

APPENDIX C – Accountability Questionnaire

This questionnaire consists of two sections, corresponding to the section of Chapter 7 of the CCO Implementation Proposal:

- Section 1:** Accountability Standards
- Section 2:** Quality Improvement Program
- Section 3:** Framework Scope of Work

For background and further information, see Chapter 7 of the CCO Implementation Proposal, “Accountability.”

Section 1 – Accountability Standards

C.1.1. Background information

Accountability for each aspect of the Triple Aim—better health, better care and lower costs—is a central tenet of health system transformation. As required by HB 3650, CCOs will be held accountable for their performance on outcomes, quality, health equity and efficiency measures identified by OHA through a robust public process in collaboration with culturally diverse stakeholders. CCO accountability metrics will function both as an assurance that CCOs are providing quality care for all of their members and as an incentive to encourage CCOs to transform care delivery in alignment with the goals of HB 3650.

OHA will distinguish CCO **accountability measures** (including both core and transformational measures) from **transparency measures** intended to promote community and consumer engagement and to enable evaluation of health systems transformation. The performance expectations outlined below (meeting minimum standards or improving on past performance) will apply to accountability metrics only. Metrics for transparency are intended to be calculated by OHA, rather than CCOs, and will be publicly reported but will not affect CCOs’ contract status or eligibility for incentives.

Accountability measures for CCOs will be phased in over time to allow CCOs to develop the necessary organizational infrastructure and enable OHA to incorporate CCO data into performance standards. In year 1, CCOs accountability will be for reporting only. In years 2 and 3, CCOs will be accountable for meeting minimum standards on core accountability measures and improving on their past performance for transformational accountability measures. Quality incentives for exceptional performance may be offered but not in the first year. Regardless of start date, all CCOs must meet minimum accountability standards by January 2014. CCOs that begin operation less than a year before that date will have a shorter reporting-only period and CCOs that start on or after January 2014 will have no phase-in period at all. While annual reporting will serve as the basis for holding CCOs accountable to contractual expectations, OHA will assess performance more frequently (e.g. quarterly or semi-annually) on an informal basis to facilitate timely feedback, mid-course corrections, and rapid improvement.

Proposed core and transformational accountability measures are shown in the below Table, along with the domain(s) and, where applicable, alignment with national quality measure sets. Potential transparency measures are shown as well. The next stage of metrics development will be for OHA to establish a technical group of culturally diverse internal and external experts to build measure specifications, including data sources, and to finalize a reporting schedule. This stage of the work will be completed by May 2012. Further work, such as establishing benchmarks for core measures and annually reviewing CCO accountability metrics for appropriateness and effectiveness, will also involve the technical workgroup. It is possible that CMS may request the inclusion of additional measures from its Adult Medicaid and CHIPRA core measure sets as CCO accountability measures.

Appendix C - Initial Proposed CCO Accountability Metrics (transparency metrics also listed)

