WA Medicaid Demonstration Performance Measures

Better Health Together Current State

September 20, 2017

Demonstration project areas

2A **Bi-directional integration of behavioral health and primary care**

2B Community-based care coordination (Pathways)

2C Transitional care

2D Diversion interventions

3A **Addressing the opioid use public health crisis**

3B Maternal and child health

3C Access to oral health services

3D Chronic disease prevention and control

Disclaimers for current state performance

- Data presented are not the official ACH baseline performance; HCA intends to release official baseline data in fall 2018.
- Official measure specifications have not been published; final specification detail may differ from measures in the 'current state performance' summary.
- Not all measures are available by ACH or with county-level breakouts, or with state-level or national comparators.
- HCA has not yet released benchmarks or "improvement targets" for the measures (anticipated at the end of the month).

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ACH performance measures overview

P4R: Demonstration-specific measures generally associated with project milestones (e.g. number of providers trained)

P4P: Somewhat more standardized process and outcome measures (e.g. HEDIS). Some measures apply to multiple project areas:

P4P Measure	Integ.	Coord.	Trans.	Div.	Opioid	MCH	Oral	CD
ED utilization	✔	✔	✔	✔	✔	✔	✔	✔
Inpatient hospital utilization	✔	✔	✔		✔			✔
Follow-up after ED or hospitalization (6 meas.)	✔	✔	✔					
MH or SA treatment penetration	✔	✔				✔		
All-cause readmission	✔	✔	✔					
Percent homeless	✔	✔	✔	✔				✔
Comprehensive diabetes care (3 measures)	✔							✔
Asthma medication management	✔							✔
Children's / adolescents' access to primary care	✔							✔

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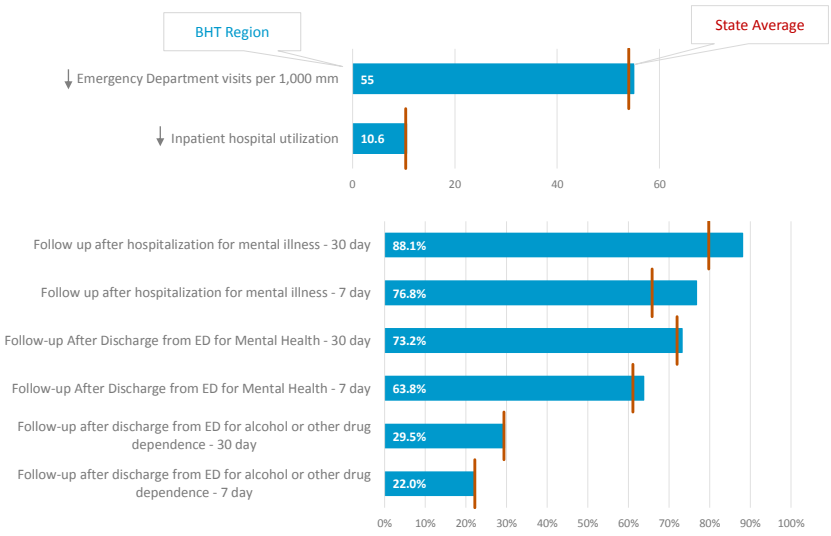
BHT performance (*unofficial*) for most common measures



↓ = A lower rate is better for this measure

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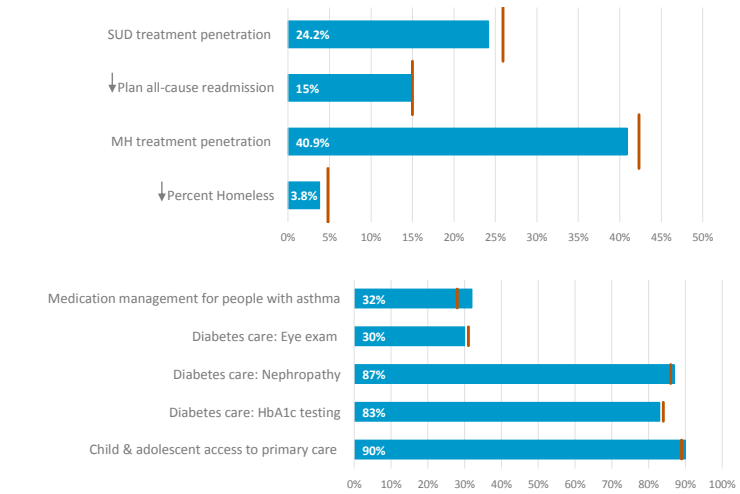
BHT performance (*unofficial*) for most common measures



