

Coordinated Care Organizations (CCO)

RFA 3402

Appendix H: Transformation Scope Elements

RESPONSE to APPENDIX H is OPTIONAL

Appendix H contains certain Health System Transformation elements that can serve as a starting point for incorporating the Applicant’s proposals into Contract language. This is Applicant’s opportunity to facilitate the contracting process by supplying language that translates its unique approach to coordination and integration of care into a form that can be a starting point for Contract negotiations. Applicant may modify Appendix H, submit its own proposed approach to Contract provisions, or allow OHA to draft the statement of work.

Applicant is invited and encouraged to use its response to Appendix H or its alternative proposed Contract language, to inform OHA about how it proposes to accomplish the Work, including the flexibilities and local initiatives that are being proposed. See **Section 3.2** of the RFA for additional instructions.

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Response to APPENDIX H is OPTIONAL.

General Overview of Health Transformation

In 2011 the Oregon Legislature and Governor John Kitzhaber created coordinated care organizations (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.

Consistent with the CCO Implementation Proposal of the Oregon Health Policy Board dated January 24, 2012, Contractor is a community-based organization governed by a partnership among providers of care, socially and culturally diverse community members and those taking financial risk. Contractor has a single global Medicaid budget that grows at a fixed rate, and is responsible for the integration and coordination of physical, mental, behavioral and dental health care for people eligible for Medicaid. Contractor is the single point of accountability for the health quality and equitable outcomes for the Medicaid population it serves. Contractor has the financial flexibility within available resources to achieve the greatest possible outcomes for their membership.

Contractor acts as an agent of Health System Transformation as called for by HB 3650 (2011) and SB 1580 (2012) and applicable administrative rules. Contractor's Work is guided by the policy objectives of Health System Transformation and will help to achieve the triple aims of health reform: a healthy population, extraordinary patient care and reasonable costs. Contractor's objectives include:

- Ensuring access to an appropriate delivery system network centered on Patient-Centered Primary Care Homes(PCPCH);
- 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.

In general, Contractor implements Health System Transformation consistent with its Application as negotiated with and approved by OHA during the RFA certification and contracting process. Contractor achieves baseline objective of Health System Transformation and has an accountable plan for achieving all of the objectives over the period of its certification.

A. CCO Criteria

Part 1 – Governance and Organizational Relationships

1. Governing Board and Governance Structure

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

2. Community Advisory Council (CAC)

Contractor establishes a Community Advisory Council (CAC) that includes appropriate community representation in each service area. 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 is subject to OHA approval, and may include a clinical advisory panel. If Contractor convenes a clinical advisory panel, this group has representation on the governing board. The clinical advisory panel has representation from behavioral health and physical health systems and Member representation.

4. Community Health Assessment and Community Health Improvement Plan

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 health assessment and adopt a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by Contractor. Community health assessment includes 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 health assessment is transparent and public in both process and result.

- a. The community health assessment adopted by the CAC describes the scope of the activities, services and responsibilities that the Contractor considers upon implementation of the plan. The activities, services and responsibilities defined in the plan may include, but are not limited to:
 - (1) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;
 - (2) Health policy;
 - (3) System design;
 - (4) Outcome and Quality Improvements;
 - (5) Integration of service delivery; and
 - (6) Workforce development

Through its community health 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 work with OHA Office of Equity and Inclusion to develop meaningful baseline data on health disparities.

b. Community Health Improvement Plan

The Contractor, through its CAC, develops and implements a community health improvement plan. The community health improvement plan describes the scope of the activities, services and responsibilities that the Contractor considers upon implementation of the plan. The Contractor provides a copy of the plan and any updates to the OHA. The activities, services and responsibilities defined in the plan may include, but are not limited to:

- (1) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;
- (2) Health policy;
- (3) System design;
- (4) Outcome and Quality Improvement;
- (5) Integration of service delivery; and
- (6) Workforce development.

Part 2 – Health Equity and Eliminating Health Disparities

Contractor demonstrates how it carries out the health improvement strategies tailored to reduce health disparities and improve the health and well-being of all Members.

Contractor collects and maintains race, ethnicity, and primary language data, including mental health and substance abuse disorder data, for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS. Contractor tracks and reports on any quality performance improvements and outcome measures by these demographic factors and develops, implements, and evaluates strategies to improve health equity among Members.

