

Rhode Island Executive Office of Health and Human Services (EOHHS) Medicaid Program Accountable Entity Roadmap Document



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I. Roadmap Overview and Purpose

This Accountable Entity (AE) Roadmap is being submitted by the RI EOHHS, as the single state Medicaid agency in Rhode Island, to CMS for review and approval in accordance with Special Term and Condition (STC) 48 of Rhode Island's Health System Transformation Project (HSTP) Amendment to the state's 1115 Medicaid Demonstration Waiver.

The purpose of this document is to:

- Document the State's vision, goals and objectives under the Waiver Amendment.
- Detail the state's intended path toward achieving the transformation to an accountable, comprehensive, integrated cross-provider health care delivery system for Medicaid enrollees, and detail the intended outcomes of that transformed delivery system.
- Request review and approval by CMS, as is required before the state can begin payments of federal Incentive Funds under the Waiver Amendment

The Accountable Entity "Roadmap" is a requirement of the Special Terms and Conditions (STCs) of RI's Health System Transformation Waiver (STC 48). The State must develop an Accountable Entity Roadmap for the Health System Transformation Project to be submitted to CMS for CMS's 60-day process of review and approval. The State may not claim FFP for Health System Transformation Projects until after CMS has approved the Roadmap. Once approved by CMS, this document will be incorporated as Attachment N of the STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved waivers, expenditure authorities and STCs. (Changes to the protocol will apply prospectively, unless otherwise indicated in the protocols.)

The Accountable Entity Roadmap will be a conceptualized living document that will be updated annually to ensure that best practices and lessons that are learned throughout implementation can be leveraged and incorporated into the State's overall vision of delivery system reform. This Roadmap is not a blueprint; but rather an attempt to demonstrate the State's ambitions for delivery systems reform and to outline what the State and its stakeholders consider the payment reforms required for a high quality and a financially sustainable Medicaid delivery system.

This roadmap has been developed with input from participating MCOs, Accountable Entities and stakeholders. A draft roadmap was posted for public input in December 2016. Twenty-four (24) comments were received from a variety of stakeholders representing provider, insurers, and advocates. Thirteen (13) public input sessions were held between January and March 2017 to inform the final roadmap. A full list of public sessions can be found in **Appendix B**.

A detailed list of the required Roadmap elements, and the location of each element in this document, is provided in **Appendix C**.

II. Rhode Island's Vision, Goals and Objectives

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

However, there are important limitations to our current system of care – recognized here in Rhode Island and nationally:

- It is generally fee based rather than value based,
- It does not generally focus on accountability for health outcomes,
- There is limited emphasis on a Population Health approach, and
- There is an opportunity to better meet the needs of those with complex health needs and exacerbating social determinants.

As such, the current system of care, both in Rhode Island and nationally, focuses predominantly on high quality medical care treatment of individual conditions – as is encouraged and reinforced by our fee for service (FFS) payment model. As a result of this model, there is often siloed and/or fragmented care, with high readmissions and missed opportunities for intervention. Specifically:

- *Within Medical Care:* There is limited focus on transitions, discharges, care coordination, and medication management across and between hospitals, specialists and primary care providers.
- *Between Medical Care and Behavioral Health care:* There is limited effective coordination between medical and behavioral providers, often acting as two distinct systems of care.
- *Complicated by growing needs of an aging population:* This will challenge medical models of care and require broader definitions of care (e.g., dementia, cognitive issues).
- *Between Medical Care and Social Determinants:* There is limited recognition and adaptation of a medical model that recognizes common factors impacting health of Medicaid populations – such as childhood trauma and its long term impacts, mistrust of the health care system, etc. There is also limited capacity to address broader social needs, which often overshadow and exacerbate medical needs – e.g., housing/housing security, food security, domestic violence/sexual violence.

As a result, although individual providers are often high performing, **no single entity “owns” service integration, and no single entity is accountable for overall outcomes - only specific services.** Effective interventions must “break through” the financing and delivery system disconnects, to build partnerships across payment systems, delivery systems and medical/social support systems that effectively align financial incentives and more effectively meet the real life needs of individuals and their families.

These issues are particularly problematic when serving the most complex Medicaid populations -- the six percent of Medicaid users with the most complex needs and highest costs that account for almost two thirds (65%) of Medicaid claims expenditure. Specifically:

- **Populations receiving institutional and residential services**
Nearly half (45%) of claims expenditure on high cost users is on nursing facilities for the elderly and disabled, and on residential and rehabilitation services for persons with developmental disabilities.
- **Populations with integrated physical and behavioral health care needs**
Forty percent (40%) of claims expenditure on high cost users is for individuals living in the community, most (82%) of whom have multiple co-morbidities, with both physical and mental health or substance abuse needs that require an integrated approach.

The vision, as expressed in the *Reinventing Medicaid* report is for “...a reinvented Medicaid in which our Medicaid managed care organizations (MCOs) contract with Accountable Entities (AEs), integrated provider organizations that will be responsible for the total cost of care and healthcare quality and outcomes of an attributed population.”

The goals are consistent with initiatives taking hold across the country – a movement toward Accountable Care Organizations, including value based payment, new forms of organization, and increased care integration. [Specific goals of this initiative](#), developed in alignment with SIM and other ongoing initiatives in our RI environment include:¹

- Transition from fee for service to value based purchasing
- Focus on Total Cost of Care (TCOC)
- Create population based accountability for an attributed population
- Build interdisciplinary care capacity that extends beyond traditional health care providers
- Deploy new forms of organization to create shared incentives across a common enterprise
- Apply emerging data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs

As a result of this transformation of the Rhode Island Medicaid program (and in partnership with other efforts such as SIM), RI anticipates that **by 2022, Rhode Island will have achieved the following objectives:**

- Improvements in the balance of long term care utilization and expenditures, away from institutional and into community-based care;
- Decreases in readmission rates, preventable hospitalizations and preventable ED visits;
- Increase in the provision of coordinated primary care and behavioral health services in the same setting; and
- Increased numbers of Medicaid members who choose or are assigned to a primary care practice that functions as a patient centered medical home (as recognized by EOHHS).

¹ RI’s Office of the Health Insurance Commissioner (OHIC) received a SIM (State Innovation Model) grant from CMS to test health care payment and service delivery reform models over the next four years, in a project called Healthy Rhode Island.

This document establishes the Roadmap to achieve the vision, goals and objectives described here.

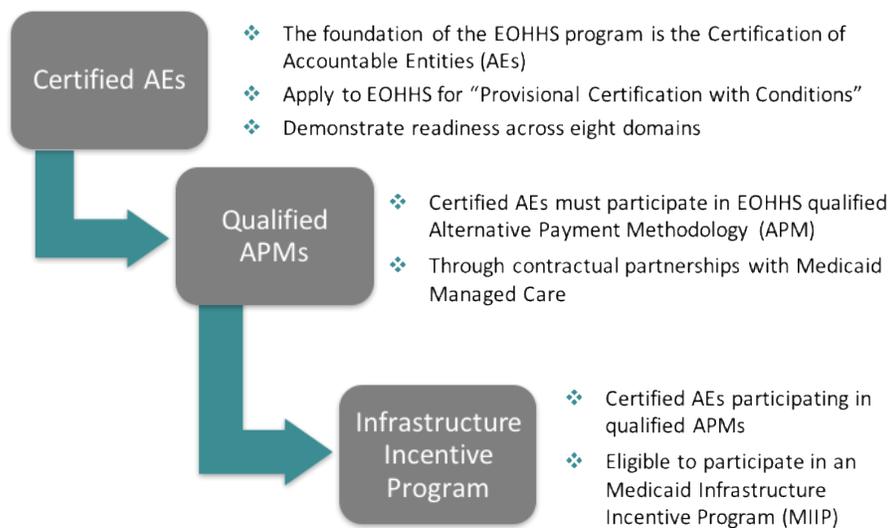
III. Our Approach

As stated above, the Rhode Island Accountable Entity Program is intended to “break through the financing and delivery system disconnects, to build partnerships across payment systems, delivery systems and medical/social support systems that effectively align financial incentives and more effectively meet the real life needs of individuals and their families.”

The Accountable Entity program shall be developed within, and in partnership with, Rhode Island’s existing managed care model, building on its existing strengths. The AE program will enhance the capacity of MCOs to serve high-risk populations by increasing delivery system integration and improving information exchange/clinical integration across the continuum.

Structurally, the Accountable Entity program includes three core “pillars”:

- (1) EOHHS Certified Accountable Entities and Population Health,
- (2) Progressive Movement toward EOHHS approved Alternative Payment Methodologies,
- (3) Infrastructure Incentive Payments for EOHHS Certified AEs, as depicted below:



Not all providers are at the same level of readiness for the interdisciplinary integration and transition to alternative payment methodologies envisioned by this program. As such, EOHHS is taking a **multi-pronged strategy**, in order to effectively “meet providers where they are” and enable the necessary system transformation. **EOHHS anticipates at least three specific programs:**

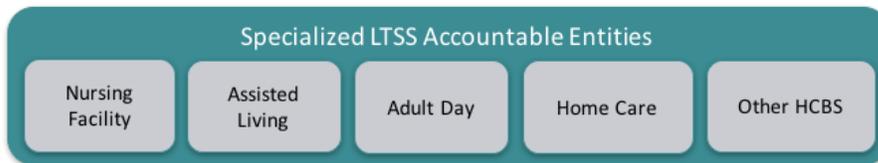
Phase 1: Comprehensive AE Program

EOHHS views the full development of high performing Comprehensive AEs as the core objective of its Health System Transformation Program. The Comprehensive AE Pilot already underway shall be expanded and enhanced for full implementation. The Comprehensive AE

represents an interdisciplinary partnership of providers with a strong foundation in primary care and inclusive of other services, most notably behavioral health and social support services. The AE will be accountable for the coordination of care for attributed populations and will be required to adopt a defined population health approach.

Phase 2: Specialized LTSS AE Pilot Program

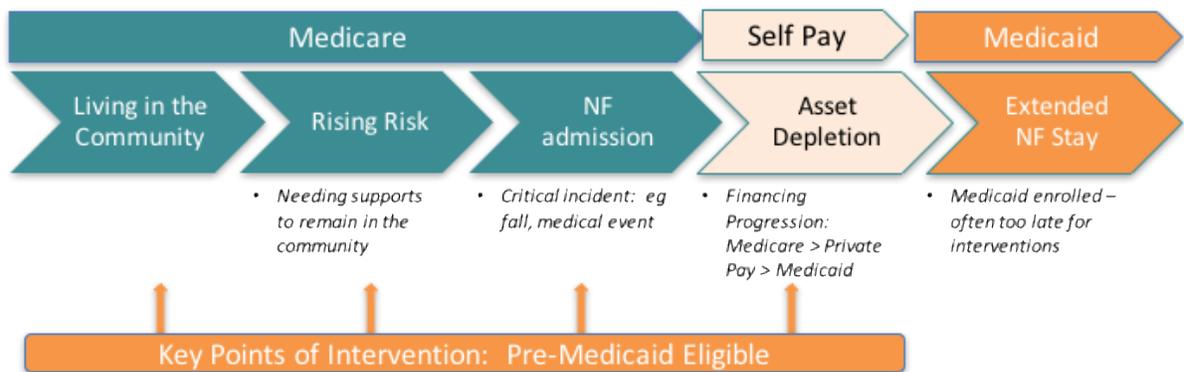
EOHHS is working with stakeholders to develop and implement an LTSS AE pilot program, intended to encourage participating LTSS providers to build collaborative LTSS-focused integrated care delivery systems that include a continuum of care, as shown below. The ability of an LTSS AE to address persons with behavioral health needs and dementia will be critical.



Multiple providers and groups of providers of LTSS services have expressed strong interest in this pilot. However, Rhode Island’s LTSS system of care is fragmented and dominated by specialized providers who are geographically and/or service specific. Significant infrastructure development is required to build the necessary capacity and capabilities for these providers to effectively manage a population under a total cost of care model.

Phase 3: Medicaid Pre-Eligibles Pilot Program

EOHHS is seeking Medicaid prevention/deferral strategies to enable and encourage aging populations to live successfully in the community. To be effective, EOHHS must work “upstream”, and support people in the community who are not yet Medicaid eligible but are at high risk of becoming so when/if faced with a critical incident or depletion of resources. Effective programs in this arena must “break through” the financing system disconnects shown below to create financial incentives for participating providers.



As such, EOHHS is in the process of developing a pilot program intended to engage high volume Medicare providers in the development and implementation of targeted interventions for Medicaid Pre-eligibles, especially at risk populations residing in the community. This pilot is still in the design phase – to be implemented subject to approval by CMS in future iterations of this roadmap.

EOHHS anticipates that additional programs may be added over time, based on learnings from the current programs and pilots.

EOHHS is taking a phased approach to implementation, with a process and timeline that allows for the incorporation of ongoing learnings, as shown below:

AE Type	Primary Target Population	Program Phase	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Comprehensive AE	Medicaid only	Program Design and Pilot Certification								
		Pilot Performance Period		***						
		Certification Renewal/ Full Certification								
		Full program performance period								
Specialized LTSS	LTSS Eligibles*	Program Design and Pilot Certification								
		Pilot Performance Period				***				
		Certification Renewal/ Full Certification								
		Full program performance period								
Medicaid Pre-Eligibles	Medicaid LTSS Prevention: Medicare eligibles at risk of becoming duals	Program Design and Pilot Certification								
		Pilot Performance Period					***			
		Certification Renewal/ Full Certification								
		Full program performance period								
*** Initial pilot performance period begins										
* Includes duals and non duals eligible for LTSS										

Note that the Comprehensive AE program is already underway, as Pilot AEs were certified in the fall of 2015 and APM contracts were in place between MCOs and Pilot AEs in 2016. EOHHS plans to move the Comprehensive AE program to full certification in CY 2017 with the first full program performance period beginning in CY 2018. The two new pilot programs (Specialized LTSS AE and Medicaid Pre-Eligibles) will follow a similar trajectory, with staged implementation dates and targeted pilot performance periods in CY 2018 and CY2019 respectively.

