

Accountable Entity Coordinated Care Pilot Program Program Description and Application

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Table of Contents

I. Introduction and Purpose

II. Background and Context

Current Program Characteristics
Authority and Governance
Multi-Year Plan for Reinventing Medicaid
Accountable Entity Program Design

III. Coordinated Care Pilot Program Structure

IV. Qualifications for a Coordinated Care Pilot Entity

Domain 1: Responsible Entity and Governance
Domain 2: Organizational Capability: Leadership and Management Structure
Domain 3: Organizational Capability: Readiness to Develop and/or Provide an Integrated Multidisciplinary System of Care
Domain 4: Minimum Population Served
Domain 5: Data and Analytics Capacity

V. Guidelines for Submission of an Application

A. Cover Letter Specifications
B. Summary of Proposal
C. Description of Proposed Approach and Evidence of Readiness
D. Evidence of Quality Performance
E. Implementation Plan: Pilot and AE Development Projects

VI. Applicant Evaluation and Selection

VII. Timeline

VIII. Appendix A

DRAFT AE Certification Standards -- for reference and review

I. Introduction and Purpose

The Rhode Island Executive Office of Health and Human Services (EOHHS), through the contracted Medicaid Managed Care Organizations (MMCOs), invites provider based entities interested in participating in a SFY 2016 Coordinated Care Pilot program to contract with Rhode Island MMCOs to provide care to Medicaid managed care enrollees. The Coordinated Care Pilot program is part of a broader initiative by EOHHS to promote and support the development of integrated multi-disciplinary Accountable Entities (AEs) capable of providing superior health outcomes for Medicaid populations within value based payment arrangements.

This pilot program, slated to begin in January 2016, provides a fast-track path for interested organizations to partner with EOHHS and its contracted Medicaid managed care organizations (MCOs) in transforming the structure of the health care delivery system to reward value instead of volume. It also presents an opportunity for early learnings to inform development of the Certified Accountable Entity (AE) Program.

Shortly following the issuing of this guidance for the Coordinated Care Pilot program EOHHS will be initiating its process for certification of Accountable Entities. EOHHS intends that certified accountable entities will provide the central platform for transforming the structure of the delivery system as envisioned in the Final Report of the Reinventing Medicaid Working Group that was convened by Governor Raimondo in March of 2015. The core objectives of the AE program include:

- Substantially transition away from fee-for-service models
- Define Medicaid-wide population health targets, and, where possible, tie them to payments.
- Maintain and expand on our record of excellence in delivering high quality care.
- Deliver coordinated, accountable care for high-cost/high-need populations
- Ensure access to high-quality primary care
- Shift Medicaid expenditures from high-cost institutional settings to community-based settings

Certified Accountable Entities will have responsibility for coordinating the full continuum of health care services for defined populations. Populations will be identified through an attribution process based primarily on where they receive their primary medical care. Included in any such population will be people with complex and specialized needs since these are the groups within the larger population who are most in need of an effectively coordinated system. An effective AE must be able to meet the needs of the full population but must also have distinct competencies to recognize and address the special needs of high risk and “rising risk” sub groups. Two high priority capabilities for the Medicaid population are:

- *Priority 1: Integration and Coordination of Long term services and supports*
Nearly half (45%) of claims expenditure on high cost users is on nursing facilities and residential and rehabilitation services for persons with developmental disabilities.
- *Priority 2: Physical and behavioral health integration*
Forty percent (40%) of claims expenditure on high cost users (those with over \$15,000 in annual payments for services) is on high utilizers living “in the community”. Among these high

utilizers living in the community, 82% of expenditures were for persons with co-occurring mental health or substance and physical health needs, underscoring the need for an integrated person-centered approach to care.

Toward this end, Certified Accountable Entities will ultimately be required to demonstrate that they meet specified standards, including provider representation, governance requirements, required scope of services and capacity. These entities will then be qualified to contract with MMCOs within the allowable contractual parameters documented here. Pending federal approval, Certified Accountable Entities will also be eligible to participate in the state's Delivery System Reform Incentive Program (DSRIP), which is currently under discussion between EOHHS and CMS.

Under this Coordinated Care Pilot Program, applicants deemed pilot eligible will immediately be eligible to enter into a contractual arrangement with the Medicaid MCOs to manage a population of Medicaid members under a risk adjusted cost of care arrangement. Two types of Coordinated Care Pilots are envisioned:

- **Type 1 Coordinated Care Pilot: Total Population, All Services**
Authority to contract for all attributed populations, for all Medicaid services
- **Type 2 Coordinated Care Pilot: SPMI/SMI Population, All Services**
Authority to contract for a specialized population, for all Medicaid services. For the pilot, Type 2 Coordinated Care Pilots may only be established for persons with SPMI or SMI.

The requirements for designation as Pilot eligible entity are less rigorous than the anticipated AE certification standards. EOHHS recognizes that Pilot participants will not have sufficient time to put all of the AE certification elements in place in the time frame for the Pilot but must specify their Notice of Intent to pursue certification within the longer term AE Certification process.

The state intends that over time this new program structure will ultimately become the primary contracting model in the Medicaid program. Payments to and enrollment in these Accountable Entities will then be one of the main mechanisms by which the Reinventing goals of transitioning to value-based care delivery will be accomplished. As such, EOHHS intends that by 2018, 25 percent of Medicaid members will be enrolled in an accountable integrated provider network.

Note that EOHHS does not intend to contract directly with Pilot Eligible Accountable Entities. The intent of this Pilot application and the designation of Pilot Eligible Entities is therefore to provide qualifications and guidelines for the Medicaid MCOs, as they transition to value based purchasing models and accountable care. As such, these qualifications and guidelines shall also be reflected in the Medicaid Managed Care procurements.

II. Background and Context

Rhode Island has a strong history of successful Medicaid managed care implementation with an established MCO infrastructure and a strong multi-payer medical home infrastructure (CSI). Medicaid managed care members have access to broad networks of care, robust member services and supports and high levels of beneficiary responsiveness/coordination. RI MCOs are nationally recognized as among the highest quality MCOs in the United States.

While there are considerable strengths in the current system – which EOHHS seeks to retain - there are also significant opportunities to continue to improve and move beyond current levels of performance. A core premise of Medicaid MCO reform in Rhode Island is that the program can better meet the triple aim -- enhanced care experience, improved health, and reduced cost of care -- if we can better align with the following principles articulated in the Reinventing Medicaid report:

- Pay for value, not for volume
- Coordinate physical, behavioral, and long-term health care
- Rebalance the delivery system away from high-cost settings

This proposed Accountable Entity structure is therefore intended to establish a structure for financial alignment of incentives across providers that could better align with these principles, and therefore better meet the triple aim.

Current Program Characteristics

Effective certification standards and contracting requirements must also consider the following characteristics of the current Rhode Island Medicaid program, as described in the Rhode Island Annual Medicaid expenditure report for SFY 2014. Specifically:

- *Populations Served*

The Rhode Island Medicaid program served 221,000 average eligibles in SFY 2014. Including the Medicaid expansion population, more than one-quarter of Rhode Islanders were enrolled in Medicaid for some part of SFY 2014. Over half of Medicaid SFY 2014 expenditures (59.7%) was for Elders and Adults with Disabilities. Children & families, children with special health care needs and Medicaid Expansion Populations accounted for 24.8%, 8.7% and 6.8% of Medicaid expenditures respectively.

While significant, the average number of eligibles in SFY 2014 understates the current picture as it masks the program growth that began in the second half of SFY 2014. Effective January 1, 2014 eligibility began for the Expansion population of low income (less than 133% of the federal poverty level) adults without dependent children. Enrollment in the Rite Care program for children and families has also continued to grow, though at a much lower level.