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Project 2A: Bi-Directional Integration

Funding

	6 projects	8 projects
Project weight	35%	32%
Estimated max funding (5 years)	$30.9 M	$28.5 M

Project Selection:
☑ Required Project
☐ Selected by ACH

Expectations

Approaches

- Both directions: PC → BH and BH → PC
- Bree Collaborative model
- UW Collaborative Care model
- Milbank recommendations for integrating PC into behavioral health settings

Example Strategies

- Integrated care teams
- Shared patient information
- Psychiatric consultation or case review
- Workflows for integration & coordination, follow-up, relapse prevention
- Quality improvement plan

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2A: Integration Performance Measures

Year	Type	Metric	Report Timing
DY 3-5	ACH Reported (pay for reporting)	• QIP Metrics • # of practices / providers implementing evidence-based approaches • # of practices / providers trained on evidence-based practices: projected vs actual • % PCP in partnering provider organizations meeting PCMH requirements • # of partnering PCPs who achieve special recognition / certifications / licensure (e.g., MAT)	Semi-annual
DY 3 - 5	State Reported (pay for performance)	• Antidepressant medication management • Child and adolescent' access to primary care practitioners • Comprehensive diabetes care: HbA1c testing • Comprehensive diabetes care: Medical attention for nephropathy • Medication management for people with asthma (5-64 years) • Mental health treatment penetration (broad) • Emergency Department visits per 1,000 mm • Plan all-cause readmission rate (30 day) • Substance use disorder treatment penetration	Annual
DY 4-5	ACH Reported (pay for reporting)	• Depression screening and follow up for adolescents and adults	Annual
DY 4-5	State Reported (pay for performance)	• Comprehensive diabetes care: Eye exam performed • Follow-up after discharge from ED for mental health, alcohol or other drug dependence • Follow up after hospitalization for mental illness • Inpatient hospital utilization	Annual

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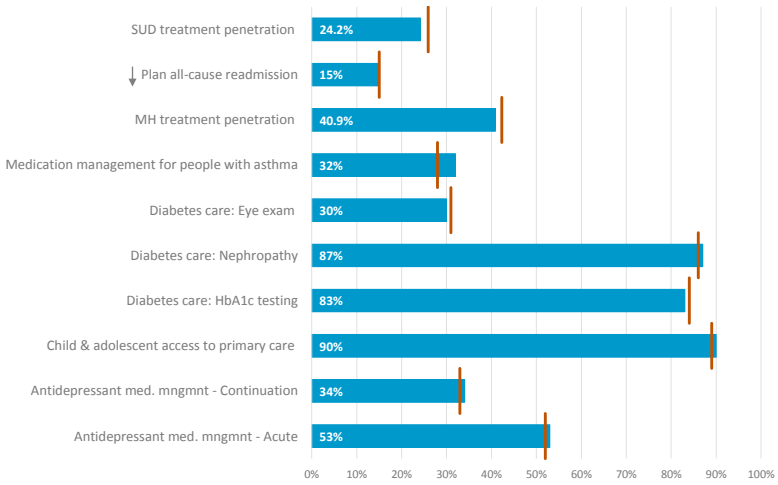
Integration current state highlights (*unofficial*)



