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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 Group. 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 costs 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.  
- **Goal 5**: Implement coordinated, accountable care for high-cost/high-need populations.

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1 See [http://reinventingmedicaid.ri.gov](http://reinventingmedicaid.ri.gov) for additional documentation.
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. Targets for alternative payment arrangements are as follows:

Requirements for agreements between EOHHS and Managed Care Organizations for the five contract

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For Contract Period 1 (March 1, 2017 – June 30, 2018)

- By the final quarter of Contract Period 1 at least 45% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology.
- By the final quarter of Contract Period 1, at least 30% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology #1: Total Cost of Care Model with EOHHS Certified Accountable Entities.
- The percent of high need members enrolled in an EOHHS certified and MCO-contracted Accountable Entity that are high need, high cost, as defined in this document, shall be equal to or greater than the percent of high cost, high need persons in the MCOs entire enrolled membership.

For Contract Period 2 (July 1, 2018 – June 30, 2019)

- At least 45% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology or the percent of Managed Care Organization payments to providers made through an EOHHS approved Alternative Payment Methodology shall be 5% higher than the percent in the final quarter of the Contract Period #1.

For example, if in the final quarter of Contract Period #1 35% of Managed Care Organization payments to providers were made through an EOHHS approved Alternative Payment Methodology, for Contract Period #2 at least 40% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology.

- The percent of high need members enrolled in an EOHHS certified MCO contracted Accountable Entity that are high need, high cost, as defined in this document, shall be equal to or greater than the percent of high cost, high need persons in the MCO’s entire enrolled membership.
- By the final quarter of Contract Period #2, at least 45% of members are assigned to a primary care practice that functions as a patient centered medical home as recognized by EOHHS.

For Contract Period 3 (July 1, 2019 – June 30, 2020)

- At least 50% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology or the percent of Managed Care Organization payments to providers made through an EOHHS approved Alternative Payment Methodology shall be 5% higher than the percent required for Contract Period #2.

For example, if for Contract Period #2 40% of Managed Care Organization payments to providers were made through an EOHHS approved Alternative Payment Methodology, for Contract Period #3 at least 45% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology.

- The percent of high need members enrolled in an EOHHS certified MCO contracted Accountable Entity that are high need, high cost, as defined in this document, shall be equal or greater than the percent of high cost, high need persons in the MCO’s entire enrolled membership.
• At least 55% of members are assigned to a primary care practice that functions as a patient centered medical home as recognized by EOHHS.

For Contract Period 4 (July 1, 2020 – June 30, 2021)

• At least 60% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology or the percent of Managed Care Organization payments to providers made through an EOHHS approved Alternative Payment Methodology shall be 5% higher than the percent required for Contract Period #3.
• At least 10% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology that includes provisions for both shared savings and shared risk.

For example, if for Contract Period #3 the required level was 45% of Managed Care Organization payments to providers were made through an EOHHS approved Alternative Payment Methodology, for Contract Period #3 at least 55% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology.

• The percent of high need members enrolled in an EOHHS certified MCO contracted Accountable Entity that are high need, high cost, as defined in this document, shall be equal or greater than the percent of high cost, high need persons in the MCO’s entire enrolled membership.
• At least 60% of members are assigned to a primary care practice that functions as a patient centered medical home as recognized by EOHHS.

For Contract Period 5 (July 1, 2021 – June 30, 2022)

• At least 65% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology or the percent of Managed Care Organization payments to providers made through an EOHHS approved Alternative Payment Methodology shall be 10% higher than the percent required for Contract Period #3.

For example, if for Contract Period #4 the required level was 45% of Managed Care Organization payments to providers were made through an EOHHS approved Alternative Payment Methodology, for Contract Period #3 at least 55% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology.

At least 10% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology that includes provisions for both shared savings and shared risk.

• The percent of high need members enrolled in an EOHHS certified MCO contracted Accountable Entity that are high need, high cost, as defined in this document, shall be equal or greater than the percent of high cost, high need persons in the MCO’s entire enrolled membership.
• At least 60% of members are assigned to a primary care practice that functions as a patient centered medical home as recognized by EOHHS.
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:

A. Improving quality of care;
B. Improving population health;
C. Impacting cost of care and/or cost of care growth;
D. Improving patient experience and engagement; and/or
E. 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>
<thead>
<tr>
<th>Table 2: Qualified Alternative Payment Methodologies</th>
<th>Applicable Timeframe</th>
<th>Payments Included in APM Target Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total cost of care (TCOC) based contracts with EOHHS certified Comprehensive Accountable Entities</td>
<td>All Contract Years</td>
<td>All Payments as set forth in Attachment B, “EOHHS Total Cost of Care (TCOC)”</td>
</tr>
<tr>
<td>Requirement</td>
<td>Requirements for the AE Program*</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td></td>
</tr>
<tr>
<td>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 limits as set forth in Attachment B unless directly approved by EOHHS.</td>
<td>All Contract Years</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td>All Contract Years</td>
<td></td>
</tr>
<tr>
<td>4. Episode Based Bundled Payments either prospectively paid or retrospectively reconciled, with a risk component</td>
<td>All Contract Years</td>
<td></td>
</tr>
<tr>
<td>5. PCMH - Care Transformation PMPM*</td>
<td>Thru June 30, 2020</td>
<td></td>
</tr>
<tr>
<td>6. Supplemental infrastructure and Pay-for-performance payments** for non-LTSS providers</td>
<td>Thru June 30, 2020</td>
<td></td>
</tr>
<tr>
<td>7. Supplemental infrastructure and Pay-for-performance payments** for LTSS providers</td>
<td>Thru June 30, 2020</td>
<td></td>
</tr>
<tr>
<td>8. Other non-FFS payments that meet the definition of an Alternative Payment Methodology as approved by EOHHS.</td>
<td>All Contract Years</td>
<td></td>
</tr>
<tr>
<td>9. Other payments that meet the definition of an Alternative Payment Methodology as approved by EOHHS</td>
<td>All Contract Years</td>
<td></td>
</tr>
</tbody>
</table>

*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.

**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.**

The Alternative Payment Methodology (APM) target means the aggregate use of the above defined methodologies as a percentage of a Managed Care Organization’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, 2020**.

