

Rhode Island Medicaid Accountable Entity Program

Accountable Entity Certification Standards

Rhode Island Executive Office of Health and Human Services
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Table of Contents

I. Certification Standards Overview and Purpose	3
II. Background and Context	5
III. Public Input Process	7
IV. Certification Standards: Comprehensive Accountable Entity	10
V. Certification Standards: Specialized LTSS Accountable Entity	34
Attachment A: Scope of Benefits Included In EOHHS Contracts with Managed Care Organizations	55
Attachment B: Definitions of Services that may Qualify for Attribution	69

I. Certification Standards Overview and Purpose

This Accountable Entity (AE) Certification Standards Document is being submitted by the RI EOHHS, as the single state Medicaid agency in Rhode Island, to CMS for review and approval in accordance with Special Term and Condition (STC) 47 of Rhode Island's Health System Transformation Project (HSTP) Amendment to the state's 1115 Medicaid Demonstration Waiver. The requirements for AE Certification Standards under STC 47 are as follows:

"The state must develop AE Certification Standards that the state will use to certify the potential AEs within the state. The final certification standards will be submitted to CMS to review, by June 1, 2017 as Attachment K; CMS has 60 days to review and submit suggestions to the state. The state will notify the MCOs of the approved certified AEs. After an organization is certified as an AE and it elects to make a material modification, in its operations, the state must review and approve such modification, in the AE's operations, prior to the implementation of the AE."

The purpose of this document is to formalize the Certification Standards for Accountable Entities. Interested parties will then be invited to submit applications for certification and participation in the program. The issuance of AE Certification Standards, as well as the application and approval process, through the various stages, will be managed directly by EOHHS. These standards have been compiled based on a combination of the following:

- Learnings to date from the existing AE Pilot program
- National/emerging lessons from other states implementing Medicaid ACOs
- EOHHS multi-year participation in a Medicaid ACO Learning Collaborative facilitated by the Center for Health Care Strategies (CHCS) and sponsored by the Commonwealth Foundation
- Lessons learned from the existing Medicare ACO programs
- Alignment with SIM and the ACO standards developed by RI Office of the Health Insurance Commissioner (OHIC)
- Stakeholder feedback and comments, as described in Section III

The AE Certification standards and the corresponding application and approval process are intended to promote the development of new forms of organization, care integration, payment, and accountability. Successful organizations will be multi-disciplinary in composition, inter-disciplinary in practice and focused on population health, with programs tailored to address varying levels and types of needs. Participants will be demonstrably engaged in a common enterprise with incentives to work together to do a better job meeting the needs of attributed populations. There will be strong emphasis on integration of activities to address social determinants of health.

EOHHS anticipates that these certification standards may be updated annually, and modifications may be required during implementation to ensure that best practices and lessons that are learned

throughout implementation can be leveraged and incorporated into the program design. Any such revisions shall be formally posted on the EOHHS website and shall allow for a 30 day public comment period prior to implementation.

II. Background and Context

The Rhode Island Executive Office of Health and Human Services (EOHHS), through the contracted Medicaid Managed Care Organizations (MMCOs) is currently implementing the RI Medicaid Accountable Entity (AE) Program. This program is intended to break through the financing and delivery system disconnects, to build partnerships across payment systems, delivery systems and medical/social support systems that effectively align financial incentives and more effectively meet the real life needs of individuals and their families.

EOHHS intends that Certified AEs will provide the central platform for transforming the structure of the delivery system as envisioned in the Final Report of the Reinventing Medicaid Working Group that was convened by Governor Raimondo in March of 2015. The core objectives of the AE program include:

- Substantially transition away from fee-for-service models
- Define Medicaid-wide population health targets, and, where possible, tie them to payments.
- Maintain and expand on our record of excellence in delivering high quality care.
- Deliver coordinated, accountable care for high-cost/high-need populations
- Ensure access to high-quality primary care
- Shift Medicaid expenditures from high-cost institutional settings to community-based settings

Certified Accountable Entities will have responsibility for coordinating a full continuum of health care services for defined populations. Included in any such population will be people with complex and specialized needs since these are the groups within the larger population who are most in need of an effectively coordinated system. An effective AE must be able to meet the needs of the full population but must also have distinct competencies to recognize and address the special needs of high risk and “rising risk” sub groups.