↓ = A lower rate is better for this measure

Note: all but HbA1c testing are also 2017 MCO contract measures

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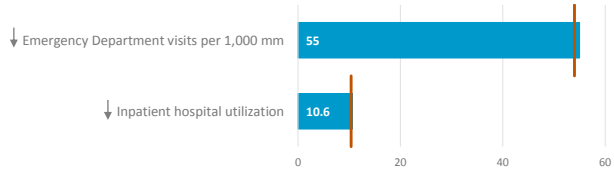
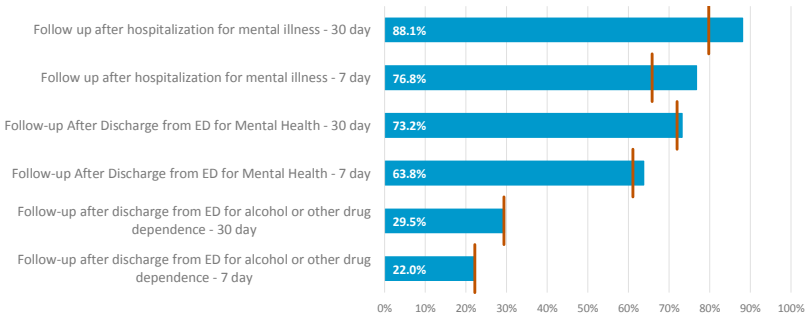
Integration current state highlights (*unofficial*)





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Note: all are also 2017 MCO contract measures

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Project 2B: Community Care Coordination

Funding

	6 projects	8 projects
Project weight	24%	22%
Estimated max funding (5 years)	$21.3 M	$19.6 M

Project Selection:
- ☐ Required for Demonstration
- ☑ Selected by ACH

Expectations

Approaches

- Pathways Community HUB

Example Strategies

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2B: Care Coordination Measures

Year	Type	Metric	Report Timing
DY 3-5	ACH Reported (pay for reporting)	• QIP Metrics • # of partners trained by focus area or pathway: projected vs actual and cumulative • # of partners participating / # implementing each selected pathway • % PCP in partnering provider organizations meeting PCMH requirement • % partnering provider organizations using selected care management technology platform • % partnering provider organizations sharing information via HIE to better coordinate care • % of partnering provider organizations with staffing ratios better or equal to recommended • # of new patients with a care plan • Total # of patients with an active care plan	Semi-annual
DY 5	ACH Reported (pay for reporting)	• VBP arrangement with payment / metrics to support adopted model	Semi-annual
DY 3 -5	State Reported (pay for performance)	• Mental health treatment penetration (broad) • Emergency Department visits per 1,000 mm • Percent homeless (narrow) • Plan all-cause readmission rate (30 day) • Substance use disorder treatment penetration	Annual
DY 4 -5	State Reported (pay for performance)	• Follow-up after discharge from ED for mental health, alcohol or other drug dependence • Follow up after hospitalization for mental illness • Inpatient hospital utilization	Annual

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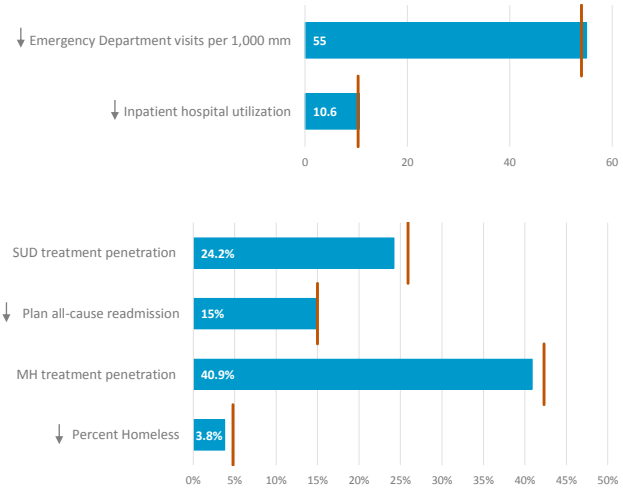
Coordination current state highlights (*unofficial*)



