# Rhode Island Medicaid Accountable Entity Program

## Attachment L 1: Accountable Entity Total Cost of Care Requirements – Program Year Two Requirements

Rhode Island Executive Office of Health and Human Services

Amended for Technical Correction as of April 30, 2019

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## A. TCOC Definition

The total cost of care (TCOC) calculation is a fundamental element in any shared savings and/or risk arrangement. Most fundamentally, it includes a historical baseline or benchmark cost of care specifically tied to an Accountable Entity's (AE) attributed population projected forward to the performance period. Actual costs during the performance period are then compared to those projections to identify a potential shared savings or risk pool, depending on the terms of the arrangement.

Effective TCOC methodologies provide an incentive for AEs to invest in care management and other appropriate services to address the needs of their attributed populations and reduce duplication of services. For populations with long-term care needs, effective TCOC methodologies also provide incentives for AEs to help beneficiaries live successfully in the community and reduce use of institutional services. In doing so, AEs will be able to improve outcomes, lower overall healthcare costs, and be able to earn savings. Shared savings distributions must be based on well-defined quality and outcomes metrics.

## B. TCOC Methodology Goals

These TCOC guidelines have been designed to support **Meaningful Performance Measurement**, thereby creating financial incentives to reduce costs and improve quality. In order to accomplish meaningful performance measurement, this methodology must incorporate the following:

- **Provide opportunity for a sustainable business model**
  Create ongoing opportunity for effective AEs by: (1) recognizing efficient historical performers; (2) allowing for shared savings to be retained for system investment; (3) creating greater financial incentives for being inside the AE program than for being outside; (4) identifying clinical pathways for complex co-occurring chronic conditions that are prevalent among Medicaid high utilizers; (5) addressing social determinants (e.g., housing, food security, access to non-medical transportation) that impact health outcomes and costs; and (6) implementing effective interventions to help elders and adults with disabilities remain in the community.
- **Be fiscally responsible for all participating parties**
  Adequately protect the solvency of the AEs and managed care organizations (MCOs) and the financial interests of the RI Medicaid Program.
- **Specifically recognize and address the challenge of small populations**
  Implement mitigation strategies to minimize the impact of small numbers, given the state's small size.
- **Incorporate quality metrics related to increased access and improved member outcomes**
- Have reporting mechanisms for MCOs and AEs that allow for timely data exchange and

performance improvement to ensure access and quality.

- **Define and establish a progression toward meaningful AE risk**
- **Establish consistent core components of the TCOC methodology while still allowing some innovation and flexibility**
  Balance these competing goals. Allow for some variation in TCOC methodology within uniform state guidelines/criteria.

## C. General Requirements for Program Participants

1. **Minimum Membership and Population Size**
   MCOs may utilize TCOC-based payment models only with AEs which have at least 5,000 attributed Medicaid members, across all MCOs. Comprehensive AEs must have at least 2,000 members per MCO-AE contract.

2. **State/MCO Capitation Arrangement**
   The MCO retains the base contract with the State; the MCO medical capitation will be adjusted for savings/risk associated with the program as described in the State/MCO contract. This does not preclude MCOs from creating value-based purchasing arrangements with non-AE providers; however, those contracts would still be subject to the State gain-share and would not be included in the State's assessment of the MCO's value-based payment performance standards related to AEs.

3. **Exclusivity of Approved TCOC Methodologies**
   MCO TCOC arrangements shall supersede and be exclusive of any other TCOC-related shared savings arrangements with an AE or any of its constituent providers for Medicaid members.

4. **Attribution**
   AE specific historic base data must be based on the AE's attributed lives for a given period, in accordance with EOHHS defined attribution requirements, as defined separately. TCOC performance period data must account for and be aligned with the list of attributed members MCOs are required to generate on a monthly basis, as described in the attribution requirements.

## D. TCOC Methodology: Required Elements for Comprehensive AEs

MCO TCOC arrangements with comprehensive AEs must meet the following requirements, listed here and described in more detail below:

1. Defining a Historical Base
2. Required Adjustments to the Historical Base
3. TCOC Expenditure Target for the Performance Period
4. Actual Expenditures for the Performance Period
5. Shared Savings/(Loss) Pool Calculations
6. AE Share of Shared Savings/(Loss) Pool
7. Required Progression to Risk Based Arrangements

### 1. Defining a Historical Base

**a. AE-Specific Historical Cost Data**

The TCOC historical base shall include three years of AE-specific historical cost data with equal weighting applied to each year. MCOs are strongly encouraged to use three years of historic data in creating the benchmark to stabilize the historic base; at a minimum, all existing AE experience must be utilized.

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

**b. Covered Services**

TCOC methodologies shall include all costs associated with covered services that are included in EOHHS's contract with MCOs for the performance year, with the following clarifications/exceptions. Any further adjustments to covered services outside of those listed below must be requested in writing and pre-approved by EOHHS prior to MCO-AE contract execution for the affected contractual performance year:

i. Exclude services covered under stop-loss provisions between EOHHS and the MCO, as specified in the EOHHS/MCO Contract for Medicaid Managed Care Services.

ii. Exclude HSTP performance incentive payments and CTC payments.

iii. Include and define any other infrastructure payments made by MCOs to AEs and AE-affiliated providers.

