opportunity to receive contraception in the postpartum period (defined as wit

Numerator:

The eligible population that was provided a most or moderately effective method of contraception.

Step 1: Define the numerator by identifying women who were provided a most (sterilization, IUD, implant) or moderately (injection, oral pills, patch, ring, or diaphragm) effective method of contraception in the measurement year.

Step 2: Adjust for LARC removals and re-insertions. The LARC methods can be removed at the woman's request so adjustments must be made to reflect this.

Step 3: Determine the date that the contraceptive method was provided to identify: (a) women that received contraception in the immediate postpartum period of 3 days after delivery; and (b) women that were provided contraception within 60 days of delivery. The second category will also include women who were provided contraception in the first 3 days postpartum.

Dental Sealants for Children at Elevated Caries Risk

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Percent of children enrolled in Medicaid at elevated risk of dental caries (i.e., "moderate" or "high") who received a sealant on a permanent first molar tooth within the reporting year. Reported separately by age group: 6-9 years, 10-14 years.

Name and date of specification used: DQA Measures: SL1-CHA-A (NQF #2508), SL2-CHA-A (NQF #2509); Effective January 1, 2017.

Measure type: Other

If other, specify: Developed by Dental Quality Alliance (DQA).

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications:
http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/DQA_2017_Dental_Services_Sealants_6-9_Years.pdf?la=en;
http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/DQA_2017_Dental_Services_Sealants_10-14_Years.pdf?la=en

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	6-14 years. Two age stratifications used: 6-9 years; 10-14 years.
Continuous Medicaid enrollment criteria	180 days during the measurement period.
Allowable gap in enrollment	None

Dental Sealants for Children at Elevated Caries Risk

Anchor date	Last day of measurement year.
Measurement period	3 years
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	Children 6-14 years at elevated risk of dental caries.
Identification window	N/A

Denominator:

Unduplicated number of Medicaid beneficiaries meeting the eligible population criteria at elevated risk (i.e., “moderate” or “high”).

Elevated risk is determined by CDT codes in either the a.) measurement year; b.) in any of the three years prior to the

Numerator:

• Unduplicated number of all enrolled children age 6–9 years at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent first molar tooth as a dental service.

• Unduplicated number of enrolled children age 10–14 years at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent second molar tooth as a dental service.

Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: The percent of discharges for Medicaid beneficiaries 18 years of age and older who had a visit to the emergency department with a primary diagnosis alcohol or other drug dependence during the measurement year AND who had a follow-up visit within 30 days of discharge with any provider with a corresponding primary diagnosis of alcohol or other drug dependence. Two rates are reported:

(1) The percentage of discharges for beneficiaries who received follow-up within 30 days of discharge;

(2) The percentage of discharges for beneficiaries who received follow-up within 7 days of discharge.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	Adolescents and adults 13 years and older; age as of the date of ED visit.
Continuous Medicaid enrollment criteria	Date of the ED visit through 30 days after the ED visit.

Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence

Allowable gap in enrollment	No gaps in enrollment.
Anchor date	None.
Measurement period	• Denominator: The measurement year, absent the last 30 days of the measurement year. This is to permit the measurement of 30 days of follow-up from index visit. • Numerator: The discharge date through 7 days and 30 days after the discharge date.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	An ED visit with a principal diagnosis of mental illness on or between January 1 and December 1 of the measurement year.
Identification window	N/A

Denominator:

Population meeting eligible population criteria.

Numerator:

An outpatient visit, intensive outpatient encounter, or partial hospitalization, with any practitioner, with a primary diagnosis of alcohol or other drug dependence within a.) 30 days; b.) 7 days after the ED visit. Include outpatient visit, intensive outpatient encounter, or partial hospitalization that occur on the date of the ED visit.

Follow-up After Emergency Department Visit for Mental Health

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: The percent of discharges for Medicaid beneficiaries 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health during the measurement year AND who had a follow-up visit within 30 days of discharge with any provider with a corresponding primary diagnosis of alcohol or other drug dependence. Two rates are reported:

(1) The percentage of discharges for beneficiaries who received follow-up within 30 days of discharge;

(2) The percentage of discharges for beneficiaries who received follow-up within 7 days of discharge.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	6 years and older; age as of the date of ED visit.
Continuous Medicaid enrollment criteria	Date of the ED visit through 30 days after the ED visit.
Allowable gap in enrollment	No gaps in enrollment.
Anchor date	None.