CCO Accountability Measures – tied to contractual accountability & incentives		Transparency Measures – Collected/reported by OHA for public reporting, evaluation, etc.
Core Measures	Transformational Measures	
<p>1. Experience of Care*^ – Key domains TBD from member experience survey (version TBD and may alternate by year) <i>Domain(s): Member experience & activation</i> <i>Data type: Survey (collected by OHA)</i> <i>Also part of: Medicaid Adult Core, CHIPRA, Medicare ACOs, Medicare Part C, OR PCPCH, others</i></p> <p>2. Rate of tobacco use among CCO enrollees*^ <i>Domain(s): Prevention, outpatient physical, overall health status, cost control</i> <i>Data type: Survey</i> <i>Also part of: Nat'l Quality Strategy</i></p> <p>3. Access – Outpatient and ED utilization per member-month*^ <i>Domain(s): Access, community engagement</i> <i>Data type: Claims/encounter</i> <i>Also part of: CHIPRA Core, NCQA HEDIS</i></p> <p>4. BMI assessment & follow-up plan*^ / Weight assessment and counseling for children and adolescents <i>Domain(s): Prevention, outpatient physical</i> <i>Data type: Medical record</i> <i>Also part of: Medicare ACOs, OR PCPCH, CHIPRA</i></p> <p>5. Screening for clinical depression and follow-up plan^ <i>Domain(s): Mental health</i> <i>Data type: medical record</i> <i>Also part of: Adult Medicaid Core, Medicare ACOs</i></p> <p>6. Alcohol misuse - Screening, brief intervention, referral for treatment (SBIRT)^ <i>Domain(s): Addictions</i> <i>Data type: medical record</i> <i>Also part of: OR PCPCH</i></p>	<p>1. Rate of early childhood caries <i>Domain(s): Oral health</i> <i>Data type: Medical record</i> <i>Also part of: HP 2020</i></p> <p>2. Wrap-around care for children – TBD (% Children who receive a mental health assessment within 30 days of DHS custody or other wraparound initiative measure) <i>Domain(s): Care coordination, mental health</i> <i>Data type: TBD</i> <i>Also part of: TBD</i></p> <p>3. Effective contraceptive use - % reproductive age women who do not desire pregnancy using an effective method <i>Domain(s): Women's health, prevention</i> <i>Data type: Survey</i> <i>Also part of:</i></p> <p>4. Planning for end-of-life care: % members over 65 with a POLST form or advanced care plan or surrogate decision maker documented /on file (or documented that these were declined) <i>Domain(s): End-of-life care, care coordination</i> <i>Data type: Administrative or medical record</i> <i>Also part of: Pending</i></p> <p>5. Health and functional status – (1) % members who report the same or better mental and physical health status than 1 year ago*; (2) % members with Medicaid LTC benefit with improvement or stabilization in functional status <i>Domain(s): overall health outcomes</i> <i>Data type: Survey</i> <i>Also part of: Medicare ACOs, MA star ratings(1), SNP(2)</i></p> <p>6. ED visits – Potentially avoidable</p>	<p>CMS Adult Core Measures including:</p> <ul style="list-style-type: none"> Flu shots for adults 50-64 Breast & cervical cancer screening Chlamydia screening Elective delivery & antenatal steroids, prenatal and post-partum care Annual HIV visits Controlling high BP, comprehensive diabetes care Antidepressant and antipsychotic medication management or adherence Annual monitoring and for patients on persistent medications Transition of care record <p>CHIPRA Core Measures including:</p> <ul style="list-style-type: none"> Childhood & adolescent immunizations Developmental screening Well child visits Appropriate treatment for children with pharyngitis and otitis media Annual HbA1C testing Utilization of dental, ED care (including ED visits for asthma) Pediatric CLABSI Follow up for children prescribed ADHD medications <p>SAMSHA National Outcome Measures including:</p> <ul style="list-style-type: none"> Improvement in housing (adults) Improvement in employment (adults) Improvement in school attendance (youth) Decrease in criminal justice involvement (youth) <p>Others TBD, for example:</p>

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Core Measures	Transformational Measures	
<p>7. Initiation & engagement in of alcohol and drug treatment[^] <i>Domain(s): Addictions</i> <i>Data type: Claims/encounter</i> <i>Also part of: Medicaid Adult Core, HEDIS, Meaningful Use, OR PCPCH</i></p> <p>8. Low birth weight or adequacy of prenatal care <i>Domain(s): Overall health status, MCH</i> <i>Data type: Claims/encounter</i> <i>Also part of: CHIPRA</i></p> <p>9. Primary-care sensitive hospital admissions (PQIs) for chronic conditions like diabetes, asthma, CHF, and COPD^{*^} <i>Domain(s): Outpatient physical, prevention, cost control</i> <i>Data type: Encounter/hospital discharge</i> <i>Also part of: Adult Medicaid Core, Medicare ACOs</i></p> <p>10. Healthcare-acquired conditions – TBD <i>Domain(s): Inpatient care</i> <i>Data type: Clinical</i> <i>Also part of: CDC and OR HAI reporting, Medicare value-based purchasing, CHIPRA</i></p> <p>11. Follow-up after hospitalization[^] - % of members with follow-up visit within 7 days after hospitalization for mental illness <i>Domain(s): Care coordination</i> <i>Data type: Claims/encounter</i> <i>Also part of: Adult Medicaid Core</i></p> <p>12. Readmission rates: (1) Plan all-cause readmissions^{*^}; (2) readmissions to psychiatric care[^] <i>Domain(s): Care coordination, cost control</i> <i>Data type: Claims/encounter</i> <i>Also part of: Adult Medicaid Core, Medicare ACOs</i></p> <p>13. High needs care coordination – TBD (e.g. % of members identified</p>	<p>or other categorization TBD (*^) <i>Domain(s): Outpatient physical, care coordination, cost control</i> <i>Data type: Claims/encounter</i> <i>Also part of: TBD</i></p> <p>7. Access - % of primary care providers who report no difficulty obtaining specialty care (including behavioral health services) for members <i>Domain(s): Access, coordination and integration</i> <i>Data type: Survey</i> <i>Also part of: Unknown</i></p> <p>8. Improvement on disparities in health status or quality of health care identified by CCO in community needs assessment <i>Domain(s): Equity, cost control, potentially others</i> <i>Data type: mixed</i> <i>Also part of: Unknown</i></p> <p>9. Community Orientation - TBD <i>Domain(s): TBD</i> <i>Data type: TBD</i> <i>Also part of: TBD</i></p> <p>10. Timely transmission of transition record - % of patients discharged from any inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or health care professional within 24 hours <i>Domain(s): Care coordination</i> <i>Data type: Attestation</i> <i>Also part of: Adult Medicaid Core</i></p>	<ul style="list-style-type: none"> · Time from enrollment to first encounter and type of first encounter (urgent or non-urgent, physical, mental, etc.) · Initiation and engagement of mental health treatment

