

Rhode Island Executive Office of Health and Human Services
Transitioning to Alternative Payment Methodologies:
Requirements for Medicaid Managed Care Organizations

June 2016

Table of Contents

1. Overview regarding Alternative Payment Methodologies (APM)
2. MCO Contract APM Goals
3. Definition: EOHHS Approved Alternative Payment Methodologies
4. Definition: EOHHS Certified Accountable Entities
5. Definition: EOHHS Approved PCMH and Required PCMH Payments
6. Definition: High Cost, High Need Populations

Attachments

Attachment A:	Attribution Guidelines
Attachment B:	Total Cost of Care (TCOC) guidelines
Attachment C:	Material Modification Protocols
Attachment D:	Alternative Payment Methodology Reporting Template

1. Purpose of This Document

The purpose of this document is to set forth the requirements of the Rhode Island Executive Office of Health and Human Service (EOHHS) for managed care organizations contracted with EOHHS as Medicaid Managed Care Organizations (MMCOs). Executed agreements with MMCOs include contractual terms setting targets for payments to providers that are to be made utilizing an EOHHS approved Alternative Payment Methodology (APM) and for contracting with Patient Centered Medical Homes. With respect to APMs, particular emphasis is placed on contracting with EOHHS certified Accountable Entities.

This document provides further specification as to those requirements including:

- Alternative Payment Methodologies (APM) in Medicaid
- MCO Contract Requirements: Alternative Payment Methodologies
- Definition: EOHHS Approved Alternative Payment Methodologies
 - Specifications for Total Cost of Care (TCOC) Arrangements
 - Other APM Specifications
- Definition: EOHHS Approved PCMH and Required PCMH Payments
- Definition: High Cost, High Need Populations

Transformation to a value based health care delivery system is a fundamental policy goal for the State of Rhode Island. This is an iterative process and EOHHS reserves the right to modify these Requirements from time to time, as it deems appropriate.

2 Alternative Payment Methodologies (APM) in Medicaid

Rhode Island's Medicaid program is an essential part of the fabric of Rhode Island's health care system serving one out of four Rhode Islanders in a given year and closer to forty percent over a three year period. The program has achieved national recognition for the quality of services provided, with Medicaid health plans that are consistently ranked in the top ten in national NCQA rankings for Medicaid Health Plans.

These accomplishments come at a cost that needs to be effectively managed in order to balance state economic goals. Rhode Island currently spends more than 30 cents of every state revenue dollar on Medicaid. As the program has expanded, the costs of Medicaid have continued to rise and have crowded out investments for important economic development priorities like education, skills training and infrastructure.

Maintaining a strong Medicaid system is an economic imperative for the state. Medicaid supports a healthier population, which provides businesses and employers with a healthier workforce and more predictability of publicly funded costs.

In order to address the goals of both setting the foundation for growth in the state's economy and building a sustainable Medicaid program for the future, in March 2015 Governor Gina Raimondo issued Executive Order 15-08, establishing the "Working Group to Reinvent Medicaid" to provide recommendations for a restructuring of the Medicaid program.

Guiding this effort was the understanding that given the crucial role of the Medicaid program to the state, it is of compelling importance that the state conduct a fundamental restructuring of its Medicaid program that achieves measurable improvement in health outcomes for the people of Rhode Island and transforms the health care system to one that pays for outcomes and quality at a sustainable, predictable and affordable cost for Rhode Island taxpayers and employers.

The Governor charged the Working Group to Reinvent Medicaid to:

- Submit a report on or about April 30, 2015, of its findings and recommendations for consideration in the Fiscal Year 2016 budget.
- Submit recommendations, no later than July 1, 2015, for a plan for a multi-year transformation of the Medicaid program and all state publicly financed health care in Rhode Island.

The Reinventing Medicaid Act of 2015 set into law the fundamental recommendations of the Working Group¹; the Act also reflects the Working Group's FY 2016 budget recommendations for Medicaid. The final report of the Working Group was issued on July 8, 2015, and its Executive Summary (excerpted below) highlights its findings:

This report builds on the foundation laid by the Reinventing Medicaid Act of 2015 to propose a transformative vision for Rhode Island Medicaid. In this Working Group's first report, we proposed a set of short-term cost-saving measures that were designed to be the first step on a path towards a payment and delivery system that promotes value, quality, health, and efficiency. Working with partners from the health care sector, the advocacy community, the business community at large, and the Executive Office of Health and Human Services, we now lay out a model for a reinvented publicly financed health care system in Rhode Island based on the following principles:

1. *Pay for value, not for volume*
2. *Coordinate physical, behavioral, and long-term health care*
3. *Rebalance the delivery system away from high-cost settings*
4. *Promote efficiency, transparency, and flexibility*

From these principles, we derive ten goals for Rhode Island's Medicaid program:

- *Goal 1: Substantially transition away from fee-for-service models to a system where members get their care through provider organizations that are accountable for the quality, health outcomes and total cost of care for their members.*
- *Goal 2: Define Medicaid-wide population health targets, and, where possible, tie them to payments.*

¹ See <http://reinventingmedicaid.ri.gov> for additional documentation.

- *Goal 3: Maintain and expand on our record of excellence—including our #1 ranking—on delivering care to children.*
- *Goal 4: Maximize enrollment in integrated care delivery systems.*
- *Goal 5: Implement coordinated, accountable care for high-cost/high-need populations*
- *Goal 6: Ensure access to high-quality primary care.*
- *Goal 7: Leverage health information systems to ensure quality, coordinated care.*
- *Goal 8: Shift Medicaid expenditures from high-cost institutional settings to community-based settings.*
- *Goal 9: Encourage the development of accountable entities for integrated long-term care*
- *Goal 10: Improve operational efficiency*

Each of these goals is accompanied by specific, measurable objectives that can serve as targets to achieve along the way towards the vision of a reinvented Medicaid in which our Medicaid managed care organizations (MCOs) contract with Accountable Entities, integrated provider organizations that will be responsible for the total cost of care and healthcare quality and outcomes of an attributed population.

This will require improved contracts with the MCOs that require them to innovate in value-based purchasing strategies, including enhanced capacity for provider-level quality measurement, risk adjustment, and total cost of care measures; shared savings and bundled payment methodologies; and innovative contracting strategies with hospitals, home care providers, and long term care facilities that align their financial interests and performance metrics with those of the accountable entities—while ensuring access to medically appropriate care. We also envision a system in which case management and other member support resources are coordinated and funded through the Accountable Entity, to ensure that care is focused, aligned, and timely, and that both medical and non-medical needs of our members are met and addressed.

Rhode Island has a strong foundation for reform in Medicaid. Our managed care programs are nationally recognized for their quality and effectiveness, and we have excellent partners in the provider community who have already begun to innovate in meaningful ways.