Follow-up After Emergency Department Visit for Mental Health

Measurement period	• Denominator: The measurement year, absent the last 30 days of the measurement year. This is to permit the measurement of 30 days of follow-up from index visit. • Numerator: The discharge date through 7 days and 30 days after the discharge date.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	Beneficiaries who had an ED visit (ED Value Set) with a primary diagnosis of mental illness (Mental Illness Value Set) on or between the first day of the measurement year and the last day of the measurement year (less 30 days). Note: The denominator is based on unique ED visits, not on unique beneficiaries. If a beneficiary has more than one ED visit, include all that occur during the measurement year (less 30 days). However, if a beneficiary has more than one ED visit in a 30-day period, include only the last ED visit in each 30-day period.
Identification window	N/A

Denominator:

Population meeting eligible population criteria.

Numerator:

An outpatient visit, intensive outpatient encounter, or partial hospitalization, with any practitioner, with a primary diagnosis of mental health disorder within a.) 30 days; b.) 7 days after the ED visit. Include outpatient visit, intensive outpatient encounter, or partial hospitalization that occur on the date of the ED visit.

Follow-up After Hospitalization for Mental Illness

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: 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 an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

(1) The percentage of discharges for beneficiaries who received follow-up within 30 days of discharge;

(2) The percentage of discharges the beneficiaries who received follow-up within 7 days of discharge.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	6 years and older; age as of the date of discharge.
Continuous Medicaid enrollment criteria	Date of discharge through 30 days after discharge.
Allowable gap in enrollment	No gaps in enrollment.
Anchor date	None.

Follow-up After Hospitalization for Mental Illness

Measurement period	• Denominator: The measurement year, absent the last 30 days of the measurement year. This is to permit the measurement of 30 days of follow-up from index visit. • Numerator: The discharge date through 7 days and 30 days after the discharge date.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	Discharge alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis. The denominator for this measure is based on discharges, not individual beneficiaries. Include all discharges for beneficiaries who have more than one discharge on or between January 1 and December 1 of the measurement year.
Identification window	N/A

Denominator:

Population meeting eligible population criteria.

Numerator:

An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within a.) 30 days; b.) 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Inpatient Hospital Utilization

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: For Medicaid beneficiaries 18 years and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Lower is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance ■ DSRIP Statewide Accountability ■

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	18 years and older; age as of last day of the measurement year.
Continuous Medicaid enrollment criteria	The measurement year and the year prior to the measurement year.
Allowable gap in enrollment	1 month
Anchor date	Last day of measurement year.
Measurement period	The measurement year.

Inpatient Hospital Utilization

Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	None.
Identification window	N/A

Denominator:

Population meeting age, enrollment, and Event/Diagnosis criteria.

Numerator:

Step 1: Identify all acute inpatient discharges during the measurement year. To identify acute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

3. Identify the discharge date for the stay.

Step 2: Exclude discharges with:

• A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).

• A principal diagnosis of live-born infant (Deliveries Infant Record Value Set).

• A maternity-related principal diagnosis (Maternity Diagnosis Value Set).

• A maternity-related stay (Maternity Value Set; Maternity MS-DRG Value Set).

• A mental health, chemical dependency or rehabilitation related stay (IPU Exclusions MS-DRG Value Set).

• Newborn care (Newborns/Neonates MS-DRG Value Set).

• Inpatient stays with a discharge for death.

Step 3: Calculate total inpatient using all discharges identified after completing steps 1 and 2.

Step 4: Identify surgery and medicine using MS-DRGs. For organizations that use DRGs, categorize each discharge as surgery or medicine.

• Surgery (Surgery MS-DRG Value Set).

• Medicine (Medicine MS-DRG Value Set).