Toward this end, Certified Accountable Entities will be required to demonstrate that they meet specified standards, including provider representation, governance requirements, required scope of services and capacity. Applicants who are designated as “Certified” will immediately be eligible to enter into a contractual arrangement with the Medicaid MCOs to manage a population of Medicaid members under a total cost of care arrangement.

EOHHS recognizes that potential applicants may have differing stages of readiness. To that end AEs will be annually certified, and EOHHS anticipates that **most AEs will be “Provisionally Certified with Conditions”**. Deficiencies will need to be addressed in accordance with an agreed upon project plan in order for the AE to continue to be eligible for Infrastructure Development funds. Eventually, AEs who have demonstrated that all of the domain requirements were fully met will be designated as “Fully Certified”.

Two types of certification for Accountable Entities are envisioned:

- **Comprehensive Certified AE: Total Population, All Services**
Authority to contract for all attributed populations, for all Medicaid services
- ❖ **Specialized Certified AE: Specialized Population, All Services**
Authority to contract for a specialized population, for a defined set of LTSS related services.

Certified Accountable Entities who commit to the AE Program requirements will be eligible to participate in the Medicaid Infrastructure Incentive Program, which is intended to support Accountable Entities in building the capacity – the people, processes and technology -- required for effective system transformation.

Note that EOHHS does not intend to contract directly with Certified Accountable Entities. The intent of the designation of Certified AEs is therefore to provide qualifications and guidelines for the Medicaid MCOs, as they transition to value based purchasing models and accountable care. As such, these qualifications and guidelines shall also be reflected in EOHHS arrangements with the Medicaid Managed Care organizations.

Certification Period and Continued Compliance with Certification Standards

Certification will be on an annual basis, in compliance with CMS requirements. AEs will be required to be in compliance with all standards and requirements throughout the certification period.

At the point of certification, procedures will be set forth for a certified AE to provide notification to EOHHS of any potential changes that may impact performance or represent material modifications to the AE in relation to the entity's submission and associated approval for participation in the AE program (e.g. change in ownership; change in contracted status with a MCO; change in the AE's legal or financial status such as but not limited to changes due to a merger, acquisition, or any other change in legal status; withdrawal or change in legal status of key partners; requests to add additional partners, or other material change. Upon notice and with reasonable opportunity for the AE to address identified deficiencies, EOHHS reserves the right to suspend or terminate certification. The AE shall not assign or transfer any right, interest, or obligation under this certification to any successor entity or other entity without the prior written consent of EOHHS.

III. Public Input Process

The process for developing these Certification Standards included substantive public input and discourse, as described below.

❖ **EOHHS RFI, Summer 2015**

In August, 2015 EOHHS posted a detailed RFI for our proposed Accountable Entity Pilot program, which included draft certification standards for Accountable Entities. Comments were provided by the following stakeholders:

- Neighborhood Health Plan
- United Health Care of New
- Care New England/Integra
- Prospect Health/Charter Care
- Lifespan
- Joint comments from NHP/RIHCA (Rhode Island Health Center Association)
- Thundermist
- Family Services of RI (CEDARR)
- CareLink
- PACE
- A joint set of comments from a multiple maternal and child health providers
- RIPIN
- Kids Count
- Economic Progress Institute

❖ **Pilot Certification Standards and application, October 2015**

Incorporated learnings from the RFI and public comments

❖ **DRAFT Full Program Certification Standards, December 2016**

The Medicaid Accountable Entity Roadmap, inclusive of draft Certification Standards, were posted for public input in December 2016. Twenty-four (24) comments were received from a variety of stakeholders representing provider, insurers, and advocates, as listed below:

- Blackstone Valley Community Health Center
- Carelink
- Center for Treatment and Recovery
- CHC ACO
- Coalition for Children and Families
- Coastal Medical
- Disability Law Center
- Economic Progress Institute

- Integra
- Kids Count
- LeadingAge
- Lifespan
- Neighborhood Health Plan of Rhode Island
- Partnership for Home Care
- Prospect Health Services of RI
- Providence Community Health Center
- RI Coalition for Children
- RI Community Action Agencies
- RI Health Care Association
- RI Health Center Association
- State of Rhode Island SIM Team
- Substance Use and Mental Health Leadership Council
- Tufts Health Public Plans
- UnitedHealthcare