↓ = A lower rate is better for this measure

Note: all but percent homeless also 2017 MCO contract measures

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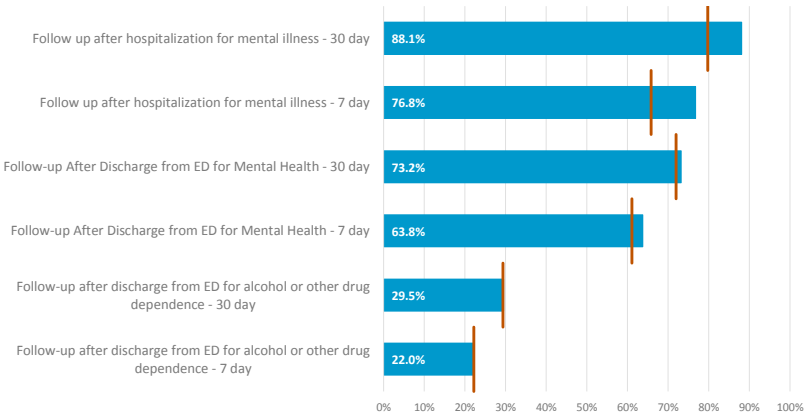
Coordination current state highlights (*unofficial*)



Note: all are also 2017 MCO contract measures

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Project 2C: Transitional Care

Funding

	6 projects	8 projects
Project weight	14%	13%
Estimated max funding (5 years)	$12.6 M	$11.6 M

Project Selection:
- ☐ Required for Demonstration
- ☑ Selected by ACH

Expectations

Approaches

Select evidence-based approaches for:
- Care management and transitional care in health care settings
- Transitional care for people with wealth and behavioral health needs leaving incarceration

Example Strategies
- Collaborative care management teams
- Home visits
- Patient and family engagement
- Increased Medicaid enrollment
- Care planning

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2C: Transitional Care Metrics

Year	Type	Metric	Report Timing
DY 3-5	ACH Reported (pay for reporting)	• QIP Metrics • # of partners trained by selected model: projected vs actual and cumulative • # of partners participating / # implementing each selected model • % partnering provider organizations sharing information via HIE to better coordinate care	Semi-annual
DY 5	ACH Reported (pay for reporting)	• VBP arrangement with payment / metrics to support adopted model	Semi-annual
DY 3 -5	State Reported (pay for performance)	• Emergency Department visits per 1,000 mm • Percent homeless (narrow) • Plan all-cause readmission rate (30 day)	Annual
DY 4 -5	State Reported (pay for performance)	• Follow-up after discharge from ED for mental health, alcohol or other drug dependence • Follow-up after hospitalization for mental illness • Inpatient hospital utilization	Annual

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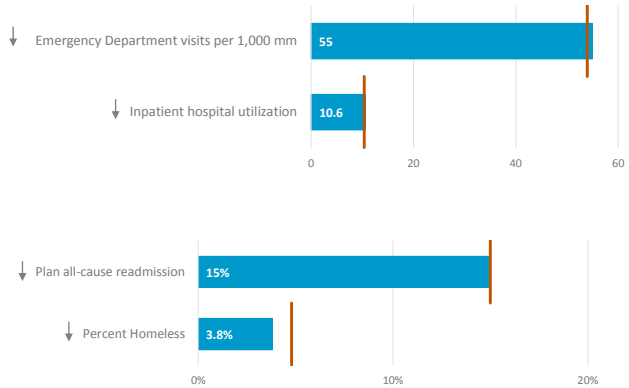
Transition current state highlights (*unofficial*)