Medication Management for People with Asthma: Medication Compliance 75%

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: The percent of Medicaid beneficiaries who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance ■ DSRIP Statewide Accountability ■

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): 50.0%; 2017 NCQA Quality Compass National Medicaid 90th Percentile

Eligible Population:

Ages	5-64 years.
Continuous Medicaid enrollment criteria	The measurement year and the year prior to the measurement year.
Allowable gap in enrollment	1 month
Anchor date	Last day of measurement year.
Measurement period	The measurement year.

Medication Management for People with Asthma: Medication Compliance 75%

Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	Step 1: Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years. • At least one ED visit (ED Value Set), with a principal diagnosis of asthma (Asthma Value Set). • At least one acute inpatient encounter (Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set). • At least four outpatient visits (Outpatient Value Set) or observation visits (Observation Value Set) on different dates of service, with any diagnosis of asthma (Asthma Value Set) and at least two asthma medication dispensing events. Visit type need not be the same for the four visits. • At least four asthma medication dispensing events. Step 2: A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Asthma Value Set), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (i.e., the measurement year or the year prior to the measurement year). Step 3: Required exclusions Exclude members who met any of the following criteria: • Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year: – Emphysema Value Set. – Other Emphysema Value Set. – COPD Value Set. – Obstructive Chronic Bronchitis Value Set. – Chronic Respiratory Conditions Due to Fumes/Vapors Value Set. – Cystic Fibrosis Value Set. – Acute Respiratory Failure Value Set. • Members who had no asthma controller medications dispensed during the measurement year.
Identification window	N/A

Medication Management for People with Asthma: Medication Compliance 75%

Denominator:

The eligible population.

Numerator:

The number of members who achieved a PDC of at least 75% for their asthma controller medications during the measurement year. Follow the steps below to identify numerator compliance:

1. Identify the IPSD. The IPSD is the earliest dispensing event for any asthma controller medication during the measurement year.

2. To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the measurement year.

3. Count the days covered by at least one prescription for an asthma controller medication during the treatment period. To ensure that a days supply that extends beyond the measurement year is not counted, subtract any days supply that extends beyond December 31 of the measurement year.

4. Calculate the member's PDC using the following equation. Round (using the .5 rule) to two decimal places.

Total Days Covered by a Controller Medication in the Treatment Period (Step 3)/Total Days in Treatment Period (Step 2).

Sum the number of members whose PDC is ≥75% for their treatment period.

Mental Health Treatment Penetration (Broad Version)

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Percent of Medicaid beneficiaries with a mental health service need who received at least one qualifying service during the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 2013 Engrossed House Bill 1519 (Chapter 320, Laws of 2013) and Second Substitute Senate Bill 5732 (Chapter 338, Laws of 2013) performance measure development process.

Name and date of specification used: DSHS(RDA) Cross-System Outcome Measures for Adults Enrolled in Medicaid; January 2017, v 1.6.

Measure type: Other

If other, specify: Developed by DSHS (RDA).

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data; RSN/BHO encounter data and DBHR-paid behavioral health services.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/cross-system/DSHS-RDA-Medicaid-MH-svc-pen-broad.pdf

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance ■ DSRIP Statewide Accountability ■

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	6 years and older. Three age stratifications used: 6-17 years; 18-64 years; 65 years and older.

Mental Health Treatment Penetration (Broad Version)

Continuous Medicaid enrollment criteria	The measurement year.
Allowable gap in enrollment	1 month
Anchor date	Last day of measurement year.
Measurement period	The measurement year.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	Beneficiaries meeting the mental health service need criteria defined per DSHS (RDA) specifications. Measurement year and year prior to measurement year used for identification window.
Identification window	The measurement year and the year prior to the measurement year.

Denominator:

All individuals in the eligible population with a mental health service need in the 24-month identification window.

Numerator:

Beneficiaries receiving at least one mental health service that meets at least of the following criteria in the 12-month measurement year: mental health service modality from RSN/BHO encounter data, tribal mental health encounter, mental health provider taxonomy, mental health procedure code, mental health condition management in primary care. See DSHS (RDA) specifications for full list of value sets.