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, #6, and #7, in Table 2 above, while generally not employing the aforementioned budget methodology, will be included in the calculation of the APM target **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. 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 Risk**
  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 Managed Care Organizations 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. 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

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3 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.
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)

### 4.1 Requirements for Contracting with EOHHS Certified AEs

- During Contract Period #1 (SFY 2018) the Managed Care Organization will subcontract with three (3) or more EOHHS certified Accountable Entities or have at least 20,000 Medicaid attributed lives in contractual agreements with two or more certified AEs. Note that all subcontracts are subject to the terms set forth in the Medicaid Managed Care Contract.
- Not later than August 31, 2018 the Managed Care Organization will have EOHHS compliant subcontracts with three or more EOHHS certified accountable entities or have at least 20,000 Medicaid attributed lives in contractual arrangements with two or more EOHHS certified AEs. EOHHS compliant means that such subcontracts are compliant with the requirements as set forth in this document and in the Medicaid Managed Care Contract.
- During Contract Periods 3 through 5 (SFY 2020 – 2022) the Managed Care Organization will have EOHHS compliant subcontracts with three or more EOHHS certified accountable entities or have at least 30,000 Medicaid attributed lives in contractual arrangements with two or more EOHHS certified AEs. EOHHS compliant means that such subcontracts are compliant with the requirements as set forth in this document and in the Medicaid Managed Care Contract.

### 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 initiative**⁴ (e.g., CTC-RI, PCMH-Kids, RIQI’S TCPI, or a payer- or ACO-sponsored program) or practice has obtained NCQA Level 3 recognition. Practice meeting this requirement through achievement of NCQA Level 3 recognition may do so independent of participating in a formal transformation initiative.

b. **Practice has implemented the following specific cost-management strategies** according to the implementation timeline included in the Plan as Attachment A (strategy development and implementation at the practice level rather than the practice site level is permissible):
   i. develops and maintains a high-risk patient registry that tracks patients identified as being at risk of avoidable intensive service use in the near future;
   ii. practice uses data to implement care management⁵, 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...

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⁴ 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.

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. 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. 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.

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.

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6 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_SFY2014_FINAL_2.pdf

EOHHS requires that MCOs propose a methodology for identification and measurement of high cost/high need eligible, in accordance with this definition, to be approved by EOHHS.
Rhode Island Medicaid Accountable Entity Program

Attachment A: Accountable Entity Attribution- Program Year Two Requirements

Rhode Island Executive Office of Health and Human Services
December 11, 2018
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   3.2. Certified Comprehensive AE-Identified Providers
   3.3 Hierarchy of Attribution for Comprehensive AEs

Attachments
- Attachment A: Excerpts from EOHHS-MCO Contracts Regarding Assignment of Primary Care Providers
- Attachment B: Qualifying Primary Care Services as Identified by CPT Codes
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.
  o 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.
  o 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.

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 can only participate in one comprehensive AE at a time for the purposes of attribution. A member can only be attributed to a single comprehensive AE at a time.

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. 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 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). 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 until IHH discharge unless the member is assigned by BHDDH to a different IHH.

**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.
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:

2.5.7 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.

Notwithstanding the above, EOHHS recognizes the importance of members enrolling in a certified AE and a Patient Centered Medical Home (PCMH) and building a relationship with the Primary Care Provider (PCP). EOHHS expects that the Contractor to auto-assign to providers in a PCMH practice before auto assigning to non-PCMH providers. The Contractor will provide EOHHS with quarterly reports of the number and percent of total members assigned to PCMH sites either by auto-assignment or member choice.

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 then 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.

### 2.5.8 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-Program Year 2 Requirements

Rhode Island Executive Office of Health and Human Services
December 11, 2018

Amended for Technical Corrections as of April 30, 2019
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Attachments

- Attachment A  
  Quality Framework and Methodology for Comprehensive Accountable Entities
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.

• 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.

### C. General Requirements for Program Participants

1. **Minimum Membership and Population Size**
   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.

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. **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 covered under stop-loss provisions between EOHHS and the MCO, as specified in the EOHHS/MCO Contract for Medicaid Managed Care Services.
      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. Trends assigned to TCOC baselines shall not exceed the final cumulative trends to the medical portion of rates by cap cell, inclusive of any state budgetary savings assumptions, as contained in the EOHHS data books. 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.

a. **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 $p \leq 0.05$), 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:

i. The adjustment must be applied to the total shared savings pool, inclusive of MCO and AE shared savings.

ii. The adjustment must allow for AEs to share in first dollar savings. As such, minimum savings rate corridors are not permitted.

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

**Shared Savings/Loss Adjustment Factor Parameters**

<table>
<thead>
<tr>
<th>Savings %</th>
<th>Small AE (2,000-9,999)</th>
<th>Medium AE (10,000-19,999)</th>
<th>Large AE (20,000+)</th>
<th>Probability of Achieving Shared Savings/Loss as a Result of Chance*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>73%</td>
<td>79%</td>
<td>89%</td>
<td>1% 27% 21% 11%</td>
</tr>
<tr>
<td>2%</td>
<td>82%</td>
<td>92%</td>
<td>97%</td>
<td>2% 18% 8% 3%</td>
</tr>
<tr>
<td>3%</td>
<td>91%</td>
<td>97%</td>
<td>99%</td>
<td>3% 9% 3% 1%</td>
</tr>
<tr>
<td>4%</td>
<td>95%</td>
<td>99%</td>
<td>100%</td>
<td>4% 5% 1% 0%</td>
</tr>
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<td>5%</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
<td>5% 2% 0% 0%</td>
</tr>
<tr>
<td>6%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>6% 1% 0% 0%</td>
</tr>
</tbody>
</table>

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 A: Quality Framework and Methodology for Comprehensive 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 TCOC Expenditure Target for the Performance Period. In instances where the AE is responsible for downside risk, the Shared Loss Pool must not exceed 5% of the AE’s TCOC Expenditure Target for the Performance Period.

6. AE Share of Savings/(Loss) Pool

In Program Year 2, 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.

<table>
<thead>
<tr>
<th>AE Shared Savings Model</th>
<th>AE Share of Savings</th>
<th>Maximum Allowable Shared Savings Pool</th>
<th>Maximum Allowable Shared Loss Pool</th>
<th>AE Share of Losses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1: Shared savings only</td>
<td>Up to 50% of Savings Pool</td>
<td>10% of the AE’s TCOC Expenditure Target for the Performance Period</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Option 2: Shared savings + risk</td>
<td>Up to 60% of Savings Pool</td>
<td>10% of the AE’s TCOC Expenditure Target for the Performance Period</td>
<td>5% of the AE’s TCOC Expenditure Target for the Performance Period</td>
<td>Up to 60% of Loss Pool</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Year</th>
<th>Marginal Risk AE Share of Losses</th>
<th>Loss Cap Maximum Shared Loss Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The percentage of any Shared Loss Pool for which the AE is financially at risk.</td>
<td>The maximum percentage of the AE's TCOC Expenditure Target for the Performance Period for which the AE is financially at risk.</td>
</tr>
<tr>
<td>Year 1</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Year 2</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Year 3</td>
<td>15 - 30% of any Shared Loss Pool</td>
<td>At least 2% No more than 10%</td>
</tr>
<tr>
<td>Year 4</td>
<td>30 - 50% of any Shared Loss Pool</td>
<td>At least 2% No more than 10%</td>
</tr>
<tr>
<td>Year 5</td>
<td>50 - 60% of any Shared Loss Pool</td>
<td>At least 2% No more than 10%</td>
</tr>
</tbody>
</table>

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. EOHHS anticipates that any AEs taking on such risk must, at a minimum, demonstrate adequate capitalization to cover three months of claims.