The vision set forward here is ambitious, as it should be, given the scale, impact, and importance of Medicaid. Rhode Island’s leaders, including policy makers, health professionals, providers, community advocates and others, must not lose their passion for reform. Long-term, sustainable reforms must remain a top priority for the state, with a commitment to implementing those reforms and measuring progress along the way.²

EOHHS’ requires that managed care partners have the capability and commitment to achieve these critical goals for a sustainable and superior Medicaid program for Rhode Island. Through this document EOHHS is setting forth specifications for meeting Alternative Payment Methodology requirements.

² Report of the Working Group to Reinvent Medicaid: Recommendations for a Plan for a Multi-Year Transformation of the Medicaid Program and All State Publicly Financed Healthcare in Rhode Island, July 8, 2015. <http://reinventingmedicaid.ri.gov>

2. MCO Contract Requirements: Alternative Payment Methodologies

EOHHS seeks to significantly reduce the use of fee-for-service payment as a payment methodology in order to mitigate the fee-for-service volume incentives which unreasonably and unnecessarily increase the overall cost of care, and to replace fee-for-service payment with alternative payment methodologies that provide incentives for better quality and more efficient delivery of health services.

Managed Care contractors will incorporate value based purchasing initiatives into their provider contracts. EOHHS is committed to creating partnerships or organizations using accountable delivery models that integrate medical care, mental health, substance abuse disorders, community health, social services and LTSS, supported by innovative payment and care delivery models that establish shared financial accountability across all partners, with a demonstrated approach to continue to grow and develop the model of integration and accountability.

Pursuant to this commitment, during FY 2016 EOHHS certified Accountable Entity Coordinated Care Pilots (AE) and MCOs are expected to execute “total cost of care” payment arrangements with certified Pilots. As of May 2016, EOHHS had certified five Accountable Entity Coordinated Care Pilots:

- Charter Care
- East Bay Community Action Program (EBCAP); certified as both Type 1 and a Type 2 AE.
- Health Key
- Integra; this includes The Providence Center certified as a Type 2 AE
- Providence Choice Care

These entities have been approved to enter into shared savings arrangements with participating MCOs, based on a total cost of care arrangement that captures all populations and services covered by the MCO. Participating MCOs must contract with at least three Type 1 (3) AE pilots or 20,000 lives, and at least 1 Type 2 pilot, for calendar year 2016 and during the initial Contract Period for MCOs contracting with EOHHS for the Contract Period beginning on or after December 1, 2016.

Additional entities have expressed interest in EOHHS certification as Accountable Entity Coordinated Care Pilots. During the first quarter of SFY 2017 EOHHS will consider applications from additional parties seeking certification.

EOHHS plans to move beyond the pilot phase of this initiative and issue certification standards for fully qualified “Accountable Entities”, as described in Section 4 of this document.

EOHHS’ FY 2016 contracts with MCOs included the following provision: Contractors will have 20% or more of their total payments to providers in alternative payment arrangements by the last quarter of SFY 2016.

Targets for alternative payment arrangements are increased for the Contract Periods covered by this procurement as follows:

Contract Period	1	2	3	4 and 5
Dates	On or after Feb. 1, 2017 – Jun 30, 2017	Jul 1, 2017 – Jun 30, 2018	Jul 1, 2018 - Jun 30, 2019	July 1, 2019 – June 30, 2021
A. Percent of Medicaid payments that shall be made through EOHHS Approved Alternative Payment Methodology #1: Total Cost of Care Model with EOHHS Certified Accountable Entities, as specified in Sections 3 and 4 of this document.	15%	35%	50%	65%
B. Percent of Medicaid payments that shall be made through an EOHHS Approved Alternative Payment Methodology, as specified in Section 3 of this document. ³ Note these totals are inclusive of payments made to EOHHS Certified Accountable Entities included in “A” above.	30%	60%	80%	80%
C. For each Contract Period the percent of high need, members enrolled in an EOHHS certified and MCO-contracted Accountable Entity that are high need, high cost as defined in Section 6 of this document shall be equal to or greater than the percent of high cost, high need persons in the MCOs entire enrolled membership.				
D. Percent of members whose PCP assignment is to a practice that functions as a Patient-Centered Medical Home as recognized by the Rhode Island Office of the Health Insurance Commissioner and as specified in Section 5 of this document.	N/A	65%	80%	80%

Targets must be met by the final month of the final quarter of each contract period. MCOs will be required to complete the APM Reporting Template (see Attachment 4) to show their status against these measures and detail their plans to attain the specified targets within the upcoming

³ This target was designed to align with the Alternative Payment Methodology Plan Recommended to Health Insurance Commissioner Kathleen C. Hittner, Adopted February 10, 2016 by the Rhode Island Office of the Health Insurance Commissioner (OHIC). In this document, OHIC requires at least 40% APM for CY 2017, and 50% for CY 2018. <http://www.ohic.ri.gov/documents/PressRelease-Affordability-Standards-2016-2017-New-Plans-FINAL.pdf>

contract periods. For Bidders responding to the Medicaid managed care Letter of Interest (LOI) the APM Reporting Template shall be included as part of the LOI submission. For contracted MCOs, the APM Reporting Template is to be submitted not later than thirty (30) days after the end of each calendar quarter. Contract Section 2.15.01.1 specifies the EOHHS withhold or offset from capitation payments to MCOs pending demonstration of compliance with these requirements. Upon demonstration of compliance with these targets for the respective quarters, the withheld amount will be paid to the MCOs.

3. Definition: EOHHS Approved Alternative Payment Methodologies

An Alternative Payment Methodology means a payment methodology structured such that provider economic incentives, rather than focusing on volume of services provided, focus upon:

- Improving quality of care;
- Improving population health;
- Reducing cost of care and/or cost of care growth;
- Improving patient experience and engagement, and
- Improving access to care.⁴

A qualified APM must include the following elements:

- The payment methodology must define and evaluate cost performance relative to a budget that may be prospectively paid or retrospectively reconciled.
- Providers must be rewarded for managing costs below the budget through shared savings, should quality performance be acceptable.
- Providers are progressively expected to be responsible for some or all of the costs that exceed the budget.

For the purpose of meeting this requirement in the respective Contract Periods the following will be recognized as qualified Alternative Payment Methodologies:

Qualified Alternative Payment Methodologies	Applicable Timeframe	Payments Included in APM Target Calculation
1. Total cost of care (TCOC) models with EOHHS certified Accountable Entities	All Contract Years	All Payments (as defined below)
2. Other Population Based Total Cost of Care models	Thru June 30, 2018	All Payments
3. Integrated Health Home Contracts	All Contract Years	Withhold payment only
4. Other Specialized population TCOC budget models (e.g. for LTSS)	All Contract Years	All Payments
5. Episode Based Bundled Payments	All Contract Years	All Payments
6. PCMH - Care Transformation PMPM	Thru June 30, 2018	PMPM Payment only
7. Other infrastructure and Pay-for-performance payments	Thru June 30, 2018	P4P Payment only
8. Other payments that meet the definition of an Alternative Payment Methodology as approved by EOHHS.	All Contract Years	All Payments

⁴ This definition is consistent with the Alternative Payment Methodology Plan Recommended to Health Insurance Commissioner Kathleen C. Hittner, Adopted February 10, 2016 by the Rhode Island Office of the Health Insurance Commissioner (OHIC). <http://www.ohic.ri.gov/documents/PressRelease-Affordability-Standards-2016-2017-New-Plans-FINAL.pdf>

The Alternative Payment Methodology (APM) target means the aggregate use of the above-defined methodologies as a percentage of a Contractor's medical expenditures during a contract period.