Patients on high-dose chronic opioid therapy by varying thresholds

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Percent of Medicaid beneficiaries prescribed chronic opioid therapy according to the following thresholds: 1.) Doses >50 mg morphine equivalent dosage (MED) in a quarter; 2.) Doses >90 mg MED in a quarter. Bree Collaborative specifies for quarterly counts; all qualifying observations for a given quarter will count towards the overall, annual estimate required for DSRIP performance measurement.

Name and date of specification used: Bree Collaborative Opioid Prescribing Metrics (July 2017).

Measure type: Other

If other, specify: Developed by Bree Collaborative.

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Lower is better.

URL of specifications: http://www.breecollaborative.org/wp-content/uploads/Bree-Opioid-Prescribing-Metrics-Final-2017.pdf

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	All ages.
Continuous Medicaid enrollment criteria	The measurement year.
Allowable gap in enrollment	[Pending - not yet defined.]
Anchor date	Last day of measurement year.

Patients on high-dose chronic opioid therapy by varying thresholds

Measurement period	4 quarters of the measurement year.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	Inclusion: Opioid prescription data for all patients in the population pulled for each calendar quarter (e.g., Oct-Dec). Members who received prescriptions lasting at least 60 days each during the calendar quarter. See Bree Collaborative specifications for the full list of included and excluded opioids. Exclusion criteria: • All patients with a cancer diagnosis or those who are on hospice, if possible • All prescriptions for buprenorphine • Prescriptions for opioid not typically used in outpatient settings or when used as part of cough and cold formulations including elixirs, and combination products containing antitussives, decongestants, antihistamines, and expectorants
Identification window	N/A

Denominator:

Number of patients in the eligible population prescribed ≥60 days supply of opioids in the calendar quarter.

Numerator:

• Number of patients in the eligible population prescribed ≥60 days supply of opioids at ≥50 mg/day MED in each calendar quarter.

• Number of patients in the eligible population prescribed ≥60 days supply of opioids at ≥90 mg/day MED in each calendar quarter.

Patients with concurrent sedatives prescriptions

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Among Medicaid beneficiaries receiving chronic opioid therapy ≥60 days, the percent that had ≥60 days of sedative hypnotics, benzodiazepines, carisoprodol, and/or barbiturates in the same calendar quarter. Bree Collaborative specifies for quarterly counts; all qualifying observations for a given quarter will count towards the overall, annual estimate required for DSRIP performance measurement.

Name and date of specification used: Bree Collaborative Opioid Prescribing Metrics (July 2017).

Measure type: Other

If other, specify: Developed by Bree Collaborative.

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Lower is better.

URL of specifications: http://www.breecollaborative.org/wp-content/uploads/Bree-Opioid-Prescribing-Metrics-Final-2017.pdf

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	All ages.
Continuous Medicaid enrollment criteria	The measurement year.
Allowable gap in enrollment	[Pending - not yet defined.]
Anchor date	Last day of measurement year.

Patients with concurrent sedatives prescriptions

Measurement period	4 quarters of the measurement year.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	Inclusion: Opioid prescription data for all patients in the population pulled for each calendar quarter (e.g., Oct-Dec). Members who received prescriptions lasting at least 60 days each during the same calendar quarter for both opioids and other sedatives. See Bree Collaborative specifications for the full list of included and excluded opioids, and for the list of included benzodiazepines, sedative-hypnotics, and anxiolytics. Exclusion criteria: • All patients with a cancer diagnosis or those who are on hospice, if possible • All prescriptions for buprenorphine • Prescriptions for opioid not typically used in outpatient settings or when used as part of cough and cold formulations including elixirs, and combination products containing antitussives, decongestants, antihistamines, and expectorants
Identification window	N/A

Denominator:

The eligible population.

Numerator:

Number of patients in the population prescribed ≥60 days supply of opioids and prescribed ≥60 days supply of sedative hypnotics, benzodiazepines, carisoprodol, and/or barbiturates in the same calendar quarter. Quarterly estimate rolled up to annual, overall estimate.

Percent Arrested

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Percent of Medicaid beneficiaries who were arrested at least once during the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 2013 Engrossed House Bill 1519 (Chapter 320, Laws of 2013) and Second Substitute Senate Bill 5732 (Chapter 338, Laws of 2013) performance measure development process.