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

TCOC expenditure data shall be adjusted to exclude costs in excess of $100,000 per

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

**d. Adjusting for a Changing Risk Profile**

To account for possible changes in the risk profile of an AE's attributed patient population over the historical base years, the MCO shall employ one of the following two risk adjustment methodologies:

- **Risk Adjustment Software**
  MCOs may apply a clinical risk adjustment software. Under such an approach, risk calculations and any adjustments shall be applied at the total population and not the EOHHS rate cell level. The TCOC methodology must describe the MCO's risk-adjustment method including underlying software parameters set by the MCO. Such information shall also be disclosed to contracting AEs.
- **Rate Cell Calculations**
  MCOs may use the population mix by rate cell, for each period, to adjust for changes in this population mix over time.

Note that if an MCO chooses to utilize a risk adjustment software, the MCO must provide a detailed description of the specific software/methodology applied, including the underlying parameters set by the MCO. Note that this is an interim solution, as the state intends to implement a standardized risk adjustment methodology over the course of this program. Should the MCO wish to further adjust for a changing risk profile using clinical and social risk factor data exogenous to the risk adjustment methodologies described above, it may do so after review and approval by EOHHS.

**e. Historical Base with Required Cost Trend Assumptions**

When projecting (or trending) historical costs forward into the performance year, TCOC methodologies shall appropriately account for trends in the medical component of capitation rates being paid to MCOs by EOHHS. Trends assigned to TCOC baselines shall not exceed the final cumulative trends to the medical portion of rates by cap cell, inclusive of any state budgetary savings assumptions, as contained in the EOHHS data books. The trends may be applied by the MCO to the AE in aggregate based on either the AE's or the MCO's member mix.

## 2. Required Adjustments to the Historical Base

In order to prospectively establish an AE's TCOC Expenditure Target, the MCO must apply the following adjustments to the historical base. Note that no additional adjustments are allowed without prior approval from EOHHS.

a. **Adjustment for Prior Year Savings**
The TCOC Expenditure Target must include an upward adjustment equal to an AE's share of prior year savings, after adjustment for quality performance, so that AEs have an opportunity to retain a portion of generated savings year over year. This adjustment must not exceed 2% of the unadjusted TCOC Expenditure Target.

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

a. **Adjustment for Historically Low-Cost AEs**
Should any AE have three years of historical cost data demonstrating that risk-adjusted per capita spending for the AE's historically attributed patient population for TCOC covered services was significantly below the MCO average (statistically significant at p <= .05), the MCO may adjust that AE's TCOC Expenditure Target upward by up to the percentage by which the TCOC fell below MCO average spending for the assessed historical time period. This adjustment must not exceed 2% of the unadjusted TCOC Expenditure Target. This adjustment shall not be applied to entities with a historically attributed patient population for TCOC covered services that was significantly above the MCO average.

### 3. TCOC Expenditure Target for the Performance Period

Once an AE-specific adjusted historical base is established, this base must be trended forward into the performance period to create an AE-specific TCOC Expenditure Target.

TCOC methodologies shall be based on a performance time period of 12 months aligned with the state fiscal year. Initial contractual performance time periods may extend longer than 12 months if necessary.

a. **Required Cost Trend Assumptions**

The adjusted historical base must be cost trended to the performance year according to the cost trend assumptions described in Section D.1.e of this document.

b. **Final Target Adjusted for Changes in the Attributed Population's Risk Profile**
The MCO must apply a risk adjustment methodology to assess any changes in an attributed population's risk profile from the risk-adjusted historical base to the contractual performance period. This methodology must be consistent with the risk adjustment methodology used in developing the adjusted historical base as described in Section D.1.d of this document.

### 4. Actual Expenditures for the Performance Period

a. **Calculate Actual Expenditures Consistent with the Historical Base Methodology**

Actual Expenditures for the Performance Period must be calculated consistent with the historical base methodology as described in Sections D.1.b and D.1.c of this document.

## 5. Shared Savings/(Loss) Pool Calculations

The Shared Savings/(Loss) Pool shall be calculated as the difference between Actual Expenditures (Section D.4) and TCOC Expenditure Target (Section D.3), after the following adjustments:

### a. Small Sample Size Adjustment for Random Variation

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

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

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

iii. The adjustment cannot be applied differentially based on historical performance.

**EOHHS Preferred Small Sample Size Adjustment for Random Variation**

MCOs shall address the impact of random variation on cost savings results through the application of a shared savings adjustment factor, defined by performance year AE attributed population size (calculated as attributed member months divided by 12). The shared savings adjustment factor adjusts the AE's shared savings/(loss) pool proportionately by the probability of true savings (1 minus the probability of achieving shared savings as a result of chance). The proportion of savings for which an AE is eligible shall by adjusted along a sliding scale by AE size, based on the parameters below.

