Certification Standards: Specialized Pilot LTSS Accountable Entity
DRAFT May 27, due to CMS June 1

EOHHS is working closely with stakeholders to develop a Specialized LTSS AE Pilot Program to focus on providers of long-term services and supports (LTSS). The objective of the LTSS AE Pilot 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.

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

- Children with special health care needs;
- Adults, including non-elderly adults with disabilities and elderly adults.

By applying for Certification, LTSS Pilot AEs are committing to program requirements in the following areas:

1. Breadth and Characteristics of Participating Providers
2. Organizational Structure and Governance
3. Leadership and Management
4. IT Infrastructure – Data Analytic Capacity and Deployment
5. Commitment to Population Health and System Transformation
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. Specialized AEs are expected to work directly with partner organizations to address needs related to social determinants within a care plan.

EOHHS recognizes that the long term services system in Rhode Island is fragmented and dominated by specialized providers who are geographically and/or service specific, and that potential applicants may have differing stages of readiness. To that end, EOHHS anticipates that most LTSS AEs will be "Provisionally Certified with Conditions." For each requirement, applicants must either demonstrate specific compliance or identify how they will achieve compliance and a timeline for doing so. As this is a pilot, applicants may also propose an equivalent alternative that satisfies the intent and core structural elements.

It should be noted that compliance with these performance requirements need not be accomplished through direct AE capabilities. In some instances, these performance requirements may be partially met by an engaged partner, such as an MCO. EOHHS encourages active partnerships between the AE and MCO to both capture the capabilities that each brings to the relationship and to avoid duplication.

Note that the domains and requirements are aligned with the requirements for Comprehensive AEs. Comprehensive AEs may apply to participate in the LTSS Pilot AE program, provided that the LTSS AE specific capacities and capabilities detailed below are adequately demonstrated.

1. Breadth and Characteristics of Participating Providers

An LTSS Pilot AE needs to have a critical mass of either employed, partner or affiliated providers that are inter-disciplinary with core LTSS expertise specific to the populations the AE proposes to serve. The applicant will need to identify participating partners, the role of the partners, and the core of the LTSS AE delivery system.

The AE must have a base attributable Medicaid population (adults and children) of at least 500 members in the LTSS Pilot AE eligible population. Attributable members shall be calculated in accordance with EOHHS defined Attribution Guidance and shall include managed care enrolled and fee for service members receiving at least one of the following services from an LTSS AE employed clinician, or partner or affiliated provider:

Attributable Service*	Adults	Children
Attributable Home and Community Based Services	• Homemaker • Personal Care Services • Adult Day Services • Assisted Living • Supported Living Arrangements/ Shared Living	• Certified Nursing Assistant Services • Pediatric Private Duty Nursing
Attributable Institutional Services	• Long-Stay Nursing Facility Care	

*Notes: These services are further defined in Attachment B. Services managed by the Department of Behavioral Health, Developmental Disabilities, and Hospitals for people with intellectual and developmental disabilities are excluded from the attributable services.

LT**LTSS Pilot AEs serving adults must demonstrate <u>direct</u>** home care (including homemaker and personal care assistance) and adult day care capacity within the participating LTSS AE provider base (employed clinician, or partner or affiliated providers) as specified below:

• **Direct Homemaker capacity includes** services that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

Homemakers shall meet such standards of education and training as required by the RI Department of Health for the provision of these activities and specified in the "Rules and regulations for licensing home nursing care providers and home care providers (R23-17-HNC/HC/PRO]".

- **Direct Personal Care capacity** to provide direct support in the home or community to an individual in performing Activities of Daily Living (ADL) tasks that he/she is functionally unable to complete independently due to disability. Personal Care Services may be provided by A Certified Nursing Assistant which is employed under a State licensed home care/home health agency and meets such standards of education and training as are established by the State for the provision of these activities.

- **Direct Adult Day capacity** includes programs licensed by the RI Department of Health for frail seniors and other adults who need supervision and health services during the daytime. dult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health services are for adults who return to their homes and caregivers at the end of the day.

LTSS Pilot AEs serving children must demonstrate <u>direct</u> personal care services and private duty nursing capacity within the participating LTSS AE provider base (employed clinician, or partner or affiliated providers) as specified below:

- **Direct Certified Nursing Assistant Service capacity** to assist individuals with physical disabilities, mental impairments, and other health care needs with their Activities of Daily Living (ADL) and provide bedside care — including basic nursing procedures — all under the supervision of a Registered Nurse. .

- **Direct Pediatric Private Duty Nursing capacity** to provide hourly, skilled nursing care in a client's home. Private duty nursing provides more individual and continuous skilled care than can be provided during a skilled nursing visit through a home health agency. The intent of private duty nursing is to support the child with complex medical issues to remain at home. Private duty nursing services are provided for children living at home who have been diagnosed with moderate to severe physical conditions. These children have chronic health care needs that require health and related services beyond those required by children generally.

