

## **ATTACHMENT D: DSRIP FUNDING AND MECHANICS PROTOCOL**

### **Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration Approved January 9, 2017**

#### **I. Preface**

##### *a. Medicaid Transformation: Delivery System Reform Incentive Program*

On January 9, 2017, the Centers for Medicare and Medicaid Services (CMS) approved Washington State's request for a Section 1115 Medicaid demonstration entitled *Medicaid Transformation Project*. Under this demonstration, the state will make performance-based funding available to regionally-based Accountable Communities of Health (ACH) and their partnering providers with the goal of transforming the delivery system for Medicaid beneficiaries. This transformation will be supported by payment reform efforts to move Medicaid payment from primarily volume-based to primarily value-based payment over the course of the demonstration period.

The Special Terms and Conditions (STC) of the demonstration set forth in detail the nature, character, and extent of federal involvement in the demonstration, the state's implementation of the expenditure authorities, and the state's obligations to CMS during the demonstration period. The Delivery System Reform Incentive Program (DSRIP) requirements specified in the STCs are supplemented by two attachments to the STCs. The DSRIP Funding and Mechanics Protocol (this document, Attachment D) describes the process for applying incentive payment methodologies, reporting requirements, and consequences if an ACH fails to demonstrate progress and meet performance targets for project metrics.

In accordance with STC 35, the state may submit modifications to this protocol for CMS review and approval. Any changes approved by CMS will apply prospectively unless otherwise specified by CMS.

#### **II. 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 promising practices, 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.

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 RSA designation was directed by the state’s Legislature in 2014 through legislation that further required the state to regionalize 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 critical mass 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.

<b>ACH</b>	<b>Counties</b>
Better Health Together	Adams, Ferry, Lincoln, Pend Oreille, Spokane Stevens
Greater Columbia ACH	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, Yakima
Southwest Washington ACH	Clark, Klickitat, Skamania
Cascade Pacific Action Alliance	Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, Wahkiakum
Olympic Community of Health	Clallam, Kitsap, Jefferson
King County ACH	King
Pierce County ACH	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, will be important criteria in evaluating Project Plan applications. Expectations around ACH decision-making composition is specified in STC 23.

The ACH will serve as the lead for the projects with partnering providers who are participating in Medicaid transformation projects. The ACH will submit a single Project Plan application on behalf of the partnering providers, and serve as the single point of performance accountability to the state. The ACH’s responsibilities include supporting participating 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 providers in ACH leadership and oversight; and leading and complying with all state and CMS reporting requirements.

*d. 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 the outlined composition and participation guidelines. Each ACHs will leverage its primary decision-making body for final decisions regarding the selection of transformation projects. Each ACH and the state will collaborate and agree on each ACH's approach to its decision-making structure for purposes of this demonstration.

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

As part of Project Plan development, the ACH will use its governance structure to facilitate and oversee decision-making.

**III. Projects, Metrics and Metric Targets**

*a. Overview of Projects*

ACHs will 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 will be responsive for demonstrating progress against process milestones and outcome metrics for each project.

*b. Project Metrics*

As part of their Project Plans, ACHs will 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 assess ACH performance.

ACHs will report on these metrics in their semi-annual reports (described in Section V). For each reporting period, ACHs will be 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. Performance Metric Goals and Improvement Target*

ACHs will have a performance goal for each performance metric. For each semi-annual reporting period, 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, based on historical data that will be generated when complete data is available for the baseline time period. For certain measures, which may include newly created measures, baseline data will be collected during DY1, at which point the performance goal and annual ACH improvement targets will be established for Demonstration Years (DY) 3, 4 and 5.

Performance targets will be developed by the state during DY1, based on indicators of high quality of care and performance for state or national data, or an alternative method approved by CMS. The state's goals for metrics may be based on Washington State Medicaid results (preferred source) or national data where possible and on DY1 results for metrics where state or national data are unavailable.

Annual improvement targets for ACH performance metrics will be established using the methodology of reducing the gap to the goal by up to 10 percent. Baseline data will be established as soon as complete data is available for the baseline period and will be used as the foundation to determine the gap to goal to set the improvement target. This will be specified in a Measures Specification and Reporting Manual developed during DY1.

