Rhode Island Medicaid Accountable Entity Program

Attachment L 1: Accountable Entity Total Cost of Care Requirements

Rhode Island Executive Office of Health and Human Services

September 29, 2017

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A. TCOC 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 address the needs of their attributed populations and reduce duplication of services. For populations with long-term care needs, effective TCOC methodologies also provide incentives for AEs to help beneficiaries live successfully in the community and reduce use of institutional services. In doing so, AEs will be able to improve outcomes, lower overall healthcare costs, and be able to earn savings. Shared savings distributions must be based on well-defined quality and outcomes metrics.

B. TCOC Methodology Goals

These TCOC guidelines have been designed to support **Meaningful Performance Measurement**, thereby creating financial incentives to reduce costs and improve quality. In order to accomplish meaningful performance measurement, this methodology must incorporate the following:

- **Provide opportunity for a sustainable business model**
  Create ongoing opportunity for effective AEs by: (1) recognizing efficient historical performers; (2) allowing for shared savings to be retained for system investment; (3) creating greater financial incentives for being inside the AE program than for being outside; (4) identifying clinical pathways for complex co-occurring chronic conditions that are prevalent among Medicaid high utilizers; (5) addressing social determinants (e.g., housing, food security, access to non-medical transportation) that impact health outcomes and costs; and (6) implementing effective interventions to help elders and adults with disabilities remain in the community.
- **Be fiscally responsible for all participating parties**
  Adequately protect the solvency of the AEs and managed care organizations (MCOs) and the financial interests of the RI Medicaid Program.
- **Specifically recognize and address the challenge of small populations**
  Implement mitigation strategies to minimize the impact of small numbers, given the state's small size and particularly related to LTSS.
- **Incorporate quality metrics related to increased access and improved member outcomes**
  Have reporting mechanisms for MCOs and AEs that allow for timely data exchange and performance improvement to ensure access and quality.
- **Define and establish a progression toward meaningful AE risk**

- **Establish consistent core components of the TCOC methodology while still allowing some innovation and flexibility**
  Balance these competing goals. Allow for some variation in TCOC methodology within uniform state guidelines/criteria, with recognition of the importance of alignment in the methodology for the managed care and fee-for-service populations attributed to specialized LTSS AEs.

C. General Requirements for Program Participants

1. **Minimum Membership and Population Size**
   For comprehensive AEs, MCOs may utilize TCOC-based payment models only with AEs which have at least 5,000 attributed Medicaid members, across all MCOs. For specialized LTSS AEs, there must be at least 500 attributed lives in Medicaid managed care and/or Medicaid fee-for-service.

2. **State/MCO Capitation Arrangement**
   The MCO retains the base contract with the State; the MCO medical capitation will be adjusted for savings/risk associated with the program as described in the State/MCO contract. 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 related to AEs.

3. **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 for Medicaid members.

4. **Other Approved Alternative Payment Methodologies for LTSS Providers**
   The MCO and Medicaid fee-for-service may also implement other approved alternative payment methodologies (APMs) (as described in Section G), in addition to TCOC arrangements, for providers in specialized LTSS AEs. Participation in those APMs is voluntary for providers.

5. **Attribution**
   AE specific historic base data must be based on the AE's attributed lives for a given period, in accordance with EOHHS defined attribution requirements, as defined separately. TCOC performance period data must account for and be aligned with the list of attributed members MCOs are required to generate on a monthly basis, as described in the attribution requirements.

D. TCOC Methodology: Required Elements for Comprehensive AEs

MCO TCOC arrangements with comprehensive AEs must meet the following requirements, listed here and described in more detail below:

1. Defining a Historical Base
2. Required Adjustments to the Historical Base
3. TCOC Expenditure Target for the Performance Period
4. Actual Expenditures for the Performance Period
5. Shared Savings/(Loss) Pool Calculations
6. AE Share of Shared Savings/(Loss) Pool
7. Required Progression to Risk Based Arrangements

1. Defining a Historical Base

a. AE-Specific Historical Cost Data

The TCOC historical base shall include three years of AE-specific historical cost data with equal weighting applied to each year. MCOs are strongly encouraged to use three years of historic data in creating the benchmark to stabilize the historic base; at a minimum, all existing AE experience must be utilized.

b. Covered Services

TCOC methodologies shall include all costs associated with covered services that are included in EOHHS's contract with MCOs for the performance year, with the following clarifications/exceptions. Any further adjustments to covered services outside of those listed below must be requested in writing and pre-approved by EOHHS prior to MCO-AE contract execution for the affected contractual performance year:

I. Exclude services currently covered under stop-loss provisions between EOHHS and the MCO, as outlined below:

- Long-term care in an intermediate or skilled facility in excess of 30 days.
- Costs associated with the transplant of a bodily organ. Includes costs incurred from the date of admission through the date of discharge associated with the specific hospital stay in which an organ is implanted. The AE TCOC calculation will include all costs up to the transplant of a bodily organ.
- Early Intervention Services in excess of $5,000 for an individual.
- Hepatitis C Pharmacy Costs: Costs in excess of the per member per month level as set forth in the *Provisions for Stop Loss Claiming for Pharmacy Expenditure in Treatment of Enrollees with Hepatitis C*.

II. Exclude HSTP performance incentive payments and CTC payments.

III. Include and define any other infrastructure payments made by MCOs to AEs and AE-affiliated providers.

c. Mitigation of Impact of Outliers: Claims threshold for high cost claims

TCOC expenditure data shall be adjusted to exclude costs in excess of $100,000 per member per year. However, TCOC expenditures must include 10% of any annualized spending per member above the truncation threshold.

d. Adjusting for a Changing Risk Profile

To account for possible changes in the risk profile of an AE's attributed patient population over the historical base years, the MCO shall employ one of the following two risk adjustment methodologies:

- **Risk Adjustment Software**
  MCOs may apply a clinical risk adjustment software. Under such an approach, risk calculations and any adjustments shall be applied at the total population and not the EOHHS rate cell level. The TCOC methodology must describe the MCO's risk-adjustment method including underlying software parameters set by the MCO. Such information shall also be disclosed to contracting AEs.
- **Rate Cell Calculations**
  MCOs may use the population mix by rate cell, for each period, to adjust for changes in this population mix over time.

Note that if an MCO chooses to utilize a risk adjustment software, the MCO must provide a detailed description of the specific software/methodology applied, including the underlying parameters set by the MCO. Note that this is an interim solution, as the state intends to implement a standardized risk adjustment methodology over the course of this program. Should the MCO wish to further adjust for a changing risk profile using clinical and social risk factor data exogenous to the risk adjustment methodologies described above, it may do so after review and approval by EOHHS.

e. Historical Base with Required 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 EOHHS. Unless otherwise approved by EOHHS, trends assigned to TCOC baselines shall not exceed the final cumulative trends to the medical portion of rates contained in the EOHHS data books by cap cell. The trends may be applied by the MCO to the AE in aggregate based on either the AE's or the MCO's member mix.

2. Required Adjustments to the Historical Base

In order to prospectively establish an AE's TCOC Expenditure Target, the MCO must apply the following adjustments to the historical base. Note that no additional adjustments are allowed without prior approval from EOHHS.

a. Adjustment for Prior Year Savings

The TCOC Expenditure Target must include an upward adjustment equal to an AE's share of prior year savings, after adjustment for quality performance, so that AEs have an opportunity to retain a portion of generated savings year over year. This adjustment must not exceed 2% of the unadjusted TCOC Expenditure Target.

b. Adjustment for Historically Low-Cost AEs

Should any AE have three years of historical cost data demonstrating that risk-adjusted per capita spending for the AE's historically attributed patient population for TCOC covered services was significantly below the MCO average (statistically significant at p <= .05), the MCO may adjust that AE's TCOC Expenditure Target upward by up to the percentage by which the TCOC fell below MCO average spending for the assessed historical time period. This adjustment must not exceed 2% of the unadjusted TCOC Expenditure Target. This adjustment shall not be applied to entities with a historically attributed patient population for TCOC covered services that was significantly above the MCO average.