### E. 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. 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.

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:

**a. 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?

**b. Benchmark Data Source**

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

---

8 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](http://webserver.rilin.state.ri.us/Statutes/Title27/27-4.7/INDEX.HTM)


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

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

d. **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.

e. **Treatment of State Budgetary Savings Assumptions**

Please specify the treatment of state budgetary savings assumptions in the TCOC methodology. Description of the adjustment must include how the per AE adjustment is calculated, and how the adjustment is applied.

f. **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?

g. **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.

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.

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.

<table>
<thead>
<tr>
<th>Program Year 2: Performance Quarters</th>
<th>Quarterly Report Due to EOHHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1: Jul 1st – Sep 30th 2019</td>
<td>January 28th 2020</td>
</tr>
<tr>
<td>Q2: Oct 1st – Dec 31st 2019</td>
<td>April 29th 2020</td>
</tr>
<tr>
<td>Q3: Jan 1st – Mar 31st 2020</td>
<td>July 29th 2020</td>
</tr>
</tbody>
</table>
## F. Comprehensive AE TCOC Methodology Example

### OMHS Comprehensive AE Total Cost of Care (TCOC) Guidance

#### Comprehensive AE TCOC Calculation Tool

<table>
<thead>
<tr>
<th>Comprehensiue AE TCOC Calculation Tool</th>
<th>Specific Variables</th>
<th>Calculation Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: all data is illustrative only*

### Calculating the Base Historical and Initial TCOC Target

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>Historical Base</th>
<th>Performance Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$20,569,806</td>
<td>$382.05</td>
</tr>
</tbody>
</table>

#### Details below

- **Base Year**: 2014
- **Year 2**: 2015
- **Year 3**: 2016
- **Identifiers**: Year 1, Year 2, Year 3
- **Trend Adjustment**: $486,490
- **Risk Adjustment**: $433,619
- **Total Cost of Care (Adjusted)**: $22,065,697
- **Historical Performance Adjustment**: $417,400
- **Total Cost of Care (Adjusted, with Sustainability Adjustments)**: $22,483,097
- **Projected Trend**: $335.00
- **Time Period (Yrs)**: 4

### Calculating the Final TCOC Target

- **Total Cost of Care (Final Target)**: $28,115,475
- **TCOC Initial PV Target**: $377.21

### Calculating and Distributing the Shared Savings Pool

#### Details below

- **Total Cost of Care (Actual Expenditures)**
- **TCOC Actual**

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>Historical Base</th>
<th>Performance Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$20,569,806</td>
<td>$382.05</td>
</tr>
</tbody>
</table>

#### Details below

- **Random Variation Adjustment**: $50
- **Quality and Outcomes Adjustment**: $50
- **Eligible Shared Savings Pool**: $2,065,475
- **Eligible Shared Loss Pool**: $2,065,475
- **Maximum Allowable Shared Savings Pool**: NO
- **Maximum Allowable Shared Loss Pool**: NO
- **Final Shared Savings Pool**: $8,010,475
- **Final Shared Loss Pool**: $8,010,475

### All Share of Shared Savings (Loss) Pool

<table>
<thead>
<tr>
<th>Option</th>
<th>AE Share</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$486,380</td>
<td>$13,11</td>
<td>$1,653,730</td>
</tr>
</tbody>
</table>

### All Share of Shared Savings (Loss) Pool

- **Option 1**: AE Share Savings Only
- **Option 2**: AE Share Savings and Risk

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Adjustment Details

#### Historical Base and Initial TCOC Target Adjustments

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Historical Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Risk Score</td>
<td>0.95</td>
<td>0.97</td>
<td>0.99</td>
<td>0.97</td>
</tr>
<tr>
<td>TCOC (Dollars): Years 1 and 2 Adjusted to Year 3 Risk Mix</td>
<td>$859.12</td>
<td>$834.35</td>
<td>$220.40</td>
<td>$344.96</td>
</tr>
<tr>
<td>Risk Adjustment</td>
<td>$14.53</td>
<td>$7.35</td>
<td>$0.00</td>
<td>$7.23</td>
</tr>
</tbody>
</table>

#### Adjustment for Prior Year Savings

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Year Savings: Target - Actual TCOC (ppm)</td>
<td>$7.90</td>
<td>$-</td>
</tr>
<tr>
<td>Eligible Adjustment: AF Share</td>
<td>$44.90</td>
<td>40%</td>
</tr>
<tr>
<td>Total Dollars</td>
<td>$78.40</td>
<td>$-</td>
</tr>
<tr>
<td>Maximum Adjustment for Prior Year Savings (2%)</td>
<td>$411.20</td>
<td>$2% Max Allowable</td>
</tr>
<tr>
<td>Eligible Adjustment or Max Allowable</td>
<td>$78.40</td>
<td>$-</td>
</tr>
</tbody>
</table>

#### Historical Performance Adjustments

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO Average Cost (ppm)</td>
<td>$334.00</td>
<td>$-</td>
</tr>
<tr>
<td>MCO Average Risk Score</td>
<td>$4.50</td>
<td>$-</td>
</tr>
<tr>
<td>AE Average Risk Score</td>
<td>$3.99</td>
<td>$-</td>
</tr>
<tr>
<td>AE Cost (ppm)</td>
<td>$320.00</td>
<td>$-</td>
</tr>
<tr>
<td>AE Cost with PQHI PPS Adjustment (ppm)</td>
<td>$229.00</td>
<td>$-</td>
</tr>
<tr>
<td>AE Average Risk Normalized Cost (ppm)</td>
<td>$333.23</td>
<td>$-</td>
</tr>
<tr>
<td>Cost Score (% above/below MCO Average)</td>
<td>$14.13</td>
<td>$4%</td>
</tr>
<tr>
<td>Eligible Adjustment</td>
<td>$411.20</td>
<td>$-</td>
</tr>
<tr>
<td>Total Dollars</td>
<td>$411.20</td>
<td>$-</td>
</tr>
<tr>
<td>Max Allowable</td>
<td>$411.20</td>
<td>$-</td>
</tr>
</tbody>
</table>

#### Final TCOC Target Adjustments

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Risk Score</td>
<td>1.01</td>
<td>$-</td>
</tr>
<tr>
<td>Risk Adjustment</td>
<td>$7.58</td>
<td>$-</td>
</tr>
</tbody>
</table>