Qualifying APM medical expenditures for purposes of the APM target shall include:

- All fee-for-service or non-fee-for-service payments under a population based total cost of care (TCOC) contract with shared savings or shared risk.
- Episode based (bundled) payments; primary care, specialty care or other limited scope-of-service capitation payments, and global capitation payments.
- Quality payments that are associated with a non-fee-for-service payment (e.g. a quality payment on top of a bundled payment or PCP capitation).
- Supplemental payments for infrastructure development and/or Care Manager services to PCMHs and to Accountable Entities, through June 30, 2018.
- Shared savings distributions or payments.

Note that methodologies #6 and #7 above, pay-for-performance payments and supplemental payments for patient-centered medical home functions paid to PCPs, to ACOs or to EOHHS certified AEs, while generally not employing the aforementioned budget methodology, will be included in the calculation of the APM target only through June 30, 2018.

Also note that EOHHS requires progressive movement toward methodology #1 - Total Cost of Care (TCOC) payment models with certified Accountable Entities -- over the course of the contract period. As such, "Other Population Based" total cost of care models will be included in the calculation of the APM target only through June 30, 2018.

Specifications for Total Cost of Care (TCOC) Arrangements

The total cost of care calculation (TCOC) is a fundamental element in any shared savings and/or risk arrangement and requires careful analysis. Most fundamentally it will include a baseline or benchmark historical cost of care carried forward to the performance period. Actual costs during the performance period are then compared to those projections to identify a potential shared savings or risk pool, depending on the terms of the arrangement.

For any APM methodology that utilizes a TCOC calculation, this calculation must be consistent with the TCOC guidelines for EOHHS certified Coordinated Care Pilot Accountable Entities included as Attachment B of this document. As described in that guidance, OHHS will review the MCO's TCOC methodologies and reserves the right to ask for modifications before granting

approval.⁵ EOHHS anticipates that additional requirements may be added to this guidance as the state proceeds with Accountable Entity certification.

It is worth noting that any savings observed must be in light of an appropriate comprehensive quality score factor to determine the actual amount of the pool eligible for distribution. The TCOC methodology must specify both the quality/outcome metrics as well as the quality score factor – that is, how the metrics impact the calculation of shared savings distributions.

Other APM Specifications

Some additional APM specifications are described below:

- **Required Quality Score Factor**
All Alternative Payment Methodologies must include both a defined set of metrics and a quality performance score that must be met in order for payments to be made.
- **Limits on Downside Risk**
Contractors shall not enter into a Risk Sharing Contract or a Global Capitation contract where potential risk exceeds four (4%) percent of TCOC payments unless the Contractor has determined in accordance with procedures established by EOHHS that the AE or provider organization entering into the contract has the operational and financial resources needed to assume clinical and financial responsibility for covered services to members attributable to the provider organization.
- **Attribution Method**
For all budget based APMs Contractors will conform with the attribution guidance established by EOHHS. Current attribution guidelines for EOHHS certified Coordinated Care Pilot Accountable Entities is posted on the EOHHS website; however, EOHHS anticipates that additional requirements may be added to this guidance as the state proceeds with Accountable Entity certification.⁶
- **Individual members or enrollees can only be recognized in one APM at a time.**
This is to ensure that TCOC calculations and shared savings are not “double counted” across multiple entities.

⁵ In addition to this EOHHS requirement, note that depending on circumstances transparency in such arrangements is specifically required in CFR42 §438.6 Contract requirements: 438.6(g) Inspection and audit of financial records – Risk contracts must provide that the state agency and the Department may inspect and audit any financial records of the entity or its subcontractors. 438.6(h) Physician Incentive plans – MCO contracts must provide for compliance with the requirements set forth in 422.208 and 422.210 of this chapter. 438.6(l) All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

⁶ See the link below for the latest EOHHS attribution guidance
<http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Guidance/AccountableEntityAttribution.pdf>

4. Definition: EOHHS Certified Accountable Entities

Preliminary Accountable Entity Certification Standards were posted for community feedback via a Request for Information (RFI) in August 2015.⁷ A revised draft incorporating substantial public input was again posted for comment as part of a pilot accountable entity application in October 2015.⁸ Rhode Island finalized those standards and received certification applications from interested parties. As of May 2016 EOHHS had certified five entities in this pilot program. During the first quarter of SFY 2017 EOHHS will consider applications from additional parties seeking certification as part of the pilot program. Accountable entities that meet state defined certification standards are qualified to enter into value-based payment arrangements with Medicaid MCOs to serve Medicaid populations.

Certification standards for Pilots have been designed to ensure that qualified Accountable Entities either have or are developing the capacity and authority to integrate and manage the full continuum of physical and behavioral health care, from preventive services to hospital based services and to long term services and supports and /nursing home care. Such entities must also demonstrate their capacity and authority to address members' "social determinants"; that is, non-medical services that impact a member's health and ability to access care (e.g., housing, food), in a way that is acceptable to CMS and the State.

These standards established two "types" of qualified AEs depending on the capacity and focus of the participating entities:

- **Type 1 Accountable Entity: Total Population, All Services**
Authority to contract for all attributed populations, for all Medicaid services. A Type 1 AE must be responsible for the total cost of care of all attributed Medicaid populations enrolled in managed care and all Medicaid covered services that are included in EOHHS' contracts with MCOs. Services that are reimbursed by EOHHS in its fee for service programs shall not be included.
- **Type 2 Accountable Entity (Interim): Specialized Population, All Services**
Authority to contract for a specialized population, for all Medicaid services. A Type 2 AE must be responsible for the total cost of care for a specific, defined population (e.g., persons with SPMI or SMI) and all Medicaid covered services that are included in EOHHS' contracts with MCOs. Services that are reimbursed by EOHHS in its fee for service programs shall not be included.

Based on learnings during the pilot period EOHHS will proceed to develop the certification standards for fully qualified Accountable Entities. In order to retain certification, Accountable Entity Coordinated Care Pilots will be expected to become fully compliant with these new standards.

⁷ <http://www.purchasing.ri.gov/RVIP/StateAgencyBids/7549802.pdf>

⁸ <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE%20Pilot%20Application.pdf>

5. Contracting with EOHHS Approved PCMHs and Required PCMH Payments

Fundamental to health care system transformation is a strong foundation of high performing primary care practices. EOHHS is committed to continued support for primary care practice transformation and is aligning in this effort with the RI Office of the Health Insurance Commissioner.

For participating MCOs, by the end of the second contract period (by June 30, 2018) Contractor shall take such actions as are necessary so that 65% of members are assigned to a PCP in a practice that functions as a Patient-Centered Medical Home as recognized by the Rhode Island Office of the Health Insurance Commissioner and by EOHHS and as defined below.

