Rhode Island Accountable Entity Program Total Cost of Care Technical Guidance for Program Year 3

Rhode Island Executive Office of Health and Human Services
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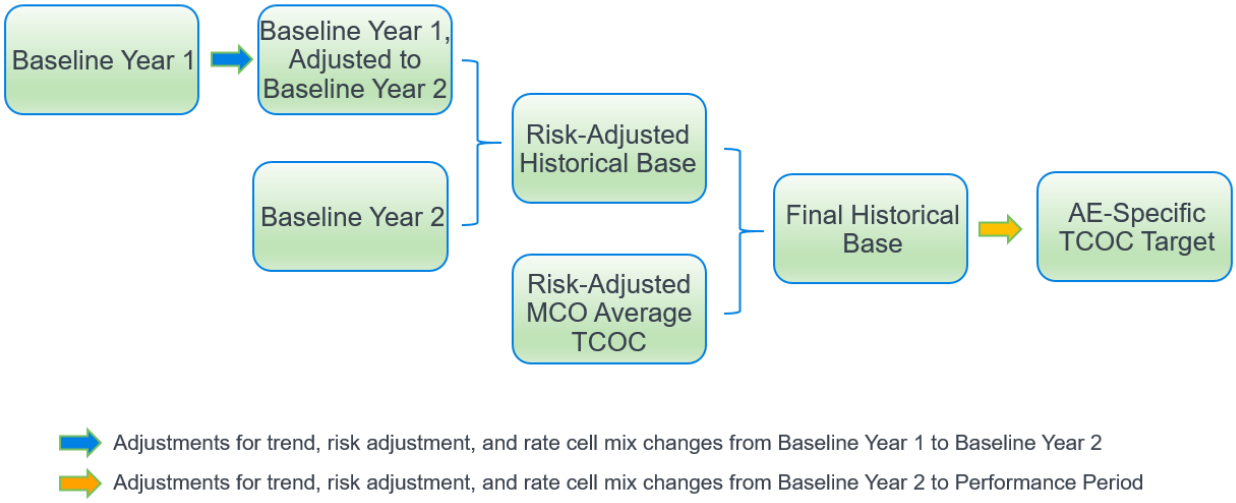
Program Year 3: Total Cost of Care Technical Guidance

The process for determining the TCOC Expenditure Target involves a series of adjustments. These adjustments are illustrated at a high level in the figure below. The adjustments are described in detail in Sections 1 through 3.



1. Calculate Historical Base

a. AE-Specific Historical Cost Data

The TCOC Historical Base will include two years of AE-specific historical cost data. Claims and enrollment in each year will be limited to members attributed to the AE as of the final quarterly attribution for that year. The AE's provider roster as of March 31 of the Performance Year should be used when determining claims and enrollment in the Baseline Years. The two Baseline Years will be:

I. **Baseline Year 1:** 12-month period ending 2 years before the start of the performance period.

II. **Baseline Year 2:** 12-month period ending 1 year before the start of the performance period.

Claims will be excluded if they were paid more than 6 months after the end of the Baseline Year in which they were incurred. No adjustments will be made for claims incurred but not paid (IBNP).

Member months will include all months during the year for attributed members in which a capitation payment was made to the MCO. If the MCO-AE contract does not have at least an average of 2,000 members attributed during each of the two historical Baseline Years (i.e. 24,000 member months in each year), EOHHS will evaluate whether the MCO-AE contract will be eligible for shared savings/(losses) in the Performance Period and may prescribe an alternative TCOC methodology. If the MCO-AE contract does meet the minimum attributed membership in the two-year historical base period,

the MCO-AE contract will still be eligible for shared savings/(losses) even if the average attributed members fall below 2,000 in the Performance Period.

b. Covered Services

The TCOC expenditures in the Historical Base and Performance Period will include all costs associated with covered services that are included in EOHHS's contract with MCOs for the Performance Period. This does include maternity delivery services, which are capitated through kick payments rather than per member capitation. The risk adjustment mechanism (described later) will mitigate the risk to the AE and MCO of changes in the number of deliveries between the Baseline Years and the Performance Period.

