BHT Pay for Achievement Measures

FINAL MEASURES AND ACHIEVEMENT CRITERIA FOR 2019/2020

December 12, 2018

Introduction

BHT's Board has approved a Pay-for-Reporting funds flow model for behavioral health and primary care Partnering Providers in 2019, 2020, and 2021. See this link for more information: http://www.betterhealthtogether.org/bold-solutions-content/funds-flow-for-2019-21.

The funds flow model is based on three components:

1) Partners meeting the milestones they specified in their Transformation Plans (40%)
2) Partners meeting a minimum number of Pay-for-Achievement (P4A) measures from a menu provided by BHT (40%)
    - Partnering Providers will select 4 measures to pursue for 2020
    - Partnering Providers will select an additional 4 measures (8 total) to pursue for 2021
3) Partners meeting organizational milestones for equity (20%)

Pay-for-Achievement Measures

BHT's Pay-for-Achievement measures are intended to recognize Partnering Providers' progress toward transformation. They are conceptually related to many of the statewide Medicaid Transformation pay-for-performance measures, which are part of how the region as a whole earns funds, but are more appropriate for measurement & reporting at the level of Partnering Provider organizations. The menu of P4A measures currently includes 13 items but BHT reserves the right to add or remove items in future years.

This document describes BHT's menu of Pay-for-Achievement measures for 2019/2020. A draft version of this document was circulated for comment in late November 2018 and some measures have been revised based on the feedback BHT received. Any revisions are noted in the following table.

Data Collection and Reporting

Specific procedures for reporting on the P4A metrics and other milestones will be included in annual Partnering Provider contracts. In general:

- BHT plans to ask Partnering Providers for progress reports twice a year; the specific timing is under development.

- Reporting will be done through a simple online survey form that allows for existing documents to be uploaded (to reduce data entry). BHT will ask the identified Transformation Manager at each Partnering Provider organization to take responsibility for timely and accurate reporting.
- With one exception described in the table below, BHT's P4A measures will be reported at the level of a Partnering Provider organization, rather than for each clinic or practice location. Please note, however that the *statewide* Medicaid Transformation pay-for-reporting metrics will necessitate some clinic/practice-level reporting.
- The P4A measures rely on narrative reporting, example documents, and aggregate data only. No individual-level or identifiable data about clients or providers is required to report on the measures in this menu.

BHT Menu of Pay for Achievement Measures for behavioral health and primary care Partnering Providers – 2019/2020

Achievement concept		Rationale	Measurement & Achievement Definitions	Measure may be selected by …	Revisions from November 2018 draft

1	Organizational capacity for integration	• BHT Board has emphasized importance of foundational capacity for transformation	**MEASUREMENT**: Partnering Provider's organizational domain score from the MeHAF (Maine Health Access Foundation) survey.
			
			ACHIEVEMENT: Partnering Provider's organizational domain score increases by at least 1 point during the contract period. For Partnering Providers with multiple clinic sites, achievement will be assessed at the organizational level, using the median score across sites.
			
			About the MeHAF:[1]
			• The MeHAF is a self-assessment survey designed to assess levels of primary and behavioral care integration. The survey covers two domains:
			  ◦ A) Integrated services, patient and family centeredness – 11 questions;
			  ◦ B) Practice/organization characteristics – 9 questions.
			• Each question is scored on a scale of 1-10.
			• For this P4A measure, BHT will use consider the practice/organizational domain score only. The domain score will be calculated as the average rating across the 9 questions in the domain.
			
			Additional notes:
			• **Regardless of whether this P4A measure is selected, ALL behavioral health and primary care Partnering Providers will have to complete the MeHAF survey twice a year as part of HCA's required pay-for-reporting metrics**.
			• **This measure must be reported at the clinic/site level to meet HCA specifications.**
				☑ Primary care partners
				☑ Behavioral health partners
					No substantive changes.
					
					Additional clarifying information added about the MeHAF survey and calculation of the organizational domain score.