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Core Measures	Transformational Measures	
as high need assigned to intensive care coordination) <i>Domain(s): Care coordination</i> <i>Data type: TBD</i> <i>Also part of: TBD</i>		
14. Medication management –TBD <i>Domain(s): Care coordination</i> <i>Data type: TBD</i> <i>Also part of: TBD</i>		
15. MLR - % of global budget spent on health care and services <i>Domain(s): Efficiency, cost control</i> <i>Data type: Administrative</i> <i>Also part of: Unknown</i>		
CCO-LTC System Joint Accountability Measures		
1. Care planning - % of members with Medicaid-funded LTC benefits who have a care plan in place. <i>Domain(s): Care coordination</i> <i>Data type: Administrative</i> <i>Also part of: Pending</i>	1. Transitions of care - % of LTC patients discharged from any inpatient facility to home or any other site of care for whom a transition record was transmitted to the care manager or AAA/APD within 1 business day <i>Domain(s): Care coordination</i> <i>Data type: Administrative</i> <i>Also part of: Unknown</i>	

* Report separately for members with severe and persistent mental illness

^ Report separately for individuals with Medicaid-funded Long-Term Care (LTC) benefit

Duals / Medicare 3-way Contract Accountability Measures – TBD pending negotiation with CMS

- Additional measures may apply related to quality and experience, outcomes, etc. for dually eligible individuals
- These measures will be determined in consultation with CMS by June 2012.
- Rewards for strong performance on these measures would come in part from the incentives that CMS has specified as part of the state demonstration to integrate care for dually eligible individuals, possibly in the form of a quality withhold.

Note: Depending on the particular metric, reports and data may flow from CCOs to OHA or the reverse. For example, it may be advantageous for OHA to collect member experience data on behalf of CCOs just as the agency does now for MCOs. Likewise, metrics developed from claims data can come from the OHA All-Payer All-Claims (APAC) database rather than be individually collected from CCOs.

Shared accountability for long-term care: Medicaid-funded LTC services are legislatively excluded from CCO budgets and will continue to be paid for directly by the Department of Human Services (DHS). But in order to reduce cost shifting and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTC system will need to coordinate care and share accountability. In conjunction with the state demonstration to integrate care for dual eligibles, a set of CCO-LTC joint accountability measures will be identified by June 2012 reflecting leverage areas where the activities of one system have significant impacts on the costs and outcomes realized in the other system. A selection

of these measures will be tied to future incentive payments for CCOs (and for LTC providers, depending on available funding).

- C.1.1.a.** Describe any quality measurement and reporting systems that the Applicant has in place or will implement in the first year of operation.
- C.1.1.b.** Will the Applicant participate in any external quality measurement and reporting programs (e.g. HEDIS reporting related to NCQA accreditation, federal reporting for Medicare Advantage lines of business)?
- C.1.1.c.** Explain the Applicant's internal quality standards or performance expectations to which providers and contractors are held.
- C.1.1.d.** Describe the mechanisms that the Applicant has for sharing performance information with providers and contractors for quality improvement.
- C.1.1.e.** Describe the mechanisms that the Applicant has for sharing performance information in a culturally and linguistically appropriate manner with members.
- C.1.1.f.** Describe any plans to use quality measures and/or reporting in connection with provider and contractor incentives or any alternative payment mechanisms.
- C.1.1.g.** Describe the Applicant's capacity to collect and report to OHA the accountability quality measures listed in the Table, if it is determined that those should be reported by CCOs. (Some may be collected by OHA.) Note: since measure specifications are not provided, capacity can be described in general terms based on the data type shown. Include information about the Applicant's capacity to report on measures that are not based on claims data.
- C.1.1.h.** Describe the Applicant's plans to participate in the All Payer All Claims data reporting system required by ORS 442.464 – 442.466 and ORS 414.625