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 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 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 defined performance target, incentives will be earned based on maintaining the defined performance target.

#### **IV. Incentive Funding Formula and Project Design Funds**

##### *a. Demonstration Year 1 (DY1)*

##### *i. Project Design Funds*

In accordance with STC 35(i) and STC 45, during DY1, the state will provide project design funds to ACHs for completing the designated certification process. The design funds will be a fixed component distributed equally across ACHs for completing the certification process 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 20 percent of allowable expenditures in DY1 with payments distributed mid-year of 2017. As described in the DSRIP Planning Protocol (Attachment C), ACHs will be required to complete the two-phase certification process for receipt of design funds. In order to be eligible for any incentive payment beyond design funds, an ACH will need to submit and receive state approval of a Project Plan.

*ii. Project Funding*

The state will award the remaining DY1 DSRIP funding (excluding state administrative expenses) to certified ACHs upon approval of the Project Plan application. The amounts of DSRIP funding available for each ACH will be scaled based on application scoring by the Independent Assessor.

*b. Demonstration Years 2 through 5 Funding and Project Valuation*

In accordance with STC 35(h), the state developed criteria and methodology for project valuation by which ACHs will continue to earn incentive payments in DY 2 through 5 by achieving defined reporting-based progress measures and performance-based outcome metrics. Project valuation will be calculated during DY1 once each certified ACH submits a Project Plan application detailing project selection and implementation strategies. Based on this content, the state will determine maximum incentive payments allotted to each ACH by project to be distributed to partnering providers. As described in STC 35, the annual maximum project valuation will be determined based on the attributed number of Medicaid beneficiaries residing in the ACHs regional service area(s) and on the Project Plan application scores.

The maximum amount of ACH incentive funding will be 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 will be 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*

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 DSRIP project funding available, known as the project weight. ACHs must select at least four projects, including Project

2A (Bi-Directional Integration of Care and Primary 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 project metrics that ACHs must achieve to earn funding associated with that project. An ACH’s payment for project implementation will be based on pay-for-reporting (P4R) in DY1 and DY2 and based on both P4R and pay-for-performance (P4P) between DY3 and DY5. The maximum amount of incentive funding that an ACH can earn is determined based on the ACH’s project selection, the value of the projects selected, the quality and score of Project Plan applications, and the size of the ACH’s Medicaid beneficiary population. 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.
- Strength of measures (P4R/P4P)
- 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.
- Strong evidence-based strategies to ensure a reduction in avoidable use of intensive services.
- Focus on quality, rather than quantity, to accelerate transition to value-based payment.

**Table 1. Transformation Project Weighting**

Project Weighting	
Project	Weight
2A: Bi-Directional Integration of Care and Primary 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: 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) provides the broadest support for achievement of statewide objectives and measures as it requires the highest level of integration of the other projects and moves toward P4P with the largest set of P4P metrics. Furthermore, the project has the potential to touch the vast majority of Medicaid members through the evidence-based approach and is likely to result in significant

cost-savings. Regions that have implemented fully integrated managed care will be better positioned to scale project 2A and will be eligible for an enhanced DY1 valuation.

Project 2B (Community-Based Care Coordination) has the potential of serving a large proportion of the Medicaid population through an evidence-based approach and potential to see a reduction in health care costs. 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 largest project weight of the Domain 3 projects, at 8 percent. Project 3D has the potential to touch 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 (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 defined 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.

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 has 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 attribution for the funding methodology. Maximum funding by project is calculated by multiplying the total state ACH project funds available by the respective project weight (see Table 1 for project weighting).

**Maximum Statewide Funding by Project** = [Total Statewide ACH Project Funds available] x [Project Weight]

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

**Maximum ACH Funding by Project** = [Maximum Statewide Funding by Project] x [% 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 DY5. This maximum ACH valuation will be earned upon achieving defined reporting-based progress measures and performance-based outcome metrics and may be reduced based on application of the statewide penalty described in Section VII.

For DY1, the maximum ACH Funding by Project will be adjusted based on Project Plan scores. Each ACH Project Plan will receive a score based on the quality of the application. This project plan application score will be used as a variable in calculating the maximum ACH valuation for DY1. Each project plan score will be expressed out of 100. The scoring criteria will be developed in conjunction with the Project Plan template (see DSRIP Planning Protocol).