- *Medicaid Program Expenditures*

The Rhode Island Medicaid program was a \$2,005 million program in SFY 2014. Over the period SFY 2010-2014, RI Medicaid expenditures increased by 1.1% per year on average, which is notably low as compared to national Medicaid and regional commercial experience.

- *Participating Providers*

Medicaid program funds are used to reimburse a variety of providers. Together, hospitals and

nursing facilities account for nearly half of program expenditure.

- *Long-term Services and Supports*

Long-term services and supports, including both institutional care and home and community based services, accounted for about 40% of Medicaid expenditures.

- *Managed Care*

As of SFY 2014, eighty percent (80%) of Medicaid average eligibles were enrolled in managed care programs, and these managed care enrollees accounted for 58% of Medicaid expenditures. Those figures have continued to grow as the Medicaid Expansion population is enrolled in managed care. Also, Rhody Health Options (a managed care option for persons eligible for both Medicaid and Medicare) began in November of 2013 and so was in effect for only a portion of SFY 2014. Both of Rhode Island’s participating Medicaid Managed Care Organizations (MMCOS) ranked in the top 10 Medicaid plans in the nation in CY 2014 and have been among the nation’s top rated MMCOS since the rankings began.

The table below provides a current summary of managed care enrollment by health plan.

Managed Care Enrollment as of September 2015				
	NHP	UHC	Total	% of Total
Rite Care	93,528	46,577	140,105	57%
Children with Special Health Care Needs*	7,332	1,671	9,003	4%
Rhody Health Options	18,321	0	18,321	7%
Medicaid Expansion	34,335	28,367	62,702	26%
Rhody Health Partners	6,796	7,459	14,255	6%
Combined Total	160,312	84,074	244,386	100%
<i>% of Total</i>	66%	34%	100%	

*Including children in substitute care arrangements

- *High Utilizers*

In SFY 2014, the 6% of Medicaid users with the highest costs accounted for almost two thirds (65%) of Medicaid claims expenditure. Nearly half (45%) of claims expenditure on high cost users was on nursing facilities and residential and rehabilitation services for persons with developmental disabilities.

Authority and Governance

The effort to establish and certify accountable entities is undertaken in concert with the broader health care reform efforts of the state.

- **March 2015: Working Group Established**

Governor Gina Raimondo issued Executive Order 15-08, establishing the “Working Group to Reinvent Medicaid.”

- **April 2015: Initial Working Group Report, Year 1 (SFY 2015) Plan**

The working group delivered an initial report to the Governor in April 2015 outlining a series of short-term payment and delivery system steps for fiscal year 2016 designed to lay the groundwork for longer-term reform. One key SFY 2016 initiative specified in this report was the *Coordinated Care Pilot Program*, under which EOHHS proposed to establish a coordinated care

program with a community provider that uses a shared savings model.

- **June 2015: Reinventing Medicaid Act of 2015**

In June 2015, the RI General Assembly passed the Reinventing Medicaid Act of 2015, placing into law the Working Group’s initial recommendations.

- **July 2015: Final Working Group Report, Multi-Year Plan**

In July 2015, the Working Group delivered their final report, articulating a multi-year plan for transformation of the Medicaid program. This report specified longer-term goals for system transformation based on the principles identified below.

Multi-Year Plan for Reinventing Medicaid

The final Reinventing Medicaid report articulates the following **four (4) 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

Based on these principles, the Working Group recommended **several initiatives grouped into three overarching domains**:

- **Payment and Delivery System Reforms:** initiatives that transform Rhode Island’s Medicaid system into one that pays for quality and value, rather than volume, and promotes better quality of care and patient experience.
- **Targeting Fraud, Waste, and Abuse:** initiatives that ensure Medicaid programs operate in compliance with state and federal laws and regulations, and root out wasteful, unnecessary, or fraudulent spending and utilization.
- **Administrative and Operational Efficiencies:** initiatives that streamline and improve state oversight of the Medicaid program.

The Accountable Entity Initiative, including the Coordinated Care Pilot and the anticipated Delivery System Reform Incentive Program (DSRIP) all are **part of the first domain, Payment and Delivery Reforms**.

For this first domain, the Working Group has established an **initial set of high level metrics**, to be refined through the DSRIP development process and CMS:

- By 2018, 90 percent of Medicaid payments to providers will have some aspect that is tied to quality or value
- By 2018, 50 percent of Medicaid payments will be made through an “alternative payment model,” including payments to Accountable Care Organizations, bundled payments, or others.
- By 2018, 25 percent of Medicaid members will be enrolled in an accountable integrated provider network

The Reinventing Medicaid Amendment passed by the legislature included the following provisions for implementation of these initiatives:

- *Pilot Coordinated Care Program.* EOHHS proposes to establish a coordinated care program with a community provider that uses a shared savings model. Creating a new service delivery option may require authority under the Medicaid waiver demonstration and may necessitate amendments to the state plan. The adoption of new or amended rules may also be required.
- *Alternative Payment Arrangements* – EOHHS proposes to develop and implement alternative payment arrangements that maximize value and cost-effectiveness, and tie payments to improvements in service quality and health outcomes. Amendments to the section 1115 waiver and/or the Medicaid state plan may be required to implement any alternative payment arrangements the EOHHS is authorized to pursue.

Accountable Entity Program Design

EOHHS is committed to moving forward with transformation activities – both to work with Coordinated Care Pilot partners during SFY 2016 and to set forth the pathways to achieve the longer-term goals described above.

In pursuing the development of Medicaid certified accountable entities, EOHHS' efforts align with approaches being pursued across the country by public and private payers. Integrated care initiatives incorporating principles of value-based care are in various stages of development and implementation across the country.

In Rhode Island, EOHHS' starting point was **seeking to promote and support the development of a new type of entity equipped with the necessary characteristics and capabilities to achieve meaningful improvements in our systems of care.** Key considerations include:

- **A multi-disciplinary capacity** with a strong foundation in high performing primary care practices, effective integration between behavioral health and physical health, and with specialists and/or hospitals;
- **Ability to manage the full continuum of care**, including “social determinants”. An effective accountable entity will have the capacity, tools, authority to integrate and manage the full continuum of physical and behavioral health care, from preventive services to hospital based and long term/nursing home care;
- **Analytic capacity** to support data driven decision-making and real time interventions;

To approach the task of how to best advance such models in Rhode Island, EOHHS issued an RFI in August 2015 seeking feedback on three dimensions:

- Guidance/comments on proposed certification standards for Accountable Entities
- Interest in becoming certified as an Accountable Entity, authorized to become accountable for a population of Medicaid eligibles through a risk based contract with Medicaid MCOs.
- Interest in participation in a Coordinated Care Pilot, effective January 1, 2016

EOHHS is pleased to have received 14 responses with many thoughtful comments and recommendations. Additionally, several parties expressed both strong interest in becoming a

certified AE as well as reservations about their ability to be fully ready prior to January 1, 2016. Concerns included their ability to develop infrastructure, relationships, and entities to support the pilot as well as ability to implement the strategies they thought would be most effective in impacting outcomes for the population. Respondents suggested that the state incorporate progressive steps of moving from initial phases to arrangements with full risk.

Along with issuing the RFI, EOHHS has been actively tracking the approaches and experiences in several other states that have been pursuing development of Accountable Entities. In addition to helping to inform approaches to structuring AE programs, experience in other states has also shown the distinct value of progressive learnings and program refinements based on initial steps.

Based on feedback from the RFI and experience in other states, EOHHS has therefore established two linked but parallel processes.

