

APPENDIX A – CCO Criteria Questionnaire

APPLICANT MUST RESPOND TO EACH ITEM IN THE QUESTIONNAIRE ADDRESSING THE HEALTH SERVICES TRANSFORMATION AND CCO CRITERIA REQUIREMENTS

This questionnaire consists of six sections, corresponding to the sections of Chapter 5 of the CCO Implementation Proposal:

- Section 1:** Governance and Organizational Relationships
- Section 2:** Member Engagement and Activation
- Section 3:** Delivery System: Access, Patient-Centered Primary Care Homes, Care Coordination and Provider Network Requirements
- Section 4:** Health Equity and Eliminating Health Disparities
- Section 5:** Payment Methodologies that Support the Triple Aim
- Section 6:** Health Information Technology
- Section 7:** Framework Scope of Work

For background and further information, see Chapter 5 of the CCO Implementation Proposal, “Coordinated Care Organization (CCO) Criteria.”

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response. Include reasons why your organization is able to effectively complete the CCO service delivery and program design requirements, and how this will be accomplished in time to meet the needs of CCO members on implementation.

While HB 3650 excludes Medicaid-funded long term care services and supports from being directly provided by CCOs, CCOs will still be responsible for providing physical and behavioral health services for individuals receiving Medicaid-funded Long Term Care, and will be responsible for coordinating with the Medicaid-funded LTC system. The requirements for coordinating with the Medicaid-funded LTC system are integrated throughout this section of the application.

1. Background Information about the Applicant

In narrative form, provide an answer to each of the following questions.

- a. Describe the Applicant’s legal entity status, and where domiciled.
- b. Describe Applicant’s Affiliates as relevant to the Contract.
- c. What is the Applicant’s intended effective date for serving Medicaid populations?
- d. Is the Applicant invoking Alternative Dispute Resolution with respect to any provider (*see* OAR 410-141-3005) If so, describe.
- e. Does the Applicant take exception to or desire to negotiate any terms and conditions in the sample contract, other than those mandated by Medicaid or Medicare? If so, set forth alternative language requested.
- f. What is the proposed service area/region by zip code?

- g.** What is the address for the Applicant's primary office and administration located within the proposed service area?
- h.** What counties or portions of counties are included in this service area? Describe the arrangements the Applicant has made to coordinate with county governments and establish written agreements as required by ORS 414.153.
- i.** What are the demographic estimates of the member populations for the region the Applicant proposes to serve, including race, ethnicity and language?
- j.** Prior history as a managed care organization with the OHA. Did this legal entity have a contract with the OHA as a managed care organization as of July 1, 2011 (hereinafter called "current MCO")? If so, what type of managed care organization?
- Fully capitated health plan
 - Physician care organization
 - Mental health organization
 - Dental care organization
- k.** Is this the identical organization with a current MCO contract, or has that entity been purchased, merged, acquired, or otherwise undergone any legal status change since July 1, 2011?
- l.** Does the Applicant include more than one current MCO (e.g., a combination of a current fully capitated health plan and mental health organization)? If so, provide the information requested in this section regarding each applicable current MCOs.
- m.** Does the current MCO make this application for the identical service area that is the subject of the current MCO's contract with OHA? Does this application propose any change in the current service areas?
- n.** Current experience as an OHA contractor, other than as a current MCO. Does this Applicant currently have a contract with the OHA as a Licensed Health Plan or health plan third party administrator for any of the following (hereinafter called "current OHA contractor")? If so, please provide that information in addition to the other information required in this section.
- Oregon Medical Insurance Pool
 - Healthy Kids Connect
 - Public Employees Benefit Board
 - Oregon Educators Benefit Board
 - Adult Mental Health Initiative
- o.** Does the Applicant have experience as a Medicare Advantage contractor? Does the Applicant have a current contract with Medicare as a Medicare Advantage contractor? What is the service area for the Medicare Advantage plan?
- p.** Does the Applicant hold a current certificate of insurance in the State of Oregon Department of Consumer and Business Services Insurance Division?
- q.** Applicants must describe their demonstrated experience and capacity for:

- (1) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes.
 - (2) Coordinating the delivery of physical health care, mental health and chemical dependency services, oral health care and covered long-term care services.
 - (3) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the entity's enrollees and in the entity's community.
- r. In order to organize and operate a CCO, will Applicant need to engage in activities (specifically, collaboration among public payers, private health carriers, third party purchasers and providers to identify appropriate service delivery systems and reimbursement methods to align incentives in support of integrated and coordinated health care delivery) for which it seeks state action immunity under state and federal antitrust laws? If yes, furnish a complete explanation, identifying additional documentation that OHA may request for further details.
- s. Is Applicant now, or does Applicant intend to form, a corporation:
- Whose purpose is to operate a CCO by contracting with Affiliates or other entities that hold the assets or provider contracts of the CCO, or
 - Whose solvency will be primarily assured by a guarantee from an Affiliate, or
 - Which is intended to insulate Affiliates from the financial risk or the regulation of the CCO, or
 - Which in any other manner depends upon Affiliate relationships in order to operate a CCO
- (a "Special Purpose Corporation")? If yes, furnish a detailed explanation, an assurance that the the operations and ownership of the Special Purpose Corporation will be transparent and open to inspection by OHA, and copies of all applicable guaranties, contracts, and other documents between the Applicant and its Affiliates. The explanation must include how the Special Purpose Corporation will be bankruptcy-remote. Applicant must be prepared to provide OHA with customary legal opinions on the Special Purpose Corporation, including a substantive non-consolidation opinion.]*
- [OHA is considering whether SPCs will be acceptable and invites comment on the issue.]**

2. Community Engagement in Development of Application

Applicant is encouraged to obtain community involvement in the development of the Application. The term "community" is defined in ORS 414.018 for this purpose:

"Community" means the groups within the geographic area served by a CCO and includes groups that identify themselves by age, ethnicity, race, economic status, or other defining characteristic that may impact delivery of health care services to the group, as well as the governing body of each county located wholly or partially within the CCO's service area.