#### Shared Savings (Loss) Pool Adjustments

<table>
<thead>
<tr>
<th>Savings %</th>
<th>Small AE</th>
<th>Medium AE</th>
<th>Large AE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(5-99)</td>
<td>75%</td>
<td>75%</td>
<td>89%</td>
</tr>
<tr>
<td>(10-19)</td>
<td>65%</td>
<td>65%</td>
<td>87%</td>
</tr>
<tr>
<td>(20-29)</td>
<td>55%</td>
<td>55%</td>
<td>87%</td>
</tr>
<tr>
<td>(30-39)</td>
<td>45%</td>
<td>45%</td>
<td>90%</td>
</tr>
<tr>
<td>(40-49)</td>
<td>35%</td>
<td>35%</td>
<td>94%</td>
</tr>
<tr>
<td>(50-59)</td>
<td>25%</td>
<td>25%</td>
<td>99%</td>
</tr>
<tr>
<td>(60-69)</td>
<td>15%</td>
<td>15%</td>
<td>99%</td>
</tr>
<tr>
<td>(70-79)</td>
<td>5%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>(80-89)</td>
<td>1%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>(90-99)</td>
<td>0%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

#### Small Sample Size Risk Variation Adjustment

- **Cost Score Multiplier**: 1.00
- **Detailed Quality Measure Scoring Methodology to come**

#### Notes

1. TCOC inputs must account for covered service exclusions and claims cap truncation.
2. Base Year Weights are flexible, example uses MSSP methodology.
3. Riskholder trend, to populate OHHS data trend, 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: Quality Framework and Methodology for Comprehensive 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.

The Program Year 2 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.

Note that EOHHS anticipates engaging with a quality measurement subject matter expert in the coming months and convening a series of meetings with that subject matter expert and all AE program participants to develop and formalize a refined approach for quality measurement and reporting. This process will clarify issues around data collection, benchmarking, calculating performance, and incorporating performance into the Overall Quality Score for Program Year 3 and beyond.

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)\(^{11}\), 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 may be included, as agreed upon by the MCO and AE.
- For comprehensive AEs, all admin (claims-based) measures must be generated and reported by the MCO. AEs must provide the necessary data to the MCO to generate any hybrid or EHR-only measures. Any EHR-only measures generated by an AE may be reported for the AE’s full attributed population.

\(^{11}\)https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438_16&rgn=div8
An Overall Quality Score must be generated for each AE. 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.

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Performance Time Period</th>
<th>Quality Measurement Performance Period</th>
<th>Quality Measurement Benchmark Period</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>PY 1</td>
<td>SFY 2019</td>
<td>HEDIS 2019, CY 18</td>
<td>HEDIS 2018, CY 17</td>
<td>SFY 2020</td>
</tr>
<tr>
<td>PY 2</td>
<td>SFY 2020</td>
<td>HEDIS 2020, CY 19</td>
<td>HEDIS 2019, CY 18</td>
<td>SFY 2021</td>
</tr>
<tr>
<td>PY 3</td>
<td>SFY 2021</td>
<td>HEDIS 2021, CY 20</td>
<td>HEDIS 2020, CY 19</td>
<td>SFY 2022</td>
</tr>
<tr>
<td>PY 4</td>
<td>SFY 2022</td>
<td>HEDIS 2022, CY 21</td>
<td>HEDIS 2021, CY 20</td>
<td>SFY 2023</td>
</tr>
</tbody>
</table>

C. Medicaid AE Common Measure Slate for Comprehensive AEs

In accordance with 42 CFR §438.6(c)(2)(ii)(B)\(^\text{12}\), quality performance measurement must be based on the Medicaid Comprehensive AE Common Measure Slate (see Section G below). All required measures must be reported. In addition to the 10 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.

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.

\(^{12}\) https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869e9ee0d34d0a09&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. All measures must be included in the Overall Quality Score (with a weight greater than 0%). The measure weight assigned to each measure is negotiable and shall be agreed upon by the MCO and AE (any weight greater than 0% may be applied). The Overall Quality Score must be a sum of the Measure Specific Quality Score times the Measure Weight for each measure.

**Example:**

<table>
<thead>
<tr>
<th>List of Measures</th>
<th>Measure Specific Quality Score</th>
<th>Measure Weight</th>
<th>Measure Specific Quality Score * Measure Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure 1</td>
<td>100%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Measure 2</td>
<td>100%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Measure 3</td>
<td>75%</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td>Measure 4</td>
<td>50%</td>
<td>30%</td>
<td>15%</td>
</tr>
<tr>
<td>Measure 5</td>
<td>0%</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Overall Quality Score</strong></td>
<td></td>
<td></td>
<td><strong>70%</strong></td>
</tr>
</tbody>
</table>

E. Pay for Performance Measures

For Program Year 2, at least three pay for performance measures must be included in the Overall Quality Score. The two HEDIS® admin measures included in the AE Common Measure Slate must be pay for performance:

- Breast Cancer Screening
- Follow-up after Hospitalization for Mental Illness (7-day OR 30-day measure component)*

*Note that while all measure subcomponents must be reported, an individual measure subcomponent may be selected as pay for performance.

At least one additional measure must be selected as pay for performance by the MCO and AE.
Additional pay for performance measures may be selected by the MCO and AE from the AE Common Measure Slate or incorporated as optional measures (selected from the SIM Menu Measure Set and/or the Medicaid Child and/or Adult Core Quality Measure Set).

EOHHS Preferred Pay for Performance Measure Specific Scoring Methodology
EOHHS’ preferred pay for performance measure specific quality scoring methodology is described below; however, an alternate quality scoring rubric may be used in Program Year 2 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 AE Common 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 Section G 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.

<table>
<thead>
<tr>
<th>Measure Performance Category</th>
<th>Measure Score</th>
<th>Performance Category Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Performance</td>
<td>100%</td>
<td>AE score meets or exceeds the High benchmark target</td>
</tr>
<tr>
<td>Medium Performance</td>
<td>75%</td>
<td>AE score meets or exceeds the Medium benchmark target (but is below the High benchmark target)</td>
</tr>
<tr>
<td>Measure Performance Category</td>
<td>Measure Score</td>
<td>Performance Category Criteria</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Improvement</td>
<td>50%</td>
<td>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.</td>
</tr>
<tr>
<td>Fail</td>
<td>0%</td>
<td>AE score is below the Medium benchmark target and does not show meaningful improvement over the prior year’s performance, as defined above.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>AE</th>
<th>Year 1 Score</th>
<th>Year 2 Score</th>
<th>AE Performance Category</th>
<th>Measure Specific Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>AE 1</td>
<td>66%</td>
<td>68%</td>
<td>High Performance</td>
<td>100%</td>
</tr>
<tr>
<td>AE 2</td>
<td>62%</td>
<td>64%</td>
<td>Medium Performance</td>
<td>75%</td>
</tr>
<tr>
<td>AE 3</td>
<td>55%</td>
<td>60%</td>
<td>Improvement</td>
<td>50%</td>
</tr>
<tr>
<td>AE 4</td>
<td>50%</td>
<td>52%</td>
<td>Fail</td>
<td>0%</td>
</tr>
</tbody>
</table>

F. Pay for Reporting Measures

All measures outside of the MCO and AE agreed upon pay for performance measures must be pay for reporting.