EOHHS is committed to supporting this system transformation through our Medicaid Infrastructure Incentive Program (MIIP). An estimated \$76.8 Million in Health System Transformation Funds will be allocated to the MIIP, supporting MCOs and AEs in building the capacity and tools required for effective system transformation.² These funds must be used to

² Subject to available funds captured in accordance with CMS approved claiming protocols.

support state defined priorities, in specified allowable expenditure areas, and will be tied to the achievement of AE and MCO specific milestones.

Effective implementation of this program will mean that **by 2022 at least one third (33%) of eligibles will be attributed to an EOHHS Accountable Entity, participating in an EOHHS approved Alternative Payment Methodology (APM)**. This goal will be accomplished in accordance with the following progression:

Percent of Medicaid covered lives attributed to an EOHHS approved APM

Performance Year	Target
DY 10 CY 2018	10%
CY 2019	15%
CY 2020	20%
CY 2021	25%
CY 2022	33%

Beyond this roadmap, **four core guidance documents will govern this program**, specifying requirements for EOHHS, MCOs and participating AEs:

Core Documents	Targeted CMS Submission	Description
1. AE Application and Certification Standards	Spring 2017	<ul style="list-style-type: none"> • AE certification standards • Applicant evaluation and selection criteria • Submission guidelines
2. APM Guidance	Fall 2017	<ul style="list-style-type: none"> • Required components and specifications for each allowable APM structure • AE Scorecard • Areas of required consistency, flexibility
3. Attribution Guidance	Fall 2017	<ul style="list-style-type: none"> • Required processes for AE attribution, hierarchy
4. AE Incentive Program Guidance	Fall 2017	<ul style="list-style-type: none"> • Additional details on funding allocation, required priorities, allowable areas of expenditure, milestones

Note that key elements of these core programmatic guidance documents were posted as part of the draft Roadmap in December 2016, leveraging the learnings from the Comprehensive AE pilot program plus ongoing learnings from national research and advice from industry experts. Stakeholders and participants provided many valuable comments on these key elements which will be included in the final guidance.

Additionally, EOHHS shall hold public input sessions and participant working sessions with key stakeholders and interested public participants to refine each guidance document. Draft guidance shall be posted, comments received will be reviewed, and documents will be revised in consideration of public comments before final submission to CMS for approval.

IV. Progress to Date

EOHHS has made significant progress along several aspects of the Accountable Entity strategy. Key actions taken to date include:

1. Comprehensive AE Pilot Program Implementation
2. Specialized AE Pilot Program Development
3. Establishment of funding mechanism for Infrastructure Incentive payments

Key action steps to date in each of these areas are highlighted below.

1. Comprehensive AE Pilot Program Implementation

Rhode Island has already begun moving forward with the creation and support of Accountable Entities (AEs), while simultaneously testing critical program design elements. To approach the task of how to best advance such models in Rhode Island, EOHHS issued an RFI in August 2015 and received 14 responses with many thoughtful comments and recommendations. Based on feedback from the RFI and experience in other states, the state implemented an Accountable Entity Pilot Program as a **fast-track path and an opportunity for early learnings in late fall 2015**. EOHHS then provisionally certified Pilot AEs and issued companion documents specifying attribution rules and total cost of care guidance.

Pilots were certified with the understanding that:

- The state would be proceeding to move past the Pilot phase and, based on experiences and learnings from RI and across the country, would develop more extensive and refined certification standards. Applicants for pilot certification would be expected to comply with those new standards.
- The state would pursue opportunities with the federal government that, if successful, would enable state investments in the further development of AE capabilities.

To date, there have been three rounds of pilot AE applications. Applicants had to demonstrate readiness across three key design domains, including governance, organizational capability, and data/analytic capability. Qualified pilot applicants were “Provisionally Certified with Conditions”, which specified limitations to their contracting authority and confirmed required developmental steps and timelines.

The following six provider-based entities have been designated as Provisionally Certified Pilot AEs, eligible to enter into Total Cost of Care-based shared savings programs with Medicaid MCOs beginning in January 2016:

- Blackstone Valley Community Health Center’s HealthKey Accountable Entity
- Coastal Medical, Inc.

- Community Health Center Accountable Care Organization (CHC ACO)³
- Integra Community Care Network, LLC
- Providence Community Health Centers, Inc.’s Providence ChoiceCare AE
- Prospect Health Services Rhode Island, Inc. (PHSRI)

These six AEs were certified as “Type 1” AEs, meaning they are certified to contract for all services for a total attributed population. As of July 2016, **more than one third (1/3) of total Medicaid lives were attributed to participating pilot AEs under Total Cost of Care pilot terms, as shown below:**

AE Pilot: Attributed Lives

Type 1 Attributed Lives	United	NHP	Total MCOs
Blackstone Valley (BVCHC)		8,933	8,933
Integra (CNE, SCH & RIPCPC)	19,011	20,140	39,151
PHSRI	5,350	5,411	10,761
PCHC Providence ChoiceCare AE		25,037	25,037
CHC ACO+		28,160	28,160
Total Type 1	24,361	87,681	112,042

Sources and Notes: United and NHP attributed lives from Q4 2016 snapshot reports. Coastal was provisionally certified in July 2016 and has not yet contracted with the MCOs.

These AE pilot participants provide three different models of Comprehensive Accountable Care, which will allow significant opportunities for evaluation going forward. There are two hospital based entities, one multispecialty group practice, and three FQHC based models, all of which demonstrate a commitment to primary care infrastructure and an interdisciplinary approach.

2. Specialized AE Pilot Program Development

“Specialized” AEs are generally intended as an interim arrangement to enable providers to form networks that will build the capacity and infrastructure needed to manage specialized populations across providers. Over time, EOHHS intends that these Specialized AEs would partner with a Comprehensive AE.

In conjunction with the Comprehensive AE Pilot Program implemented in late fall, 2015, EOHHS included an opportunity for provisional certification of specialized “Type 2” Accountable Entities. Specifically, the Specialized Pilot Type 2 AEs was intended to encourage and enhance integrated care for persons with SPMI/SMI (Serious & Persistent Mental Illness/Serious Mental Illness), consistent with EOHHS’ goal of integrating physical and

³ Community Health Center Accountable Care Organization (CHC ACO) currently includes East Bay Community Action Program (EBCAP), Comprehensive Community Action, Inc. (CCAP), Thundermist Health Center, Tri-Town Community Action Agency, WellOne Primary Medical & Dental Care, and Wood River Health Services.

behavioral health services. As such, organizations with attributed SPMI/SMI populations were eligible to become “Type 2” AEs, eligible to participate in a total cost of care based shared savings arrangement with participating Medicaid MCOs.

In practice, the implementation of this type of Specialized AE resulted in the alignment of Specialized AEs with Comprehensive AEs. As such, EOHHS intends to sunset the Type 2 SPMI Specialized Accountable Entity, instead encouraging integration of SPMI populations with comprehensive AEs, as has already occurred in the market. EOHHS remains committed to continued improvements and enhancements in integrated care for persons with SPMI/SMI.

EOHHS is also working closely with stakeholders to develop a Specialized LTSS AE Pilot Program to focus on providers of long term services and supports (LTSS). Activities to support this initiative so far include:

- Establishment of key program goals
- Multiple discussions with key stakeholders and public meetings
- Research and evaluation of similar programs in other states
- Detailed discussions with key stakeholders regarding potential program structure, including attribution methods, APM models and performance metrics

Specialized LTSS-focused AEs are intended to achieve the rebalancing goals of Reinventing Medicaid by effectively enabling and encouraging aging populations to live successfully in the community. This requires creating sufficient financial incentives for current LTSS providers – nursing facilities, home and community based providers -- to work together to change the way care is delivered to our aging population. As such, the Specialized LTSS focused AE program shall:

- Support **focused investments** to build capacity and fill in gaps in infrastructure to more effectively address the needs of vulnerable seniors, supporting their ability to successfully remain in the community.
- Encourage and invest in the development of **integrated care delivery models**, such that providers build collaborative LTSS focused integrated care delivery systems that include a continuum of care. Ability to address persons with behavioral health needs and dementia will be critical.
- Encourage/require **alternative payment methodologies** that support this integrated system and that align financial incentives both across payors and between the state, MCOs and providers.
- Change financial incentives for Nursing Facilities – encourage them to reduce length of stay, increase quality, and send people home quicker.

EOHHS is also beginning to design a Medicaid Pre-Eligibles Pilot Program. The conceptual design as tested with stakeholders in the draft roadmap in January 2017 was met with strong

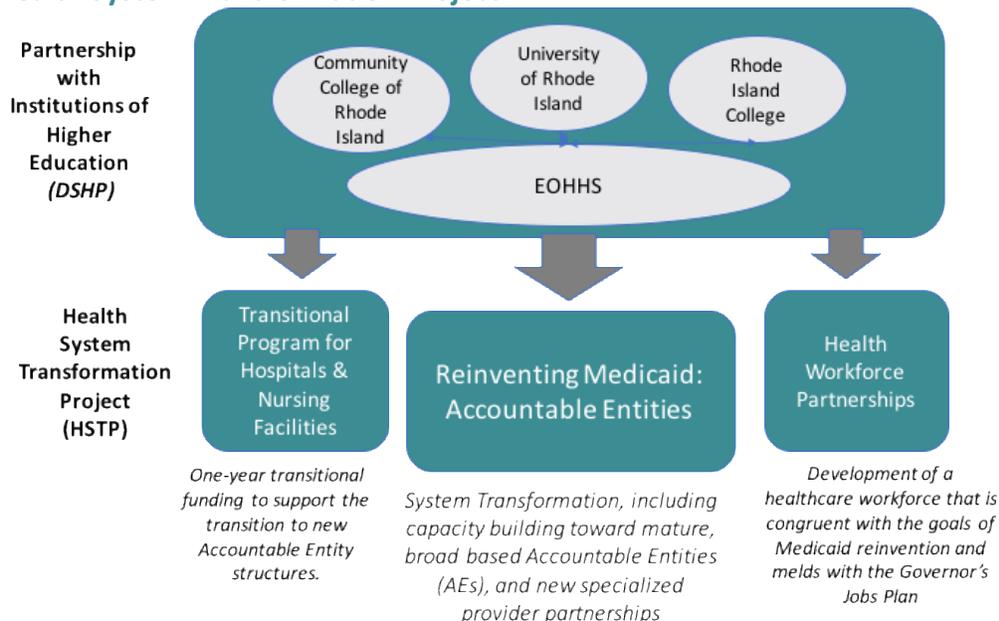
interest and positive feedback, and initial design discussions have already begun with interested stakeholders. **Over the coming months, EOHHS intends to work** with CMS and local parties to design potential pathways for this innovative approach.

3. Establishment of funding mechanism for Infrastructure Incentive payments

Beginning in late 2015, EOHHS began pursuing Medicaid waiver financing to provide support for 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 CMS approved this waiver amendment, bringing \$129.8 million to RI from November 2016 through December 2020.⁴

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

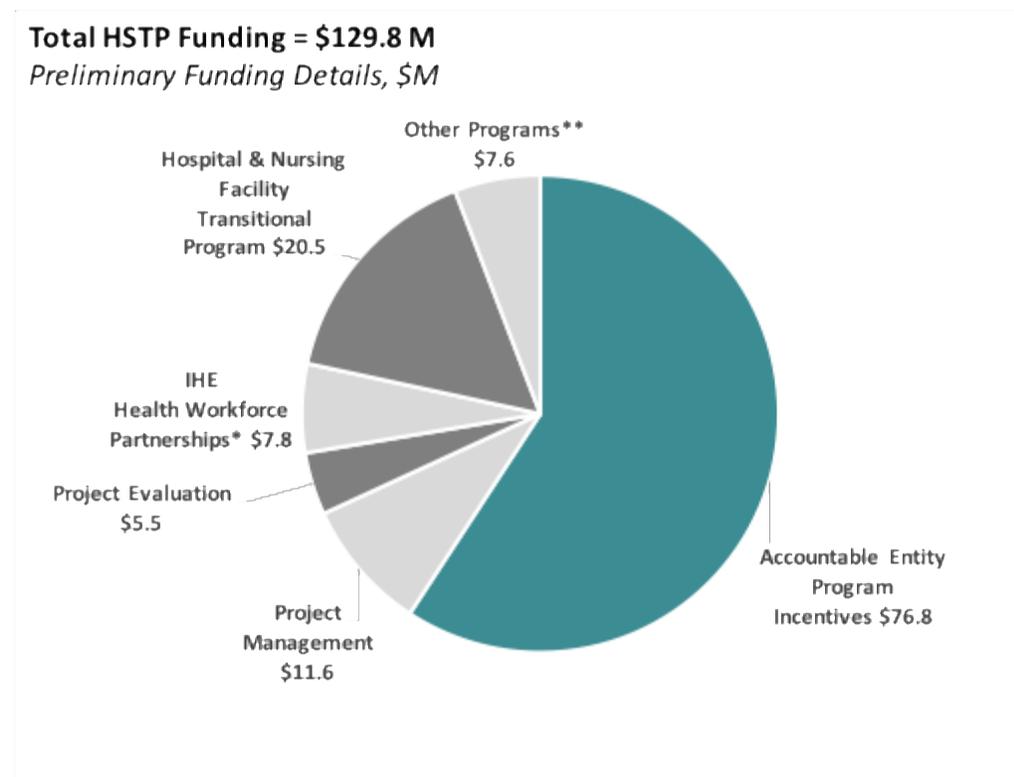
Health System Transformation Project



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

⁴ The current Rhode Island 1115 Waiver is a 5-year demonstration, ending in 2018. The STCs include DSHP funding authority through 2018, with a commitment articulated in the cover letter to extend this authority thru 2020 upon waiver renewal for a total funding opportunity of \$129 Million.