- a. Describe the process used for engaging its community in the development of this Application.

Section 1 – Governance and Organizational Relationships

A.1.1. Governance

This section should describe the governing board, community advisory council, and how the governance model will support a sustainable and successful organization that can deliver the greatest possible health within available resources, where success is defined through the Triple Aim.

A.1.1.a. Applicant may provide a brief description of your organization and all the strengths you consider are an asset to your program.

A.1.2. Governing Board

A.1.2.a. Describe the individuals who serve on the governing board of the CCO, specifying:

- Persons who share in the financial risk of the organization who must constitute a majority of the governance structure;
- Persons who represent the major components of the health care delivery system;
- At least two health care providers in active practice, including:
 - A physician licensed under ORS chapter 677 or a nurse practitioner certified under ORS 678.375, whose area of practice is primary care; and
 - A mental health or chemical dependency treatment provider;
- At least two members from the community at large; and
- At least one member of the community advisory council.

A.1.2.b. Provide a description of the relationship of the governing board with the community advisory council.

A.1.3. Community Advisory Council (CAC)

CCOs are also required to have a community advisory council to assure that the health care needs of the consumers and community are being addressed.

A.1.3.a. Describe the individuals who serve on the community advisory council (CAC), specifying:

- Persons who represent the community, including consumer representatives; and
- Persons who represent each county government served by the CCO;

A.1.3.b. Identify the membership of the committee that selected the community advisory council, specifying:

- Members who were county representatives from each county served by the CCO and
- Members of the governing body of the CCO.

A.1.3.c. Describe how the CCO governance structure will reflect the needs of members receiving Medicaid-funded LTC services and supports through representation on the governing board or community advisory council.

A.1.4. Clinical Advisory Panel

An Applicant is encouraged but not required to establish a Clinical Advisory Panel (CAP) as a means of assuring best clinical practices across the CCO's entire network of providers and facilities.

A.1.4.a. If a CAP is established, describe the role of the CAP and its relationship to the CCO governance and organizational structure.

A.1.4.b. If a CAP is not established, the Applicant should describe how its governance and organizational structure will achieve best clinical practices consistently adopted across the CCO's entire network of providers and facilities.

A.1.5. Leadership Personnel

The purpose of this section is to ensure that qualified staff is available to ensure successful implementation and sustainable operation of the CCO in meeting the policy objectives of Health Systems Transformation.

A.1.5.a. Identify and furnish résumés for the following key leadership personnel (by whatever titles designated):

- Chief Executive Officer
- Chief Financial Officer
- Chief Medical Officer
- Chief Information Officer
- Chief Administrative or Operations Officer

A.1.5.b. Attest that the CCO has an individual accountable for each of the following operational functions:

- Contract administration
- Outcomes and evaluation
- Performance measurement
- Health management and care coordination activities
- System coordination and shared accountability between Medicaid Funded LTC system and CCO
- Mental health and addictions coordination and system management
- Communications management to providers and members
- Provider relations and network management, including credentialing
- Health information technology and medical records
- Privacy officer
- Compliance officer

A.1.5.c. Provide an organizational chart showing the relationships of the various departments.

A.1.6. Agreements with Type B Area Agencies on Aging and DHS local offices for Aging and People with Disabilities (APD)

While Medicaid-funded long term care services are legislatively excluded in HB 3650 from CCO responsibility, and will be paid for directly by the Department of Human Services, CCOs will still be responsible for providing physical and behavioral health services for individuals receiving Medicaid funded LTC services, and will be responsible for coordinating with the LTC system. To implement and formalize coordination and ensure relationships exist between CCOs and the local LTC providers, CCOs will be required to work with the local type B AAA or DHS' Aging and People with Disabilities (APD) local office to develop a Memorandum of Understanding (MOU) or contract, detailing their system coordination agreements regarding members receiving Medicaid-funded LTC services.

A.1.6.a. Describe the Applicant's current status in obtaining MOU(s) with Type B AAAs or DHS local APD office.

A.1.6.b. If MOUs have not been executed, describe the Applicant's good faith efforts to do so and how the Applicant will obtain the MOU.

A.1.7. Social and support services in the service area

A.1.7.a. Describe how the Applicant has established and will maintain relationships with social and support services in the service area, such as:

- DHS Children's Adults and Families field offices in the service area
- Oregon Youth Authority (OYA) and Juvenile Departments in the service area
- Department of Corrections and local community corrections and law enforcement, local court system, problem solving courts (drug courts/mental health courts) in the service area
- School districts, education service districts that may be involved with students having special needs, and higher education in the service area
- Developmental disabilities programs
- Tribes and services provided for the benefit of Native Americans and Alaska Natives
- Housing
- Culturally-specific health care, behavioral health and social services providers
- Faith-based organizations
- Community-based family and peer support organization
- Other social and support services important to communities served

A.1.8. Community Needs Assessment and Community Health Improvement Plan

This section should detail the Applicant's annual community needs assessment process, including conducting the assessment and development of the resultant Community Health Improvement Plan. Applicant should describe how they will use the plan to inform the model of care and to realize health system transformation triple aim goals. Applicants should include information on approaches to coordinate care across the spectrum of services, as well as to encourage prevention and health promotion to create healthier communities.

The Applicant is required to work with the OHA, including the Office of Equity and Inclusion, to identify the components of the community needs assessment. Applicant is encouraged to partner with their local public health authority, hospital system, type B AAA, APD field office, community mental health authority, multi-cultural health and social services providers, culturally-diverse community based

organizations and service providers and other community partners to develop a shared community needs assessment that includes a focus on health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography or other factors in their service area.

The Public Health Institute's "Advancing the State of the Art in Community Benefit" offers a set of principles that provide guidance for this work:

- Emphasis on disproportionate unmet, health-related need
- Emphasis on primary prevention
- Building a seamless continuum of care
- Building community capacity
- Emphasis on collaborative governance of community benefit

The community health assessment is expected to be analyzed in accordance with OHA's race, ethnicity and language data policy.