↓ = A lower rate is better for this measure

Note: all but percent homeless also 2017 MCO contract measures

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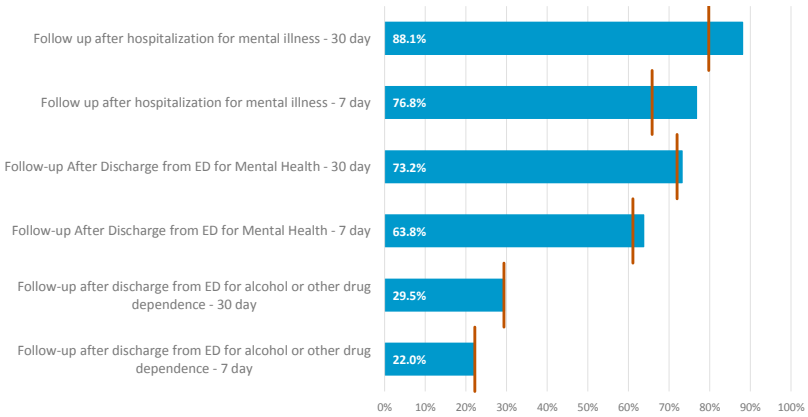
Transition current state highlights (*unofficial*)



Note: all are also 2017 MCO contract measures

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Project 2D: Diversion Interventions

Funding	6 projects	8 projects
Project weight	14%	13%
Estimated max funding (5 years)	$12.6 M	$11.6 M

Project Selection:
- ☐ Required for Demonstration
- ☑ Selected by ACH

Expectations

Approaches
- Emergency Department Diversion
- Community Paramedicine Model
- Law Enforcement Assisted Diversion (LEAD)

Example Strategies
- Linkages to Primary Care
- Shared patient information
- Workforce training
- Case management

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2D: Diversion Metrics

Year	Type	Metric	Report Timing
DY 3-5	ACH Reported (pay for reporting)	• QIP Metrics • # of partners trained by selected strategy: projected vs actual and cumulative • # of partners participating / # implementing each selected strategy • % partnering provider organizations sharing information via HIE to better coordinate care • % of partnering provider organizations with staffing ratios equal or better than recommended	Semi-annual
DY 5	ACH Reported (pay for reporting)	• VBP arrangement with payment / metrics to support adopted model	Semi-annual
DY 3 -5	State Reported (pay for performance)	• Emergency Department visits per 1,000 mm • Percent homeless (narrow)	Annual
DY 4 -5	State Reported (pay for performance)	• Percent arrested	Annual

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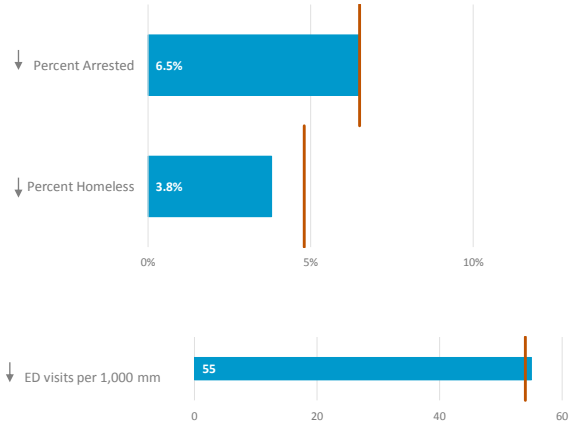
Diversion current state highlights (*unofficial*)



↓ = A lower rate is better for this measure

Note: ED visits is also a 2017 MCO contract measure

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Project 3A: Opioid

Funding

	6 projects	8 projects
Project weight	4%	4%
Estimated max funding (5 years)	$3.9M	$3.6M

Project Selection Status:
☑ Required for Demonstration
☐ Selected by ACH

Expectations

Approaches

- Clinical Guidelines
- Statewide Plans
- Implementation plan to address prevention, treatment, overdose prevention, and recovery

Example Strategies

- Prevent opioid misuse and abuse
- Link individuals with opioid use disorder to treatment
- Intervene in opioid overdoses to prevent death
- Promote long-term stabilization and whole-person care (recovery)