1. EOHHS is seeking entities interested in participating in a FY 2016 pilot.

This is an opportunity to get underway and obtain early learnings. The requirements for designation as a Pilot eligible entity are less rigorous than the AE certification standards. EOHHS recognizes that Pilot participants will not have all of the pieces of AE certification in place, but must specify their Notice of Intent to pursue certification within the longer term AE Certification process.

2. EOHHS is also developing a process and standards for establishing Certified Accountable Entities.

This process will begin in February, when final certification standards will be posted, and allows for a longer time line, linked to the commitments to CMS under DSRIP, to certify Accountable Entities who are both qualified to enter into a risk based contract with Medicaid MCOs and (pending CMS approval) eligible for DSRIP program participation and development funds.

Although certification standards remain in development by EOHHS a current draft of the Accountable Entity certification standards is included as Appendix A to this guidance. This can provide interested parties with a picture as to how EOHHS' approach has evolved since the RFI was issued.

III. Coordinated Care Pilot Program Structure

The AE Coordinated Care Pilot Program is based on a contractual agreement currently under development between the state and the MCO. Through a Contract Amendment with the State, the MCO will be required to enter into a contract with at least two Pilot Eligible entities in accordance with the terms below. Additionally EOHHS will strongly encourage MCOs to contract with all Pilot eligible AEs.

Evidence of contracts with Pilot Eligible entities will be designated in the MCO re-procurement as a highly desirable component of a bid. To the degree that AE-MCO contracts are in place the state will modify its gain sharing arrangements with the MCOs to ensure that both the AE and the MCO have incentives to enter into contracted arrangements together in accordance with this program.

Pilot applicants must commit to the following terms:

1. Agreement Term

Three year pilot term beginning January 1, 2016 or April 1, 2016, depending on the timing of entry into the program. After one year either party can choose not to renew (a) if facing substantial financial losses or (b) in the event of demonstrated poor quality in performance, or (c) other failure to fulfill contractual requirements.

2. Populations and Services Included

Applicants must specify if they are applying as a Type 1 or 2 Coordinated Care Pilot entity:

a. Type 1 Coordinated Care Pilot: Total Population, All Services

Authority to contract for all attributed populations, for all Medicaid services. A Type 1 pilot entity must include the following populations and services in the pilot and the calculations of the total cost of care:

- i. All attributed Medicaid populations enrolled in managed care; and
- ii. 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.

b. Type 2 Coordinated Care Pilot: SPMI/SMI Population, All Services

Authority to contract for a specialized population, for all Medicaid services. A Type 2 pilot entity must include the following populations and services in the pilot and the calculations of the total cost of care:

- i. Must include a specific defined population - persons with SPMI or SMI as identified per BHDDH and EOHHS protocols; and
- ii. Must include 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.

3. 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.¹

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/sharesavingsprogram/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) website

4. Member Choice

Members must have access to the right care, at the right time and in the right setting. Applicants must provide assurance that the proposed AE will not limit or restrict beneficiaries to providers within the AE network. Accountable Entity provider relationships may not impact member choice and/or the member's ability to access providers contracted or affiliated with the MCO, including not requiring patients to obtain prior approval from a primary care gatekeeper or otherwise before utilizing the services of providers outside the AE network. Consistent with CFR 438.108, members seeking care within the MCO network but outside the AE may not be charged additional fees nor be negatively impacted in any other way such as disenrollment from the AE.

While AE based network limits, restrictions and fees are prohibited, MCOs and AEs may encourage utilization of preferred networks provided that rewards or positive financial incentives used are nominal and specifically linked with health promoting plans of care. All incentives and methods of encouragement of preferred networks must be consistent with CMS requirements for Medicaid.²

¹ 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.

² Next Generation ACO summary on CMS website: <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/index.html>. Next Generation ACO RFA, which includes section on beneficiary coordinated care rewards: <https://innovation.cms.gov/Files/x/nextgenacorfa.pdf>

5. Member Assignment/Attribution

a. Basis for Attribution

The goal for the Pilot Program is for each participating Pilot Program AE to be assigned at least 5,000 members and up to 25,000 Medicaid members. However, the minimum of 5,000 members is a guideline, and smaller programs will be allowed to apply. Pilot applicants must identify the PCP practices that would be the basis for attribution of the population. These members will be either prospectively assigned by the MCO based on current PCP enrollment; or attributed based on a methodology consistent with the attribution guidelines described below. EOHHS does not intend to stipulate the terms of these arrangements but does reserve the right to review and approve them.³

b. Attribution guidelines – The attribution method must seek to preserve existing provider-recipient relationships as specified in CFR Section 438.50 and may consider:

- i. Primary use of a PCP who is an identified member of the network
- ii. A demonstrated relationship with a CMHC and/or receiving of SPMI or SMI services.
- iii. A demonstrated primary clinical relationship with another (non PCP) specialist or provider who is an identified member of the network
- iv. Census track – member who is in a census track of a participating PCP (or CMHC) who has no identifiable primary source of care.

c. Note – a member can only be attributed to one Medicaid shared savings program at a time.

6. MCO Capitation

The MCO retains the base contract with the state, and the MCO medical capitation will be adjusted for the anticipated savings associated with the pilot program. There will be no gain-share between the state and the MCO for the pilot population. This does not preclude MCOs from creating value based purchasing arrangements with non-AE providers, however those contracts would still be subject to the State gain-share and would not be included in the state's assessment of the MCO's value based payment performance standards.

7. Delegation of MCO required services

It is anticipated that successful development of an AE will include a new distribution of responsibilities between the MCO and the AE and that these will be identified in the written agreement between the parties. Given varied considerations offered in the EOHHS RFI on the appropriate distribution of functions and the time frame in which such functions might be delegated, EOHHS is not at this point taking a specific position on this question for fully certified AEs. However, for the Pilot the following services may not be delegated:

- Network contracting
- Provider payment/claims processing
- Member services
- Grievances and Appeals

³ See footnote above on transparency requirements.

Note that the limitation on network contracting does not preclude pilot AEs from implementing payment relationships with downstream providers, but rather is intended to ensure that the structure of the network and member access to providers remain the responsibility of the MCO. From the Federal point of view, note that CFR 42 Section 438 provides the primary regulatory framework for Medicaid managed care programs. Section 438.230 specifically addresses “Subcontractual relationships and delegation”. For reference Section 438.230 is provided below:

[§438.230 Subcontractual relationships and delegation.](#)

a) *General rule.* The State must ensure, through its contracts, that each MCO, PIHP, and PAHP—

- (1) Oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor; and
- (2) Meets the conditions of paragraph (b) of this section.

(b) *Specific conditions.*

- (1) Before any delegation, each MCO, PIHP, and PAHP evaluates the prospective subcontractor's ability to perform the activities to be delegated.
- (2) There is a written agreement that—
 - (i) Specifies the activities and report responsibilities delegated to the subcontractor; and
 - (ii) Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
- (3) The MCO, PIHP, or PAHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.
- (4) If any MCO, PIHP, or PAHP identifies deficiencies or areas for improvement, the MCO, PIHP, or PAHP and the subcontractor take corrective action.

IV. Qualifications for a Coordinated Care Pilot Entity

Accountable Entities interested in participating in the Coordinated Care Pilot program must demonstrate evidence of readiness across the following required domains as specified below.

Domain 1: Responsible Entity and Governance

Applicant must be a distinct corporate entity with defined responsibility for ensuring that the performance requirements of its Pilot eligibility and of its contract with an MCO are fully met. To the degree that the application is submitted on behalf of multiple partners collaborating on this project, a primary contractor must be clearly identified. Collaborative and contractual partnerships to achieve the goals of the pilot are permissible and encouraged as appropriate but the respective roles and responsibilities associated with these arrangements need to be clearly delineated.