CCOs are not expected to generate new data during their first year of operation and are encouraged to draw on existing resources. The OHA has assembled relevant resources used in current community health assessments performed by local public health agencies, mental health agencies, hospitals, etc., to be found at the following web site: TBD. Additionally, CCOs are expected to collaborate with community partners to provide additional relevant perspectives and information to help identify health disparities in the CCO's service area. The Office of Equity and Inclusion and other agencies in OHA will assist CCOs in:

- identifying and analyzing available data,
- developing a preliminary identification of health disparities,
- developing plans for gathering additional information and performing analyses on identifying more accurately and completely the significant health disparities in the CCOs service area, and
- developing a community health improvement plan for the first year's operation, to be amended based on further information gathered and analyzed in subsequent years.

The CCO's initial community health assessment methodology and approach should describe assessments currently in process and describe the model(s) being used, including data sources, and address:

- Preliminary findings from any preliminary assessment that impact the description of the care model used in this Application
- Mechanisms by which representatives of critical populations and community stakeholders will be meaningfully and systematically engaged in future health assessments
- How targets for community-level prevention will be set and how achievement will be measured, as well as mechanisms by which the Applicant will adjust its models of care to improve physical and mental health outcomes, and reduce health disparities.

In order to avoid duplication the community needs assessment should build upon, coordinate with or take the place of the community health assessments required of community mental/behavioral health, community public health and hospital system community benefit reporting. Resources: Internal Revenue Code for community needs assessments conducted by hospitals (see Internal Revenue Bulletin 2011- 52) and follows the community health assessment best practices recommended by the U.S. Centers for Disease Control and Prevention and required by the National Public Health Accreditation Board.

A.1.8.a. The Applicant should describe:

- Applicant's community needs assessment process that addresses the requirements noted above
- How in its first year of operation the CCO plans to use existing assessments and whether it has initiated or conducted a preliminary community health assessment or otherwise analyzed population health, mental health, and healthcare utilization data relevant to the service area
- Whether it has initiated or conducted a preliminary community needs assessment, and if so, any findings. If a community health improvement plan has been developed, please include.
- Mechanisms by which the CAC will meaningfully and systematically engage diverse populations as well as individuals receiving Medicaid-funded LTSS, in the community needs assessment process.

A.1.8.b. If a community needs assessment or the community health improvement plan is not available to support the Applicant's model of care used in this Application, describe what the Applicant's plan and time lines to conduct the community needs assessment and health improvement plan.

A.1.8.c. Describe the Applicant's strategy to update, on an ongoing basis, the community needs assessment and the resulting community health improvement plan to reflect changes in diverse communities and the changing needs of the community's health needs.

Section 2 – Member Engagement and Activation

A.2.1. Member and Family Partnerships

Members should be actively engaged partners in the design and implementation of their treatment and care plans through ongoing consultations regarding preferences cultural preferences and goals for health maintenance and improvement. Member choices should be reflected in the selection of their providers and in the development of treatment plans ensuring member dignity and culture will be respected.

A.2.1.a. Describe the ways in which members (and their families and support networks, where appropriate) are meaningfully engaged as partners in the care they receive as well as in organizational quality improvement activities.

A.2.1.b. The Applicant should articulate and demonstrate how it will:

- Encourage members to be active partners in their health care, understanding to the greatest extent feasible how the approach to activation accounts for the social determinants of health
- Engage members in culturally and linguistically appropriate ways
- Educate members on how to navigate the coordinated care approach and ensure access to advocates including peer wellness and other non-traditional healthcare worker resources
- Encourage members to use effective wellness and prevention resources and to make healthy lifestyle choices in a manner that is culturally and linguistically appropriate
- Provide plain language narrative that informs patients about what they should expect from the CCO with regard to their rights and responsibilities
- Meaningfully engage the community advisory council to monitor and measure patient engagement and activation

Section 3 - Delivery System: Access, Patient-Centered Primary Care Homes, Care Coordination and Provider Network Requirements

Transformation relies on ensuring that CCO members have access to high quality care: “right care, right place, right time”. This will be accomplished by the CCO through a provider network capable of meeting health systems transformation objectives. The Applicant is transforming the health and health care delivery system in its service area and communities – taking into consideration the information developed in the community needs assessment – by building relationships that develop and strengthen network and provider participation, and community linkages with the provider network.

A.3.1. Patient-Centered Primary Care Homes

Integral to transformation is the patient-centered primary care home (PCPCH), as currently defined by Oregon’s statewide standards. These standards advance the Triple Aim goals of better health, better care, lower costs by focusing on effective wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient’s physical and behavioral health care needs.

A.3.1.a. Demonstrate how the Applicant will use PCPCH capacity to achieve the goals of health system transformation, including:

- How the Applicant will partner with and/or implement a network of PCPCHs as defined by Oregon’s standards to the maximum extent feasible, as required by ORS 414.655, including but not limited to the following:
 - Assurances that the Applicant will enroll a significant percentage of members in PCPCHs certified as Tier 1 or higher according to Oregon’s standards; and
 - A concrete plan for increasing the number of enrollees that will be served by certified PCPCHs over the first five years of operation, including targets and benchmarks
 - A concrete plan for Tier 1 PCPCHs to move toward Tier 2 and 3 of the Oregon standard over the first five years of operation, including targets and benchmarks
- How the Applicant will require its other contracting health and services providers to communicate and coordinate with the PCPCH in a timely manner for comprehensive care management

A.3.1.b. Describe how the Applicant will engage their members to be fully informed partners in transitioning to this model of care.

A.3.1.c. Describe how the Applicant’s PCPCH delivery system will coordinate PCPCH providers and services with Medicaid-funded long term care providers and services.