3. TCOC Expenditure Target for the Performance Period

Once an AE-specific adjusted historical base is established, this base must be trended forward into the performance period to create an AE-specific TCOC Expenditure Target.

TCOC methodologies shall be based on a performance time period of 12 months aligned with the state fiscal year. Initial contractual performance time periods may extend longer than 12 months if necessary.

a. Required Cost Trend Assumptions

The adjusted historical base must be cost trended to the performance year according to the cost trend assumptions described in Section D.1.e of this document.

b. Final Target Adjusted for Changes in the Attributed Population's Risk Profile

The MCO must apply a risk adjustment methodology to assess any changes in an attributed population's risk profile from the risk-adjusted historical base to the contractual performance period. This methodology must be consistent with the risk adjustment methodology used in developing the adjusted historical base as described in Section D.1.d of this document.

4. Actual Expenditures for the Performance Period

a. Calculate Actual Expenditures Consistent with the Historical Base Methodology

Actual Expenditures for the Performance Period must be calculated consistent with the historical base methodology as described in Sections D.1.b and D.1.c of this document.

5. Shared Savings/(Loss) Pool Calculations

The Shared Savings/(Loss) Pool shall be calculated as the difference between Actual Expenditures (Section D.4) and TCOC Expenditure Target (Section D.3), after the following adjustments:

a. Small Sample Size Adjustment for Random Variation

TCOC methodologies shall account for statistical uncertainty in performance measurement due to the effect of random variation in utilization and spending in small populations. MCOs shall address the impact of random variation on cost savings results through the application of a shared savings adjustment factor, defined by performance year AE attributed population size (calculated as attributed member months divided by 12).

The shared savings adjustment factor adjusts the AE's shared savings/(loss) pool proportionately by the probability of true savings (1 minus the probability of achieving shared savings as a result of chance). The proportion of savings for which an AE is eligible shall by adjusted along a sliding scale by AE size, based on the parameters below. AEs with fewer than 5,000 attributed members with an MCO shall be classified as Small AEs.

Shared Savings/Loss Adjustment Factor Parameters

Shared Savings/Loss Adjustment Factor Parameters by AE Size and Savings Rate				Probability of Achieving Shared Savings/Loss as a Result of Chance*			
Savings %	**Small AE** *(5-9,999)*	**Medium AE** *(10-19,999)*	**Large AE** *(20,000+)*	**Savings %**	**5,000 members**	**10,000 members**	**20,000 members**
1%	73%	79%	89%	**1%**	27%	21%	11%
2%	82%	92%	97%	**2%**	18%	8%	3%
3%	91%	97%	99%	**3%**	9%	3%	1%
4%	95%	99%	100%	**4%**	5%	1%	0%
5%	98%	100%	100%	**5%**	2%	0%	0%
6%	99%	100%	100%	**6%**	1%	0%	0%

Source: Weissman J, Bailit MH, D'Andrea G, Rosenthal MB. "The Design And Application Of Shared Savings Programs: Lessons From Early Adopters," *Health Affairs*, September 2012

b. Impact of Quality and Outcomes

The Shared Savings/(Loss) Pool shall be adjusted based on an assessment of performance relative to a set of quality measures for the attributed population. An Overall Quality Score will be generated for each AE, according to the methodology detailed in Attachment B: Quality Framework and Methodology for Comprehensive and Specialized LTSS Accountable Entities. The Shared Savings/(Loss) Pool must be multiplied by the Overall Quality Score.

c. Maximum Allowable Shared Savings/(Loss) Pool

In any given performance year, the Shared Savings Pool must not exceed 10% of the AE's contract revenue. In instances where the AE is responsible for downside risk,

the Shared Loss Pool must not exceed 5% of the AE's contract revenue.

6. AE Share of Savings/(Loss) Pool

In Year 1, AEs may be eligible to retain up to 40% of the Shared Savings Pool, as defined in Section D.5 above. AEs assuming downside risk may be eligible for up to 60% of the Shared Savings Pool, and may be responsible for up to 60% of the Shared Loss Pool.

AE Shared Savings Model	AE Share of Savings	Maximum Allowable Shared Savings Pool	Maximum Allowable Shared Loss Pool	AE Share of Losses
Option 1: Shared savings only	Up to 40% of Savings Pool	10% of AE contract revenue	NA	NA
Option 2: Shared savings + risk	Up to 60% of Savings Pool	10% of AE contract revenue	5% of AE contract revenue	Up to 60% of Loss Pool

7. Required Progression to Risk Based Arrangements

Qualified TCOC-based contractual arrangements (or "Certified AEs") must demonstrate a progression of risk to include meaningful downside shared risk within three years of AE program participation. After five years, development and implementation funding will end, and AEs will be sustained going forward based on their successful performance and associated financial rewards in accordance with their MCO contract(s).

EOHHS has defined "meaningful risk" based on learnings from other states, OHIC requirements and federal MACRA rules. Marginal risk and loss caps are defined with a range, EOHHS anticipates that smaller organizations will fall on the lower end of that range. The required progression of increasing risk for all comprehensive AEs is as follows:

	Marginal Risk *AE Share of Losses*	**Loss Cap** *Maximum Shared Loss Pool*
Definition	*The percentage of any Shared Loss Pool for which the AE is financially at risk.*	*The maximum percentage of the AE's contract revenue for which the AE is financially at risk.*
Year 1	0	NA
Year 2	0	NA
Year 3	15 - 30% of any Shared Loss Pool	At least 2% No more than 10%
Year 4	30 - 50% of any Shared Loss Pool	At least 2% No more than 10%
Year 5	50 - 60% of any Shared Loss Pool	At least 2% No more than 10%

It is EOHHS's intent to align risk requirements with the standards established by the Office

of the Health Insurance Commissioner (OHIC) to the extent possible. Alternatives for larger organizations or entities that include a hospital may be considered in the future.

In the event of a shared risk arrangement with an AE, it is necessary to ensure that the AE has the capacity to pay for its share of any losses. To accomplish this the MCO shall utilize a withhold to ensure that funds are available for financial settlement with the AE in the event that medical expenses exceed the total cost of care projection for the performance period. At a minimum, the withhold must capture 75 percent of the maximum shared loss pool. MCO's final settlement with the AE with regard to a withhold is based on actual experience in relation to the TCOC calculation.

Should an MCO and AE wish to share risk on a more accelerated schedule than that outlined above, the MCO and AE shall submit written documentation to EOHHS, including:

- the draft contractual financial terms between the parties;
- a statement of why the AE is qualified to assume greater risk than that outlined above, including its infrastructure to manage clinical risk, an established record of meeting quality metrics, and the likelihood that the AE will meet the quality thresholds established by EOHHS and the MCO; and
- documentation of secured funds necessary to meet the maximum financial obligation that the AE could potentially incur under the terms of the proposed agreement.

EOHHS together with state partners (e.g. DBR and OHIC), will review the aforementioned information, and decide as to whether the arrangement may proceed.

Additionally, if an AE enters into an arrangement that provides for shared losses with a total potential risk that equals or exceeds 10% of expected expenditures, the AE must meet all the financial reserve and risk-based capital requirements required of an MCO, with oversight by the Department of Business Regulation.[1] EOHHS anticipates that any AEs taking on such risk must, at a minimum, demonstrate adequate capitalization to cover three months of claims.[2]

[1] As specified in the standards for minimum risk-based capital (RBC) requirements for health organizations in Chapter 27-4.7 of the RI general statute. http://webserver.rilin.state.ri.us/Statutes/Title27/27-4.7/INDEX.HTM

[2] Note that 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: 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: 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 www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf on the Government Printing Office (GPO) website

E. TCOC Methodology: Required Elements for Specialized LTSS AEs

TCOC arrangements with specialized LTSS AEs must meet the following requirements, listed here and described in more detail below:

1. Defining a Historical Base
2. Required Adjustments to the Historical Base
3. TCOC Expenditure Target for the Performance Period
4. Actual Expenditures for the Performance Period
5. Shared Savings/(Loss) Pool Calculations
6. AE Share of Shared Savings/(Loss) Pool
7. Required Progression to Risk Based Arrangements

Note that the specialized LTSS AE Program is a pilot program and as such, EOHHS intends to engage in a systematic review of the guidelines established below as the program develops.