- Investments in partnerships with Institutions of Higher Education (IHEs) for statewide health workforce development; and,
- One-time transitional funding to support hospitals and nursing facilities in the transition to new AE structures⁵ as shown in the chart below.



*Health Workforce Partnerships includes \$5.4 M for Workforce Development and \$2.4 M for Program Operations.

**Other Programs includes: Consumer Assistance, Wavemaker Fellowship, TB Clinic, RI Child Audiology Center, and Ctr for Acute Infectious Disease Epidemiology. Includes some unavailable funding.

As mentioned above, the current RI 1115 Waiver expires December 31, 2018. The STCs of the waiver amendment include expenditure authority for this program up to \$79.9 million FFP through the end date of the current waiver. The remaining \$49.9 million in funding is anticipated to be available upon the renewal of the waiver with an extension of DSHP authority through 2020.

⁵ The STCs limit this program to be one-time only and to not exceed \$20.5 million, paid on or before December 31, 2017.

V. AE Program Structure

EOHHS intends to expand and refine the current Pilot Accountable Entity Program to further support and encourage the development of Accountable Entities. As such, the Accountable Entity Program will include three core “pillars” as shown and described below. Each of these pillars will be articulated through specified arrangements with certified AEs. These three pillars are noted briefly here and described more fully later in this Roadmap.

The vehicle for implementing the AE initiative will be contractual relationships between the AE and its managed care partners. Medicaid MCOs are contractually required to increasingly enter into EOHHS approved value based APM contract arrangements. Certified AEs must enter into value based APM contracts in compliance with EOHHS guidelines in order to participate in member attribution, shared savings arrangements, and to be eligible to receive incentive-based infrastructure payments through the Health System Transformation Program.

Core Pillars of EOHHS Accountable Entity Program

1. EOHHS Certified Accountable Entities and Population Health

The foundation of the EOHHS program is the certification of Accountable Entities (AEs) responsible for the health of a population of members.

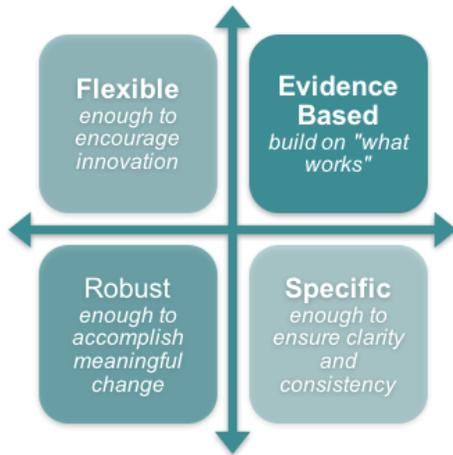
2. Progressive Movement toward EOHHS approved Alternative Payment Methodologies

Fundamental to EOHHS’ initiative is progressive movement from volume based to value based payment arrangements and movement from shared savings to increased risk and responsibility. Once an AE is certified, the AE must pursue value-based Alternative Payment Methodologies (APMs) with managed care partners in accordance with EOHHS defined guidance.

3. Infrastructure Incentive Payments for EOHHS Certified AEs

Incentive-based infrastructure funding will be available to state certified AEs who have entered into qualifying APM contractual agreements with managed care partners. As part of these agreements, AEs may earn incentive-based infrastructure funding under state-specified requirements.

Note that each of these pillars was developed with an effort to balance the following key principles:



- **Evidence Based**, leveraging learnings from our pilot, other Medicaid ACOs and national Medicare/Commercial experience
- **Flexible enough to encourage Innovation**, ACOs, and particularly Medicaid ACOs, are relatively new, and in many developmental areas clear evidence is not available
- **Robust enough to accomplish meaningful change**, and foster organizational commitments and true investments
- **Specific enough to ensure clarity and consistency**, recognizing that consistent guidelines provide clarity to participants

The following sections provide further detail on each of the three pillars.

VI. AE Certification Requirements

During the spring/summer of 2017, EOHHS will be formalizing the Certification Standards for Accountable Entities. Interested parties will then be invited to submit applications for certification and participation in the program. The issuance of AE Certification Standards, as well as the various stages of the application and approval process, will be managed directly by EOHHS. The final certification standards and application requirements will be based on a combination of the following:

- Learnings to date from the existing AE Pilot program
- National/emerging lessons from other states implementing Medicaid ACOs
- EOHHS multi-year participation in a Medicaid ACO Learning Collaborative facilitated by the Center for Health Care Strategies (CHCS) and sponsored by the Commonwealth Foundation
- Lessons learned from the existing Medicare ACO programs
- Alignment with SIM and the ACO standards as developed by the Rhode Island Office of the Health Insurance Commissioner (OHIC)
- Feedback and comments from stakeholders on the draft Certification Standards as posted in December 2016
- Feedback and comments from stakeholders gathered in public meetings/discussions during the beginning of 2017

EOHHS recognizes that potential applicants may have differing stages of readiness. As such, AEs will be annually certified, and EOHHS anticipates that most will be **“Provisionally Certified with Conditions”**. Deficiencies will need to be addressed in accordance with an agreed upon project plan in order for the AE to continue to be eligible for Infrastructure Incentive funds. Eventually, AEs who have demonstrated that all of the domain requirements were fully met will be designated as “Fully Certified”. “Full” certification is not required to be eligible for incentive funds.

EOHHS intends to certify three types of AEs:

1. **Comprehensive AEs**
2. **Specialized LTSS Pilot AEs**
3. **Specialized Medicaid Pre-Eligibles Pilot AEs**

Note that these AEs will serve distinct populations. As such, entities may apply to participate in one or more programs, as long as readiness can be appropriately and specifically demonstrated.

1. Comprehensive AE Certification Standards

EOHHS has identified the critical domains considered instrumental to the success of Comprehensive AEs in meeting the needs of the Medicaid population through system transformation. Note that these requirements do not specify a particular organizational structure. EOHHS values multiple models of AE and encourages entities with different

structures to apply (under the current pilot there are FQHC based, hospital based and primary care based Pilot AEs).

AE Applicants must meet minimum requirements in order to be considered for certification.

Preliminary minimum requirements include:

- Minimum attributed lives
- Minimum Medicaid share of lives
- Demonstrated ability to collect, share, and report data
- Demonstrated level of behavioral health integration with primary care, with an established behavioral health provider organization
- Demonstrated affiliation or working arrangement with an SUD treatment provider
- Demonstrated affiliation or working arrangement with community based organizations to address broader social contexts impacting health, outcomes

Final requirements for qualified applicants shall be included in the AE application.

Qualified AE applicants will then be required to demonstrate their specific capacity to serve the requested populations by meeting requirements across the following domains. Preliminary detailed requirements for each of these domains are included in **Appendix A**.

- **Domain 1: Breadth and Characteristics of Participating Providers**
Interdisciplinary with demonstrated ability to serve a broad continuum of needs including social determinants for attributed populations. Must include a defined affiliation or working arrangement with community based organizations to address broader social contexts impacting health, outcomes.
- **Domain 2: Corporate Structure and Governance**
An adequate and appropriate governance structure to accomplish the program goals
- **Domain 3: Leadership and Management**
A leadership structure, with commitment of senior leaders, backed by the required resources to implement and support a single, unified vision
- **Domain 4: IT Infrastructure: Data Analytic Capacity & Deployment**
A core functional IT capacity to receive, collect, integrate, and utilize information
- **Domain 5: Commitment to Population Health and System Transformation**
A concerted program built on population health principles and systematically focused on the health of the entire attributed population. A systematic population health model that works to improve the health status of the entire attributed population while systematically segmenting subpopulation risk groups with complex needs in order to implement focused strategies to improve their health status.
- **Domain 6: Integrated Care Management**
A comprehensive integrated care management program, including systematic processes and specialized expertise to identify and target populations. An organizational approach

and strategy to integrate person-centered medical, behavioral, and social services for individuals at risk for poor outcomes and avoidable high costs.

- **Domain 7: Member Engagement & Access**
Capacity for effective member engagement, including strategies to maximize outreach, engagement, and communication with members in a culturally competent manner
- **Domain 8: Quality Management**
Ability to internally report on quality and cost metrics; to use those metrics to monitor performance, emerging trends, and quality of care issues; and to use results to improve care

It is EOHHS' expectation is that the AE shall be structured and organized to provide care for all populations, including adults and children. However, EOHHS recognizes that the necessary skills and capacities of an AE will vary considerably across populations. Specifically,

- **Children**, including children with special health care needs (CSHCN) and children with high, rising and low risk
- **Adults**, including adults with complex medical needs, co-occurring BH/medical, Homeless, Substance Use Disorders, Adults with Disabilities, Developmentally Disabled adults.

As such, AE Certification may be specific to an approved population – Children, Adults – with attribution limited to the approved population. AE applicants will need to demonstrate the ability to meet the broad range of needs present in each identified population. Note that in some instances these capacities may be demonstrated by the AE itself, or through its relationship with participating MCOs.

To ensure that incentives are meaningfully and adequately sized, this will be a **competitive program**, with stricter requirements for certification beginning in year two, thereby limiting the number of Certified AEs, subject to available funding. Preliminary evaluation and selection criteria are as follows:

- **Demonstrated commitment to EOHHS priorities and Medicaid populations**
Demonstrated capabilities and capacities to serve the unique needs of the Medicaid population, and to address the goals and priorities described in Section 2.
- **Evidence of Readiness (Domains 1-3)**
Specific evidence of strong interdisciplinary network capacity, and an effective governance model and leadership team.
- **Data & Analytic Capacity (Domain 4)**
Demonstrated capacity to collect, integrate and utilize data to support decision-making.
- **System Transformation (Domains 5-8)**
Demonstrated commitment to, and capacity for, population health and system transformation, including a comprehensive, integrated and interdisciplinary care

management program, effective member engagement strategies and a strong quality management program.

Final evaluation and selection criteria shall be included in the AE application.

2. Specialized AE Certification Standards: LTSS Pilot Certified AE

The objective of an LTSS Pilot AE will be to build integrated systems of care inclusive of a continuum of services for people, as appropriate, to be able to safely and successfully reside in a community setting. Eligible entities must demonstrate readiness across the following domains:

- **Domain 1: Breadth and Characteristics of Participating Providers**
Adequate capacity and partnerships across the LTSS continuum of care, including specialized behavioral health care capacity. Must include Home and Community Based Care Providers (e.g., adult day, home care, alternative living capacity). May include Nursing Facilities who meet minimum quality standards, have a high share of beds dedicated to Medicaid, and existing/planned specialized behavioral health capacity
- **Domain 2: Governance, Leadership and Management Capabilities**
Sufficient capabilities to accomplish the program goals, enable shared operational and financial responsibility, and support quality measurement/monitoring
- **Domain 3: Integrated Care Management**
Must have sufficient care management processes and teams to support an integrated approach to LTSS
- **Domain 4: Program Commitment**
Must commit to engage in a longer-term planning process with EOHHS

Note that the Pilot certification standards are intended as a starting point to engage individual providers in the challenging tasks of partnership development. EOHHS anticipates there may be multiple pilot LTSS AEs with different combinations of participating providers and different governance and care management models. Similar to the Comprehensive AE program, EOHHS intends to allow for multiple models under the pilot and will leverage learnings from the pilot to establish more rigorous standards for full implementation.

To ensure that incentives are meaningfully and adequately sized, this will be a [competitive pilot program](#), with a limited number of selected participants, subject to available funding.

3. Specialized AE Certification Standards: Medicaid Pre-Eligibles Pilot Certified AEs

Certified Comprehensive AEs may also be eligible to participate in the Medicaid Pre-Eligibles Pilot program if they meet EOHHS specified criteria, to be developed in the coming months. Comprehensive AEs who are already working with Medicare populations (either through Medicare Advantage or Medicare ACO arrangements) are likely to provide the foundation for such a program.

VII. Alternative Payment Methodologies

Fundamental to EOHHS' initiative is progressive movement to EOHHS-approved Alternative Payment Methodologies (APMs), incorporating clear migration from volume based to value based payment arrangements and movement from shared savings to increased risk and responsibility.

The AE initiative will be implemented through managed care. AEs must enter into managed care contracts in order to participate in member attribution and shared savings within TCOC arrangements. These AEs will also be eligible to receive infrastructure incentive payments from their managed care partner through the Health System Transformation Program.

As the primary contractor with EOHHS, the MCOs will retain accountability for ensuring compliance with all contractual requirements and related Federal managed care regulations. It is anticipated that successful development of an AE will include a defined yet dynamic distribution of responsibilities between the MCO and the AE, and that these will be identified in the written agreement between the parties. The distribution of roles and responsibilities may vary among AEs and MCOs to achieve the most effective combination. Performance of certain functions can be delegated to a subcontracting AE, but delegation will be with the expressed obligation to abide by managed care regulations.

EOHHS is committed to maintaining member choice within the AE program structure. Members must have access to the right care, at the right time, and in the right setting. AE provider relationships may not impact member choice and/or the member's ability to access providers contracted or affiliated with the MCO. While AE based network limits, restrictions and fees are prohibited, MCOs and AEs may encourage utilization of preferred networks provided that rewards or positive financial incentives used are nominal and specifically linked with health-promoting plans of care. All incentives and methods of encouragement of preferred networks must be consistent with CMS requirements for Medicaid.⁶

EOHHS is also committed to ensuring that the proposed AE will not limit Medicaid beneficiary access to providers on the basis of AE attribution. It is not the intent of the accountable entity program to create new siloes of care within each system. In particular, AE affiliated hospitals and/or specialists may not in any way limit access to only AE participating providers.

Qualified APM contracts shall be in accordance with EOHHS defined APM guidance. This guidance shall be developed:

- leveraging learnings from the current pilot program guidance documents as implemented in 2016,
- in alignment with Federal MACRA rules,

⁶ Next Generation ACO summary on CMS website: <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/index.html>. Next Generation ACO RFA, which includes section on beneficiary coordinated care rewards: <https://innovation.cms.gov/Files/x/nextgenacorfa.pdf>

- in alignment with Rhode Island commercial requirements as established by the Office of the Health Insurance Commissioner, and,
- considering public and stakeholder input.