A.3.1.d. Describe how the Applicant will encourage the use of federally qualified health centers, rural health clinics, migrant health clinics, school-based health clinics and other safety net providers that qualify as patient centered primary care homes.

A.3.2. Other models of patient-centered primary health care

A.3.2.a. If the Applicant proposes to use other models of patient-centered primary health care in addition to the use of PCPCH, describe how the Applicant will assure member access to

coordinated care services that provides effective wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical and behavioral health care needs.

- A.3.2.b.** Describe how the Applicant's use of this model will achieve the goals of health care transformation.
- A.3.2.c.** Describe how the Applicant will require its other contracting health and services providers to communicate and coordinate with these patient-centered primary health care providers in a timely manner for comprehensive care management
- A.3.2.d.** Describe how the Applicant will engage their members to be fully informed partners in transitioning to this model of care.
- A.3.2.e.** Describe how the Applicant's patient centered primary health care delivery system will coordinate with PCPCH providers and services with Medicaid-funded long term care providers and services.

A.3.3. Access

Applicant's network of providers will be adequate to serve members' health care and service needs, meet access to care standards, and allow for appropriate choice for members.

- A.3.3.a.** Describe the actions the Applicant has taken to assure that coordinated care services are geographically located in settings that are as close to where members reside as possible and are, if available, offered in non-traditional settings and are accessible to families, diverse communities, and underserved populations.
- A.3.3.b.** Describe actions the Applicant will take to provide access to and inform members about how to receive assistance from non-traditional health care workers, including community health workers, personal health navigators and certified and qualified interpreters in providing culturally appropriate and whole-person care.
- A.3.3.c.** Describe agreements and arrangements by the Applicant with long term care providers in the service area.
- A.3.3.d.** Describe any formal contractual relationship with any dental care organization that serves members in the proposed service area.

A.3.4. Provider Network Development and Contracts

- A.3.4.a.** Describe how the Applicant will build on existing provider networks that deliver coordinated care and a team-based approach
- A.3.4.b.** Describe how the Applicant's provider agreements and operating policies and procedures address and support the Applicant's transformation goals and model of care,

- A.3.4.c.** Describe how the Applicant will provide support to both PCPCHs and other providers related to technical assistance, tools for care coordination, management of provider concerns, relevant member data and other supports.

A.3.5. Coordination, Transition and Care Management

Care Coordination: Applicants will describe:

- A.3.5.a.** How the Applicant will support the flow of information between providers, including Medicaid-funded LTC care providers, in order avoid duplication of services, medication errors and missed opportunities to provide effective preventive and primary care.
- A.3.5.b.** Describe how the Applicant will work with its providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including crisis management services, and community prevention and self-management programs.
- A.3.5.c.** Describe how the Applicant will develop a tool for provider use to assist in the culturally and linguistically appropriate education of members about care coordination, and the responsibilities of both providers and members in assuring effective communication.
- A.3.5.d.** Describe how the Applicant will work with providers to implement uniform methods of identifying members with multiple diagnoses and who are served with multiple healthcare and service systems. Describe how Applicant will implement an intensive care coordination and planning model in collaboration with member's primary care health home that effectively coordinates services and supports for the complex needs of these members.
- A.3.5.e.** Describe the Applicant's plan for utilizing non-traditional health workers in the coordination of care for its members.
- A.3.5.f.** Describe how the Applicant will meet state goals and expectations for coordination of care for member receiving Medicaid-funded LTC services, given the exclusion of Medicaid funded long term care services from global budgets.
- A.3.5.g.** Describe the evidence-based or innovative strategies the Applicant will use within their delivery system network to ensure coordinated care, especially for members with intensive care coordination needs, and those experiencing health disparities.

Assignment of responsibility and accountability: The Applicant must demonstrate that each member has a primary care provider or primary care team that is responsible for coordination of care and transitions.

- A.3.5.h.** Describe the Applicant's standards that ensure access to care and systems in place to engage members with appropriate levels of care and services beginning not later than 30 days after enrollment with the CCO.
- A.3.5.i.** Describe how the Applicant will provide access to primary care to conduct culturally and linguistically appropriate health screenings for members to assess individual care needs or to determine if a higher level of care is needed.

Comprehensive transitional care: The Applicant must ensure that members receive comprehensive transitional care so that members' experience of care and outcomes are improved. Care coordination and transitional care should be culturally and linguistically appropriate to the member's need.

- A.3.5.j.** Describe the Applicant’s plan to address appropriate transitional care for members facing admission or discharge from hospital, hospice or other palliative care, home health care, adult foster care, skilled nursing care, residential or outpatient treatment for mental health or chemical dependency or other care settings. This includes transitional services and supports for children, adolescents and adults with serious behavioral health conditions facing admissions or discharge from residential treatment settings.
- A.3.5.k.** Describe the applicant’s plan to coordinate and communicate with Type B AAA or APD to incent and monitor improved transitions of care for members receiving Medicaid-funded LTC services and supports, so that these members receive comprehensive transitional care.
- A.3.5.l.** Describe the Applicant’s plan to develop an effective mechanism to track member transitions from one care setting to another, including engagement of the member and family members in care management and treatment planning.

Individual care plans: As required by ORS 414.625, the Applicant will use individualized care plans to address the supportive and therapeutic needs of members with intensive care coordination needs. Care plans will reflect member or family/caregiver preferences and goals to ensure engagement and satisfaction.

- A.3.5.m.** Describe the Applicant’s standards and procedures that ensure the development of individualized care plans, including any priorities that will be followed in establishing such plans for those with intensive care coordination needs.
- A.3.5.n.** Describe the Applicant’s universal screening process that assesses individuals for critical risk factors that trigger intensive care coordination for high needs members, including those receiving Medicaid funded LTC services.
- A.3.5.o.** Describe how the Applicant will factor in relevant referral, risk assessment and screening information from local type B AAA and APD offices and Medicaid-funded LTC providers; and how they will communicate and coordinate with type B AAA and APD offices
- A.3.5.p.** Describe how the Applicant will reassess high-needs CCO members at least annually to determine whether their care plans are effectively meeting their needs in a person-centered, person-directed manner.
- A.3.5.q.** Describe how individualized care plans will be jointly shared and coordinated with relevant staff from type B AAA and APD with and Medicaid-funded LTC providers

Communication:

- A.3.5.r.** Demonstrate that providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with members and their families or caregivers and to facilitate information exchange between other providers and facilities (e.g, addressing issues of health literacy, language interpretation, having EHR capabilities, etc.)