Contractor partners with local public health and culturally, linguistically and professionally diverse community partners to address the causes of health disparities.

Part 3 – Payment Methodologies that Support the Triple Aim

Contractor demonstrates 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.

The schedule by which Contractor implements alternative payment methodologies is defined. Payments to Patient-Centered Primary Care Homes for individuals with chronic conditions, however, are implemented immediately.

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

1. 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.

2. Contractor does 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.
3. In addition to the base CCO Payment rate paid to Contractor, OHA pays a hospital reimbursement adjustment to the CCO Payment rate to Contractor in accordance with the CCO Payments calculation reflected in the rate schedule in the Core Contract. 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.
4. 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

1. Electronic Health Information

Contractor demonstrates how it will achieve minimum standards in foundational areas of HIT use (electronic health records, health information exchange) and 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)

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 facilitate advanced EHR adoption and meaningful use, Contractor:

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

b. Health Information Exchange (HIE)

- (1) Contractor facilitates electronic health information exchange in a way that allows all Providers to exchange a patient's health information with any other of its Participating Providers, including ensuring that every Provider is:
 - (a) Registered with a statewide or local Direct-enabled Health Information Service Provider (HISP); or
 - (b) 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 Contractor's network.
- (2) Contractor also considers establishing minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.

- (3) Contractor leverages HIT tools to transform from a volume-based to a value-based delivery system. In order to do so, Contractor initially identifies its 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 Contractor as well as to report the data on quality of care that allows the OHA to monitor Contractor's performance).
 - (c) Patient engagement through HIT (using existing tools such as e-mail).
 - (d) Other HIT (e.g., telehealth, mobile devices).

B. Delivery of Benefits

Part 1 – Benefits

1. Flexible Services and Supports

In addition to traditional service and supports for physical, mental health, chemical dependency and dental services, Covered Services include the provision of Flexible Services and supports that are consistent with achieving wellness and the objectives of an individualized care plan. A Flexible Service or support is ordered by and under the supervision of a Network Provider in accordance with Contractor policy for authorizing Flexible Services or supports.

2. Children's Wraparound Demonstration Project Responsibilities

As mandated by ORS 418.975 to 418.985, Contractor creates a system of care by implementing a Children's Wraparound Demonstration Project, providing oversight and, in collaboration with OHA, evaluation.

Contractor develops local and state level partnerships to collaborate with OHA on the implementation of ORS 418.975 to 418.985 in the development of the Statewide Children's Wraparound Initiative.

Part 2 – Patient Rights and Responsibilities, Engagement and Choice

1. Member and Member Representative Engagement

Contractor actively engages Members as partners in the design and, where applicable, implementation of their individual treatment and care plans through ongoing consultation regarding individual and cultural preferences and goals for health maintenance and improvement. Member choices are reflected in the development of treatment plans and Member dignity is respected. Members are positioned to fulfill their responsibilities as partners in the primary care team at the same time that they are protected against underutilization of services and inappropriate denials of services.

Contractor demonstrates the means by which Contractor:

- a. Uses Community input and the Community health assessment process to help determine the best, most culturally appropriate methods for patient activation, with the goal of ensuring that Member act as equal partners in their own care.
- b. Encourages Members to be active partners in their health care and, to the greatest extent feasible, develop approaches to patient engagement and responsibility that account for the social determinants of health and health disparities relevant to Members.
- c. Engages Members in culturally and linguistically appropriate ways.
- d. Educates Members on how to navigate the coordinated care approach.
- e. Encourages Members to use wellness and prevention resources, including mental health culturally-specific resources provided by community based organizations and service providers, and to make healthy lifestyle choices.
- f. Meaningfully engages the CAC to monitor patient engagement and activation.
- g. Provides plain language narrative and alternative (video or audio) formats for individuals with limited literacy that inform patients about what they should expect from Contractor with regard to their rights and responsibilities.
- h. Works with the Member's care team, including providers and community resources appropriate to the Member's individual and cultural health as a whole person.