By the end of the third Contract Period 3 (by June 30, 2019) and continuing through Contract Period 4 and 5 Contractor shall take such actions as are necessary so that 80% of members are assigned to a PCP in a practice that functions as a Patient-Centered Medical Home as recognized by the Rhode Island Office of the Health Insurance Commissioner and by EOHHS.

For the purposes of this provision EOHHS accepts OHICs determination of a qualified Patient-Centered Medical Home. Pursuant to Section 10(c)(2)(A) of OHIC Regulation 2, the Care Transformation Advisory Committee developed the following three-part definition of PCMH against which RI primary care practices will be evaluated and defined:

- a. ***Practice is participating in or has completed a formal transformation initiative⁹***
(e.g., CTC-RI, PCMH-Kids, RIQI'S TCPI, or a payer- or ACO-sponsored program) or practice has obtained NCQA Level 3 recognition. Practice meeting this requirement through achievement of NCQA Level 3 recognition may do so independent of participating in a formal transformation initiative.

- b. ***Practice has implemented the following specific cost-management strategies***
according to the implementation timeline included in the Plan as Attachment A (strategy development and implementation at the practice level rather than the practice site level is permissible):
 - i. *develops and maintains a high-risk patient registry that tracks patients identified as being at risk of avoidable intensive service use in the near future;*
 - ii. *practice uses data to implement care management¹⁰, focusing on high-risk patients and interventions that will impact ED and inpatient utilization;*

⁹ A formal PCMH transformation initiative is a structured training program for primary care providers and support staff with a pre-defined curriculum and technical assistance based on an evidence-based PCMH transformation model and designed to systematically build the skills within the practice to function as a PCMH.

¹⁰ Practices shall implement "care coordination" for children, which is a broader set of services not exclusively focused on high-risk patients. See R Antonelli, J McAllister, J. Popp. "Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework." The Commonwealth Fund, publication number 1277, May 2009.

- iii. *implements strategies to improve access to and coordination with behavioral health services;*
- iv. *expands access to services both during and after office hours;*
- v. *develops service referral protocols informed by cost and quality data provided by payers; and*
- vi. *develops/maintains an avoidable ED use reduction strategy.*

c. ***Practice has demonstrated meaningful performance improvement.***

During 2016 OHIC shall define the measures for assessing performance and the precise definition of “meaningful performance improvement” in consultation with the Advisory Committee. To promote measure alignment across statewide initiatives, measures selected to measure performance improvement will be selected from the multi-payer measure set adopted pursuant to CMS State Innovation Model (SIM) grant activity.

OHIC will take the lead in determining qualified practices. OHIC is coordinating with CTC, PCMH-Kids, RIQI, and payers to create a list of practices that payers may include in PCMH target calculation. By September 30, 2016, and annually thereafter, OHIC will determine applicant practices’ participation status in transformation initiatives.

6. Definition: High Cost, High Need Populations

Section 2, above, identifies the managed care contract goals for Alternative Payment methodologies. Line “C” of the table specifies the “Percent of Medicaid members enrolled in an EOHHS certified Accountable Entity, that are high cost, high need Medicaid members”. **For the purposes of this provision, high cost, high need Medicaid members are defined as those users with over \$15,000 of claims based expense.**

Background on EOHHS Selection of the \$15,000 Threshold

In SFY 2014, users with over \$25,000 in annual Medicaid claims expense accounted for 6% of Medicaid users and 65% of total program claims costs.¹¹ This phenomenon is not unique to Rhode Island, nor to public programs, as national statistics show that 5% of Americans account for nearly half of health care costs across the country.¹²

EOHHS has defined “high utilizers” as those Medicaid users with over \$15,000 of annual claims-based expense. The population with between \$15,000 and \$25,000 in annual expense is also included in the high cost, high utilizers definition, because absent intervention, they are potentially at high risk of moving into the over \$25,000 category. Using this broader definition, high utilizers made up 8% of average eligibles and 73% of Medicaid claims-specific expense in SFY 2014. Developing approaches to impact costs and reduce spending for these high utilizer populations requires an understanding of their circumstances – the programs and services they are accessing, their characteristics, and their health care needs.

EOHHS requires that Contractors propose a methodology for identification and measurement of high cost/high need eligible, in accordance with this definition, to be approved by EOHHS.

¹¹ Medicaid Expenditure Report, SFY 2014, page 30. Based on claims-specific payments, excludes expenditures that are not attributable to individual users.

http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/RI_Medicaid_Expnd_SFY2014_FINAL_2.pdf

¹² “The Concentration of Healthcare Spending”, National Institute for Healthcare Management Foundation Data Brief July 2012. Based on analysis of MEPS 2009 data.

Attachment A

OHHS Attribution Guidance for the AE Pilot Program

OHHS Attribution Guidance for the AE Pilot Program

Originally Issued: December 15, 2015

Revised: January 22, 2016

Definition

Attribution is the process of defining the population on which total costs are calculated for the purposes of identifying savings under a shared savings or risk contract. Effective attribution provides an incentive for providers and Accountable Entities to invest in care management and other appropriate services to keep their attributed population well, in the hope that they will earn savings. Attribution does not affect consumers' **freedom to choose or change their providers** at any point in their care. Consumer freedom of choice is independent of which attribution model Rhode Island Medicaid chooses.

Attribution Methodology Goals

OHHS seeks to establish an attribution method, to be applied across all MCOs and AEs that:

- Allows providers who have **historical responsibility for member costs** to earn savings by reducing those costs in the future;
- Allows **Integrated Health Homes (IHH)** to assume this responsibility for members with an approved IHH diagnosis;
- **Is transparent and understandable to all program participants;**
- **Is consistent with existing models in use in Rhode Island** – e.g., PCMH kids/ICI attribution, current PCP assignment.

Note – no single method accomplishes all of these goals.

Given the timing of this pilot we require that this methodology be implemented for January 1, 2016, for one year, during which the MCOs, together with AE partners and OHHS will assess the effectiveness of the required method and develop a plan for attribution in later years.

What we considered *(supporting materials provided in backup)*

1. EOHHS Attribution Guidance Provided to date *to MCOs in Amendment 10*
2. Learnings from other states and Medicare: Alternative Models
3. Current IHH Attribution Methodology
4. NHPRI Suggested Method
5. Integra/TPC Proposed Model
6. PCMH Kids Details

Attribution Methodology Notes

- A member can only be attributed to one (1) Pilot Entity or shared savings program at a time.

- Attribution must include all Medicaid populations enrolled in managed care. Rhody Health Options (RHO) members shall be excluded from AE attribution unless (i) the RHO member is receiving Medicaid benefits only (not Medicare), or (ii) the RHO member is receiving IHH services from a Type 2 AE contracted with the MCO.

Assignment Hierarchy

1st: IHH Assignment/Type 2 AE

If a member is assigned to an IHH, and that IHH is an approved Type 2 AE, then the member is attributed to the Type 2 AE. IHH assignment is based on BHDDH approved methodology as described below and in Backup #3.