The service cost will be measured using fee-for-service claims paid by the MCO and encounter expenditures for sub-capitated vendors contracted by the MCO. Payment amounts associated with sub-capitated vendor encounters will be consistent with the amounts included on the encounters sent to EOHHS. The following items will be explicitly excluded from the covered services definition:

i. Expenditures for services paid outside the MCO fee-for-service payment system or sub-capitated vendor claims payment system (e.g. offline payments or other services invoiced).

ii. Payment for non-claims based case management programs.

iii. Services covered under stop-loss provisions between EOHHS and the MCO in the Performance Period, as specified in the EOHHS/MCO Contract for Medicaid Managed Care Services.

iv. Health System Transformation Project (HSTP) performance incentive payments and Care Transformation Collaborative (CTC) payments.

v. Value-added services provided by the MCO.

vi. Recoveries made outside the MCO or sub-capitated vendor claims payment system, such as reinsurance, pharmacy rebates, or pay-and-chase third party liability recoveries.

vii. Amounts attributable to pharmacy benefit manager (PBM) administrative spread, i.e. the difference in the amount paid by the MCO to the PBM and the amount paid by the PBM to the pharmacy. To the extent that an MCO is unable to utilize the amount paid to the pharmacy, an adjustment will be made as described in section 1.f.

viii. Services included in the managed care program in the Baseline Years that are not covered under the MCO contract in the Performance Period.

The MCOs will report expenditures for the above services excluded from the TCOC calculation for the Baseline Years and Performance Period for review by EOHHS for reasonableness and to determine whether an adjustment is required for these services as described in section 1.f below.

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

The TCOC expenditures in the Historical Base and Performance Period will be adjusted to exclude costs in excess of a defined threshold for an individual member in a single year. The threshold is applied after removal of covered services described above, but prior to any other adjustments, such as risk adjustment and trend. This threshold will not be pro-rated for members with less than 12 months of enrollment in a given year. The threshold will be $100,000 for SFY 2018 and will be indexed in future years to reflect trends, program and policy changes, and managed care efficiency adjustments. The thresholds for SFY 2018-SFY2020 are shown below. The thresholds for SFY 2021 and subsequent years will be provided prior to the start of each year.

- SFY 2018: $100,000
- SFY 2019: $104,800
- SFY 2020: $109,800

After this adjustment, the TCOC expenditures in each rate cell and year will be divided by applicable member months in the same year to arrive at a TCOC Per Member Per Month (PMPM) Expenditures.

d. Adjust for Trend Assumptions

Baseline Year 1 will also be adjusted to account for trends, program and policy changes, and managed care efficiency adjustments, consistent with the development of the medical component of capitation rates being paid to MCOs by EOHHS. These adjustments will align generally with the cumulative adjustments made to Baseline Year 1 in the medical portion of capitation rates by rate cell. As needed, EOHHS will modify these adjustments to reflect only services included in TCOC expenditures; therefore, the adjustment factors by rate cell may differ from the values included in the capitation rate certification. The adjustments will be applied separately by rate cell**.** A sample calculation for the trend adjustment is shown in Appendix B.

e. Adjust for a Changing Risk Profile

To account for changes in the risk profile of an AE's attributed patient population over the two years in the Historical Base, a risk adjustment methodology will be applied. This adjustment is intended to make the TCOC PMPM expenditures in Baseline Year 1 more comparable to Baseline Year 2; therefore, the adjustment will be applied to Baseline Year 1 only. A separate risk adjustment, described later in this document, will be applied to the entire Historical Base to reflect changes in risk profile from Baseline Year 2 to the Performance Period.