The formal comments received on the Accountable Entity Roadmap, included approximately 72 comments specific to the certification standards. The following notes common themes present in the comments and that were reviewed in making modifications to the certification standards:

- Distinct Corporate Entity and Governance requirements
- Concerns about implications of financial requirements and risk taking for smaller providers.
- The regulatory role of the Department of Business Regulation for risk bearing entities
- Role of EOHHS in contracts between MCOs and AEs
- Concern that patient access and availability standards are too prescriptive
- Recommendation that State should consider extending the certification renewal process from one year to three years
- Providers in the Accountable Entity should not be required to have the same electronic health record platform
- Role of the state in ensuring data transparency on risk, claims and clinical data to allow AE to effectively manage care
- State should consider including social determinant of health in risk profiling

In addition to obtaining formal written comments, EOHHS has presented to the following 17 stakeholder groups regarding the HSTP/AE program.

- Integrated Care Initiative Provider Council
- 1115 Waiver Task Force
- Accountable Entity and Managed Care Organization Joint Sessions (two sessions)
- Broader Community Stakeholder Sessions (three sessions)

- Medicaid Specialized Accountable Entity Stakeholder Session (one)
- Home and Child Care Service Provider Meeting
- NASW Aging Committee
- Coalition for Children
- Governor’s Behavioral Health Council and a sub-committee (Health Transition Team)
- Department of Elderly Affairs Home and Community Care Advisory Committee
- CODAC Senior Leadership Team
- The Substance Abuse and Mental Health Leadership Council of RI

These forums have been a valuable component of our overall stakeholder engagement strategy and a venue for informing individual stakeholder groups of the Accountable Entity program status, vision, and goals. More importantly the array of stakeholder meetings has provided EOHHS with the opportunity to obtain feedback, recommendations, and address questions and concerns.

The EOHHS Accountable Entity team has also held 1:1 meetings with each Managed Care Organization, with Accountable Entities, with Home Care, Assisted Living and Nursing Home Trade association leadership teams as well as several individuals Long Term Services and Support agencies to discuss the final draft roadmap, inclusive of any concerns or questions specific to the certification standards, attribution, total cost of care methodology and quality measures, and incentive guidelines.

Most recently, two orientation sessions were held in May to provide an overview on a series of workgroup sessions that have been established to discuss the development of the Medicaid Specialized LTSS Accountable Entity program. The Specialized LTSS Accountable Entity workgroups consist of the following topic areas: certification standards/application, attribution guidelines, APM guidelines, Incentive Guidance and Contracting. The overall purpose of each workgroup is to help inform the design and development of each specific program component. The workgroups are a diverse representation of LTSS provider agencies, managed care organization, accountable entities, advocates, and state agencies. The workgroups will be meeting over the next several months.

EOHHS recognizes the value of ongoing stakeholder engagement, collaboration and consensus building and is committed to ensuring a transparent and open public process. EOHHS will continue to meet with stakeholders over the coming months, and anticipates working very closely with stakeholders, including MCOs and Accountable Entities, providers, and other community and advocacy groups to receive comments/feedback on upcoming guidance documents for total cost of care, inclusive of quality, attribution, and the incentive guidelines.

IV. Certification Standards: Comprehensive Accountable Entity

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

Summary of Domains for Certification:

1. Breadth and Characteristics of Participating Providers
2. Corporate Structure and Governance
3. Leadership and Management
4. 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. AEs are expected to work directly with partner organizations to address social determinants needs within a care plan.

For each requirement, applicants must either demonstrate specific compliance or identify how they will achieve compliance and a timeline for doing so. In the several domains for certification the AE is expected to demonstrate the ability to address the requirements. It is not necessarily the case the AE will itself have that capacity. For example, the 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.

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

1. Breadth and Characteristics of Participating Providers

An AE needs to have a critical mass of either Partner Providers or Affiliated Providers that are interdisciplinary with core expertise/direct service capacity in primary care and in behavioral health, inclusive of substance use services, for the populations the AE proposes to serve. The AE further needs to demonstrate defined relationships with providers of social services and supports to address critical social determinants of health for populations served.