Within any direct service capacity, AEs must demonstrate the capacity to meet the needs of people with behavioral health conditions, including serious mental illness and substance use conditions, across the continuum of its services.

Note that direct LTSS AE capacity for other attributable services not specified above (e.g., long stay nursing facility care, assisted living) is not a requirement; however, a successful LTSS Pilot AE will be able to recognize and address highest risk and rising risk individuals and demonstrate protocols and/or defined strategies to work collaboratively to ensure safe, timely

and appropriate transitions between care settings, including especially transitions from or to a hospital or nursing facility.

The applicant must also demonstrate the capability to coordinate all Medicaid home and community based and institutional services that support the attributed member's ability to remain in the community including a significant portion of the services for people with long term care needs, as defined in Table A. The "Included Services" listed in Table A, by population, will form the basis for a total cost of care (TCOC) calculation, and an opportunity for participating LTSS Pilot AEs to earn shared savings as specified in EOHHS defined APM guidance.

Table A: Service List by Population

LTSS Services	Children w/Special Health Care Needs		Adults including nonelderly adults with disabilities and elderly	
	Included Services	Attributable Event	Included Services	Attributable Event
Homemaker			X	X
Environmental Modifications	X		X	
Special Medical Equipment	X		X	
Minor Environmental Modifications	X		X	
Meals on Wheels			X	
Personal Emergency Response (PERS)	X		X	
LPN Services (Skilled Nursing)	X		X	
Home Health Services (skilled)	X		X	
Skilled Therapies (PT, OT, Speech)	X		X	
Community Transition Services			X	
Residential Supports			X	
Day Supports			X	
Supported Employment			X	
Supported Living Arrangements/ Shared Living			X	X
Private Duty Nursing	X	X	X	
Adult Companion			X	
Assisted Living			X	X
Personal Care Assistance/Certified Nursing Assistant Services	X	X	X	X
Respite	X		X	
Habilitative Services	X		X	
Adult Day Services			X	X
Long Stay Nursing Facility			X	X
Hospice	X		X	
Skilled Nursing Facility (SNF)	X		X	
Home Based Treatment Services (HBTS)	X			
Personal Assistance Services & Supports (PASS) Program	X			

1.1 Provider Base

1.1.1. Critical Mass of LTSS providers, as either employed clinicians or Partner Providers or Affiliated Providers, to qualify for attribution. For the purposes of these certification standards provider is differentiated from individual clinicians and is defined as a corporate entity with an identifiable tax identification number that for services to patients based the work of individual clinicians working with or for the corporate entity.

1.1.1.1. Attribution: The LTSS Pilot AE must have a **base attributable Medicaid population of at least 500 members** in the LTSS Pilot AE eligible population. Attributable members shall be calculated in accordance with EOHHS defined Attribution Guidance and shall include managed care enrolled and fee for service members who are receiving at least one of the following services from either an LTSS AE employed clinician, or partner or affiliated provider:

- **Adults:** Homemaker services, personal care services, adult day services, long stay nursing facility, assisted living, supported living arrangements/shared living
- **Children:** Certified nursing assistant services, pediatric private duty nursing

1.1.2 Population-specific LTSS capacity to serve the populations the AE proposes to serve (adults and/or children). Specifically, applicants must demonstrate:

- **Adults: Direct service capacity** within employed, partner or affiliated providers must include homemaker, personal care assistance and adult day care capacity, as defined above, including specialized capacity to meet the needs of people co-occurring physical and behavioral health needs including Alzheimer's and related dementias
- **Children: Direct service capacity** within employed, partner or affiliated providers must include certified nursing assistant and pediatric private duty nursing capacity, as defined above, including specialized capacity to meet the needs of people co-occurring physical and behavioral health needs including Alzheimer's and related dementias
- **Population specific capability to facilitate smooth and timely transitions** to, and follow up with nursing facilities and hospitals.
- **Population specific capability to coordinate** the full continuum of service needs for individuals requiring long term care services, inclusive of the services listed in Table A for attributed populations by either providing services directly or through accountable care management.

1.2 Population specific social determinants service capacity

AEs will identify social determinants of particular importance for the populations they serve.

AEs will identify three critical areas of need for social supports for each population served and have defined in-house capacity and/or defined relationships with providers of social supports to address those needs, with at least one such capacity in place within nine (9) months from the date of provisional certification. For illustration, the community-based services that can have critical impacts in promoting improved health outcomes may include the following:

- Housing stabilization and support services
- Housing search and placement;
- Utility assistance;
- Food security;
- Family, caregiver, and social supports (including services for social isolation)
- Education and literacy
- Physical activity and nutrition; and,
- Support for attributed members who have had experience of violence.

AEs may identify other areas deemed to be of critical impact. Note that it is anticipated that incentive funds through the HSTP program will be made available to help strengthen these relationships.

1.3 Relationships with medical services and other covered benefits outside LTSS continuum

Demonstrated ability maintain active contact and reporting and ensure member follow up with providers inside or outside the LTSS AE provider base, for all levels of need for any attributed population, including:

1.3.1 Primary, specialty and ancillary service providers outside LTSS continuum, that support the member's ability to remain in the community.