**Shared Savings/Loss Adjustment Factor Parameters**

| Shared Savings/Loss Adjustment Factor Parameters by AE Size and Savings Rate | | | | Probability of Achieving Shared Savings/Loss as a Result of Chance* | | | |
|---|---|---|---|---|---|---|---|
| **Savings %** | **Small AE** *(2,000-9,999)* | **Medium AE** *(10,000-19,999)* | **Large AE** *(20,000+)* | **Savings %** | **5,000 members** | **10,000 members** | **20,000 members** |
| **1%** | 73% | 79% | 89% | **1%** | 27% | 21% | 11% |
| **2%** | 82% | 92% | 97% | **2%** | 18% | 8% | 3% |
| **3%** | 91% | 97% | 99% | **3%** | 9% | 3% | 1% |
| **4%** | 95% | 99% | 100% | **4%** | 5% | 1% | 0% |
| **5%** | 98% | 100% | 100% | **5%** | 2% | 0% | 0% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **6%** | 99% | 100% | 100% | **6%** | 1% | 0% | 0% |

Source: Weissman J, Bailit MH, D'Andrea G, Rosenthal MB. "The Design And Application Of Shared Savings Programs: Lessons From Early Adopters," *Health Affairs*, September 2012

**b. Impact of Quality and Outcomes**

The Shared Savings/(Loss) Pool shall be adjusted based on an assessment of performance relative to a set of quality measures for the attributed population. An Overall Quality Score will be generated for each AE, according to the methodology detailed in Attachment A: Quality Framework and Methodology for Comprehensive Accountable Entities. The Total Shared Savings/(Loss) Pool (inclusive of both the AE and MCO portions) must be multiplied by the Overall Quality Score. The Overall Quality Score must function as a multiplier, and may not include a gate; as such, any quality points earned must be associated with a share of the Shared Savings/(Loss) Pool.

**c. Maximum Allowable Shared Savings/(Loss) Pool**

In any given performance year, the Shared Savings Pool must not exceed 10% of the AE's TCOC Expenditure Target for the Performance Period. In instances where the AE is responsible for downside risk, the Shared Loss Pool must not exceed 5% of the AE's TCOC Expenditure Target for the Performance Period.

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

In Program Year 2, AEs may be eligible to retain up to 50% of the Shared Savings Pool, as defined in Section D.5 above. AEs assuming downside risk may be eligible for up to 60% of the Shared Savings Pool, and may be responsible for up to 60% of the Shared Loss Pool.

| AE Shared Savings Model | AE Share of Savings | Maximum Allowable Shared Savings Pool | Maximum Allowable Shared Loss Pool | AE Share of Losses |
|---|---|---|---|---|
| **Option 1: Shared savings only** | Up to 50% of Savings Pool | 10% of the AE's TCOC Expenditure Target for the Performance Period | NA | NA |
| **Option 2: Shared savings + risk** | Up to 60% of Savings Pool | 10% of the AE's TCOC Expenditure Target for the Performance Period | 5% of the AE's TCOC Expenditure Target for the Performance Period | Up to 60% of Loss Pool |

## 7. Required Progression to Risk Based Arrangements

Qualified TCOC-based contractual arrangements (or "Certified AEs") must demonstrate a progression of risk to include meaningful downside shared risk within three years of AE program participation. After five years, development and implementation funding will end, and AEs will be sustained going forward based on their successful performance and associated financial rewards in accordance with their MCO contract(s).

EOHHS has defined "meaningful risk" based on learnings from other states, OHIC

requirements and federal MACRA rules. Marginal risk and loss caps are defined with a range, EOHHS anticipates that smaller organizations will fall on the lower end of that range. The required progression of increasing risk for all comprehensive AEs is as follows:

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

It is EOHHS's intent to align risk requirements with the standards established by the Office of the Health Insurance Commissioner (OHIC) to the extent possible. Alternatives for larger organizations or entities that include a hospital may be considered in the future.

In the event of a shared risk arrangement with an AE, it is necessary to ensure that the AE has the capacity to pay for its share of any losses. To accomplish this the MCO shall utilize a withhold to ensure that funds are available for financial settlement with the AE in the event that medical expenses exceed the total cost of care projection for the performance period. At a minimum, the withhold must capture 75 percent of the maximum shared loss pool. MCO's final settlement with the AE with regard to a withhold is based on actual experience in relation to the TCOC calculation.

Should an MCO and AE wish to share risk on a more accelerated schedule than that outlined above, the MCO and AE shall submit written documentation to EOHHS, including:

- the draft contractual financial terms between the parties;
- a statement of why the AE is qualified to assume greater risk than that outlined above, including its infrastructure to manage clinical risk, an established record of meeting quality metrics, and the likelihood that the AE will meet the quality thresholds established by EOHHS and the MCO; and
- documentation of secured funds necessary to meet the maximum financial obligation that the AE could potentially incur under the terms of the proposed agreement.