*d. Earning Incentive Payments*

In DY2 through DY5, ACHs will earn incentive payments for successful implementation 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 will be evaluated against these designated metrics and awarded Achievement Values (AV), which are point values assigned to each metric that is payment-driving. This maximum value of an AV is one in the instance when an ACH meets the designated metric.

ACHs may earn partial AVs in proportion to the progress made in achieving the performance metric targets during the performance period. A minimum threshold of 25 percent of the gap-to-goal closure must be reached in order to earn a portion of the AV.

Based on the progress reported, each metric will be categorized as follows to determine the applicable achievement value for the metric:

- Full achievement of performance goal (achievement value = 1)
- Less than full 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 achievement of performance goal (achievement value = 0)

To determine Total Achievement Value (TAV) for each project in a given payment period, the AVs earned within the project will be 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 ACH project funding as follows:

**Table 2. Example Calculation of Achievement Values**

Measure/Metric	Achievement Value	Weighting
Progress Measure 1	1	25%
Outcome Metric 1	0	25%
Outcome Metric 2	1	25%
Outcome Metric 3	0.5	25%
<b>TAV</b>	<b>2.5</b>	
<b>PAV</b>	<b>62.5%</b>	

*Note: for a subset of outcome metrics that are associated with multiple projects selected by an ACH, in a given payment period, the metric will earn an AV within the project where the metric is associated with the highest possible funds and for all other selected projects, the funds associated with that metric will be redistributed across the remaining measures and metrics so as to not duplicate payment for an outcome. The applicable subset of outcome metrics will be defined within the Measures and Metrics Specification Guide.*

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

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

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

*e. Managed Care Integration*

A primary goal of the demonstration is to support implementation of a fully integrated managed care system. Although there are regional service areas that have made progress toward integration, a large portion of the state needs to make significant investments to achieve this transition by January 2020. The Transformation Project Toolkit (Attachment C) calls for the submission of binding letters of intent to implement full integration by 2020 as an Implementation Stage 1 progress measure under Project 2A (Bi-Directional Integration of Care and Primary Care Transformation).

Regions that implement fully integrated managed care prior to 2020 will be eligible to earn incentive payments above the maximum valuation for project 2A. 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.

$$\text{Integration Incentive} = [\$2 \text{ million}] + [\$36 \times \text{Total Attributed Medicaid Beneficiaries}] \times [\text{Phase Weight}]$$

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 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 STC 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 and improvement toward VBP targets.

**V. ACH Reporting Requirements**

These activities are detailed below.

*a. Semi-Annual Reporting for ACH Project Achievement*

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

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

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

## **VI. State Oversight Activities**

The state will provide various types of 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 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 ACHs 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 will set forth the requirements and obligations of the ACHs as the leads for DSRIP and other partnering providers. The contract will address 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 will require 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; and describe upcoming activities. The reports will provide sufficient information for CMS to understand 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.

*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. The draft evaluation report will be submitted to CMS by January 31, 2022.

**VII. Statewide Performance and Unearned DSRIP Funding**

*a. Accountability for State Performance*

The state will be accountable for demonstrating progress toward meeting the demonstration's objectives. Funding for ACHs and partnering providers may be reduced in DY3, DY4, and DY5 if the state fails to demonstrate quality and improvement on the 11 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, DY5. During DY3 and DY4, annual assessment of quality and improvement from a defined baseline toward these goals will be used to 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. Psychiatric Hospital Readmission Rate
4. Outpatient Emergency Department Visits per 1000 Member Months
5. Plan All-Cause Readmission Rate (30 days)
6. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
7. Antidepressant Medication Management
8. Medication Management for People with Asthma (5 – 64 Years)
9. Controlling High Blood Pressure
10. Comprehensive Diabetes Care - Blood Pressure Control
11. 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 11 statewide accountability measures for the demonstration. Each measure will be 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 will then be 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 historical state data and the input of subject matter experts.

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 quality improvement score.

*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. The state does not plan to withhold any amounts to subsidize this reinvestment pool.

**VIII. Demonstration Mid-point Assessment**

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

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