Note that the allowable APMs do NOT require a change the underlying structure of payment between the MCOs and the AEs. Participating providers may continue to get paid as they always have. Payment models that maintain the existing fee-for-service structure, with a total cost of care overlay (thereby creating an opportunity for shared savings and risk between payors and providers) would qualify as an APM.

Each of the three AE Programs will specify qualifying APMs that will be based on a specified population of attributed lives, as defined in the table below. Within these respective populations, attribution to an AE shall be implemented in a consistent manner by all participating MCOs based upon EOHHS defined guidance, to be developed with input from stakeholders this spring and submitted for approval by CMS.

AE Attributable Populations

Program	Attributable Populations
1. Comprehensive AEs	Medicaid-only eligibles
2. Specialized LTSS AEs	LTSS eligible, including duals and nonduals
3. Specialized Medicaid Pre-Eligibles AEs	Medicare-only eligible

The specific terms of the savings and risk transfer to the AE are at the discretion of the contracting parties. EOHHS does not intend to stipulate the terms of these arrangements but expects they will operate within the bounds of EOHHS defined APM Guidance. In addition, EOHHS does reserve the right to review and approve such arrangements.^{7, 8}

Additional program specific APM requirements are as follows:

1. Comprehensive AE Alternative Payment Methodology: Total Cost of Care

Managed Care Contracts with Comprehensive Accountable Entities must be based on total cost of care (TCOC). These TCOC arrangements shall supersede and be exclusive of any other TCOC-related shared savings arrangements with an AE or any of its constituent providers.

Qualified total cost of care (TCOC) contracts must incorporate the EOHHS Quality Scorecard. A comprehensive quality score factor, based on the *Quality Scorecard*, must be applied to any shared savings and/or risk arrangements when calculating the total cost of care. A draft version

⁷ In addition to this EOHHS requirement, note that in certain circumstances transparency in such arrangements is specifically required in CFR42 §438.6.

⁸ CMS has issued guidance for shared savings programs for both Medicaid and for Medicare Shared Savings Programs. See <https://www.medicare.gov/federal-policy-guidance/federal-policy-guidance.html> and <https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/sharedsavingsprogram>

of this *Quality Scorecard* has been posted for public comment. The final *Quality Scorecard* will be modified, based on stakeholder input, and will align with the quality measures for Accountable Care Organizations (ACOs), which were endorsed by RI SIM. EOHHS anticipates a steady progression from process to outcome measures within the *Scorecard*.

Qualified TCOC-based contractual arrangements must also demonstrate a progression of risk to include meaningful downside shared risk or full risk. By the end of the anticipated five-year waiver period in October 2021, infrastructure funding will be phased out. AEs will be sustained going forward based on their successful performance and associated financial rewards in accordance with their contract with MCOs.

2. Specialized LTSS Pilot AE: LTSS Bundle

Ideally, participating AEs would be responsible for the total cost of care. However, for dual eligible populations Medicare is primary for many services, with different arrangements depending on the program structure. As such, this interim APM arrangement will project the total cost of care for services included within the identified “bundle” of Long Term Services and Supports for the attributed population. This calculation will provide the basis for comparing actual financial experience with the projected financial experience.

To start, this program may also include a performance bonus for Pilot LTSS AE performance across a set of agreed upon dimensions. Given that EOHHS anticipates significant challenges in both capturing key data elements and measuring performance across populations, EOHHS would likely begin with a pay for reporting period for some components.

3. Specialized Medicaid Pre-Eligibles Pilot AEs

EOHHS sees an important opportunity in creating a targeted program to address Medicaid pre-eligibles. Previous studies of Medicaid migration patterns for long term care recipients here in Rhode Island have shown that much of the extended stay nursing home population is already in a nursing home when becoming eligible for Medicaid, likely having entered a nursing home and then spent down their assets until they became Medicaid eligible. This suggests that strategies to “rebalance,” away from expensive nursing home settings and toward more cost effective community based care would benefit from a multi-payer approach, as these high risk individuals must be identified well before they spend down assets and become Medicaid eligible – before they enter a nursing home.

As this program is not slated to begin during this DY approval period, EOHHS intends to work with interested entities in the coming months to develop a reporting and data sharing arrangement that effectively enables combined Medicare and Medicaid population reporting and tracking for populations transitioning from Medicare to Medicaid.

VIII. Medicaid Infrastructure Incentive Program (MIIP)

Beginning in late 2015, EOHHS began pursuing Medicaid waiver financing to provide support for 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.

CMS has approved up to \$129.8 Million in HSTP program funds⁹. An estimated \$76.8 M shall be allocated to the AE Program, subject to available funds captured in accordance with CMS approved claiming protocols, as shown below. 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.

	SFY 17	SFY 18	SFY 19	SFY 20	SFY 21	Total
Accountable Entity Program	\$0.0	\$10.0	\$29.4	\$23.9	\$13.5	\$76.8

An AE Program Advisory Committee shall be established by EOHHS. This committee shall be chaired by EOHHS, with a community Co-Chair and shall include representation from participating MCOs, AEs, and community stakeholders and shall:

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

Detailed guidance for this program shall be set forth by EOHHS, with assistance from the AE Program Advisory Committee, in the final HSTP Guidelines for Health System Transformation Project Plans. Draft guidance shall be posted, comments received will be reviewed, and documents will be revised in consideration of public comments before final submission to CMS for approval.

A. Program Structure

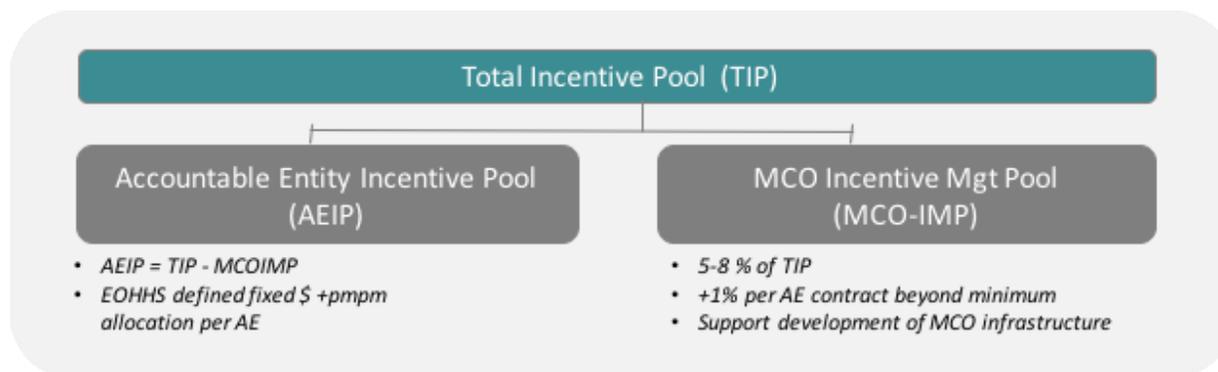
The Medicaid Infrastructure Incentive Program (MIIP) shall consist of three core programs: (1) Comprehensive AE Program; (2) Specialized LTSS AE Pilot Program; and (3) Specialized Pre-eligibles AE Pilot Program. EOHHS shall allocate available HSTP funds to these three programs as follows, subject to available funds and EOHHS identification of priority areas of focus and

⁹ The current Rhode Island 1115 Waiver is a 5-year demonstration, ending in 2018. The STCs include DSHP funding authority through 2018, with a commitment articulated in the cover letter to extend this authority thru 2020 upon waiver renewal for a total funding opportunity of \$129 Million.

assessment of readiness. This allocation shall be revisited annually.

AE Programs	Share of Available AE Funds	
	Program Year 1	Full Program
Comprehensive AE Program	60-70%	60% - 70%
Specialized LTSS Pilot AE Program	30-40%	25% - 35%
Specialized Pre-eligibles Pilot AE Program		5%-15%

For each MCO the MIIP shall include three dimensions:



1. Maximum Total Incentive Pool (TIP) for MCOs

The maximum TIP for each MCO shall be determined by EOHHS with consideration to the MCO share of AE attributed lives in accordance with EOHHS defined attribution guidelines and associated reports.

2. MCO Incentive Program Management Pool (MCO-IMP)

Assuming satisfactory MCO performance, the MCO Incentive Program Management Pool shall minimally be five percent (5%) of the Total Incentive Pool. To the degree that the MCO has more than the minimally required number of contracts with AEs, the MCO-IMP shall be increased by one percent for each AE contract to a maximum of eight percent. These funds are intended for use toward advancing program success, including program administration and oversight, assisting with the development of the necessary infrastructure to support a new business model, and establishing shared responsibilities, information requirements and reporting between EOHHS, the MCO and the Accountable Entities.

3. Accountable Entity Incentive Pool (AEIP)

The Accountable Entity Incentive Pool shall equal the Total Incentive Pool minus the MCO Incentive Program Management Pool (AEIP =TIP – MCO-IMP). This pool shall be divided into the three distinct programs as specified above. In developing contracts with AEs, MCOs shall propose AE Infrastructure Payment Criteria and Methodology for EOHHS review and approval that are consistent with EOHHS defined guidance. 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.

3a. Accountable Entity Specific Incentive Pools

Certified AEs in qualified Alternative Payment Methodology (APM) contracts consistent with EOHHS guidance must be eligible for the Medicaid Infrastructure Incentive Program. Each MCO must create an AE Incentive Pool for each Certified AE to establish the total incentive dollars that may be earned by each AE during the period. The Pool calculation shall include a base amount plus a pmpm component based on attributed lives at the start of each contract year in accordance with EOHHS defined guidance. An example of an AE Incentive Pool calculation for a sample AE is shown below – please note the numbers shown here are illustrative only.

AE #1 Incentive pool Year 1: Illustrative Example Calculation

AE 1 has 15,000 attributed lives, 10,000 are with MCO 1, and 5,000 with MCO 2

Payments from each MCO are for distinct attributed populations and therefore not duplicative.

	MCO 1	MCO 2	Total		
Attributed lives	10,000	5,000	15,000		Illustrative Example Assumptions
Base Amount	\$200,000	\$200,000	\$400,000	\$200,000	base per MCO
pmpm	\$ 180,000	\$ 90,000	\$270,000	\$ 1.50	pmpm
AE 1 Incentive Pool	\$380,000	\$290,000	\$670,000		

3b. Performance Based Incentive Payments

AEs must develop individual Health System Transformation 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. 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.

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. Any Incentive Program funds that are not earned by EOHHS Certified AEs as planned during a given contract year shall be tracked and retained by the MCO exclusively for future Accountable Entity Incentive Pool uses during the following contract year. Any funds not earned during the following contract year shall be returned to EOHHS within thirty days of such request by EOHHS. An AE’s failure to fully meet a performance metric within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment). An AE that fails to meet a performance metric in a timely fashion can earn the incentive payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric.

B. Program Spending Guidance

Incentive Program funds are designed to be used by AEs to prepare project plans and to build the capacity and tools required for effective system transformation. Allowable expenditures must align with EOHHS program priority areas and shall be distributed by the MCOs to the AEs in designated performance areas.



Allowable Areas of Expenditure

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

Domains	Allowable Uses of Funds	Allowable Expenditure Mix		
		Yr 1	Yr 2-3	Yr 4
A. Readiness		<50%	<25%	<10%
1. Breadth and Characteristics of Participating Providers	<ul style="list-style-type: none"> Building provider base, population specific provider capacity, interdisciplinary partnerships, developing a defined affiliation with community based organizations (CBOs) Developing full continuum of services, Integrated PH/BH, Social determinants 			
2. Corporate Structure and Governance	<ul style="list-style-type: none"> Establishing a distinct corporation, with interdisciplinary partners Joined in a common enterprise 			
3. Leadership and Management	<ul style="list-style-type: none"> Establishing an initial management structure/staffing profile Developing ability to manage care under Total Cost of Care (TCOC) arrangement, with increased risk and responsibility 			
B. IT Infrastructure		30%	30%	30%
4. Data Analytic Capacity and Deployment	<ul style="list-style-type: none"> Building core infrastructure: EHR capacity, patient registries, Current Care Provider/care managers' access to information: Lookup capability, medication lists, shared messaging, referral management, alerts Patient portal Analytics for population segmentation, risk stratification, predictive modeling Integrating analytic work with clinical care: Clinical decision support tools, early warning systems, dashboard, alerts Staff development and training – individual/team drill downs re: conformance with accepted standards of care, deviations from best practice 			

C. System Transformation		20%	45%	70%
5. Commitment to Population Health and System Transformation	<ul style="list-style-type: none"> Developing an integrated strategic plan for population health that is population based, data driven, evidence based, client centered, recognizes Social Determinants of Health, team based, integrates BH, IDs risk factors Healthcare workforce planning and programming 			
6. Integrated Care Management	<ul style="list-style-type: none"> Systematic process to ID patients for care management Defined Coordinated Care Team, with specialized expertise and staff for distinct subpopulations Individualized person centered care plan for high risk members 			
7. Member Engagement and Access	<ul style="list-style-type: none"> Defined strategies to maximize effective member contact and engagement Use of new technologies for member engagement, health status monitoring and health promotion 			
8. Quality Management	<ul style="list-style-type: none"> Defined quality assessment & improvement plan, overseen by quality committee 			

EOHHS anticipates that spending may be heavily weighted toward the Readiness Core Area (domains 1-3) in year one, as AEs build the capacity and tools required for effective system transformation. However, over time the allowable areas of expenditure will be required to shift toward system transformation (domains 5-8). A preliminary allowable mix of expenditures is shown above.

Program 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 Advisory Committee and shown below. Note: This is a draft set of priorities – a final set of priorities shall be reviewed and confirmed by the Advisory Committee, and specified in the final APM guidance document.