2	Basic chronic disease and	• Screening for primary care and behavioral health	Partnering Provider has an active protocol for screening in *each* of these three categories: • Chronic disease (at least 1 condition, e.g. diabetes)	☑ Primary care partners	1) Achievement expectation for the second contract

[1] Maine Health Access Foundation (MeHAF) is a self-assessment survey designed to assess levels of primary and behavioral care integration. This is the tool required by HCA for waiver pay-for-reporting purposes. The tool has 21 questions grouped into two domains: 1) integrated services and patient- and family-centeredness; and 2) practice / organization capacity including things like leadership, patient & family input, provider training, etc. See this link for more information: https://www.hca.wa.gov/assets/P4R-physical-behavioral-health-integration-practice-site.pdf

Achievement concept		Rationale	Measurement & Achievement Definitions	Measure may be selected by …	Revisions from November 2018 draft
	behavioral health screening	concerns in both PC and BH settings supports integration • Common aim from Partnering Provider Transformation Plans • Supports performance on MTP ACH-level P4P metrics related to chronic disease management and behavioral health treatment penetration	• Depression • Substance abuse MEASUREMENT: For each category: 1) List/name the evidence-based screening tool(s) used for each category; 2) Upload protocol(s) or workflow documentation, at least one example per category 3) Report % of eligible Medicaid patients screened in the past 12 months (numerator and denominator) ACHIEVEMENT: • Reporting only (all three elements) in the first contract period. • For the second contract period, Partnering Providers will be expected to improve the screening rate that was lowest during the first period. For example, if a Partnering Provider screened 80% of eligible patients for both depression and a chronic disease in the first period but only screened 45% of eligible patients for substance abuse, the Partnering Provider would be expected to increase the substance abuse screening rate during the second contract period. • Currently, BHT is not specifying how much the lowest screening rate must improve in the second contract period. BHT will work with partners to consider options for minimum improvement-over-self and/or threshold attainment in the future, after baseline data becomes available. Additional notes: • Note that when reporting the % of eligible patients screened (#3 above), “eligible” should be based on the Partnering Provider’s own definitions / the requirements of the evidence-based screening tool(s) in use. This measure does not require Partnering Providers to report to BHT using any particular measure specifications (such as NQF 0418 for depression screening). Partnering Providers should report in whatever way matches their protocols and is feasible within their data systems.	☑ Behavioral health partners	period changed to requirement that Partnering Provider improves whichever screening rate was lowest in the first period. 2) Removed expectation for Partnering Providers to improve by 10% over their own past performance. Minimum improvement expectations will be set in the future based on consideration of baseline data.

Achievement concept		Rationale	Measurement & Achievement Definitions	Measure may be selected by …	Revisions from November 2018 draft
3	Universal[2] screening & follow-up - SDOH	• Connects to community-based care coordination aims and activities • Connects to BHT's regional priority of whole person care	Partnering Provider has protocol for screening for social determinant of health needs (e.g. using PRAPARE[3] or another tool), recording data, and making relevant referrals (if patients desire). MEASUREMENT: 1) List/name the SDOH screening tool(s) used; 2) Upload protocol or workflow documentation; 3) Report % of eligible Medicaid patients screened in the past 12 months (numerator and denominator) ACHIEVEMENT: • Reporting only in the first contract period. • Currently, BHT is not specifying how much the lowest screening rate must improve in the second contract period. BHT will work with partners to consider options for minimum improvement-over-self and/or threshold attainment in the future, after baseline data becomes available.	☑ Primary care partners ☑ Behavioral health partners	Removed expectation for Partnering Providers to improve by 10% over their own past performance. Minimum improvement expectations will be set in the future based on consideration of baseline data.
4	Peers and CHWs	• CHWs, peer specialists, and similar roles can facilitate person-centered care and recovery • Increasing the number of peers, CHWs, and similar roles—as appropriate for the organizational business model—was a common aim from the Partnering	Partnering Provider increases availability of peer support workers community health workers, or similar roles (Health Coaches, Doulas, Navigators, etc.) MEASUREMENT: 2-part survey question: 1) Current FTE for each relevant category of worker; and 2) Total number of Medicaid patients served in past 12 months ACHIEVEMENT: Reporting only; no increase in FTE-to-patient ratio is required.	☑ Primary care partners ☑ Behavioral health partners	None

[2] Universal screening as opposed to screening 'as indicated' or diagnostic screening. This does not imply that ALL clients must be screened.