EOHHS together with state partners (e.g. DBR and OHIC), will review the aforementioned information, and decide as to whether the arrangement may proceed.

Additionally, if an AE enters into an arrangement that provides for shared losses with a total potential risk that equals or exceeds 10% of expected expenditures, the AE must meet all the financial reserve and risk-based capital requirements required of an MCO, with oversight by the Department of Business Regulation.[1] EOHHS anticipates that any AEs taking on such risk must, at a minimum, demonstrate adequate capitalization to cover three months of claims.[2]

[1] As specified in the standards for minimum risk-based capital (RBC) requirements for health organizations in Chapter 27-4.7 of the RI general statute. http://webserver.rilin.state.ri.us/Statutes/Title27/27-4.7/INDEX.HTM

[2] Note that CMS has issued guidance for shared savings programs for both Medicaid and for Medicare Shared Savings Programs. For ease of reference links to relevant State Medicaid Director Letters are provided: www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf; www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-002.pdf. Links for the Medicare Shared Savings Program final rule and a CMS Factsheet are also provided: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Methodology_Factsheet_ICN907405.pdf. The Shared Savings Program final rule can be downloaded at www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf on the Government Printing Office (GPO) website

## E. TCOC Development Approval and Reporting Process

### 1. TCOC Development Approval

Medicaid MCOs and AEs must establish TCOC calculation methodologies in accordance with these requirements to serve as the basis for their shared savings and/or risk arrangements. These methodologies must be approved by EOHHS. EOHHS will review the MCO's TCOC methodologies and reserves the right to ask for modifications before granting approval.[3] EOHHS also reserves the right to review these methodologies on an annual basis. EOHHS' approval, denial, or requests for amendment will be transmitted in writing, without unreasonable delay.

MCOs must submit details of their TCOC methodologies to EOHHS for approval in writing, in advance of contracting with AEs. Applications must document and demonstrate specific compliance with the requirements outlined in Sections C, D, and E of these requirements. Simple numerical examples may be helpful. Applications must also include comprehensive answers to the questions below:

**a. Benchmark Time Period**

What is the time period for the historical data used to establish an AE's cost benchmark? How does the methodology account for attributed patients for whom no historical data is available?

**b. Benchmark Data Source**

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

**c. Mid-Year Changes**

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

**d. Risk Adjustment**

What risk adjustment methodology will be applied to assess changes in the risk profile of an AE's attributed patient population, over the historic base years, and between the historic base and performance period? If a clinical risk adjustment software will be utilized, provide a detailed description of the underlying software parameters.

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

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

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

adjustment is calculated, and how the adjustment is applied.

**f. Shared Savings/Loss Distribution Rate and Calculation**
What portion of the eligible shared savings pool (after accounting for scaling based on quality and outcomes metrics) will be distributed to the AE?

**g. Shared Savings/Loss Distribution Timing**
At what time are shared savings distributions made to qualifying AEs? If distributions are made more frequently than annually, please also describe any true-up processes.

Material amendments to TCOC methodology must be approved by EOHHS in advance. If an MCO utilizes a TCOC methodology that differs in any respect from the approved methodology, EOHHS reserves the right to calculate risk- and gain-share with the MCO as if the approved methodology had been utilized, and the MCO shall provide EOHHS with all information necessary to make that calculation.

MCOs must complete and submit the *MCO/AE TCOC Reporting Template* as defined by EOHHS for each AE within 15 days, at the latest, of executing any AE contract.

**2. Required Ongoing Reporting**
In order to monitor AE financial performance, AEs and MCOs will be required to furnish financial reports regarding risk performance on a quarterly basis to EOHHS. Quarterly reports must be submitted to EOHHS within 120 days of the close of the quarter, as detailed below.

| Program Year 2: Performance Quarters | Quarterly Report Due to EOHHS |
|---|---|
| Q1: Jul 1st – Sep 30th 2019 | January 28th 2020 |
| Q2: Oct 1st – Dec 31st 2019 | April 29th 2020 |
| Q3: Jan 1st – Mar 31st 2020 | July 29th 2020 |
| Q4: Apr 1st – Jun 30th 2020 | October 28th 2020 |

# F. Comprehensive AE TCOC Methodology Example

**OHHS Comprehensive AE Total Cost of Care (TCOC) Guidance** — AE Specific Variables
**Comprehensive AE TCOC Calculation Tool** — Calculation Variables

*Note: all data is illustrative only

| | | SFY 2014 | SFY 2015 | SFY 2016 | | SFY 2018 | |
|---|---|---|---|---|---|---|---|
| | **AE Specific Historical Data Input: Membership and Cost** | **Year 1** | **Year 2** | **Year 3** | **Historical Base** | **Performance Year** | |
| INPUT -> | Attributed Lives (Members) | 5,000 | 5,000 | 5,250 | 5,083 | 5,250 | |
| INPUT -> | PMPM | $345.00 | $347.00 | $320.00 | $337.05 | $350.00 | 1 |