Section 2 – Quality Improvement Program

C.2.1. Quality Assurance and Performance Improvement (QAPI)

As in the past, Oregon will continue to develop and maintain a Quality Strategy to assess and improve the quality of CCO services and to ensure compliance with established standards. CCO accountability measures and related incentives will be core elements of the state's Quality Strategy. Pending negotiations with CMS, this will be a joint strategy/performance improvement plan for all Medicaid populations, including dual eligibles.

Oregon will continue its robust monitoring of CCO system performance and will continue to assure that established standards for quality assessment and improvement are met. Many oversight mechanisms used today will continue in the future. The transition from managed physical and mental health care organizations (and dental care organizations, over time) to CCOs will mean a greater focus on person-centered care, prevention and continuous quality improvement.

- C.2.1.a.** Describe the Applicant's Quality Improvement (QI) program.
- C.2.1.b.** Describe the Quality Committee structure and accountability including how it reflects the diverse member and practitioner community within the proposed service area.

- C.2.1.c.** Describe how the Quality plan is reviewed and developed over time.
- C.2.1.d.** Describe how all Applicant’s practitioners, culturally diverse community-based organizations and members can be involved and informed in the planning, design and implementation of the QI program.
- C.2.1.e.** Describe how the QI program specifically addresses health care and health outcome inequities, care coordination and transitions between care settings.
- C.2.1.f.** Describe how regular monitoring of provider’s compliance and corrective action will be completed.
- C.2.1.g.** Describe how the Applicant addresses QI in relation to:
 - Customer satisfaction: clinical, facility, cultural appropriateness
 - Fraud and Abuse/Member protections
 - Treatment planning protocol review/revision/dissemination and use with evidence based guidelines

C.2.2. 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.

- C.2.2.a.** If a CAP is established, is a representative of the CAP included on the governing board.
- C.2.2.b.** If a CAP is not established, describe how its governance and organizational structure will achieve best clinical practices.
- C.2.2.c.** Describe how the Applicant has implemented a utilization management system that matches services to member needs, in consideration of individual care plans, including safeguards against underutilization or inappropriate denial of covered services. How will these outcomes be used in relationship to the QI Program.

C.2.3. Continuity of Care/Outcomes/Quality Measures/Costs

- C.2.3.a.** Please describe policies, processes, practices and procedures you have in place that serve to improve member outcomes, including evidence-based best practices, emerging best practices, and innovative strategies in all areas of health care transformation, including patient engagement and activation.
- C.2.3.b.** Also describe key quality measures in place that are consistent with existing state and national quality measures, and will be used to determine progress towards improved outcomes such as benchmarks, evaluation results, decreases and/or elimination of health disparities, customer satisfaction, patient-centered primary care homes, the involvement of local governments in governance and service delivery.
- C.2.3.c.** Please describe your experience and plan to emphasize and implement wellness and health improvement activities and practices within your organization for members and staff, including partners and contracts in place to strengthen this aspect of health care.

- C.2.3.d.** Outline your experience, staffing, policies, procedures, and capacity to collect the necessary electronic and other data that will be required for meeting regular performance benchmarks to evaluate the value of health services delivered by your CCO. CCO accountability metrics serve to ensure quality care is provided and to serve as an incentive to improve care and the delivery of services.
- C.2.3.e.** What other strategies will you implement to improve patient care outcomes, decrease duplication of services, and make costs more efficient?
- C.2.3.f.** Describe your policies and procedures to ensure a continuity of care system for the coordination of care and the arrangement, tracking and documentation of all referrals and prior authorization.