1.3.2 Behavioral health providers, supporting co-occurring physical and behavioral health needs and serious mental illness.

1.3.3 Providers of Integrated SUD treatment, across the spectrum of need including opioid addiction services.

1.3.4 Community Based Organizations (CBOs) and/or Community Health Team addressing targeted social determinant area, e.g. focus on housing/housing security.

1.3.5 Transportation providers and services.

1.3.6 Development and implementation of agreed upon protocols that guide interaction between providers across the continuum of care and integrate care delivery.

1.4 Relationships of Providers to the Entity

1.4.1 Description of types of member providers and clinicians and their relationship to the Entity: Partner vs. affiliate vs associated/contracted providers.

- **Entity-employed clinicians** are by definition participating in, and accountable for health care transformation efforts of the Partners of Affiliates that employ them.

- **Partner Providers** are the core organizational partners in the AE, with voting rights on the AE Board of Directors, who participate in shared savings, movement to risk, participate in written mutual requirements and protocols for collaborative practice (e.g. data sharing, care management) to promote and support integrated care and, as applicable. Partner providers are recognized providers in attribution methodologies.
- **Affiliate providers** are recognized providers in attribution methodologies. Although not necessarily represented as voting members of the AE, Affiliate providers are part of the direct core capacity the AE brings to the organization of care, have meaningful direct and contractually defined participation in shared savings arrangements and progression to risk, and participate in written mutual requirements and protocols for collaborative practice (e.g. data sharing, care management) to promote and support integrated care.
- **Associate Providers** have established referral and working relationships with AE Partners or Affiliates but do not provide a basis for attribution. These would include, but not be limited to, arrangements to fulfill the "breadth of provider base" requirements related to providers of social supports to address social determinants of health. Relationships with Associate Providers can be essential to demonstrate the ability to coordinate care for the full continuum of needs for attributed populations, particularly rising risk and needs individuals. Depending on the nature of the agreement between the parties the AE may or may not have shared savings or incentive arrangements with those providers.

1.4.2 Certification that all identified partner and affiliate providers have agreed to participate in, and be accountable for health care transformation efforts, including use of Alternative Payment Methodology consistent with EOHHS defined guidance.

1.5 Able to Ensure Timely Access to Care

As financial incentives for participating providers shift in accordance with new alternative payment models, it is critically important to ensure that quality and access standards are maintained. Participating LTSS AEs must therefore demonstrate, and continuously track and report, on timely access to care.

1.5.1 Commitment to work with EOHHS to define and implement appropriate access standards for participating LTSS AEs within 9 months of certification. Standards under consideration include:
- Home care services initiated within 24 hours of acceptance of referral.
- Ability to meet all service needs of attributed patients for the services they receive from AE providers (including weekend and evening hours) unless the patient chooses to receive services from multiple providers.

      1.5.2   Commitment to provide timely and accurate data & reporting to support such standards.

2   Organizational Structure and Governance

A fundamental EOHHS objective is to promote the development of a new type of organization in Rhode Island Medicaid to promote a population health- focused and person-centered system of care. Such an organization must meet a core set of corporate requirements set forth in these requirements.

The intent of these requirements is:
- to ensure multi-disciplinary providers are actively engaged in a shared enterprise and have a stake in both financial opportunities and decision-making of the organization;
- to ensure that assets and resources intended to support Medicaid are appropriately allocated, protected, and retained in Rhode Island;
- to ensure that the mission and goals of the new entity align with the goals of EOHHS and the needs of the Medicaid population; and
- to ensure a structured means of accountability to the population served.

A qualified AE applicant will demonstrate its ability to meet all of the requirements of these certification standards including corporate structure and governance. A qualified applicant must be a legal entity incorporated within Rhode Island and with a federal tax identification number.

The AE applicant may be formed by two or more entities joining together for the purpose of forming an AE. Alternatively, a single entity that includes all required capabilities may be a qualified applicant.
- If the AE applicant is formed by two or more parties, it must be a distinct corporation and meet all the requirements for corporate structure and governance. It must have an identifiable governing body with sole and exclusive authority to execute the functions and make final decisions on behalf of the AE. The governing body must be separate and unique to the AE and must not be the same as the governing body of any other entity participating in the AE.
- If the applicant is a single entity, the AE's board of directors may be the same as that of the single entity. However, the single entity applicant must establish a Governance Committee with distinct obligations and authorities in management of the AE program. The composition of the Governance Committee must include participation of various constituencies as set forth below. The Governance Committee must have sole authority to make binding decisions regarding the distribution of any shared savings or losses to Affiliated Providers, Associate Providers or other contracted partners, as applicable.

Whether the applicant is a single-entity or a multiple entity AE:
- There shall be an established means for shared governance that provides all AE Providers

participating in savings and/or risk arrangements with an appropriate, meaningful proportionate participation in the AE's decision-making processes. The structure of the AE should ensure that Governing Board or Governing Committee members 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.