2. Member Engagement and Activation

Contractor implements policies and procedures assuring that each Member:

- a. Is encouraged to be an active partner in directing the Member's health care and services and not a passive recipient of care.
- b. Is educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system.
- c. Has access to advocates, including qualified Peer Wellness Specialists where appropriate, Personal Health Navigators, and qualified Community Health Workers who are part of the Member's care team to provide assistance that is culturally and linguistically appropriate to the Member's need to access appropriate services and participate in processes affecting the Member's care and services.
- d. Is encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.
- e. Is encouraged to work with the Member's care team, including providers and community resources appropriate to the Member's health as a whole person

Part 3 – Providers and Delivery System

1. Integration and Coordination

Contractor develops, implements and participates in activities supporting a continuum of care that integrates mental health, addiction, dental health and physical health interventions in ways that are seamless and whole to the Member and serves Members in the most integrated setting appropriate to their health. Integration activities span a continuum ranging from communication to coordination to co-management to co-location to the fully integrated Patient Centered Primary Care Home.

2. Delivery System Features

Contractor ensures that Members have access to high quality appropriate integrated and coordinated care. Contractor accomplishes this through a Provider Network capable of meeting Health System Transformation objectives. Contractor focuses on the following elements of a transformed delivery system critical to improving the Member's experience of care as a partner in care rather than as a passive recipient of care:

a. Patient-Centered Primary Care Homes

Contractor demonstrates the method and means by which Contractor uses PCPCH capacity to achieve the goals of health system transformation including:

- How Contractor partners with and implement a network of PCPCHs as defined by Oregon's standards to the maximum extent feasible, including but not limited to the following
 - Assurances that the Contractor enrolls 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 served by certified PCPCHs over the first five years of operation, including targets and benchmarks; and
 - 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 Contractor requires Contractor's other contracting health and services providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology, where available, in order to assure a comprehensive delivery system network with the PCPCH at the center, and with other health care providers and local services and supports under accountable arrangements for comprehensive care management.
- How Contractor's PCPCH delivery system elements ensures that Members of all communities in its service area receive integrated, culturally and linguistically appropriate person-centered care and services, and that Members are fully informed partners in transitioning to this model of care.
- How Contractor encourages the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as PCPCHs to ensure the continued critical role of those providers in meeting the health of underserved populations.

b. Care Coordination

Contractor demonstrates the methods and means by which Contractor addresses the following elements of care coordination in their applications for certification:

- How Contractor supports the flow of information, identify a lead Provider or care team to confer with all providers responsible for a Member's care, and, in the absence of full health information technology capabilities, how Contractor implements a standardized approach to patient follow-up.
- How Contractor works with Providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including culturally specific community based organizations, community based mental health services, DHS Medicaid-funded LTC services and mental health crisis management services.
- How Contractor develops culturally and linguistically appropriate tools for provider use to assist in the education of Members about care coordination and the responsibilities of each in the process of communication.
- How Contractor meets OHA goals and expectations for coordination of care for individuals receiving DHS Medicaid-funded LTC services given the exclusion of Medicaid funded long term services from Contractor's global budget.
- How Contractor meets OHA goals and expectations for coordination of care for individuals receiving both Medicaid-funded and non-Medicaid-funded residential addictions and mental health services given the initial exclusion of these services from Contractor's global budget.
- How the contractor coordinates with the state institutions and other mental health hospital settings to facilitate incoming Member's transition into the most appropriate, independent, and integrated community-based settings.

Contractor demonstrates the methods and means by which Contractor utilizes evidence-based or innovative strategies within Contractor's delivery system networks to ensure coordinated care, especially for Members with intensive care coordination health, including members with severe and persistent mental illness receiving home and community based services under the State's 1915(i) State Plan Amendment, as follows:

- *Assignment of responsibility and accountability:* Contractor demonstrates that each Member has a primary care Provider or primary care team that is responsible for coordination of care and transitions.
- *Individual care plans:* Contractor uses individualized care plans to the extent feasible to address the supportive and therapeutic and cultural and linguistic health of each Member, particularly those with intensive care coordination health. Plans reflect Member, Family or caregiver preferences and goals to ensure engagement and satisfaction.
- *Communication:* Contractor demonstrates that Providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with Members and their Families, extended family, kinship networks or caregivers and to facilitate information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record (EHR) capabilities, etc.).

Contractor develops of a coordinated and integrated delivery system Provider Network that demonstrates communication, collaboration and shared decision making across the various providers and care settings. Contractor demonstrates, over time:

- How Contractor ensures a network of Providers to serve Members' health care and service health, meet access-to-care standards, and allow for appropriate choice for Members.