1. **Defining a Historical Base**
   a. **AE Specific Historical Cost Data**
   The TCOC historical base shall include three years of AE-specific historical cost data with equal weighting applied to each year. MCOs are strongly encouraged to use three years of historic data in creating the benchmark in order to stabilize the historic base; at a minimum, all existing AE experience must be utilized. For newly established AEs, the TCOC historical base can be created on a simulated attributed population identified using historical utilization data, as historical authorization data for the AE may not be available.

   b. **Covered Services**
   TCOC methodologies shall include all Medicaid costs associated with covered services listed in Attachment A that are included in EOHHS' contract with MCOs, with the clarifications/exceptions listed below. In addition, EOHHS intends to include equivalent Medicaid fee-for-service covered services for people not enrolled in managed care, for the performance year. Any further adjustments to covered services outside of those listed below must be requested in writing and pre-approved by EOHHS prior to MCO-AE contract execution for the affected contractual performance year:
      I. Exclude services currently covered under stop-loss provisions between EOHHS and the MCO;
      II. Exclude services managed by BHDDH for people with intellectual and development disabilities;
      III. Exclude long-stay/custodial nursing facility costs in excess of six consecutive months (disregarding any short-term acute hospital or skilled nursing facility stays that interrupt an otherwise continuous long-stay/custodial nursing facility stay);
      IV. Exclude HSTP performance incentive payments and CTC payments.

V. Include and define any other infrastructure payments made by MCOs or EOHHS to AEs and AE-affiliated providers.

c. Mitigation of Impact of Outliers: Claims threshold for high cost claims

TCOC data shall be adjusted to exclude costs in excess of $100,000 per member per year. However, TCOC expenditures must include 10% of any annualized spending per member above the truncation threshold.

d. Adjusting for a Changing Risk Profile

To account for possible changes in the risk profile of an AE's attributed patient population over the historical base years, a risk adjustment methodology, using a clinical risk adjustment software, shall be applied. Under such an approach, risk calculations and any adjustments shall be applied at the total attributed population and not the EOHHS rate cell level. The TCOC methodology must describe the risk-adjustment method including underlying software parameters set by the MCO/payer. With EOHHS approval, adjustments using clinical and social risk factor data exogenous to the risk adjustment methodologies described above may be used. The MCO/payer may also propose an alternative approach to risk adjustment. The risk adjustment method must be equivalently provided to the MCO-enrolled and Medicaid fee-for-service populations within the AE. Information on risk adjustment methodologies shall be disclosed to contracting AEs.

e. Historical Base with Required Cost Trend Assumptions

When projecting (or trending) historical costs forward into the performance year, TCOC methodologies shall appropriately account for trends in nursing facility and home and community-based LTSS spending. Unless otherwise approved by EOHHS, trends assigned to TCOC baselines shall not exceed the final cumulative trends to the medical portion of Rhody Health Options rates for the nursing facility and the community LTSS capitation cells for Medicaid-only and Medicare-Medicaid populations contained in the EOHHS data books. The trends shall be applied to the AE in aggregate based on the AE's member mix.

2. Required Adjustments to the Historical Base

In order to prospectively establish an AE's TCOC Expenditure Target, the following adjustments to the historical base must be applied. No additional adjustments are allowed without prior approval from EOHHS. EOHHS anticipates that historic costs for members enrolled in the Medicare-Medicaid plan may require adjustment.

a. Adjustment for Prior Year Savings

The TCOC Expenditure Target must include an upward adjustment equal to an AE's share of prior year savings, after adjustment for quality performance, so that AEs have an opportunity to retain a portion of generated savings year over year. This adjustment must not exceed 2% of the unadjusted TCOC Expenditure Target.

b. Adjustment for Historically Low-Cost AEs

Should any AE have three years of historical cost data demonstrating that risk-adjusted per capita spending for the AE's historically attributed patient population for TCOC covered services (see Attachment B) was significantly below the MCO average (statistically significant at p <= .05), the MCO may adjust that AE's TCOC Expenditure Target upward by up to the percentage by which the TCOC fell below MCO average spending for the assessed historical time period. This adjustment must not exceed 2% of the unadjusted TCOC Expenditure Target. This adjustment shall not be applied to entities with a historically attributed patient population for TCOC covered services that was significantly above the MCO average.

3. TCOC Expenditure Target for the Performance Period

Once an AE-specific, adjusted historical base is established, this base must be trended forward into the performance period to create an AE-specific TCOC Expenditure Target. TCOC methodologies shall be based on a performance time period of 12 months aligned with the state fiscal year. Initial contractual performance time periods may extend longer than 12 months if necessary.

a. Required Cost Trend Assumptions

The adjusted historical base must be cost trended to the performance year according to the LTSS cost trend assumptions described in Section E.1.e of this document.

b. Final Target Adjusted for Changes in the Attributed Population's Risk Profile

A risk adjustment methodology must be applied to assess any changes in an attributed population's risk profile from the risk-adjusted historical base to the contractual performance period, provided it can be equally applied to the MCO-enrolled and Medicaid fee-for-service populations within the AE. This methodology must be consistent with the LTSS risk adjustment methodology used in developing the adjusted historical base as described in Section E.1.d of this document.

4. Actual Expenditures for the Performance Period

a. Calculate Actual Expenditures Consistent with the Historical Base Methodology

Actual Expenditures for the Performance Period must be calculated consistent with the LTSS historical base methodology as described in Sections E.1.b and E.1.c of this document.

5. Shared Savings/(Loss) Pool Calculations

The Shared Savings/(Loss) Pool shall be calculated as the difference between Actual Expenditures (Section E.4) and the TCOC Expenditure Target (Section E.3), after the following adjustments:

a. Small Sample Size Adjustment for Random Variation: Minimum Savings (Loss) Rate

Shared savings calculations are intended to provide an incentive for outcomes based on performance. There is a methodological challenge posed in differentiating results based on performance versus random variation. In the calculations for comprehensive AE TCOC projections, an accommodation is made to adjust for the

impact of random variation in small populations. Given the smaller sizes in the attributed populations of the specialized LTSS AEs, there is a higher likelihood of volatility in shared savings pool calculations. EOHHS is continuing to review potential approaches to stabilizing the shared savings pool calculations. The method outlined here is preliminary pending further examination and input.

Given the smaller attributed populations expected to be attributed to specialized LTSS AEs, it is necessary to account for statistical uncertainty in performance measurement due to the effect of random variation in utilization and spending. Specialized LTSS AEs will be subject to a 4% Minimum Savings (Loss) Rate. A specialized LTSS AE must achieve shared savings of greater than or equal to 4% of the TCOC Expenditure Target in order to be eligible for shared savings. Where the AE is responsible for downside risk, the AE will share in losses if the shared loss rate is greater than or equal to 4% of TCOC Expenditure Target. During the pilot, EOHHS will assess the effectiveness of the Minimum Savings (Loss) Rate for the specialized LTSS AE program and may make changes to the adjustment or develop an alternative approach to better account for random variation. These approaches may include, but are not limited to, exclusion of low frequency high-cost services and separate calculations for higher cost conditions.

b. Impact of Quality and Outcomes

The Shared Savings/(Loss) Pool shall be adjusted based on an assessment of performance relative to a set of quality measures for the attributed population. An Overall Quality Score will be generated for each AE, according to the methodology detailed in Attachment B: Quality Framework and Methodology for Comprehensive and Specialized LTSS Accountable Entities. The Shared Savings/(Loss) Pool must be multiplied by the Overall Quality Score.

c. Adjustment for MCO Enrollment[3]

The Shared Savings/(Loss) Pool will be adjusted based on the percentage of member months that the AE's attributed population is enrolled in managed care. With EOHHS approval, an MCO may apply a risk adjustment methodology to account for differences in the risk of the MCO-enrolled and Medicaid fee-for-service populations.

d. Maximum Allowable Shared Savings/(Loss) Pool

In any given performance year, the Shared Savings Pool must not exceed 10% of the

[3] The TCOC methodology may include MCO-enrolled and Medicaid fee-for-service populations to increase the reliability and validity of the TCOC calculations for the specialized LTSS AEs. However, EOHHS does not have federal authority to distribute shared savings payments to AEs for Medicaid beneficiaries who are not enrolled in managed care. As a result, the TCOC methodology adjusts for the proportion of a specialized LTSS AE's attributed population that is enrolled in managed care. In contrast, specialized LTSS AEs will be eligible to earn Incentive Payments based on the AE's performance relative to the AE's TCOC Expenditure Target for its total attributed population, which includes MCO-enrolled and Medicaid fee-for-service beneficiaries. As articulated in the Incentive Program Requirements, 20% of the specialized LTSS AE Specific Incentive Pool shall be set aside to support potential shared savings achieved by an AE relative to the AE's TCOC Expenditure Target, without adjustment for MCO Enrollment.