- The AE 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 LTSS, medical, behavioral health, and social needs.

- Governing Board of Directors or Governing Committee shall meet regularly, not less than bi-monthly (every other month)

- There must be sufficient community representation in the governance and decision-making of the entity.

Note that the requirements defined in Sections 2.2 -2.4 are consistent with the requirements for Comprehensive AE organizational structure and governance. Structurally, comprehensive AEs participating in the LTSS Pilot Program should not form LTSS specific governance structures, instead adapting the appropriate provider and community representation to support both programs.

EOHHS recognizes that the LTSS AE program is a pilot, intended to encourage the formation of new partnerships and collaborations across the continuum of LTSS services and structures that are not currently in place. As such, in Section 2.1 EOHHS has defined minimum LTSS AE pilot governance requirements for multiple entity applicants, as a pathway toward a more formal governance structure.

2.1 Multiple Entity AE Applicant: Minimal LTSS AE Pilot Structure

2.1.1   An identified **lead agency** with administrative and reporting responsibilities for the entity

2.1.2   **A contractual agreement**, between participating providers, outlining the program expectations for the LTSS AE, including financial terms, attribution expectations

2.1.3   **Data sharing agreements** between participating providers. The lead agency must have demonstrated capability and authority to securely receive and send member level enrollment, financial and quality data on behalf of and between all participating providers

2.1.4   **Governing Committee**, in accordance with Section 2.4, that is distinct and separate from the governing board of any specific AE participant, has responsibility for oversight of the AE program, and has sole authority to make binding decisions regarding the distribution of any shared savings or losses to

Affiliated Providers, Associate Providers or other contracted partners, as applicable.

- • Governing Committee must meet regularly, not less than bi-monthly (every other month), with responsibility for monitoring and oversight of the AE program and including review of various committees and operating reports pertinent to the work of the AE program.

2.1.5 **Statement of Purpose** – Mission Statement that aligns with EOHHS goals Documented commitment to progression to an integrated and accountable system of care with a primary concern for the health outcomes of attributed members, the progressive use of outcome-based metrics to assess progress and success, and particular concern for those with the most complex set of LTSS, medical, behavioral health, and social needs.

2.1.6 **Community Advisory Committee**, consisting of at least 5 persons who are either attributed patients or their caregivers who are representative of the populations served by the AE or advocates.

2.1.7 Commitment and plan specifying **proposed transition** to meet the requirements as specified for either a distinct corporation (2.2) or a Single Entity Applicant (2.3) (if applicable).

2.2 Multiple Entity Applicant - Distinct Corporation

2.2.1 **Separate and distinct corporation**, recognized and authorized under applicable Rhode Island State law and with an applicable Taxpayer Identification Number.

2.2.2 **Governing Board** must meet regularly and be separate and unique to the AE and not the same as a governing board of any specific AE participant.

2.2.3 **Statement of Purpose** – Mission Statement that aligns with EOHHS goals Committed to progression to an integrated and accountable system of care with a primary concern for the health outcomes of attributed members, the progressive use of outcome-based metrics to assess progress and success, and particular concern for those with the most complex set of LTSS, medical, behavioral health, and social needs.

2.2.4 **By-Laws** set forth Membership on the Board of Directors with voting rights that is inclusive of the minimum requirements set forth by EOHHS.

2.2.5 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.

2.2.6 Include **quarterly progress dashboards** to monitor quality and cost effectiveness to support the MCO's and AE's ability to monitor and improve performance.

2.2.7 A **Compliance Officer** with an unimpeded line of communication with the Board and who is not the legal counsel for the Board.

2.2.8 **Community Advisory Committee**, consisting of at least five (5) persons who are either attributed patients or who are appropriate family representatives of those beneficiaries or advocates who are representative of the populations served by the AE or advocates.

2.2.9 **Fiduciary and Administrative Responsibility** Resides with Board of Directors. The AE's administration must report exclusively to the Governing Board through the AE's chief executive officer

2.2.10 Defined **conflict of interest** provisions that:

- Require each member of the governing body, sub-committees, employees and consultants to disclose relevant financial interests;
- Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise; and
- Address remedial action for members of the governing body that fail to comply with the policy.

2.3 Single Entity Applicant

2.3.1 **Established corporation**, recognized and authorized under applicable Rhode Island State law and with an applicable Taxpayer Identification Number.

2.3.2 The AE must establish a **Governing Committee** that is distinct and separate from the governing board of any specific accountable entity participant for oversight of the quality of the AE's services to attributed members, providing guidance in decisions related to program design and implementation, and with sole authority to make binding decisions regarding the distribution of any shared savings or losses to Affiliated Providers, Associate Providers or other contracted partners, as applicable.

2.3.3 **Governing Committee** must meet regularly, not less than bi-monthly (every other month), with responsibility for monitoring and oversight of the AE program and including review of various committees and operating reports pertinent to the work the AE program.

