

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

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1. EOHHS Requirements for Transitioning to Alternative Payment Methodologies

1.1. Background and Purpose of This Document

The purpose of this document is to set forth the requirements of the Rhode Island Executive Office of Health and Human Service (EOHHS) for managed care organizations contracted with EOHHS as Medicaid Managed Care Organizations (MCOs). Executed agreements with MCOs include contractual terms setting targets for payments to providers that are to be made utilizing an EOHHS approved Alternative Payment Methodology (APM). EOHHS approved Alternative Payment methodologies that MCOs may pursue to achieve compliance with the targeted requirements are identified in Section 2.1 of this document.

While Table 2 (below) identifies approved Alternative Payment methodologies, note that approval for certain of these methodologies sunsets at the close of State Fiscal Year 2019. The primary pathway for MCO compliance for Medicaid-only community based beneficiaries is through Alternative Payment Methodology #1, **Total cost of care (TCOC) models with EOHHS-certified Comprehensive Accountable Entities (AEs)**. The Accountable Entity program is a core component of Governor Raimondo's Reinventing Medicaid initiative and of the CMS approved Health System Transformation Program (HSTP). In October 2015 EOHHS issued certification standards for the Accountable Entity pilot program and invited applications to participate in the program. Pursuant to this work six applicant entities were certified as pilot Comprehensive Accountable Entities during 2016. During State Fiscal Year 2018 EOHHS is furthering development of the AE program. EOHHS has solicited applications for certification as a Comprehensive Accountable Entity. The Comprehensive AEs program is moving beyond the pilot phase to establish the AE program as an ongoing core component of the Medicaid program.

In October 2016, through an amendment to the 1115 waiver, Rhode Island reached an agreement with CMS providing substantial regulatory and financial support for EOHHS' Health System Transformation Program. HSTP incentive funds for certified AEs are a core component of this program.

This document provides further specification as to requirements for Alternative Payment Methodologies including:

- MCO Contract Requirements: Alternative Payment Methodologies
- EOHHS Approved Alternative Payment Methodologies
- Specifications for Total Cost of Care (TCOC) Arrangements
 - Additional APM Specifications
- EOHHS Certified Accountable Entities
- Contracting with EOHHS Approved, OHIC Recognized PCMHs
- High Cost, High Need Populations

The primary text of this document provides an overview of the program requirements. The attachments contain considerable technical detail as to EOHHS program requirements and constitute essential components of this requirements document.

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

1.2. Reinventing Medicaid and Alternative Payment Methodologies (APMs)

In March 2015 Governor Gina Raimondo issued Executive Order 15-08, establishing the “Working Group to Reinvent Medicaid” to provide recommendations for a restructuring of the Medicaid program. The Governor charged the Working Group to Reinvent Medicaid to:

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

The Reinventing Medicaid Act of 2015 set into law the fundamental recommendations of the Working Group¹. The final report of the Working Group was issued on July 8, 2015, and its Executive Summary (excerpted below) highlights its findings:

Working with partners from the health care sector, the advocacy community, the business community at large, and the Executive Office of Health and Human Services, we now lay out a model for a reinvented publicly financed health care system in Rhode Island based on the following principles:

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

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

- *Goal 1: Substantially transition away from fee-for-service models to a system where members get their care through provider organizations that are accountable for the quality, health outcomes and total cost of care for their members.*
- *Goal 2: Define Medicaid-wide population health targets, and, where possible, tie them to payments.*
- *Goal 3: Maintain and expand on our record of excellence—including our #1 ranking—on delivering care to children.*
- *Goal 4: Maximize enrollment in integrated care delivery systems.*

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

- *Goal 5: Implement coordinated, accountable care for high-cost/high-need populations*
- *Goal 6: Ensure access to high-quality primary care.*
- *Goal 7: Leverage health information systems to ensure quality, coordinated care.*
- *Goal 8: Shift Medicaid expenditures from high-cost institutional settings to community-based settings.*
- *Goal 9: Encourage the development of accountable entities for integrated long-term care*
- *Goal 10: Improve operational efficiency.²*

EOHHS' contracts with MCOs require that managed care partners have the capability and commitment to achieve these critical goals for a sustainable and superior Medicaid program for Rhode Island. Through this document EOHHS is setting forth specifications for meeting Alternative Payment Methodology requirements as is delineated in the Medicaid Managed Care contract.

2. MCO Contract Requirements: Alternative Payment Methodologies

EOHHS seeks to significantly reduce the use of fee-for-service payment as a payment methodology and to replace fee-for-service payment with alternative payment methodologies that provide incentives for better quality and more efficient delivery of health services.

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

Pursuant to this commitment, during FY 2016 EOHHS certified Accountable Entity Coordinated Care Pilots (AE) and MCOs were required to execute "total cost of care" payment arrangements with certified Pilots.

In FY 2018 EOHHS moved beyond the pilot phase of this initiative by issuing certification standards for fully qualified comprehensive Accountable Entities, as described in Section 4 of this document.

EOHHS' contracts with MCOs include defined targets for implementing contracts with alternative payment arrangements (see Table 1).

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

Targets for alternative payment arrangements are as follows:

Table 1: APM Requirements for MCOs		
<i>For all Managed Care Contracts with the Exception of Rhody Health Options and the Medicare-Medicaid Plan</i>		
Contract Period 1: March 1, 2017 - June 30 2018		
By the final Qtr % in approved APM method	45%	
By the final Qtr % in APM #1	30%	
Percent high need in an AE equal to or greater than in full membership	Y	
Percent assigned to PCMH as recognized by EOHHS		
Contract Period #2: July 1, 2018 - June 30, 2019		
Percent For the Contract Period in an approved APM	45%	or 5% higher than final quarter of Contract Period #1
Percent high need in an AE equal to or greater than in full membership	Y	
Percent assigned to PCMH as recognized by EOHHS	45%	
Contract Period #3: July 1, 2019 - June 30, 2020		
Percent For the Contract Period in an approved APM	50%	or 5% higher than required amt. for Contract Period #2
Percent high need in an AE equal to or greater than in full membership	Y	
Percent assigned to PCMH as recognized by EOHHS	55%	
Contract Period #4: July 1, 2020 - June 30, 2021		
Percent For the Contract Period in an approved APM	60%	or 5% higher than the percent required for Contract Period #3
Percent of payments in an EOHHS approved APM that includes both shared savings and shared risk	10%	
Percent high need in an AE equal to or greater than in full membership	Y	
Percent assigned to PCMH as recognized by EOHHS	60%	
Contract Period #5: July 1, 2021 - June 30, 2022		
Percent For the Contract Period in an approved APM	65%	or 10 % higher than the percent required for Contract Period #4
Percent of payments in an EOHHS approved APM that includes both shared savings and shared risk	10%	
Percent high need in an AE equal to or greater than in full membership	Y	
Percent assigned to PCMH as recognized by EOHHS	60%	

MCOs will be required to complete the APM Reporting Template (see Attachment E) to show their status against these measures. The APM Reporting Template is to be submitted to EOHHS not later than forty-five (45) days after the end of each calendar quarter. For the Contract Period beginning July 1, 2018 EOHHS’ contracts with MCOs specify that EOHHS shall withhold 0.05% from capitation payments to MCOs pending demonstration of compliance with these requirements. Upon demonstration of compliance with these targets for the respective quarters, the withheld amount will be paid to the MCOs.

2.1. EOHHS Approved Alternative Payment Methodologies

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

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

Progressively, a qualified APM will include the following elements:

- The payment methodology must define and evaluate actual cost experience during the contracted performance period as compared to a projected total cost of care for the performance period.
- Providers must be rewarded for managing costs below the projected total cost of care through shared savings, should quality performance be acceptable.
 - The total value of a shared savings pool shall be derived through the use of a quality multiplier (e.g. Observed total savings (Projected TCOC – Actual TCOC > zero) x quality multiplier = actual shared savings pool. The quality multiplier can range from low of 0 to a maximum value of 1.0.)
- When determined qualified to accept downside risk, Providers may also be responsible for some or all the costs that exceed the budget.

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

Table 2: Qualified Alternative Payment Methodologies	Applicable Timeframe	Payments Included in APM Target Calculation
1. Total cost of care (TCOC) based contracts with EOHHS certified Comprehensive Accountable Entities	All Contract Years	All Payments as set forth in Attachment B, "EOHHS Total Cost of Care"

		<i>(TCOC) Requirements for the AE Program"</i>
2. Other Population Based Total Cost of Care models (inclusive, for example, all covered services in EOHHS-MCO contract and global capitation payments or a limited scope model such as a PCP capitation). Savings and/or risk arrangements shall not exceed the the limits as set forth in Attachment B unless directly approved by EOHHS.	All Contract Years	All payments for services as defined in TCOC arrangement and compliant with EOHHS requirements
3. Other Population Based Total Cost of Care Models that include both shared savings and risk arrangements (inclusive, for example, of all covered services in EOHHS-MCO contract or a limited scope model such as a PCP capitation). Savings and/or risk arrangements shall not exceed limits set forth in Attachment B unless directly approved by EOHHS	All Contract Years	All payments for services as defined in TCOC arrangement and compliant with EOHHS requirements
4. Episode Based Bundled Payments either prospectively paid or retrospectively reconciled, with a risk component	All Contract Years	All Payments included within the bundle
5. PCMH - Care Transformation PMPM*	Thru June 30, 2019	PMPM Payment only
6. Supplemental infrastructure and Pay-for-performance payments** for non-LTSS providers	Thru June 30, 2019	P4P Payment only
7. Supplemental infrastructure and Pay-for-performance payments** for LTSS providers	Thru June 30, 2020	P4P Payment only
8. Other non-FFS payments that meet the definition of an Alternative Payment Methodology as approved by EOHHS.	All Contract Years	All Payments
9. Other payments that meet the definition of an Alternative Payment Methodology as approved by EOHHS	All Contract Years	Determined on an individual basis
<p>*Care Transformation: Such payments include PMPM payment to support development and maintenance of a care management function within that practice and is not limited to supporting a care manager, per se. The purpose of the infrastructure payment is to compensate practices for the time and effort involved in achieving PCMH recognition and establishing basic policies and procedures necessary for PCMH function, including developing clinical data capture, reporting and analysis capacity.</p> <p>**Pay-for-performance payments, supplemental infrastructure payments for person centered integrated care functions, including care management, paid to PCPs, ACOs and other providers, and supplemental infrastructure payments to specialists and other providers to provide incentives to improve communications and coordination among care providers.</p>		

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

2.2 Qualifying APM Medical Expenditures for Purposes of the APM Target

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

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

Note that shared risk arrangements with providers must comply with EOHHS requirements for risk as set forth in Attachment B, *EOHHS Total Cost of Care (TCOC) Requirements for the AE Program*.

Methodologies #5, and #6 above, pay-for-performance payments and supplemental payments for patient-centered medical home functions paid to PCPs, to ACOs or to EOHHS certified AEs, while generally not employing the aforementioned budget methodology, **will be included in the calculation of the APM target only through June 30, 2019. Methodology #7 will be included in the calculation of the APM target only through June 30, 2020.**

3. Specifications for 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 benchmark historical cost of care carried forward to the performance period. Actual costs during the performance period are then compared to those projections to identify a potential shared savings or risk pool, depending on the terms of the arrangement.