[3] For reference only, see this link for a PRAPARE Implementation and Action Toolkit: http://www.nachc.org/research-and-data/prapare/toolkit/ . This brief from the Institute of Medicine contains recommendations about social and behavioral measures to include in electronic health records: http://nationalacademies.org/hmd/Reports/2014/EHRdomains2.aspx

Achievement concept		Rationale	Measurement & Achievement Definitions	Measure may be selected by …	Revisions from November 2018 draft
		Provider Transformation Plans	Additional notes: ▪ Some definitions for peer support workers[4] and community health workers[5] are provided below as informational resources (not intended as requirements)		
5	Medication Assisted Treatment	▪ Aligns with MTP ACH-level P4R metrics about connection to medication assisted treatment ▪ Lack of MAT capacity noted in several Collaborative and Partnering Provider Transformation Plans ▪ BHT is also interested in how the willingness of non-prescribing SUD providers to treat clients receiving MAT is changing over time	Partnering Provider increases Medication Assisted Treatment (MAT) services for opioid use disorder. MEASUREMENT: 2-part survey question: 1) Total provider FTE currently providing MAT to patients of the clinic/organization 2) Total number of Medicaid patients who received MAT in past 12 months With additional text question: How easy is it for your clinic/practice to refer patients receiving MAT to other forms of outpatient SUD treatment (e.g. counseling)? ACHIEVEMENT: ▪ An increase during the contract period in the number of patients undergoing MAT. ▪ Currently, BHT is not specifying how much the number of MAT patients must increase in the second contract period. BHT will work with partners to consider options for minimum improvement-over-self and/or threshold attainment in the future, after baseline data becomes available.	☑ Primary care partners ☑ Behavioral health partners	1) Revised 2nd part of measurement to number of Medicaid patients receiving MAT treatment in last 12 months 2) Changed the achievement requirement to an increase in the number of patients receiving MAT (rather than an increase in MAT providers-to-patient ratio)
6	Care compacts	▪ Compacts facilitate integration and care coordination between partners	Partnering Provider has care compacts[6] (a framework for standardized communication between providers to improve care coordination and transitions) with at least three (3) referral partners, at least one of which must be a social determinant of health partner (not a health care partner)	☑ Primary care partners	1) Added a requirement that at least one of the three care compacts to be with an SDoH provider.

[4] A peer support worker may be a self-identified consumer of mental health and addiction services who has completed specialized training and passed an examination to be recognized as a 'peer counselor'. Peer support workers draw on their own life experiences to provide support, encouragement, and resources to those with similar experiences. Description modified from WAC 388-877-0200.

[5] A CHW is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusted relationship enables the CHW to serve as a liaison or intermediary between health/social services and the community. Definition is from the American Public Health Association, as adopted by the Washington Community Health Worker Taskforce recommendations report, 2016.

[6] See for example: http://www.cms.org/uploads/PCMH-Primary-Care-Specialty-Care-compact-(10-22-10).pdf

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		• Referral pathways and information exchange between partners were common aims in Partnering Provider Transformation Plans	**MEASUREMENT**: List the 3 referral partners and describe / upload care compacts **ACHIEVEMENT:** Three documented current compacts / agreements Additional notes: • BHT will provide examples and key elements of care compacts as part of its 2019 learning cohort activities • Note that achievement for this measure does **not** require communication between partners involved in the care compacts to be electronic.	☑ Behavioral health partners	2) Some clarifying information added under Additional Notes.
7	Complex care planning	• Connects to foundational capacity for transformation • Supports use of evidence-based care models	Partnering Provider has: established process for proactively identifying and managing individuals in need of complex care[7] **MEASUREMENT**: 2-part question: 1) Describe / upload document describing Partnering Provider's operational definition of at least one "complex care" population 2) Describe / upload ONE protocol / workflow process for identifying and providing care management to an identified complex care group (e.g. the most recently updated protocol) **ACHIEVEMENT:** At least one definition and protocol / workflow submitted Additional notes: • The workflow / protocol submitted for this measure should not be the same as submitted for #2 or #3, as those aren't specific to a complex care population	☑ Primary care partners ☑ Behavioral health partners	None.

[7] For example, see conceptual taxonomy for identifying high-need patients from the National Academy of Medicine's 2015-16 work on Effective Care for High-Need Patients: https://nam.edu/wp-content/uploads/2017/06/Effective-Care-for-High-Need-Patients-Key-Points.pdf

