ATTACHMENT D: DSRIP FUNDING AND MECHANICS PROTOCOL

I. Accountable Communities of Health

a. Introduction

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

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

b. ACH Service Regions

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

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

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

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

c. ACH Composition and Partnering Provider Guidelines

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

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

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

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

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

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

II. Projects, Metrics and Metric Targets

a. Overview of Projects

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

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

b. Project Metrics

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

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

c. Outcome Metric Goals and Improvement Target

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

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

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

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

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

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

performance above the goal. If an ACH has already surpassed the goal in the baseline year, the measure will be dropped and value of the remaining measures rebased.

(2) Improvement-Over-Self: For those metrics without a state or national Medicaid benchmark available, including innovative metrics, the state will set a standard percent improvement relative to each ACH's previous DY performance. This percent improvement target will be determined on a metric-by-metric basis based on available evidence of a reasonable expectation for magnitude of change. Improvement targets for these metrics will be set to be consistent with the magnitude of change required to meet targets in the gap-to-goal methodology measures. The improvement-over-self-target for each metric will be consistent across each ACH.[1]

If an ACH baseline rate for an IOS metric reflects the maximum possible rate (100% or 0% depending on whether higher or lower rates indicate better outcomes) and thus an improvement target cannot be calculated, the measure will be dropped and the value of the remaining measures rebased.

III. Incentive Funding Formula and Project Design Funds

a. Demonstration Year 1 (DY1)

i. Project Design Funds

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

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

ii. Project Funding

[1] CMS approved 5.16.22, for DY5 and DY6 annual improvement targets for ACH outcome metrics will be established using the IOS methodology for all metrics given the differential disruption to the health care system across the nation and the associated impact to national data collection. Due to these factors, using a gap-to-goal method to set improvement targets would be problematic.

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

b. Demonstration Years 2 through 6 Funding and Project Valuation

In accordance with STC 35(h), the state has developed criteria and methodology for project valuation by which ACHs will continue to earn incentive payments in DY 2 through 6 by reporting on and achieving progress measures and performance-based outcome metrics. Project valuation is calculated during DY1 once each certified ACH submits a Project Plan application detailing project selection and implementation strategies. Based on this content, the state determines maximum incentive payments allotted to each ACH, by project, which will be available for distribution to partnering providers. As described in STC 35, the annual maximum project valuation is determined based on the attributed number of Medicaid beneficiaries residing in the ACH RSA(s) and on the Project Plan application scores.

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

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

c. Calculating Maximum ACH Project Valuation

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

Step 1: Assigning Project Weighting

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

Each project has associated metrics that ACHs must achieve to earn funding tied to the project. An ACH's payment for project implementation is based on pay-for-reporting (P4R) in DY1 and DY2 and based on both P4R and pay-for-performance (P4P) in DY3, DY4[2], DY5, and DY6. The maximum amount of incentive funding that an ACH can earn is determined based on the ACH's project selection[3], the value of the projects selected, the quality and score of Project Plan applications, and the number of Medicaid beneficiaries[4] attributed to the ACH. Project weights outlined in Table 1 were assigned with consideration of the following factors:

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

Table 1. Transformation Project Weighting

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

Projects listed in order of Project Weighting

Project 2A (Bi-Directional Integration of Care and Primary Care Transformation) represents the state's primary objective under Initiative 1 of the demonstration. Project 2A requires the highest level of integration of all other projects and, therefore, houses the largest corresponding set of P4P metrics. Furthermore, Project 2A has the potential to yield the

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

[4] For DY6, CMS approved a minimum regional threshold for project incentives. The minimum threshold is set at $5 million and the state will consider both the minimum threshold and the regional beneficiary calculation, applying the greater of the two.

greatest achievement of value for Medicaid members through an evidence-based approach—and is likely to result in significant cost-savings for both the state and federal government. Regions that have implemented fully integrated managed care are be better positioned to scale project 2A and are eligible for an enhanced DY1 valuation based on project plan scoring methodology.

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

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

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

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

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

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

Step 2: Calculating Maximum ACH Project Funding

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

be set at $5 million per region for DY6. The state will consider both the minimum threshold and the regional beneficiary calculation, applying the greater of the two. Based on this change, the minimum threshold will apply to two of the nine ACHs and IHCP funding, resulting in a weighted decrease to the other ACHs.[5]

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

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

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

This formula will be repeated for all selected projects, and the sum of selected project valuations equals the maximum amount of financial incentive payments each ACH can earn for successful project implementation over the course of the demonstration. Each ACH is required to select at least four projects, including Project 2A and Project 3A. If ACHs choose fewer than the total eight projects, project weights will be rebased proportionately for DY2 through DY6. This maximum ACH valuation will be earned upon achieving defined reporting-based progress measures and performance-based outcome metrics and may be reduced based on application of the statewide penalty described in Section VII.

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

d. Earning Incentive Payments

In DY2 through DY6, ACHs earn incentive payments for successful implementation and reporting of selected projects. Successful implementation is defined for each project as meeting the associated reporting-based progress measures and performance-based outcome metrics.