A.3.6. Care Integration

Mental Health and Chemical Dependency Services and Supports

- A.3.6.a.** Describe how the Applicant has a sufficient provider network, including providers from culturally, linguistically and socially diverse backgrounds for members needing access to mental health and chemical dependency treatment and recovery management services. This includes members in all age groups, from all cultural and social backgrounds and different levels of symptom and condition severity.
- A.3.6.b.** Describe how the Applicant will provide care, treatment engagement and follow-up services for members with serious mental health and chemical dependency conditions requiring medication-assisted therapies, residential and hospital levels of care. This includes members who may not be motivated to seek these services even when it would be in their best health interest to do so and members with limited social support systems.
- A.3.6.c.** Describe how the Applicant has integrated care and service delivery to address mental health and chemical dependency issues by proactively identifying members with them, arranging and facilitating the provision of care, and coordinating care with related health services including Medicaid-funded long term care services and other health services not funded by the Applicant. This includes members from all cultural, linguistic and social backgrounds at different ages and developmental stages.
- A.3.6.d.** Describe how the Applicant has organized a system of services and supports for mental health and chemical dependency services, including integration of primary care across systems, including partnering with culturally diverse community based organizations.

Oral Health

No later than July 1, 2014, ORS 414.625 requires each CCO to have a formal contractual relationship with any dental care organization that serves members of the CCO in the area where they reside.

- A.3.6.e.** Describe the Applicants plan for developing a contractual arrangement with any DCO that serves members in the area where they reside by July 1, 2014. Identify major elements of this plan, including target dates and benchmarks.
- A.3.6.f.** Describe the Applicant's plan for coordinating care for member dental needs, including facilitating appropriate referrals to dental care and for medical care of chronic disease issues related to oral health.

Hospital and Specialty Services

Adequate, timely and appropriate access to hospital and specialty services will be required. Hospital and specialty service agreements should be established that include the role of patient-centered primary care homes.

- A.3.6.g.** Describe how the Applicant's agreements with its hospital and specialty care providers will address:
- Coordination with a member's patient-centered primary care home or primary care provider
 - Processes for PCPCH or primary care provider to refer for hospital admission or specialty services and coordination of care..

- Performance expectations for communication and medical records sharing for hospital and specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments
- A plan for achieving successful transitions of care for CCO members, with the PCPCH or primary care provider and the member in central treatment planning roles.

A.3.7. Medicaid-funded Long Term Care Services

CCOs will be responsible for the provision of coordinated care services to members receiving Medicaid funded LTC services. Medicaid funded Long Term Care Services include, but are not limited to, in-home supports/services, Adult Foster Care, Residential Care Facilities, Assisted Living Facilities, LTC nursing facility state plan, State Plan Personal Care for APD, Adult Day Services, Contract Nursing Program, administrative examinations and reports, non-medical transportation (except in some regions where contracted to transportation brokerages) and PACE state plan (including Medicare benefits).

A.3.7.a. Describe how the Applicant

- Will effectively provide coordinated care services to members receiving Medicaid-funded LTC services whether served in their own home, community-based care or nursing facility and coordinate with the Applicant’s Medicaid-funded LTC delivery system in its service area, including the role of type B AAA or the APD office;
- Will use best practices applicable to individuals in LTC settings including best practices related to care coordination and transitions of care;
- Will use any of the following models for better coordinating care between the medical and LTC systems, or describe any alternative models for coordination of care?
 - Co-Location: co-location of staff such as type B AAA and APD case managers in medical settings or co-locating behavioral health specialists in medical or care settings where members live or spend time,
 - Team approaches: care coordination positions jointly funded by the LTC and medical systems, or team approaches such as a multi-disciplinary care team including LTC representation,
 - Services in Congregate Settings: Includes a range of LTC and medical services provided in congregate settings.. Services can be limited to one type of services such as “in home” personal care services provided in an apartment complex or can be a comprehensive model such as the Program of All-Inclusive Care for the Elderly (PACE).
 - Clinician/Home-Based Programs: These include increased use of Nurse Practitioners, Physician Assistants, or Registered Nurses who perform assessments, plan treatments, and provide interventions to the person in their home, community-based or nursing facility setting.

A.3.8. Utilization management

A.3.8.a. In the context of achieving the Applicant’s strategy for implementing health system transformation, describe how the utilization management system assures that coordinated care services address member needs, in consideration of individual care plans where appropriate, including safeguards against underutilization or inappropriate denial of covered services.

A.3.9. Learning Collaborative

Attest that the Applicant will participate in the learning collaboratives required by ORS 442.210.

Section 4 - Health Equity and Eliminating Health Disparities

Health equity and identifying and addressing health disparities are an essential component of health systems transformation. Health Equity is the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing efforts to eliminate health disparities.

- A.4.1.** Coordinated Care Organizations and their providers are encouraged to work together to develop best practices of culturally appropriate care and service delivery to reduce health disparities and improve health and well-being of members. If applicable, describe how the Applicant and its providers will achieve this objective.
- A.4.2.** Applicant will attest to collect maintain and analyze race, ethnicity, and primary language data for all members on an ongoing basis in accordance with standards jointly established by OHA and Oregon's Department of Human Services in order to identify and track the elimination of health inequities. (Attach Standards)
- A.4.3.** Describe how the Applicant and its culturally diverse community based partners will track and report on quality measures by these demographic factors.
- A.4.4.** Describe how the Applicant and its culturally diverse community based partners will develop, implement, and evaluate strategies to improve health equity among members as part of its long-range planning.