EOHHS Required Pay for Reporting Measure Specific Scoring Methodology

A pass/fail score (either 100% or 0%) shall be awarded for pay for reporting measures. There shall be no partial credit for reporting. Both of the following conditions must be met to receive a pass score:

1. Reporting of required data for the measure is timely and in accordance with agreed upon formats; and
2. The process and methodology for calculating measure performance in accordance with the agreed upon formats has been adequately demonstrated.

The MCO and AE shall agree upon the manner and format for demonstrating that appropriate measurement processes and methodologies are in place. For hybrid measures, this includes: defining the clinical population and data sources, extracting data elements from the EMR, and
reviewing data quality for accuracy and validity of measure scores. For the SDOH Screening measure, AEs must demonstrate that processes are in place to administer the screening tool at the practice level, and data collection processes are aligned across the AE.

**Example: Pay for Reporting Measure Scoring**

<table>
<thead>
<tr>
<th>Pay for Reporting Measures</th>
<th>Measure Reported (Y/N)</th>
<th>Process/Methodology Demonstrated (Y/N)</th>
<th>Measure Specific Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure 1</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>Measure 2</td>
<td>N</td>
<td>N</td>
<td>0%</td>
</tr>
<tr>
<td>Measure 3</td>
<td>Y</td>
<td>N</td>
<td>0%</td>
</tr>
<tr>
<td>Measure 4</td>
<td>N</td>
<td>Y</td>
<td>0%</td>
</tr>
</tbody>
</table>
### G. Comprehensive AE Common Measure Slate

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>NQF #</th>
<th>Measure Steward</th>
<th>Measure Domain</th>
<th>Measure Source</th>
<th>Measure Description</th>
<th>Age Cohort</th>
<th>High Benchmark</th>
<th>Medium Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Breast Cancer Screening</td>
<td>2372</td>
<td>HEDIS®</td>
<td>Preventive Care</td>
<td>Admin</td>
<td>The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer</td>
<td>Adult</td>
<td>QC 75th percentile</td>
<td>QC 66th percentile</td>
</tr>
<tr>
<td>2. Weight Assessment &amp; Counseling for Physical Activity, Nutrition for Children &amp; Adolescents</td>
<td>0024</td>
<td>HEDIS®</td>
<td>Preventive Care</td>
<td>Hybrid</td>
<td>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 documentation, Counseling for Physical Activity, and Counseling for Nutrition</td>
<td>Pediatric</td>
<td>QC 90th percentile</td>
<td>QC 66th percentile</td>
</tr>
<tr>
<td>3. Developmental Screening in the 1st Three Years of Life</td>
<td>1448</td>
<td>OHSU</td>
<td>Preventive Care</td>
<td>Admin or Hybrid</td>
<td>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</td>
<td>Pediatric</td>
<td>65% score</td>
<td>50% score</td>
</tr>
</tbody>
</table>

*Measures are subject to change based on the recommendations of OHIC’s Measure Alignment Review Committee*
<table>
<thead>
<tr>
<th>Measure Name</th>
<th>NQF #</th>
<th>Measure Steward</th>
<th>Measure Domain</th>
<th>Measure Source</th>
<th>Measure Description</th>
<th>Age Cohort</th>
<th>High Benchmark</th>
<th>Medium Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Adult BMI Assessment</td>
<td>N/A</td>
<td>HEDIS®</td>
<td>Preventive Care</td>
<td>Hybrid</td>
<td>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.</td>
<td>Adult</td>
<td>QC 90th percentile</td>
<td>QC 66th percentile</td>
</tr>
<tr>
<td>5. Tobacco Use: Screening and Cessation Intervention</td>
<td>0028</td>
<td>AMA-PCPI</td>
<td>Preventive Care</td>
<td>Admin or Hybrid</td>
<td>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.</td>
<td>Adult</td>
<td>N/A Reporting only in Y1</td>
<td>N/A Reporting only in Y1</td>
</tr>
<tr>
<td>6. Comp. Diabetes Care: HbA1c Control (&lt;8.0%)</td>
<td>0575</td>
<td>HEDIS®</td>
<td>Chronic Illness</td>
<td>Hybrid</td>
<td>The percentage of members 18-75 years of age with diabetes (type 1 and 2) w/HbA1C control &lt;8.0%</td>
<td>Adult</td>
<td>QC 75th percentile</td>
<td>QC 66th percentile</td>
</tr>
</tbody>
</table>
| 7. Controlling High Blood Pressure                      | 0018  | HEDIS®         | Chronic Illness | Hybrid         | The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year based on the following criteria:  
  - 18-59 years of age whose BP was <140/90 mm Hg  
  - 60-85 years of age with a dx of diabetes whose BP was <140/90 mm Hg  
  - 60-85 years of age without a dx of diabetes whose BP was <150/90 mm Hg | Adult      | QC 90th percentile | QC 66th percentile |
<table>
<thead>
<tr>
<th>Measure Name</th>
<th>NQF #</th>
<th>Measure Steward</th>
<th>Measure Domain</th>
<th>Measure Source</th>
<th>Measure Description</th>
<th>Age Cohort</th>
<th>High Benchmark</th>
<th>Medium Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Follow-up after Hospitalization for Mental Illness (7 days and 30 days)</td>
<td>0576</td>
<td>HEDIS*</td>
<td>Behavioral Health</td>
<td>Admin</td>
<td>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</td>
<td>Adult and Pediatric</td>
<td>QC 90th percentile</td>
<td>QC 66th percentile</td>
</tr>
<tr>
<td>9. Screening for Clinical Depression &amp; Follow-up Plan</td>
<td>0418</td>
<td>CMS</td>
<td>Behavioral Health</td>
<td>Practice-reported</td>
<td>Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented</td>
<td>Adult and Pediatric</td>
<td>N/A Reporting only in Y1</td>
<td>N/A Reporting only in Y1</td>
</tr>
<tr>
<td>10. Social Determinants of Health (SDOH) Screen</td>
<td>N/A</td>
<td>N/A</td>
<td>Social Determinants</td>
<td>N/A</td>
<td>% of members screened as defined per the SDOH elements in the Medicaid AE certification standards*</td>
<td>Adult and Pediatric</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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.
EOHHS Medicaid Infrastructure Incentive Program: Attachment C: Medicaid Managed Care and Certified Accountable Entities-Program Year 2 Requirements

Rhode Island Executive Office of Health and Human Services
December 11, 2018
Amended for Technical Correction as of June 1, 2019
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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.\(^\text{13}\)

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.

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:

- Investments in partnerships with Institutions of Higher Education (IHEs) for statewide health workforce development and technical assistance to AEs

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\(^{13}\) The current Rhode Island 1115 Waiver is a 5-year demonstration, ending 12/31/2023. 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.
• One-time funding to support hospitals and nursing facilities with the transition to new AE structures\(^{14}\)
• 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

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.