Program	Priorities
Comprehensive AEs	<ul style="list-style-type: none"> Planning and core infrastructure development Medical enhancements: enhanced systems of care, workforce development <ul style="list-style-type: none"> For children For Adults Integration and innovation in behavioral health care <ul style="list-style-type: none"> For children For Adults Integration and innovation in SUD treatment Integration and intervention in social determinants, including cross system impacts
Specialized Pilot LTSS AEs	<ul style="list-style-type: none"> Building partnerships, including governance, leadership and financial arrangements, between LTSS providers. Developing programs and care coordination processes towards effective and timely care transitions and reduced institutional/ED utilization Repurposing skilled nursing capacity for acute psychiatric transitions and/or adult day capacity

	<ul style="list-style-type: none"> Home and Community based Behavioral Health capacity development for behavioral health specialized adult day care, home care, and alternative living arrangements.
Specialized Medicaid Pre-Eligibles AEs	<ul style="list-style-type: none"> Developing processes, tools and protocols for identification of at risk Medicaid pre-eligible populations Developing effective and timely interventions to support community based care for these populations. EOHHS is committed to working with these entities to define and develop opportunities (mechanisms to pay for) for the specific services needed for identified Medicaid pre-eligible populations that may not currently be Medicare covered services – e.g., home based primary care, palliative care, community health workers, etc.

Performance Areas

AEs must develop AE Specific Health System Transformation Project Plans. These plans shall specify the performance that would qualify an AE to earn incentive payments. Earned funds shall be distributed by the MCO to the AE in accordance with the distribution by performance area defined in the AE specific Health System Transformation Plan, consistent with the requirements defined below:

Performance Area	Minimum Milestones	Year 1	Year 2	Year 3	Year 4
Planning and Design	<ul style="list-style-type: none"> Initial Workplan & budget for developing an AE Project Plan, including completed EOHHS Budget Template Detailed AE Gap Analysis, with specified impacts by domain and population 	70%	15%	0%	0%
Developmental Milestones	<ul style="list-style-type: none"> Detailed Health System Transformation Project Plan, including proposed Infrastructure Development Budget by Project, Domain and population, in accordance with state specified template Quarterly Progress Report in accordance with state defined template Quarterly financial report, in accordance with state defined template, including documented evidence of expenditures Developmental milestones MCO/AE Defined (at least 3 unique developmental milestones per year) 	30%	85%	75%	50%
Value based purchasing metrics	<ul style="list-style-type: none"> Demonstrated APM Progression Marginal Risk Requirements Minimum required share of marginal risk for which the AE is liable, in accordance with EOHHS define APM guidelines 	0%	0%	20%	30%
System Performance Metrics	<ul style="list-style-type: none"> Preventable Admissions Readmissions Avoidable ED Use 	0%	0%	5%	10%

	<ul style="list-style-type: none"> MCO/AE Specific Performance Targets (up to 3) 				
Final Deliverable		0%	0%	0%	10%

The early milestones are intended to allow AEs to develop the foundational tools and human resources that will enable AEs to build core competencies and capacity. In accordance with EOHHS’ agreement with CMS, participating AEs must fully meet milestones established in the AE specific health system transformation 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.

These 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.

C. Implementation and Oversight

As described above, the Medicaid Infrastructure Incentive Program (MIIP) includes EOHHS **program priority areas, allowable areas of expenditure, and AE specific performance areas** that qualify an AE to earn incentive payments. With the assistance of the Advisory Committee EOHHS will develop “EOHHS Guidelines for Health System Transformation Project Plans” that will further specify each of these program elements. This guidance will define specific implementation requirements that must be adhered to by AEs and MCOs to ensure that incentive programs are designed and implemented to maximum effect.

Three key elements of these implementation requirements to be further stipulated in the guidelines are as follows:

1. Specifications Regarding Allowable HSTP Project Plans

Specifications shall delineate additional details regarding:

- Core Goals
- Allowable Priority areas
- Allowable Areas of Expenditure
- Required Performance Areas
- Characteristics of approvable project plans:
 - Approvable project plans must demonstrate how the project will advance the core goals and identify clear objectives and steps for achieving the goals.
 - Approvable project plans must set timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance.

2. MCO Review Committee Guidelines for Evaluation

The MCO shall convene a review committee to evaluate each proposal. EOHHS shall have a

designee that participates on the MCO submission evaluation committee to ensure the state's engagement in the process to evaluate the project plan and associated recommendations for approval or disapproval. The MCO Review Committee, in accordance with EOHHS guidelines, shall determine whether:

- **Project as submitted is eligible for award**
Eligible projects will include a project plan that clearly address EOHHS priority areas and clearly includes the types of activities targeted for funds.
- **Project merits Incentive Funding**
Projects must show appropriateness for submission for this program by including the following:
 - Clear statement of understanding regarding the intent of incentive dollars
 - Rationale for this incentive opportunity, including a clear description of objective for the project and how achieving that objective will promote health system transformation for that AE
 - Confirmation that project does not supplant funding from any other source and is non-duplicative of submission that may be made to another MCO
 - High quality proposal that includes a gap analysis, explains how the workplan and budget addresses these gaps, and describes the AE's current strengths and weaknesses in this area
 - 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.

3. 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
 - Performance schedule
 - 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 must submit semi-annual reports to the MCO using a standard reporting form to document progress in meeting quality and cost objectives

that would entitle the AE to qualify to receive Health System Transformation Project payments, and that such reports will be shared directly by the MCO with EOHHS.

- Stipulate that the AE must 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. no payment for partial fulfillment).
- Provide a process by which an AE that fails to meet a performance metric in a timely fashion (and thereby forfeits the associated Health System Transformation Project Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric.

IX. Program Monitoring, Reporting, & Evaluation Plan

Rhode Island has an established track record of expansions and improvements to its managed care programs as well as a systematic and active program of oversight of our contracted MCOs. The development of the Accountable Entities program provides a new and significant opportunity to further transform the performance of our delivery systems and improve health outcomes for Rhode Island's Medicaid population.

Rhode Island initiated its first managed care program in 1994 with the enrollment of children and families into its Rite Care program. In the years following there have been many changes in the structure of the program so that it now includes the large majority of Medicaid covered beneficiaries, a broad range of Medicaid covered services with very few service "carve outs", and an array of program initiatives intended to advance program effectiveness and cost efficiencies. At each step along the way we have adapted and expanded our program oversight activities to promote high quality performance and ensure program compliance.

Rhode Island's Accountable Entity program is designed to work within and in partnership with our managed care program. Certification of AEs is performed directly by EOHHS, establishing their eligibility to participate in the program. Annual certification ensures continued compliance with requirements to retain eligibility. Eligible AEs will then contract with managed care organizations within the requirements set forth by EOHHS. As the primary contractors with EOHHS, the MCOs will be directly accountable for the performance of their subcontractors. EOHHS is responsible for overseeing compliance and performance of the MCOs in accordance with EOHHS contractual requirements and federal regulation, including performance of subcontractors.

The AE program, AE performance, and MCO-AE relations will be integrated into existing EOHHS managed care oversight activities. For this initiative EOHHS will build upon and enhance its program monitoring and oversight activities in the following four key areas, each of which is described below:

1. MCO Compliance and Performance Reporting Requirements
2. In-Person Meetings with MCOs
3. State Reporting Requirements
4. Evaluation Plan

1. MCO Compliance and Performance Reporting Requirements

Under current contract arrangements, MCOs submit regular reports to EOHHS across a range of operational and performance areas such as access to care, appeals and grievances, quality of care metrics, consumer experience, program operations and others. EOHHS reserves the right to review performance in any area of contractual performance, including flow down requirements to Accountable Entity subcontractors.

For this initiative, MCO reporting requirements that have more typically been provided by the MCOs and reviewed by EOHHS at the plan-level will be extended to also require reporting at the AE level. A menu of metrics and measures that will be used by the MCOs to assess the performance of the AEs and that will be reported to EOHHS will be further specified in the final APM guidance document. Areas of current reporting that are under review as requirements for MCOs to report on data aggregated at the Accountable Entity level include:

MCO Required Reports	Description
1. Provider Access Survey Report	Report completed by each Health Plan by the following provider types: primary care, specialty care, and behavioral health for routine and urgent care. This report measures whether appointments made are meeting Medicaid accessibility standards.
2. Provider Panel Report	A report of which provider panels by each Health Plan are at capacity and/or closed to enrollees.
3. Appeal and Grievance Report	An aggregate report of clinical and administrative denials and appeals by each Health Plan, including External Review.
4. Informal Complaint Report	An aggregate report of the clinical and administrative complaints specified by category and major provider sub-groups for each Health Plan
5. Accountable Entity Shared Savings Report	This financial report is included as part of each Health Plan's risk share report and provides financial data and information as to how each Accountable Entity is performing relative to their total cost of care benchmark.
6. Quality Scorecard	This report consists of the set of NCQA HEDIS and other clinical and quality measures that are used to determine the quality multiplier for total cost of care.
7. MCO Performance Incentive Pool Report	Detailed budgeted and actual MCO expenditures in accordance with EOHHS defined templates

In addition to enhancement of current reports, the Medicaid MCOs will be required to submit reports on a quarterly basis that demonstrate their performance in moving towards value based payment models, including:

- Alternate Payment Methodology (APM) Data Report
- Value Based Payment Report

Pertaining more directly to AE program operations, the Medicaid MCOs will be required to submit Accountable Entity specific reports, including the following.

- AE Attributed Lives
This quarterly report will provide EOHHS with the number of Medicaid MCO lives attributed to each specific Accountable Entity as well as in total.
- AE Population Extract File
This monthly report will provide EOHHS with a member level detailed report of all Medicaid

MCO members attributed to each AE. This data will be used by EOHHS for data validation purposes as well as for the purposes of ad-hoc analysis.

- **AE Participating Provider Roster**

This monthly provider report will provide EOHHS with an ongoing roster of the AE provider network, inclusive of provider type/specialty and affiliation (participating, affiliated, referral etc.) to the Accountable Entity.

2. In-Person Meetings with MCOs

As part of its ongoing monitoring and oversight of its MCOs, EOHHS conducts an in-person meeting on a monthly basis with each contracted MCO. These meetings provide an opportunity for a more focused review of specific topics and areas of concerns. Additionally, they provide a venue for a review of more defined areas of program performance such as quality, finance, and operations. During the initial pilot phase with comprehensive AEs and as the program moves forward, these meetings provide an important forum to identify and address statewide AE performance, emerging issues, and trends that may be impacting the AE program. In addition to the reporting noted above, these meetings support EOHHS' ability to report to CMS (in quarterly waiver reports) issues that may impact AE's abilities to meet metrics or identify factors that may be negatively impacting the program.

In support of discussion on AEs at these meetings, MCOs will be required to submit reports on such areas as:

- A description of actions taken by the MCO to monitor the performance of contracted AEs
- The status of each AE under contract with the MCO, including AE performance, trends, and emerging issues
- A description of any negative impacts of AE performance on enrollee access, quality of care or beneficiary rights
- A mitigation/corrective action plan if any such negative impacts are found/reported

Monthly meetings with MCOs provide a structured venue for oversight. At the same time, EOHHS communications with MCOs take place daily on a variety of topics. Additional meetings to address particular areas of concern that may arise are a routine part of EOHHS' oversight activities. Rhode Island's small size greatly facilitates these in person interactions with both MCOs and AEs.

3. State Reporting Requirements

The state will incorporate information about the Health System Transformation waiver amendment into its existing requirements for waiver reports, including quarterly, annual, and final waiver program reports, and financial/expenditure reports. In addition, the state shall

supply separate sections of such reports to meet the reporting requirements in the STCs that are specific to the Health Systems Transformation waiver amendment.

The state will provide quarterly expenditure reports to CMS using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority subject to budget neutrality. This project is approved for expenditures applicable to allowable costs incurred during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the expenditures as specified in Section XVI of the STCs.

The state will also separately report these expenditures by quarter for each FFY on the Form CMS-37 (narrative section) for all expenditures under the demonstration, including HSTP Project Payments, administrative costs associated with the demonstration, and any other expenditures specifically authorized under this demonstration. The report will include:

- A description of any issues within any of the Medicaid AEs that are impacting the AE's ability to meet the measures/metrics.
- A description of any negative impacts to enrollee access, quality of care or beneficiary rights within any of the Medicaid AEs.

4. Evaluation Plan

EOHHS will draft an Evaluation Plan, which will include a discussion of the goals, objectives, and evaluation questions specific to the entire delivery system reform demonstration.

Key areas of attention in the evaluation will tie to the goals and objectives set forth in this Roadmap, as specified in Section II. The draft Evaluation Plan shall list the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. The Evaluation Plan will include a detailed description of how the effects of the demonstration will be isolated from other initiatives occurring within the state (i.e., SIM grant activities). The draft Evaluation Plan will include documentation of a data strategy, data sources, and sampling methodology.

The state will issue an RFP, based on the CMS-approved evaluation plan, for a qualified independent entity to conduct the evaluation. The Evaluation Plan will describe the minimum qualifications of the evaluation contractor, a budget, and a plan to assure no conflict of interest.

The state plans to submit an Interim Evaluation Report of the Accountable Entities program to CMS by 90 calendar days following the completion of DY 4. The purpose of the Interim Evaluation Report is to present preliminary evaluation findings and describe plans for completing the evaluation plan. The state also plans to submit a Final Evaluation Report after the completion of the demonstration.

Appendix A: DRAFT Certification Standards

Note: These are DRAFT certification standards as posted publicly on December 27, 2016. EOHHS received many valuable comments and feedback on these standards that have not yet been incorporated.

EOHHS' expectation is that the AE shall be structured and organized to assure its commitment to the objectives and requirements of an EOHHS certified Accountable Entity and demonstrate its ability to provide care for each population it proposes to serve. Applicants are required to identify the populations they propose to serve – children, adults, or both. Certification by EOHHS will be specific to each population and based on the particular qualifications to meet requirements for each population.