Risk adjustment will be applied separately to each rate cell, accounting for changes in the average risk score in that rate cell between Baseline Year 1 and Baseline Year 2. For instance, if the average risk score for attributed members in the Medicaid Expansion Females 19-24 rate cell is 1.100 in Baseline Year 1 and 1.200 in Baseline Year 2, the TCOC PMPM Expenditures in Baseline Year 1 will be multiplied by a factor

of (1.200 / 1.100) = 1.091. After this risk adjustment factor is applied, the Historical Base TCOC by rate cell will be aggregated using the mix of rate cells for attributed members in Baseline Year 2. A sample calculation for the risk adjustment is shown in Appendix C.

Encounter data will be used for the development of average risk scores by rate cell. A concurrent risk adjustment algorithm will be used, meaning that the time period used to collect diagnosis codes and/or prescription drug claims will align with the time period being risk-adjusted. The risk adjustment software for this adjustment will be determined by EOHHS at the start of each Performance Period. The same software and version will be used in both Baseline Years and the Performance Period.

Within each program year, risk scores will be normalized in each Baseline Year and Performance Period such that the average statewide risk score (including all MCOs) in each rate cell remains constant over time. Risk scores may be recalibrated before calculating Baseline Year and Performance Period risk scores in the following program year.

f. Special adjustments for changes in payment mechanisms or reporting

EOHHS reserves the right to make an additional adjustment to account for changes in MCO payment mechanisms or expenditure reporting between the Baseline Years and Performance Period. EOHHS will review the expenditures excluded from the TCOC calculation, as outlined in section 1.b, to ensure consistent treatment in the Baseline Years and Performance Year. The need for an adjustment will be considered on a case-by-case basis, and if determined to be necessary, will be developed by EOHHS. Examples of situations that may require this adjustment include:

i. A change in services covered by sub-capitation arrangements materially impacts the reporting of those services.

ii. A material amount of offline or lump sum payments were made in the Baseline Years and not the Performance Period, or vice versa.

iii. A change in reporting of recoveries outside of the claims payment system impacts the reported expenditures in the Baseline Years or Performance Years.

iv. The MCO is unable to remove PBM administrative spread from the experience at the member level.

v. Claims completion after six months of run-out is estimated to vary significantly between the Baseline Years and Performance Period in a manner that materially impacts the TCOC target and/or savings calculations.

g. Blend Baseline Years

After applying the trend adjustment and risk adjustment to Baseline Year 1, the TCOC PMPM Expenditures for both Baseline Years will be combined to arrive at the Risk-

Adjusted Historical Base. The Baseline Years will be weighted consistently with the MCO rate setting for the State Fiscal Year aligning with the Performance Period. A sample calculation is shown in Appendix D.

2. Adjust Historical Base Relative to Market Average

In order to prospectively establish an AE's TCOC Expenditure Target, an additional adjustment will be made to the Historical Base to reflect the AE's historical experience relative to peers. This adjustment is required because AE's that have already achieved high levels of efficiency will have difficulty continuously achieving trends below the market rate. However, these AE's provide value to the MCOs by maintaining low expenditures relative to the market.

This adjustment will be determined by comparing the AE's Risk-Adjusted Historical Base to the Risk-Adjusted Historical Base for all of the MCO's members. This includes members attributed to other providers who are not included in any AE. The Risk-Adjusted Historical Base for all of the MCO's members will be calculated using the same methodology as the AE's Risk-Adjusted Historical Base.

The adjustment will be a multiplicative factor applied to all rate cells in the Historical Base. The factor will be calculated as follows:

a. Calculate Risk-Adjusted Historical Base for the AE.

b. Calculate Risk-Adjusted Historical Base for all of the MCO's members.

c. For each rate cell, adjust the result of (b) by a factor equal to the average Baseline Year 2 risk score for the AE's members divided by the average Baseline Year 2 risk score for all of the MCO's members. This is intended to normalize the MCO average costs in each rate cell to be comparable to the AE's attributed members.

d. Aggregate the result of (c) by using the AE's mix of members by rate cell in Baseline Year 2. This is intended to normalize the MCO's aggregate risk-adjusted costs to be comparable to the AE's attributed member mix.

e. Subtract the result of (a) from the result of (d). If this difference is positive, multiply by the Below Market Weight. If this difference is negative, multiply by the Above Market Weight. These weights will vary by Program Year, as shown in the table below.