For All Methodology #1 the TCOC calculation, must be compliant with the TCOC guidelines for EOHHS certified Accountable Entities included as Attachment B ("EOHHS Total Cost of Care (TCOC) Requirements for the AE Program") of this document. As described in that guidance, EOHHS will review the MCO's TCOC methodologies and reserves the right to require

modifications before granting approval.³ Although other TCOC based APMs are not required to strictly adhere to the requirements set forth in Attachment B, such arrangements must incorporate core features of such a model including clear methodology for calculation of total cost of care targets vis a vis actual costs for the performance period, method for recognizing changes in the risk profiles of attributed populations, and additional APM specifications as described below:

- **Required Quality Score Factor**

All Alternative Payment Methodologies must include both a defined set of metrics and a quality performance score that must be met for payments to be made. Attachment C to this document provides the Quality Framework and TCOC Quality Multiplier for contracts with certified AEs and should be used as a reference for any other APMs.

- **Limits on Downside Risk⁴**

EOHHS has established certain limits on downside risk. These limits are identified in Attachment B (“EOHHS Total Cost of Care (TCOC) Requirements for the AE Program”)

- **Attribution Method**

For all budget based Methodology #1 APMs Contractors will conform with the attribution guidance established by EOHHS (see Attachment A to this document: EOHHS Attribution Guidance for the AE Program). For other related APMs clear attribution methodology must be established.

- **Individual members or enrollees can only be recognized in one Accountable Entity at a time.**

This is to ensure that TCOC calculations and shared savings are not “double counted” across multiple entities.

⁴ In addition to this EOHHS requirement, note that depending on circumstances transparency in such arrangements is specifically required in CFR42 §438.6 Contract requirements: 438.6(g) Inspection and audit of financial records – Risk contracts must provide that the state agency and the Department may inspect and audit any financial records of the entity or its subcontractors. 438.6(h) Physician Incentive plans – MCO contracts must provide for compliance with the requirements set forth in 422.208 and 422.210 of this chapter. 438.6(l) All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

4. EOHHS Certified Accountable Entities

Contractual arrangements with Accountable Entities must be compliant with the requirements set forth in Attachment B, Medicaid Accountable Entity Total Cost of Care (TCOC) Requirements, including Quality Framework and Measures.

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

For additional detail on certification standards for AEs see:

- Rhode Island Accountable Entity Program: Accountable Entity Certification Standards. (<http://www.eohhs.ri.gov/Initiatives/AccountableEntities.aspx>)

For additional information on Rhode island's Health System Transformation see:

- Rhode Island Accountable Entity Roadmap
(<http://www.eohhs.ri.gov/Initiatives/AccountableEntities.aspx>)

5. Contracting with EOHHS Recognized PCMHs

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

For participating MCOs, by the last quarter of the contract period ending June 30, 2019 the MCO shall take such actions as are necessary so that 45% of members are assigned to a PCP in a practice that functions as a Patient-Centered Medical Home as recognized by the Rhode Island Office of the Health Insurance Commissioner and by EOHHS and as defined below.

For Contract Periods ending June 30, 2020 shall take such actions as are necessary so that 55% of members are assigned to a PCP in a practice that functions as a Patient-Centered Medical Home as recognized by the Rhode Island Office of the Health Insurance Commissioner and by EOHHS. For the Contract Periods ending June 30, 2021 and June 30, 2022 the PCMH target is 60%.

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

- a. Practice is participating in or has completed a formal transformation initiative⁵ (e.g., CTC-RI, PCMH-Kids, RIQI'S TCPI, or a payer- or ACO-sponsored program) or practice has obtained NCQA Level 3 recognition. Practice meeting this requirement through achievement of NCQA Level 3 recognition may do so independent of participating in a formal transformation initiative.*
- b. Practice has implemented the following specific cost-management strategies according to the implementation timeline included in the Plan as Attachment A (strategy development and implementation at the practice level rather than the practice site level is permissible):*
 - i. develops and maintains a high-risk patient registry that tracks patients identified as being at risk of avoidable intensive service use in the near future;*

⁵ A formal PCMH transformation initiative is a structured training program for primary care providers and support staff with a pre-defined curriculum and technical assistance based on an evidence-based PCMH transformation model and designed to systematically build the skills within the practice to function as a PCMH.

- ii. *practice uses data to implement care management⁶, focusing on high-risk patients and interventions that will impact ED and inpatient utilization;*
- iii. *implements strategies to improve access to and coordination with behavioral health services;*
- iv. *expands access to services both during and after office hours;*
- v. *develops service referral protocols informed by cost and quality data provided by payers; and*
- vi. *develops/maintains an avoidable ED use reduction strategy.*

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

OHIC takes the lead in determining qualified practices. Annually OHIC coordinates with CTC, PCMH-Kids, RIQI, and payers to create a list of practices that payers should include in PCMH target calculations. OHIC posts this list on its website.

Also note that the MCO contract requires that the MCO auto-assign members to a qualified PCMH practice prior to assigning to a non-qualifying site.

⁶ Practices shall implement “care coordination” for children, which is a broader set of services not exclusively focused on high-risk patients. See R Antonelli, J McAllister, J. Popp. “Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework.” The Commonwealth Fund, publication number 1277, May 2009.

6. High Cost, High Need Populations

Section 2, above, identifies the managed care contract goals for Alternative Payment methodologies. Line “C” of the table specifies *the “Percent of high cost, high need Medicaid members that shall be enrolled in an EOHHS certified Accountable Entity, shall be equal to or greater than the percent of high cost, high need persons in the MCO’s entire enrolled Medicaid membership (high cost, high need Medicaid members are as defined in Section 6 of this document”*. **For the purposes of this provision, high cost, high need Medicaid members are defined as those users with over \$15,000 of claims based expense in a 12 month period.**

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

In SFY 2014, users with over \$25,000 in annual Medicaid claims expense accounted for 6% of Medicaid users and 65% of total program claims costs.⁷ This phenomenon is not unique to Rhode Island, nor to public programs, as national statistics show that 5% of Americans account for nearly half of health care costs across the country.⁸

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

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

⁷ Medicaid Expenditure Report, SFY 2014, Based on claims-specific payments, excludes expenditures that are not attributable to individual users. http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/RI_Medicaid_Expend_SF2014_FINAL_2.pdf

⁸ “The Concentration of Healthcare Spending”, National Institute for Healthcare Management Foundation Data Brief July 2012. Based on analysis of MEPS 2009 data.

Rhode Island Medicaid Accountable Entity Program

Attachment A: Accountable Entity Attribution Requirements

Rhode Island Executive Office of Health and Human Services

September 29, 2017

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1. Attribution Overview

Attribution is the process of defining for an accountable group the population for which it will be clinically and economically responsible and on which total costs are calculated for the purposes of identifying savings under a shared savings or risk contract. Effective attribution provides an incentive for providers and Accountable Entities (AEs) to invest in care management and other appropriate services to keep their attributed population well, with the intention of earning savings by lowering total costs and ensuring high quality care. Attribution does not affect members' freedom to choose or change their providers at any point as allowed by their benefit plan. However, AEs are expected to have continuing responsibility for the care and outcomes of their attributed members on an on-going basis, unless there is a compelling reason for that responsibility to change.

1.1. Attribution Methodology Goals

The attribution method, to be applied across all Managed Care Organizations (MCOs) and AEs, is intended to:

- Allow providers who through the AE have identified responsibility for member costs to earn savings by reducing those costs in the future;
- Allow Integrated Health Homes (IHH) to assume this responsibility for members with an approved IHH diagnosis and to allow Long-Term Services and Supports (LTSS) providers to assume this responsibility for members receiving certain long-term care services; and
- Be transparent and understandable to all members.

2. Background

Attribution is the foundation of the linkage of the member to an AE. Attribution identifies the population that the AE is accountable for in the overall AE program. This includes accountability of the AE for the health and health care for that group as represented in access, quality, and total cost of care metrics. The program intent is to recognize and strengthen an existing relationship of the member with the AE and its care management and clinical programs. For comprehensive AEs, it is also to establish the basis for such relationship for members who do not have an established relationship with a primary care provider (PCP).

The foundations for attribution are:

- A population of Medicaid beneficiaries eligible for attribution.
- A defined provider roster of the certified AE to which members may be attributed.
 - Each certified AE will have a defined roster of providers that will qualify the AE for attributed members.
 - For comprehensive AEs, the provider roster will consist of:

- IHH providers as licensed by the Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH) if an IHH is a recognized Partner Provider or Affiliate Provider in the AE; and
 - PCPs, as described in Section 3.2, at a Partner Provider or Affiliate Provider in the AE.
 - For specialized LTSS AEs, the provider roster will consist of agencies licensed by the Rhode Island Department of Health to provide one or more of the attributable services listed in Table A in Section 4.2.
- A clear methodology for attribution of eligible members to a certified AE.
 - For comprehensive AEs, this includes:
 - MCO algorithm for initial PCP assignment and attribution; and
 - Methodology for updated attribution based on utilization of identified primary care services provided by an eligible PCP.
 - For specialized LTSS AEs, this includes:
 - Monthly attribution based on service authorizations; and
 - AE validation of the attribution.

These attribution requirements set forth the basis for:

- (a) Identifying the specific AE provider roster eligible for attribution; and
- (b) The basis for attribution of members to the AE.

An Attribution-Eligible Provider (AEP) can be a primary care physician or an IHH provider and can only participate in one comprehensive AE at a time. An attribution-eligible provider can only participate in one specialized LTSS AE at a time for the purposes of attribution.

A member can only be attributed to a single comprehensive AE at a time. A member can only be attributed to a single specialized LTSS AE at a time. However, a member who meets the requirements for attribution to both a comprehensive AE and a specialized LTSS AE at the same time will be attributed to both AEs.

3. Comprehensive AE Attribution

3.1. Population Eligible for Attribution to a Comprehensive AE

The population eligible for attribution to a comprehensive AE consists of all Medicaid-only beneficiaries enrolled in managed care. Rhody Health Options (RHO) members shall be included in AE attribution if the RHO member is receiving Medicaid benefits only (not Medicare). RHO and Medicare-Medicaid Plan members who have both Medicare and Medicaid coverage are not eligible for attribution to a comprehensive AE.

3.2.Certified Comprehensive AE-Identified Providers

Attribution of members to comprehensive AE's will be based on the defined roster of providers included within the structure of the AE. For IHHs, recognition by BHDDH as a qualified IHH will be the basis for attributing members to the AE.