**HSTP AE Advisory Committee established by EOHHS.**

The HSTP AE Advisory Committee shall provide input and guidance on the strategic direction of the Medicaid HSTP AE program. This committee shall be co-chaired by the EOHHS Medicaid Director and an appointed co-chair. The Advisory Committee shall be conducted in a public meeting format. The Medicaid HSTP AE Advisory Committee shall be representative of diverse interests and include Consumer Advocates, Managed Care Organizations, Certified Medicaid Accountable Entities, Health Provider Organizations, Clinical and Population Health Experts, and State Agency representatives.

**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.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$30 M</td>
<td>$30 M</td>
<td>$20 M</td>
<td>$15 M</td>
<td>$95 M</td>
<td></td>
</tr>
</tbody>
</table>

The MIIP shall consist of two core programs:
(1) Comprehensive AE Program; and (2) Specialized AE Pilot Program. *EOHHS shall allocate available HSTP funds to these 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.*

\(^{14}\) The STCs limit this program to be one-time only and to not exceed $20.5 million, paid on or before December 31, 2017.
### III. Determining Maximum Incentive Pool Funds

#### A. Maximum Incentive Pools

The MIIP shall include three dimensions:

The Total Incentive Pool (TIP), which is composed of the AE Incentive Pool (AEIP) and the MCO Incentive Management Pool (MCO-IMP), as depicted below.

The Managed Care Organization shall have distinct responsibilities with respect to the AEIP and the MCO-IMP. The respective portion of potential incentive dollars that the AE will actually earn within the AEIP and that the Managed Care Organization will actually earn within the MCO-IMP will be based on performance.

**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.

<table>
<thead>
<tr>
<th></th>
<th>$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive AE Program</td>
<td>$22.5 M</td>
<td>75%</td>
</tr>
<tr>
<td>Specialized AE Pilot Program*</td>
<td>$7.5 M</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Total Funds</strong></td>
<td><strong>$30 M</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

*The Specialized AE Pilot Program includes both the Specialized LTSS and Specialized Pre-eligibles components. Note that authority for the Pre-eligibles program is dependent upon CMS approval under the RI Medicaid 1115 waiver. The Specialized AE Pilot Program is pending.

AEs participating in both the Comprehensive AE Program and Specialized AE Pilot Program will be eligible to receive funding from both incentive pools.
and reporting between EOHHS, the MCO and the Accountable Entities.

<table>
<thead>
<tr>
<th>MIIP Funds</th>
<th>Accountable Entity Incentive Pool (AEIP)</th>
<th>MCO Incentive Management Pool (MCO-IMP)</th>
<th>Total Incentive Pool (TIP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Data Exchange and Validation Funding</td>
<td>$1,395,000</td>
<td>$1,395,000</td>
<td>$2,790,000</td>
</tr>
<tr>
<td>% Total</td>
<td>50%</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td>Total PY 2 Funding</td>
<td>$20,520,000</td>
<td>$4,770,000</td>
<td>$25,290,000</td>
</tr>
<tr>
<td>% Total</td>
<td>81%</td>
<td>19%</td>
<td>100%</td>
</tr>
</tbody>
</table>

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 2 MIIP funds shall be allocated as follows, subject to available funds:

3. **Additional Program Year Two Incentive Funding for Clinical Data Exchange and Validation Activities**

For Program Year 2 generation of certain Common Measure Slate measures, EOHHS is requiring MCOs to collect clinical data from AEs via electronic data exchange, consistent with milestone requirements separately established in writing by EOHHS. These data shall be used to calculate baseline performance for assessing Program Year 3 performance improvement.

In recognition of the level of effort required to ensure these clinical data are a) collected and then aggregated by the AE, b) exchanged with contracted MCOs, and c) assessed and confirmed for each AE for completeness and validity, EOHHS has allocated additional incentive funds to Program Year Two to support these activities.

$2,790,000 in unallocated Program Year One incentive funds are allocated to these activities. These funds were budgeted for allocation in Program Year One, but based on the actual number of MCO contracts and AE attributed lives, were unallocated to specific MCO-IMP and AEIP incentive pools in Program Year One. The additional funding has been allocated equally to the MCO-IMP and AEIP for Program Year Two, resulting in increased total available MIIP funds for Program Year Two, as shown below:

The additional incentive funding has been incorporated in the MCO-IMP and AEIP eligible incentive funding amounts provided in the following section.

B. Calculating AE-Specific Incentive Pools

1. **MCO-IMP AE-Specific Incentive Pools**

Each MCO-IMP is a defined, fixed amount per AE contract that is specific to the relationship between the MCO and AE. The value of each MCO-IMP shall be determined by EOHHS based on:
(a) the number of contracts that the MCO has with AEs; and
(b) whether those contracts have been fully executed by September 20, 2019.

For Program Year 2, the MCO-IMP eligible incentive funding amount per AE contract is shown below. Note that eligible MCO-IMP incentive funds are reduced by 20% for contracts executed after September 20, 2019.

<table>
<thead>
<tr>
<th>Contract Executed</th>
<th>By September 20, 2019</th>
<th>After September 20, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>AE Contract 1</td>
<td>$460,000</td>
<td>$368,000</td>
</tr>
<tr>
<td>AE Contract 2</td>
<td>$460,000</td>
<td>$368,000</td>
</tr>
<tr>
<td>AE Contract 3</td>
<td>$460,000</td>
<td>$368,000</td>
</tr>
<tr>
<td>AE Contract 4</td>
<td>$105,000</td>
<td>$84,000</td>
</tr>
<tr>
<td>AE Contract 5</td>
<td>$105,000</td>
<td>$84,000</td>
</tr>
<tr>
<td><strong>Total MCO-IMP Funding</strong></td>
<td><strong>$4,770,000</strong></td>
<td><strong>$3,816,000</strong></td>
</tr>
</tbody>
</table>

**2. AEIP AE-Specific Incentive Pools**

AEs certified through the 2019 EOHHS certification process that are in good standing, and in qualified Alternative Payment Methodology (APM) contracts consistent with EOHHS requirements, must be eligible to participate in the Medicaid Infrastructure Incentive Program. EOHHS establishes an AE-Specific Incentive Pool to establish the total incentive dollars that may be earned by each AE during the period. The MCO implements and operates the AE Incentive Pool and determines whether an AE achieves the milestones.

For Program Year 2, the AEIP AE-Specific Incentive Pool amount shall be derived from a per member per month (PMPM) multiplier times the number of attributed lives, in accordance with the following formula.