Summary of Domains for Certification:

1. Breadth and Characteristics of Participating Providers
2. Corporate Structure and Governance
3. Leadership and Management
4. Commitment to Population Health and System Transformation
5. IT Infrastructure – Data Analytic Capacity and Deployment
6. Integrated Care Management
7. Member Engagement and Access
8. Quality Management

Within each of the domains considerable attention is given to the integration of activities focused on social determinants. AEs are expected to work directly with partner organizations to address social determinants needs within a care plan.

1. Breadth and Characteristics of Participating Providers

An AE needs to have a critical mass of either Partner Providers or Affiliated Providers that are multi-disciplinary with core expertise/direct service capacity in primary care, behavioral health, social supports/determinants for the populations the AE proposes to serve. An application will need to explain who are the partners, the role of the partners, and the core of the AE delivery system. The AE must have a base attributable Medicaid population of 5,000 members, based on PCP assignment of record within the MCO or assignment to an IHH as reported by BHDDH.

For any population that is to be attributed to the AE, the applicant must have the capability to address and coordinate the needs of populations at all levels and the ability to coordinate and direct a significant portion of care for those populations. AEs should not only have a strong foundation in primary care but also be able to effectively coordinate care beyond the scope of PCP medical care.

A major objective of this initiative is that participants be able to define methods of care for people with high end needs, including co-occurring chronic conditions, and persons with co-occurring physical and behavioral health needs. A successful AE will be able to recognize and address high risk and rising risk individuals and improve care at points of transition from higher levels of care to less intensive levels of care.

1.1. Provider Base

- 1.1.1.** Critical Mass, as either Partner Providers or Affiliated Providers to qualify for attribution
 - 1.1.1.1.** Attribution: A comprehensive AE must have a base attributable Medicaid population of 5,000 members.
- 1.1.2.** Population specific AE application: Children, adults, duals/seniors
- 1.1.3.** Description of types of member providers and their relationship to the Entity: Partner vs. affiliate vs associated/contracted providers. Certification that all identified providers are willing to participate in, and be accountable for health care transformation efforts, including use of a total cost of care based Alternative Payment Methodology.
 - 1.1.3.1.** Partner Providers are the core organizational partners in the AE, with voting rights on the AE, who participate in shared savings, movement to risk, participate in mutual requirements and protocols for collaborative practice (e.g. data sharing, care management) to promote and support integrated care and, as applicable, are recognized providers in attribution methodologies.
 - 1.1.3.2.** Affiliate providers although not necessarily represented as voting members of the AE, are part of the direct capacity the AE brings to the organization of care, have meaningful direct participation in shared savings arrangements and progression to risk, and participate in mutual requirements and protocols for collaborative practice (e.g. data sharing, care management) to promote and support integrated care, and as applicable, are recognized providers in attribution methodologies.
 - 1.1.3.3.** Associate Providers have referral and working relationships with AE Partners or Affiliates but do not participate in shared savings or as a basis for attribution.
- 1.1.4.** Multi-disciplinary, with direct service capacity in primary care, BH, including high end behavioral health services, and in services to address social determinants of health
- 1.1.5.** Defined affiliation, working arrangements with CBOs, such as Health Equity Zone participants, to address broader social contexts impacting health, outcomes. For different populations Table 2 below indicates community based services that can have critical impacts in promoting improved health outcomes.

Table 2: Population Focused Community Based Services	
Population	Community Based Services
Duals/Individuals with Disabilities Requiring LTSS	<ul style="list-style-type: none"> - Housing - Nutrition - Employment supports - Self-care education - Assistance with ADLs and IADLs - Homemaker - Home health aide - PCA - Adult day health - Habilitation - Caregiver respite services - Assistive technology and home modifications
Adults - SMI/SPMI	<ul style="list-style-type: none"> - Housing - Nutrition - Employment supports - Self-care education - Navigators - Peer supports - Assistive technology and home modifications if appropriate - Host home/Foster care - Group home - Adult day services - Financial support services - In-home supports if appropriate - Caregiver respite services
Children	<ul style="list-style-type: none"> - Pediatric providers consistent with access standards - BH specialists in child and adolescent behavioral health - Coordination with relevant social service agencies and providers including schools - Specialists as appropriate and necessary - DME providers as appropriate and necessary - Coordination of Medicaid and Medicare services for duals only - Adaptive medical equipment - Parental support groups - Recreational activities - Early intervention - Family counseling/training
Developmentally Disabled	<ul style="list-style-type: none"> - Supported living services (individualized supports in a home setting based on needs and preferences. <ul style="list-style-type: none"> o Can include up to 24 hours of care, supervision and training for up to five individuals with DD) - Host home/Foster care - Group home - Adult day services - Financial services - In-home supports - Caregiver respite services - Assistive technology and home modifications - Adaptive medical equipment - Housing - Nutrition - Employment supports - Self-care education - Navigators - Peer support

1.2. Ability to coordinate for All Levels of Need for any Attributed population

- 1.2.1.** Demonstrate that the AE either directly provides or is contracted with organizations capable of meeting all AE requirements to deliver the full continuum of AE services.
 - 1.2.1.1.** Physical Health: service delivery/coordination capacity beyond the scope of PCP medical care. For primary care, participants achieve PCMH recognition (NCQA Level 3) for at least 50% of the AE’s attributed membership (PCMH recognition as defined by OHIC) in year one of certification.
 - 1.2.1.2.** Behavioral Health: meet preventive and routine behavioral health needs.
 - 1.2.1.3.** Ability to address high end behavioral health needs. Linkages with BDDH recognized IHH providers.
- 1.2.2.** Integrated PH/BH: Evidence of direct participation of identified working relationships with high end BH providers
- 1.2.3.** Social Determinants: Community Health Team, CBO partner addressing targeted social determinant area, focus on housing/housing security
- 1.2.4.** Develop protocols that guide the interaction between providers across the continuum of care and to integrate care delivery.

1.3. Defined Methods to Care for People with Complex Needs

- 1.3.1.** Ability to identify and address rising risk, high risk populations
- 1.3.2.** Improve care at points of transition from higher to less intensive levels of care
- 1.3.3.** Ability to work effectively at key points of life transition or impact, such as discharge from corrections, engagement with DCYF protective custody, risk of loss of housing, homelessness, substance use, domestic violence/sexual violence
- 1.3.4.** Ability to care for people with Co-occurring chronic conditions, especially BH

1.4. Able to Ensure Timely Access to Care

Minimally - Able to Demonstrate Compliance with all pertinent MCO Access requirements

- 1.4.1.** Assuring timely (within 30 minutes) after-hours phone access
- 1.4.2.** Use of open access scheduling in primary medical care and behavioral health care- rate of same day appointment availability 30%+
 - 1.4.2.1.** Minimum Access Standards:

<i>Appointment</i>	<i>Access Standard</i>
After Hours Care Telephone	24 hours 7 days a week
Urgent Care Appointment	Within 24 hours
Routine Care Appointment	Within 30 calendar days
New Member Appointment	30 calendar days
Physical Exam	180 calendar days
EPSDT appointment	Within 6 weeks

Non-emergent, non-urgent mental health or substance use condition	Within ten (10) business days for diagnosis or treatment
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2. Corporate Structure and Governance

A fundamental EOHHS objective is to promote the development of a new type of organization in Rhode Island Medicaid. Such an organization must meet a core set of corporate requirements set forth in these requirements. AEs will be a separate and distinct corporation recognized and authorized under applicable Rhode Island State law and have a governing board that is separate and unique to the AE and not the same as a governing board of any specific AE participant.

There shall be an established means for shared governance that provides all AE Partner Providers with an appropriate, meaningful proportionate control over the AE’s decision-making processes. The structure of the AE should ensure that partners have shared and aligned incentives to drive efficiencies, improve health outcomes, work together to manage and coordinate care for Medicaid beneficiaries, and share in savings and in potential risk.

AEs must have a mission statement that aligns with EOHHS goals – a focus on population health, a commitment to an integrated and accountable system of care, a primary concern for the health outcomes of attributed members, the progressive use of outcome-based metrics, and particular concern for those with the most complex set of medical, behavioral health, and social needs.

2.1. Distinct Corporation

- 2.1.1.** Separate and distinct corporation, recognized and authorized under applicable Rhode Island State law and with an applicable Taxpayer Identification Number.
- 2.1.2.** Governing Board must meet regularly and be separate and unique to the AE and not the same as a governing board of any specific accountable entity participant.
- 2.1.3.** Statement of Purpose – Mission Statement that aligns with EOHHS goals
 - 2.1.3.1.** Committed to progression to an integrated and accountable system of care with a primary concern on the health outcomes of attributed members and the progressive use of outcome-based metrics to assess progress and success
- 2.1.4.** By-Laws Set forth Membership on the Board of Directors with voting rights that is inclusive of the minimum requirements set forth by EOHHS
- 2.1.5.** Inclusion of Board Level Governance Committees with a distinct focus on Medicaid, such as an Integrated Care Committee, a Quality Oversight Committee, and a Finance Committee

- 2.1.6. Include quarterly progress dashboards to monitor quality and cost effectiveness to support the MCO's and AE's ability to monitor and improve performance.
- 2.1.7. A Compliance Officer with an unimpeded line of communication with the Board and who is not the legal counsel for the Board
- 2.1.8. Community Advisory Committee
 - 2.1.8.1. CAC consisting of at least ten persons who are attributed Medicaid beneficiaries who are representative of the populations served by the AE.
- 2.1.9. Fiduciary and Administrative Responsibility Resides with BOD.
 - 2.1.9.1. The AE's administration must report exclusively to the governing Board through the AE's chief executive officer
- 2.1.10. Defined conflict of interest provisions that
 - 2.1.10.1. Require each member of the governing body, sub-committees, employees and consultants to disclose relevant financial interests
 - 2.1.10.2. Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise.
 - 2.1.10.3. Address remedial action for members of the governing body that fail to comply with the policy

2.2. Corporate Members: Multi-Disciplinary Partners Joined in a Common Enterprise

2.2.1. Core Premises

- 2.2.1.1. Shared governance provides all AE Partner Providers with an appropriate, meaningful proportionate control over the AE's decision-making processes.
- 2.2.1.2. Multi-disciplinary in composition and organizationally integrated in practice.
- 2.2.1.3. Defined, transparent structure ensuring partners have shared and aligned incentives
- 2.2.1.4. Leverage strengths of partners toward an integrated person-centered system of care

2.2.2. Board Membership – Organizational Membership

- 2.2.2.1. No less than 66% of voting members of the Board shall be primary care providers plus behavioral health providers from participating Partner or Affiliate provider organizations, provided that at least three members of the BOD shall be primary care providers and three members shall be behavioral health providers.
- 2.2.2.2. Minimal board representation requirements, for each population certified to serve
 - 2.2.2.2.1. **Children:** Pediatric PCP, Pediatric BH, Pediatric representative member of CAC, CBO provider of age appropriate social supports

- 2.2.2.2.2. Adults:** Internal Medicine PCP, Adult BH provider, Adult representative member of CAC, CBO provider of age appropriate social supports
- 2.2.2.2.3. Duals/Seniors:** Internal Medicine/geriatric PCP, Adult BH provider, LTSS provider (including LTC/NH and HCBS provider), Adult representative member of CAC, CBO provider of age appropriate social supports

2.3. Compliance

- 2.3.1.** Provisions for assuring compliance with State, Federal law re: Medicaid, Medicare
- 2.3.2.** Debarred providers, discrimination, protection of privacy, use of electronic records
- 2.3.3.** Anti-trust
- 2.3.4.** Compliance Officer reports jointly to the Governing Board

2.4. Required - an Executed Contract with a Medicaid Managed Care Organization

- 2.4.1.** Required for attribution, shared savings required for DSHP incentive funds eligibility
- 2.4.2.** Comport with EOHHS defined delegation rules re: AE/MCO distribution of functions

3. Leadership and Management

AEs should have a single, unified vision and leadership structure, with the commitment of senior leaders and backed by the required resources to implement and support the vision. The application should describe how the AE will address key operational and management areas and how the various component parts of the AE will be integrated into a coordinated system of care.

The Accountable Entity should have a defined, integrated strategic plan for population health that describes how it will organize its resources to impact care and health outcomes for attributed populations. The goal should be a population health model that works to improve the health status of the entire attributed population while systematically segmenting subpopulation risk groups with complex needs in order to implement focused strategies to improve their health status.

An effective system will recognize interrelated conditions and factors that influence the health of populations, identify systematic variations in their patterns of occurrence, and implement actions to improve the health and well-being of those populations.

3.1. Leadership Structure

There must be a single, unified vision and leadership structure, with commitment of senior leaders, backed by the required resources to implement and support the vision. This includes:

- 3.1.1.** Chief Executive responsible to the BOD and responsible for AE operations. Appointment of removal of the chief executive is under the control of the governing board.
- 3.1.2.** Management structure/staffing profile describing how the various component parts of the AE will be integrated into a coordinated system of care. May include specific management services agreements with MCOs or subcontracts under the direction of the AE. Pertinent areas include:
 - 3.1.2.1.** Integrated Care Management
 - 3.1.2.2.** IT Infrastructure/Data Analytics
 - 3.1.2.3.** Quality Assurance and Tracking
 - 3.1.2.4.** Finance - Description of infrastructure for
 - 3.1.2.4.1.** Unified financial leadership and systems
 - 3.1.2.4.2.** Financial modeling capabilities and indicators
 - 3.1.2.4.3.** Designing incentives that encourage coordinated, effective, efficient care
- 3.1.3.** Develops ability to manage care under a total cost of care (TCOC) approach. Includes commitment and approach to increasing risk and responsibility over time.

4. Commitment to Population Health and System Transformation

Defined, integrated strategic plan for population health that sets out its theory of action as to how the entity proposes to organize resources and actions to impact care and health outcomes for attributed populations. Central to the AE is progression to a systematic population health model that works to improve the health status of the entire attributed population while systematically segmenting subpopulation risk groups with complex needs in order to implement focused strategies to improve their health status. An effective system recognizes interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and develops a road map to address social determinants of health based on best practices nationally. Along with clinical and claims data, the entity identifies population needs in collaboration with state and local agencies using publicly available data to develop a plan.