AE's contract revenue. In instances where the AE is responsible for downside risk, the Shared Loss Pool must not exceed 5% of the AE's contract revenue.

6. AE Share of Savings (Loss) Pool

In Year 1, AEs may be eligible to retain up to 40% of the Shared Savings Pool, as defined in Section E.5 above. AEs assuming downside risk may be eligible for up to 60% of the Shared Savings Pool, and may be responsible for up to 60% of the Shared Loss Pool. However, no specialized LTSS AEs will be eligible to assume downside risk in the first year of the AE program. EOHHS will issue additional requirements in the future on downside risk arrangements for specialized LTSS AEs.

Specialized LTSS AE Shared Savings Model	AE Share of Savings	Maximum Allowable Shared Savings Pool	Maximum Allowable Shared Loss Pool	AE Share of Losses
Shared savings only	Up to 40% of Savings Pool	10% of AE contract revenue	NA	NA

7. Required Progression to Risk Based Arrangements

It is anticipated that, over time, shared savings and incentive opportunities will be in relation to shared risk. AEs will be expected to move into downside risk arrangements within four to five years of the launch of the specialized LTSS AE program. After five years, development and implementation funding will end, and AEs will be sustained going forward based on their successful performance and associated financial rewards in accordance with their MCO contract(s).

EOHHS has defined "meaningful risk" based on learnings from other states, Office of the Health Insurance Commissioner (OHIC) requirements, and federal MACRA rules. Marginal risk and loss caps are defined with a range, EOHHS anticipates that smaller organizations will fall on the lower end of that range. The required progression of increasing risk for all specialized LTSS AEs is as follows:

	Marginal Risk *AE Share of Losses*	**Loss Cap** *Maximum Shared Loss Pool*
Definition	*The percentage of any Shared Loss Pool for which the AE is financially at risk.*	*The maximum percentage of the AE's contract revenue for which the AE is financially at risk.*
Year 1	0	NA
Year 2	0	NA
Year 3	0	NA
Year 4	15-30% of any Shared Loss Pool	At least 2% No more than 10%
Year 5	30-50% of any Shared Loss Pool	At least 2% No more than 10%

It is EOHHS's intent to align risk requirements with the standards established by the

Office of the Health Insurance Commissioner (OHIC) to the extent possible. Alternatives for larger organizations or entities that include a hospital may be considered in the future.

In the event of a shared risk arrangement with an AE, it is necessary to ensure that the AE has the capacity to pay for its share of any losses. To accomplish this the MCO shall utilize a withhold to ensure that funds are available for financial settlement with the AE in the event that medical expenses exceed the total cost of care projection for the performance period. At a minimum, the withhold must capture 75 percent of the maximum shared loss pool. MCO's final settlement with the AE with regard to a withhold is based on actual experience in relation to the TCOC calculation.

Should an MCO and AE wish to share risk on a more accelerated schedule than that outlined above, the MCO and AE shall submit written documentation to EOHHS, including:

- the draft contractual financial terms between the parties;
- a statement of why the AE is qualified to assume greater risk than that outlined above, including its infrastructure to manage clinical risk, an established record of meeting quality metrics, and the likelihood that the AE will meet the quality thresholds established by EOHHS and the MCO;
- documentation of secured funds necessary to meet the maximum financial obligation that the AE could potentially incur under the terms of the proposed agreement.

EOHHS together with state partners (e.g. DBR and OHIC), will review the aforementioned information, and decide as to whether the arrangement may proceed.

Additionally, if an AE enters into an arrangement that provides for shared losses with a total potential risk that equals or exceeds 10% of expected expenditures, the AE must meet all of the financial reserve and risk-based capital requirements required of an MCO, with oversight by the Department of Business Regulation.[4] EOHHS anticipates that any AEs taking on such risk must, at a minimum, demonstrate adequate capitalization to cover three months of claims.[5]

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[4] As specified in the standards for minimum risk-based capital (RBC) requirements for health organizations in Chapter 27-4.7 of the RI general statute. http://webserver.rilin.state.ri.us/Statutes/Title27/27-4.7/INDEX.HTM

[5] Note that 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: 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: 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 www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf on the Government Printing Office (GPO) website

F. TCOC Development Approval and Reporting Process

1. TCOC Development Approval

Medicaid MCOs and AEs must establish TCOC calculation methodologies in accordance with these requirements to serve as the basis for their shared savings and/or risk arrangements. These methodologies must be approved by EOHHS. EOHHS will review the MCO's TCOC methodologies and reserves the right to ask for modifications before granting approval.[6] EOHHS also reserves the right to review these methodologies on an annual basis. EOHHS' approval, denial, or requests for amendment will be transmitted in writing, without unreasonable delay. Further, for specialized LTSS AEs, the TCOC calculation methodologies must be equivalently applied to the MCO-enrolled and Medicaid fee-for-service populations if both are included in the AE.

MCOs must submit details of their TCOC methodologies to EOHHS for approval in writing, in advance of contracting with AEs. Applications must document and demonstrate specific compliance with the requirements outlined in Sections C, D, and E of these requirements. Simple numerical examples may be helpful. Applications must also include comprehensive answers to the questions below:

1. **Benchmark Time Period**
   What is the time period for the historical data 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. **Mid-Year Changes**
   How does the TCOC calculation account for month-to-month changes in MCO enrollment and/or PCP assignment/specialized LTSS AE attribution, whether during benchmark years or the performance year? How does the TCOC calculation account for month-to-month changes in the PCP/LTSS provider roster of an AE, whether during benchmark years or the performance year?
4. **Risk Adjustment**

   What risk adjustment methodology will be applied to assess changes in the risk profile of an AE's attributed patient population, over the historic base years, and between the historic base and performance period? If a clinical risk adjustment software will be utilized, provide a detailed description of the underlying software parameters.
5. **Shared Savings/Loss Distribution Rate and Calculation**
   What portion of the eligible shared savings pool (after accounting for scaling based on

[6] 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.

quality and outcomes metrics) will be distributed to the AE?

6. **Shared Savings/Loss Distribution Timing**
   At what time are shared savings distributions made to qualifying AEs? If distributions are made more frequently than annually, please also describe any true-up processes.
7. **Alignment between MCO and FFS populations (Specialized AEs only)**
   Can the TCOC methodology be applied equally to MCO and Medicaid fee-for-service populations within a single specialized LTSS AE?

Where appropriate, MCOs should respond separately to the questions for comprehensive and specialized LTSS AEs. Material amendments to TCOC methodology must be approved by EOHHS in advance. If an MCO utilizes a TCOC methodology that differs in any respect from the approved methodology, EOHHS 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 EOHHS with all information necessary to make that calculation.

MCOs must complete and submit the *MCO/AE TCOC Reporting Template* as defined by EOHHS for each AE within 15 days, at the latest, of executing any AE contract. If any entity is certified and contracted as both a comprehensive AE and a specialized LTSS AE, separate comprehensive AE and specialized LTSS AE templates must be completed for the entity.