An application will need to identify participating partners, the role of the partners, and the core of the AE delivery system. The AE must have a base attributable Medicaid population of 5,000 members,

based on PCP assignment of record within an MCO or assignment to an Integrated Health Home (IHH) as reported by BHDDH.

For each population (children and/or adults) that is to be attributed to the AE, the applicant must demonstrate that it has the capability to address and coordinate the needs of populations at all levels and the ability to coordinate and direct a significant portion of care for those populations. AEs should not only have a strong foundation in primary care but also be able to effectively coordinate care beyond the scope of PCP medical care. Total costs of care calculations are based on the full range of benefits and services included within EOHHS's contract with managed care organizations. Note, for reference, Attachment A provides a table identifying all services covered within the managed care contracts, including a supplemental table delineating required areas of behavioral health services coverage.

Primary care (PCP) capacity is evidenced through health services provided through a Rhode Island licensed, board-certified, or board eligible general practitioner, family practitioner, pediatrician or internal medicine physician, primary care geriatrician or through a licensed Advanced Practice Certified Nurse Practitioner, and/or Physician Assistant. Such clinicians shall have demonstrated core expertise in primary care and will serve as the member's initial and critical point of interaction. PCP responsibilities must include at a minimum:

- ❖ Serving as the member's Primary Care Provider (PCP) and medical home
- ❖ Willing and able to provide the level of care and range of services necessary to address the medical and behavioral needs of members, including those members with chronic conditions
- ❖ Provide overall clinical direction and serve as the central point for the integration and coordination of care
- ❖ Make referrals for specialty care, other medically necessary services, and services to address social determinants of health.

Whether located directly in the primary care provider setting or through direct coordination with arrangements made with or by the AE entity, the primary care provider shall also have the demonstrated capacity to provide integrated care management, particularly for complex need individuals, through nurse care manager or other specified care management support.

Behavioral health (BH) capacity must be demonstrated through evidence of direct BH service capacity within the AE. This may be through a Provider Partnership, an Affiliate Partnership with an IHH provider, through BH capacity within a single entity AE, or through an Associate Provider agreement with a separate behavioral health provider. Behavioral health capacity shall be commensurate with the size and needs of the attributed population. It is not required that direct capacity within the AE be able to provide the full range of services in the BH continuum of care (e.g. see BH section of Attachment A) but BH service capacity shall include, through direct service provision by a partner or through established relationships with other providers, the ability to ensure that a broad range of treatment options representing a continuum of care is available to members of each population for which certification is sought (children, adults).

Direct service capacity within the AE shall be evidenced by the participation of Rhode Island licensed providers. This can include programs licensed by the Office of Facilities and Program Standards within the R.I. Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH) for the provision of services to individuals who are developmentally disabled, mentally ill or individuals who have substance use or substance dependent disorders and can include programs licensed by the Department of Children, Youth, and Families. Direct service capacity can also be demonstrated through the participation of BH providers who are licensed by the Rhode Island Department of Health and who are permitted to practice and bill Medicare or Medicaid autonomously, whether in a private practice or in association with a private agency or institution. This can include but is not limited to licensed psychologists, psychiatrists, licensed psychiatric nurses, and licensed mental health counselors (LMHC), licensed marriage and family therapists (LMFT), and licensed independent clinical social workers (LICSW). Approved licensed provider agencies may expand their BH capacity through clinical supervision to a defined staff of BH practitioners not otherwise licensed to perform at the independent level. The overarching will accept responsibility for the quality of service provision as well as supervision of staff practicing under the independent license.

Physical and behavioral health providers are responsible for forming and maintaining partnerships to ensure overall wellness of AE members. In addition, BH practitioners will adhere to guidelines that incorporate dignity and worth of the individuals served, cultural awareness, diversity, as well as the individual's right to self-determination. Practitioners must adhere to Rhode Island General Law including Mental Health Law Chapter 40.1-5.

Substance Use Disorder (SUD) Treatment Capacity – capacity must be demonstrated through evidence of direct Substance Use treatment providers within the AE. This may be through a Provider Partnership, through in-house substance use service capacity within a single entity AE, or through an Associate Provider agreement with a separate SUD provider. SUD treatment capacity shall be commensurate with the size and needs of the attributed population. It is not required that direct capacity within the AE be able to provide the full range of services in the Substance Use continuum of care (e.g. see Substance Use Services section of Attachment A) but Substance Use service capacity shall include, through direct service provision by a partner or through established relationships with other providers, the ability to ensure that a broad range of treatment options is available to members of each population for which certification is sought (children, adults).