4.1. Key Population Health Elements

- 4.1.1.** Population Based
- 4.1.2.** Data driven
- 4.1.3.** Evidence based
- 4.1.4.** Client centered: Strength based individual and family support
- 4.1.5.** Recognizes/Addresses the determinants of health. Creates programmatic interventions by sub-population.
- 4.1.6.** Team based, including Care management and care coordination, effectively manages transitions of care, Community Health Workers as integral partners
- 4.1.7.** Integration of BH and PH/primary care

- 4.1.8. Identification of modifiable, non-modifiable risk factors for poor behavioral health outcomes.

4.2. Social Determinants of Health

- 4.2.1. Recognizes and seeks methods to approach key social determinants of health. These can include social factors such as housing, family and social support, education and literacy, food security, employment, transportation, criminal justice involvement, safety and domestic violence, and neighborhood stress levels.

4.3. System Transformation and the Healthcare Workforce

In consideration of the essential role that AEs will play in RI's health system transformation, AEs will be required, and funded, to partner with EOHHS, URI, RI College, CCRI, and other education and training providers to support RI's workforce transformation efforts. Such efforts shall include, but not be limited to, the following activities:

- 4.3.1. Healthcare workforce transformation planning
 - 4.3.1.1. Participate on the EOHHS Healthcare Workforce Transformation Committee and/or other related committees to provide ongoing assessment of healthcare workforce transformation needs and strategies.
 - 4.3.1.2. Participate in periodic employer surveys of healthcare workforce development needs and opportunities
- 4.3.2. Healthcare workforce transformation programming
 - 4.3.2.1. Develop partnerships with URI, RIC, CCRI and/or other education and training providers to assist in educational planning, curriculum development, instruction, clinical training, research, and/or other educational activities related to healthcare workforce transformation.
 - 4.3.2.2. Develop partnerships with URI, RIC, CCRI and/or other education and training providers to expand clinical rotations and/or internships to prepare health professional students with new knowledge and skills, for new occupations and roles, in new settings and new models of care to achieve RI's health system transformation goals.
 - 4.3.2.3. Develop partnerships with URI, RIC, CCRI and/or other education and training providers to expand continuing education for current employees of AE partners to provide them with new knowledge and skills, for new occupations and roles, in new settings and new models of care, to achieve RI's health system transformation goals.
 - 4.3.2.4. Develop partnerships with secondary schools, public workforce development agencies, and/or community based organizations to develop career pathways that prepare culturally and linguistically-

divers students and adults for entry level jobs leading to career advancement in health-related employment.

5. IT Infrastructure – Data Analytic Capacity and Deployment

IT infrastructure and data analytic capabilities are widely recognized as critical to effective AE performance. The high performing AE will make use of comprehensive health assessment and evidence-based decision support systems based on complete patient information and clinical data across life domains. This data will be used to inform and facilitate Integrated Care Management across disciplines, including strategies to address social determinants of health care.

It is not necessary that an AE use limited resources to independently invest in and develop “big data” capabilities. There are many efforts underway in Rhode Island to standardize data collection and take advantage of emerging technologies, to build all payer data systems, to enable access to an up-to-date comprehensive clinical care record across providers (e.g. CurrentCare), and to forge system connections that go beyond traditional medical claims and eligibility systems (e.g. SNAP, homelessness, census tract data on such factors as poverty level, percent of adults who are unemployed, percent of people over age 25 without a high school degree). MCOs have long established administrative claims data and eligibility files.

A successful AE will be able to draw upon and integrate multiple information sources that use validated and credible analytic profiling tools to conduct regular risk stratification/predictive modeling to segment the population into risk groups and to identify those beneficiaries who would benefit most from care coordination and management.

The goal of analytical tools is to define processes to promote evidence-based care, report on quality and cost measures, and coordinate care. Analytic tools should be deployed to reshape workflows that impact costs through a focus on operational metrics and measurable business processes. HIT tools can provide clinical decision support to providers to help ensure they follow the evidence-based care pathways and to alert the care management team to critical changes in utilization. AEs may evidence various forms of partnership with MCOs and others to advance these capabilities.

5.1. Core Data Infrastructure and Provider and Patient Portals

5.1.1. Able to receive, collect, integrate, utilize person specific clinical and health status information.

5.1.1.1. Able to ensure data quality, completeness, consistency of fields, definitions

5.1.1.2. EHR capacity: Common platforms across partner providers, ability to share information with affiliate providers.

5.1.1.2.1. Achieve “State 2 Meaningful Use” requirements based on CMS EHR Incentive program. Use EHR systems to

document medical, behavioral, and social needs in one common medical record which can be shared across the network within HIPAA guidelines. Complies with enhanced certification standards or EHRs promoted through CMS EHR incentive Payment Program that require EHRs to capture clinical data necessary for quality measurement as part of care delivery and calculate and report electronic clinical quality for all patients treated by individual providers.

- 5.1.1.3.** Patient registries – shared patient lists (e.g. PCP, BH provider, Care management) to ensure providers are aware of patient engagements.
- 5.1.1.4.** Demonstrate that at least 60% of AE patients are enrolled in CurrentCare and/or document a plan to increase CurrentCare enrollment.
- 5.1.1.5.** AE provider participants must contribute data from their EHRs to CurrentCare (AE office based providers will send encounter data in a Clinical Care Document Format (CCD) via “Direct” secure messages). AE provider participants must have the ability to receive data from CurrentCare or CurrentCare enrolled patients in at least one of the following ways: Through bi-directional interfaces with CurrentCare, or where RIQI and AE provider participants’ EHR vendor capacity exists, ensure staff have appropriate access to CurrentCare viewer or CurrentCare data within their EHR.

5.2. Provider and Care Managers’ Access to information

- 5.2.1.** Look up capability – connecting clients, client records and providers
 - 5.2.1.1.** Ability to review medications lists
 - 5.2.1.2.** Promote Collaborative service delivery
 - 5.2.1.3.** Ensure capability to communicate via shared messaging
 - 5.2.1.4.** Referral management - Ability to create & rout referrals; receive information back
 - 5.2.1.5.** Provider Alerts & notifications: Critical incidents, Hospital admissions & discharges
- 5.2.2.** Patient Portals to enhance engagement, awareness, and self-management opportunities.

5.3. Using Data Analytics for Population Segmentation, Risk stratification, Predictive Modeling

Able to draw upon and integrate multiple information sources to conduct regular risk stratification/predictive modeling to segment the population into risk groups, identify the specific people that will benefit the most from care coordination and management. Ideally such tools would incorporate social risk factors.

- 5.3.1. Risk stratification: Highest complexity, rising/imminent risk groups
- 5.3.2. By population groups: Children, adults, duals/seniors
- 5.3.3. Incorporating social determinants (e.g. housing, family support systems) into risk profiling, by population
- 5.3.4. Able to identify their use of validated, effective, credible tools for analytic profiling

5.4. Reshaping workflows by Deploying Analytic Tools – Business Process Support Systems & Metrics

Development of defined strategic focus on the AE processes and outcomes that impact costs. Integrated Care - Translation of integrated care into business process design and assessment

- 5.4.1. Defined set of business process metrics re: Efficiency
- 5.4.2. Actions to Enhance Ability to Manage Care – operational metrics. Reshaping workflows for: availability and access, high impact interventions, reduce variance in quality/outcomes
- 5.4.3. Monitoring implementation of the care model

5.5. Integrating Analytic work with Clinical Care and Care Management Processes

- 5.5.1. HIT tools to provide clinical decision support to providers to help ensure they follow the evidence-based care pathways
- 5.5.2. Define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care.
- 5.5.3. Provision of actionable information to providers within the system
 - 5.5.3.1. Analysis of gaps, needs, risks based on evidence based practice. Gaps in care reports based on deviations from evidence based practice.
 - 5.5.3.2. To help enhance, help direct care coordination/care management. E.g. Medications management – info on the Pharm claims. Script filled?
- 5.5.4. Early warning system

Established methods to alert, engage the care management team to critical changes in utilization. Alerted before bearing the full burden of costs.

 - 5.5.4.1. Employ a Care Management Dashboard (real time dashboard of patient-admissions and discharges to EDs and hospitals)
 - 5.5.4.2. Employ Care Management Alerts (ADT notification via direct messaging of ED and hospital admissions and discharges)
 - 5.5.4.3. Contribute provider files on own AE organization and providers to statewide common provider directory

5.6. Staff Development – Training

- 5.6.1. Training in, and expectation for, using data systems effectively, using data to manage patients care.

- 5.6.2.** Ongoing aggregate reporting with individual/team drill-downs re: Conformance with accepted standards of care, deviations from best practice, identified breakdowns in process

6. Integrated Care Management

The AE shall create

The integration approach will be developed in collaboration with providers across the care continuum and incorporate evidence based strategies into practice. An effective AE must have a systematic process to target the top 1% - 5% most complex patients in each relevant subpopulation for care management and support. The AE will have tools to systematically track and coordinate care across specialty care, facility- based care and community organizations, as well as the ability to rapidly recognize and effectively respond to changes in a condition.

An AE should have a care coordination team with specialized expertise pertinent to the characteristics of each targeted population and should be able to direct the majority of care within a well-defined set of providers. The goal is to create interdependence among institutions and practitioners and to facilitate collaboration and information sharing with a focus on improved clinical outcomes and efficiencies.

Care coordination for high-risk members should include an individualized person centered care plan based on a comprehensive assessment of care needs, including incorporation of plans to mitigate impacts of social determinants of health. Person centered care plans reflect the patient's priorities and goals, ensures that the member is engaged in and understands the care he/she will receive, and includes empowerment strategies to achieve those goals.

6.1. Systematic Processes to Identify Patients for Care Management

Electronic systems to support Effective Case management, Targeted Care coordinating function, top 1% - 5% in each relevant subpopulation, including:

- 6.1.1.** Systematically utilizes analytics, risk segmentation to identify/target individuals for more hands-on, individual care management. May include indicators such as poly-pharmacy, behavioral health diagnosis, limits to physical mobility, release from corrections, neighborhood stress index, depression, hospitalization, clinical indicators (e.g. diabetes), gaps in care.
- 6.1.2.** Tools to systematically track & coordinate care across specialty care, facility- based care and community organizations
- 6.1.3.** Referral Tracking and Follow-Up
- 6.1.4.** Ability to rapidly recognize and effectively respond to changes in a condition to activate care coordination and help avoid use of unnecessary services, particularly emergency department visits or hospitalizations

6.2. Defined Care Coordination Team with Specialized Expertise Pertinent to Characteristics of Target population

- 6.2.1. Coordinated Care Team – with evidence of ability, tools to manage care**
 - 6.2.1.1.** Deliver evidence based care management to individuals at high risk for poor outcomes based on identified core principles and related processes specified in the care. Should be able to direct, organize majority of care
 - 6.2.1.2.** Develop and implement a transitions of care approach for individuals who are moving between health care settings, including care transition protocols to proactively address the needs of individuals in transition according to evidence based practices whenever possible.
 - 6.2.1.3.** Well defined set of providers – can vary, but in all cases must represent PCPs, BH, and expertise in social determinants and LTSS, e.g. Community Health Worker, Social Worker
 - 6.2.1.4.** Can represent multiple organizations, but must have clear delineation of roles
 - 6.2.1.5.** Greatest impact and member benefit if care (handoffs) remain *within* the network of participating providers where possible – to promote coordination, accountability and efficiency
- 6.2.2. Specialized expertise and staff for work with distinct sub-populations**
 - 6.2.2.1.** Integration of BH and Medical care – children, adults, seniors
 - 6.2.2.2.** coordination of care for persons with chronic diseases and the elderly, including medical management, Coordinating transitions of care (ED, hospital, home, SNF)

6.3. Individualized Person Centered Care Plan - Care Coordination for High-Risk Members

- 6.3.1.** Comprehensive assessment of care needs and gaps: Symptom severity, Functional status, Potentially Avoidable Hospital Readmission Strategies and Improvement Plan
- 6.3.2.** Individual Care Plans
Culturally and linguistically appropriate care management. Based on assessment, develop a care plan that takes into account: Gaps in care, Functional status, Behavioral health and social service needs, managing transitions, Increased patient medication adherence and use of medication therapy
- 6.3.3.** Incorporates mitigation strategies for social determinants of health
E.g., Housing security, Nutrition, Food security, Physical /activity and Nutrition, Safety, safe environment; Involvement with criminal justice, parole
- 6.3.4.** Multi-disciplinary care plan across providers
 - 6.3.4.1.** Care Plan coordinates efforts of medical, behavioral and social support providers.
 - 6.3.4.2.** Entity has established methods to promote access, engagement, accountability.

- 6.3.4.3. Engagement with CBOs, providers of social support services as part of the implementation of the care plan
 - 6.3.4.4. AE pays close attention to effective, warm handoffs where they occur.
 - 6.3.5. Person Centered Care plan is driven by the patient’s priorities, motivations, and goals, ensures that the member is engaged in and understands the care she will receive.
 - 6.3.5.1. Begins by looking at the person. Motivational interviewing. Care plan built around the person, not around services.
 - 6.3.5.2. The Care Plan is readily available to the member
 - 6.3.5.3. Strength based. Provides for continuity
 - 6.3.5.4. Processes for working closely with members, family members and caregivers, range of providers to assure adherence to the care plan
 - 6.3.5.5. Encourage patient and/or family health education and promotion
 - 6.3.5.6. Leverage Home-based services, and telephonic and web-based communications, group care, and the use of culturally and linguistically appropriate care;
 - 6.3.5.7. Programs to promote healthy lifestyles, developing skills in self-care. Sees intermittent failure as part of the pathway.
 - 6.3.6. Educates and trains providers across the full continuum of care regarding the care integration strategy and provider requirements for participation.