For primary care, each AE shall have a defined roster of PCPs. A PCP is defined as the individual plan physician or team selected by or assigned to the member to provide and coordinate all the member's health care needs and to initiate and monitor referrals for specialized services when required. PCPs are Medical Doctors or Doctors of Osteopathy in the following specialties: family and general practice, pediatrics, internal medicine, or geriatrics who have a demonstrated clinical relationship as the principal coordinator of care for children or adults and who have contracted with the MCO to undertake the responsibilities of serving as a PCP as stipulated in the MCO's primary care agreements. PCPs shall also meet the credentialing criteria established by the MCO and approved by EOHHS. In addition to physicians, the PCP may be a nurse practitioner, physician assistant, or a Federally Qualified Health Center (FQHC) if credentialed by the MCO and have an individual NPI and group or individual provider number. Clinicians included in the provider roster shall be identified by TIN and by NPI.

AEs that include FQHCs are required to provide, through an attestation, a list of the clinicians' NPIs that provide direct patient primary care services in an FQHC. This attestation will be part of the application process for all comprehensive AEs and shall be updated minimally on a quarterly basis.

3.3.Hierarchy of Attribution for Comprehensive AEs

Members will be attributed to a comprehensive AE as follows:

Assignment Hierarchy

1st: IHH Assignment

If a member is assigned to an IHH, and that IHH is a part of a comprehensive AE, then the member is attributed to that AE. IHH assignment is based on monthly roster produced by BHDDH and provided to the MCO. IHH assignment is based on two sequential steps.

- Step 1: Assignment to the AE based on assignment to IHH, as determined by BHDDH. Note that IHH based attribution is inclusive of persons utilizing ACT services.
- Step 2: Quarterly Updates to that assignment
 - A member attributed to an AE based on assignment to an IHH shall continue to be attributed to that AE for one year following IHH discharge unless:
 - The member is assigned by BHDDH to a different IHH;
 - The member requests that the MCO change his or her PCP to one that is participating in an AE.

2nd: PCP Assignment by the MCO

PCP assignment by the MCO will be based on two sequential steps:

- Step 1: PCP assignment by the MCO at the point of enrollment by the member into the MCO
- Step 2: Quarterly updates to that assignment based on:
 - Member requests to the MCO to change his or her PCP; and
 - Analyses of actual patterns of utilization that demonstrate member use of a different PCP than the one assigned by the MCO.

Step 1: Assignment by the MCO at the point of entry into the MCO

A fundamental requirement of EOHHS' contract with the MCO is that, to ensure the member's timely ability to meaningfully access health care services, the MCO must ensure that the member has an identified PCP. The challenge for the MCO is that the MCO has very limited information about whether a new member has an established relationship with, or preference for assignment to, a specific PCP. The MCO contract sets forth certain requirements on procedures for PCP assignment that are intended to promote an appropriate PCP assignment for the member (see Attachment A). A member may change his or her PCP assignment at any time, and MCOs routinely inform members of their right to change PCPs at any time upon request.

Step 2: Quarterly updates to PCP assignment and attribution based on:

- Member requests that the MCO change the PCP to one that is not participating in the AE
- Analyses of actual patterns of utilization that demonstrate member use of a different PCP than the one assigned by the MCO

Despite best efforts by MCOs at initial PCP assignment and the ready accommodation of member requests for a change in the assigned PCP, there will be some differences between the assigned PCP of record and the actual pattern of primary care utilization by the member. MCOs will update attribution on a quarterly basis based on retrospective analysis of actual patterns of primary care use.

EOHHS establishes a stepwise attribution algorithm hierarchy to be used in updating the attribution. Requirements for PCP related attribution are as follows:

1. Attribution to the AE will be based on PCP assignment of record within the MCO. PCP assignment of record shall be based on:
 - 1.1. Original assignment by the MCO
 - 1.2. Change of PCP assignment of record based on a member's request to change PCP
 - 1.3. Change of PCP assignment of record based on analysis of the member's actual primary care utilization
2. Attribution based on actual primary care utilization:

- 2.1. Not later than thirty days after the close of each calendar quarter, claims for eligible members shall be analyzed to identify the presence of visits to a PCP with qualifying primary care services as identified by CPT codes and/or FQHC encounter codes for the preceding twelve-month period (see Attachment B for qualifying CPT codes). The provider specialty must be a PCP eligible for attribution.
- 2.2. Attribution will be at the AE level based on aggregating utilization across all TINs that are part of the AE roster of attributable providers. Multiple visits to PCPs within an AE will be aggregated to that AE.
- 2.3. For attributed members that have received all their qualified primary care services from a qualified provider within the AE, the PCP assignment will be unchanged from the PCP assignment as recognized by the MCO.
- 2.4. For beneficiaries that have not received any primary care services during the period, the attribution will continue to be based on the MCO's PCP assignment.
- 2.5. The MCO will identify beneficiaries who have had at least two visits to a PCP with qualifying primary care services as described in 2.1 and received at least one primary care service from a PCP who is not a participating provider in the AE.
 - 2.5.1. For those beneficiaries, the attribution hierarchy will then be as follows:
 - 2.5.1.1. Where there are two or more visits to providers, attribution is based on a plurality of primary care visits, with attribution based on the AE providers or on the non-AE PCP providing the highest number of visits. If the AE's providers are tied for the highest number of visits, attribution will remain with the AE.

To be enrolled in Medicaid managed care, an individual must be Medicaid eligible. MCOs shall be required monthly to provide contracted AEs with electronic lists of attributed members, inclusive of identification of additions and deletions. These lists will be updated to reflect changes including new members, persons who have lost Medicaid eligibility, persons who have requested a PCP not included in the AE, and the results of quarterly updates to PCP assignment and attribution.

4. Specialized LTSS AE Attribution

4.1. Population Eligible for Attribution to a Specialized LTSS AE

The population eligible for attribution to a specialized LTSS AE consists of all adult (age 21 and older) Medicaid-only and Medicare-Medicaid beneficiaries enrolled in managed care, including the Medicare-Medicaid Plan, or receiving Medicaid benefits through Medicaid fee-for-service. Children under age 21 are not currently eligible for attribution to a specialized LTSS AE. An LTSS eligibility determination in the State Medicaid eligibility system is not required for attribution.

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.

4.2.Certified Specialized LTSS AE-Identified Providers

Attribution of members to a specialized LTSS AE will be based on the defined roster of providers included within the structure of the AE. Each AE shall have a defined roster of providers. For specialized LTSS AEs, the provider roster will consist of agencies licensed by the Rhode Island Department of Health to provide one or more of the attributable services listed in Table A. Actual attribution will depend on the composition of providers in the specialized LTSS AE.

Table A: Specialized LTSS AE Attributable Services and Billing Codes

Service Type	Attributable Services
Home and Community Based Services	<ul style="list-style-type: none"> • Home Care Services, including: <ul style="list-style-type: none"> ○ Homemaker Services <ul style="list-style-type: none"> ▪ S5130 ○ Home Health Aide/CNA/Attendant Care Services <ul style="list-style-type: none"> ▪ S5125 ▪ S9122 ▪ T1004 • Adult Day Health Services <ul style="list-style-type: none"> ○ S5100-S5109 • Assisted Living <ul style="list-style-type: none"> ○ T2031 • Supported Living Arrangements/Shared Living <ul style="list-style-type: none"> ○ S5136 ○ T2025 ○ T2028
Institutional Services	<ul style="list-style-type: none"> • Long-Stay/Custodial and Skilled Nursing Facility Care

Services managed by BHDDH for people with intellectual and developmental disabilities are excluded as attributable services.

4.3.Attribution Methodology for Specialized LTSS AEs

Attribution to a specialized LTSS AE will be based on two sequential steps each month:

- Step 1: Monthly attribution based on service authorizations; and
- Step 2: Validation of the attribution.

Step 1: Monthly attribution based on service authorizations

When a Medicaid beneficiary in Medicaid managed care or Medicaid fee-for-service receives any of the attributable services in Table A, a service authorization or approval is entered into one or more information systems used by the MCO or the State to manage beneficiaries' services. For specialized LTSS AE attribution, this authorization and approval information will be used to link a beneficiary to a specific provider and will be used to attribute beneficiaries to a specialized LTSS AE monthly using the attribution requirements described below.

The initial attribution to the AE will be based on any active authorization or approval, as of the first day of the month, for a service listed in Table A with any provider on the AE roster.

Monthly, the initial attribution will be updated to reflect new authorizations for services, changes in authorization, and changes in Medicaid eligibility. These updates will include people newly attributed to an AE, people who are removed from AE attribution, and people who move from the attribution for one AE to the attribution for another AE.

AEs are expected to have continuing responsibility for the care and outcomes of their patients on an on-going basis, unless there is a compelling reason for that responsibility to change. Once attributed to a specialized LTSS AE, a Medicaid beneficiary will continue to be attributed monthly to the specialized LTSS AE for at least 9 months after the beneficiary stops receiving services from a provider in the specialized LTSS AE, unless there is a new authorization for a different attributable service with a provider in a different specialized LTSS AE. When this occurs, the attribution will be updated to the specialized LTSS AE that includes the provider with the new authorization after 90 days. If the new authorization begins more than 90 days after the terminated authorization ends, the attribution will be updated at the next monthly attribution update. Examples of attribution scenarios are provided for illustrative purposes in Table B.

Table B: Illustrative Examples of Specialized LTSS AE Attribution Scenarios

Scenario	Impact on Attribution	Example
An authorization for an attributable service with a provider in an AE is terminated. Within three months of the authorization terminating, a new authorization for an attributable service with a provider in a different AE becomes effective.	The beneficiary's will remain attributed to the AE that includes the provider with the terminated authorization for 90 days after the authorization is terminated. The attribution will be updated to the AE that includes the provider with the new authorization during the next monthly update that occurs 90 days after the first authorization is terminated.	Mary is receiving Home Care Services from a provider in AE 1. Her Home Care authorization is terminated when she has a Long-Stay/Custodial Nursing Facility admission on January 15 and a new authorization for a Long-Stay/Custodial Nursing Facility Care with a provider in AE 2 becomes effective. She remains in the facility for over 90 days. Mary's attribution is updated from AE 1 to AE 2 in the attribution update that is effective May 1.

Table B: Illustrative Examples of Specialized LTSS AE Attribution Scenarios

Scenario	Impact on Attribution	Example
An authorization for an attributable service with a provider in an AE is terminated. More than three months after the authorization terminated, a new authorization for an attributable service with a provider in a different AE becomes effective.	The attribution will be updated to the AE that includes the new provider during the next monthly update that occurs after the new authorization is effective.	Sue is receiving Adult Day Health Services from a provider in AE 3. She stops going to this Adult Day Health Services provider on March 12. She begins going to another Adult Day Health Services Provider, which is part of AE 4, on August 16. Sue remains attributed to AE 3 until August 31. Her attribution is updated from AE 3 to AE 4 in the attribution update that is effective September 1.
An authorization for an attributable service with a provider in an AE is terminated. There is no other active authorization for an attributable service for more than 9 months.	The beneficiary will remain attributed to the AE for 9 months after the authorization is terminated. The attribution will be updated to remove this person in the next monthly update that occurs 9 months after the authorization is terminated.	Eduardo is receiving Home Care Services from a provider in AE X. His Home Care authorization is terminated on April 20, 2018, and no other authorization for an attributable service is active for the next 9 months. Eduardo remains attributed to AE X for 9 months after April 20, 2018. He is removed from AE X's attribution in the attribution update that is effective May 1, 2019.