1. **IHH Claims.** Includes CMHC claims only. Certain Procedure Codes excluded. Age \geq 18
2. **Diagnosis:** Include any claim with an approved diagnosis (backup #7).
3. **Specific Agency:** Specific agency based on the most recent paid claim.
4. **RIBHOLD:** Cross referenced vs. RIBHOLD list. Clients with an approved IHH diagnosis reported in RIBHOLD added to the attributed list.
5. **Active OTP Health Home clients** removed (not IHH attributed).

2nd: PCP Assignment

Attribute to the PCP to whom they are assigned upon enrollment

Considerations

- + **Builds on what we have** – consistent with the CTC and PCMH kids methodology.
- + **Easily implemented** – no new data to be collected, process already in place
- + **Captures all members** – all members either select or are assigned a PCP upon enrollment
- + **Prioritizes designated IHH providers who are Type 2 AEs**
- + **Prioritizes Level 3 PCMH** – consistent with MCO contract amendment 9, EOHHS priorities
- **Accuracy unclear** - ~10% of members select a PCP upon enrollment --reliant on assignment
- **Implications for AE attributed lives unclear** -- Assignment rules vary by MCO, and current MCO prioritization rules may result in limited attribution to some new AEs

Backup Documentation

1. Allowed IHH diagnosis codes

Backup: Allowed IHH diagnosis codes

ID	DSM-IV Code	DSM Code2	Axis	ICD-9 Dx Categories	DSM-IV-TR Category
1	295.10	29510	I	HEBEPHRENIA-UNSPEC	Schizophrenia, Disorganized Type
2	295.11	29511	I	HEBEPHRENIA-SUBCHRONIC	
3	295.12	29512	I	HEBEPHRENIA-CHRONIC	
4	295.13	29513	I	HEBEPHREN-SUBCHR/EXACERB	
5	295.14	29514	I	HEBEPHRENIA-CHR/EXACERB	
6	295.15	29515	I	HEBEPHRENIA-REMISSION	
7	295.2	2952	I	CATATONIC SCHIZOPHRENIA*	
8	295.20	29520	I	CATATONIA-UNSPEC	Schizophrenia, Catatonic Type
9	295.21	29521	I	CATATONIA-SUBCHRONIC	
10	295.22	29522	I	CATATONIA-CHRONIC	
11	295.23	29523	I	CATATONIA-SUBCHR/EXACERB	
12	295.24	29524	I	CATATONIA-CHR/EXACERB	
13	295.25	29525	I	CATATONIA-REMISSION	
14	295.3	2953	I	PARANOID SCHIZOPHRENIA*	
15	295.30	29530	I	PARANOID SCHIZO-UNSPEC	Schizophrenia, Paranoid Type
16	295.31	29531	I	PARANOID SCHIZO-SUBCHR	
17	295.32	29532	I	PARANOID SCHIZO-CHRONIC	
18	295.33	29533	I	PARAN SCHIZO-SUBCHR/EXAC	
19	295.34	29534	I	PARAN SCHIZO-CHR/EXACERB	
20	295.35	29535	I	PARANOID SCHIZO-REMISS	
28	295.5	2955	I	LATENT SCHIZOPHRENIA*	
29	295.50	29550	I	LATENT SCHIZOPHREN-UNSP	
30	295.51	29551	I	LAT SCHIZOPHREN-SUBCHR	
31	295.52	29552	I	LATENT SCHIZOPHREN-CHR	
32	295.53	29553	I	LAT SCHIZO-SUBCHR/EXACER	
33	295.54	29554	I	LATENT SCHIZO-CHR/EXACER	
34	295.55	29555	I	LAT SCHIZOPHREN-REMISS	
35	295.6	2956	I	RESIDUAL SCHIZOPHRENIA*	
36	295.60	29560	I	RESID SCHIZOPHREN-UNSP	Schizophrenia, Residual Type
37	295.61	29561	I	RESID SCHIZOPHREN-SUBCHR	
38	295.62	29562	I	RESIDUAL SCHIZOPHREN-CHR	
39	295.63	29563	I	RESID SCHIZO-SUBCHR/EXAC	
40	295.64	29564	I	RESID SCHIZO-CHR/EXACERB	
41	295.65	29565	I	RESID SCHIZOPHREN-REMISS	
42	295.7	2957	I	SCHIZOAFFECTIVE TYPE*	
43	295.70	29570	I	SCHIZOAFFECTIVE-UNSPEC	Schizoaffective Disorder
44	295.71	29571	I	SCHIZOAFFECTIVE-SUBCHR	
45	295.72	29572	I	SCHIZOAFFECTIVE-CHRONIC	

46	295.73	29573	I	SCHIZOAFF-SUBCHR/EXACER	
47	295.74	29574	I	SCHIZO AFFECT-CHR/EXACER	
48	295.75	29575	I	SCHIZO AFFECTIVE-REMISS	
49	295.8	2958	I	SCHIZOPHRENIA NEC*	
50	295.80	29580	I	SCHIZOPHRENIA NEC-UNSPEC	
51	295.81	29581	I	SCHIZOPHRENIA NEC-SUBCHR	
52	295.82	29582	I	SCHIZOPHRENIA NEC-CHR	
53	295.83	29583	I	SCHIZO NEC-SUBCHR/EXACER	
54	295.84	29584	I	SCHIZO NEC-CHR/EXACERB	
55	295.85	29585	I	SCHIZOPHRENIA NEC-REMISS	
56	295.9	2959	I	SCHIZOPHRENIA NOS*	
57	295.90	29590	I	SCHIZOPHRENIA NOS-UNSPEC	Schizophrenia, Undifferentiated Type
58	295.91	29591	I	SCHIZOPHRENIA NOS-SUBCHR	
59	295.92	29592	I	SCHIZOPHRENIA NOS-CHR	
60	295.93	29593	I	SCHIZO NOS-SUBCHR/EXACER	
61	295.94	29594	I	SCHIZO NOS-CHR/EXACERB	
62	295.95	29595	I	SCHIZOPHRENIA NOS-REMISS	
63	295.96	29596	I	SCHIZOPHRENIA NOS-REMISS	
64	296	296	I	AFFECTIVE PSYCHOSES*	
65	296.0	2960	I	MANIC DIS, SINGL EPISODE*	
66	296.00	29600	I	MANIC DISORDER-UNSPEC	Bipolar I Disorder, Single Manic Episode, Unspecified
67	296.01	29601	I	MANIC DISORDER-MILD	Bipolar I Disorder, Single Manic Episode, Mild
68	296.02	29602	I	MANIC DISORDER-MOD	Bipolar I Disorder, Single Manic Episode, Moderate
69	296.03	29603	I	MANIC DISORDER-SEVERE	Bipolar I Disorder, Single Manic Episode, Severe Without Psychotic Features
70	296.04	29604	I	MANIC DIS-SEVERE W PSYCH	Bipolar I Disorder, Single Manic Episode, Severe With Psychotic Features
71	296.05	29605	I	MANIC DIS-PARTIAL REMISS	Bipolar I Disorder, Single Manic Episode, In Partial Remission
72	296.06	29606	I	MANIC DIS-FULL REMISSION	Bipolar I Disorder, Single Manic Episode, In Full Remission
73	296.1	2961	I	MANIC, RECURRENT EPISODE*	
74	296.10	29610	I	RECUR MANIC DIS-UNSPEC	
75	296.11	29611	I	RECUR MANIC DIS-MILD	
76	296.12	29612	I	RECUR MANIC DIS-MOD	
77	296.13	29613	I	RECUR MANIC DIS-SEVERE	
78	296.14	29614	I	RECUR MANIC-SEV W PSYCHO	
79	296.15	29615	I	RECUR MANIC-PART REMISS	
80	296.16	29616	I	RECUR MANIC-FULL REMISS	
81	296.2	2962	I	DEPR PSYCH, SINGL EPISOD*	
82	296.20	29620	I	DEPRESS PSYCHOSIS-UNSPEC	Major Depressive Disorder, Single Episode, Unspecified