7. Member Engagement

An AE must have defined strategies to maximize effective member contact and engagement, including the ability to effectively outreach to and connect with hard-to-reach high need target populations. The best strategies will use evidence-based and culturally appropriate engagement methods to actively develop a trusting relationship with patients. A successful AE will make use of new technologies for member engagement and health status monitoring. Social media applications and telemedicine can be used to promote adherence to treatment and for support and monitoring of physiological and functional status of older adults.

7.1. Defined Strategies to Maximize Effective Member Contact and Engagement

Able to effectively outreach to and connect with hard-to-reach high need target populations. Specific to attributed populations served.

- 7.1.1. Communication approach that recognizes highly complex, multi-condition high cost members Recognizes that the roots of many problems are based in childhood trauma; that many of the highest need individuals have a basic mistrust of the health care system. Often does not have a primary existing affiliation with a PCP.
- 7.1.2. Identified strategies, methods to actively develop a trusting relationship through the use of evidence-based and patient-centered engagement methods

7.1.3. Use culturally competent communication methods and materials with appropriate reading level and communication approaches.

7.1.3.1. Uses methods adapted to recognize that compliance with patient notification requirements is not the same as effective communication with members

7.1.3.2. Tools are understandable, and culturally and linguistically appropriate

7.2. Implementation, Use of New technologies for Member Engagement, Health Status Monitoring, and Health Promotion

7.2.1. Social media applications to promote adherence to treatment

7.2.2. Demonstrated use of telemedicine

7.2.3. Demonstrated use of Products that support monitoring and management of an older adult's physiological status and mental health (e.g. vital sign monitors, activity/sleep monitors, mobile PERS with GPS)

7.2.4. Demonstrated use of Products that support monitoring and maintaining the functional status of older adults in their homes (Fall detection technologies, environmental sensors, video monitoring)

7.2.5. Use of technologies that enable older adults to stay socially connected (Social communication/PC mobile apps for remote caregivers, cognitive gaming & training, social contribution)

7.2.6. Technologies, products that support both informal and formal caregivers providing timely, effective assistance.

8. Quality Management

8.1. Defined Quality Assessment and Improvement Plan, Overseen by the Quality Committee

8.1.1. The AE will maintain an ongoing quality program overseen by qualified healthcare professional responsible for the AE's quality assurance and improvement program

8.1.2. The AE will have an identified board certified Medical Director licensed in the State of Rhode Island who is an AE provider and who is physically present at the AE location on a regular basis and have an individual from a community based service organization who is familiar with how to meet needs associated with social determinants of health.

8.1.3. AE will develop an infrastructure for its Partners, Affiliates and providers/suppliers to address the integration of medical, behavioral, and social supports for AE members; and to internally report on quality and cost metrics that enables the AE to monitor performance, emerging trends and quality of care and to use these

results to improve care over time. AE will have the ability to track and report on key performance metrics. Performance metrics shall include consumer reported quality measures.

- 8.1.4.** AE will identify a method for integration and review of clinical pathways, care management pathways based on evidence based practice and for establishing, reporting, and ensuring provider compliance with health care quality criteria, including quality performance standards
- 8.1.5.** AE will identify a. The AE will be able to identify how it will require AE participants and providers/suppliers to comply with and implement each process, including the remedial processes and penalties (including the potential for expulsion) applicable to AE participants and AE providers/suppliers for failure to comply with and implement the required process; and explain how it will employ its internal assessments of cost and quality of care to improve continuously the AE's care practices
- 8.1.6.** The AE shall undertake to promote evidence-based medicine. These processes must cover diagnoses with significant potential for the AE to achieve quality improvements taking into account the circumstances of individual beneficiaries.
- 8.1.7.** EOHHS shall establish quality performance measures to assess the quality of care furnished by the AE. If the AE demonstrates to the MCO that it has satisfied the quality performance requirements and the AE meets all other applicable requirements, the AE is eligible for shared savings.

Appendix B: Stakeholder Meetings and Feedback

EOHHS has presented to thirteen (13) stakeholder meetings regarding the HSTP/AE Program.

- HSTP/AE Presentation to ICI Provider Council
- HSTP/AE presentation to 1115 Task Force
- AE/MCO meetings on AE initiative (2 sessions)
- Broad Stakeholder meeting/presentation on Comprehensive AEs (2 sessions)
- Stakeholder meeting on Specialized AEs
- HSTP/AE meeting to home care/child service providers
- NASW Aging Committee meeting
- Coalition for Children presentation
- Governor BH council (scheduled)
- BHDDH Health Transition team (scheduled)
- DEA Home and Community Care Advisory Committee (scheduled)

Additionally, twenty-four (24) comments were received by EOHHS from the following interested parties:

1. Blackstone Valley Community Health Center
2. Carelink
3. Center for Treatment and Recovery
4. CHC ACO
5. Coalition for Children and Families
6. Coastal Medical
7. Disability Law Center
8. Economic Policy Institute
9. Integra
10. Kids Count
11. LeadingAge
12. Lifespan
13. Neighborhood Health Plan of Rhode Island
14. Partnership for Home Care
15. Prospect Health Services of RI
16. Providence Community Health Center
17. RI Coalition for Children
18. RI Community Action Agencies
19. RI Health Care Association
20. RI Health Center Association
21. State of Rhode Island SIM Team
22. Substance Use and Mental Health Leadership Council
23. Tufts Health Public Plans
24. UnitedHealthcare

Many of these comments provided valuable input to the final roadmap as documented here. Some required additional discussion, and were further refined through public input sessions in March 2017, prior to finalizing the roadmap.

Note that the draft roadmap that was posted in January 2017 for comments included both an in-depth discussion of Rhode Island's vision, goals and objectives of Rhode Island's AE program, as well as appendices that outlined initial details of programmatic guidance for AEs. As such, many of the comments received were more directly related to future anticipated guidance – either APM guidance, Incentive Program Guidance or Attribution guidance, and shall be addressed as part of that public input process.

The following is a summary of the comments received by thematic areas.

State Policy Alignment

A number of comments spoke to the need to ensure that state policy outside of the Accountable Entity program was aligned to ensure success. Detailed points of alignment included:

- Statutory authority for data sharing
- Budgetary support for the Integrated Care Initiative, Rhode Island's dual-eligible demonstration program
- Flexibility in Long Term Care Facility Bed Licensing
- Integration of Public Health Initiatives

Overall Program Strategy

Commenters also spoke to the general program strategy and vision as outlined in the roadmap. Frequent comments focused on the following topics:

- *Timeline and milestone expectations* – Many commenters expressed concern at the speed with which the state was proposing to implement the program.
- *Flexibility* – A number of comments spoke with varying degrees of support for the granting of flexibility from the state to MCOs and from MCOs to AEs.
- *Consumer Choice and Access* – Commenters highlighted the need to ensure the protection of consumer choice in the Medicaid program and to protect access to services given the preferred network structure that some AEs may consider developing.

Program Operational Details

Commenters provided significant feedback on operational details that EOHHHS will develop further through upcoming guidance documents. Specific areas of feedback included:

- AE Certification
- Alternative Payment Methodologies
- Attribution

- Delegation of Responsibilities
- Incentive Payment Program
- Quality Scorecard
- Reporting and Data Sharing
- Social Service Integration
- Specialized AEs (LTSS)

Appendix C: Roadmap Required Components

	STC Required Elements of Roadmap	Where Addressed
A	(a) Specify that a menu of metrics and measures that will be used by the MCOs to assess the performance of the AEs through the activities of the AE subcontractors shall be defined in the APM guidance document.	<i>Section IX. Program Monitoring, Reporting, & Evaluation Plan</i> <ul style="list-style-type: none"> Page 35, 1st paragraph
B	(b) Include guidelines requiring AEs to develop individual AE Health System Transformation Project Plans, which shall include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance;	<i>Section VIII. Medicaid Infrastructure Incentive Program (MIIP)</i> <i>Section C. Implementation & Oversight</i> <ul style="list-style-type: none"> Page 31, in bullets under paragraph titled 1. Specifications
C	(c) Report to CMS any issues within the AEs that are impacting the AE’s ability to meet the measures/metrics, or any negative impacts to enrollee access, quality of care or beneficiary rights. The state, working with the MCOs shall monitor statewide AE performance, trends, and emerging issues within and among AEs on a monthly basis, and provide reports to CMS on a quarterly basis.	<i>Section IX. Program Monitoring, Reporting, & Evaluation Plan</i> <ul style="list-style-type: none"> Page 36, in paragraph titled 2. In-Person Meetings with MCOs
D	(d) Provide minimum standards for the process by which EOHHS seek public input in the development of the AE Certification Standards;	<i>Section VI. AE Certification Requirements</i> <ul style="list-style-type: none"> Page 18, 1st and 2nd paragraphs
E	(e) Specify a State review process and criteria to evaluate each AE’s individual Health System Transformation Project Plan and develop its recommendation for approval or disapproval;	<i>Section VIII. Medicaid Infrastructure Incentive Program (MIIP)</i> <i>Section C. Implementation & Oversight</i> <ul style="list-style-type: none"> Page 31-32, in paragraph titled 2. MCO Review Committee
F	(f) Describe, and specify the role and function, of a standardized, AE-specific application to be submitted to the State on an annual basis for participation in the AE Incentive Program, as well as any data books or reports that AEs may be required to submit to report baseline information	<i>Section VI. AE Certification Requirements</i> <ul style="list-style-type: none"> Page 18, 1st paragraph <i>Section IX: Program Monitoring, Reporting, & Evaluation Plan</i> <ul style="list-style-type: none"> Page 35-36, in paragraph beginning with “Pertaining more directly to

	or substantiate progress;	AE program operations..."
G	(g) Specify that AEs must submit semi-annual reports to the MCO using a standardized reporting form to document its progress in achieving quality and cost objectives, that would entitle the AE to qualify to receive Health System Transformation Project Payments;	<p><i>Section VIII. Medicaid Infrastructure Incentive Program (MIIP)</i> <i>Section C. Implementation & Oversight</i></p> <ul style="list-style-type: none"> • Page 32, in paragraph titled 3. <i>Required Structure for Implementation</i>, 4th bullet
H	(h) Specify that each MCO must contract with Certified AEs in accordance with state defined APM guidance and state defined AE Incentive Program guidance. The APM guidance will include a Total Cost of Care (TCOC) methodology and quality benchmarks. For specialized AEs where TCOC methodologies may not be appropriate, other APM models will be specified. Describe the process for the state to review and approve each MCO’s APM methodologies and associated quality gates to ensure compliance with the standards and for CMS review of the APM guidance as stated in STC 47(e).	<p><i>Section VII: Alternative Payment Methodologies</i></p> <ul style="list-style-type: none"> • Page 23, in paragraph titled AE Attributable Populations
I	(i) Specify the role and function of the AE Incentive Program guidance to specify the methodology MCOs must use to determine the total annual amount of Health System Transformation Project incentive payments each participating AE may be eligible to receive during implementation. Such determinations described within the APM guidance document shall be associated with the specific activities and metrics selected of each AE, such that the amount of incentive payment is commensurate with the value and level of effort required; these elements are included in the AE incentive plans referenced in STC 47 (f). Each year, the state will submit an updated APM guidance document, including APM Program guidance and the AE Incentive Program Guidance.	<p><i>Section VIII. Medicaid Infrastructure Incentive Program (MIIP)</i> <i>Section A. Program Structure</i></p> <ul style="list-style-type: none"> • Page 26, in paragraph titled 3. <i>Accountable Entity Incentive Pool</i> <p><i>Section VIII. Medicaid Infrastructure Incentive Program (MIIP)</i> <i>Section C. Implementation & Oversight</i></p> <ul style="list-style-type: none"> • Page 31-32, in paragraph titled 2. <i>MCO Review Committee</i>, 3rd bullet • Page 32, in paragraph titled 3. <i>Required Structure for Implementation</i>, in 2nd bullet, 4th sub-bullet
J	(j) Specify a review process and timeline to evaluate AE progress on its Health System	<i>Section VIII. Medicaid Infrastructure Incentive Program (MIIP)</i>

	Transformation Project Plan metrics in which 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;	<p><i>Section C. Implementation & Oversight</i></p> <ul style="list-style-type: none"> Page 32, in paragraph titled 3. <i>Required Structure for Implementation</i>, in 3rd bullet
K	(k) Specify that AE’s failure to fully meet a performance metric under its AE Health System Transformation Project Plan within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment);	<p><i>Section VIII. Medicaid Infrastructure Incentive Program (MIIP)</i></p> <p><i>Section C. Implementation & Oversight</i></p> <ul style="list-style-type: none"> Page 32-33, in paragraph titled 3. <i>Required Structure for Implementation</i>, 5th bullet
L	(l) Describe a process by which an AE that fails to meet a performance metric in a timely fashion (and thereby forfeits the associated Health System Transformation Project Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric,	<p><i>Section VIII. Medicaid Infrastructure Incentive Program (MIIP)</i></p> <p><i>Section C. Implementation & Oversight</i></p> <ul style="list-style-type: none"> Page 32-33, in paragraph titled 3. <i>Required Structure for Implementation</i>, 6th bullet
M	(m) Include a process that allows for potential AE Health System Transformation Project Plan modification (including possible reclamation, or redistribution, pending State approval) and an identification of circumstances under which a plan modification may be considered, which shall stipulate that CMS 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; and	<p><i>Section VIII. Medicaid Infrastructure Incentive Program (MIIP)</i></p> <p><i>Section B. Program Spending Guidance</i></p> <ul style="list-style-type: none"> Page 31, 2nd paragraph
N	(n) Include a State process of developing an evaluation of Health System Transformation Project as a component of the draft evaluation design as required by STC 132.	<p><i>Section IX. Program Monitoring, Reporting, & Evaluation Plan</i></p> <ul style="list-style-type: none"> Page 37, in paragraph titled 4. <i>Evaluation Plan</i>