- Pilot eligible AEs will be required to convene a Community Advisory Council made up of stakeholders in the AE's service area, the majority of whom must be consumer representatives with representation from the different populations served by the AE (e.g., families, people with different types of disabilities, seniors). The Community Advisory Council shall meet at least bi-monthly. The entity must establish standards for publicizing the activities of the AE and the AE's Community Advisory Council, as necessary, to keep the community informed.
- Pilot eligible AEs must establish and maintain a governing board with adequate authority to execute the required services and functions of an AE. Critical community participants must be included in the governing board of the Accountable Entity and must have the ability to influence or direct the integration of care and clinical practice to improve outcomes. If the AE is not a single corporation, the governing board must be separate and unique to the AE and not the same as a governing board of any specific accountable entity participant. However, individuals may be allowed to serve on the governing board of both the AE and an AE participant. The governing board must be fully responsible for the AE's administrative, fiduciary and clinical operations. The administration must report exclusively to the governing board. Participants in the governing board are specified as follows – note that one person cannot fill more than one of the below specified requirements:
 - Need not be proportional to AE participants, but must be representative of a variety of participating practitioners (e.g., primary care, specialties, behavioral health, waiver services). Must include a community child health practitioner.
 - Must include at least two health care providers in active practice, including a physician or a nurse practitioner whose area of practice is primary care; and a mental health or chemical dependency treatment provider.
 - Must include at least two members from the community at large, at least one of whom understands and can represent the unique needs of the different Medicaid populations, to ensure that the organization's decision-making is consistent with the values of the members and the community.
 - Must include at least one Medicaid beneficiary served by the AE.
 - Must include at least one member of the AE's Community Advisory Council.

Domain 2: Organizational Capability: Leadership and Management Structure

A Pilot eligible AE must have a leadership and management structure that includes a Rhode Island based executive, a medical director who is board-certified and licensed in the State of Rhode Island, and a compliance officer. The AE must establish and maintain an ongoing quality assurance and process improvement program overseen by an appropriately qualified Rhode Island based health care professional.

Domain 3: Organizational Capability: Readiness to Develop and/or Provide an Integrated Multi-Disciplinary System of Care

Pilot eligible AEs will have accountability for the total cost of care for a full spectrum of services as appropriate to serve the specified population. AEs must demonstrate that they have the capacity to develop and/or provide a full range of primary, specialty, behavioral health and care management services.

- **Provider Network and Profile**

The AE must be able to identify a strong complement of providers participating in its proposed delivery system with particular emphasis on high performing primary care practices (e.g., the number and type of primary care providers and provider sites of its delivery system and which of them have been accredited as Patient Centered Medical Homes; behavioral health providers; specialists, hospitals, community health supports, others). Note this capacity may exist in concert with that of a participating managed care organization that, for example, has contractual arrangements with a broader network of providers than is resident within the applicant structure.

- **Integrated Multi-Disciplinary System of Care**

A central goal of EOHHS in this initiative is promoting the development of Accountable Entities with the capabilities to play central roles in transforming the system of care for Medicaid eligible populations. EOHHS understands that this is a process of furthering capabilities that are in various stages of development; and applicant pilot AEs are unlikely to have in place the full set of organizational competencies necessary to be successful. To that end, successful applicants will describe the critical organizational and/or clinical practice actions they would seek to undertake to enable them to most effectively impact on the health outcomes for populations they propose to serve.

Domain 4: Minimum Population Served – Linkage to Provider Network

Minimum volume thresholds are important to ensure that entities can reasonably be held accountable to the total cost of care. Absent a minimum volume of Medicaid eligibles, variations in cost associated with individual high cost cases cannot be adequately managed. As such, EOHHS intends that Type 1 Pilot eligible AEs be responsible for the total cost of care associated with a minimum of 5,000 unique Medicaid enrollees. AE applicants who will be responsible for fewer than 5,000 unique Medicaid enrollees must explain how they will manage variation in costs given a smaller population. Type 2 Pilot eligible AEs must be responsible for the total cost of care associated with their attributed population of Medicaid eligibles uniquely identified as SPMI or SMI.

As of September 2015 just over 244,000 Medicaid eligibles were enrolled in Medicaid managed care plans. These include children and families in Rite Care, children with special health care needs, adults

with disabilities in Rhody Health Partners or Rhody Health Options, and adults without dependent children (Expansion population). With a reasonable degree of accuracy the applicant AE will be able to identify the segments and size of the population served by the system of care included in their proposal. EOHHS anticipates that the primary method of attribution will be use of a primary care provider in the network or use of behavioral health provider for individuals with SPMI or SMI.

Domain 5: Data and Analytic Capacity

Data capacity is central to the ability of the organization to effectively recognize short and long term utilization and cost patterns for the population and to identify critical points of intervention for individuals. A pilot eligible AE will need to have the ability to monitor and understand utilization and cost data and will need access to real time or near real time data for coordination of care for individuals. Beyond data alone, the entity will need to have the analytic capacity to effectively use that data to inform care. Such data capacity may be resident within the applicant entity or provided in part by another party, e.g. an MCO. Development of effective data capacity remains an ongoing challenge throughout the health care system. Applicant entities must be able to describe plans for data and analytic capacity.

V. Guidelines for Submission of an Application

The Coordinated Care Pilot Program application will have two rounds—the first application due date will be **November 13, 2015**, with an initial agreement term that begins **January 1, 2016**, and consists of three one-year performance periods. The second application due date will be **January 6, 2016**, with an initial agreement term that begins **April 1, 2016**, and consists of *two* one-year performance periods.

This Pilot is an opportunity for early learnings toward a more rigorous certification process and DSRIP program requirements currently under development at EOHHS. As such, interested Pilot applicants must respond to this request by the deadlines specified in the timeline (Section VII of this document) with the following five components, further described below:

- A. Cover Letter
- B. Summary of Proposal
- C. Description of Proposed Approach and Evidence of Readiness
- D. Evidence of Quality Performance
- E. Pilot Implementation Plan

Applicants may then be invited to meet with EOHHS to review/discuss status of the organization and readiness to participate in the pilot

After this meeting, EOHHS will provide formal notice designating successful applicants as Pilot eligible AEs and as such those designated AEs **will be immediately eligible to contract with participating MMCOs under the terms of the pilot for the specified pilot period**. Depending on circumstances this designation of Pilot eligibility may include contingencies identifying any requirements that the applicant must meet and/or commit to meeting in order to become designated as Pilot eligible.

Applicants that agree to these commitments will also be deemed Pilot Eligible and will be eligible to contract with participating MCOs under the terms of the pilot for the specified pilot period. Note that a condition for all Pilot eligible AEs will be that the Pilot AE fulfills its commitment to pursuing Certified Accountable Entity status as that process moves forward.

In February 2016, EOHHS intends to post the final Accountable Entity Certification standards, linked to the commitments to CMS under DSRIP. EOHHS seeks to certify Accountable Entities that are (a) qualified to enter into a risk-based contract with Medicaid MCOs and (b) (pending CMS approval) eligible for DSRIP program participation and development funds. EOHHS intends that Pilot AEs will be designated as a target recipient of DSRIP funds and prequalified for a higher level of DSRIP funding support, assuming they are able to successfully achieve full AE certification within a defined time frame. In the letter of intent, Pilot applicants must commit to participating in this broader program.

EOHHS reserves the right to decide at any time not to move forward with the Certified Accountable Entity program and/or the Coordinated Care Pilot or to modify or terminate the program if it is determined that it is not achieving the established principles and goals.