83	296.21	29621	I	DEPRESS PSYCHOSIS-MILD	Major Depressive Disorder, Single Episode, Mild
84	296.22	29622	I	DEPRESSIVE PSYCHOSIS-MOD	Major Depressive Disorder, Single Episode, Moderate
85	296.23	29623	I	DEPRESS PSYCHOSIS-SEVERE	Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
86	296.24	29624	I	DEPR PSYCHOS-SEV W PSYCH	Major Depressive Disorder, Single Episode, Severe With Psychotic Features
87	296.25	29625	I	DEPR PSYCHOS-PART REMISS	Major Depressive Disorder, Single Episode, In Partial Remission
88	296.26	29626	I	DEPR PSYCHOS-FULL REMISS	Major Depressive Disorder, Single Episode, In Full Remission
89	296.3	2963	I	DEPR PSYCH, RECUR EPISOD*	
90	296.30	29630	I	RECURR DEPR PSYCHOS-UNSP	Major Depressive Disorder, Recurrent, Unspecified
91	296.31	29631	I	RECURR DEPR PSYCHOS-MILD	Major Depressive Disorder, Recurrent, Mild
92	296.32	29632	I	RECURR DEPR PSYCHOS-MOD	Major Depressive Disorder, Recurrent, Moderate
93	296.33	29633	I	RECUR DEPR PSYCH-SEVERE	Major Depressive Disorder, Recurrent, Severe Without Psychotic Features
94	296.34	29634	I	REC DEPR PSYCH-PSYCHOTIC	Major Depressive Disorder, Recurrent, Severe With Psychotic Features
95	296.35	29635	I	RECUR DEPR PSYC-PART REM	Major Depressive Disorder, Recurrent, In Partial Remission
96	296.36	29636	I	RECUR DEPR PSYC-FULL REM	Major Depressive Disorder, Recurrent, In Full Remission
97	296.4	2964	I	BIPOLAR AFFECTIVE, MANIC*	
98	296.40	29640	I	BIPOL AFF, MANIC-UNSPEC	Bipolar I Disorder, Most Recent Episode Hypomanic, Manic, Unspecified
99	296.41	29641	I	BIPOLAR AFF, MANIC-MILD	Bipolar I Disorder, Most Recent Episode Manic, Mild
100	296.42	29642	I	BIPOLAR AFFEC, MANIC-MOD	Bipolar I Disorder, Most Recent Episode Manic, Moderate
101	296.43	29643	I	BIPOL AFF, MANIC-SEVERE	Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features
102	296.44	29644	I	BIPOL MANIC-SEV W PSYCH	Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features
103	296.45	29645	I	BIPOL AFF MANIC-PART REM	Bipolar I Disorder, Most Recent Episode Manic, In Partial Remission
104	296.46	29646	I	BIPOL AFF MANIC-FULL REM	Bipolar I Disorder, Most Recent Episode Manic, In Full Remission
105	296.5	2965	I	BIPOLAR AFFECT, DEPRESS*	
106	296.50	29650	I	BIPOLAR AFF, DEPR-UNSPEC	Bipolar I Disorder, Most Recent Episode Depressed, Unspecified
107	296.51	29651	I	BIPOLAR AFFEC, DEPR-MILD	Bipolar I Disorder, Most Recent Episode Depressed, Mild
108	296.52	29652	I	BIPOLAR AFFEC, DEPR-MOD	Bipolar I Disorder, Most Recent Episode Depressed, Moderate

109	296.53	29653	I	BIPOL AFF, DEPR-SEVERE	Bipolar I Disorder, Most Recent Episode Depressed, Severe Without Psychotic Features
110	296.54	29654	I	BIPOL DEPR-SEV W PSYCH	Bipolar I Disorder, Most Recent Episode Depressed, Severe With Psychotic Features
111	296.55	29655	I	BIPOL AFF DEPR-PART REM	Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission
112	296.56	29656	I	BIPOL AFF DEPR-FULL REM	Bipolar I Disorder, Most Recent Episode Depressed, In Full Remission
113	296.6	2966	I	BIPOLAR AFFECTIVE, MIXED*	
114	296.60	29660	I	BIPOL AFF, MIXED-UNSPEC	Bipolar I Disorder, Most Recent Episode Mixed, Unspecified
115	296.61	29661	I	BIPOLAR AFF, MIXED-MILD	Bipolar I Disorder, Most Recent Episode Mixed, Mild
116	296.62	29662	I	BIPOLAR AFFEC, MIXED-MOD	Bipolar I Disorder, Most Recent Episode Mixed, Moderate
117	296.63	29663	I	BIPOL AFF, MIXED-SEVERE	Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features
118	296.64	29664	I	BIPOL MIXED-SEV W PSYCH	Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features
119	296.65	29665	I	BIPOL AFF, MIX-PART REM	Bipolar I Disorder, Most Recent Episode Mixed, In Partial Remission
120	296.66	29666	I	BIPOL AFF, MIX-FULL REM	Bipolar I Disorder, Most Recent Episode Mixed, In Full Remission
121	296.7	2967	I	BIPOLAR AFFECTIVE NOS	Bipolar I Disorder, Most Recent Episode Unspecified
122	296.70	29670	I	BIPOLAR AFFECTIVE NOS	
123	296.8	2968	I	MANIC-DEPRESSIVE NEC/NOS*	
124	296.80	29680	I	MANIC-DEPRESSIVE NOS	Bipolar Disorder NOS
125	296.81	29681	I	ATYPICAL MANIC DISORDER	
126	296.82	29682	I	ATYPICAL DEPRESSIVE DIS	
127	296.89	29689	I	MANIC-DEPRESSIVE NEC	Bipolar II Disorder
128	301.2	3012	II	SCHIZOID PERSONALITY*	
129	301.20	30120	II	SCHIZOID PERSONALITY NOS	Schizoid Personality Disorder
131	301.22	30122	II	SCHIZOTYPAL PERSONALITY	Schizotypal Personality Disorder
138	301.83	30183	II	BORDERLINE PERSONALITY	Borderline Personality Disorder
139	300.3	3003	I	OBSESSIVE-COMPULSIVE DIS	Obsessive-Compulsive Disorder
140	300.30	30030	I	OBSESSIVE-COMPULSIVE DIS	
144	297.1	2971	I	PARANOIA	Delusional Disorder
145	297.10	29710	I	PARANOIA	
146	298.9	2989	I	PSYCHOSIS NOS	Psychotic Disorder NOS
147	298.90	29890	I	PSYCHOSIS NOS	
150	296.9	2969	I	MOOD DISORDER NOS*	
151	296.90	29690	I	MOOD DISORDER NOS	Mood Disorder NOS