Section 5 - Payment Methodologies that Support the Triple Aim

- A.5.1.** Describe how the Applicant will move from a predominantly fee-for-service system to alternative payment methods that base reimbursement on the quality rather than quantity of services provided, promote patient-centered care and continually improve member and community health outcomes over time.
- A.5.2.** Demonstrate how Applicant's payment methodologies promote or will promote the following principles:
- Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;
 - Hold organizations and providers accountable for the efficient delivery of quality care;
 - Reward good performance;
 - Limit increases in medical costs;
 - Promote primary prevention, early identification and intervention of risk factors and health conditions that lead to chronic illnesses and complications and discourage care that doesn't improve health;
 - Provide comprehensive coordination or create shared responsibility across provider types and levels of care and creates incentives for using such delivery systems such as patient-centered primary care homes;
 - Provide financial support, differentially based on the tier level achieved, to patient-centered primary care homes for meeting the PCPCH standards;
 - Utilize evidence-based practices and health information technology to improve patient and community health and health care and health equity; and
 - Include the member, the providers, and the CCO itself in the alignment of incentives to promote improved outcomes, elimination of health inequities and increased efficiency.
- A.5.3.** Describe how the Applicant will rely on previously developed and tested payment approaches where available.
- A.5.4.** Describe how the Applicant will create and align incentives for evidence-based and best practices to increase health care quality and patient safety and to result in more efficient use of health care services.
- A.5.5.** To ensure successful transition to new payment methods, describe how the Applicant will build network capacity and help restructure systems and workflows to be able to respond effectively to new payment incentives.

Section 6 - Health Information Technology

A.6.1. Electronic Health Record Systems (EHRs)

- A.6.1.a.** What is the estimated current EHR adoption rate in Applicant's service area, divided by provider type (and possibly by geographic region) within the service area (including certified and non-certified EHRs)?
- A.6.1.b.** What are the Applicant's strategies to increase adoption rates of certified EHRs? Specifically, how will Applicant:
- Track EHR adoption rates; rates may be divided by provider type and/or geographic region.
 - Develop and implement strategies to increase adoption rates of certified EHRs.

A.6.2. Health Information Exchange (HIE)

- A.6.2.a.** Describe how the Applicant will facilitate HIE in a way that will allow all providers within the CCO network to exchange a patient's health information electronically with any other provider in the network.
- A.6.2.b.** Describe what the Applicant's plan is to ensure that every provider in its network either:
- Is registered with a statewide or local Direct-enabled Health Information Services Provider (registration will ensure the proper identification of participants and secure routing of health care messages and appropriate access to the information); or
 - Is a member of an existing Health Information Organization (HIO) with the ability for providers any EHR system (or with no EHR system) to be able to share electronic information with any other provider within the CCO network.
- A.6.2.c.** Describe how the Applicant will establish minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.

A.6.3. Additional Health Information Technology (HIT)

- A.6.3.a.** Describe how the Applicant will leverage HIT tools (beyond EHRs & HIE) to transform from a volume-based to a value-based delivery system.
- A.6.3.b.** Identify Applicant's current capacity in the following areas:
- Data Analytics (to assess provider performance, effectiveness and cost-efficiency of treatment, etc.)
 - Quality Reporting (to facilitate quality improvement within the CCO as well as to report the data on quality of care that will allow the OHA to monitor the performance of the CCO)
 - Patient Engagement through HIT (using existing tools such as e-mail, personal health records, etc.)
 - Other HIT (telehealth, mobile devices, etc.)
 - Health record/information exchange, in key areas (e.g. care coordination and transitions) with the Medicaid-funded LTC system

A.6.3.c. Describe how the Applicant will develop and implement a plan for improvement (including goals/milestones, etc.) in these areas.

DRAFT

Section 7 - Proposed Scope of Work

Applicant is invited and encouraged to submit a proposed scope of work to address the part of the Contract governing the health services transformation strategies and model of care described within the scope of this questionnaire. Exhibit A to this questionnaire offers a Framework Scope of Work containing provisions that Applicant may, but is not required to, include in its proposed scope of work. Please see RFA Section 3.2 for further information about Applicant's proposed scope of work.

Exhibit A: Framework Scope of Work

General Overview of Health Transformation

In 2011 the Oregon Legislature and Governor John Kitzhaber created CCO's in House Bill 3650 (2011), aimed at achieving the Triple Aim of improving health, improving health care and lowering costs by transforming the delivery of health care. The legislation builds on the work of the Oregon Health Policy Board since 2009. Essential elements of that transformation are:

- Integration and coordination of benefits and services;
- Local accountability for health and resource allocation;
- Standards for safe and effective care, including culturally and linguistically competent care; and
- A global Medicaid budget tied to a sustainable rate of growth.

The CCO Implementation Proposal of the Oregon Health Policy Board dated January 24, 2012, explained that CCOs are community-based organizations governed by a partnership among providers of care, socially and culturally diverse community members and those taking financial risk. A CCO will have a single global Medicaid budget that grows at a fixed rate, and will be responsible for the integration and coordination of physical, mental, behavioral and dental health care for people eligible for Medicaid or dually eligible for both Medicaid and Medicare. CCOs will be the single point of accountability for the health quality and equitable outcomes for the Medicaid population they serve. They will also be given the financial flexibility within available resources to achieve the greatest possible outcomes for their membership.