Name and date of specification used: DSHS(RDA) Cross-System Outcome Measures for Adults Enrolled in Medicaid; December 2016, v 1.1.

Measure type: Other

If other, specify: Developed by DSHS (RDA).

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data; Washington State Identification System (WASIS) arrest database.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Lower is better.

URL of specifications: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/cross-system/DSHS-RDA-Medicaid-Arrests.pdf#overlay-context=node/28464

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	18-64 years.
Continuous Medicaid enrollment criteria	A minimum of 7 months of Medicaid enrollment is required in the measurement year.

Percent Arrested

Allowable gap in enrollment	None defined.
Anchor date	Last day of measurement year.
Measurement period	The measurement year.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	N/A
Identification window	N/A

Denominator:

The eligible population.

Numerator:

Include all denominator-eligible members with at least one arrest in the measurement year recorded in the Washington State Identification System (WASIS) arrest database maintained by the Washington State Patrol. The database is comprised of arrest charges for offenses resulting in fingerprint identification. The database provides a relatively complete record of felony and gross misdemeanor charges, but excludes some arrest charges for misdemeanor offenses that are not required to be reported.

Percent Homeless (Narrow Definition)

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Percent of Medicaid beneficiaries who were homeless in at least one month in the measurement year. Excludes "homeless with housing" ACES living arrangement code.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 2013 Engrossed House Bill 1519 (Chapter 320, Laws of 2013) and Second Substitute Senate Bill 5732 (Chapter 338, Laws of 2013) performance measure development process.

Name and date of specification used: DSHS(RDA) Cross-System Outcome Measures for Adults Enrolled in Medicaid; December 2016, v 1.2.

Measure type: Other

If other, specify: Developed by DSHS (RDA).

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data; DSHS Economic Services Administration's Automated Client Eligibility

System (ACES).

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Lower is better.

URL of specifications: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/cross-system/DSHS-RDA-Medicaid-Homelessness.pdf

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	All ages. Three age stratifications used: 0-17 years; 18 – 64 years; 65 years and older.

Percent Homeless (Narrow Definition)

Continuous Medicaid enrollment criteria	A minimum of 7 months of Medicaid enrollment is required in the measurement year.
Allowable gap in enrollment	None defined.
Anchor date	Last day of measurement year.
Measurement period	The measurement year.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	N/A
Identification window	N/A

Denominator:

The eligible population.

Numerator:

Include all denominator-eligible members with at least one month with a living arrangement status of "Homeless without Housing", "Emergency Shelter" or "Battered Spouse Shelter" recorded in the ACES eligibility data system.

Periodontal Evaluation in Adults with Chronic Periodontitis

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Percent of Medicaid beneficiaries age 30 years and older with chronic periodontitis who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the measurement year.

Name and date of specification used: DQA Measure: PEV-A-A; Effective January 1, 2017.

Measure type: Other

If other, specify: Developed by Dental Quality Alliance (DQA).

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications:
http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/DQA_2017_Perio_Eval.pdf?la=en

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	30 years and older.
Continuous Medicaid enrollment criteria	180 days during the measurement period.
Allowable gap in enrollment	None.
Anchor date	Last day of measurement year.
Measurement period	3 years

Periodontal Evaluation in Adults with Chronic Periodontitis

Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	History of periodontitis, defined as: if beneficiary has a [CDT Code] = D4240 or D4241 or D4260 or D4261 or D4341 or D4342 or D4910 in any of the three years prior to the measurement year. NOTE: There is no minimum enrollment criterion during the 3 years prior to the reporting year. This past history is a "look back" period for available claims. The reporting year remains a single year and is the only year during which minimum enrollment length must be verified.
Identification window	N/A

Denominator:

Unduplicated number of eligible population with a history of periodontitis.

Numerator:

Unduplicated number of individuals in the measure eligible population who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation. Periodontal evaluation or comprehensive or periodic oral evaluation is defined as: [CDT CODE] = D0120 or D0150 or D0180.