NOTE: Table B provides examples of some specialized LTSS AE attribution scenarios for illustrative purposes only. It is not intended to address all potential attribution scenarios.

Attribution to a specialized LTSS AE will be unaffected by changes in Medicaid managed care enrollment (e.g., moved from Medicaid fee-for-service to Rhody Health Options, moved from Rhody Health Options to the Medicare-Medicaid Plan), as long as the AE is contracted with the MCO/payer the beneficiary is enrolled in.

If a beneficiary has active authorizations for services from providers in different AEs at the same time, the hierarchy for attribution will be as follows:

1. If a beneficiary is authorized to receive Home Care Services from more than one agency, attribution will be to the AE that includes the provider authorized for the highest number of service hours. If there is a tie for the provider with the highest number of hours, attribution will be based on the provider that historically has provided the highest number of hours.
2. If a beneficiary is authorized to receive Adult Day Health Services and Home Care Services, attribution will be to the AE that includes the Adult Day Health provider if

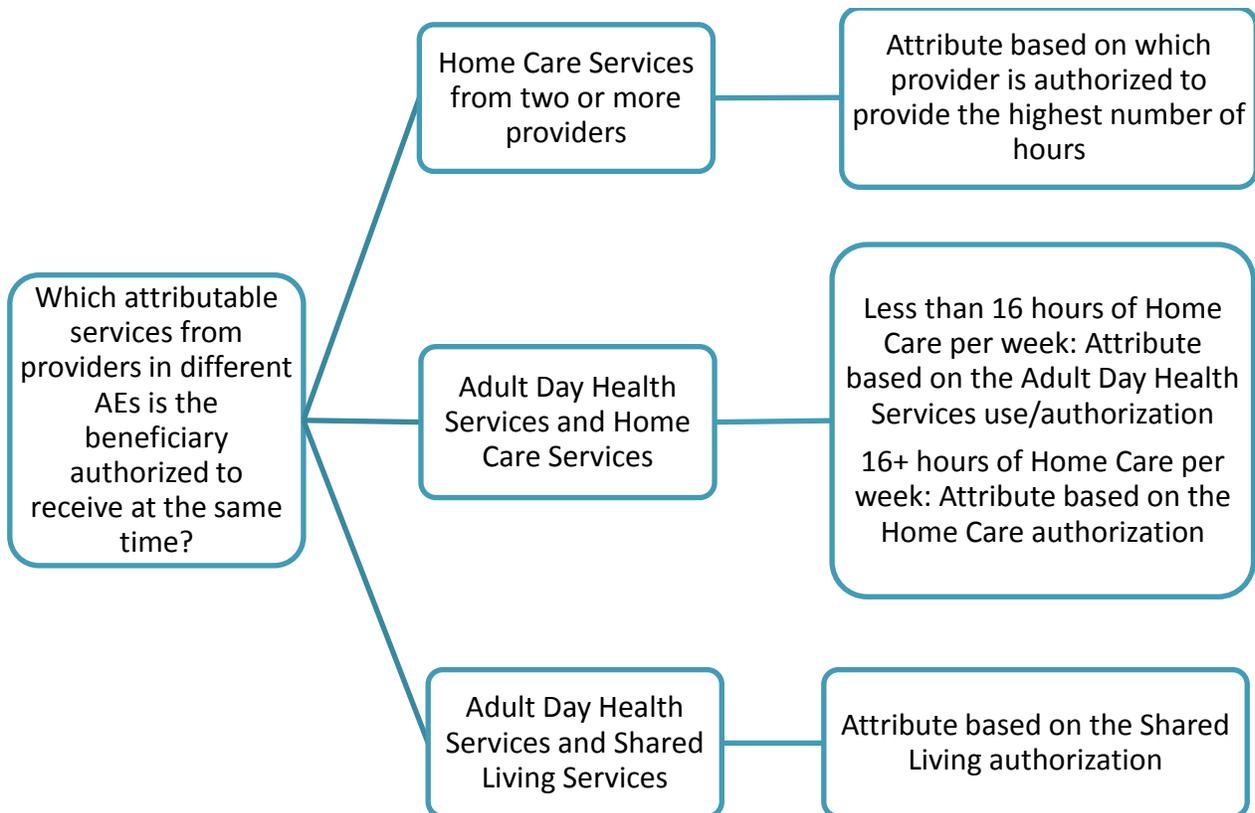
the beneficiary is receiving fewer than sixteen (16) hours per week of Home Care Services from a single provider. Otherwise, attribution will be based on the AE that includes the provider with the highest number of Home Care Services.

3. If an adult beneficiary is authorized to receive Adult Day Health Services and Shared Living Services, attribution will be to the AE that includes the Shared Living provider.

These guidelines apply to both the initial attribution and the monthly updates. Due to Medicaid rules related to service use, beneficiaries should not receive Home Care Services while receiving Shared Living, Assisted Living, or Nursing Facility services or receiving Adult Day Health Services while receiving Assisted Living or Nursing Facility services. Beneficiaries should also not receive Shared Living, Assisted Living, and Nursing Facility services simultaneously. As a result, the attribution hierarchy does not address those situations. In the event that a beneficiary is identified to have overlapping authorizations for these services, the MCO and/or EOHHS will validate the authorization information and ensure appropriate assignment. Where other discrepancies in the attribution are identified, the MCO and/or EOHHS may also validate and adjust the assignment as needed on a case-by-case basis.

Figure 1 summarizes the attribution rules when beneficiaries receive specialized LTSS AE attributable services from two or more providers in different AEs at the same time.

Figure 1: Attributing Beneficiaries Who Simultaneously Receive Attributable Services from Providers in Different AEs



NOTE: Figure 1 addresses only those scenarios in which beneficiaries receive attributable services from multiple providers simultaneously. As a result, it does not reference all types of attributable services.

Step 2: Validation of the attribution

No more than 5 calendar days after the first day of each month, each AE will receive a list of all Medicaid beneficiaries attributed to the AE from each MCO/payer. The AE will have 5 business days to identify and report any person actively receiving any of the attributable services in Table A who is not included in the attribution list. The MCO (for managed care enrolled members) and the State or its designee (for Medicaid fee-for-service beneficiaries) will validate the AE-reported information and update the attribution list as appropriate. Where other discrepancies in the attribution list are identified, the MCO/payer may also validate and adjust the assignment as needed on a case-by-case basis.

To be attributed to a specialized LTSS AE, an individual must be Medicaid eligible. He or she may be receiving services through either managed care or fee-for-service. The MCO/payer shall be required monthly to provide contracted AEs with electronic lists of attributed members, inclusive of identification of additions and deletions. These lists will be updated to reflect changes including new members, persons who have lost Medicaid eligibility, and persons whose attribution has changed pursuant to these guidelines.

Attachment A: Excerpts from EOHHS-MCO Contracts Regarding Assignment of Primary Care Providers

PCP assignment by the MCOs must comply with EOHHS contractual requirements. The following excerpts from Sections 2.05.07 and 2.05.08 of EOHHS' Medicaid Managed Care Services contracts with the MCOs describe the MCOs' contractual requirements related to PCP assignment:

2.05.07 Assignment of Primary Care Providers (PCPs)

Contractor shall have written policies and procedures for assigning each of its members who have not selected a primary care provider (PCP) at the time of enrollment to a PCP. The process must include at least the following features:

- The Contractor must allow each enrollee to choose his or her health professional to the extent possible and appropriate.
- If a Medicaid-only member does not select a PCP during enrollment, Contractor shall make an automatic assignment, taking into consideration such factors as current provider relationships, language needs (to the extent they are known), member's area of residence and the relative proximity of the PCP to the member's area of residence. Contractor then must notify the member in a timely manner by telephone or in writing of his/her PCP's name, location, and office telephone number, and how to change PCPs if desired. Contractor shall auto assign members to a NCQA recognized patient centered medical home, where possible.

In addition to the above, EOHHS recognizes the importance of members being enrolled in a certified AE and a Patient Centered Medical Home (PCMH). EOHHS expects that, as applicable to the eligible populations, the Contractor will prioritize auto-assignment (a) first, to PCPs in a PCMH practice that is also a participating provider in a certified and contracted AE; second, to PCPs in a PCMH practice that are not in a contracted AE; third to non-PCMH PCP participating in a contracted AE; and fourth to PCPs in a non-PCMH and non- AE participating practice

The Contractor is responsible for creating an auto- assignment algorithm and submitting this algorithm to EOHHS for review and approval within 90 days of the execution of this contract. Once this logic is approved by EOHHS, the health plan should operationalize this within 60 days. Contractor should consider the following when creating the algorithm: a) When auto assignment is being utilized, the Contractor must regularly monitor member panel size to ensure that providers have not exceeded their panel size; b) The provider's ability to comply with EOHHS's specified access standards, as well as the provider's ability to accommodate persons with disabilities or other special health needs must be considered during the auto-

assignment process; c) In the event of a full panel or access issue, the algorithm for auto assignment must allow a provider to be skipped until the situation is resolved. Additionally, the Contractor will be required to provide registries of patients to each PCP facility where the patients are assigned, no less frequent than quarterly or at an interval defined by EOHHS.

- Contractor shall notify PCPs of newly assigned members in a timely manner.
- If a Medicaid-only member requests a change in his or her PCP, Contractor agrees to grant the request to the extent reasonable and practical and in accordance with its policies for other enrolled groups. It is EOHHS's preference that a member's reasonable request to change his or her PCP be effective the next business day.

Contractor shall make every effort to ensure a PCP is selected during the period between the notification to the Contractor by EOHHS and the effective date of the enrollee's enrollment in the Contractor's Health Plan. If a PCP has not been selected by the enrollee's effective date of enrollment, the Contractor will assign a PCP. In doing so, Contractor will review its records to determine whether the enrollee has a family member enrolled in the Contractor's Health Plan and, if so and appropriate, the family member's PCP will be assigned to the enrollee. If the enrollee does not have a family member enrolled in the Health Plan but the enrollee was previously a member of the Health Plan, the enrollee's previous PCP will be assigned by the Contractor to the enrollee, if appropriate.

2.05.08 **Changing PCPs**

Contractor shall have written policies and procedures for allowing members to select or be assigned to a new PCP including when a PCP is terminated from the Health Plan, or when a PCP change is ordered as part of the resolution to a formal grievance proceeding. In cases where a PCP has been terminated, Contractor must allow members to select another PCP or make a re-assignment within ten (10) calendar days of the termination effective date.

Attachment B: Qualifying Primary Care Services as Identified by CPT Codes

Evaluation/Management CPT Codes: 99201-99205, 99211-99215

Consultation CPT Codes: 99241-99245

Preventive Medicine CPT Codes: 99381-99387, 99391-99397

Rhode Island Medicaid Accountable Entity Program

Attachment B: Accountable Entity Total Cost of Care Requirements

Rhode Island Executive Office of Health and Human Services
September 29, 2017
Amended for Technical Corrections as of February 22, 2018

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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. Comprehensive AEs must have at least 2,000 members per MCO-AE contract. 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.