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3A: Opioid Metrics

Year	Type	Metric	Report Timing
DY 3-5	ACH Reported (pay for reporting)	• QIP Metrics • # and location of buprenorphine prescribers (MDs, ARNPs, and PAs) • # and location of MH/SUD providers delivering acute care and recovery services to people with OUD • # and list of community partnerships (list of members and roles, and ID which partners offer MAT) • # of health care providers, by type, trained on AMDG's Interagency Guideline on Prescribing Opioids for Pain • # of health care organizations with EHRs that newly provide clinical decision support for opioid guidelines • # of local health jurisdictions / CBOs that received TA to organize or expand syringe exchange programs • # of EDs with protocols for overdose education and take home naloxone for opioid overdose • # and type of access points for MAT (e.g., EDs, SUD / MH settings, corrections, etc)	Semi-annual
DY 3-5	State Reported (pay for performance)	• MAT with buprenorphine or methadone • Emergency Department visits per 1,000 mm • Patients on high-dose chronic opioid therapy by varying thresholds (in development) • Patients with concurrent sedatives prescriptions (in development)	Annual
DY 4-5	State Reported (pay for performance)	• Inpatient hospital utilization • Substance Use Disorder treatment penetration - opioid (in development)	Annual

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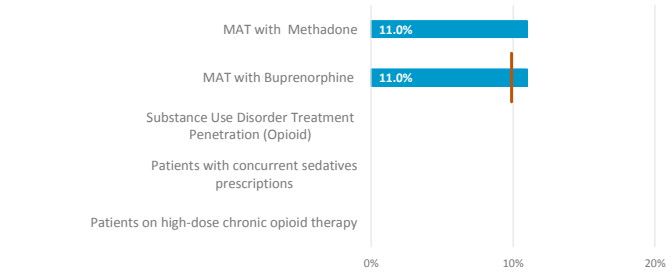
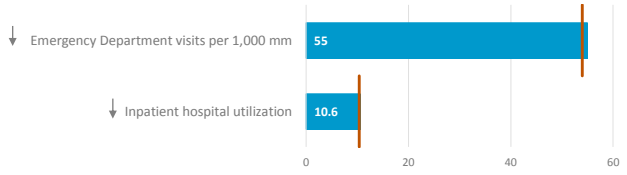
Opioid current state highlights (*unofficial*)





↓ = A lower rate is better for this measure

Note: ED visits & inpatient utilization are also 2017 MCO contract measures

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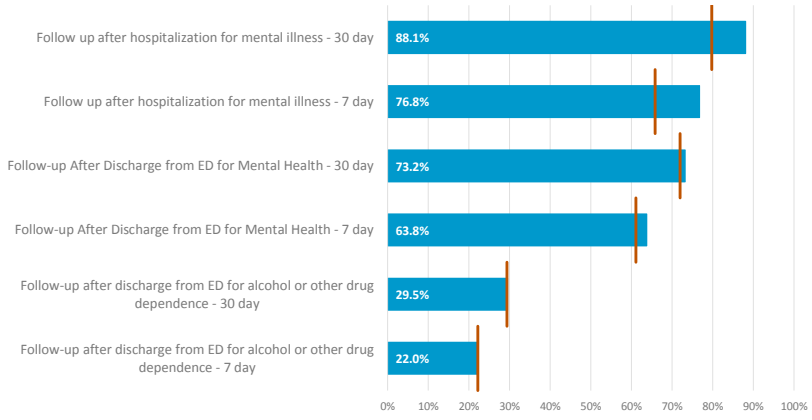
Opioid current state highlights (*unofficial*)



Note: all are also 2017 MCO contract measures

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Project 3B: Maternal & Child Health

Funding

	6 projects	8 projects
Project weight	--	5%
Estimated max funding (5 years)	--	$4.5M

Project Selection:
- ☐ Required for Demonstration
- ❑ Selected by ACH

Expectations

Approaches

- CDC's 10 recommendations to improve pre-conception health
- Evidence-based home visiting model for pregnant high-risk mothers, including Nurse Family Partnership or other federally recognized evidence-based home visiting model operating in WA
- Evidence-based model or promising practice to improve well child visits and immunization rates

Example Strategies

- Access to family planning services
- Education for health care providers and families
- Home visiting education and case management

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3B: Maternal & Child Health Metrics