Plan All-Cause Readmission Rate (30 Days)

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Among Medicaid beneficiaries age 18-64 years old, the percent of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Lower is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance ■ DSRIP Statewide Accountability ■

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	18 years and older.
Continuous Medicaid enrollment criteria	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap in enrollment	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge date.
Anchor date	Discharge date (from inpatient stay).

Plan All-Cause Readmission Rate (30 Days)

Measurement period	The measurement year.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	An acute inpatient discharge on or between the first day and first day of the last month of the measurement year.
Identification window	N/A

Denominator:

The denominator for this measure is based on discharges, not members. Include all acute inpatient discharges for qualified members who had one or more discharges on or between first day and first day of the last month of the measurement year.

Numerator:

At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Primary Caries Prevention Intervention by Primary Care Medical Providers

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Measure is a modification of the State Common Measure Set measure. Among eligible Medicaid beneficiaries, the measure quantifies all fluoride varnish applications provided by professional providers (non-dental primary care medical provider) during a child's primary care medical visit. In contrast to previously endorsed NQF 1419 and the SCMS measure, the current measure calculation does not limit the data filter in the Medicaid Claims to EPSDT claims type.

Name and date of specification used: Specifications developed by HCA, with support by Arcora Foundation; modified version of retired NQF# 1419 and measure included in the WA State Common Measure Set.

Measure type: Other

If other, specify: Developed by HCA/Arcora Foundation.

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: N/A

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	Under 21 years of age.
Continuous Medicaid enrollment criteria	None.
Allowable gap in enrollment	None.
Anchor date	Last day of measurement year.

Primary Caries Prevention Intervention by Primary Care Medical Providers

Measurement period	The measurement year.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	Visit with PCMP/clinic with provision of fluoride varnish application.
Identification window	N/A

Denominator:

Unduplicated number of Medicaid beneficiaries meeting the eligible population criteria.

Numerator:

Unduplicated number of beneficiaries that received at least one fluoride varnish service by a primary care medical provider during child routine visit in the measurement year. Fluoride varnish applications are identified in Medicaid claims data by selecting CDT code D1206 or D1208.

Statin Therapy for Patients with Cardiovascular Disease (Prescribed)

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Percent of Medicaid beneficiaries 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.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	21-75 years (males) and 40-75 years (females).
Continuous Medicaid enrollment criteria	Continuous enrollment in measurement year and year prior to measurement year.
Allowable gap in enrollment	45 days in prior year and 45 days in measure year.
Anchor date	Last day of measurement year.
Measurement period	The measurement year.

Statin Therapy for Patients with Cardiovascular Disease (Prescribed)

Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	In prior OR measurement year, events that qualify: MI, CABG, PCI, Revascularization OR, In prior AND measurement year diagnosis of IVD.
Identification window	N/A

Denominator:

Beneficiaries meeting the eligible population criteria. In addition, individuals with a history of Pregnancy, IVF, Cirrhosis, ESRD, Myalgia, myositis, myopathy or rhabdomyolysis in the measurement year or the year prior to the measurement year are exclude

Numerator:

Among those who meet the criteria for the denominator, those who had at least one dispensing event for a high or moderate-intensity statin medication in measurement year.

Substance Use Disorder Treatment Penetration

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: The percentage of Medicaid beneficiaries with a substance use disorder treatment need who received substance use disorder treatment in the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 2013 Engrossed House Bill 1519 (Chapter 320, Laws of 2013) and Second Substitute Senate Bill 5732 (Chapter 338, Laws of 2013) performance measure development process.

Name and date of specification used: DSHS(RDA) Cross-System Outcome Measures for Adults Enrolled in Medicaid; December 2016, v 1.3.

Measure type: Other

If other, specify: Developed by DSHS (RDA).

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data; RSN/BHO encounter data and DBHR-paid behavioral health services; CARE assessment diagnoses for identification of SUD treatment need.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/cross-system/DSHS-RDA-Medicaid-SUD-treatment-penetration.pdf

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance ■ DSRIP Statewide Accountability ■

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	12 years and older. Three age stratifications used: 12-17 years; 18-64 years; 65 years and older.