Program Year	Below Market Weight	Above Market Weight
1	10%	0%
2	10%	0%
3	10%	0%
4	20%	10%
5	30%	15%

f. Divide the result of (e) by the Risk-Adjusted Historical Base for the AE (a) and add 1.00. This results in a factor that will be applied to the AE's Historical Base.

A sample calculation of the development of this factor is shown in Appendix E.

Applying this multiplicative factor to the all rate cells in the Risk-Adjusted Historical Base will result in the Final Historical Base.

3. Calculate TCOC Expenditure Target for the Performance Period

Once the Final Historical Base is established, this base will be trended forward into the performance period to create an AE-specific TCOC Expenditure Target.

a. Historical Base with Required Trend Assumptions

The Final Historical Base will be adjusted to account for trends, program and policy changes, and managed care efficiency adjustments, consistent with the development of the medical component of capitation rates being paid to MCOs by EOHHS. These adjustments will align generally with the cumulative adjustments to the medical portion of capitation rates by rate cell. As needed, EOHHS will modify these adjustments to reflect only services included in TCOC expenditures; therefore, the adjustment factors by rate cell may differ from the values included in the capitation rate certification. Consistent with Section 1.f, EOHHS may also make special adjustments for payment mechanisms or reporting between the Historical Base and the Performance Period.

The adjustments will be applied to the AE separately by rate cell. Prior to the start of the Performance Period, a Preliminary AE-specific TCOC Expenditure Target will be established using the AE's mix of rate cells in Baseline Year 2. The Final AE-specific TCOC Expenditure Target will be adjusted for changes in risk profile and rate cell mix between Baseline Year 2 and the Performance Period, as described below. As needed, EOHHS will also adjust the prospective adjustments for trends, program and policy changes, and managed care efficiency adjustments for any capitation rate amendments made after the Preliminary AE-specific TCOC Expenditure Target was established.

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

A risk adjustment methodology will be applied to account for changes in the risk profile of an AE's attributed patient from Baseline Year 2 to the Performance Period. The methodology will be consistent with the risk adjustment methodology used in developing the adjusted historical base as described in Section 1.e of this document and the example in Appendix C. Risk adjustment will be applied separately to each rate cell, accounting for changes in the average risk score in that rate cell between Baseline Year 2 and the Performance Period. For instance, if the average risk score for attributed members in the Medicaid Expansion Females 19-24 rate cell is 1.200 in Baseline Year 2 and 1.300 in the Performance Period, the TCOC expenditures in the

Historical Base will be multiplied by a factor of (1.300 / 1.200) = 1.083. After this risk adjustment factor is applied, the Historical Base TCOC by rate cell will be aggregated using the mix of rate cells for attributed members in the Performance Period. The result of this step is the Final AE-specific TCOC Expenditure Target.

EOHHS reserves the right modify the Final AE-specific TCOC Expenditure Target after the Performance Period for extraordinary and unforeseen circumstances. For instance, if MCO reimbursement for non-AE providers materially changes, it may have unintended consequences on the TCOC Expenditure Target.

4. Calculate Actual Expenditures for the Performance Period

a. Calculate Actual Expenditures Consistent with the Historical Base Methodology

The TCOC methodology will be based on a Performance Period of 12 months aligned with the State Fiscal Year. Actual Expenditures for the Performance Period will be calculated consistent with the Historical Base methodology as described in Sections 1.b and 1.c of this document. Claims will be excluded if they were paid more than 6 months after the end of the Performance Period.

5. Calculate Shared Savings/(Loss) Pool

The Shared Savings/(Loss) Pool will be calculated as the difference between Actual Expenditures (Section 4) and Final AE-specific TCOC Expenditure Target (Section 3), after the following adjustments:

a. Minimum Savings Rate (One-Sided Model Only)

EOHHS requires a minimum savings rate (MSR) to limit the potential for Shared Savings payments related to cost reductions generated strictly due to the effect of random variation in utilization and spending in small populations**.** If the AE is in a "one-sided" model (described in Section 6), the Shared Savings Pool will be $0 if the difference between Actual Expenditures and TCOC Expenditure Target does not exceed the MSR. There is no MSR or minimum loss rate (MLR) for AEs participating in a "two-sided" model.

