**RFP Sec. 5.5, E.1 Form of Agreement P-600**

**Section 12.4**

* 1. **Accountable Care Organization Standards and Reporting**.
     1. Objectives. Contractor’s Accountable care organization (ACO) arrangements shall be designed to achieve three (3) primary objectives: (i) improve health outcomes and the quality of care for Members; (ii) improve affordability and contain costs for Members and City; and, (iii) improve patient experience.
     2. Access to Care. Contractor shall ensure that contracted ACOs provide Members with adequate access to care through its defined provider networks including by, but not limited to: (i) providing emergent care; (ii) providing same-day appointments for routine and urgent services for both medical and behavioral health; (iii) providing non-urgent and urgent appointments outside of regular business hours (e.g., before 8 a.m. and after 5 p.m.); (iv) providing alternative clinical encounters (e.g., telehealth, onsite/near-site clinics); and, (v) identifying and acting on opportunities to improve access to care by Members.
     3. Quality and Cost Criteria. Contractor shall provide City with established quality and cost criteria for ACOs as part of the annual rates and benefits renewal process for each applicable plan year.
     4. Coordinated Care. Contractor shall require its contracted ACOs to coordinate care for the attributed or assigned Members or provide care coordination services itself. Contractor or its contracted ACO shall have a systematic process for identifying and engaging Members who may benefit from care coordination.
     5. Quality and Efficiency Measures. Contractor shall use, to the best of its abilities, the quality and efficiency measures listed in Appendix E-2 (Performance Guarantees and Metrics), including patient experience of care measures, to assess the performance of its ACOs.
     6. Performance Improvement. Contractor shall have protocols in place to help ACOs improve performance if ACO providers perform poorly on the identified quality measures, including failure to achieve one or more measures in more than two (2) consecutive quarters within or across multiple plan years, and Contractor shall terminate the ACO arrangement with any ACOs that do not improve performance if the removal of such providers does not lead to access issues or unmitigable service disruptions for Members, as determined by the City.
     7. High Quality Care Strategies. Contractor shall implement payment and contracting strategies that promote value by incentivizing contracted ACOs to offer high quality care, at a reasonable cost to Members and City (“High Quality Care Strategies”). High Quality Care Strategies shall be reported to City quarterly or as modified by Contractor. High Quality Care Strategies shall include, but are not limited to:

1. Pay for appropriate services that were not previously covered. In non-capitated arrangements, Contractor shall pay ACO providers to encourage the delivery of appropriate services that were not previously covered, such as care coordination and telehealth.
2. Pay appropriate relative amounts for services. In non-capitated arrangements, Contractor shall adjust the underlying fee schedule to establish relative amounts that encourage providers to deliver appropriate care.
3. Balance payment between primary and specialty care. Contractor shall implement payment strategies that increase and prioritize payment for primary care services, such as payment for care coordination, as well as strategies to reduce payment differentials between primary and specialty care.
4. Pay according to performance. Contractor shall evaluate and implement payment approaches that differentiate providers that meet or exceed quality standards. Payments to effective providers should reflect their performance.
5. Use payment methods that put providers at financial risk. Contractor shall encourage ACO providers to accept financial responsibility and risk for patients' care over a specified period of time. In such arrangements, providers are financially liable for not meeting specified cost and quality targets.
6. Use payments that encourage adherence to clinical guidelines. Contractor shall evaluate and implement approaches to payment that encourage adherence to clinical guidelines in the delivery of health care services.
   * 1. Cost Targets. Contractor shall establish cost targets in collaboration with City. Contractor shall encourage its contracted ACOs to reduce overall spending and meet established targets. If ACO providers continue to perform poorly on the identified cost metrics within a specified period of time, Contractor shall have protocols in place to help such ACOs improve performance and Contractor shall terminate the ACO arrangement with any ACOs that do not improve performance if the removal of such providers does not lead to access issues or unmitigable service disruptions for Members, as determined by the City.