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

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

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

[5] This change was made in collaboration with the regional ACHs and partners. The impacts of the change are understood, and partners agree this will result in a more equitable incentive distribution in DY6.

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

To determine Total Achievement Value (TAV) for each project in a given payment period, the AVs earned within the project are summed according to their relative weighting as illustrated in Table 2. From there, the Percentage Achievement Value (PAV) is calculated by dividing the TAV by the weighted total of possible AVs for the project in that payment period. The purpose of the PAV is to represent the proportion of metrics an ACH has achieved for each project in each payment period and will be used to determine the distribution of dollars earned out of the maximum annual ACH project funding as follows:

Table 2. Example Calculation of Achievement Values

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

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

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

Metric Type	DY1	DY2	DY3	DY4	DY5	DY6
P4R	100%	100%	75%	50%	25%	25%
P4P	0%	0%	25%	50%	75%	75%

e. Managed Care Integration

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

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

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

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

Table 4. Weighting of Integration Progress Measures by Phase

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

f. Value-based Payment Incentives

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

In DY6 the state will no longer provide regional ACH incentives and statewide MCO incentives. This change was made due to the limited total funding available in DY6 and the significant advancement made DY1-DY5 surrounding VBP. The STCs state that no more than 15 percent of annually available DSRIP funds can be set aside to reward VBP progress, and the state is choosing not to use that flexibility in DY6. This change was discussed extensively with MCOs and ACHs.[6] There is a shared understanding that the change will ensure DSRIP funding is maximized in DY6 for provider incentives and sustainability efforts. In addition, the state believes there are adequate accountabilities and incentives in place to support continued VBP progress as outlined in the Apple Health Appendix, including the managed care withhold. It is important to note that this change only relates to MCO and ACH VBP incentives under DSRIP. The VBP adoption targets remain for statewide accountability and are reinforced through the Apple Health Appendix and the state's managed care withhold program.

IV. ACH Reporting Requirements

[6] MCOs and ACHs will be officially notified of this DY6 change once approved.

These activities are detailed below.

a. Pay for Reporting for ACH Project Achievement

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

These reports will be due as indicated below after the end of each reporting period:

- DY1-DY5: For the reporting period encompassing January 1 through June 30 of each year; the semi-annual report and the corresponding request for payment must be submitted by the ACH to the state before July 31.
- DY1-DY5: For the reporting period encompassing July 1 through December 31 of each year; the semi-annual report and the corresponding request for payment must be submitted by the ACH to the state before January 31.
- DY6: The first P4R report and corresponding request for payment must be submitted by the ACH to the state before April 8.
- DY6: The second P4R report and corresponding request for payment must be submitted by the ACH to the state before October 7.

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

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

V. State Oversight Activities

The state will provide oversight to ensure accountability for the demonstration funds being invested in Washington State, as well as to promote learning with the state and across the country from the work being done under the MTP demonstration. Throughout the demonstration, the state and/or its designee will oversee the activities of ACHs and submit regular reports to CMS pursuant to STC 37.

Each ACH must enter into a contract with the Washington State Health Care Authority

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

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

a. Quarterly Operational Reports

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

b. Learning Collaboratives

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

c. Program Evaluation

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

VI. Statewide Performance and Unearned DSRIP Funding

a. Accountability for State Performance

The state is accountable for demonstrating progress toward meeting the demonstration's objectives. Funding for ACHs and partnering providers may be reduced in DY3, DY4[7], DY5 and DY6 if the state fails to demonstrate quality and improvement on the

[7] Due to COVID-19 impacts, Statewide accountability has been waived for DY 4. At-risk funding is therefore reduced from 10% to 0% for DY4.

statewide measures listed below. STC 44 specifies the amount of annual DSRIP funding at risk based on statewide performance on these measures. The funding reductions will be applied proportionally to all ACHs based on their maximum Project Funding amount.

A statewide performance goal will be established for the statewide metrics. The state will be accountable for achieving these goals by the end of the demonstration period. During DY3 and DY4[7], annual assessment of quality and improvement from a defined baseline toward these goals will be used to measure and evaluate whether or not the statewide metric improvement target has been achieved.

Statewide Accountability Metrics

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

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

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

[8] In 2021, NCQA Hedis® retired Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life. This measure was replaced with Child and Adolescents Well-Care visits 3 – 11 Years of Age. This change will apply to DY 4 and DY 5 results.

[9] Controlling high blood pressure has been removed from Statewide accountability QIS counts. The measure is inactive for DY3-DY5.

[10] Comprehensive Diabetes Care: Blood Pressure Control is retired by NCQA® starting 2022 performance period. HCA is still determining an adequate replacement and will provide an update when approved.

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

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

b. Reinvestment of Unearned DSRIP Funding

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

VII. Demonstration Mid-point Assessment

In accordance with STC 21, a mid-point assessment will be conducted by the Independent Assessor in DY3. Based on qualitative and quantitative information, and stakeholder and community input, the mid-point assessment will be used to systematically identify recommendations for improving individual ACHs and implementation of their Project Plans. If the state decides to discontinue specific projects that do not merit continued funding, the project funds may be made available for expanding successful project plans in DY 4 through DY 6.

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