Year	Type	Metric	Report Timing
DY 3-5	ACH Reported (pay for reporting)	• QIP Metrics • # of partners trained by selected model / approach: projected vs actual and cumulative • # of partners participating / # implementing each selected model / approach	Semi-annual
DY 3-5	State Reported (pay for performance)	• Chlamydia screening in women ages 16-24 • Mental health treatment penetration (broad) (women / children) • Emergency Department visits per 1,000 mm • Substance use disorder treatment penetration (women / children) • Well child visits in the 3rd, 4th, 5th, and 6th years of life	Annual

DY 4-5	State Reported (pay for performance)	• Childhood immunization status
		• Contraceptive care (NQF 2903, 2904, and 2902) – annual improvement on at least one measure
		  • Women aged 15-44 using most or moderately effective contraception
		  • Women aged 15-44 using long-acting reversible contraception (LARC)
		  • Women aged 15-44 who received most or moderately effective contraception postpartum
		• Prenatal care in the first trimester
		• Well child visits in the first 15 months of life
			Annual

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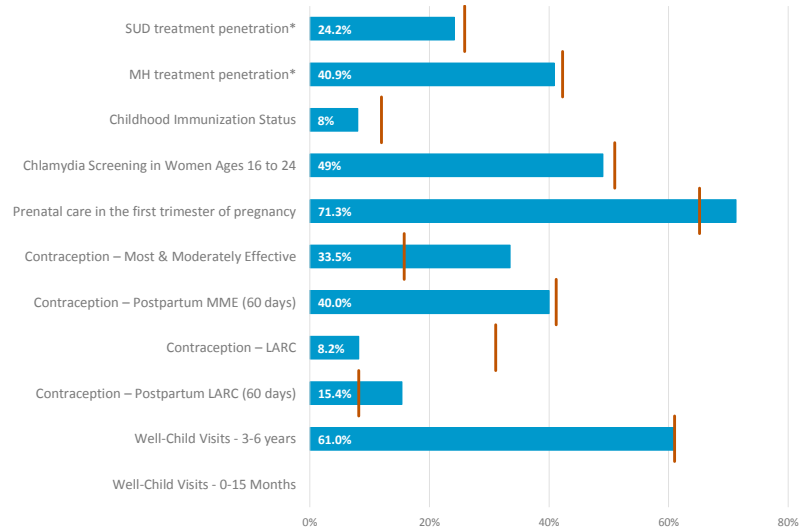
MCH current state highlights (*unofficial*)



Note: Other than contraception metrics, these are also 2017 MCO contract measures

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Project 3C: Oral Health

Funding	6 projects	8 projects
Project weight	--	3%
Estimated max funding (5 years)	--	$2.7M

Project Selection:
- ☐ Required for Demonstration
- ❑ Selected by ACH

Expectations

Approaches

- Oral Health in Primary Care – integrating oral health screening, assessment, intervention and referral into the primary care setting
- Mobile/Portable Dental Care

Example Strategies

- Adopt workflows for oral health screening, action, & referral in PC
- Engage & train providers
- Secure & equip vehicle for mobile services

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3C: Oral Health Measures

Year	Type	Metric	Report Timing
DY 3-5	ACH Reported (pay for reporting)	• QIP Metrics • # of Medicaid beneficiaries served: projected vs actual and cumulative • # of partners / providers trained on evidence-based approach: projected vs actual and cumulative • # of partners / providers implementing the evidence-based approach	Semi-annual
DY 3-5	State Reported (pay for performance)	• Emergency Department visits per 1,000mm • Primary caries prevention intervention as part of well child care / offered by primary care providers • Utilization of dental services by Medicaid beneficiaries	Annual
DY 4-5	State Reported (pay for performance)	• Dental sealants for children at elevated caries risk • Ongoing care in adults with chronic periodontitis • Periodontal evaluation in adults with chronic periodontitis	Annual