The MSR levels are calculated as a percentage of the TCOC Expenditure Target. The percentage varies based on the average number of attributed members in the Performance Period, as shown in the table below. The MSR for the AE will be determined by interpolating between the upper and lower bounds for the range based on the AE's number of attributed members. This table and methodology for "one-sided" models is consistent with the Medicare Shared Savings Program (MSSP)[1], with the exception that AEs with fewer than 5,000 members will have a 4.0% MSR.

Minimum Savings Rate by AE Size

[1] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V7.pdf, page 35

Average Attributed Members, Performance Period		Minimum Savings Rate	
Low End	High End	Low End	High End
0	4,999	4.0%	4.0%
5,000	5,999	3.9%	3.6%
6,000	6,999	3.6%	3.4%
7,000	7,999	3.4%	3.2%
8,000	8,999	3.2%	3.1%
9,000	9,999	3.1%	3.0%
10,000	14,999	3.0%	2.7%
15,000	19,999	2.7%	2.5%
20,000	49,999	2.5%	2.2%
50,000	59,999	2.2%	2.0%
60,000	Max	2.0%	2.0%

b. Impact of Quality and Outcomes

In cases where there are shared savings – that is, the Shared Savings Pool is positive after the application of the MSR/MLR, the pool will be adjusted based on an assessment of performance relative to a set of quality measures for the attributed population. An Overall Quality Score will be generated for each AE, according to the methodology detailed in *Attachment A: Quality Framework and Methodology for Comprehensive Accountable Entities.* In cases where the Shared Savings Pool is positive, the total Shared Savings Pool (inclusive of both the AE and MCO portions) will be multiplied by the Overall Quality Score. The Overall Quality Score must function as a multiplier, and may not include a gate; as such, any quality points earned must be associated with a share of the Shared Savings Pool.

In cases where there are not shared savings – that is, the Shared Savings Pool is $0 or there is a Shared Loss Pool instead - the Quality Score will not affect the Shared Savings/(Loss) Pool.

c. Risk Exposure Cap

In instances where the AE is responsible for downside risk, a Risk Exposure Cap may be established. The Risk Exposure cap can be expressed as a percentage of the AE-specific TCOC Expenditure Target or as a percentage of the AE's revenue.
Savings or losses that exceed 10% in any program year will trigger a review by EOHHS to determine if all Performance Period TCOC and target TCOC calculations are accurate. If the risk exposure cap is greater than or equal to 10%, the AE must present an actuarial analysis that estimates maximum potential loss. The actuarial analysis must be performed by an independent actuary and the results of the analysis be provided in a letter signed by the responsible actuary. This analysis will be used to substantiate the risk mitigation plan proposed by the AE. EOHHS reserves the right to

revise any errors and adjust for unforeseen programmatic or data issues that may be contributing to overstated losses or savings.

6. Determine AE Share of Savings/(Loss) Pool

AEs in shared savings-only models must be eligible to retain up to 50% of the Shared Savings Pool. The Shared Savings Pool is defined above in Section 5. Due to the COVID-19 emergency, EOHHS is no longer requiring that AEs assume downside risk in Program Year 3. However, should an AE and MCO negotiate a contract under which the AE will assume downside risk, EOHHS encourages the AE and MCO to adopt the minimum standards that EOHHS had adopted and intended to apply before the crisis: that AEs assuming downside risk be eligible to retain at least 60% of the Shared Savings Pool and be responsible for at least 30% of any Shared Loss Pool.