2. Required Ongoing Reporting

In order to monitor AE financial performance, AEs and MCOs will be required to furnish financial reports regarding risk performance on a quarterly basis to EOHHS. Quarterly reports must be submitted to EOHHS within 120 days of the close of the quarter, as detailed below.

Performance Period 1: Performance Quarters	Quarterly Report Due to EOHHS
Q1: Jan 1st – Mar 31st 2018	July 29th 2018
Q2: Apr 1st – Jun 30th 2018	October 28th 2018
Q3: Jul 1st – Sep 30th 2018	January 28th 2018
Q4: Oct 1st – Dec 31st 2018	April 29th 2018
Q5: Jan 1st – Mar 31st 2019	July 29th 2019
Q6: Apr 1st – Jun 30th 2019	October 28th 2019

G. Other APMs for Specialized LTSS AEs

Currently, most Medicaid nursing facility and home and community-based LTSS in Rhode Island are reimbursed using encounter-based and other fee-for-service payment models that do not reward quality, efficiency, or value. EOHHS seeks to move away from fee-for-service payment models toward alternative payment models (APMs) that incentivize providers to be more accountable for Medicaid patients' care and outcomes. EOHHS intends to pilot test APMs, including bundled payments, per member per month (PMPM) payments, episodic payments, and other value-based payment (VBP) models, on a voluntary basis with Partner and Affiliate Providers in specialized LTSS AEs. EOHHS anticipates requesting expenditure authority under

Section 1115(a)(2) of the Social Security Act to implement APMs for nursing facility and home and community-based LTSS. Additional requirements around the APMs and the APM pilot opportunities will be provided separately.

H. Comprehensive AE TCOC Methodology Example

OHHS Comprehensive AE Total Cost of Care (TCOC) Guidance — AE Specific Variables
Comprehensive AE TCOC Calculation Tool — Calculation Variables

*Note: all data is illustrative only

		SFY 2014	SFY 2015	SFY 2016		SFY 2018	
	AE Specific Historical Data Input: Membership and Cost	**Year 1**	**Year 2**	**Year 3**	**Historical Base**	**Performance Year**	
INPUT >	Attributed Lives (Members)	5,000	5,000	5,250	5,150	5,250	
INPUT >	PMPM	$345.00	$347.00	$320.00	$330.29	$350.00	1

1 Calculating the Historical Base and Initial TCOC Target

		Year 1	Year 2	Year 3	Historical Base $	Historical Base pmpm	Performance Year Target $	Performance Year Target pmpm	
A	Total Cost of Care (Unadjusted)	$20,700,000	$20,820,000	$20,160,000	**$20,412,000**	**$330.29**			
B	Base Year 3 Weight	10%	30%	60%					2
C	Trend Factor		2%	2%					3
D	Trend Adjustment	$836,280	$416,400	$0	$208,548	$3.37			
Details below	E Risk Adjustment	$871,579	$429,278	$0	$215,941	$3.49			
	F Total Cost of Care (Adjusted)	$22,407,859	$21,665,678	$20,160,000	**$20,836,489**	**$337.16**			
Details below	G Prior Year Savings Adjustment			$176,400	$176,400	$2.85			
Details below	H Historical Performance Adjustment			$408,240	$408,240	$6.61	**Projected Trend**	**Time Period (Yrs)**	
	I Total Cost of Care (Adjusted, with Sustainability Adjustments)				**$21,421,129**	**$346.62**	2%	2	
	J Total Cost of Care (Initial Target)						**$22,286,543**	**$360.62**	4
							TCOC Initial PY Target		

2 Calculating the Final TCOC Target

Details below	A Risk Adjustment		$458,976	$7.29
	B *Final Target based on risk-adjusted PMPM with performance year membership	*Impact of change in membership*	$432,748	$0.00
	Total Cost of Care (Final Target)		**$23,178,267**	**$367.91**
			TCOC Final PY Target	

3 Calculating and Distributing the Shared Savings (Loss) Pool

			Performance Year $	Performance Year pmpm
	A **Total Cost of Care (Actual Expenditures)**		**$22,050,000**	**$350.00**
			TCOC Actual	
	B **Shared Savings (Loss) Pool**		**$1,128,267**	**$17.91**
Details below	C Random Variation Adjustment		-$22,565	-$0.36
Details below	D Quality and Outcomes Adjustment		$0	$0.00
	E **Shared Savings (Loss) Pool (Adjusted)**		**$1,105,702**	**$17.55**
	F Eligible Shared Savings Pool		$1,105,702	$17.55
	G Eligible Shared Loss Pool		NO	NO
Cap: 10% AE Contract	H Maximum Allowable Shared Savings Pool		$2,317,827	$36.79
Cap: 5% AE Contract	I Maximum Allowable Shared Loss Pool		-$1,158,913	-$18.40
	J **Final Shared Savings Pool**		**$1,105,702**	**$17.55**
	K **Final Shared Loss Pool**		**NO**	**NO**

L **AE Share of Shared Savings (Loss) Pool**

M **Option 1 AEs: Shared Savings Only**	***AE Share***	**20%**		**30%**		**40%**	
		$	pmpm	$	pmpm	$	pmpm
Shared Savings		**$221,140**	**$3.51**	**$331,711**	**$5.27**	**$442,281**	**$7.02**

N **Option 2 AEs: Shared Savings and Risk**	***AE Share***	**40%**		**50%**		**60%**	
		$	pmpm	$	pmpm	$	pmpm
Shared Savings		**$442,281**	**$7.02**	**$552,851**	**$8.78**	**$663,421**	**$10.53**
Shared Loss		**NO**	**NO**	**NO**	**NO**	**NO**	**NO**

Adjustment Details

1 Historical Base and Initial TCOC Target Adjustments

		Year 1	Year 2	Year 3	Historical Base	
Risk Adj	E Average Risk Score	0.95	0.97	0.99	0.98	<- INPUT
	TCOC (Dollars): Years 1 and 2 Risk-Adjusted to Year 3 Risk Mix	$359.53	$354.15	$320.00	$334.20	
	Risk Adjustment	$14.53	$7.15	$0.00	$3.60	

Adjustment for Prior Year Savings	G Prior Year Savings: Target to Actual TCOC (pmpm)		$7.00	<- INPUT	
	Eligible Adjustment: AE Share		$2.80	40%	AE Share
	Eligible Adjustment: Total Dollars		$176,400		
	Maxium Adjustment for Prior Year Savings (2%)		$408,240		*2% **Max Allowable***
	Eligible Adjustment or Max Allowable		$176,400		

Historical Performance Adjustment	H MCO Average Cost (pmpm)		$334.00	<- INPUT
	MCO Average Risk Score		1.00	
	AE Average Risk Score		0.99	
	AE Cost (pmpm)		$320.00	
	AE Cost with FQHC PPS Adjustment (pmpm)		$320.00	$0.00 FQHC PPS Adjustment (pmpm), if applicable
	AE Average Risk Normalized Cost (pmpm)		$323.23	
	Cost Score (% above/below MCO Average)		-4%	
	Eligible Adjustment		$13.84	
	Eligible Adjustment: Total Dollars		$855,593	
	Max Allowable Adjustment		$408,240	*2% **Max Allowable***
	Eligible Adjustment or Max Allowable		$408,240	

2 Final TCOC Target Adjustments

		PY	
Risk Adj	A Average Risk Score	1.01	<- INPUT
	Risk Adjustment	$7.29	

3 Shared Savings (Loss) Pool Adjustments

Small Sample Size Random Variation Adjustment

C **Shared Savings (Loss) Adjustment Factor Parameters by AE Size and Savings Rate**

Savings %	Small AE (5-9,999)	Medium AE (10-19,999)	Large AE (20,000+)
1%	73%	79%	89%
2%	82%	92%	97%
3%	91%	97%	99%
4%	95%	99%	100%
5%	98%	100%	100%
6%	99%	100%	100%