<table>
<thead>
<tr>
<th>PMPM Multiplier*</th>
<th>x Attributed Lives</th>
<th>x 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>$8.44</td>
<td>At the start of each Program Year in accordance with EOHHS defined requirements</td>
<td>Translate to Member Month</td>
</tr>
</tbody>
</table>

*Note that the PMPM Multiplier shown above has been established by EOHHS for Program Year 2; the PMPM Multiplier will be defined and released on a yearly basis by EOHHS.

In order to establish a clear TIP for each MCO-AE relationship, the value for each AEIP and MCO-IMP shall be fixed by EOHHS prior to the beginning of the performance period. EOHHS recognizes that over the term of the performance period there will be fluctuations in the number of attributed members. Such changes will not alter the value of the AEIP for the performance period unless there is a material reduction in the number of attributable lives. A material reduction shall be a reduction of 15% or more sustained over two quarters. In such case the AEIP will be reduced accordingly with appropriate reductions made to any remaining incentive payments within the AEIP. The AEIP will not be increased if there is a growth in the attributed lives so as to not exceed the HSTP funds available to EOHHS for this initiative. However, changes in the number of attributed lives will continue to be a factor in calculations in TCOC related contracts with MCOs.
EOHHS’ determination of the value of the AEIP shall be based upon the number of AE attributed lives. Such determination shall be consistent with attribution provisions set forth in this document. Upon its determination of the AEIP for each AE-MCO relationship EOHHS shall communicate in writing to both the MCO and the respective AE the established TIP for that MCO-AE relationship.

### IV. AE Specific Health System Transformation Project Plans (HSTP Project 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 Project 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, increasing capability to exchange quality data, 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 AE\(^\text{15}\) 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)

\(^{15}\) Note: Membership in this Working Group shall be specified in the AE application, as a condition of certification.
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. A more detailed workplan and budget must be developed for Program Year 2 that identifies a requested set of core projects in the pertinent Domains needed to address the Shared MCO/AE Priorities. Workplan objectives for subsequent years (Program Years 3-4) would be at a higher level with increased refinement for the subsequent periods. To avoid duplication of funds, each core project must include MCO specific milestones, and must be linked to the domain areas eligible for award of AEIP funds described 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 HSTP Project Plan described above. 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. Project Plan can be the same across MCOs, but project funding must be equally distributed and 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.

Upon approval of the HSTP Project Plan by the MCO Review Committee, the MCO shall submit the HSTP Project Plan to EOHHS. EOHHS will review and approve each HSTP Project Plan. EOHHS can request participation in the MCO review and approval process to expedite the process as needed.
Development of the HSTP Project Plan and its acceptance by the MCO Review Committee and EOHHS 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 quarterly 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.\(^{16}\)
- 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 Plan 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.

**Note:** AE performance metrics in the “Fixed Percentage Allocations Based on Specific Achievements” category are specific to the performance period and must be met by the close of the performance year in order for an AE to earn the associated incentive payment.

**Payment and 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. AEIP and MCO-IMP milestones will be paid on a quarterly basis. MCOs shall make associated payments to AEs within thirty (30) calendar days of approving AE milestone achievement based on satisfactory evidence. 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 thirty (30) calendar days of the end of each calendar quarter, the MCO will provide the report to EOHHS for internal tracking of funds. The MCO will work with EOHHS to resolve any reporting discrepancies within fifteen (15) calendar days of notification of such discrepancy.

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\(^{16}\) Reporting templates will be developed in partnership with EOHHS
Within forty-five (45) calendar days after the close of each program year, EOHHS will review the budgeted AEIP funds retained by the MCO and deduct associated AEIP funds from the following program year incentive pool. At the conclusion of the program and/or termination of an agreement, any Incentive Program funds that are not earned by EOHHS Certified AEs as planned will be returned to EOHHS within thirty (30) calendar 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.  

**HSTP 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**

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

- Integration and innovation in behavioral health care
- Integration and innovation in SUD treatment
- Integration and intervention in social determinants, including cross system impacts

Comprehensive AEs shall be required to demonstrate that at least 10% of Program Year 2 incentive funds are allocated to partners who provide specialized services to support behavioral health care, substance abuse treatment and/or social determinants.

Comprehensive AEs shall be required to demonstrate that at least 10% of Program Year 2 incentive funds are allocated to partners who provide specialized services to support behavioral health care, substance abuse treatment and/or social determinants.

**VI. HSTP Projects Eligible for Award of AEIP Funds**

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17 This is a CMS requirement per our Special Terms and Conditions of the 1115 waiver. CMS Waiver List, page 176 states: “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 one-time performance on the next metric in the performance sequence, in accordance with the requirements for Material Modifications described in section VIII.C.3 of this document.”
HSTP Project Plans must focus on tangible projects within the AE Certification domain areas, linking recognized areas of need and opportunity to developmental tasks. HSTP projects eligible for award of AEIP funds must be linked to one or more of the eight domains described below.

EOHHS anticipates that in early program years HSTP projects may be weighted toward development in core readiness domains 1-3, as AEs build the capacity and tools required for effective system transformation. However, over time HSTP projects must shift toward system transformation capacities (domains 4-8). For Program Year 2, HSTP projects linked to the Readiness Category (Category A, Domains 1 through 3 below) are limited to no more than 25% of an AE’s total incentive pool.

<table>
<thead>
<tr>
<th>Domains</th>
<th>HSTP Projects Eligible for Award of AEIP Funds</th>
</tr>
</thead>
</table>
| A. Readiness | Building provider base, population specific provider capacity, interdisciplinary partnerships, developing a defined affiliation with community-based organizations (CBOs)  
| 1. Breadth and Characteristics of Participating Providers | Developing full continuum of services, Integrated PH/BH, Social determinants |
| 2. Corporate Structure and Governance | Establishing a distinct corporation, with interdisciplinary partners joined in a common enterprise |
| 3. Leadership and Management | 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* | Building core infrastructure: EHR capacity, patient registries, Current Care  
| 4. Data Analytic Capacity and Deployment | 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 | 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  
| 5. Commitment to Population Health and System Transformation | Healthcare workforce planning and programming |
| 6. Integrated Care Management | 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 | 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 | 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, HSTP funds would not be available for the AE to separately purchase such a tool.

VII. Required Performance Areas and Milestones

A. Accountable Entity Incentive Pool (AEIP)

AEs must develop AE specific HSTP Project Plans. These plans shall specify the performance that would qualify an AE to earn incentive payments. The HSTP Project Plan must include clearly defined performance requirements and milestones. These milestones will represent tangible points of progress in the development of enhanced capabilities in agreed upon areas of the Domains identified in Section VI. Achievement of these milestones will be the basis for incentive payments during the course of the performance period. The HSTP Project Plan shall support the AE in developing and enhancing its capacity for effective system transformation and for achieving quality and performance outcomes. Allowable incentive programs and milestones must be targeted to identified AE-specific opportunities for improved capability, and must focus on capabilities in one or more of the Domains identified in Section VI.