Services and supports are geographically as close to where Members reside as possible and, to the extent necessary, offered in nontraditional integrated settings that are accessible to families, socially, culturally, and linguistically diverse communities, and underserved populations.

- How Contractor builds on existing Provider Networks and transforms them into a cohesive network of providers, including how it arranges for services with providers external to Contractor's service area, to ensure access to a full range of services to accommodate Member health.
- How it works to develop formal relationships with providers, community health partners, including culturally and socially diverse community based organizations and service providers, and state and local government support services in its service area(s), and how Contractor participates in the development of coordination agreements between those groups.

c. Care Integration

- *Mental Health and Chemical Dependency Treatment:* Outpatient mental health and chemical dependency treatment are integrated in the person-centered care model and delivered through and coordinated with physical health care services by Contractor.
- *Oral Health:* By July 1, 2014, Contractor will have a formal contractual relationship with any DCO that serves Members of Contractor in the area where they reside.
- *Hospital and Specialty Services:* Contractor provides adequate, timely and appropriate access to hospital and specialty services. Hospital and specialty service agreements are established that include the role of patient-centered primary care homes and that specify: processes for requesting hospital admission or specialty services and performance expectations for communication and medical records sharing for specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments. Contractor demonstrates how hospitals and specialty services are accountable to achieve successful transitions of care. Contractor transitions Members out of hospital settings into the most appropriate, independent, and integrated community-based settings.

d. **Health Leadership Council High Value Medical Home (*only applies in areas involved with this specific project*)**

Contractor cooperates with OHA project for clinics as Patient Centered Medical Homes (PCMHs) as follows:

- (1) OHA will pay Contractor a PCMH reimbursement payment in addition to the CCO Payment in accordance with the CCO Payments calculation reflected in the rate schedule in Appendix G, Exhibit C, Attachment 2. OHA will from time to time determine the PCMH reimbursement payment for each PCMH clinic designated by OHA, in an amount not to exceed \$XX per Member assigned to PCMH per month.
- (2) Contractor distributes all of such PCMH reimbursement payment amounts to eligible clinics, designated by OHA, located in the State that receive PCMH reimbursement payment determined by Enrollment of designated high risk Members, in accordance with requirements established by OHA, for services outside the scope of services for which Contractor is compensated by the CCO Payments.

- (3) Contractor submits to OHA all Claims, financial and other required data elements within 45 days from the Date of Service.

3. Delivery System Dependencies

a. Shared Accountability for DHS Medicaid-funded Long-term Care Services

DHS Medicaid-funded LTC services are legislatively excluded in HB 3650 from CCO global budgets and will be paid for directly by the Department of Human Services, creating the possibility of misaligned incentives and cost-shifting between Contractor and the DHS Medicaid-funded LTC system. Cost-shifting is a sign that the best care for a beneficiary's health is not being provided. In order to prevent cost-shifting and ensure shared responsibility for delivering high quality, culturally and linguistically appropriate person-centered care, Contractor and the DHS Medicaid-funded LTC system share accountability, including financial accountability.

A shared financial accountability system will be developed based on incentives and/or penalties linked to performance metrics applied to the Contractor and/or to the DHS Medicaid-funded LTC system in its Service Area. Other elements of shared accountability between Contractor and the DHS Medicaid-funded LTC system in its Service Area will include contractual elements such as specific requirements for coordination between the two systems; requirements to clearly define roles and responsibilities between the two systems, through a memorandum of understanding, a contract, or other mechanism; and reporting of metrics related to better coordination between the two systems.

Further, since individuals receiving DHS Medicaid-funded LTC services and supports represent a significant population served by Contractor, Contractor includes these individuals and the DHS Medicaid-funded LTC delivery system in its Service Area in the community health assessment processes and policy development structure

b. Intensive Care Coordination for Special Health Members

- (1) Contractor prioritizes working with Members who have high health care health, multiple chronic conditions, mental illness or chemical dependency and communities experiencing health disparities (as identified in the community health assessment) and involves those Members in accessing and managing appropriate preventive, remedial and supportive care and services to reduce the use of avoidable emergency room visits and hospital admissions.
- (2) Contractor provides intensive care coordination or Case Management Services to Members who are aged, blind, disabled or who have complex medical health consistent with ORS 414.712, including Members with mental illness and Members with severe and persistent mental illness receiving home and community based services under the State's 1915(i) SPA.
- (3) Contractor implements procedures to share the results of its identification and Assessment of any Member identified as aged, blind, disabled (including mental illness or substance abuse disorders) or having complex medical health with Participating Providers serving the Member so that those activities need not be duplicated. Contractor creates the procedures and shares information under ORS 414.679 in compliance with the confidentiality requirements of the Contract.