A. Cover Letter Specifications

The Letter of Intent must include the following:

1. Applicant Information

- a. Provide the legal name and brief description of the applicant Accountable Entity. For example is this a single corporation? Is it a formal partnership?
- b. Provide the mailing address for the applicant entity.
- c. Provide the name, title, mail address, telephone and email information about the lead contact for the application. This individual will be the primary point of contact between EOHHS and the applicant. The person should be an executive employed by the applicant or a consultant retained by one or more of the parties who is designated by the applicant to have primary responsibility for responding to EOHHS inquiries.

2. Intent to Participate in the AE Coordinated Care Pilot

- a. Specify the applicant's intention to participate as a Type 1 or Type 2 Pilot AE.
- b. Specify the applicant's intention to apply in Round 1 (initial agreement term that begins January 1, 2016) or Round 2 (initial agreement term that begins April 1, 2016).

3. Intent to apply to become a Certified Accountable Entity

Confirm applicant's intent to apply for Certified AE status when such an application is released (anticipated in February, 2016).

B. Summary of Proposal

Please provide a brief description of the proposal that demonstrates an understanding of the goals of the Pilot Program and pilot requirements. Please also include a justification for participation in the Pilot, outlining the organization's readiness in accordance with the five domains specified above.

C. Description of Proposed Approach and Evidence of Readiness

1. Description of Proposed Approach

Applicants must provide the following evidence of organizational structure and readiness to serve as a Pilot eligible Accountable Entity.

Domain 1: Responsible Entity and Governance

Describe the corporate structure of the applicant AE – single entity or partnership. If structure is a partnership, please include a description of all AE participants and a description of the partnership structure, including the criteria used to enter into agreements with providers/partners and how any shared savings or risk will be distributed among applicant AE participants.

Please include the following documentation:

- a. Legal documentation of AE formation, including articles of incorporation and

organizational bylaws. If the entity has no separate legal structure, describe current and anticipated future structure.

- b. Sampling of current partnership agreements, employment contracts and operating policies that demonstrate the current structure of such arrangements. Personal information (e.g. SSN and home addresses) should be redacted from such documents.
- c. Documentation specifying transparency standards, including standards for publicizing the activities of the AE and the AE's Community Advisory Council.
- d. List of members of the governing body, specifying how they fulfill the governance requirements.
- e. Description of plans to convene a Consumer Advisory Council and to publicly disseminate information about the AE and the Council.
- f. Most recent three years of audited financial statements for the entity must be available upon request.

Domain 2: Organizational Capability: Leadership and Management Structure

Describe the organizational structure of the applicant AE, including specifying the executive, Medical Director, compliance officer and their responsibilities. Describe the planned implementation of the Pilot Program compliance plan, including description of how federal and state regulatory requirements and changes are tracked and updated. Describe how the applicant AE will assure that participants and provider partners adhere to the quality assurance and improvement program and clinical guidelines.

Please include the following documentation:

- a. A copy of the compliance plan if it is already developed.
- b. Documentation that supports the quality assurance and improvement program, such as participation agreements, employment contracts and operating policies. As above, personal information should be redacted.

Domain 3: Organization Capability: Readiness to Develop and/or Provide an Integrated System of Care

Describe the applicant AE's network development/ network strategy for RI and the status of this development effort, including description of known gaps in the network and how these gaps are currently addressed. Describe the applicant AE's readiness to be responsible for the total cost of care for a population of Medicaid eligibles, specifically to include complex behavioral health services. Also describe experience in managing complex behavioral health services, both here in Rhode Island and/or in other markets. Specifically address experience in managing substance use disorder services and patients, and experience managing the Serious and Persistent Mental Illness (SPMI) population as well as experience managing patients with other types of complex needs (e.g., people with IDD, TBI, quadriplegia). Describe current and planned relationships with community organizations that can address social determinants of health – housing, employment, food security, transportation and substance use disorder recovery.

3a. Provider Network and Profile

Please include the following documentation:

1. Documentation delineating and quantifying the AE network scale and scope, including PCP counts, BH provider counts and specialists by type.
2. Documentation confirming that the primary care network is PCMH based.
3. List any current and planned relationships with community mental health centers or other behavioral health organizations.

3b. Integrated System of Care

Describe the critical organizational and/or clinical practice actions the organization would seek to undertake to best achieve the goals of the integrated system of care. Include descriptions of any specific projects currently planned or underway.

3c. Prior Relevant Experience

Describe any current or prior total cost of care, shared savings, or risk based contracts. For each contract, please describe the partnering entities, populations and services included, and the financial incentives involved (shared savings, shared risk, global capitation, incentive payments, etc.).

Please provide at least three references of partners or affiliates experienced in working with the applicant. Applicants with prior total cost of care, shared savings or risk-based contracts should include references from those specific contracts. Include at least one Rhode Island health plan partner, serving commercial or Medicaid eligibles (not Medicare). Include at least one Rhode Island based provider organization that is not specifically included in the Accountable Entity governance. Please provide the name of the organization, a specific contact person, and their phone number and email address.

Domain 4: Identification of the Minimum Required Population

Document the current number of Rhode Island Medicaid enrolled members that have either selected a PCP or primarily use a PCP who is an identified member of the applicant's network. If possible, provide a report of such enrolled members by PCP.

Domain 5. Data and Analytics Capacity

Describe the means that will be used by the applicant AE to assure the ability to submit claims/encounter data to the MCO and receive aggregated performance data. Describe the status of EHR meaningful use within the AE, including current stage of meaningful use conditions and recent progress and future plans toward achieving meaningful use standards. Demonstrate adoption and workflow integration of a hospital and ED notification service (e.g. CurrentCare Hospital Alerts) for admissions/discharges/transfers.

D. Evidence of Quality Performance

Applicant AEs must demonstrate high quality and clinical performance standards as evidenced in recent and historical trends related to both national and local providers. Please include the following metrics as evidence of quality performance. To the extent possible, include local performance, and at least three years of historical performance.

- **Member Experience Metrics**
 - Member satisfaction with access to urgent care (CAHPS)
 - Patient experience (CAHPS) for providers
 - Complaints

- **Utilization Metrics**
 - Ambulatory Care Sensitive ED Visit utilization
 - All cause and Avoidable Inpatient readmission within 30 days
 - Return to ED within 7 days of hospital discharge
 - Outpatient/ambulatory care utilization
 - Behavioral Health Utilization

- **Member Access Metrics**
 - Network adequacy/Geographic access standards
 - Timeliness to Behavioral Health, primary care appointments
 - Provider visit within 7 days of discharge
 - Follow up after Hospitalization for Mental Illness within 7 days/30 days of discharge

Please also include any other relevant quality metrics currently tracked by the entity, along with specific baselines and identified benchmarks/goals. Examples include CAHPS, HEDIS, JCAHO, etc. Where possible/relevant, please specify the local (Rhode Island specific) quality and clinical performance of the entity.

E. Implementation Plan: Pilot and AE Development Projects

Please provide a detailed workplan for implementation of the Coordinated Care Pilot with an MCO partner organization, including key milestones, deliverables and business owners.

Please also identify and provide an implementation plan for a set of at least three clearly defined longer-term projects working toward the development and enhancement of an effective Accountable Entity. These projects must be intended to either (1) Increase delivery system integration through forming teams of providers across the continuum of care; or (2) Improve information exchange and clinical integration across the existing continuum of care. Where possible, these projects should specifically relate to one of the two priorities described in Section I: Introduction and Purpose:

- Priority 1: Integration and Coordination of Long term services and supports
- Priority 2: Physical and Behavioral Health Integration

VI. Applicant Evaluation and Selection

All responsive applications received by the deadline will be evaluated by the State on a 100-point scale considering the following:

1. Summary of Proposal (10 points)
2. Description of Proposed Approach and Evidence of Readiness (50 points)
3. Evidence of Quality Performance (25 points)
4. Implementation Plan: Pilot and AE Development Projects (15 points)

The state reserves the right to reject any or all proposals as “not qualified” if they do not demonstrate reasonable potential for successful AE development.