Substance Use Disorder Treatment Penetration

Continuous Medicaid enrollment criteria	The measurement year.
Allowable gap in enrollment	Member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	Last day of measurement year.
Measurement period	The measurement year.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	Substance use disorder treatment need is identified by the occurrence of any of the following in the identification window: 1. Diagnosis of a drug or alcohol use disorder in any health service event (SUD-Tx-Pen-Value-Set-1.xlsx) 2. Receipt of a substance use disorder treatment service meeting numerator criteria: a. Procedure, DRG, revenue and related codes (SUD-Tx-Pen-Value-Set-2.xls) b. NDC codes (SUD-Tx-Pen-Value-Set-3.xlsx) 3. Receipt of brief intervention (SBIRT) services (SUD-Tx-Pen-Value-Set-4.xlsx) 4. Receipt of medically managed detox services (SUD-Tx-Pen-Value-Set-5.xlsx). Value sets can be found at DSHS(RDA) webpage: https://www.dshs.wa.gov/sesa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid.
Identification window	The measurement year and the year prior to the measurement year.

Denominator:

Include in the denominator all individuals in the eligible population with a substance use disorder treatment need.

Numerator:

Include in the numerator all individuals receiving at least one substance use disorder treatment service meeting at least one of the following criteria in the 12-month measurement year (SUD- Tx-Pen-Value-Set-2.xlsx and SUD-Tx-Pen-Value-Set-3.xlsx):

1. Inpatient or residential substance use disorder treatment services

Substance Use Disorder Treatment Penetration

2. Outpatient substance use disorder treatment services

3. Methadone opiate substitution treatment services

4. Other medication-assisted treatment using medications indicated in SUD-Tx-Pen-Value- Set-3.xlsx

Substance Use Disorder Treatment Penetration (Opioid)

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: The percent of Medicaid beneficiaries with an identified opioid use disorder treatment need who received medication assisted treatment (MAT) or medication-only treatment for opioid use disorder in the measurement year.

These specifications are derived from the Substance Use Disorder Treatment Penetration measure, which was developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 2013 Engrossed House Bill 1519 (Chapter 320, Laws of 2013) and Second Substitute Senate Bill 5732 (Chapter 338, Laws of 2013) performance measure development process.

Name and date of specification used: Specifications are a variant of the DSHS(RDA)Cross-System Outcome Measures for Adults Enrolled in Medicaid - "Substance Use Disorder Treatment Penetration (December 2016, v 1.3)."

Measure type: Other

If other, specify: Developed by DSHS (RDA).

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data; RSN/BHO encounter data and DBHR-paid behavioral health services; CARE assessment diagnoses for identification of SUD treatment need.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: N/A

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	Pending - under development. 12 years and older. Three age stratifications used: 12-17 years; 18-64 years; 65 years and older.

Substance Use Disorder Treatment Penetration (Opioid)

Continuous Medicaid enrollment criteria	The measurement year.
Allowable gap in enrollment	Member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	Last day of measurement year.
Measurement period	The measurement year.
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	Opioid use disorder treatment need is identified by the occurrence of any of the following in the identification window: 1. Diagnosis of a opioid use disorder in any health service event 2. Receipt of a opioid use disorder treatment service meeting numerator criteria: a. Procedure, DRG, revenue and related codes b. NDC codes 3. Receipt of brief intervention (SBIRT) services 4. Receipt of medically managed detox services Value sets in development, and will be derived from SUD treatment penetration measure value sets.
Identification window	The measurement year and the year prior to the measurement year.

Denominator:

Include in the denominator all individuals in the eligible population with a opioid use disorder treatment need.

Numerator:

Include in the numerator all individuals receiving at least one opioid use disorder treatment service that meets any of the following criteria in the measurement year:

1. Inpatient or residential substance use disorder treatment services in combination with MAT

2. Outpatient substance use disorder treatment services in combination with MAT

3. Methadone opiate substitution treatment services

4. Other medication-assisted treatment for OUD (Vivitrol, Buprenorphine)

Timeliness of Prenatal Care

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: The percent of all live birth deliveries for Medicaid beneficiaries that received a prenatal care visit in the first trimester of pregnancy, or within 42 days of enrollment.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data; Vital statistics - birth certificate data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): 91.7%; 2017 NCQA Quality Compass National Medicaid 90th Percentile

Eligible Population:

Ages	None specified.
Continuous Medicaid enrollment criteria	43 days prior to delivery through 56 days after delivery.
Allowable gap in enrollment	No allowable gap during the continuous enrollment period.
Anchor date	The date of delivery.
Measurement period	280 days prior to delivery.