     2. Transparency. Contractor acknowledges that transparency on quality and costs is critical for City, Department, Members, and providers within its contracted ACOs. Thus, Contractor agrees to: (i) provide information to Members on individual provider's quality performance and the price of services of providers participating in the ACO, including customized Member cost-sharing amounts; and (ii) Provide information to providers on: individual provider's quality performance, the relative price/price bands of other providers participating in the ACO, and the quality performance of other providers participating in the ACO to facilitate high-value referrals.
     3. Maintaining Market Competition. Contractor shall ensure that its contracted ACOs and the ACOs' contracted providers do not engage in the following actions: (i) withholding quality and cost data from statewide or regional public performance reporting initiatives; (ii) requiring exclusive contracts with physician groups, hospitals and ambulatory surgery centers (ASC) such that they are precluded from entering into contracts with other ACOs or commercial payers; (iii) instituting non-disclosure provisions that prohibit ACOs or commercial payers from disclosing quality, utilization, price and cost data and information to Members or City; (iv) instituting non-disclosure provisions that prohibit use of their claims in a multi- or all-payer claims databases that is a designated Centers for Medicare and Medicaid Services Qualified Entity.
     4. Network and benefit design strategies. Contractor shall help City develop and introduce new benefit designs and/or incentives, as well as communication strategies, that encourage Members to become active participants in their care with respect to cost and quality, helping them identify the highest-value services and providers in the ACO. These steps shall include, but are not limited to, the following:
7. Analyzing price, cost and quality data. On an annual basis, Contractor shall conduct an analysis of price variation among the providers within the contracted ACOs. Contractor shall share information with City indicating those procedures or services with the widest variation and greatest cost savings opportunities through benefit design strategies.
8. Supporting benefit designs that shift Members to high-value services and providers. Contractor shall support City in implementing benefit designs that encourage Members to seek high-value services or care from high-value providers.
   * 1. Performance Reporting. Contractor shall provide City with bi-annual reports of ACO performance.
     2. Quality and Utilization Reporting. Contractor shall provide City with bi-annual reports of ACO quality and utilization the reflect, at minimum, the following:
9. Cervical Cancer Overscreening, defined as, the percentage of women 21–64 years of age who received more cervical cancer screenings than necessary according to evidence-based guidelines, using either of the following criteria: (a) Women age 21–64 who had cervical cytology performed every 3 years; or (b) Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.
10. Controlling High Blood Pressure, defined as, The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.
11. Comprehensive Diabetes Care, defined as, the percentage of patients 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: (a) Hemoglobin A1c (HbA1c) testing (NQF#0057) , (b) HbA1c poor control (>9.0%) (NQF#0059), (c) Medical attention for nephropathy (NQF#0062), (d) BP control (<140/90 mm Hg) (NQF#0061).
12. Use of Opioids at High Dosage, defined as, for members 18 years and older, the rate per 1,000 receiving prescription opioids for ≥15 days during the measurement year who are prescribed opioids at high dosage MED >120 mg.
13. Childhood Immunization Status: Combination 10, defined as the percentage of children 2 years of age who had four DtaP; three polio (IPV); one MMR; three HiB; three HepB; one VZV; four PCV; one HepA; RV; and two flu vaccines by their second birthday.
14. Potentially Avoidable ER Visits (per 1,000 members), defined as patient visits to the ER that meet the following specifications: Non-emergent, Emergent but treatable through primary care, Emergent but could have been prevented through timely and effective ambulatory care.
15. AHRQ Prevention Quality Indicator #90: Ambulatory Sensitive Admissions (per 1,000 members), defined as an 11-item composite constructed by summing the hospitalizations across the component conditions and dividing by the population. Rates are to be adjusted for age and gender when comparing across regions or demographic groups.
16. CAHPS Clinician and Group Surveys (CG-CAHPS)-Adult, Child (CG-CAHPS is a standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding 12 months. The survey includes standardized questionnaires for adults and children. (NQF# 0005)).
17. HCAHPS (HCAHPS is a 32-item survey instrument for recently discharged (between two days and six weeks) hospital patients ages 18 and older who had an inpatient stay over one or more nights. The survey produces 11 publicly reported measures. (NQF# 0166)).