Attachment B:

EOHHS Total Cost of Care (TCOC) Guidance for the AE Pilot Program

EOHHS Total Cost of Care (TCOC) Guidance for the AE Pilot Program

January 28, 2016

Definition

The total cost of care (TCOC) calculation is a fundamental element in any shared savings and/or risk arrangement. Most fundamentally it includes a historical baseline or benchmark cost of care specifically tied to an Accountable Entity's (AE) attributed population projected forward to the performance period. Actual costs during the performance period are then compared to those projections to identify a potential shared savings or risk pool, depending on the terms of the arrangement.

Effective TCOC methodologies provide an incentive for AEs to invest in care management and other appropriate services to keep their attributed population well, in the hope that they will earn savings. Shared savings distributions must be scaled in light of comprehensive and well-defined quality and outcomes metrics.

TCOC Development and Approval

Medicaid Managed Care Organizations (MCOs) and AEs will establish TCOC calculation methodologies to serve as the basis of their shared savings and/or risk arrangements. These methodologies must be approved by OHHS.

OHHS will review the MCO's TCOC methodologies and reserves the right to ask for modifications before granting approval.¹³ MCOs may submit details of their TCOC methodologies to OHHS for approval in advance of contracting with AEs.

Alternatively, if their TCOC methodology has not been approved in advance, then MCOs must submit details of their TCOC methodology to OHHS within 15 days of concluding contracts with AEs at the latest. If MCOs choose to utilize the post-contracting TCOC approval option, then their AE contracts must include appropriate language to account for the possibility of alterations to their TCOC methodology resulting from the OHHS approval process.

MCOs must submit applications for TCOC approval to OHHS in writing. Applications must demonstrate compliance with the requirements outlined in this guidance, and must provide comprehensive answers to all questions posed herein. Simple numerical examples may be helpful. OHHS's approval, denial, or requests for amendment will also be transmitted in

¹³ In addition to this EOHHS requirement, note that depending on circumstances transparency in such arrangements is specifically required in CFR42 §438.6 Contract requirements 438.6(g): Inspection and audit of financial records – Risk contracts must provide that the state agency and the Department may inspect and audit any financial records of the entity or its subcontractors. 438.6(h) Physician Incentive plans – MCO contracts must provide for compliance with the requirements set forth in 422.208 and 422.210 of this chapter. 436.6(k) All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

writing, without unreasonable delay. Material amendments to TCOC methodology must be approved by OHHS in advance.

If an MCO utilizes a TCOC methodology that differs in any respect from the approved methodology, then OHHS reserves the right to calculate risk- and gain-share with the MCO as if the approved methodology had been utilized, and the MCO shall provide OHHS with all information necessary to make that calculation.

OHHS also reserves the right to review these methodologies on an annual basis. In future years, OHHS may consider working with the MCOs and AEs to develop a uniform TCOC methodology.

TCOC Methodology Goals

In reviewing proposed TCOC methodologies, OHHS will favor methodologies that, to the greatest extent possible:

1. Maximize the financial incentives for AEs to engage with higher cost patient populations, and to reduce health care spending in these populations through the provision of high-quality and coordinated care;
2. Minimize the financial incentives for AEs to “cherry pick,” i.e. to lower an AE’s TCOC through increased representation within an AE’s attributed population of patients who would be expected to be lower-cost even absent the AE’s approach to care coordination;
3. Minimize the financial incentives for AEs to lower costs through withholding, delaying, or restricting access to medically appropriate care or services;
4. Include adequate application of comprehensive quality and outcomes metrics before the calculation of any shared savings distribution;
5. Build baselines and performance year projections using reliable historical data and actuarially sound methodology that is specific to the attributed population of each AE and, when projecting forward to performance year, includes appropriate risk adjustment methodologies;
6. Adequately protect the solvency of AEs, MCOs, and the RI Medicaid program.

Considerations

- **Ensure that the methodology supports the goals of the AE program and the Reinventing Medicaid initiative**
- **Allow variation in pilot methodology**
Provide MCOs and AEs freedom and flexibility to develop own approaches, and build on current practices if available. Allow OHHS to review and evaluate different approaches, and potentially identify best practices.

- **Recognize (and limit where possible) challenges associated with a lack of uniformity**
May make it difficult for AEs to work towards a single set of performance goals. May make program evaluation difficult.
- **Allow OHHS and MCOs to work towards standardization** in future years if appropriate

TCOC Methodology: Required Elements

MCO TCOC arrangements with Accountable Entities must meet the following requirements:

1. Covered Services

TCOC methodologies shall include all costs associated with benefits and services that are included in OHHS's contract with MCOs for the performance year. Any excluded costs must be explicitly requested and pre-approved by EOHHS, whether for baselining or for performance measurement purposes.

2. Historical Benchmarking

Baselines and performance year projections must use data that are specific to the attributed population of each AE. The methodology must describe how the baseline population is matched to the attributed population. Unless specifically approved by OHHS, risk adjustment shall not be applied while calculating an AE's historical baseline costs, though changes in an attributed population's risk profile may be considered when projecting historical costs forward into the performance year.

3. Performance Time Period

TCOC methodologies shall include a minimum 12-month performance period during which costs will be measured and compared to projections, and where quality and outcome metrics will be measured with scores impacting eligibility for shared savings distributions. The methodology must specify this performance period.

4. Cost Trend Assumptions

When projecting (or trending) historical costs forward into the performance year, TCOC methodologies shall appropriately account for trends in the medical component of capitation rates being paid to MCOs by OHHS. Unless otherwise approved by OHHS, trends assigned to TCOC baselines shall not exceed the final cumulative trends to the medical portion of rates contained in the OHHS data books for the appropriate product line, after consideration of all factors affecting the medical component of capitation rates. For the rate period of Jan. 1, 2016 through June 30, 2016, those trends can be found in the following tables of the following data books:

- RIte Care – Table 8
- Children with Special Healthcare Needs – Table 10¹⁴
- Rhody Health Partners – Table 11
- Rhody Health Options – Exhibit 11

¹⁴ The CSHN data book for this period contains two Table 10s. We refer to the Table 10 found at page 21, rather than the Table 10 found at page 17.