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

<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Minimum Milestones</th>
<th>PY 2 Allocation</th>
</tr>
</thead>
</table>
| Developmental Milestones: Fixed Percentage Allocations Based on Specific Achievements | • Execution of an EOHHS qualified APM contract with the MCO, including performance milestones agreed upon by both parties (5%)  
• Submission of a detailed HSTP Project Plan in accordance with state specified template within 60 days of execution of APM contract (5%)  
• Execution of an agreement with SDOH, BH, and/or SUD Provider by the end of the calendar year (10%) | 20%             |
| Annual Reporting on Outcome Metrics<sup>18</sup>          | Outcome Metrics Reporting Requirements:  
• Inpatient Admissions per 1,000  
• 30 Day Readmissions  
• ED Visits per 1,000                                                                                                                                  | 15%             |

<sup>18</sup> For Program Year 2, outcome metrics will be assessed on a pay for reporting basis. EOHHS anticipates transitioning outcome metrics to pay for performance in Program Year 3 and increasing the funds allocation to this performance area accordingly.
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 HSTP Project Plan 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.

B. MCO Incentive Management Pool (MCO-IMP)

MCO-IMP funds are intended for use toward advancing AE 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, MCO, and AE.

MCO-IMP funds shall be earned based on satisfactory MCO performance relative to the MCO-IMP Performance Milestones outlined below.

<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Minimum Milestones</th>
<th>PY 2 Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Performance Areas and Milestones</td>
<td></td>
<td>70%</td>
</tr>
<tr>
<td>APM Contracting with AEs</td>
<td>• Execution of APM contract with Certified AE for the period August 30, 2019 forward (5%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Execution of AEIP Incentive Contracts with required number of</td>
<td>15%</td>
</tr>
</tbody>
</table>

EOHHS has defined the Ambulatory Care Sensitive ED Visits measure based on a modified version of the Billings NYU classification system and will provide detailed measure specifications for implementation of this measure.

At least two MCO/AE Specific Performance Targets targeted to performance areas based on an analytic profile of the utilization patterns, need characteristics, and service gaps of the AE’s attributed population shall be agreed to by the MCO and AE.
Within 60 days of executing an APM contract, AE must submit an HSTP Project Plan to MCO (December 16, 2019). MCO must approve HSTP project plans within 30 days of submission from AE and submit approved HSTP project plan to EOHHS within 10 days of approval, including documentation of the MCO Review Committee’s formal review process and a summary report of the recommendations provided to the AE. If the initial HSTP Project Plan submission is not approved by the MCO Review Committee, specific criteria including a process for the AE to resubmit the HSTP Project Plan shall be provided to the AE and EOHHS. If the HSTP Project Plan is not approved by EOHHS, a revised HSTP Project Plan must be re-submitted to EOHHS within 10 days. EOHHS and MCOs can meet to expedite this process as needed.

<table>
<thead>
<tr>
<th>AEIP Program Development</th>
<th>15%</th>
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<tbody>
<tr>
<td>• Provision of population specific data analysis of the AE’s attributed population to help inform HSTP Project Plan development (10%)</td>
<td></td>
</tr>
<tr>
<td>• MCO Review Committee for evaluation of AE proposals has met and established specific incentive provisions for the AEIP contract¹ (5%)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>AEIP Program Implementation</th>
<th>30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Implementation of Shared Management Structure, including conducting at least one Shared Management meeting per quarter with the Contracted AE (5%)</td>
<td></td>
</tr>
<tr>
<td>• Provision of Monthly Attribution Rosters - within fifteen (15) calendar days of the start of each month, and in support of the MCO/AE co-signed attribution report submitted to EOHHS at the start of the program year (15%)</td>
<td></td>
</tr>
<tr>
<td>• On a monthly basis, provision and review of member specific “claims level” utilization and cost data to each AE in accordance with EOHHS required specifications (10%)</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>AEIP Program Oversight</th>
<th>40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Quarterly Report on results of monitoring of member access to care (5%)</td>
<td></td>
</tr>
<tr>
<td>• Summary reports on assessment of AE Performance to determine whether Incentive Payments have been earned and if applicable, basis for AEIP payments to be made (10%)</td>
<td></td>
</tr>
<tr>
<td>• Completion of required operational, quality, and financial reporting to EOHHS on AE initiative (10%)</td>
<td></td>
</tr>
<tr>
<td>• Quarterly reporting on outcome metrics, as defined in Part A above (15%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Data Validation Performance Areas and Milestones</th>
<th>30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational Plan</td>
<td>40%</td>
</tr>
<tr>
<td>Detailed plan describing the operational steps the MCO will take a) with each AE to obtain electronic clinical data needed to generate each AE P4P measure and b) to calculate hybrid measures with the data obtained from the AE.</td>
<td></td>
</tr>
<tr>
<td>• Due to EOHHS November -1</td>
<td></td>
</tr>
<tr>
<td>• Because AEs differ in structure and in the screening tools they are using, and because some MCOs are already receiving AE clinical data files, the plan should have AE-specific detail</td>
<td></td>
</tr>
<tr>
<td>• The plan should extend through the production of PY2 (CY2019) Common Measure Slate calculations for measures requiring clinical data, to be completed by 7-1-20</td>
<td></td>
</tr>
</tbody>
</table>

¹ Within 60 days of executing an APM contract, AE must submit an HSTP Project Plan to MCO (December 16, 2019). MCO must approve HSTP project plans within 30 days of submission from AE and submit approved HSTP project plan to EOHHS within 10 days of approval, including documentation of the MCO Review Committee’s formal review process and a summary report of the recommendations provided to the AE. If the initial HSTP Project Plan submission is not approved by the MCO Review Committee, specific criteria including a process for the AE to resubmit the HSTP Project Plan shall be provided to the AE and EOHHS. If the HSTP Project Plan is not approved by EOHHS, a revised HSTP Project Plan must be re-submitted to EOHHS within 10 days. EOHHS and MCOs can meet to expedite this process as needed.
| **Data Validation Plan** | Data validation plan describing how the MCO will have the completeness and accuracy of AE-reported clinical data externally validated, including audit procedures, and what steps will be taken when an AE’s data fails the validation process.  
- Due to EOHHS Dec-1  
- The data validation plan will be evaluated against that employed by Minnesota Community Measurement (MNMC)  
- The MCO should use MNCM or another vendor approved by the State. MCOs may choose to consider NCQA eMeasure certification vendors  
- Final reporting instructions to be provided by EOHHS to MCOs by September -1 | 40% |
| **Implementation Status Reports** | Summary reports detailing the status of work with each AE, including progress made since the prior status report, and identification of major issues that need to be resolved.  
- Three reports to be submitted, due: Feb-1, Apr-1, Jun-1 (6.7% per report) | 20% |
| **Total: All Milestones** | | 100% |
ATTACHMENT D

Alternative Payment Methodology Reporting Template

APMReport_Template_v.3 (1).xlsx