18. Depression Remission at 6 Months, defined as adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate a response to treatment at six months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score.
19. NTSV C-Section, defined as nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section.
20. Primary Care Office Visits. A primary care provider is a generalist clinician who provides care to patients at the point of first contact and takes continuing responsibility for providing the patient’s care. Such a provider must have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine.
21. Specialty Care Office Visits. Specialist clinicians have a recognized expertise in a specific area of medicine.  For physicians, they have undergone formal residency and/or fellowship training programs and have passed the specialty board examination in that field.  Examples include oncologists, ENTs, cardiologists, OB-GYNs, renal care specialists, etc.  Nurse practitioners and physician assistants working in a non-primary care setting are also considered specialists.
22. Emergency Room Visits. The number of visits to an Emergency Department (ED) during the measurement period.
23. Urgent Care Visits. The number of visits to an Urgent Care department during the measurement period.
24. Hospital Admissions. The number of acute inpatient stays during the measurement period.
25. Hospital all-cause readmissions (per 1,000 members), defined as, for patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.
26. Percent (%) of attributed/assigned member visits to non-ACO in-network providers, defined as “the number (#) of office visits from attributed members to providers who are not part of the ACO (numerator), over the total attributed members office visits (denominator).
    * 1. Annual Outcome Reporting. Contractor shall provide City with annual reports of patient outcomes that reflect, at minimum, the following:
27. Asthma medication. The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
28. Breast cancer screening. The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.
29. Cervical Cancer screening, defined as the percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: (a) Women age 21–64 who had cervical cytology performed every 3 years, or (b) Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.).
30. Colorectal screening rates. The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.
31. Statin Therapy for Patients with Cardiovascular Disease. (The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria: (a) Received Statin Therapy and (b) Statin Adherence 80%.).
32. Statin Therapy for Patients with Diabetes. The percentage of members 40–75 years of age during the measurement year, with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: (a) Received Statin Therapy, (b) Statin Adherence 80%.
33. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis. The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.
34. Chlamydia Screening in Women. The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
35. Immunizations for Adolescents, Combination 2. The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) vaccine and three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.
36. Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.
37. Concurrent Use of Opioids & Benzodiazepines. Percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines.
38. Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents.
39. Flu Vaccinations for Adults 18-64. The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure is collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, and commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older.
40. Adult BMI Screening & Follow-Up. Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI > or = 23 and < 30. Age 18-64 years BMI > or = 18.5 and < 25.
41. Screening for Clinical Depression & Follow Up Plan. Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.
42. Ischemic Vascular Disease: Aspirin Use. The percentage of patients 18 years of age and older who were discharged from an inpatient setting with an acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary intervention (PCI) during the 12 months prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of routine use of aspirin or another antiplatelet during the measurement year.
43. Optimal Diabetes Care Combination. The percentage of adult diabetes patients who have optimally managed modifiable risk factors to prevent/reduce future complications associated with poorly managed diabetes. Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, Blood Pressure < 140/90, Statin use unless contraindications or exceptions, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated.
    * 1. Operational Reporting. Contractor shall provide City with bi-annual reports of operations that reflect, at minimum, the following:
44. Total Cost of Care. All costs associated with treating Members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services.
45. Non-visit related payments. Non-visit related payments charged to Purchaser for ACO program., including, but is not limited to, payment for outreach and care coordination/management; after-hour availability; patient communication enhancements, health IT infrastructure and use. Non-visit related payments may come in the form of care/case management fees, medical home payments, infrastructure payments, meaningful use payments, etc.
46. PMPM (decline) or increase in cost compared to prior plan year.
47. Current gross PMPM (savings) or losses vs. Comparison Group.
48. Gross aggregate (savings) or losses versus Comparison Group.
49. Net aggregate (savings) or losses versus Comparison Group.
    * 1. Contractor shall provide all reporting to City on an annual or bi-annual basis as specified in this subsection 12.4, within sixty (60) days of the close of the applicable reporting period.