Parameter Lookup

Savings %	4.87%	5.00%	**5.00%**	**Savings Rate Bracket Lookup**
Small AE	98%			
Medium AE	100%			
Large AE	100%			
Random Variation Adjustment	**98%**		**Small AE**	**AE Size Classification**

Quality Adj	D Quality Score Multiplier	1.00	<- INPUT
	Detailed Quality Measure Scoring Methodology to come		

1 TCOC inputs must account for covered service exclusions and claims cap truncation

2 Base Year 1 Weights are flexible, example uses MSSP methodology

3 Placeholder trend, to be populated. DHHS data book trends, Year 2 trend = Year 2 / Year 1

4 Change compounding formula based on time period between Base Year 3 and Performance Year 1 (assumes 2.0 year period)

I. Specialized LTSS AE TCOC Methodology Example

OHHS Specialized AE Total Cost of Care (TCOC) Guidance		AE Specific Variables
Specialized AE TCOC Calculation Tool		Calculation Variables

*Note: All data is illustrative only

	AE Specific Historical Data Input: Membership and Cost	SFY 2014 Year 1	SFY 2015 Year 2	SFY 2016 Year 3	Historical Base	SFY 2018 Performance Year	
INPUT =>	Attributed Lives (Members)	1,000	1,000	1,000	1,000	1,000	
INPUT =>	PMPM	$1,225.00	$1,250.00	$1,275.00	$1,262.50	$1,225.00	1

1 Calculating the Historical Base and Initial TCOC Target

		Year 1	Year 2	Year 3	Historical Base $	Historical Base pmpm	Performance Year Target $	Performance Year Target pmpm	
A	Total Cost of Care (Unadjusted)	$14,700,000	$15,000,000	$15,300,000	**$15,150,000**	**$1,262.50**			
B	Base Year Weight	10%	30%	60%					2
C	Trend Factor		2%	2%					3
D	Trend Adjustment	$593,880	$300,000	$0	$149,388	$12.45			
Details below	E Risk Adjustment	$0	$0	$0	$0	$0.00			
	F Total Cost of Care (Adjusted)	$15,293,880	$15,300,000	$15,300,000	**$15,299,388**	**$1,274.95**			
Details below	G Prior Year Savings Adjustment			$303,000	$303,000	$25.25			
Details below	H Historical Performance Adjustment			$303,000	$303,000	$25.25	Projected Trend	met Period (Yrs)	
	I Total Cost of Care (Adjusted, with Sustainability Adjustments)				**$15,905,388**	**$1,325.45**	2%	2	
	J **Total Cost of Care (Initial Target)**						**$16,547,966**	**$1,379.00**	4
							TCOC Initial PY Target		

2 Calculating the Final TCOC Target

Details below	A Risk Adjustment	$0	$0.00	
	B *Final Target based on risk-adjusted PMPM with performance year membership *Impact of change in membership*	$0	$0.00	
	Total Cost of Care (Final Target)	**$16,547,966**	**$1,379.00**	
		TCOC Final PY Target		

3 Calculating and Distributing the Shared Savings (Loss) Pool

		Performance Year $	Performance Year pmpm	
	A **Total Cost of Care (Actual Expenditures)**	**$14,700,000**	**$1,225.00**	
		TCOC Actual		
	B **Shared Savings (Loss) Pool**	**$1,847,966**	**$154.00**	
	C **Shared Savings Pool**	**$1,847,966**	**$154.00**	
	D **Shared Loss Pool**	**NO**	**NO**	
Details below	E **Shared Savings Pool After MSR**	**$1,847,966**	**$154.00**	
	F **Shared Loss Pool After MLR**	**NO**	**NO**	
	G Quality and Outcomes Adjustment: Quality Score Multiplier	1.00		<- INPUT
	H **Shared Savings Pool (Adjusted)**	**$1,847,966**	**$154.00**	
	I **Shared Loss Pool (Adjusted)**	**NO**	**NO**	
	J Adjustment for MCO Enrollment (% MCO Member Months)	50%		<- INPUT
	K **Eligible MCO-Adjusted Shared Savings Pool**	**$923,983**	**$77.00**	
	L **Eligible MCO-Adjusted Shared Loss Pool**	**NO**	**NO**	
Cap: 10% AE Contract	M Maximum Allowable MCO Shared Savings Pool	$827,398	$68.95	
Cap: 5% AE Contract	N Maximum Allowable MCO Shared Loss Pool	-$413,699	-$34.47	
	O **Final MCO Shared Savings Pool**	**$827,398**	**$68.95**	
	P **Final MCO Shared Loss Pool**	**NO**	**NO**	

Q	**AE Share of Final Shared Savings (Loss) Pool**								
R	**Option 2 ACEs: Shared Savings Only**	***AE Share***	**20%**		**30%**		**40%**		
			$	pmpm	$	pmpm	$	pmpm	
	Shared Savings		**$165,480**	**$13.79**	**$248,219**	**$20.68**	**$330,959**	**$27.58**	

Adjustment Details

1 Historical Base and Initial TCOC Target Adjustments

			Year 1	Year 2	Year 3	Historical Base	
Risk Adj	E	Average Risk Score	1.0	1.0	1.0	1.00	<- INPUT
		TCOC (Dollars): Years 1 and 2 Risk-Adjusted to Year 3 Risk Mix	$1,225.00	$1,250.00	$1,275.00	$1,262.50	
		Risk Adjustment	$0.00	$0.00	$0.00	$0.00	

Adjustment for Prior Year Savings	G	Prior Year Savings: Target vs Actual TCOC (pmpm)			$65.00	<- INPUT	
		Eligible Adjustment: AE Share			$26.00	40%	AE Share
		Eligible Adjustment: Total Dollars			$312,000		
		Maxium Adjustment for Prior Year Savings (2%)			$303,000		*2% **Max Allowable***
		Eligible Adjustment for Max Allowable			$303,000		

Historical Performance Adjustment	H	MCO Average Cost (pmpm)			$1,350.00	<- INPUT	
		MCO Average Risk Score			1.0		
		AE Average Risk Score			1.0		
		AE Cost (pmpm)			$1,275.00		
		AE Average Risk Normalized Cost (pmpm)			$1,275.00		
		Cost Score (% above/below MCO Average)			-6%		
		Eligible Adjustment			$70.14		
		Eligible Adjustment: Total Dollars			$841,667		
		Max Allowable Adjustment			$303,000		*2% **Max Allowable***
		Eligible Adjustment for Max Allowable			$303,000		

2 Final TCOC Target Adjustments

			PY	
Risk Adj	A	Average Risk Score	1.00	<- INPUT
		Risk Adjustment	$0.00	

3 Shared Savings (Loss) Pool Adjustments

MSR/MLR	E/F	**Application of Minimum Shared Savings (Loss) Rate**		
		Minimum Savings (Loss) Rate	4.0%	Targeted Expenditures
		Minimum Savings	$661,919	$55.16
		Minimum Loss	-$661,919	-$55.16

1 TCOC inputs must account for covered service exclusions and claims cap/truncation

2 Base Year Weights are flexible, example uses MSSP methodology

3 Placeholder trend, to be populated OHHS data book trends, Year 2 trend = Year 2/Year 1

4 Change compounding formula based on time period between Base Year 3 and Performance Year (assumes 2 year period)

Attachment A: Services Included in Specialized LTSS AE TCOC Analyses

Homemaker
Environmental Modifications
Special Medical Equipment
Minor Environmental Modifications
Meals on Wheels
Personal Emergency Response (PERS)
LPN Services (Skilled Nursing)
Home Health Services (skilled)
Skilled Therapies (PT, OT, Speech)
Community Transition Services
Residential Supports
Day Supports
Supported Employment
Supported Living Arrangements/Shared Living
Private Duty Nursing
Adult Companion
Assisted Living
Personal Care Assistance/Certified Nursing Assistant (CNA)/Attendant Care Services
Respite
Habilitative Services
Adult Day Services
Long Stay Nursing Facility
Hospice
Skilled Nursing Facility (SNF)

Attachment B: Quality Framework and Methodology for Comprehensive and Specialized LTSS Accountable Entities

A. Principles and Quality Framework

A fundamental element of the EOHHS Accountable Entity (AE) program, and specifically the transition to alternative payment models, is a focus on quality and outcomes. Measuring and rewarding quality as part of a value based model is critical to ensuring that quality is maintained and/or improved while cost efficiency is increased. As such, the payment model must be designed to both recognize and reward historically high-quality AEs while also creating meaningful opportunities and rewards for quality improvement. This model must be measurable, transparent and consistent, such that participants and stakeholders can view and recognize meaningful improvements in quality as this program unfolds.