Note that historical cost data must be adjusted to account for any changes in covered services between the base years and performance period. AE historical cost data must be associated with a population of 2,000 or more members. Historic base years associated with fewer than 2,000 members shall be excluded.

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. EOHHS strongly recommends that TCOC expenditures include 10% of any annualized spending per member above the truncation threshold. Absent the inclusion of expenditures above the truncation threshold, demonstration of an alternative mechanism to ensure ongoing management of high-cost members is required.

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.

Absent this adjustment, an alternative mechanism ensuring high-performing AEs are protected against the erosion of savings opportunity year-over-year must be demonstrated. Mechanisms for protecting against the erosion of savings opportunity must consider quality performance; savings achieved at the expense of quality shall not be rewarded.

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 $p \leq .05$), 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

EOHHS recommends, but does not require, a small sample size adjustment to account for statistical uncertainty in performance measurement due to the effect of random variation in utilization and spending in small populations. EOHHS’ preferred small sample size adjustment methodology is detailed below. Effective equivalents to this adjustment will be accepted for application to populations under 5,000 lives, under the following conditions:

- (a) The adjustment must be applied to the total shared savings pool, inclusive of MCO and AE shared savings.
- (b) The adjustment must allow for AEs to share in first dollar savings. As such, minimum savings rate corridors are not permitted.
- (c) The adjustment cannot be applied differentially based on historical performance.

EOHHS Preferred Small Sample Size Adjustment for Random Variation

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 be adjusted along a sliding scale by AE size, based on the parameters below.

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 (2,000-9,999)	Medium AE (10,000-19,999)	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 Total Shared Savings/(Loss) Pool (inclusive of both the AE and MCO portions) must be multiplied by the Overall Quality Score. The Overall Quality Score must function as a multiplier, and may not include a gate; as such, any quality points earned must be associated with a share of the Shared Savings/(Loss) Pool.

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.

AE contract revenue refers to the billable services performed by the AE directly (for members attributed to the AE), as opposed to total of care for those members, which

includes the billable services provided by the AE plus the cost of services that the AE does not perform.

6. AE Share of Savings/(Loss) Pool

In Year 1, AEs may be eligible to retain up to 50% 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 50% 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 <i>AE Share of Losses</i>	Loss Cap <i>Maximum Shared Loss Pool</i>
<i>Definition</i>	<i>The percentage of any Shared Loss Pool for which the AE is financially at risk.</i>	<i>The maximum percentage of the AE’s contract revenue for which the AE is financially at risk.</i>
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%
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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.⁹ EOHHS anticipates that any AEs taking on such risk must, at a minimum, demonstrate adequate capitalization to cover three months of claims.¹⁰

⁹ 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>

¹⁰ 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.medicare.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf; www.medicare.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

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 $p \leq .05$), 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 Enrollment¹¹

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 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

¹¹ 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.

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 <i>AE Share of Losses</i>	Loss Cap <i>Maximum Shared Loss Pool</i>
<i>Definition</i>	<i>The percentage of any Shared Loss Pool for which the AE is financially at risk.</i>	<i>The maximum percentage of the AE’s contract revenue for which the AE is financially at risk.</i>
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.¹² EOHHS anticipates that any AEs taking on such risk must, at a minimum, demonstrate adequate capitalization to cover three months of claims.¹³

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.¹⁴

¹² 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>

¹³ 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.medicare.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf; www.medicare.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/sharesavingsprogram/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

¹⁴ In addition to this EOHHS requirement, note that depending on circumstances transparency in such arrangements is specifically required in CFR42 §438.6 Contract requirements 438.6(g): Inspection and audit of financial records – Risk contracts must provide that the state agency and the Department may inspect and audit any financial records of the entity or its subcontractors. 438.6(h) Physician Incentive plans – MCO contracts must provide for compliance with the requirements set forth in 422.208 and 422.210 of this chapter. 438.6(k) All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

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 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 1 st – Mar 31 st 2018	July 29 th 2018
Q2: Apr 1 st – Jun 30 th 2018	October 28 th 2018
Q3: Jul 1 st – Sep 30 th 2018	January 28 th 2018
Q4: Oct 1 st – Dec 31 st 2018	April 29 th 2018
Q5: Jan 1 st – Mar 31 st 2019	July 29 th 2019
Q6: Apr 1 st – Jun 30 th 2019	October 28 th 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		
<i>*Note: all data is illustrative only</i>								
		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	5,083		5,250	
INPUT ->	PMPM	\$345.00	\$347.00	\$320.00	\$337.05		\$350.00	
1 Calculating the Historical Base and Initial TCOC Target					Historical Base		Performance Year Target	
		Year 1	Year 2	Year 3				
A Total Cost of Care (Unadjusted)		\$20,700,000	\$20,820,000	\$20,160,000	\$20,560,000	\$337.05		
B Base Year Weight		33%	33%	33%				
C Trend Factor			2%	2%				
D Trend Adjustment		\$836,280	\$416,400	\$0	\$417,560	\$6.85		
Details below	E Risk Adjustment	\$871,579	\$429,278	\$0	\$433,619	\$7.11		
Details below	F Total Cost of Care (Adjusted)	\$22,407,859	\$21,665,678	\$20,160,000	\$21,411,179	\$351.00		
Details below	G Prior Year Savings Adjustment			\$176,400	\$176,400	\$2.89		
H Historical Performance Adjustment				\$411,200	\$411,200	\$6.74		
I Total Cost of Care (Adjusted, with Sustainability Adjustments)					\$21,998,779	\$360.64	Projected Trend	Time Period (Yrs)
J Total Cost of Care (Initial Target)							2%	2
							\$22,887,530	\$375.21
							TCOC Initial PY Target	
2 Calculating the Final TCOC Target								
Details below	A Risk Adjustment						\$477,534	\$7.58
B *Final Target based on risk-adjusted PMPM with performance year membership				Impact of change in membership			\$750,411	\$0.00
Total Cost of Care (Final Target)							\$24,115,475	\$382.79
							TCOC Final PY Target	
3 Calculating and Distributing the Shared Savings (Loss) Pool							Performance Year	
A Total Cost of Care (Actual Expenditures)							\$22,050,000	\$350.00
							TCOC Actual	
B Shared Savings (Loss) Pool							\$2,065,475	\$32.79
Details below	C Random Variation Adjustment						\$0	\$0.00
Details below	D Quality and Outcomes Adjustment						\$0	\$0.00
E Shared Savings (Loss) Pool (Adjusted)							\$2,065,475	\$32.79
F Eligible Shared Savings Pool							\$2,065,475	\$32.79
G Eligible Shared Loss Pool							NO	NO
Cap: 10% AE Contract	H Maximum Allowable Shared Savings Pool						\$2,411,547	\$38.28
Cap: 5% AE Contract	I Maximum Allowable Shared Loss Pool						-\$1,205,774	-\$19.14
J Final Shared Savings Pool							\$2,065,475	\$32.79
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		\$413,095	\$6.36	\$619,642	\$9.84	\$826,190	\$13.11	
N Option 2 AEs: Shared Savings and Risk		AE Share		40%	50%	60%		
		\$	pmpm	\$	pmpm	\$	pmpm	
Shared Savings		\$826,190	\$13.11	\$1,032,737	\$16.39	\$1,239,285	\$19.67	
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	0.97	<- INPUT
		TCOC (Dollars): Years 1 and 2 Risk-Adjusted to Year 3 Risk Mix	\$359.53	\$354.15	\$320.00	\$344.56	
		Risk Adjustment	\$14.53	\$7.15	\$0.00	\$7.23	
Adjustment for Prior Year Savings	G	Prior Year Savings: Target - Actual TCOC (ppm)			\$7.00		<- INPUT
		Eligible Adjustment: AE Share			\$2.80	40%	AE Share
		Eligible Adjustment: Total Dollars			\$176,400		
		Maximum Adjustment for Prior Year Savings (2%)			\$411,200		2% Max Allowable
		Eligible Adjustment or Max Allowable			\$176,400		
Historical Performance Adjustment	H	MCO Average Cost (ppm)			\$334.00		<- INPUT
		MCO Average Risk Score			1.00		
		AE Average Risk Score			0.99		
		AE Cost (ppm)			\$320.00		
		AE Cost with FQHC PPS Adjustment (ppm)			\$320.00	\$0.00	FQHC PPS Adjustment (ppm), if applicable
		AE Average Risk Normalized Cost (ppm)			\$323.23		
		Cost Score (% above/below MCO Average)			-4%		
		Eligible Adjustment			\$14.13		
		Eligible Adjustment: Total Dollars			\$861,796		
		Max Allowable Adjustment			\$411,200		2% Max Allowable
		Eligible Adjustment or Max Allowable			\$411,200		

2 Final TCOC Target Adjustments

		PY		
Risk Adj	A	Average Risk Score	1.01	<- INPUT
		Risk Adjustment	\$7.58	

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	Medium AE	Large AE	
		(5-9,999)	(10-19,999)	(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 %	8.56%	9.00%	9.00%	Savings Rate Bracket Lookup	
Small AE	100%				
Medium AE	100%				
Large AE	100%				
Random Variation Adjustment	100%			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 Weights are flexible, example uses MSSP methodology
- 3 Placeholder trend, to populate 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)

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

	SFY 2014	SFY 2015	SFY 2016		SFY 2018
INPUT ->				Historical Base	Performance Year
INPUT ->	1,000	1,000	1,000	1,250.00	1,000
	\$1,225.00	\$1,250.00	\$1,275.00	\$1,250.00	\$1,225.00

1 Calculating the Historical Base and Initial TCOC Target				Historical Base		Performance Year Target	
	Year 1	Year 2	Year 3	\$	pppm	\$	pppm
A Total Cost of Care (Unadjusted)	\$14,700,000	\$15,000,000	\$15,300,000	\$15,000,000	\$1,250.00		
B Base Year Weight	33%	33%	33%				
C Trend Factor		2%	2%				
D Trend Adjustment	\$593,880	\$300,000	\$0	\$297,960	\$24.83		
E Risk Adjustment	\$0	\$0	\$0	\$0	\$0.00		
F Total Cost of Care (Adjusted)	\$15,293,880	\$15,300,000	\$15,300,000	\$15,297,960	\$1,274.83		
G Prior Year Savings Adjustment			\$300,000	\$300,000	\$25.00		
H Historical Performance Adjustment			\$300,000	\$300,000	\$25.00		
I Total Cost of Care (Adjusted, with Sustainability Adjustments)				\$15,897,960	\$1,324.83	2%	2
J Total Cost of Care (Initial Target)						\$16,540,238	\$1,378.35

2 Calculating the Final TCOC Target				Performance Year	
				\$	pppm
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)				\$16,540,238	\$1,378.35

3 Calculating and Distributing the Shared Savings (Loss) Pool				Performance Year	
				\$	pppm
A Total Cost of Care (Actual Expenditures)				\$14,700,000	\$1,225.00