VII. Timeline

The timeline for this project is specified in detail below:

	Pilot Round 1	Pilot Round 2	AE Certification	DSRIP
Oct 2015	Posted pilot application		Draft AE certification standards posted by EOHHS	
Nov 2015	Round 1 Responses Applications due for Round 1 Pilot candidates			
Dec 2015	<ul style="list-style-type: none"> Meeting to review status of organization along dimensions of AE Pilot eligibility standards Add'l Requirements Specified: State IDs required AE commitments to be deemed pilot eligible Deemed Pilot Eligible AE agrees to required commitments 		Comments due on draft AE certification standards	EOHHS Submits DSRIP application to CMS
Jan 2016	Round 1 Pilot Effective Date	Round 2 Responses Applications due for Round 2 candidates Meeting to review status of organization along dimensions of AE Pilot eligibility standards		
Feb 2016		Add'l Req'ts Specified State IDs required commitments to be deemed pilot eligible Deemed Pilot Eligible AE agrees to required commitments	Final certification standards and Certified AE application posted by EOHHS	
Mar 2016				EOHHS posts grant req'ts for DSRIP Component 2: Transition to AE (draft)
Apr 2016		Round 2 Pilot Effective Date	Certified AE Applications Due	
May 2016				
Jun 2016				
Jul 2016			AEs Certified by EOHHS <ul style="list-style-type: none"> DSRIP Eligible Certified AEs may enter risk based contracts w/ MMCOs 	<ul style="list-style-type: none"> CMS DSRIP Approval Final DSRIP grant requirements posted by EOHHS (Only Certified AEs may apply)
Aug 2016				Grant applications due
Sep 2016				
Oct 2016				Grants approved, funds available

Specific, immediate deadlines for the Pilot program are as follows:

Friday, October 30th, 2015

Final Pilot application distributed by EOHHS and participating health plans
Draft Full AE Certification requirements distributed for comment

Pilot Round 1

- Friday, November 13, 2015:
Round 1 Pilot applications due
- Friday November 27th, 2015
Round 1 Pilot Eligible Entities designated
- Friday, January 1, 2016
Pilot effective date

Pilot Round 2

- Wednesday, January 6th, 2016
Round 2 Pilot applications due
- Wednesday January 27th 2016
Round 2 Pilot Eligible Entities designated
- Friday, April 1, 2016
Round 2 Pilot effective date

Full AE Certification (Draft timeline, may be revised)

- Tuesday, December 15th, 2016
Comments due to EOHHS on draft AE certification standards
- Friday, February 12th, 2016
Final AE Application and Certification Standards posted
- Friday, April 1, 2016
AE Applications Due
- Friday, June 24, 2016
AEs certified by EOHHS

VIII. Appendix

DRAFT AE Certification Standards – for reference and review

Definition of an Accountable Entity

The Dartmouth Institute defines an Accountable Care Organization as follows:

*A Group of primary care providers, specialists and/or hospital and other health professionals who manage the full continuum of care and are accountable for the total costs and quality of care for a defined population.*⁴

More specifically, EOHHS' starting point was **seeking to promote and support the development of a new type of entity equipped with the necessary characteristics and capabilities to achieve meaningful improvements in our systems of care.** As such, a Rhode Island Medicaid Certified Accountable Entity (AE) must include:

- **A multi-disciplinary capacity** with a strong foundation in high performing primary care practices, effective integration between behavioral health and physical health, and with specialists and/or hospitals;
- **Ability to manage the full continuum of care**, including “social determinants”. An effective accountable entity will have the capacity, tools, authority to integrate and manage the full continuum of physical and behavioral health care, from preventive services to hospital based and long term/nursing home care;
- **Analytic capacity** to support data driven decision-making and real time interventions:

Draft certification standards require that Accountable Entities be certified as at one of three levels depending on the readiness of the participating entities. The state intends that all Accountable Entities will make substantial progress toward becoming fully certified within 3 years. The state reserves the right to reconsider certification decisions absent such progress, as experience in other states and Medicare would suggest that such a commitment to substantial progress is critical to ongoing program development and success.

Accountable Entity Types

AEs must specify their intention to be certified as a Type 1 or 2 Accountable Entity.

- **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

⁴ The Dartmouth Institute for Health Policy and Clinical Practice
<http://tdi.dartmouth.edu/research/evaluating/health-system-focus/accountable-care-organizations/about-us>

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.

Note: This is an interim classification – all Type 2 AEs must transition to Type 1 within 2 years.

Accountable Entity Certification Levels

In order to be certified, an AE must demonstrate readiness across a specified list of requirements, as shown below. Based on the combined readiness across these requirements, an AE will be certified as at one of three stages of readiness.

- **Initial Certification**
AEs with strong potential for development. Many of the core elements, and/or commitments are in place. This is a one-year certification – AEs with “Initial Certification” must progress to “Provisional Certification” by year 2.
- **Provisional Certification**
AEs who provided a strong proposal with most of the core elements and/or commitments in place AND a specific plan to achieve readiness on a defined schedule. This is a 2-year certification – AEs with “Provisional Certification” must progress to “Full Certification” by year 3.
- **Full Certification (Type 1 only)**
AEs who demonstrated that all of the core elements and commitments are in place AND are ready to implement.

EOHHS recognizes that AE “readiness” will vary considerably, and that most AEs are not likely to achieve full certification in year one. As such, the certification process allows for different stages of readiness, and entities will be expected to “progress toward” Full Certification within the timelines specified above.

AE Certification Standards

Entities seeking to be Type 1 or Type 2 Certified Accountable Entities must demonstrate readiness across the following required domains as specified below:

1. Responsible Entity and Governance
2. Organizational Capability: Leadership and Management Structure
3. Organizational Capability: Readiness to Provide an Integrated, Multi-disciplinary System of Care
4. Minimum Population Served – Linkage to Provider Network
5. Data and Analytic Capacity
6. Financial Requirements: Total Cost of Care and Quality Score
7. Provider Exclusivity and Member Choice
8. Administrative Capacity for Delegated Functions
9. Demonstrated Quality and Clinical Performance

Domain 1 Responsible Entity and Governance

As stated above, EOHHS' starting point was seeking to promote and support **the development of a**

new type of entity equipped with the necessary characteristics and capabilities to achieve meaningful improvements in our systems of care. As such, these governance rules are designed to ensure that Accountable Entities are distinctly and uniquely organized, and are not simply a new line of business for an existing provider entity. Additionally, EOHHS intends that critical community participants are included in the leadership team of the AE and that such participants have the ability to influence or direct clinical practice to improve outcomes.

- **Corporate Structure**

Applicant must be a distinct corporate entity, uniquely organized to be an Accountable Entity, with defined responsibility for ensuring that the performance requirements of its state certification and of its contract with an MCO are fully met.

- Corporate structure must allow direct contracting with an MCO and accountability for total cost of care and assurance of quality for an attributed population.
- An Accountable Entity may be either a single corporate structure or a network of providers (AE participants) organized through formal contractual relationships. To the extent the AE is a network of providers with formal contractual relationships – there must be a single corporate entity, with responsibility for the performance and compliance of each of its parts.
- Each Accountable Entity will be required to convene a Community Advisory Council (CAC), made up of stakeholders in the AE’s service area, the majority of whom must be consumer representatives with representation from the different populations served by the AE (e.g., families, people with different types of disabilities, seniors).