As a starting point, the Year 1 requirements described below are intended to provide an interim structure that permits baseline measurement and assessment, while allowing for future refinements that continuously "raise the bar" toward critical improvements in quality and outcomes.

B. Shared Savings Opportunity

Medicaid AEs are eligible to share in earned savings based on a quality multiplier to be determined as follows:

- The AE must meet the established total cost of care (TCOC) threshold as determined using the EOHHS approved TCOC methodology to be eligible for shared savings.
- The quality measures included as part of the Medicaid Accountable Entity Common Measure Slate (including up to 4 additional optional menu measures for comprehensive AEs) will be used to determine a quality score for each AE.
- For comprehensive AEs, all admin (claims-based) measures must be generated and reported by the MCO. AEs must provide the necessary data to the MCO to generate any hybrid or EHR-only measures. Any EHR-only measures generated by an AE may be reported for the AE's full attributed population.
- For specialized LTSS AEs, measures must be generated for an AE's entire Medicaid attributed population, including MCO-enrolled and not enrolled beneficiaries.
- The quality score will be used as a multiplier to determine the percentage of the shared savings pool the AE is eligible to receive. Quality scores will be calculated distinctly for each MCO with which the AE is contracted.
- Performance year periods, which are aligned with the state fiscal year calendar, will be tied to the calendar year quality performance period ending within the performance year period. The prior calendar year quality performance period will serve as the benchmark period, as shown below.

Performance Year	Performance Time Period	Quality Measurement Performance Period	Quality Measurement Benchmark Period	Payment
PY 1	SFY 2019*	HEDIS 2019, CY 18	HEDIS 2018, CY 17	SFY 2020
PY 2	SFY 2020	HEDIS 2020, CY 19	HEDIS 2019, CY 18	SFY 2021
PY 3	SFY 2021	HEDIS 2021, CY 20	HEDIS 2020, CY 19	SFY 2022
PY 4	SFY 2022	HEDIS 2022, CY 21	HEDIS 2021, CY 20	SFY 2023

*Performance Year 1 may be an extended performance period to allow for differential start dates; as such it must begin no earlier than January 1, 2018 and no later than July 1, 2018 and must end on June 30, 2019.

C. Medicaid AE Common Measure Slate for Comprehensive AEs

For comprehensive AEs, EOHHS requires the use of the measures included in the Medicaid Comprehensive AE Common Measure Slate (see below). In addition to the 11 required core measures, each MCO and AE may include up to 4 additional optional measures identified by the MCO and AE from the RI State Innovation Model (SIM) menu measure set and/or Medicaid Child and/or Adult Core Set.

Note that EOHHS may define an additional member retention measure for piloting in Year 1, and full implementation beginning in Year 2.

The Common Measure Slate for comprehensive AEs has been developed with the following considerations:

- Alignment with the RI SIM core measure set.
- Cross cutting measures across multiple domains with a focus on clinical/chronic care, behavioral health, and social determinants of health.
- Feasibility of data collection and measurement and minimization of administrative burden.
- A minimum number of measures necessary to enable a concentrated effort and meaningful assessment of quality.
- Focus on statewide strategic priorities outlined by EOHHS, RI Department of Health, RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, and the Office of the Health Insurance Commissioner.

D. Comprehensive AE Quality Score Determination

Part 1: Relative Weight of Individual Measures for Comprehensive AEs

The Quality Score is to be developed based on assigning a weight to each individual measure. Measure weighting is subject to negotiation between the MCO and AE, but must meet the following requirements:

- Measures for which the AE's baseline meets or exceeds the current Medium benchmark cannot exceed 10% weight,

- Measures with no baseline cannot exceed 10% weight, and
- The Social Determinants of Health (SDOH) Screen measure must be assigned a 10% weight.

Mandatory measures for which baseline data can be calculated will be pay for performance in Year 1. A Measure Score will be generated for each measure according to the criteria specified below in Section E Part 2.

The following four mandatory measures, for which baseline data is not available, will be pay for reporting in Year 1:

- Measure 5. Tobacco Use: Screening and Cessation Intervention
- Measure 9. Screening for Clinical Depression & Follow-up Plan
- Measure 10. Social Determinants of Health (SDOH) Screen
- Measure 11. Self-assessment/rating of health status

A pass/fail score (either 100% or 0%) will be awarded for these measures, based on timely submission of required data in accordance with agreed upon formats. There will be no partial credit for reporting. Year 1 data will be used to establish a baseline for these measures.

Optional admin (claims-based) measures must be pay for performance in Year 1. Optional hybrid or EHR-only measures may be pay for performance or pay for reporting in Year 1.

The overall Quality Score must be a sum of the Measure Specific Quality Score times the Measure Weight for each measure.

Example:

List of Measures	Measure Specific Quality Score	Measure Weight	Measure Specific Quality Score * Measure Weight
Measure 1	100%	20%	20%
Measure 2	100%	20%	20%
Measure 3	75%	20%	15%
Measure 4	50%	30%	15%
Measure 5	0%	10%	0%
Overall Quality Score			**70%**

Part 2) Comprehensive AE Measure Specific Performance

Measure specific performance is intended to both reward historically high-quality providers and create opportunities for low performers to benefit from improvement.

For each measure included in the Measure Slate, two measure specific benchmark targets are established based on NCQA Medicaid Quality Compass data.

- High benchmark target: NCQA Medicaid Quality Compass percentile measure score defined by measure based on current MCO performance (see Common Measure Slate for measure specific benchmarks)
- Medium benchmark target: NCQA Medicaid Quality Compass 66th percentile measure score for all measures

For those measures for which NCQA Medicaid Quality Compass data is not available, a Medicaid statewide median benchmark will be generated, and a High and Medium benchmark target will be established.

Each measure must be assessed and scored based on performance relative to the benchmark targets or achievement of meaningful improvement, as defined below.

Comprehensive AE Measure Specific Scoring

Measure Performance Category	Measure Score	Performance Category Criteria
High Performance	100%	AE score meets or exceeds the High benchmark target
Medium Performance	75%	AE score meets or exceeds the Medium benchmark target (but is below the High benchmark target)
Improvement	50%	AE score is below the Medium benchmark target but shows meaningful improvement over the prior year's performance. Meaningful improvement is defined as improvement half way from the AE's baseline to the Medium performance target, or 10 percentage point improvement, whichever is lower, with a minimum required improvement of at least 3 percentage points.
Fail	0%	AE score is below the Medium benchmark target and does not show meaningful improvement over the prior year's performance, as defined above.