**1 Calculating the Historical Base and Initial TCOC Target**

| | | | | | Historical Base | | Performance Year Target | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Year 1 | Year 2 | Year 3 | $ | pmpm | $ | pmpm | |
| A | Total Cost of Care (Unadjusted) | $20,700,000 | $20,820,000 | $20,160,000 | **$20,560,000** | **$337.05** | | | |
| B | Base Year Weight | 33% | 33% | 33% | | | | | 2 |
| C | Trend Factor | | 2% | 2% | | | | | 3 |
| D | Trend Adjustment | $836,280 | $416,400 | $0 | $417,560 | $6.85 | | | |
| Details below | E Risk Adjustment | $871,579 | $429,278 | $0 | $433,619 | $7.11 | | | |
| | F Total Cost of Care (Adjusted) | $22,407,859 | $21,665,678 | $20,160,000 | **$21,411,179** | **$351.00** | | | |
| Details below | G Prior Year Savings Adjustment | | | $176,400 | $176,400 | $2.89 | | | |
| Details below | H Historical Performance Adjustment | | | $411,200 | $411,200 | $6.74 | Projected Trend | Time Period (Yrs) | |
| | I Total Cost of Care (Adjusted, with Sustainability Adjustments) | | | | **$21,998,779** | **$360.64** | 2% | 2 | |
| | J **Total Cost of Care (Initial Target)** | | | | | | **$22,887,530** | **$375.21** | 4 |
| | | | | | | | **TCOC Initial PY Target** | | |

**2 Calculating the Final TCOC Target**

| | | | | |
|---|---|---|---|---|
| Details below | A Risk Adjustment | | $477,534 | $7.58 |
| | B *Final Target based on risk-adjusted PMPM with performance year membership | *Impact of change in membership* | $750,411 | $0.00 |
| | **Total Cost of Care (Final Target)** | | **$24,115,475** | **$382.79** |
| | | | **TCOC Final PY Target** | |

**3 Calculating and Distributing the Shared Savings (Loss) Pool**

| | | | Performance Year | |
|---|---|---|---|---|
| | | | $ | pmpm |
| | A **Total Cost of Care (Actual Expenditures)** | | **$22,050,000** | **$350.00** |
| | | | **TCOC Actual** | |
| | B **Shared Savings (Loss) Pool** | | **$2,065,475** | **$32.79** |
| Details below | C Random Variation Adjustment | | $0 | $0.00 |
| Details below | D Quality and Outcomes Adjustment | | $0 | $0.00 |
| | E **Shared Savings (Loss) Pool (Adjusted)** | | **$2,065,475** | **$32.79** |
| | F Eligible Shared Savings Pool | | $2,065,475 | $32.79 |
| | G Eligible Shared Loss Pool | | NO | NO |
| *Cap: 10% AE Contract* | H Maximum Allowable Shared Savings Pool | | $2,411,547 | $38.28 |
| *Cap: 5% AE Contract* | I Maximum Allowable Shared Loss Pool | | -$1,205,774 | -$19.14 |
| | J **Final Shared Savings Pool** | | **$2,065,475** | **$32.79** |
| | K **Final Shared Loss Pool** | | **NO** | **NO** |

L **AE Share of Shared Savings (Loss) Pool**

| M | **Option 1 AEs: Shared Savings Only** | ***AE Share*** | **20%** | | **30%** | | **40%** | |
|---|---|---|---|---|---|---|---|---|
| | | | **$** | pmpm | **$** | pmpm | **$** | pmpm |
| | **Shared Savings** | | **$413,095** | **$6.56** | **$619,642** | **$9.84** | **$826,190** | **$13.11** |

| N | **Option 2 AEs: Shared Savings and Risk** | ***AE Share*** | **40%** | | **50%** | | **60%** | |
|---|---|---|---|---|---|---|---|---|
| | | | **$** | pmpm | **$** | pmpm | **$** | pmpm |
| | **Shared Savings** | | **$826,190** | **$13.11** | **$1,032,737** | **$16.39** | **$1,239,285** | **$19.67** |
| | **Shared Loss** | | **NO** | **NO** | **NO** | **NO** | **NO** | **NO** |

**Adjustment Details**

**1 Historical Base and Initial TCOC Target Adjustments**

| | | Year 1 | Year 2 | Year 3 | Historical Base | |
|---|---|---|---|---|---|---|
| Risk Adj | E Average Risk Score | 0.95 | 0.97 | 0.99 | 0.97 | <- INPUT |
| | TCOC (Dollars): Years 1 and 2 Risk-Adjusted to Year 3 Risk Mix | $359.53 | $354.15 | $320.00 | $344.56 | |
| | Risk Adjustment | $14.53 | $7.15 | $0.00 | $7.23 | |

| | | | | | |
|---|---|---|---|---|---|
| Adjustment for Prior Year Savings | G Prior Year Savings: Target - Actual TCOC (pmpm) | | $7.00 | <- INPUT | |
| | Eligible Adjustment: AE Share | | $2.80 | 40% | AE Share |
| | Eligible Adjustment: Total Dollars | | $176,400 | | |
| | Maxium Adjustment for Prior Year Savings (2%) | | $411,200 | *2%* ***Max Allowable*** | |
| | Eligible Adjustment or Max Allowable | | $176,400 | | |