Direct service capacity within the AE shall be evidenced by the participation of Rhode Island licensed providers. This can include programs licensed by the Office of Facilities and Program Standards within the R.I. Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH) for the provision of services to individuals who have substance use or substance dependent disorders. Direct service capacity can also be demonstrated through the participation of Substance Use providers who are licensed by the Rhode Island Department of Health as Licensed Chemical Dependency Professionals and who are permitted to practice and bill Medicare or Medicaid autonomously, whether in a private practice or in association with a private agency or institution. Direct service capacity can also be demonstrated through the participation of Licensed Chemical Dependency Professionals who are permitted to practice under approved licensed provider agencies. Such licensed providers may expand

their treatment capacity through clinical supervision to a defined staff practicing under the Recognized Clinical Supervisor (RCS).

Substance use treatment, behavioral health, and physical health providers are responsible for forming and maintaining partnerships to ensure overall wellness of AE members. There may be times when SUD treatment is mandated by a Court. This should never interfere with the provision of service. Providers should coordinate with the Court as indicated by the AE member while also adhering to 42 CFR part 2.

Social determinants capacity – Social factors can play crucial roles in the health status and health outcomes. These include unstable housing, food insecurity, and exposure to safety risks and domestic violence, as well as many other factors. These examples raise stress levels, impact the progression of health conditions, impact one’s ability to mitigate health risks, or to access basic health care. A core feature of the AE initiative is to advance the systematic integration of social determinants of health into an individuals’ total care. The applicant is expected to identify three key domains of social need for each population for which certification is being sought (children, adults) and identify arrangements in place for the provision of pertinent services. EOHHS identifies three priority domains that would be expected areas of attention. However, on the basis of the needs of the population served an AE may propose different areas of focus for consideration. The three priority domains identified by EOHHS are:

- Housing Insecurity: Housing stabilization and support services; housing search and placement
- Food insecurity
- Safety and domestic violence

Services to help mitigate these needs can take a variety of forms (e.g. tenant/landlord mediation; legal supports; assisting members to access related services that they are entitled to, employment supports, other).

Social determinants capacity shall be evidenced by the participation of providers of pertinent social supports within the AE. This may be through defined relationships with community-based organizations, through in-house social supports capacity within a single entity AE, or through an Associate Provider agreement with a separate social supports agency. It is not required that direct capacity within the AE be able to provide the full range of social supports that may be appropriate to meet the needs of the attributed population (see for reference Table 2 below). Qualifying will be demonstrated in-house capacity and/or defined affiliations and working arrangements with CBOs that might fill in gaps in in-house capacity, such as Health Equity Zone participants, to address identified social contexts impacting health, outcomes. The requirement is for three domains of social determinants, not necessarily multiple affiliations.

1.1. Provider Base

- 1.1.1. Critical Mass for attribution. Identification of either Partner Providers or Affiliated Providers of primary care of BHDDH-recognized IHHs 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 for services to patients based on the work of individual clinicians working with or for the corporate entity.

1.1.1.1. Attribution: A comprehensive AE must have a base attributable Medicaid population of 5,000 members in accordance with EOHHS Attribution Guidance.

1.1.2. Population specific AE application: Delineation of capacity by population served: Children, adults

1.1.2.1 Population specific primary care and behavioral health capacity to serve children, including adequate pediatricians, family practice clinicians, and APRNs/PAs and pediatric behavioral health providers.

1.1.2.2 Population specific primary care and behavioral health capacity to serve adults, including adequate internists, family practice clinicians, primary care geriatricians, and/or APRNs/PAs and adult behavioral health providers.

1.1.2.3 Population Specific substance use service capacity

1.1.2.4 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. 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.

1.2. Relationship of Providers to the AE

1.2.1. Partner vs. affiliate vs. associated/contracted providers. Certification that all identified partner and affiliate providers have agreed to participate in, and be accountable for health care transformation efforts, as set forth in these certification standards, including use of a total cost of care based Alternative Payment Methodology, in accordance with EOHHS APM Guidance.