B Shared Savings (Loss) Pool				\$1,840,238	\$153.35
C Shared Savings Pool				\$1,840,238	\$153.35
D Shared Loss Pool				NO	NO
E Shared Savings Pool After MSR				\$1,840,238	\$153.35
F Shared Loss Pool After MLR				NO	NO
G Quality and Outcomes Adjustment: Quality Score Multiplier				1.00	
H Shared Savings Pool (Adjusted)				\$1,840,238	\$153.35
I Shared Loss Pool (Adjusted)				NO	NO
J Adjustment for MCO Enrollment (% MCO Member Months)				50%	
K Eligible MCO-Adjusted Shared Savings Pool				\$920,119	\$76.68
L Eligible MCO-Adjusted Shared Loss Pool				NO	NO
M Maximum Allowable MCO Shared Savings Pool				\$827,012	\$68.92
N Maximum Allowable MCO Shared Loss Pool				-\$413,506	-\$34.46
O Final MCO Shared Savings Pool				\$827,012	\$68.92
P Final MCO Shared Loss Pool				NO	NO

Q AE Share of Final Shared Savings (Loss) Pool				Option 1 AE's: Shared Savings Only	
	AE Share	20%	30%	40%	
		\$	pppm	\$	pppm
Shared Savings		\$165,402	\$13.78	\$248,104	\$20.68
				\$330,805	\$27.57

Cap: 10% MCO-Adj. Target
Cap: 5% MCO-Adj. Target

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	\$1,250.00	
	Risk Adjustment	\$0.00	\$0.00	\$0.00	\$0.00	

Adjustment for Prior Year Savings	G Prior Year Savings: Target - Actual TCOC (ppm)			\$65.00	<- INPUT	
	Eligible Adjustment: AE Share			\$26.00	40%	AE Share
	Eligible Adjustment: Total Dollars			\$312,000		
	Maximum Adjustment for Prior Year Savings (2%)			\$300,000		2% Max Allowable
	Eligible Adjustment or Max Allowable			\$300,000		

Historical Performance Adjustment	H MCO Average Cost (ppm)			\$1,350.00	<- INPUT	
	MCO Average Risk Score			1.0		
	AE Average Risk Score			1.0		
	AE Cost (ppm)			\$1,275.00		
	AE Average Risk Normalized Cost (ppm)			\$1,275.00		
	Cost Score (% above/below MCO Average)			-6%		
	Eligible Adjustment			\$69.44		
	Eligible Adjustment: Total Dollars			\$833,333		
	Max Allowable Adjustment			\$300,000		2% Max Allowable
	Eligible Adjustment or Max Allowable			\$300,000		

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	\$661,610	\$55.13	
	Minimum Loss	-\$661,610	-\$55.13	

- 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 populate 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 (the “Overall Quality Score”) 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.
- In accordance with 42 CFR §438.6(c)(2)(ii)(B)¹⁵, quality performance measurement must be based on the Medicaid Accountable Entity Common Measure Slate. All required measures must be reported. Up to 4 additional optional menu measures for comprehensive AEs may be included, as agreed upon by the MCO and AE.
- An Overall Quality Score must be generated for each AE. Of the 11 required measures included in the Medicaid AE Common Measure Slate, a minimum of 9 measures must be included in the calculation of the Overall Quality Score, inclusive of the 4 pay-for-reporting measures. In other words, the MCO and AE may choose to exclude up to 2 of the pay-for-performance measures from the Overall Quality Score in Program Year 1.
- 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.

¹⁵https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438_16&rgn=div8

- The Overall Quality Score will be used as a multiplier to determine the percentage of the shared savings pool the AE and MCO are eligible to receive. Overall Quality Scores must 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

In accordance with 42 CFR §438.6(c)(2)(ii)(B)¹⁶, quality performance measurement must be based on the Medicaid Comprehensive AE Common Measure Slate (see Section F below). All required measures must be reported. 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.

¹⁶https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438_16&rgn=div8

- 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 Overall Quality Score Determination

As articulated in Section D.5.b of the Total Cost of Care Requirements, an Overall Quality Score must be generated for each AE and the Total Shared Savings/(Loss) Pool (inclusive of both the AE and MCO portions) must be multiplied by the Overall Quality Score. The Overall Quality Score must function as a multiplier, and may not include a gate; as such, any quality points earned must be associated with a share of the Shared Savings/(Loss) Pool.

The Overall 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. 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%

E. Comprehensive AE Measure Specific Performance: EOHHS Preferred Methodology

EOHHS’ preferred measure specific quality scoring methodology is described below; however, an alternate quality scoring rubric may be used in Program Year 1 if approved by EOHHS. EOHHS will work to develop a standard quality scoring rubric through a stakeholder process, and anticipates standardization of the quality scoring methodology in the future. EOHHS’ measure specific quality scoring methodology 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 is assessed and scored based on performance relative to the benchmark targets or achievement of meaningful improvement, as defined below.

Comprehensive AE Measure Specific Scoring: EOHHS Preferred Methodology

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%

F. Comprehensive AE Common Measure Slate*

The Comprehensive AE Common Measure Slate is detailed below.

Note that mandatory measures for which baseline data can be calculated will be pay for performance in Year 1. 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%) shall be awarded for the pay for reporting measures listed above, 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.

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 66 th 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 90 th percentile	QC 66 th 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
3. Developmental Screening in the 1 st 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 90 th percentile	QC 66 th percentile
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 Control (<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 75 th percentile	QC 66 th percentile

Measure Name	NQF #	Measure Steward	Measure Domain	Measure Source	Measure Description	Age Cohort	High Benchmark	Medium Benchmark
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: <ul style="list-style-type: none"> • 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 90 th percentile	QC 66 th percentile
8. Follow-up after Hospitalization for Mental Illness (7 Days and 30 Days ¹⁷)	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 90 th percentile	QC 66 th percentile
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

¹⁷ Reporting on the Follow-up after Hospitalization for Mental Illness measure must include both the 7 day and 30 day measure components. Both components should be reported, but the MCO and AE may choose either definition for inclusion in the Overall Quality Score.

Measure Name	NQF #	Measure Steward	Measure Domain	Measure Source	Measure Description	Age Cohort	High Benchmark	Medium Benchmark
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
Aligned Measure

G. 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.

H. 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;...”*

EOHHS Medicaid Infrastructure Incentive Program: Attachment C: Requirements for Medicaid Managed Care Organizations and Certified Accountable Entities

Rhode Island Executive Office of Health and Human Services
September 29, 2017
Amended for Technical Correction as of February 22, 2018

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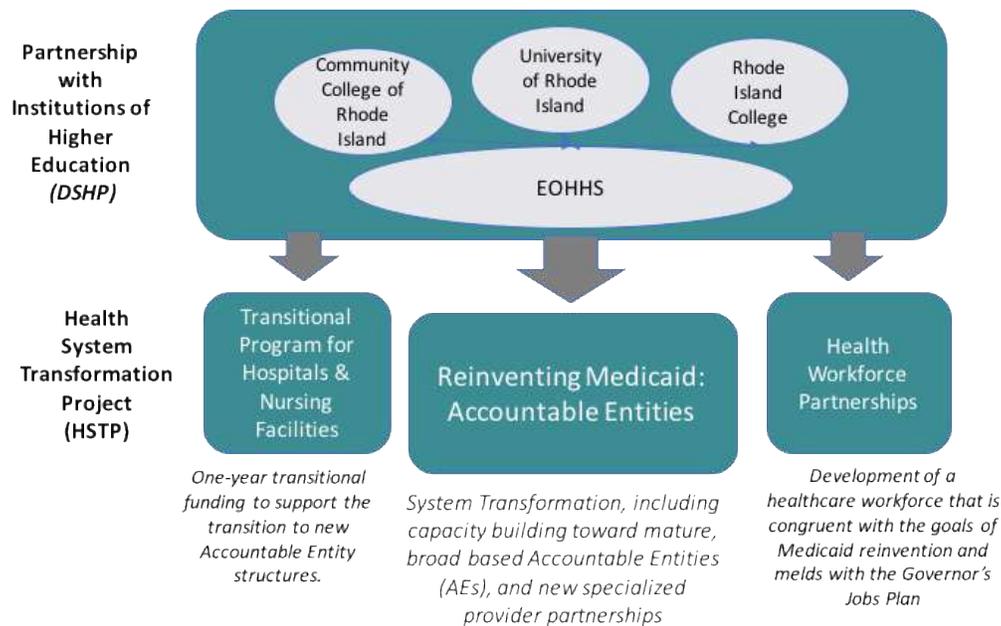
EOHHS Incentive Program Requirements

I. Background and Context

Beginning in late 2015, the Rhode Island (RI) Executive Office of Health and Human Services (EOHHS) began pursuing Medicaid waiver financing to provide support for Accountable Entities (AEs) by creating a pool of funds primarily focused on assisting in the design, development and implementation of the infrastructure needed to support Accountable Entities. RI submitted an application for such funding in early 2016 as an amendment to RI’s current Global Medicaid 1115 Waiver. In October 2016, the Centers for Medicare & Medicaid Services (CMS) approved this waiver amendment, bringing \$129.8 million in Federal Financial Participation (FFP) to RI from November 2016 through December 2020.¹⁸

This funding is based on the establishment of an innovative **Health Workforce Partnership** with RI’s three public institutions of higher education (IHE): University of Rhode Island (URI), Rhode Island College (RIC), and the Community College of Rhode Island (CCRI), as illustrated below.

Health System Transformation Project



The majority of the financing from this waiver amendment will be provided to AEs as incentive-based infrastructure funding via the state’s managed care contracts. Other CMS supported components include:

¹⁸ The current Rhode Island 1115 Waiver is a 5-year demonstration, ending 12/31/2018. The STCs include DSHP funding authority through 2018, with a commitment articulated in the cover letter to extend this authority thru 2020 upon waiver renewal for a total funding opportunity of \$129 Million.

- Investments in partnerships with Institutions of Higher Education (IHEs) for statewide health workforce development and technical assistance to AEs
- One-time funding to support hospitals and nursing facilities with the transition to new AE structures¹⁹
- Project management support to ensure effective and timely design, development and implementation of this program
- Project demonstration pilots and project evaluation funding to support continuous program learning, advancement and refinement
- Other supporting programs, including Consumer Assistance, Wavemaker Fellowship, TB Clinic, RI Child Audiology Center, and Center for Acute Infectious Disease Epidemiology

As mentioned above, the current RI 1115 Waiver expires December 31, 2018. The Special Terms and Conditions (STCs) of the waiver amendment include expenditure authority for this program of up to \$79.9 million FFP through the end date of the current waiver.

II. Medicaid Infrastructure Incentive Program (MIIP)

Over the course of program years 1 through 4 EOHHS projects it will allocate an estimated \$95 million to the AE program through the Medicaid Infrastructure Incentive Program (MIIP), as shown below. This allocation is subject to available funds captured in accordance with CMS approved claiming protocols, and annual EOHHS review and approval. This program shall begin no earlier than January 2018 and shall be aligned with the state fiscal years as shown below. Note that Program Year 1 is 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.