| | | | | |
|---|---|---|---|---|
| Historical Performance Adjustment | H MCO Average Cost (pmpm) | $334.00 | <- INPUT | |
| | MCO Average Risk Score | 1.00 | | |
| | AE Average Risk Score | 0.99 | | |
| | AE Cost (pmpm) | $320.00 | | |
| | AE Cost with FQHC PPS Adjustment (pmpm) | $320.00 | $0.00 | FQHC PPS Adjustment (pmpm), if applicable |
| | AE Average Risk Normalized Cost (pmpm) | $323.23 | | |
| | Cost Score (% above/below MCO Average) | -4% | | |
| | Eligible Adjustment | $14.13 | | |
| | Eligible Adjustment: Total Dollars | $861,796 | | |
| | Max Allowable Adjustment | $411,200 | *2%* ***Max Allowable*** | |
| | Eligible Adjustment or Max Allowable | $411,200 | | |

**2 Final TCOC Target Adjustments**

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

**3 Shared Savings (Loss) Pool Adjustments**

Small Sample Size Random Variation Adjustment

C **Shared Savings (Loss) Adjustment Factor Parameters by AE Size and Savings Rate**

| Savings % | Small AE *(5-9,999)* | Medium AE *(10-19,999)* | Large AE *(20,000+)* |
|---|---|---|---|
| **1%** | 73% | 79% | 89% |
| **2%** | 82% | 92% | 97% |
| **3%** | 91% | 97% | 99% |
| **4%** | 95% | 99% | 100% |
| **5%** | 98% | 100% | 100% |
| **6%** | 99% | 100% | 100% |

**Parameter Lookup**

| | | | | |
|---|---|---|---|---|
| Savings % | 8.56% | 9.00% | **9.00%** | **Savings Rate Bracket Lookup** |
| Small AE | 100% | | | |
| Medium AE | 100% | | | |
| Large AE | 100% | | | |
| **Random Variation Adjustment** | **100%** | | **Small AE** | **AE Size Classification** |

| | | | |
|---|---|---|---|
| Quality Adj | D Quality Score Multiplier | 1.00 | <- INPUT |
| | Detailed Quality Measure Scoring Methodology to come | | |

*1* TCOC inputs must account for covered service exclusions and claims cap truncation
*2* Base Year Weights are flexible, example uses MSSP methodology
*3* Placeholder trend, to populate OHHS data book trends, Year 2 trend = Year 2/Year 1
*4* Change compounding formula based on time period between Base Year 3 and Performance Year (assumes 2 year period)

# Attachment A: Quality Framework and Methodology for Comprehensive Accountable Entities

## A. Principles and Quality Framework

A fundamental element of the EOHHS Accountable Entity (AE) program, and specifically the transition to alternative payment models, is a focus on quality and outcomes. Measuring and rewarding quality as part of a value based model is critical to ensuring that quality is maintained and/or improved while cost efficiency is increased. As such, the payment model must be designed to both recognize and reward historically high-quality AEs while also creating meaningful opportunities and rewards for quality improvement. This model must be measurable, transparent and consistent, such that participants and stakeholders can view and recognize meaningful improvements in quality as this program unfolds.

The Program Year 2 requirements described below are intended to provide an interim structure that permits baseline measurement and assessment, while allowing for future refinements that continuously "raise the bar" toward critical improvements in quality and outcomes.

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

## B. Shared Savings Opportunity

Medicaid AEs are eligible to share in earned savings based on a quality multiplier (the "Overall Quality Score") to be determined as follows:

- The AE must meet the established total cost of care (TCOC) threshold as determined using the EOHHS approved TCOC methodology to be eligible for shared savings.
- In accordance with 42 CFR §438.6(c)(2)(ii)(B)[4], quality performance measurement must be based on the Medicaid Accountable Entity Common Measure Slate. All required measures must be reported. Up to 4 additional optional menu measures for may be included, as agreed upon by the MCO and AE.
- For comprehensive AEs, all admin (claims-based) measures must be generated and reported by the MCO. AEs must provide the necessary data to the MCO to generate any hybrid or EHR-only measures. Any EHR-only measures generated by an AE may be reported for the AE's full attributed population.
- An Overall Quality Score must be generated for each AE. The Overall Quality Score will be used as a multiplier to determine the percentage of the shared savings pool the AE

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

and MCO are eligible to receive. Overall Quality Scores must be calculated distinctly for each MCO with which the AE is contracted.