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8	Patient Advisory group	• Supports patient-centered care • Involves patients in shaping transformation	Partnering Provider has a Patient & Family Advisory group[8] or similar body / function that contributes to decision-making about ways to improve processes, procedures, care delivery, and outcomes. **MEASUREMENT**: 1) Describe / upload document describing the clinic or organization's Patient & Family Advisory structure; 2) Provide an example of how patient & family input was used to change policy or practice. **ACHIEVEMENT:** Partnering Provider's Patient & Family Advisory mechanism should include: 1) At least 3 meetings/year in which patients & family members provide input on specific topic(s); 2) A clear mechanism for communicating patient feedback and recommendations to leadership in a timely manner. Additional Notes: • For purposes of this P4A measure, Partnering Providers with multiple clinic locations do not need to have a separate patient & family advisory group for each site. • Conducting patient satisfaction surveys or holding a one-time focus group does **not** meet the intent of this measure.	☑ Primary care partners ☑ Behavioral health partners	None.
9	Behavioral Health service capacity	• Connects to BHT's regional priority of improving behavioral health access • Supports performance on MTP ACH-level P4P metrics of MH and SUD treatment penetration	Partnering Provider increases provision of mental health and/or SUD services (whether onsite or via tele-medicine) **MEASUREMENT**: 2-part survey question: 1) Unduplicated number of Medicaid clients seen in the last 12 months who received a mental health service (outpatient service, procedure, or prescription); and	☑ Primary care partners ☑ Behavioral health partners	Removed expectation for Partnering Providers to improve by 10% over their own past performance. Minimum improvement expectations will be set in the

[8] For example, the National Partnership for Women & Families gave this description to practices participating in the Comprehensive Primary Care Initiative: "A Patient & Family Advisory Council is an established council within a health care practice which meets regularly and consists of patients and family members who receive care at the practice. Select providers, clinicians, office staff, and leadership are also integrated members of the PFAC and work with the patient and family advisors to discuss improvements in care, processes, and experiences. Key to the PFAC is that patients and family caregivers are viewed as respected partners and essential resources to the practice." See: https://innovation.cms.gov/Files/x/cpci-patientfamengresource.pdf.

Achievement concept		Rationale	Measurement & Achievement Definitions	Measure may be selected by …	Revisions from November 2018 draft
			2) Unduplicated number of Medicaid clients seen in the last 12 months who received a substance use disorder service (of any kind; outpatient, inpatient/residential, or MAT) **ACHIEVEMENT:** ▪ Reporting only in the first contract period. ▪ Currenlty, BHT is not specifying how much the provision of behavioral health services must increase in the second contract period. BHT will work with partners to consider options for minimum improvement-over-self and/or threshold attainment in the future, after baseline data becomes available. Additional Notes: ▪ For purposes of this achievement measure, BHT intentionally is not providing strict definitions about what counts as an MH or SUD service. The intent is to give Partnering Providers flexibility and to focus on improvement over self, rather than comparisons between providers. ▪ In contrast, the Medicaid Transformation mental health and SUD treatment penetration pay-for-performance measures, to which BHT is accountable, do have specific definitions that use service type codes and provider taxonomies.		future based on consideration of baseline data.
10	Project ECHO, tele-medicine, or e-consults	▪ These strategies can help improve access to care and increase practice capacity without requiring additional workforce at the practice site. ▪ Challenges with provider recruitment and retention were frequently mentioned in Partnering Providers' Transformation Plans	Partnering Provider participates in Project ECHO or other e-consult / learning model, or enhances availability of specialty care via new implementation of telemedicine or e-consults **MEASUREMENT**: Attest to (yes/no) and describe or upload document describing: 1) Clinician or practice team participation in a Project ECHO program; **and/or** 2) New or expanded implementation of telemedicine; **and/or** 3) New or expanded implementation of e-consults consults **ACHIEVEMENT:** New or expanded implementation of any *one* of the three items above during the contract period meets the achievement threshold	☑ Primary care partners ☑ Behavioral health partners	1) Clarified the description of the achievement concept and provided additional notes and references 2) Clarified that both new and expanded implementation of e-consult or telemedicine models during the contract period will be viewed as achievement

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			Additional notes: ▪ Project ECHO[9] is a case-based tele-mentoring learning model that through videoconferencing connects practicing clinicians with specialist teams (e.g. psychiatrists, hepatologists, addictions medicine, dermatologists, etc.) Participation can enhance the capacity of primary care & behavioral health providers to treat complex illnesses, thereby improving patient access to care. A number of ECHO programs are offered through the University of Washington. ▪ Telemedicine consults typically involve a direct provider-to-patient relationship and encounter[10] ▪ E-Consults[11] are an asynchronous, consultative, provider-to-provider communication within a shared electronic health record (EHR) or web-based platform. E-consults are intended to improve access to specialty expertise for patients and providers without the need for a face-to-face visit.		
11	Identified PCP	▪ Having an identified PCP is a first step for coordination and integration of care between behavioral health and primary care under any model (Collaborative Care, Bree, etc.)	MEASUREMENT: Survey question - For what % of Medicaid clients/patients seen in the last 12 months do you have a primary care provider[12,13] identified in your records? Report numerator & denominator. ACHIEVEMENT: Partnering Provider has an identified PCP for at least 90% of patients who have had a visit in the last 12 months.	❑ Primary care partners ☑ Behavioral health partners	No substantive changes; some clarifying information added under additional notes.