- (4) Contractor establishes policies and procedures, including a standing referral process for direct access of specialists, in place for identifying, assessing and producing a treatment plan for each Member identified as having a special healthcare need. Each treatment plan is:
 - (a) Developed by the Member’s designated practitioner with the Member’s participation;
 - (b) Includes consultation with any specialist caring for the Member;
 - (c) Approved by the Contractor in a timely manner, if this approval is required; and
 - (d) In accordance with any applicable State quality assurance and utilization review standards.

c. State and Local Government Agencies and Community Social and Support Services Organizations

Contractor promotes communication and coordination with state and local government agencies and culturally diverse community social and support services organizations, including early child education, special education, behavioral health and public health, as critical for the development and operation of an effective Delivery System Network (DSN). Contractor consults and collaborates with Contractor DSN Providers to maximize Provider awareness of available resources for different Members’ health, and to assist DSN Providers to be able to make referrals to the appropriate providers or organizations. The assistance that Contractor provides to DSN Providers in making referrals to State and local governments and to community social and support services organizations takes into account the following referral and service delivery factors:

d. Cooperation with Dental Care Organizations

Contractor coordinates preauthorization and related services with DCOs to ensure the provision of dental care that is required to be performed in an outpatient hospital or ambulatory surgical setting due to the age, disability, or medical condition of the Member.

e. Cooperation with Residential, Nursing Facilities, Foster Care & Group Homes

Contractor arranges to provide medication that is part of Capitated Services to nursing or residential facility and group or foster home residents in a format that is reasonable for the facility’s delivery, dosage and packaging requirements and Oregon law.

C. Accountability

Part 1 - Quality and Performance Outcomes and Accountability

1. Quality and Performance Outcomes

As required by Health System Transformation, Contractor is held accountable for its performance on outcomes, quality, and efficiency measures incorporated into the Contract. Accountability metrics 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 System Transformation. Further, Members and the public know about the quality and efficiency of their

health care so metrics of outcomes, quality and efficiency are publicly reported. Health care transparency provides consumers with the information necessary to make informed choices and allows the community to monitor the performance of Contractor.

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 quality assurance and improvement measures demonstrating the methods and means by which Contractor carries out planned or established mechanisms for:

- a.** Establishing a complaint, Grievance and Appeals resolution process, including how that process is 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; and
- c.** Implementing an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies.

3. Measurement and reporting requirements

Contractor plans and implements the necessary organizational infrastructure to address performance standards established for the Contract.

- a.** In the first year, accountability is for reporting only.
- b.** In future years, Contractor is 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” is based on the effective date of each the contract; that is, year 1 a contract that starts operation in July 2012 runs through December 2013 and year 1 for a Contractor that is certified in October 2012 will run through December 2013. Contractor meets 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 affects Contractor’s eligibility for financial and non-financial rewards. Contractor’s performance with respect to minimum expectations is assessed as part of OHA monitoring and oversight. Initially, monitoring and oversight is aimed at root cause analysis and assisting Contractor in developing improvement strategies; continued subpar performance leads 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 serves as the basis for holding Contractor accountable to contractual expectations; however, OHA assesses 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 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 Coordinated Care Services. The performance measures reporting requirements expressly survive the expiration, termination or amendment of the 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.
- h.** Contractor includes any additional measures requested by CMS from its Adult Medicaid and CHIPRA core measure sets as CCO accountability measures.

4. Specific areas of CCO accountability metrics

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

- a.** Core measures are triple-aim oriented measures that gauge Contractor performance against key expectations for care coordination, consumer satisfaction, quality and outcomes. The measures are uniform across CCOs and encompass the range of services included in CCO global budgets (e.g. behavioral health, hospital care, women's health, etc.).
- b.** Transformational metrics assess Contractor progress toward the broad goals of Health System Transformation and therefore require systems transitions and experimentation in effective use. This subset may include newer kinds of indicators (for which Contractor may 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 are found at in RFA Table C-1.