AE Shared Savings Model	AE Share of Savings	AE Share of Losses
Shared savings only	Up to 50% of Shared Savings Pool	N/A

7. Required Progression to Risk Based Arrangements

a. AEs qualified to assume downside risk

Certified AEs qualified to assume downside risk must demonstrate a progression of risk to include meaningful downside shared risk within three years of AE program participation, however PY3 will not be counted towards these three years due to the COVID-19 emergency. After development and implementation funding ends, AEs will be sustained based on their successful performance and associated financial rewards in accordance with their MCO contract(s).

EOHHS has defined "meaningful risk" based on learnings from other states, Office of the Health Insurance Commissioner (OHIC) requirements and rules under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The required progression of increasing risk for AEs qualified to assume downside risk is as follows:

	Shared Savings Cap *Maximum Shared Savings Pool*	**Risk Exposure Cap** *Maximum Shared Loss Pool*	**Risk Sharing Rate** *AE Share of Losses*
Definition	*A cap on the Shared Savings Pool, expressed as a percentage of the total cost of care*	*A cap on the Shared Loss Pool, expressed as a percentage of a) the total cost of care, or b) the annual provider revenue from the insurer under the contract*	*The percentage of the Shared Loss Pool shared by the provider with the insurer under the contract after the application of the risk exposure cap*
Year 1	At least 10% of TCOC	N/A	0
Year 2	At least 10% of TCOC	N/A	0

Year 3	At least 10% of TCOC	N/A	0
Year 4	At least 10% of TCOC	**At least** the lesser of 1% of TCOC; or 3% of AE Revenue	At least 30%
Year 5	At least 10% of TCOC	**At least** the lesser of 3% of TCOC; or 6% of AE Revenue	At least 40%

Note that for Program Year 4, EOHHS has aligned minimum downside risk requirements proportionally with the most marginal risk standards established by the OHIC. Alternative risk requirements for larger organizations or entities that include a hospital may be considered in the future as AEs develop risk-bearing capacity.

Additionally, approved TCOC contracts for Program Year 3 and beyond that include downside risk must be pre-qualified by OHIC to ensure that an AE has a risk mitigation plan sufficient to cover its maximum possible loss under such a contract. Details of OHIC's pre-qualification process for risk-bearing provider organizations is found in *Attachment B: Pre-Qualification of Accountable Entities Bearing Financial Risk.*

b. AEs not eligible to assume downside risk

In accordance with CMS guidance, EOHHS must ensure that Federally Qualified Health Centers receive and retain 100% of the Medicaid payments and cannot be put at risk for receiving less than PPS for FQHC services.

The goal of the Health System Transformation Project is transition from fee-for-service to a methodology that rewards quality and efficiency over volume of care. In lieu of downside risk arrangements that encourage and demonstrate this transformation, EOHHS will require that FQHCs remaining in upside only contracts demonstrate how they are progressing from volume to value. Due to the COVID-19 emergency, this requirement will not apply for PY3, but rather will be postponed until PY4.

Starting in PY4, progress from volume to value will be demonstrated by an analysis showing that key initiatives are addressing cost drivers to the AE and that they are or will create a positive return on investment for the AE's Medicaid Line of Business. Examples may include but not be limited to the replacement of existing processes with evidence-based processes, or incentives for cost reduction. EOHHS encourages AEs to propose initiatives that are aligned with efforts undertaken with other payers.

EOHHS-approved proposals must include:

Identification and description of two investments or changes that have a projected positive material ROI for the AE's Medicaid Line of Business;

Analysis of historic AE cost or utilization data supporting the AE's focus on the two investments or changes;

Quantification of the ROI of each investment or change over the next 3 years;

Evidence and justification of assumptions of the ROI analysis;

High level workplan for each of the two investments or changes, including how potential challenges will be addressed;

Schedule:

Proposal due to EOHHS: August 1, 2021

Notification of Approval to AE's: September 1, 2021

Division of responsibilities between MCOs and EOHHS

The calculations to determine shared savings/(losses) will be a collaborative effort between EOHHS and the MCOs. The table below summarizes the party responsible for each of the tasks described in this document, along with target dates for completion.