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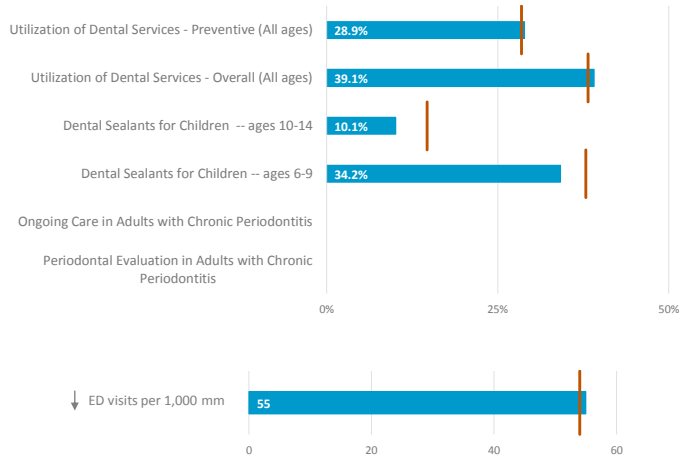
Oral health current state highlights (*unofficial*)



↓ = A lower rate is better for this measure

Note: ED visits and broad dental utilization are also 2017 MCO contract measures

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Project 3D: Chronic Disease

Funding

	6 projects	8 projects
Project weight	9%	8%
Estimated max funding (5 years)	$7.7M	$7.1M

Project Selection Status:
- ☐ Required for Demonstration
- ☑ Selected by ACH

Expectations

Approaches

- Chronic Care Model

Example Strategies

- Self-management support and education for patients
- Adopt workflows for decision support, collaborative management, evidence-based approaches, and patient engagement
- Sharing patient and population information

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3D: Chronic Disease Measures

Year	Type	Metric	Report Timing
DY 3-5	ACH Reported (pay for reporting)	• QIP Metrics • # of partners trained on selected model / approach: projected vs actual and cumulative • # of partners participating / implementing each selected model / approach • # of new / expanded nationally recognized self-management support programs (e.g., CDSMP, NDPP) • # of home visits for asthma services, hypertension • % of documented, up-to-date Asthma Action Plans • # of health care providers trained in appropriate blood pressure assessment practices • % of patients provided with automated blood pressure monitoring equipment	Semi-annual
DY 3-5	State Reported (pay for performance)	• Child and adolescent access to primary care practitioners • Comprehensive diabetes care: HbA1c testing • Comprehensive diabetes care: Medical attention for nephropathy • Medication management for people with asthma (5-64 years) • Emergency Department visits per 1,000mm	Annual
DY 4-5	State Reported (pay for performance)	• Comprehensive diabetes care: Eye exam performed • Inpatient hospital utilization • Statin therapy for patients with cardiovascular disease (prescribed)	Annual

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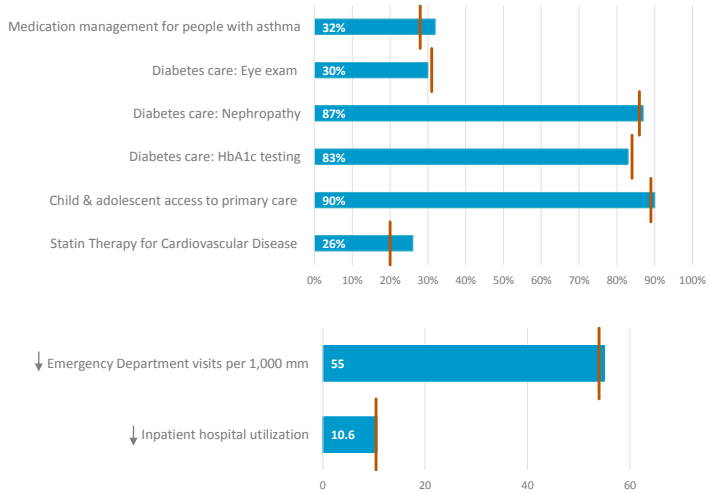
Chronic disease current state highlights (*unofficial*)



↓ = A lower rate is better for this measure

Note: all but HbA1c testing are also 2017 MCO contract measures

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Questions

Healthier Washington Data Dashboard, and other resources:
https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard

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