Example: Comprehensive AE Measure 1. Breast Cancer Screening
High Benchmark = 65.06 (75th Percentile NCQA Quality Compass)
Medium Benchmark = 63.10 (66th Percentile NCQA Quality Compass)

AEs	Year 1 Score	Year 2 Score	AE Performance Category	Measure Specific Score
AE 1	66%	68%	High Performance	100%
AE 2	62%	64%	Medium Performance	75%
AE 3	55%	60%	Improvement	50%
AE 4	50%	52%	Fail	0%

Proposed Comprehensive AE Common Measure Slate*

Measure Name	NQF #	Measure Steward	Measure Domain	Measure Source	Measure Description	Age Cohort	High Benchmark	Medium Benchmark
1. Breast Cancer Screening	2372	HEDIS®	Preventive Care	Admin	The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer	Adult	QC 75th percentile	QC 66th percentile
2. Weight Assessment & Counseling for Physical Activity, Nutrition for Children & Adolescents	0024	HEDIS®	Preventive Care	Hybrid	The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/Gyn and who had evidence of the following during the measurement year: BMI percentile, Counseling for Physical Activity and Nutrition	Pediatric	QC 90th percentile	QC 66th percentile
3. Developmental Screening in the 1st Three Years of Life	1448	OHSU	Preventive Care	Admin or Hybrid	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life; this is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age	Pediatric	65% score	50% score
4. Adult BMI Assessment	N/A	HEDIS®	Preventive Care	Hybrid	The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement or the year prior to the measurement year	Adult	QC 90th percentile	QC 66th percentile

*Measures are subject to change based on the recommendations of OHIC's Measure Alignment Review Committee

Measure Name	NQF #	Measure Steward	Measure Domain	Measure Source	Measure Description	Age Cohort	High Benchmark	Medium Benchmark
5.Tobacco Use: Screening and Cessation Intervention	0028	AMA-PCPI	Preventive Care	Admin or Hybrid	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	Adult	N/A Reporting only in Y1	N/A Reporting only in Y1
6. Comp. Diabetes Care: HbA1c Contro (<8.0%)	0575	HEDIS®	Chronic Illness	Hybrid	The percentage of members 18-75 years of age with diabetes (type 1 and 2) w/HbA1C control <8.0%	Adult	QC 75th percentile	QC 66th percentile
7.Controlling High Blood Pressure	0018	HEDIS®	Chronic Illness	Hybrid	The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year based on the following criteria: • 18-59 years of age whose BP was <140/90 mm Hg • 60-85 years of age with a dx of diabetes whose BP was <140/90 mm Hg • 60-85 years of age without a dx of diabetes whose BP was <150/90 mm Hg	Adult	QC 90th percentile	QC 66th percentile
8. Follow-up after Hospitalization for Mental Illness (7 Days)	0576	HEDIS®	Behavioral Health	Admin	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnosis and who had a follow-up visit with a mental health practitioner	Adult and Pediatric	QC 90th percentile	QC 66th percentile

Measure Name	NQF #	Measure Steward	Measure Domain	Measure Source	Measure Description	Age Cohort	High Benchmark	Medium Benchmark
9. Screening for Clinical Depression & Follow-up Plan	0418	CMS	Behavioral Health	Practice-reported	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	Adult and Pediatric	N/A Reporting only in Y1	N/A Reporting only in Y1
10. Social Determinants of Health (SDOH) Screen	N/A	N/A	Social Determinants		% of members screened as defined per the SDOH elements in the Medicaid AE certification standards*	Adult and Pediatric	N/A	N/A
11. Self-Assessment/Rating of Health Status	N/A	N/A			Measure to be defined and submitted to EOHHS for approval (e.g., Institute for Healthcare Improvement)	Adult and Pediatric	N/A	N/A

Technical specifications for the measures above will be provided separately.

* Section 5.2.2 of the AE Certification Standards requires that each AE:
"*Together with partner MCOs, develop, implement, and maintain procedures for completing an initial SDOH Care Needs Screening for Attributed Members based on a defined protocol…. The screening shall evaluate Attributed Members' health-related social needs in order to determine the need for social service intervention. Such services shall include but not be limited to:*

- *Housing stabilization and support services;*
- *Housing search and placement;*
- *Food security;*
- *Support for Attributed Members who have experience of violence.*
- *Utility assistance;*
- *Physical activity and nutrition;…"*

Optional Menu Metrics for Comprehensive AEs

Select no more than 4 measures from the SIM Menu Measure Set and/or the Medicaid Child and/or Adult Core Quality Measure Set.


2017-child-core-set (1).pdf


2017-adult-core-set .pdf


Crosswalk of RI Aligned Measure Se

E. Medicaid AE Common Measure Slate for Specialized LTSS AEs

For specialized LTSS AEs, EOHHS requires the use of all measures included in the Medicaid Specialized LTSS AE Common Measure Slate (see below). The Common Measure Slate for specialized LTSS AEs has been developed with the following considerations:

- Cross cutting measures across multiple domains with a focus on LTSS, healthy aging, behavioral health, and social determinants of health.
- Feasibility of data collection and measurement and minimization of administrative burden.
- A focused set of measures that will enable a concentrated effort and meaningful assessment of quality.
- Focus on statewide strategic priorities outlined by EOHHS and the RI Division of Elderly Affairs.

F. Specialized LTSS AE Quality Score Determination

Year 1: Unlike the Comprehensive AEs, the SIM measure set does not specifically include a set of LTSS-related measures. As such, there is a strong emphasis on reporting and establishing baseline data for the measures in the first year of the specialized LTSS AE program. All measures must be reported using EOHHS measure specifications (to be released separately). For Year 1, all measures included in the Measure Slate will be assigned a weight and included in the Overall AE Quality Score for each AE. The Quality Weight will be determined in the contract between the MCO and AE. However, the minimum Quality Weight for the SDOH measure is 10%. Each measure will also be given a Reporting Score, which will be a pass/fail score (either 100% or 0%), based on timely submission of required data in accordance with agreed upon formats; there will be no partial credit for reporting. The Measure Specific Quality Score will be calculated as the product of the Quality Weight and the Reporting Score for the measure (i.e., Measure Specific Quality Score = Quality Weight x Reporting Score). The Overall AE Quality Score will be calculated as the sum of the Measure Specific Quality Scores for each measure.

Example: Overall AE Quality Score Calculation for a Specialized LTSS AE in Year 1

Measure	Quality Weight	Reporting Score	Quality Score
Measure 1	5%	100%	5%
Measure 2	15%	100%	15%
Measure 3	10%	100%	10%
Measure 4	10%	100%	10%
Measure 5	20%	0%	0%
Measure 6	5%	100%	5%
Measure 7 (SDOH Screening)	10%	100%	10%
Measure 8	5%	0%	0%
Measure 9	10%	100%	10%
Measure 10	10%	100%	10%
Overall AE Quality Score			75%

After Year 1: After Year 1, the Quality Score Determination for specialized LTSS AEs will be designed to both reward high-quality providers and create opportunities for low performers to benefit from improvement. It will also shift the emphasis from reporting to performance. The requirements will be updated in the future to describe how the Overall AE Quality Score will be calculated. However, the approach will be aligned with the comprehensive AE approach to the extent feasible and practical.

Proposed Medicaid Specialized LTSS AE Common Measure Slate

Measure Name	Preliminary Measure Description
1. Depression Screening and Follow-up	% of attributed population who were screened for clinical depression using a standardized tool, and received appropriate follow-up care within 30 days if positive
2. Falls with Major Injury	% of attributed population experiencing one or more falls with major injury
3. Advanced Care Planning	% of attributed population 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
4. Discharge to the Community from Nursing Home	% of short-stay residents attributed to the AE who were successfully discharged to the community
5. ED Utilization	Rate of emergency department visits (that do not result in inpatient stays) among the attributed population
6. 30-Day All-Cause Readmission	% of acute inpatient stays among the attributed population that were followed by an unplanned acute readmission for any diagnosis within 30 days
7. Social Determinants of Health (SDOH) Screening	% of attributed population screened as defined per the SDOH elements in the Medicaid AE certification standards*
8. Patient/Client Satisfaction	Average patient/client satisfaction rating among the attributed population
9. Caregiver Support/ Caregiver Burden	To be determined
10. Social Isolation	To be determined

*Section 5.2.2 of the AE Certification Standards requires that each AE:
"*Together with partner MCOs, develop, implement, and maintain procedures for completing an initial SDOH Care Needs Screening for Attributed Members based on a defined protocol…. The screening shall evaluate Attributed Members' health-related social needs in order to determine the need for social service intervention. Such services shall include but not be limited to:*

- *Housing stabilization and support services;*
- *Housing search and placement;*
- *Food security;*
- *Support for Attributed Members who have experience of violence.*
- *Utility assistance;*
- *Physical activity and nutrition;…"*