1.2.2. Description of types of member providers and clinicians and their relationship to the Entity:

Note that clinicians employed by a participating provider entity are by definition deemed to be participating in, and accountable for health care transformation efforts of the Partners or Affiliates that employ them.

- 1.2.2.1. Partner Providers are the core organizational and corporate 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, as applicable. Primary care Partner Providers and BHDDH identified IHH providers are recognized providers in attribution methodologies.
- 1.2.2.2. Affiliate providers are primary care providers or BHDDH identified IHH providers that 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.
- 1.2.2.3. 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 substance use services or 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.

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

- 1.3.1. Demonstrate that the AE is capable of meeting all AE requirements to deliver the full continuum of needs for attributed populations by either providing services directly or through accountable care management to ensure smooth transitions to, and follow up and maintain active contract with service providers across the full continuum of member need. (For reference, see Attachment A)
 - 1.3.1.1. Physical Health: service delivery/coordination capacity beyond the scope of PCP medical care, including specialty and inpatient care.
 - 1.3.1.2. Behavioral Health: meet preventive, routine, and high-end behavioral health needs.
 - 1.3.1.3. Integrated PH/BH: Evidence of direct participation of identified working relationships with a full continuum of BH providers as shown in Attachment A, including recognized IHH providers

- 1.3.1.4. Integrated SUD treatment, across the spectrum of need including opioid addiction services
- 1.3.1.5. Social Determinants: Community Health Team, CBO partner addressing targeted social determinant area (e.g. focus on housing/housing security).
- 1.3.2. Develop and implement agreed upon protocols that guide the interaction between providers across the continuum of care and to integrate care delivery.

1.4. Defined Methods to Care for People with Complex Needs

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

1.5. Able to Ensure Timely Access to Care

Minimally - Able to Demonstrate Compliance with all pertinent MCO Access requirements, as specified in the MCO contract and documented below

- 1.5.1. Assuring timely (within 30 minutes) after-hours phone access

1.5.1.1. Minimum Access Standards:

Appointment	Access Standard
After Hours Care Contact (Telephone, text, email)	24 hours 7 days a week
Urgent Care Appointment	Within 24 hours
Routine Care Appointment	Within 30 calendar days
New Member Appointment	30 calendar days
Physical Exam	180 calendar days
EPSDT appointment	Within 6 weeks
Non-emergent, non-urgent mental health or substance use condition	Within ten (10) business days for diagnosis or treatment

2. Corporate 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 include: (1) 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; (2) to ensure that assets and resources intended to support RI Medicaid are appropriately allocated, protected, and retained in Rhode Island; (3) to ensure that the mission and goals of the new entity align with the goals of EOHHS and the needs of the Medicaid population; (4) 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 Accountable Entity. Or, a single entity that includes all required capabilities may be a qualified applicant.

If two or more parties form the AE applicant, 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 Governing Committee with distinct obligations and authorities in management of the AE program. The composition of the Governing Committee must include participation of various constituencies as set forth below. The Governing 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 parties, 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 medical, behavioral health, and social needs.
- Governing Board of Directors or Governing Committee shall meet regularly, not less than bi-monthly

These requirements are further defined in sections 2.1 -2.6. For each requirement, applicants must either demonstrate specific compliance or propose an approach and timeline not to exceed nine months from the date of provisional certification to come into full compliance.