- Performance year periods, which are aligned with the state fiscal year calendar, will be tied to the calendar year quality performance period ending within the performance year period. The prior calendar year quality performance period will serve as the benchmark period, as shown below.

| Performance Year | Performance Time Period | Quality Measurement Performance Period | Quality Measurement Benchmark Period | Payment |
|---|---|---|---|---|
| PY 1 | SFY 2019 | HEDIS 2019, CY 18 | HEDIS 2018, CY 17 | SFY 2020 |
| PY 2 | SFY 2020 | HEDIS 2020, CY 19 | HEDIS 2019, CY 18 | SFY 2021 |
| PY 3 | SFY 2021 | HEDIS 2021, CY 20 | HEDIS 2020, CY 19 | SFY 2022 |
| PY 4 | SFY 2022 | HEDIS 2022, CY 21 | HEDIS 2021, CY 20 | SFY 2023 |

### C. Medicaid AE Common Measure Slate for Comprehensive AEs

In accordance with 42 CFR §438.6(c)(2)(ii)(B)[5], quality performance measurement must be based on the Medicaid Comprehensive AE Common Measure Slate (see Section G below). All required measures must be reported. In addition to the 10 required core measures, each MCO and AE may include up to 4 additional optional measures identified by the MCO and AE from the RI State Innovation Model (SIM) menu measure set and/or Medicaid Child and/or Adult Core Set.

The Common Measure Slate for comprehensive AEs has been developed with the following considerations:

- Alignment with the RI SIM core measure set.
- Cross cutting measures across multiple domains with a focus on clinical/chronic care, behavioral health, and social determinants of health.
- Feasibility of data collection and measurement and minimization of administrative burden.
- A minimum number of measures necessary to enable a concentrated effort and meaningful assessment of quality.
- Focus on statewide strategic priorities outlined by EOHHS, RI Department of Health, RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, and the Office of the Health Insurance Commissioner.

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

## D. Comprehensive AE Overall Quality Score Determination

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

The Overall Quality Score is to be developed based on assigning a weight to each individual measure. All measures must be included in the Overall Quality Score (with a weight greater than 0%). The measure weight assigned to each measure is negotiable and shall be agreed upon by the MCO and AE (any weight greater than 0% may be applied). The Overall Quality Score must be a sum of the Measure Specific Quality Score times the Measure Weight for each measure.

*Example:*

| List of Measures | Measure Specific Quality Score | Measure Weight | Measure Specific Quality Score * Measure Weight |
|---|---|---|---|
| Measure 1 | 100% | 20% | 20% |
| Measure 2 | 100% | 20% | 20% |
| Measure 3 | 75% | 20% | 15% |
| Measure 4 | 50% | 30% | 15% |
| Measure 5 | 0% | 10% | 0% |
| **Overall Quality Score** | | | **70%** |

## E. Pay for Performance Measures

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

- Breast Cancer Screening
- Follow-up after Hospitalization for Mental Illness (7 day OR 30 day measure component)*
  *Note that while all measure subcomponents must be reported, an individual measure subcomponent may be selected as pay for performance.

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

### EOHHS Preferred Pay for Performance Measure Specific Scoring Methodology

EOHHS' preferred pay for performance measure specific quality scoring methodology is described below; however, an alternate quality scoring rubric may be used in Program Year 2 if approved by EOHHS. EOHHS will work to develop a standard quality scoring rubric through a stakeholder process, and anticipates standardization of the quality scoring methodology in the future.

EOHHS' measure specific quality scoring methodology is intended to both reward historically high-quality providers and create opportunities for low performers to benefit from improvement.

For each measure included in the AE Common Measure Slate, two measure specific benchmark targets are established based on NCQA Medicaid Quality Compass data.

- High benchmark target: NCQA Medicaid Quality Compass percentile measure score defined by measure based on current MCO performance (see Section G for measure specific benchmarks)
- Medium benchmark target: NCQA Medicaid Quality Compass 66$^{th}$ percentile measure score for all measures

For those measures for which NCQA Medicaid Quality Compass data is not available, a Medicaid statewide median benchmark will be generated, and a High and Medium benchmark target will be established.

Each measure is assessed and scored based on performance relative to the benchmark targets or achievement of meaningful improvement, as defined below.

| Measure Performance Category | Measure Score | Performance Category Criteria |
|---|---|---|
| **High Performance** | 100% | AE score meets or exceeds the High benchmark target |
| **Medium Performance** | 75% | AE score meets or exceeds the Medium benchmark target (but is below the High benchmark target) |
| **Improvement** | 50% | AE score is below the Medium benchmark target but shows meaningful improvement over the prior year's performance.<br>Meaningful improvement is defined as improvement half way from the AE's baseline to the Medium performance target, or 10 percentage point improvement, whichever is lower, with a minimum required improvement of at least 3 percentage points. |

| Measure Performance Category | Measure Score | Performance Category Criteria |
|---|---|---|
| **Fail** | 0% | AE score is below the Medium benchmark target and does not show meaningful improvement over the prior year's performance, as defined above. |

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

| AEs | Year 1 Score | Year 2 Score | AE Performance Category | Measure Specific Score |
|---|---|---|---|---|
| AE 1 | 66% | 68% | High Performance | 100% |
| AE 2 | 62% | 64% | Medium Performance | 75% |
| AE 3 | 55% | 60% | Improvement | 50% |
| AE 4 | 50% | 52% | Fail | 0% |