- **Governing Board**

An AE must establish and maintain a governing board with full authority to execute the required services and functions of an AE. Critical community participants must be included in the leadership team of the Accountable Entity and must have the ability to influence or direct the integration of care and clinical practice to improve outcomes.

- If the AE is not a single corporation, the governing board must be separate and unique to the AE and not the same as a governing board of any specific accountable entity participant. However, individuals may be allowed to serve on the governing board of both the AE and an AE participant.
- The governing board must be fully responsible for the AE’s administrative, fiduciary and clinical operations. The administration must report exclusively to the governing board.
- The governing board must have a conflict of interest policy calling for disclosure of relevant financial interests and for a procedure to determine whether conflicts exist and an appropriate process to resolve conflicts in line with the requirements of the MCO contracts and CFR 438.610⁵.
- Participants in the governing board are specified as follows, note that one person cannot

⁵ CFR 438.610 (Medicaid MCO) cannot knowingly contract with or have a relationship with an individual who is debarred, suspended or otherwise excluded from participating and/or an individual who is an affiliate of director, officer, partner of MCO, who has beneficial ownership of 5% or more of MCO equity, or has a significant employment or consulting arrangement with the MCO.

fill more than one of the below specified requirements:

- Need not be proportional to AE participants, but must be representative of a variety of participating practitioners (e.g., primary care, specialties, behavioral health, waiver services). Must include a community child health practitioner. Partner organizations (e.g., FQHCs, hospitals, specialist groups, nursing homes, etc.) must also be appropriately represented.
- Must include at least two health care providers in active practice, including a physician or a nurse practitioner whose area of practice is primary care; and a mental health or chemical dependency treatment provider.
- Must include at least two members from the community at large, at least one of whom understands and can represent the unique needs of the different Medicaid populations, to ensure that the organization's decision-making is consistent with the values of the members and the community.
- Must include more than one Medicaid beneficiary served by the AE.
- Must include at least one member of the AE's Community Advisory Council.

- **Transparency**

The AE governing board must establish standards for publicizing the activities of the AE and the AE's Community Advisory Council, as necessary, to keep the community informed. Transparency standards must cover costs, quality and shared saving distributions. All transparency information must be made available to the State upon request, and must be consistent with federal requirements as specified in §438.6.⁶

Domain 2 Leadership and Management Structure

AEs must have a leadership and management structure that includes clinical and administrative systems as described below.

- Operations are managed by a Rhode Island based executive who must certify that all AE participants are willing to be accountable for overall care of the Medicaid beneficiaries assigned to the AE and to report on quality and cost measures for those beneficiaries.
- The appointment and removal of the executive must be under the control of the AE's governing board.
- The AE must have a medical director who is an AE physician and is board-certified and licensed in the State of Rhode Island. This physician, who may be part time, must be physically present at one of the AE's Rhode Island locations at least 20% of the time.
- The AE must have a compliance officer who reports directly to the governing board. The compliance officer cannot be legal counsel to the AE.

⁶ 438.6(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.

The AE must establish and maintain an ongoing quality assurance and process improvement program overseen by an appropriately qualified Rhode Island based health care professional and shall include organizational arrangements and ongoing procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in health care administration and delivery.

- The quality management procedures shall include defined methods for the identification and selection of standardized quality measures applicable to the populations served by the AE.
- Quality performance metrics shall be jointly developed by the AE and MCO and derived from multiple sources, including but not limited to administrative (claims and encounter) data, medical record reviews, participant complaints, consumer surveys, disease registries and other data sources as deemed necessary.
- The AE shall address deficiencies identified through these processes using a standard quality improvement methodology.
- EOHHS shall have the right to review documents such as meeting minutes, policies and protocol, committee structures, oversight and monitoring protocols, audit plans within compliance work plan, and other materials related to the quality management and improvement program to ensure that an appropriate quality management and improvement program is in place.

Domain 3: Organizational Capability: Readiness to Provide an Integrated Multi-Disciplinary System of Care

AEs will be held accountable to total cost of care for the entire attributed population and for the full spectrum of Medicaid managed care In Plan services, including primary, specialty, and behavioral health services as appropriate to serve the specified population.

- **Provider Network and Profile**
AEs must demonstrate a strong complement of providers participating in its proposed delivery system with particular emphasis on high performing primary care practices (e.g., the number and type of primary care providers and provider sites of its delivery system and which of them meet OHIC's definition of Patient Centered Medical Homes; behavioral health providers; specialists, hospitals, community health supports, others). Note this capacity may exist in concert with that of a participating managed care organization that, for example, has contractual arrangements with a broader network of providers than is resident within the AE structure.
- **Integrated Multi-Disciplinary System of Care**
A central goal of EOHHS in this initiative is promoting the development of Accountable Entities with the capabilities to play central roles in transforming the system of care for Medicaid eligible populations. EOHHS understands that this is a process of furthering capabilities that are in various stages of development; and applicants for certification are unlikely to have in place the full set of organizational competencies necessary to be successful. To that end, successful applicants will describe the critical organizational and/or clinical practice actions they will undertake to enable them to most effectively impact on the health outcomes for populations they propose to serve.

- **Patient Centered Medical Home**

AEs must be patient centered medical home based: at least 50% of an Accountable Entity's attributed members must be enrolled in a qualified PCMH as defined by OHIC.

- **Social Determinants**

AEs must integrate with community organizations that can address social determinants of health: housing, employment, food security, transportation and substance use disorder recovery.

Domain 4 Minimum Population Served – Linkage to Provider Network

Minimum volume thresholds are important to ensure that entities can reasonably be held accountable to the total cost of care. Absent a minimum volume of Medicaid eligibles, variations in cost associated with individual high cost cases cannot be adequately managed.

As such, EOHHS intends that Type 1 AEs be responsible for the total cost of care associated with a minimum of 5,000 unique Medicaid enrollees. AEs who will be responsible for fewer than 5,000 unique Medicaid enrollees must explain how they will manage variation in costs given a smaller population. Type 2 AEs must be responsible for the total cost of care associated with their attributed Medicaid eligibles uniquely identified as part of their specified population but do not need to meet a minimum population served.

As of September 2015 just over 244,000 Medicaid eligibles were enrolled in Medicaid managed care plans. These include children and families in Rite Care, children with special health care needs, adults with disabilities in Rhody Health Partners or Rhody Health Options, and adults without dependent children (Expansion population). With a reasonable degree of accuracy the AE will be able to identify the segments and size of the population served by the system of care included in the proposal. EOHHS anticipates that the primary method of attribution will be use of a primary care provider in the network or use of a specialist health provider for individuals attributed to Type 2 AEs.

Domain 5 Data and Analytic Capacity

Expert guidance suggests that In order to move to a more accountable model of care, AEs must have access to real time or near real time data and have the analytic capacity to effectively use that data to inform care. As such, AEs must demonstrate the following minimum data and analytic capacity:

- Ability to submit claims data to the MCO and receive aggregated performance data
- Meet “stage 2 meaningful use” conditions according to the CMS EHR Incentive program.⁷
- Demonstrate that a minimum of 25% of AE patients are currently enrolled in Current Care, and document a plan for increased Current Care enrollment.

Domain 6 Financial Requirements: Total Cost of Care and Quality Score

Contracted relationships with MCOs must be based on a total cost of care (TCOC) calculation. 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

⁷ <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>

benchmark risk adjusted 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. In such an arrangement, (1) the benchmark risk adjusted total cost of care projected forward to the performance period minus (2) the actual cost of care in the performance period equals (3) the potential shared savings pool.

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. In such an arrangement, actual shared savings pool should equal (1) potential shared savings pool multiplied by (2) the percent of minimum quality score achieved. If quality scores are below a specified threshold the multiplier must be zero (e.g. achieved quality score cannot be less than 75% of minimum).