Section 3 – 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

Part 1 - Quality and Performance Outcomes and Accountability

1. Quality and Performance Outcomes

Accountability for each aspect of the Triple Aim—better health, better care and lower costs—is a central tenet of health system transformation. As required by Health Systems Transformation, CCO is held accountable for its performance on outcomes, quality, and efficiency measures incorporated into this Contract. CCO accountability metrics will function both as an assurance that Contractor is providing quality care for all of its members and as an incentive to encourage Contractor to transform care delivery in alignment with the goals of Health Systems Transformation. Further, members and the public deserve to know about the quality and efficiency of their health care so metrics of outcomes, quality and efficiency will be publicly reported. Health care transparency provides consumers with the information necessary to make informed choices and allows the community to monitor the performance of their community CCO.

Contractor implements data reporting systems necessary to timely submit claims data to the All Payer All Claims data system in accordance with ORS 414.625, and the requirements of ORS 442.464 to 442.466.

2. Quality Assurance and Improvement

Contractor implements, based on its proposal approved during certification, quality assurance and improvement measures demonstrating the methods and means by which Contractor will carry out planned or established mechanisms for:

- a. Establishing a complaint, grievance and appeals resolution process, including how that process will be for communicated to members and providers;
- b. Establishing and supporting an internal quality improvement committee that develops and operates under an annual quality strategy and work plan with feedback loops;
- c. Implementing an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols/policies.

3. Measurement and reporting requirements

Contractor implements, based on its proposal approved during certification, plans to develop the necessary organizational infrastructure to address performance standards established for this Contract.

- a. In the first year, accountability will be for reporting only.
- b. In future years, Contractor will be accountable for meeting specified performance benchmarks (see accountability standards below), specifically: to meet or exceed minimum performance expectations set for core measures and to improve on past year performance for transformational measures (see below for description of care and transformational categories).
- c. Initially, “reporting year” will be based on the effective date of each the contract; that is, year 1 a contract that starts operation in July 2012 runs through June 2013 and year 1 for a Contractor that is certified in October 2012 will run through September 2013. However, Contractor must meet performance benchmarks by January 2014. (Contracts that begin operation less than a year before that date will have a shorter reporting-only accountability period and Contracts that start on or after January 2014 will have no phase-in period at all.)
- d. Performance relative to targets will affect Contractor’s eligibility for financial and non-financial rewards. Contractor’s performance with respect to minimum expectations will be assessed as part of OHA monitoring and oversight. Initially, monitoring and oversight will be aimed at root cause analysis and assisting Contractor in developing improvement strategies; continued subpar performance will lead to progressive remediation established in the Contract, including increased frequency of monitoring, corrective action plans, enrollment restrictions, financial and non-financial sanctions, and ultimately, non-renewal of contracts.
- e. OHA will convene a Metrics and Scoring Committee to assist in building measure specifications and establishing performance targets for year 2 forward. The Committee will also advise OHA annually on adopting, retiring, or re-categorizing Contractors performance measures, based on evaluation of the metrics’ appropriateness and effectiveness.
- f. Annual reporting will serve as the basis for holding Contractor accountable to contractual expectations; however, OHA will assess performance more frequently (e.g. quarterly or semi-annually) on an informal basis to facilitate timely feedback, mid-course corrections, and rapid improvement recommendations to Contractor. The parties will document any changes agreed to during these informal procedures.
- g. The performance measures reporting requirements measure the quality of health care and services during a time period in which Contractor was providing Capitated Services. The performance measures reporting requirements expressly survive the expiration, termination or amendment of this Contract, even if Contract expiration, termination or amendment results in a

termination, modification or reduction of the Contract or the Contractor's enrollment or service area, since performance measures services are rendered when the Contractor is providing Capitated Services under this Contract.

- h.** It is possible that CMS may request the inclusion of additional measures from its Adult Medicaid and CHIPRA core measure sets as CCO accountability measures.

4. Specific areas of CCO accountability metrics

Contractor will be accountable for both core and transformational measures of quality and outcomes:

- a.** Core measures will be triple-aim oriented measures that gauge Contractor performance against key expectations for care coordination, consumer satisfaction, quality and outcomes. The measures will be uniform across CCOs and will encompass the range of services included in CCO global budgets (e.g. behavioral health, hospital care, women's health, etc.).
- b.** Transformational metrics will assess Contractor progress toward the broad goals of health systems transformation and will therefore require systems transitions and experimentation in effective use. This subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners.
- c.** Accountability metrics that are applicable in Year 1 of this Contract can be found at in the above draft table.

REVIEW the MANDATORY CONTRACT LANGUAGE IN Exhibit B, Part 9 of 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.