[9] For more information, see: https://echo.unm.edu/

[10] For example, see this definition and description: https://www.medicaid.gov/medicaid/benefits/telemed/index.html

[11] For example, see this article: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4561452/pdf/10.1177_1357633X15582108.pdf

[12] For reference, this is the definition of PCP from Washington State 2018 model contracts for MCOs and FIMC: "PCP means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to Enrollees, initiating referrals for specialist care, and maintaining the continuity of Enrollee care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Naturopathic physicians, medical residents (under the supervision of a teaching physician), Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the Contractor." See: https://www.hca.wa.gov/assets/billers-and-providers/model_contract_ahmc.pdf or https://www.hca.wa.gov/assets/billers-and-providers/ipbh_fullyintegratedcare_medicaid.pdf.

[13] For reference, RCW 48.150.010 (8) defines primary care as "routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury."

Achievement concept		Rationale	Measurement & Achievement Definitions	Measure may be selected by …	Revisions from November 2018 draft
		• Aligns with MCO contract requirements of PCP assignment	Additional notes: • The goal of this measure is to ensure that Partnering Providers know / have a record of who their patients' primary care providers are. • The measure specifies that a PCP should be recorded for "patients seen in the last 12 months,' in order to make the expectation reasonable; in other words, BHT does not expect the Partnering Provider to have a PCP name on file for clients/patients that the Partnering Provider has not seen in over a year. • The measure is **not** attempting to measure frequency of primary care visits or PCP access. • The listed PCP should be an individual person, not a clinic or an MCO. • Some PCP and primary care definitions provided in footnotes are informational resources only and not intended as requirements		
12	Pregnancy intent	Connects to BHT's regional priority of reducing unintended pregnancies	Partnering Provider increases the proportion of women of reproductive age women screened for pregnancy intent. MEASUREMENT: Survey question - Proportion of women aged 15-44 (inclusive) at risk of unintended pregnancy with a visit in last 12 months who have a documented response to a pregnancy intention screening question that uses closed-ended response categories ACHIEVEMENT: • Reporting only in the first contract period. • Currently, BHT is not specifying the degree to which pregnancy intent screening should improve in the second contract period. BHT will work with partners to consider options for minimum improvement-over-self and/or threshold attainment in the future, after baseline data becomes available.	☑ Primary care partners ❑ Behavioral health partners	1) Specified 15-44 as the age range for this measure 2) Removed expectation for Partnering Providers to improve by 10% over their own past performance. Minimum improvement expectations will be set in the future based on consideration of baseline data.
13	Fluoride provision in primary care	Connects to BHT's regional priority of improving oral health	Partnering Provider increases the proportion of children under age 19 who receive fluoride varnish as prevention for dental caries. MEASUREMENT: Proportion of with a visit in the last 12 months who had topical fluoride varnish applied by a non-dental provider. Report numerator and denominator for two age groups: • 0 – 5 years	☑ Primary care partners ❑ Behavioral health partners	1) Split reporting into two age groups 2) Removed expectation for Partnering Providers to improve by 10% over their own past performance.

Achievement concept		Rationale	Measurement & Achievement Definitions	Measure may be selected by …	Revisions from November 2018 draft
			• 6 – 19 years ACHIEVEMENT: • Reporting only in the first contract period. • Currently, BHT is not specifying the degree to which provision of fluoride varnish in PC settings should improve in the second contract period. BHT will work with partners to consider options for minimum improvement-over-self and/or threshold attainment in the future, after baseline data becomes available. Additional notes: • See WA Medicaid Billing Guide for information on when HCA will cover fluoride varnish in a primary care setting[14]		Minimum improvement expectations will be set in the future based on consideration of baseline data. 3) Updated link to Medicaid Billing Guide under Additional Notes.
(14)	Future measure for HIT/HIE	Provider-to-provider information exchange will be critical for integration and ongoing transformation	For the second contact period, BHT intends to add a measure related to HIE to the Pay-for-Achievement menu		None – placeholder only.

[14] See Billing Guide dated October 16, 2018: https://www.hca.wa.gov/assets/billers-and-providers/physician-related-serv-bg-20181016.pdf pages 284-286.