The Priority Performance Metrics defined in Domain 9 must form the basis of the quality score factor. An AE who does not meet threshold minimum requirements on these Priority Performance Metrics must not be eligible for any shared savings.

Certified AEs must demonstrate a progression of risk to include meaningful downside shared risk or full risk within three years of any MCO contractual arrangement. Further requirements of this risk progression will be defined in the final version of these certification requirements. The specific terms of the savings and risk transfer between the MCO and the AE are at the discretion of the contracting parties. EOHHS does not intend to stipulate the terms of these arrangements but does reserve the right to review and approve them.^{8,9}

EOHHS intends to ensure that certified Accountable Entities have the financial experience and capacity to manage a global budget. As such, the AE will be required to furnish financial reports regarding risk performance on a monthly, quarterly or annual basis to the contracted MCO and to the state. The AE must also demonstrate the experience and capacity for managing financial risk and for operating within a fixed global budget.

Additionally, if the AE enters into an arrangement that provides for shared losses with a downside risk limit or risk corridor that exceeds 10% of the total cost of care, the AE must meet all of the financial reserve and risk based capital requirements required of a Managed Care Organization, with oversight by the Department of Business Regulation.

Domain 7 Provider Exclusivity and Member Choice

Members must have access to the right care, at the right time and in the right setting. AEs must provide assurance that the proposed AE will not limit or restrict beneficiaries to providers within the AE network. Accountable Entity provider relationships may not impact member choice and/or the

⁸ In addition to this EOHHS' requirement, note that depending on circumstances transparency in such arrangements is specifically required in CFR42 §438.6 See previous footnote for more details.

⁹ CMS has issued guidance for shared savings programs for both Medicaid and for Medicare Shared Savings Programs. www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf; www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-002.pdf. Similarly CMS links for the Medicare Shared Savings Program final rule and a CMS Factsheet are 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 found at <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf> on the Government Printing Office (GPO) website.

member's ability to access providers contracted or affiliated with the MCO, including not requiring patients to obtain prior approval from a primary care gatekeeper or otherwise before utilizing the services of providers outside the AE network. Consistent with CFR 438.108, members seeking care within the MCO network but outside the AE may not be charged additional fees nor be negatively impacted in any other way such as disenrollment from the AE.

While AE based network limits, restrictions and fees are prohibited, MCOs and AEs may encourage utilization of preferred networks provided that rewards or positive financial incentives used are nominal and specifically linked with health promoting plans of care. All incentives and methods of encouragement of preferred networks must be consistent with CMS requirements for Medicaid.¹⁰

In order to support effective global budgeting and member attribution, primary care providers must be exclusive to a specific AE, and may not be members of multiple AEs for purposes of serving Medicaid members. This exclusivity is also intended to ensure that PCPs transform their practices in a consistent manner and are not subject to different administrative requirements or clinical care pathways from different AEs.

All other providers, including specialists and ancillary providers/facilities, must be accessible to all Medicaid members regardless of their AE affiliation, insofar as they are a part of the network of the member's MCO. These non-PCP providers may not be exclusive to a specific AE.

Domain 8 Administrative Capacity for Delegated Functions

It is anticipated that successful development of an AE will include a new distribution of responsibilities between the MCO and the AE and that these will be identified in the written agreement between the parties. In a fully delegated, global capitation relationship, EOHHS envisions that the MCO, in alignment and compliance with federal requirements set forth in 42 CFR 438.6, would delegate certain of the medical management and operational functions to the AE. The state intends to ensure that the relationship is successful for the member, the plan and the providers, and that transition to AEs does not impede a member's ability to access the right care, at the right time and in the right setting. As such, a certified AE must meet specified federal and state requirements to perform certain delegated functions on behalf of the MCO and the member.

For each of the managed care functions specified below, AEs must be specifically qualified for delegated responsibility, based on their expertise, local capacity and local experience in performing this function. Potentially delegated functions requiring specific authority include:

- Provider payment/claims processing
- Network contracting

If these functions are delegated to the AE, then the AE must meet MCO network adequacy requirements.¹¹

The following services may not be delegated by the MCO to the AE:

¹⁰ CMS has issued guidance in this area pertaining to Medicare. Applicability to Medicaid requires further review. Next Generation ACO summary on CMS website: <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/index.html>. Next Generation ACO RFA, which includes section on beneficiary coordinated care rewards: <https://innovation.cms.gov/Files/x/nextgenacorfa.pdf>

¹¹ To be defined further in final certification requirements.

- Encounter and claims reporting
- Member services
- Grievances and appeals

Regardless of the delegation model, the MCO remains responsible to oversee the services that are delegated to the provider so that the MCO remains compliant with the terms of both the contract it has with the state and as stated in CFR §438.230 Subcontractual relationships and delegation.¹²

Domain 9 Demonstrated Quality and Clinical Performance

AE applicants must report on a set of 20 Priority Performance Measures, jointly defined by the MCO and the AE and approved by the state, in accordance with the specifications below. To the extent possible, these measures will leverage the work of the SIM Measure Alignment workgroup currently underway.

- **Member Experience Metrics (3 of the following)**
 - Member satisfaction with access to urgent care (CAHPS)
 - Patient experience for providers (CAHPS)
 - Member engagement, with particular focus on high utilizers
 - Complaints
- **Utilization Metrics (5)**
 - Ambulatory Care Sensitive ED Visits
 - All cause and avoidable Inpatient readmission within 30 days
 - Return to ED within 7 days of hospital discharge
 - Outpatient/ambulatory care utilization
 - Behavioral Health Utilization
- **Member Access Metrics (3 of the following)**
 - Network adequacy/Geographic access standards
 - Timeliness to Behavioral Health, primary care appointment
 - Provider visit within 7 days of discharge
 - Follow up after Hospitalization for Mental Illness within 7 days/30 days of discharge
- **Structural Metrics (5 of the following)**

¹² §438.230 Subcontractual relationships and delegation. a) *General rule.* The State must ensure, through its contracts, that each MCO, PIHP, and PAHP— (1) Oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor; and (2) Meets the conditions of paragraph (b) of this section. (b) *Specific conditions.* (1) Before any delegation, each MCO, PIHP, and PAHP evaluates the prospective subcontractor's ability to perform the activities to be delegated. (2) There is a written agreement that—(i) Specifies the activities and report responsibilities delegated to the subcontractor; and (ii) Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. (3) The MCO, PIHP, or PAHP monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations. (4) If any MCO, PIHP, or PAHP identifies deficiencies or areas for improvement, the MCO, PIHP, or PAHP and the subcontractor take corrective action.

At least 5 structural metrics intended to measure access to care, care management/care coordination, and integration of physical and behavioral health including information exchange and referrals among providers (Further definition required):

- Health Risk Assessments conducted on identified high-risk members
- Referrals to specialty care and BH
- Current care enrollment
- % of PCP qualify for EHR incentive payment
- PCMH certification level
- Referrals and link to social supports (housing etc..)
- Need additional structural metrics that demonstrate AEs effectiveness at identifying and intervening with high cost, complex individuals.

- **Outcome Metrics (4)**

- Self Reported Health Status
- Population health vs. patient panel health.
- Social determinants – e.g., housing stability, recidivism.
- *Further metrics still to be defined*

- **Priority Driven Metrics**

At least 5 of the metrics selected from the lists above must be specifically related to the two priorities described in Section I: Introduction and Purpose: Priority 1: Integration and Coordination of Long term services and supports; and Priority 2: Physical and Behavioral Health Integration.

- Type 2 AEs must adapt the selected quality measure and clinical performance measures to reflect the specialized population. As such a Type 2 AE must suggest and the state shall approve an adapted list.