2.1 Multiple Entity Applicant - Distinct Corporation

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

- 2.1.2. Governing Board must meet regularly and be separate and unique to the AE and not the same as a governing board of any specific accountable entity participant.
- 2.1.3. Statement of Purpose – Mission Statement that aligns with EOHHS goals
 - 2.1.3.1. Committed to progression to an integrated and accountable system of care with a primary concern for the health outcomes of attributed members and the progressive use of outcome-based metrics to assess progress and success
- 2.1.4. By-Laws Set forth Membership on the Board of Directors with voting rights that is inclusive of the minimum requirements set forth by EOHHS
- 2.1.5. Inclusion of Board Level Governing Committees with a distinct focus on Medicaid, and inclusive of as an Integrated Care Committee, a Quality Oversight Committee, and a Finance Committee
- 2.1.6. Include quarterly progress dashboards to monitor quality and cost effectiveness to support the MCO's and AE's ability to monitor and improve performance.
- 2.1.7. A Compliance Officer with an unimpeded line of communication with the Board and who is not the legal counsel for the Board
- 2.1.8. Community Advisory Committee
 - 2.1.8.1. CAC consisting of at least seven persons who are attributed Medicaid beneficiaries or who are appropriate family representatives of those beneficiaries and who are representative of the populations served by the AE.
- 2.1.9. Fiduciary and Administrative Responsibility Resides with BOD.
 - 2.1.9.1. The AE's administration must report exclusively to the governing Board through the AE's chief executive officer
- 2.1.10. Defined conflict of interest provisions that
 - 2.1.10.1. Require each member of the governing body, sub-committees, employees and consultants to disclose relevant financial interests
 - 2.1.10.2. Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise.
 - 2.1.10.3. Address remedial action for members of the governing body that fail to comply with the policy

2.2. Single Entity Applicant

- 2.2.1. Established corporation, recognized and authorized under applicable Rhode Island State law and with an applicable Taxpayer Identification Number.
- 2.2.2. 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.
- 2.2.3. Governing Committee must meet regularly, not less than bi-monthly, 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

- 2.2.4. Statement of Purpose – Mission Statement that aligns with EOHHS goals
 - 2.2.4.1. Committed to progression to an integrated and accountable system of care with a primary concern on the health outcomes of attributed members and the progressive use of outcome-based metrics to assess progress and success
- 2.2.5. 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
- 2.2.6. Inclusion of governance sub-committees with a distinct focus on Medicaid, including an Integrated Care Committee, a Quality Oversight Committee, and a Finance Committee
- 2.2.7. Include quarterly progress dashboards to monitor quality and cost effectiveness to support the MCO's and AE's ability to monitor and improve performance.
- 2.2.8. A designated Compliance Officer with an unimpeded line of communication with the Board of Directors of the single entity.
- 2.2.9. Community Advisory Committee
 - 2.2.9.1. CAC consisting of at least seven persons who are attributed Medicaid beneficiaries or an appropriate family representative of those beneficiaries and 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.
- 2.2.10. Defined conflict of interest provisions that
 - 2.2.10.1. Require each member of the governing committee, sub-committees, employees and consultants to disclose relevant financial interests
 - 2.2.10.2. Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise.
 - 2.2.10.3. Address remedial action for members of the governing committee that fail to comply with the policy

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

2.3.1. 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.

- 2.3.1.1. Multi-disciplinary in composition and inter-disciplinary in practice.

- 2.3.1.2. Defined, transparent structure ensuring partners have shared and aligned incentives
- 2.3.1.3. Leverage strengths of partners toward an integrated person-centered system of care

2.3.2. Board or Governing Committee Membership

- 2.3.2.1. The majority of voting members of the Board or the Governing Committee shall be primary care providers (i.e. representatives appointed by the respective provider) plus behavioral health providers (i.e. representatives appointed by the respective provider) from participating Partner or Affiliate provider organizations, provided that at least three members shall be primary care providers and three members shall be behavioral health providers. The meaning of the term provider is as set forth in Section 1.1.1
- 2.3.2.2. Minimal representation requirements, for each population certified to serve
 - 2.3.2.2.1. **Children:** Pediatric primary care provider, Pediatric BH provider, Pediatric representative member of Consumer Advisory Committee, CBO provider of age appropriate social supports (i.e. representatives appointed by the respective provider)
 - 2.3.2.2.2. **Adults:** Internal Medicine primary care provider, Adult BH provider, Adult representative member of Consumer Advisory Committee, CBO provider of age appropriate social supports (i.e. representatives appointed by the respective provider)

2.4. Compliance

- 2.4.1. Provisions for assuring compliance with State, Federal law re: Medicaid, Medicare
- 2.4.2. Policies and Procedures related to debarred providers, discrimination, protection of privacy, use of electronic records
- 2.4.3. Policies and procedures for compliance with anti-trust rules and regulations.
- 2.4.4. 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 Governing Committee.