5. Impact of Quality and Outcomes on Distributions

An appropriate comprehensive quality score factor must be applied to any shared savings pool to determine the actual amount of the pool eligible for distribution (e.g. a quality score of 75% applied to a shared savings pool of \$100 = maximum pool of \$75). The methodology must specify the quality and outcome metrics that are considered in calculating shared savings distributions. Quality and outcome metrics must, to the greatest extent possible, be comprehensive and include the full range of Medicaid-funded care that AE-attributed patients will receive. Recognizing that this may not be possible in year 1, OHHS also prefers for MCOs to utilize measures identified by the Measure Alignment Workgroup of RI's State Innovation Model (SIM) project. The TCOC methodology must also specify the quality score factor – that is, how the metrics impact the calculation of shared savings distributions.

6. Maximum Total Shared Savings Pool

The total savings pool for an AE eligible for shared savings calculation shall not exceed 10% of the projected TCOC for that AE.

7. Exclusivity of Approved TCOC Methodologies

MCO TCOC arrangements shall supersede and be exclusive of any other TCOC-related shared savings arrangements with an AE or any of its constituent providers.

TCOC Application

MCO TCOC applications must demonstrate compliance with the TCOC requirements outlined above. Applications must also include detailed answers to the following:

1. Benchmark Time Period

Historical data from what time period is used to establish an AE's cost benchmark? How does the methodology account for attributed patients for whom no historical data is available?

2. Benchmark Data Source

What data sources are used to establish an AE's cost benchmark?

3. Risk Adjustment

What risk adjustment methodology is used to project an AE's cost benchmark forward into the performance year?

4. Risk Mitigation

What strategies or methodologies are used to truncate or exclude outlier costs to mitigate an AE's risk for catastrophically large costs?

5. Trend Projections

How is an AE's baseline cost projected forwarded into the performance year? What trend factors are used and how are those trend factors calculated? How are the trend factors appropriately linked to trends in capitation rates paid to MCOs by OHHS, as outlined in the

appropriate OHHS rate development data book tables? How do the trend projections account for changes to the MCO in-plan benefit package between the baseline year(s) and performance year?

6. Mid-Year Changes

How does the TCOC calculation account for month-to-month changes in MCO enrollment and/or PCP assignment, whether during benchmark years or the performance year? How does the TCOC calculation account for month-to-month changes in the PCP roster of an AE, whether during benchmark years or the performance year?

7. Minimum Savings Rate

What is the minimum threshold rate of savings that must be achieved before an AE is eligible for shared savings distributions?

8. Quality and Outcome Metrics

What quality and outcome metrics are being used to measure AE performance? Please include National Quality Forum (NQF) numbers or other details allowing OHHS to identify each measure specifically. How are benchmarks or goals identified for each metric? How are those metrics applied to impact potential shared savings distributions? What efforts have been made (or will be made in the future) to utilize measures identified by the SIM Measure Alignment Workgroup?

9. Shared Savings Distribution Rate and Calculation

What portion of the eligible shared savings pool (after accounting for scaling based on quality and outcomes metrics) will be distributed to the AE?

10. Shared Savings Distribution Timing

At what time are shared savings distributions made to qualifying AEs? If distributions are made more than annually, please also describe any true-up processes.

11. Small Populations

Does the TCOC model differ when an AE's attributed populations is relatively small? If so, how? And at what population size thresholds do these differences attach? If the population threshold is something other than 5,000 lives, then please explain why this threshold is the appropriate one.

Appendices:

1. Prior EOHHS TCOC Guidance as described in the AE Application

Appendix 1: Prior TCOC Guidance as included in the AE Pilot Application

Total Cost of Care Calculation and Quality Score

The total cost of care calculation (TCOC) is a fundamental element in any shared savings and/or risk arrangement and requires careful analysis. Most fundamentally it will include a baseline or benchmark cost of care projected forward to the performance period. Actual costs during the performance period are then compared to those projections to identify a potential shared savings or risk pool, depending on the terms of the arrangement.

Any savings observed must be in light of defined quality metrics to help ensure that any cost savings that are realized are due to improved care and outcomes rather than denial of care. EOHHS will require that any agreement with an MCO will provide that an appropriate quality score factor be applied to any shared savings pool to determine the actual amount of the pool eligible for distribution (e.g. a quality score of 75% applied to a shared savings pool of \$100 = maximum pool of \$75).

The specific terms of the savings and risk transfer between the MCO and the AE are at the discretion of the contracting parties. Note that shared savings, shared risk and full risk models are all potential constructs for these arrangements. EOHHS does not intend to stipulate the terms of these arrangements but does reserve the right to review and approve them.¹⁵

CMS has issued guidance for shared savings programs for both Medicaid and for Medicare Shared Savings Programs. For ease of reference links to relevant State Medicaid Director Letters are provided below:

- www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf
- www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-002.pdf

Links for the Medicare Shared Savings Program final rule and a CMS Factsheet are also provided:

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Methodology_Factsheet_ICN907405.pdf

The Shared Savings Program final rule can be downloaded at <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf> on the Government Printing Office (GPO)

¹⁵ In addition to this EOHHS requirement, note that depending on circumstances transparency in such arrangements is specifically required in CFR42 §438.6 Contract requirements 438.6(g): Inspection and audit of financial records – Risk contracts must provide that the state agency and the Department may inspect and audit any financial records of the entity or its subcontractors. 438.6(h) Physician Incentive plans – MCO contracts must provide for compliance with the requirements set forth in 422.208 and 422.210 of this chapter. 436.6(k) All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

Attachment C

PROTOCOL FOR SUBMISSION OF MATERIAL MODIFICATION REQUESTS BY PROVISIONALLY CERTIFIED
PILOT ACCOUNTABLE ENTITIES

PROTOCOL FOR SUBMISSION OF MATERIAL MODIFICATION REQUESTS BY PROVISIONALLY CERTIFIED
PILOT ACCOUNTABLE ENTITIES

The Executive Office of Health and Human Services (OHHS) has received requests to consider allowing individual Accountable Entities (AEs) to materially enhance their PCP networks or make other substantive changes. All requested changes must be pre-approved by the OHHS. The following is the formal process that a provisionally certified AE must use to submit a request:

1. An official request must be submitted in writing by the provisionally certified AE.
2. Requests will be reviewed as part of the quarterly AE Review Process by OHHS.
3. Request must include the following:
 - A brief description of the requested change
 - A brief statement of the anticipated impact the change will have on each of the 5 domains, as noted under “Qualifications for Pilot Entities” in the Guidelines for Accountable Entity Certification
 - Listing of any proposed changes in PCP or other provider networks, as appropriate
4. Request must include assurance that if approved, the change will be acceptable to any MCO’s with which the Pilot AE has a contractual relationship.

Submit any requests for changes to:

Sharon Kernan Interdepartmental Project Manager Executive Office of Health and Human Services 74 West Road
Cranston RI 02920 Sharon.kernan@ohhs.ri.gov 401-462-3392
Fax 401 462-6352

RI EOHHS

February 2, 2016 1

ATTACHMENT D

Alternative Payment Methodology Reporting Template

KRISTIN

**APM REPORTING TEMPLATE GOES HERE
COULD BE A PASTED PICTURE OR A URL REFERENCE**