## F. Pay for Reporting Measures

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

### EOHHS Required Pay for Reporting Measure Specific Scoring Methodology

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

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

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

*Example: Pay for Reporting Measure Scoring*

| Pay for Reporting Measures | Measure Reported (Y/N) | Process/Methodology Demonstrated (Y/N) | Measure Specific Score |
|---|---|---|---|
| Measure 1 | Y | Y | 100% |
| Measure 2 | N | N | 0% |
| Measure 3 | Y | N | 0% |
| Measure 4 | N | Y | 0% |

## G. Comprehensive AE Common Measure Slate*

| Measure Name | NQF # | Measure Steward | Measure Domain | Measure Source | Measure Description | Age Cohort | High Benchmark | Medium Benchmark |
|---|---|---|---|---|---|---|---|---|
| 1. Breast Cancer Screening | 2372 | HEDIS® | Preventive Care | Admin | The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer | Adult | QC 75th percentile | QC 66th percentile |
| 2. Weight Assessment & Counseling for Physical Activity, Nutrition for Children & Adolescents | 0024 | HEDIS® | Preventive Care | Hybrid | The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/Gyn and who had evidence of the following during the measurement year: BMI percentile documentation, Counseling for Physical Activity, and Counseling for Nutrition | Pediatric | QC 90th percentile | QC 66th percentile |
| 3. Developmental Screening in the 1st Three Years of Life | 1448 | OHSU | Preventive Care | Admin or Hybrid | The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life; this is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age | Pediatric | 65% score | 50% score |
| 4. Adult BMI Assessment | N/A | HEDIS® | Preventive Care | Hybrid | The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement or the year prior to the measurement year | Adult | QC 90th percentile | QC 66th percentile |

*Measures are subject to change based on the recommendations of OHIC's Measure Alignment Review Committee

| Measure Name | NQF # | Measure Steward | Measure Domain | Measure Source | Measure Description | Age Cohort | High Benchmark | Medium Benchmark |
|---|---|---|---|---|---|---|---|---|
| 5.Tobacco Use: Screening and Cessation Intervention | 0028 | AMA-PCPI | Preventive Care | Admin or Hybrid | Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user | Adult | N/A Reporting only in Y1 | N/A Reporting only in Y1 |
| 6. Comp. Diabetes Care: HbA1c Control (<8.0%) | 0575 | HEDIS® | Chronic Illness | Hybrid | The percentage of members 18-75 years of age with diabetes (type 1 and 2) w/HbA1C control <8.0% | Adult | QC 75th percentile | QC 66th percentile |
| 7.Controlling High Blood Pressure | 0018 | HEDIS® | Chronic Illness | Hybrid | The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year based on the following criteria:<br>• 18-59 years of age whose BP was <140/90 mm Hg<br>• 60-85 years of age with a dx of diabetes whose BP was <140/90 mm Hg<br>• 60-85 years of age without a dx of diabetes whose BP was <150/90 mm Hg | Adult | QC 90th percentile | QC 66th percentile |
| 8. Follow-up after Hospitalization for Mental Illness (7 days and 30 days) | 0576 | HEDIS® | Behavioral Health | Admin | The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnosis and who had a follow-up visit with a mental health practitioner | Adult and Pediatric | QC 90th percentile | QC 66th percentile |

| Measure Name | NQF # | Measure Steward | Measure Domain | Measure Source | Measure Description | Age Cohort | High Benchmark | Medium Benchmark |
|---|---|---|---|---|---|---|---|---|
| 9. Screening for Clinical Depression & Follow-up Plan | 0418 | CMS | Behavioral Health | Practice-reported | Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented | Adult and Pediatric | N/A Reporting only in Y1 | N/A Reporting only in Y1 |
| 10. Social Determinants of Health (SDOH) Screen | N/A | N/A | Social Determinants | | % of members screened as defined per the SDOH elements in the Medicaid AE certification standards* | Adult and Pediatric | N/A | N/A |

Technical specifications for the measures above will be provided separately.

* Section 5.2.2 of the AE Certification Standards requires that each AE:
"*Together with partner MCOs, develop, implement, and maintain procedures for completing an initial SDOH Care Needs Screening for Attributed Members based on a defined protocol…. The screening shall evaluate Attributed Members' health-related social needs in order to determine the need for social service intervention. Such services shall include but not be limited to:*

- *Housing stabilization and support services;*
- *Housing search and placement;*
- *Food security;*
- *Support for Attributed Members who have experience of violence.*
- *Utility assistance;*
- *Physical activity and nutrition;…"*

**Optional Menu Metrics for Comprehensive AEs**

Select no more than 4 measures from the SIM Menu Measure Set and/or the Medicaid Child and/or Adult Core Quality Measure Set.


2017-child-core-set (1).pdf


2017-adult-core-set .pdf


Crosswalk of RI Aligned Measure Se