2.3.4 **Statement of Purpose** – Mission Statement that aligns with EOHHS goals Committed to progression to an integrated and accountable system of care with a primary concern for the health outcomes of attributed members, the progressive use of outcome-based metrics to assess progress and success, and particular concern for those with the most complex set of LTSS, medical, behavioral health, and social needs.

2.3.5 **Established charter** that sets forth Membership on the Governing Committee with a defined scope of authority and voting rights that is inclusive of the minimum requirements set forth by EOHHS.

2.3.6 **Inclusion of governance subcommittees** with a distinct focus on Medicaid, including an Integrated Care Committee, a Quality Oversight Committee, and a Finance Committee.

2.3.7 Include **quarterly progress dashboards** to monitor quality and cost effectiveness to support the MCO's and AE's ability to monitor and improve performance.

2.3.8 A designated Compliance Officer with an unimpeded line of communication with the Board of Directors of the single entity.

2.3.9 **Community Advisory Committee**, consisting of at least five (5) persons who are either attributed patients or who are appropriate family representatives of those

beneficiaries or advocates who are representative of the populations served by the AE. If 51% or more of the voting members of the Board of Directors of the single entity consists of consumers of the services of the single entity a separate Community Advisory Committee is not required for the AE. In such case the Governing Committee of the AE shall include as a voting member at least one consumer per attributed population who is (a) on the single entity's Board of Directors and (b) is an attributed Medicaid beneficiary or an appropriate family representative of an attributed beneficiary.

2.3.10 Defined **conflict of interest provisions** that:

2.3.10.1 Require each member of the governing committee, sub-committees, employees and consultants to disclose relevant financial interests;

2.3.10.2 Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise; and

2.3.10.3 Address remedial action for members of the governing committee that fail to comply with the policy.

2.4 Governing Board or Governing Committee Members: Inter-Disciplinary Partners Joined in a Common Enterprise

2.4.1 **Core Premises**

Shared governance provides all AE participants with an appropriate, meaningful proportionate control over the AE's decision-making processes and including oversight of the quality of the AE's services to attributed members, providing guidance in decisions related to program design and implementation, and with sole authority to make binding decisions regarding the distribution of any shared savings or losses to Affiliated Providers, Associate Providers or other contracted partners, as applicable

2.4.1.1 Multi-disciplinary in composition and organizationally integrated in practice.

2.4.1.2 Defined, transparent structure ensuring partners have shared and aligned incentives.

2.4.1.3 Leverage strengths of partners toward an integrated person-centered system of care.

2.4.2 **Board or Governing Committee Membership**

2.4.2.1 The majority of voting members of the Board or the Governing Committee shall be provider representatives from participating Partner or Affiliate provider organizations, provided that at least three members shall be LTSS providers and one member shall be a behavioral health provider.

2.4.2.2 Minimal representation requirements, for each population certified to serve

2.4.2.2.1 **Children**: Pediatrician, pediatric LTSS provider, pediatric behavioral health provider, pediatric representative member of consumer advisory

committee, CBO provider of age appropriate supports

2.4.2.2.2 **Adults:** Geriatrician, representative member of Consumer Advisory Committee, CBO provider of age appropriate social supports

2.5 Compliance

2.5.1 Provisions for assuring compliance with State and Federal laws and regulations regarding Medicaid and Medicare

2.5.2 Policies and procedures related to debarred providers, discrimination, protection of privacy, and use of electronic records

2.5.3 Policies and procedures for compliance with anti-trust rules and regulations

2.5.4 Compliance Officer: A single entity AE may use an existing Corporate Compliance Officer in this role provided that it the Compliance Officer's scope of activities includes compliance with AE program requirements and at least twice annual reporting to the Governance Committee.

2.6 Required - an Executed Contract with a Medicaid Managed Care Organization

2.6.1 Required for attribution, participation in EOHHS defined Alternative Payment Models and shared savings opportunities, participation in EOHHS' Health System Transformation Program (HSTP) Incentive program

2.6.2 Comport with EOHHS defined delegation rules re: AE/MCO distribution of functions

3 Leadership and Management

AEs must have a single, unified vision and a clear leadership structure, with the commitment of senior leaders of the participating providers and backed by the required resources to implement and support the vision. There should be a clear plan to 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 AE 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

3.1.1 **For a multiple entity AE applicant with a minimal LTSS pilot structure as described in section 2.1,** the LTSS AE must have a specified, dedicated LTSS AE Program Director

3.1.2 For a multiple entity AE as described in Section 2.2, there must be a Chief Executive responsible for AE operations. Appointment of and removal of the chief executive is under the control of the governing board. The multiple entity AE shall have a defined Medicaid AE Program Director to provide core direction to this program and who reports directly to the Chief Executive Officer if the Program Director is a different person than the Chief Executive Officer

 3.1.2.1 For those multiple entity AEs that are both Comprehensive and Specialized there must be a specified, dedicated Pilot LTSS AE Program Manager

3.1.3 For a single entity AE, a defined Medicaid AE Program Director to provide core direction to this program and who works directly with the Governing Committee and is responsible to the Chief Executive Officer, Executive Director, or Administrator of the single entity.