Task Number	Description	Responsible Party	Target Date to Complete Calculations
1.a-c	Summarize AE-Specific Historical Cost Data by Rate Cell and Baseline Year	MCO	3 months prior to start of Performance Period
1.d	Adjust for Trend Assumptions	EOHHS	1 month prior to start of Performance Period
1.e	Adjust for Changing Risk Profile	EOHHS	1 month prior to start of Performance Period
1.f	Adjust for Changes in MCO Payment or Reporting	EOHHS	1 month prior to start of Performance Period
1.g	Blend Baseline Years	EOHSS	1 month prior to start of Performance Period
2.a	Adjustment for Historical Costs Relative to Market – Calculate TCOC PMPM Expenditures for All MCO Members	MCO	3 months prior to start of Performance Period
2.a	Adjustment for Historical Costs Relative to Market – Risk Adjustment and Final Calculations	EOHSS	1 month prior to start of Performance Period
3.a	Calculate Preliminary TCOC Target Applicable to Performance Period	EOHHS	1 month prior to start of Performance Period
3.b	Calculate Final TCOC Target Applicable to Performance Period	EOHHS	10 months after end of Performance Period
4.a	Calculate Actual TCOC in the	MCO	8 months after end of Performance

	Performance Period by Rate Cell		Period
5. a	Apply Minimum Savings Rate	EOHHS	10 months after end of Performance Period
5.b	Determine Impact of Quality and Outcomes	MCO	8 months after end of Performance Period
5.c	Apply Risk Exposure Cap	EOHHS	10 months after end of Performance Period
6.a	Determine AE Share of Savings/(Loss) Pool	EOHHS	10 months after end of Performance Period
7.a	Ensure AE Follows Required Progression to Risk-Based Arrangements	MCO	Ongoing

To summarize, there will be four sets of calculations for each MCO-AE contract:

1. MCO will provide cost and enrollment data for AE members and all MCO members in the Historical Base, summarized by rate cell and Baseline Year. Data will be provided by three months prior to the start of the Performance Period, which allows for three months to complete calculations after the required run-out period. EOHHS will review the submitted cost and enrollment data for reasonableness.

2. EOHHS will apply a trend adjustment, risk adjustment, and adjustment for rate cell mix changes to Baseline Year 1. EOHHS will then determine the adjustment for historical costs relative to the market average and apply prospective adjustments for trends, program and policy changes, and managed care efficiency adjustments. This will result in the Preliminary AE-specific TCOC Expenditure Target. This will be completed by the start of the Performance Period, which allows for three months to complete calculations after receipt of all required data from the MCOs.

3. MCO will provide cost and enrollment data for AE members in the Performance Period, summarized by rate cell. MCOs will also provide the multiplier for quality and outcome data applicable to the AE. Data should be provided by nine months after the end of the Performance Period, which allows for three months to complete calculations after the required run-out period. EOHHS will review the submitted cost and enrollment data for reasonableness.

4. EOHHS will apply risk adjustment to the Preliminary AE-specific TCOC Expenditure Target to reflect actual Performance Period risk scores. As needed, EOHHS will also adjust the prospective adjustments for trends, program and policy changes, and managed care efficiency adjustments for any capitation rate amendments made after the Preliminary AE-specific TCOC Expenditure Target was established. EOHHS then aggregates the results using the AE's mix of rate cells for attributed members in the Performance Period. This will result in the Final AE-specific TCOC Expenditure Target. EOHHS will determine the Shared Savings/(Loss) Pool, as well as the AE share of the

Shared Savings/(Loss) Pool. This will be completed by 10 months after the end of the Performance Period, which allows for one month to complete calculations after receipt of all required data from the MCOs.

MCOs will also be expected to provide quarterly updates to each AE on its Performance Period TCOC expenditures. MCOs are not expected to estimate risk scores or make any other adjustments to the AE-specific TCOC targets for the quarterly updates. The updates are intended to provide AEs with information about emerging experience that they can use to track performance and assess any material deviations from expectations. It is not expected that quarterly updates can be used to project full year results with a high degree of precision.