	Program Year 1 SFY 2018-19 <i>Jan 2018-Jun2019</i>	Program Year 2 SFY 2020 <i>Jul 2019- Jun 2020</i>	Program Year 3 SFY 2021 <i>Jul 2020-Jun 2021</i>	Program Year 4 SFY 2022 <i>Jul 2021-Jun 2022</i>	Total
Medicaid Infrastructure Incentive Program (MIIP)	\$30 M	\$30 M	\$20 M	\$15 M	\$95 M

An AE Program Advisory Committee shall be established by EOHHS.

This committee shall be chaired by EOHHS, with a community Co-Chair and shall include representation from participating managed care organizations (MCOs), AEs, and community stakeholders and shall:

- Support the development of AE infrastructure priorities
- Help target Medicaid Infrastructure Incentive Program funds to specific priorities that maximize impact
- Review specific uses of funds by each AE and MCO, such that individual AE Project plans are designed and implemented to maximum effect

¹⁹ The STCs limit this program to be one-time only and to not exceed \$20.5 million, paid on or before December 31, 2017.

- Support effective program evaluation and integrated learnings
- Identify effective ways to leverage the intersection between AE project plans and workforce development partnerships

The MIIP shall consist of three core programs:

(1) Comprehensive AE Program; (2) Specialized LTSS AE Pilot Program; and (3) Specialized Pre-eligibles AE Pilot Program. EOHHS shall allocate available HSTP funds to these three programs as follows, subject to available funds and EOHHS identification of priority areas of focus and assessment of readiness. This allocation shall be revisited annually.

AE Programs	Program Year 1		Full Program
	\$	%	
Comprehensive AE Program	\$21 M	65-70%*	60% - 70%
Specialized LTSS Pilot AE Program	\$9 M	30-35%*	25% - 35%
Specialized Pre-eligibles Pilot AE Program**	\$0 M	0%	5%-15%
Total Funds	\$30 M	100%	100%

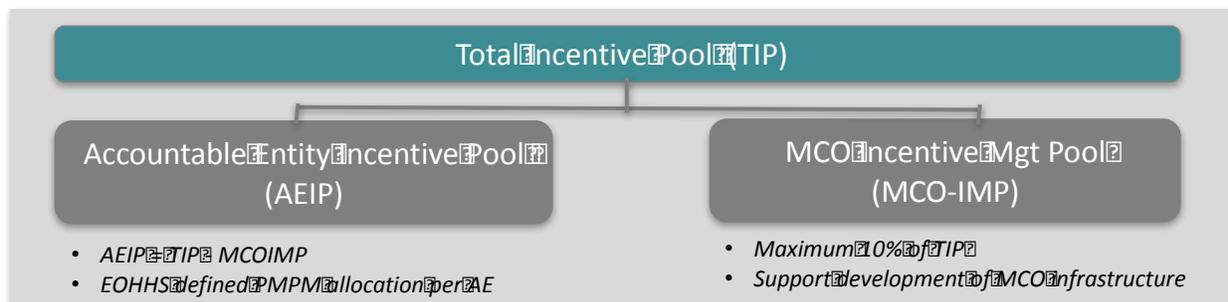
*For the purposes of illustration, PY 1 assumes a 70/30 distribution of funds between the Comprehensive AE Program and the Specialized LTSS AE Pilot Program

**Authority for this program is dependent upon CMS approval under the RI Medicaid 1115 waiver renewal, to be submitted to CMS in December 2017, effective 1/1/2019.

AEs participating in both the Comprehensive AE Program and Specialized LTSS Pilot AE Program will be eligible to receive funding from both incentive pools.

III. Determining Maximum Incentive Pool Funds

The MIIP shall include three dimensions:



Maximum Total Incentive Pool (TIP)

The maximum Total Incentive Pool (TIP) is provided in the table below. This TIP shall be allocated to AEIP and MCO-IMP pools specific to each MCO-AE relationship by EOHHS based on the guidelines established below and specific funding details defined and released by EOHHS on a yearly basis.

1. MCO Incentive Management Pool (MCO-IMP)

Assuming satisfactory MCO performance, the MCO Incentive Management Pool that can be earned by the MCOs shall be eight percent (8%) of the Total Incentive Pool. However, to

the degree that the MCO has more than the minimally required number of contracts with AEs, the maximum MCO-IMP shall be increased by one percent for each AE contract to a maximum of ten percent (10%). These funds are intended for use toward advancing program success, including program administration and oversight, assisting with the development of the necessary infrastructure to support a new business model, and establishing shared responsibilities, information requirements and reporting between EOHHS, the MCO and the Accountable Entities.

2. Accountable Entity Incentive Pool (AEIP)

The Accountable Entity Incentive Pool shall equal the Total Incentive Pool minus the maximum MCO Incentive Program Management Pool (AEIP =TIP – MCO-IMP). This shall determine the total annual amount and schedule of incentive payments each participating AE may be eligible to receive from the Accountable Entity Incentive Pool.

Consistent with this structure, Program Year 1 MIIP funds shall be allocated as follows, subject to available funds:

MIIP Funds Program Year 1 <i>Jan 2018-Jun2019</i>	Accountable Entity Incentive Pool (AEIP)	MCO Incentive Management Pool (MCO-IMP)	Total Incentive Pool (TIP)
Comprehensive AE Program	\$18.9 M	\$ 2.1 M	\$21.0 M
Specialized LTSS Pilot Program	\$8.1 M	\$0.9 M	\$9.0 M
Total Funds	\$27.0 M	\$3.0 M	\$30.0 M
<i>% Total</i>	<i>90%</i>	<i>10%</i>	<i>100%</i>

AE-Specific Incentive Pools

Certified AEs in qualified Alternative Payment Methodology (APM) contracts consistent with EOHHS requirements must be eligible to participate in the Medicaid Infrastructure Incentive Program. Each MCO must create an AE-Specific Incentive Pool for each Certified AE to establish the total incentive dollars that may be earned by each AE during the period.

For Program Year 1, this AE Specific Incentive Pool shall be calculated by the MCOs as follows:

- **Comprehensive AE- Specific Incentive Pools** shall be an incentive pool amount derived from a per member per month (PMPM) times the number of attributed lives in accordance with the following formula.

PMPM Multiplier*	x Attributed Lives	x 12
\$7.87	At the start of each Program Year in accordance with EOHHS defined requirements	Translate to Member Month

*Note that the PMPM Multiplier shown above has been established by EOHHS for Program Year 1; the PMPM Multiplier will be defined and released on a yearly basis by EOHHS.

The Specialized LTSS Pilot AE-Specific Incentive Pool shall be determined on a per AE basis, in accordance with the formula below. The pool funding depends upon the number of Certified participating LTSS Pilot AEs as follows. This pool structure shall be finalized by EOHHS within 30 days of AE Certification. If there are fewer than four (4) certified AEs, the funds per AE remain unchanged, and any unallocated funds will be retained for future Specialized AE program use.

# Certified LTSS AEs	Program Year 1 Total \$ Per Certified LTSS AE
2	\$2.0 M
3	\$2.0 M
4	\$2.0 M
5	\$1.6 M
6	\$1.4 M

Note that the Specialized LTSS Program is a pilot, and as such is intended to both enhance core capabilities and provide a basis for testing the validity of the APM model. As such, 20% of the AE Specific Incentive Pool shall be set aside to support the potential shared savings associated with each AE’s Total Cost of Care target, inclusive of the required quality multiplier, in accordance with state defined APM requirements, as specified in Section VII of this document.

IV. AE Specific Health System Transformation Project Plans (HSTP Plans)

Under the terms of Rhode Island’s agreement with the federal government, this is not a grant program. AEs must earn payments by meeting metrics defined by EOHHS and its managed care partners, and approved by CMS to secure full funding.

Certified AEs and MCOs must jointly develop individual Health System Transformation Project Plans (HSTP Plans) that identify clear project objectives and specify the activities and timelines for achieving the proposed objectives. Actual AEIP incentive payment amounts to AEs will be based on demonstrated AE performance, accordingly, incentive payments actually earned by the AE may be less than the amount they are potentially eligible to earn. MCOs shall not be entitled to any portion of funds from the Accountable Entity Incentive Pool that are not earned by the AE. Any monies not remitted to an AE from the Accountable Entity Incentive Pool must be returned to EOHHS.

Specifications Regarding Allowable AE Specific HSTP Project Plans

Approvable HSTP Project Plans must specify:

- Core Goals**
 Approvable project plans must demonstrate how the project will advance the core goals of the Health System Transformation Project and identify clear objectives and steps for achieving the goals.
- Data Driven Identification of Shared MCO/AE Priorities**
 Plan must identify a set of shared MCO/AE priorities based on population specific analysis of service needs, capabilities and key performance indicators. To inform this work the MCO

shall provide a population specific analysis of the AE's attributed population. The data driven assessment may provide a basis for risk segmentation of the population served by the AE that can help guide project plans. Data analyses may identify patterns of gaps in coordinated care for population subgroups such as adults with co-occurring medical and behavioral health needs and/or may identify avoidable inpatient or emergency department utilization in specific geographic areas. Project plans then focus on tangible projects within the certification domain areas, such as IT capability to identify and track needs or strengthen targeted care management or patient engagement processes. This provides for the linkage between recognized areas of need/opportunity and developmental tasks. Shared priorities must be developed through a joint MCO/AE working group that includes clinical leadership from both the MCO and the AE²⁰ and using a data driven approach to consider issues such as:

- EOHHS priorities, as defined in Section V
 - Data driven assessment of the specific needs of the population served by the AE
 - The service profile of the AE (current and proposed)
 - Specific gaps in AE capacities and capabilities as defined in the AE Certification Application
 - Key Performance gaps, in quality and outcomes, relative to the populations served
 - Areas of potential enhancement of workforce skill sets to better enable system transformation
- **AE Specific Core Projects: Workplan and Budget**

The AE must develop a multi-year workplan and budget to address these priorities over the course of the program (Program Year 1-4). A more detailed workplan and budget must be developed for Program Year 1 that identifies a requested set of core projects in the pertinent Domains needed to address the Shared MCO/AE Priorities. Workplan objectives for Program Years 2-4 would be at a higher level with increased refinement for the subsequent periods. To avoid duplication of funds, each core project must be MCO specific, and must specify the requested **Areas of Expenditure consistent with requirements in Section VI.**
 - **Performance Areas and Milestones**

Approvable project plans must set milestones and deadlines for the meeting of metrics associated with each of the Core Projects to ensure timely performance, **consistent with requirements in Section VII.**

MCO Review Committee Guidelines for Evaluation

The MCO shall convene a review committee to evaluate the Detailed Workplan and Budget described above. EOHHS shall have a designee that participates on the MCO evaluation committee to ensure the state's engagement in the evaluation of the project plan and

²⁰ Note: Membership in this Working Group shall be specified in the AE application, as a condition of certification.

associated recommendations for approval or disapproval. The MCO Review Committee, in accordance with EOHHS guidelines, shall determine whether:

- **Core Projects as submitted are eligible for award**
Eligible core projects will include a workplan that clearly addresses EOHHS priority areas and includes the types of activities targeted for funds.
- **Core Projects that merit Incentive Funding**
Projects must show appropriateness for this program by including the following:
 - Clear statement of understanding of the intent of incentive dollars
 - Rationale for this incentive opportunity, including a clear description of the objective for the project and how achieving that objective will promote health system transformation for that AE
 - Confirmation that the project does not supplant funding from any other source and that project funding is non-duplicative of any submissions made to another MCO
 - The inclusion of a gap analysis and an explanation of how the workplan and-associated incentive plan and budget address these gaps
 - Clear interim and final project milestones and projected impacts, as well as criteria for recognizing achievement of these milestones and quantifying these impacts
- **Incentive Funding request is reasonable and appropriate**
The funding request must be reasonable for the project identified, with funds clearly dedicated to this project. The level and apportionment of the incentive funding request must be commensurate with value and level of effort required.