 3.1.3.1 For those single entity AEs that are both Comprehensive and Specialized there must be a specified, dedicated LTSS AE Program Manager .

3.2 Management Structure and Staffing profile

3.2.1 A clearly defined management structure that demonstrates how the various component parts of the AE will be integrated into a coordinated system of care, regardless of whether the AE is a separate and distinct corporation or under a lead agency. May include specific management services agreements with MCOs or subcontracts under the direction of the AE.

3.2.2 Key capabilities include:

 3.2.2.1 Integrated Care Management;

 3.2.2.2 IT Infrastructure/Data Analytics;

 3.2.2.3 Quality Assurance and Tracking;

 3.2.2.4 Finance - Infrastructure for unified financial leadership and systems, financial modeling capabilities and indicators, and designing incentives that encourage coordinated, effective, efficient care.

3.3 Ability to manage care under a total cost of care (TCOC) or other alternative payment model.

3.3.1 A defined approach to manage care under a total cost of care (TCOC) approach. Total cost of care calculations are based on the full scope of LTSS benefits as defined in Table A.. Although the AE will not have direct responsibility for providing that full scope of services it will need to have a defined, disciplined approach for impacting the total scope of services needed by attributed members.

3.3.2 As of the date of issuance of these certification standards, EOHHS is working to refine the requirements that AEs will need to meet to be able to demonstrate adequate financial protections to support proportionate financial risk. It is anticipated that over time, shared savings and incentive opportunities will be in relation to shared risk. As these requirements are finalized, AEs will be asked to provide constructive comments as to appropriate standards and defined pathways and timeframes to move into risk relationships.

4   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 (inclusive of functional status 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.

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. As such, many of these required capacities and capabilities may best be achieved through various forms of partnerships with MCOs and others to avoid duplicative infrastructure.

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.

4.1   Core Data Infrastructure
Ability to receive, collect, integrate, utilize, and share person-specific clinical, functional status and health information.
4.1.1 **Patient registries** – shared patient lists (e.g. PCP, BH provider, Care management) to ensure providers are aware of patient engagements.
4.1.2 **Share/receive secure data -** demonstrated capability and authority to securely receive and send member level enrollment, financial and quality data on behalf of and between all participating providers
4.1.3 **EHR capacity:** Ability to share information with partner and affiliate providers.

4.1.4 **Current Care -** Demonstrate that at least 60% of AE patients are enrolled in CurrentCare and/or document a plan to increase CurrentCare enrollment.

4.1.5 **Data quality -** Able to ensure data quality, completeness, consistency of fields, and definitions.

4.2 Provider and Care Managers' Access to information

4.2.1 **Look up capability** – connecting clients, client records and providers (care management dashboard, shared messaging).

4.2.2 Ability to review **medication lists**.

4.2.3 **Referral management** - Ability to create and electronically rout referrals; receive information back.

4.2.4 Ensure capability to communicate **via shared messaging**.

4.2.5 **Provider Alerts & notifications**: Hospital admissions & discharges

4.2.6 **Early warning system** -- Established methods to alert, engage the care management team to critical changes in utilization, critical incidents. Alerted before bearing the full burden of costs.

4.3 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. Such tools should incorporate social risk factors (e.g., housing, family support systems) into risk profiling, by population.

4.4 Staff Development – Training

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

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

5   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 recognized best practices locally and 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.

5.1 Key Population Health Elements

A qualified applicant will be prepared to describe its approach to population health management inclusive of the following:

5.1.1 Population based

5.1.2 Data driven

5.1.3 Evidence based

5.1.4 Client centered: Strength-based individual, family, and caregiver support

5.1.5 Recognizes/addresses the determinants of health. Creates programmatic interventions by sub-population.

5.1.6 Team based, including care management and care coordination, effectively manages transitions of care, Community Health Workers as integral partners

5.1.7 Integration of behavioral health

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

5.2 Social Determinants of Health

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

5.2.2 Evaluate the social needs of their members and ensure that Attributed Members receive appropriate care and follow-up based on their identified social needs. EOHHS requires that such interventions shall be provided through strong demonstrated in-house capacity and/or through affiliations with community partners to assertively ensure member-specific interventions. The specific collaborations shall be at the discretion of the AE and the community based organization(s) {CBO}.

5.3 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 expected to work 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:

5.3.1 Healthcare workforce transformation planning

5.3.1.1 Participate on the EOHHS Healthcare Workforce Transformation Committee and/or other related committees to provide ongoing assessment of healthcare workforce transformation needs and strategies.