Timeliness of Prenatal Care

Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits, and individuals with family planning only services. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	Delivered a live birth during the measurement year.
Identification window	N/A

Denominator:

All live birth deliveries from beneficiaries, who meet the continuous enrollment criteria.

Numerator:

A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment and the gaps in enrollment during the pregnancy. Include only visits that occur while the member was enrolled.

Utilization of Dental Services by Medicaid Beneficiaries

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: Dental service utilization among Medicaid beneficiaries. Reported for all services (preventative and restorative), by age up to 21 years old, and 21 years and older.

Name and date of specification used: Specifications used for annual HCA reporting; December 2017.

Measure type: Other

If other, specify: Developed by HCA.

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: N/A

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): N/A (improvement over self)

Eligible Population:

Ages	All ages. Two age stratifications are used: •20 years and under •21 years and above
Continuous Medicaid enrollment criteria	Continuously enrolled for 180 days at time of measurement.
Allowable gap in enrollment	Subject to Validation: None.
Anchor date	Last day of measurement year.
Measurement period	3 years

Utilization of Dental Services by Medicaid Beneficiaries

Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	None.
Identification window	N/A

Denominator:

The eligible population.

Numerator:

Among the eligible population, the unduplicated count of those who received any dental service (preventative or restorative) during the measurement year.

Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: The percent of children 3-6 years of age enrolled in Medicaid who had one or more well-child visits with a primary care provider during the measurement year.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance ■ DSRIP Statewide Accountability ■

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): 82.8%; 2017 NCQA Quality Compass National Medicaid 90th Percentile

Eligible Population:

Ages	3–6 years; age as of last day of the measurement year.
Continuous Medicaid enrollment criteria	The measurement year.
Allowable gap in enrollment	1 month
Anchor date	Last day of measurement year.
Measurement period	The measurement year.

Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	None.
Identification window	N/A

Denominator:

Population meeting eligible population criteria.

Numerator:

• At least one well-child visit (Well-Care Value Set) with a PCP during the measurement year.

• The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Well-Child Visits in the First 15 Months of Life

January 17, 2018
DSRIP P4P v1.0

Description:

Measure description: The percent of children 15 months old enrolled in Medicaid who had the recommended number of well-child visits with a primary care provider during their first 15 months of life. For the purpose of performance measurement, the rate of children receiving 6 or more visits is used.

Name and date of specification used: HEDIS 2017 Technical Specifications for Health Plans - NCQA.

Measure type: HEDIS

If other, specify: N/A

Data collection method: Administrative

Data source: ProviderOne Medicaid claims and enrollment data.

Claim status: Include only final paid claims or accepted encounters in measure calculation.

Direction of quality improvement: Higher is better.

URL of specifications: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

DSRIP Program Summary:

Measure utility: ACH P4P ■ ACH High Performance □ DSRIP Statewide Accountability □

DSRIP measurement year: January 1, 2017 – December 31, 2017 (Baseline)

Absolute Benchmark/Source

Absolute benchmark value for DY 3 (2019): 72.5%; 2017 NCQA Quality Compass National Medicaid 90th Percentile

Eligible Population:

Ages	15 months old during the measurement period.
Continuous Medicaid enrollment criteria	31 days - 15 months of age.
Allowable gap in enrollment	1 month
Anchor date	The day the child turns 15 months old.
Measurement period	15 months

Well-Child Visits in the First 15 Months of Life

Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid, and beneficiaries with primary insurance other than Medicaid.
Event/diagnosis	None.
Identification window	N/A

Denominator:

Children who turn 15 months in the measurement year.

Numerator:

Children who have 6 or more well-child visits during their first 15 months of life.

This page left intentionally blank.