Certified as a CCO, Contractor acts as an agent of health system transformation as called for by HB 3650 (2011) and SB 1580 (2012) and applicable administrative rules. At a general level, this Work will include providing a single benefit package that includes physical, oral and mental health services covered under Medicaid and Medicare benefits, to Members including Medicaid, CHIP, and Medicaid/Medicare Dual Eligible, managed within a fixed global budget. The policy objectives of OHA Health Systems Transformation and Contractor's Work will help to achieve the triple aims of health reform: a healthy population, extraordinary patient care and reasonable costs. These objectives include:

- Ensuring access to an appropriate delivery system network centered on patient-centered primary care homes;
- Ensuring member rights and responsibilities;
- Working to eliminate health disparities among their member populations and communities;
- Using alternative provider payment methodologies to reimburse on the basis of outcomes and quality;
- Developing a health information technology (HIT) infrastructure and participating in health information exchange (HIE);
- Ensuring transparency, reporting quality data, and;
- Assuring financial solvency.

Part 1 – Governance and Organizational Relationships

1. Governing Board and Governance Structure

Contractor establishes, maintains and operates with a governance structure complies with the requirements of ORS 414.625(1)(o).

2. Community Advisory Council (CAC)

a. Contractor shall establish a Community Advisory Council (CAC). The CAC must:

- (1)** Include representatives of the community and of each county government served by the Contractor, but consumer representatives must make up the majority of membership
- (2)** Meet no less frequently than once every three months; and
- (3)** Have its membership selected by a committee composed of equal numbers of county representatives from each county served by the Contractor and members of the governing body of the Contractor.

b. The duties of the CAC include, but are not limited to:

- (1)** Identifying and advocating for preventive care practices to be utilized by the Contractor;
- (2)** Overseeing a community health assessment and adopting a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by the Contractor; and
- (3)** Annually publishing a report on the progress of the community health improvement plan.

3. Clinical Advisory Panel

Contractor establishes an approach within its governance structure to assure best clinical practices. This approach will be subject to OHA approval, and may include a clinical advisory panel. If Contractor convenes a clinical advisory panel, this group should have representation on the governing board. The clinical advisory panel shall have representation from behavioral health and physical health systems and member representation.

4. Community Needs Assessment

Contractor's CAC partners with the local public health authority, local mental health authority, community based organizations and hospital system to develop a shared community needs assessment and adopts a community health improvement plan to serve a strategic population health and health care system service plan for the community served by Contractor. Community needs assessment will include a focus on health disparities experienced by various dimensions of the community, including but not limited to racial and ethnic disparities in the Community. The needs assessment is transparent and public in both process and result.

The Community Needs Assessment adopted by the CAC should describe the scope of the activities, services and responsibilities that the Contractor will consider upon implementation of the plan. The activities, services and responsibilities defined in the plan may include, but are not limited to:

- a. Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;
- b. Health policy;
- c. System design;
- d. Outcome and quality improvements;
- e. Integration of service delivery; and
- f. Workforce development

Through its Community needs assessment, Contractor identifies health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography, occupation or other factors in its service areas. Contractor and Contractor's CAC will work with OHA Office of Equity and Inclusion to develop meaningful baseline data on health disparities.

5. Community Health Improvement Plan

The Contractor, through its CAC, develops and implements a community health improvement plan. The community health improvement plan should describe the scope of the activities, services and responsibilities that the Contractor will consider upon implementation of the plan. The activities, services and responsibilities defined in the plan may include, but are not limited to:

- a. Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;
- b. Health policy;
- c. System design;
- d. Outcome and quality improvement;
- e. Integration of service delivery; and
- f. Workforce development.

Part 2 – Health Equity and Eliminating Health Disparities

Health equity means reaching the highest possible level of health for all people. Historically, health inequities result from health, economic, and social policies that have disadvantaged communities. These systemic shortcomings result in tragic health consequences for vulnerable populations and increased health care costs to the entire system, costs which are borne by taxpayers, employers, workers, and the uninsured. CCO must implement its proposal approved during certification demonstrating how it will work toward the goal of

ensuring that everyone is valued and health improvement strategies are tailored to meet the individual needs of all members, with the ultimate goal of eliminating health disparities.

This annual assessment will include an action plan, the components of which will be developed by the OHA Office of Equity and Inclusion, based on current and emerging best practices for eliminating health disparities, in order of priority, to improve the health of diverse communities in its service area. An annual report of activities, progress towards goal of eliminating health disparities, and accomplishments will be required.

Contractor must collect and maintain race, ethnicity, and primary language data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS. Contractor shall track and report on any quality performance improvements and outcome measures by these demographic factors and will be expected to develop, implement, and evaluate strategies to improve health equity among members.

Contractor will be expected to partner with local public health and culturally, linguistically and professionally diverse community partners to address the causes of health disparities, many of which originate outside of the clinical environment, including chronic stress, access to fresh and affordable produce, educational and economic attainment, safe work places, and healthy and affordable housing and healthy indoor and outdoor environments.

Part 3 – Payment Methodologies that support the Triple Aim

To achieve improvements in quality and efficiency in the delivery system, it will be necessary for CCOs to move from a traditionally fee-for-service payment system to alternative methods that link payment to desired outcomes, promote patient-centered care, and compensate providers for prevention, care coordination, and other activities necessary for keeping people healthy. These methods should include transparent measurement of outcomes aligned with the Triple Aim and be guided by the principles outlined by the OHPB Incentives and Outcomes Committee in 2010:

- *Equity* - Payment for health care should provide incentives for delivering evidence-based culturally and linguistically appropriate care (or emerging best practices) to all people;
- *Accountability* - Payment for health care should create incentives for providers and health plans to deliver health care and supportive services necessary to reach Oregon's Triple Aim goals;
- *Simplicity* - Payment for health care should be as simple and standardized as possible to reduce administrative costs, increase clarity and lower the potential for fraud and abuse;
- *Transparency* - Payment for health care should allow consumers, providers and purchasers to understand the incentives created by the payment method, the price of treatment options and the variations in price and quality of care across providers; and
- *Affordability (Cost Containment)* - Payment for health care should create incentives for providers and consumers to work together to control the growth of health care costs by encouraging prevention and wellness, discouraging care that does not improve health, and rewarding efficiency and the elimination of health disparities.