5.3.1.2 Participate in periodic employer surveys of healthcare workforce development needs and opportunities.

5.3.2   Healthcare workforce transformation programming
Develop Memoranda of Understanding with URI, RIC, CCRI and/or other education and training providers regarding shared healthcare workforce transformation efforts, such as:

5.3.2.1   to assist in educational planning, curriculum development, instruction, clinical training, research, and/or other educational activities related to healthcare workforce transformation.

5.3.2.2   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.

5.3.2.3   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.

5.3.2.4   Develop partnerships with secondary schools, public workforce development agencies, and/or community based organizations to develop career pathways that prepare culturally and linguistically-diverse students and adults for entry level jobs leading to career advancement in health-related employment.

6   Integrated Care Management

The AE shall create an organizational approach to care integration and document such approach in a plan that defines a person-centered strategy to integrate, coordinate, and manage services for individuals at highest risk for poor outcomes and avoidable high costs. The integration approach will be developed in collaboration with providers across the care continuum and incorporate evidence based strategies into practice.

A successful LTSS Pilot AE will have tools and processes in place to frequently and systematically assess the attributed population, and identify individuals who are most at risk for institutional and hospital care or admission, considering medical, social and environmental factors such as support systems/caregiver exhaustion, social isolation and medical complexity.

The AE will also demonstrate the ability to rapidly and effectively respond to changes in a condition with interventions and care plan refinements as needed to enable such individuals to remain in the community. Such entities shall demonstrate protocols and/or defined strategies to work collaboratively with providers across the continuum of LTSS services as defined in Table A to ensure safe, timely and appropriate transitions between care settings, including especially transitions from or to a hospital or nursing facility.

 An AE should have a care coordination team with specialized expertise pertinent to the characteristics of each targeted population. 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.

EOHHS notes that there are existing integrated care management capacities in place (e.g., MCO, DHS, DEA). As such, many of these required capacities and capabilities might best be achieved through various forms of partnerships with MCOs and others to avoid duplicative infrastructure.

6.1 Systematic Processes to Identify Patients for Care Management

6.1.1 Processes to systematically and regularly assess the attributed population for risk, including after critical incidents (e.g., falls), acute events (e.g., hospitalizations, ED visits), social and environmental indicators (e.g. support system/caregiver exhaustion, social isolation)

6.1.2 Processes to systematically track transitions of care between facilities and the community, including effective referral and follow up.

6.1.3 Ability to rapidly adapt risk assessment and escalate high risk individuals in response to changes in a condition, to activate care management team based on patient needs, and to help avoid use of unnecessary services, particularly emergency department visits or hospitalizations, or enable such individual to remain in the community.

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

Care Management team – with evidence of ability and tools to manage care

6.2.1 Deliver **evidence based care management to individuals at highest risk** for poor outcomes based on identified core principles and related processes specified in the care plan. Should be able to direct and/or organize the majority of care for the attributed population.

6.2.2 Develop protocols and/or defined strategies to work collaboratively at key points of life transitions, to ensure safe **transitions between care settings**, including especially transitions from or to a hospital or nursing facility

6.2.3 **Well defined set of providers** – can vary, but in all cases, must represent LTSS caregivers. **Should also include** PCPs, behavioral health, and expertise in social determinants (e.g., Community Health Worker, Social Worker) as needed.

6.2.4 Greatest impact and member benefit if care (handoffs) **remain *within* the network o**f participating providers where possible – to promote coordination, accountability and efficiency.

6.2.5 **Population specific expertise** to support populations served, including children with special health care needs, non elderly adults with disabilities and/or elderly adults

6.2.6 Specialized expertise and staff for work with **distinct sub-populations**.

6.2.6.1 Integration of behavioral health services, including mental health and substance use treatment.

6.2.6.2 Coordination of care for persons requiring services to address social determinants.

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, social isolation, social determinants, behavioral health needs, and potentially avoidable hospital readmission strategies and improvement plan.

6.3.2 Individual care plans

6.3.2.1 Culturally and linguistically appropriate care management.

6.3.2.2 Based on assessment, development of 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.

6.3.2.3 Driven by the patient's priorities, motivations, and goals, ensures that the member is engaged in and understands the care she will receive.

6.3.2.4 Incorporates mitigation strategies for social determinants of health, E.g., housing security, nutrition, food security, physical/activity and nutrition, safety, safe environment, criminal justice involvement.

6.3.2.5 Inter-disciplinary across providers, with specific attention to transitions of care between home/community and institutional settings.

6.3.2.6 Engages and supports family and informal caregivers, as appropriate.

6.3.3 Educates and trains providers across the full continuum of care regarding the care integration strategy and provider requirements for participation.

6.3.4 Developed in coordination with other care management resources available to the patient.

6.4 Defined Methods for Rapid Intervention and Response

6.4.1 Processes and strategies for rapid and effective response to changes in individual risk status/condition with interventions and care plan refinements as needed to enable such individuals to remain in the community.

6.4.2 Protocols and/or defined strategies to work collaboratively at key points of life transitions, to ensure safe transitions between care settings, including especially transitions from or to a hospital or nursing facility .