At the discretion of the EOHHS designee, the designee may refer the proposed project for EOHHS review and approval prior to development of the subcontract between the MCO and the AE.

Development of the proposed project plan and its acceptance by the MCO Review Committee shall be considered a Performance Milestone of the HSTP Program, as specified in Section VII.

Required Structure for Implementation

The Incentive Funding Request **must be awarded to the AE via a Contract Amendment** between the MCO and the AE. The Contract Amendment shall:

- Be subject to EOHHS review and approval
- Incorporate the central elements of the approved AE submission, including:
 - Stipulation of program objective
 - Scope of activity to achieve (may be incorporated via reference to separate project plan)
 - Performance schedule and performance metrics
 - Payment terms – basis for earning incentive payment(s) commensurate with the value and level of effort required.
- Define a review process and timeline to evaluate progress and determine whether AE performance warrants incentive payments. The MCO must certify that an AE has met its

approved metrics as a condition for the release of associated Health System Transformation Project funds to the AE.

- Minimally require that AEs submit semi-annual reports to the MCO using a standard reporting form to document progress in meeting quality and cost objectives that would entitle the AE to qualify to receive Health System Transformation Project payments; such reports will be provided to EOHHS by the MCO.²¹
- Stipulate that the AE earn payments through demonstrated performance. The AE's failure to fully meet a performance metric under its AE Health System Transformation Project Plan within the timeframe specified will result in forfeiture of the associated incentive payment (i.e. there will be no payment for partial fulfillment).
- Provide a process by which an AE that fails to meet a performance metric in a timely manner (thereby forfeiting the associated Health System Transformation Project Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric.

Reconciliation

In advance of the MCOs payments to AEs, the MCO shall receive payment from EOHHS in the amount and schedule agreed upon with EOHHS. MCOs shall make associated payments to AEs within thirty (30) calendar days of receipt of payment. The MCO will maintain a report of funds received and disbursed by transaction in a format and in the level of detail specified by EOHHS. Within fifteen days after the end of each calendar quarter, the MCO will provide the report to EOHHS for reconciliation. The MCO will work with EOHHS to resolve any discrepancies within fifteen calendar days of notification of such discrepancy. Any Incentive Program funds that are not earned by EOHHS Certified AEs as planned will be returned to EOHHS within thirty days of such request by EOHHS. An AE's failure to fully meet a performance metric within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment). An AE that fails to meet a performance metric in a timely fashion can earn the incentive payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric.

Project Plan Modifications

Subcontracts between the AE and the MCO associated with AE-specific HSTP Project Plans may only be modified with state approval. EOHHS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved.

V. EOHHS Priorities

²¹ Reporting templates will be developed in partnership with EOHHS

Each MCO’s AE Incentive Pool budget and actual spending must align with the priorities of EOHHS as developed with the support of the Advisory Committee and shown below. Note: This is a draft set of priorities – a final set of priorities shall be reviewed by the Advisory Committee and confirmed by EOHHS.

Program	Priorities
Comprehensive AEs	<ul style="list-style-type: none"> • Integration and innovation in behavioral health care • Integration and innovation in SUD treatment • Integration and intervention in social determinants, including cross system impacts
Specialized Pilot LTSS AEs	<ul style="list-style-type: none"> • Developing programs and care coordination processes to enable people to reside safely in a community setting and to promote timely care transitions and reduced institutional/ED utilization • Home and Community based Behavioral Health capacity development for specialized adult day care, home care, and alternative living arrangements with capacity to serve members with behavioral health and/or dementia/Alzheimer’s related service needs • Repurposing skilled nursing capacity for acute psychiatric transitions and/or adult day capacity

Consistent with these priorities and the requirements of the AE Certification Standards, Comprehensive AEs shall be required to demonstrate that at least 10% of Program Year 1 Incentive funds are allocated to partners who provide specialized services to support behavioral health care, substance abuse treatment and/or social determinants.

VI. Allowable Areas of Expenditure

Allowable uses of funds include the following three core areas and eight domains. Costs must be reasonable for services rendered.

EOHHS anticipates that some AEs incentives in Program Year 1 may be weighted toward development in core readiness domains 1-3 as set forth in the certification standards, as AEs build the capacity and tools required for effective system transformation. However, over time the allowable areas of expenditure will be required to shift toward system transformation capacities (domains 4-8). As such, in Program Year 1, allowable Readiness Expenditures (Category A, Domains 1 through 3 below), are limited as follows:

- Comprehensive AEs may devote no more than 30% of the total HSTP incentive pool to projects in the in the readiness category (Domains 1-3)
- Specialized AEs may devote no more than 60% of the total HSTP incentive pool to projects in the readiness category (Domains 1-3)

Domains	Allowable Uses of Funds
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A. Readiness	1. Breadth and Characteristics of Participating Providers	<ul style="list-style-type: none"> Building provider base, population specific provider capacity, interdisciplinary partnerships, developing a defined affiliation with community based organizations (CBOs) Developing full continuum of services, Integrated PH/BH, Social determinants
	2. Corporate Structure and Governance	<ul style="list-style-type: none"> Establishing a distinct corporation, with interdisciplinary partners joined in a common enterprise
	3. Leadership and Management	<ul style="list-style-type: none"> Establishing an initial management structure/staffing profile Developing ability to manage care under Total Cost of Care (TCOC) arrangement with increased risk and responsibility
B. IT Infrastructure*	4. Data Analytic Capacity and Deployment	<ul style="list-style-type: none"> Building core infrastructure: EHR capacity, patient registries, Current Care Provider/care managers' access to information: Lookup capability, medication lists, shared messaging, referral management, alerts Patient portal Analytics for population segmentation, risk stratification, predictive modeling Integrating analytic work with clinical care: Clinical decision support tools, early warning systems, dashboard, alerts Staff development and training – individual/team drill downs re: conformance with accepted standards of care, deviations from best practice
C. System Transformation	5. Commitment to Population Health and System Transformation	<ul style="list-style-type: none"> Developing an integrated strategic plan for population health that is population based, data driven, evidence based, client centered, recognizes Social Determinants of Health, team based, integrates BH, IDs risk factors Healthcare workforce planning and programming
	6. Integrated Care Management	<ul style="list-style-type: none"> Systematic process to ID patients for care management Defined Coordinated Care Team, with specialized expertise and staff for distinct subpopulations Individualized person-centered care plan for high risk members
	7. Member Engagement and Access	<ul style="list-style-type: none"> Defined strategies to maximize effective member contact and engagement Use of new technologies for member engagement, health status monitoring and health promotion
	8. Quality Management	<ul style="list-style-type: none"> Defined quality assessment & improvement plan, overseen by quality committee

* The state may make direct investments in certain technology to support provider to provider EHR communication, such as dashboards and alerts. This investment would be made directly by the state with vendor(s) which would have the capacity and expertise to create and implement this technology in AEs statewide. This may be done in certain technology areas where direct purchasing by the state would result in significant efficiencies and cost savings. The products and tools resulting from this direct state technology investment would be made available to all AEs at no upfront charge. AEs would have the choice to either utilize the statewide tool at no charge or pay for their own tool. In this case, DSRIP funds would not be available for the AE to separately purchase such a tool.

Note that the allowable uses of funds specified above may not include any of the following

expenditures:

- Alcoholic beverages
- Capital expenditures (unless approved in advance by EOHHS)
- Debt restructuring and bad debt
- Defense and prosecution of criminal and civil proceedings, and claims
- Donations and contributions
- Entertainment
- Fines and penalties
- Fund raising and investment management costs
- Goods or services for personal use
- Idle facilities and idle capacity
- Insurance and indemnification
- Interest expense
- Lobbying
- Marketing/member communication expense, unless approved in advance by EOHHS
- Memberships and subscription costs
- Patent costs

These non-allowable expenditures have been developed in alignment with Section 2 CFR 200 which outlines Financial Management and Internal Control Requirements for receipt, tracking and use of federal funds by non-Federal awardees, and shall be updated by EOHHS as appropriate.

VII. Required Performance Areas and Milestones

AEs must develop AE Specific Health System Transformation Project Plans. These plans shall specify the performance that would qualify an AE to earn incentive payments. The execution of an EOHHS qualified APM contract with the MCO shall be considered the first Performance Milestone of the HSTP Program, as shown below.

Earned funds shall be awarded by the MCO to the AE in accordance with the distribution by performance area defined in the AE specific Health System Transformation Plan, consistent with the requirements defined below:

Performance Area	Minimum Milestones	Program Year 1
Developmental Milestones: Fixed Percentage Allocations Based on Specific Achievements	<ul style="list-style-type: none"> • Execution of an EOHHS qualified APM contract with the MCO, including performance milestones agreed upon by both parties • Detailed Health System Transformation Project Plan, including a specified set of Core Projects, and a proposed Infrastructure Development Budget by Project and Domain in accordance with state specified template • Agreement with SDOH, BH, and/or SUD Provider 	35%

Developmental Milestones: Variable Percentage Allocations Based on the HSTP Project Plan	<ul style="list-style-type: none"> Developmental milestones MCO/AE Defined (at least 3 unique developmental milestones per Core Project per year) 	45%
Quarterly Reporting on Outcome Metrics*	<p>Comprehensive</p> <ul style="list-style-type: none"> Inpatient Admissions per 1,000 30 Day Readmissions ED Visits per 1,000 MCO/AE Specific Performance Targets <p>Specialized</p> <ul style="list-style-type: none"> Total Cost of Care, inclusive of quality multiplier, in accordance with state defined APM requirements Preventable Admissions Readmissions Completion of Advanced Directives 	20%
Total		100%

*Note: For Program Year 1, at least 50% of the performance goals on outcome metrics shall be based on reporting only (for both Comprehensive and Specialized LTSS AEs).

The early milestones are intended to allow AEs to develop the foundational tools and human resources that will enable AEs to build core competencies and capacity. In accordance with EOHHS’ agreement with CMS, participating AEs must fully meet milestones established in the AE specific Health System Transformation Project prior to payment. EOHHS recognizes the financial constraints of many participating AEs and that timely payment for the achievement of early milestones will be critical to program success.

ATTACHMENT D

Alternative Payment Methodology Reporting Template



APM Data
Report.xlsx