CCO must implement its proposal approved during certification demonstrating how it will use alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for their members. Examples include but are not limited to:

- Per-member per-month or other payments designed to support Patient-Centered Primary Care Homes, recognizing the tier level achieved;
- Bundled payments (case rates, fee-for-service rates with risk sharing, or other) for acute episodes, or for episodes of chronic care defined by a calendar period;

- Incentives for service agreements between specialty and primary care physicians;
- Gain-sharing arrangements with providers, if volume is sufficient;
- Quality bonuses or other payment incentives for performance improvement on Triple Aim-focused quality, efficiency, and outcomes metrics; and
- Incentives for the use of evidence-based and emerging best practices and health information technology.

1. **Phased-In Approach**

The schedule by which Contractor shall implement alternative payment methodologies shall be defined by Contractor's proposal approved during certification. Payments to Patient-Centered Primary Care Homes for individuals with chronic conditions as defined in section 5c shall be implemented immediately.

2. **Additional Statutory Requirements**

Contractor's payment methodologies comply with additional requirements established in law in conjunction with those requirements under Health Systems Transformation that encourage efficiency and the elimination of care defects and waste, including:

- a. Contractor pays hospitals other than Type A and B rural hospitals using Medicare-like payment methodologies that pay for bundles of care rather than paying a percentage of charges (SB 204); and
- b. Contractor may not pay any provider for services rendered in a facility if the condition is a health care acquired condition for which Medicare would not pay the facility.
- c. In addition to the base CCO Payment rate paid to Contractor, OHA will pay a hospital reimbursement adjustment to the CCO Payment rate to Contractor in accordance with the CCO Payments calculation reflected in the rate schedule in Appendix G, Exhibit C, Attachment 2. Contractor distributes such hospital reimbursement adjustment amounts to eligible hospitals located in Oregon that receive Medicare reimbursement based upon diagnostic related groups, in accordance with requirements established by OHA.
- d. Contractor or its Subcontractors are responsible for appropriate management of all federal and state tax obligations applicable to compensation or payments paid to Subcontractors under this Contract.

Part 4 – Health Information Systems

3. **Electronic Health Information**

OHPB requested that the Health Information Technology Oversight Council (HITOC) provide advice on appropriate health information technology (HIT) certification criteria for CCOs. In order to ensure that coordinated care delivery is enabled through the availability of electronic information to all participants, HITOC suggests that CCOs will need to develop the HIT capabilities described below. CCOs will span different provider types across the continuum of care and different geographic regions across the state, each of which is at different stages of HIT adoption and maturity. The proposed approach for achieving advanced HIT capability is to meet providers and communities where they are and require improvement over time.

Contractor must implement its proposal approved during certification demonstrating how it will ultimately achieve minimum standards in foundational areas of HIT use (electronic health records, health information exchange) and to develop its own goals for transformational areas of HIT use (analytics, quality reporting, patient engagement, and other health IT).

a. Electronic Health Records Systems (EHRs)

Consistent with its proposal approved during certification, Contractor facilitates Providers' adoption and meaningful use of EHRs. Electronic Health Records are a foundational component of care coordination because they enable Providers to capture clinical information in a format that can be used to improve care, control costs, and more easily share information with patients and other providers. In order to achieve advanced EHR adoption and meaningful use, Contractor is expected to:

- (1) Identify EHR adoption rates; rates may be divided by provider type and/or geographic region.
- (2) Develop and implement strategies to increase adoption rates of certified EHRs.
- (3) Consider establishing minimum requirements for EHR adoption over time. Requirements may vary by region or provider type;

b. Health Information Exchange (HIE)

(1) Consistent with its proposal approved during certification, Contractor will facilitate electronic health information exchange in a way that allows all Providers to exchange a patient's health information with any other Provider in that CCO. Health Information Exchange is a foundational component of care coordination because it enables Providers to access pertinent health information when and where it is needed to provide the best care possible and to avoid performing duplicative services. CCOs will be expected to ensure that every Provider is:

- (a) Either registered with a statewide or local Direct-enabled Health Information Service Provider (HISP)

Direct is a way for one provider to send secure information directly to another Provider without using sophisticated information systems. Direct secure messaging will be available to all providers as a statewide service, and while EHR vendors will continue to develop products with increasingly advanced Direct functionality, using Direct secure messaging does not require an EHR system. Registration will ensure the proper identification of participants and secure routing of health care messages, and the e-mail address provided with Direct secure messaging registration will be accessible from a computer, smart phone or tablet, and through EHR modules over time.

- (b) Or is a member of an existing Health Information Organization (HIO) with the ability for providers on any EHR system (or with no EHR system) to be able to share electronic information with any other provider within the CCO network.

- (2) Consistent with its proposal approved during certification, Contractor should also consider establishing minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.
- (3) Consistent with its proposal approved during certification, Contractor will leverage HIT tools to transform from a volume-based to a value-based delivery system. In order to do so, Contractor should initially identify their current capacity and develop and implement a plan for improvement (including goals/milestones, etc.) in the following areas:
 - (a) Analytics that are regularly and timely used in reporting to its provider network (e.g., to assess provider performance, effectiveness and cost-efficiency of treatment, etc.).
 - (b) Quality Reporting (to facilitate quality improvement within the CCO as well as to report the data on quality of care that will allow the OHA to monitor the CCO's performance).
 - (c) Patient engagement through HIT (using existing tools such as e-mail).
 - (d) Analysis of quality of collection of race, ethnicity and language data, and subsequent analysis of clinical and non-clinical data to identify and track progress on elimination of health care access, quality and outcome disparities by these and other demographics.
 - (e) Other HIT (e.g., telehealth, mobile devices).

REVIEW the MANDATORY CONTRACT LANGUAGE IN APPENDIX G

Applicant should review the provisions in the Core Contract and Mandatory Statement of Work in Appendix G. Applicant's proposed scope of work and provisions of the framework scope of work, will be integrated into the pertinent portions of the Contract for a single integrated document.