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 also 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. Recognizing that many of these new technologies for health status monitoring and health promotion are not currently covered benefits, EOHHS anticipates that successful AEs will begin by promoting such products and encouraging their use, and anticipates that infrastructure investments (including HSTP incentive funds) may be utilized to develop such capacities.

7.1 Defined Strategies to Maximize Effective Member Contact and Engagement
7.1.1 Able to effectively outreach to and connect with hard-to-reach high need target populations.   Specific to attributed populations served.
7.1.2 Communication approach that recognizes highly complex, multi-condition high cost members.
7.1.3 Identified population-specific strategies, methods to actively develop a trusting relationship through the use of evidence-based and patient-centered engagement methods.
7.1.4 Use of culturally competent communication methods and materials with appropriate reading level and communication approaches.

7.2 Implementation and Use of New Technologies for Member Engagement, Health Status Monitoring, and Health Promotion.
7.2.1 Established capabilities to educate members/promote the use of technologies for member engagement that may not be covered by Medicaid but might support/enable individuals to remain in the community impact on the and educate members and caregivers on their use, including, but not limited to:

7.2.1.2 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).
7.2.1.3 Products that support monitoring and maintaining the functional status of older adults in their homes (e.g., fall detection technologies, environmental sensors, video monitoring).
7.2.1.4 Other Technologies and products that support both informal and formal caregivers in providing timely, effective assistance.

7.2.2 Established capabilities to leverage relevant, cost effective technologies including, but not limited to:
7.2.2.2 Demonstrated use of social media applications to promote adherence

to treatment.

   7.2.2.3   Demonstrated use of technologies that enable older adults to stay socially connected

   7.2.2.4   Demonstrated use of telemedicine.

8   Quality Management

An AE must have a defined quality assessment and improvement plan, overseen by a Quality Committee.

8.1 Quality Program

   8.1.1   The AE will maintain an ongoing Quality Committee that reports to the Governing Board or Governing Committee of the AE. The AE shall have a defined quality program overseen by qualified healthcare professional responsible for the AE's quality assurance and improvement program

   8.1.2   The AE will have a Quality Committee that will minimally include individuals with clinical, operational, and quality measurement expertise for the attributed population and that includes an individual from a community based service organization who is familiar with how to address the social determinants of health.

8.2 Quality Performance Measures

The AE shall identify and have the ability to report on a set of core quality metrics that enable the AE to monitor performance, emerging trends and quality of care and to use these results to improve care over time. The AE will have the ability to track and report on key performance metrics. Performance metrics shall include consumer reported quality measures.

   8.2.1   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. The AE may also be eligible for other APMs.

Attachment B
Definitions of Services that may Qualify for Attribution

Services for Adults

Homemaker
Homemaker Services consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him/herself or others in the home. Homemakers shall meet such standards of education and training as are established by the state for the provision of these activities.

Personal Care Services
Personal Care Services provide direct support in the home or community to an individual in performing Activities of Daily Living (ADL) tasks that he/she is functionally unable to complete independently due to disability. Personal Care Services may be provided by a Certified Nursing Assistant which is employed under a State licensed home care/home health agency and meets such standards of education and training as are established by the State for the provision of these activities.

Adult Day Services
Adult Day Health services are for frail seniors and other adults who need supervision and health services during the daytime. Adult Day Health programs offer nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting. Adult Day Health services are for adults who return to their homes and caregivers at the end of the day.

Assisted Living
Assisted Living includes personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed community care facility in conjunction with residing in the facility. This service includes twenty-four (24) hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. An Assisted Living residence is any residence licensed by the state pursuant to R.I.G.L. §23.17-4 and regulated by the Department of Health in accordance with R23-17.4-ALR.

Supportive Living Arrangements/Shared Living
Shared Living is a supported living arrangement in which personal care and services, homemaker, chore, attendant care, companion services, and medication oversight (to the extent permitted under State law) are provided in a private home by a principal care provider

who lives in the home. Shared Living services are furnished to adults who receive these services in conjunction with residing in the home.

Long-Stay Nursing Facility Care
Long-Stay Nursing Facility Care is long-term services and supports provided in a licensed nursing facility. Individuals who receive Long-Stay Nursing Facility Care reside in a nursing facility for non-skilled or convalescent care.

Services for Children

Pediatric Private Duty Nursing
Pediatric Private Duty Nursing is hourly, skilled nursing care in a client's home. Private duty nursing provides more individual and continuous skilled care than can be provided during a skilled nursing visit through a home health agency. The intent of private duty nursing is to support the child with complex medical issues to remain at home. Private duty nursing services are provided for children living at home who have been diagnosed with moderate to severe physical conditions. These children have chronic health care needs that require health and related services beyond those required by children generally.

Certified Nursing Assistant Services
Certified Nursing Assistants are a class of paraprofessionals who assist individuals with physical disabilities, mental impairments, and other health care needs with their Activities of Daily Living (ADL) and provide bedside care — including basic nursing procedures — all under the supervision of a Registered Nurse.