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

- 2.5.1. Required for attribution, shared savings required for participation in Health System Transformation Program (HSTP) incentive funds eligibility
- 2.5.2. Comport with EOHHS defined delegation rules re: AE/MCO distribution of functions

3. Leadership and Management

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

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

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

3.1. Leadership Structure

There must be a single, unified vision and leadership structure, with commitment of senior leaders, backed by the required resources to implement and support the vision. The AE shall describe how its current structure meets these requirements or set forth a defined plan with fixed dates and deliverables as to how compliance would be progressively achieved within nine months of the date of provisional certification. This includes:

- 3.1.1. For a multiple entity AE a Chief Executive responsible to the BOD and responsible for AE operations. Appointment of removal of the chief executive is under the control of the governing board. 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. 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 of the single entity.
- 3.1.3. Management structure/staffing profile describing how the various component parts of the AE will be integrated into a coordinated system of care. May include specific management services agreements with MCOs or subcontracts under the direction of the AE. Pertinent areas include:
 - 3.1.3.1. Integrated Care Management
 - 3.1.3.2. IT Infrastructure/Data Analytics
 - 3.1.3.3. Quality Assurance and Tracking
 - 3.1.3.4. Finance - Description of infrastructure for
 - 3.1.3.4.1. Unified financial leadership and systems
 - 3.1.3.4.2. Financial modeling capabilities and indicators
 - 3.1.3.4.3. Designing incentives that encourage coordinated, effective, efficient care
- 3.1.4. 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 benefits that are included within the MCO contract with EOHHS. 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.

- 3.1.5. 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 and evidence-based decision support systems based on complete patient information and clinical data across life domains. This data will be used to inform and facilitate Integrated Care Management across disciplines, including strategies to address social determinants of health care.

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

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

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

4.1. Core Data Infrastructure and Provider and Patient Portals

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

- 4.1.1.1. Able to ensure data quality, completeness, consistency of fields, definitions
- 4.1.1.2. EHR capacity: Ability to share information with partner and affiliate providers.
 - 4.1.1.2.1. Achieve “State 2 Meaningful Use” requirements based on CMS EHR Incentive program or equivalent standard subject to EOHHS approval. Use EHR systems to document medical, behavioral, and social needs in one common medical record that can be shared across the network within HIPAA guidelines. Complies with enhanced certification standards or EHRs promoted through CMS EHR incentive Payment Program that require EHRs to capture clinical data necessary for quality measurement as part of care delivery and calculate and report electronic clinical quality for all patients treated by individual providers.
- 4.1.1.3. Patient registries – shared patient lists (e.g. PCP, BH provider, Care management) to ensure providers are aware of patient engagements.
- 4.1.1.4. Demonstrate that at least 60% of AE patients are enrolled in CurrentCare and/or document a plan to increase CurrentCare enrollment.
- 4.1.1.5. AE provider participants must contribute data from their EHRs to CurrentCare (AE office based providers will send encounter data in a Clinical Care Document Format (CCD) via “Direct” secure messages). AE provider participants must have the ability to receive data from CurrentCare or CurrentCare enrolled patients in at least one of the following ways: Through bi-directional interfaces with CurrentCare, or where RIQI and AE provider participants’ EHR vendor capacity exists, ensure staff have appropriate access to CurrentCare viewer or CurrentCare data within their EHR.

4.2. Provider and Care Managers’ Access to information

- 4.2.1. Look up capability – connecting clients, client records and providers
 - 4.2.1.1. Ability to review medications lists
 - 4.2.1.2. Promote Collaborative service delivery
 - 4.2.1.3. Ensure capability to communicate via shared messaging
 - 4.2.1.4. Referral management - Ability to create & rout referrals; receive information back
 - 4.2.1.5. Provider Alerts & notifications: Critical incidents, Hospital admissions & discharges
 - 4.2.1.6. **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.
- 4.2.2. Patient Portals to enhance engagement, awareness, and self-management opportunities.

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 supports into risk profiling, by population)

- 4.3.1. Identified methodology and tools for attributed member risk stratification: Highest complexity, rising/imminent risk groups
- 4.3.2. By population groups included in certification: Children, adults,
- 4.3.3. Incorporating social determinants (e.g. housing, family support systems) into risk profiling, by population
- 4.3.4. Able to identify their use of validated, effective, credible tools for analytic profiling

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

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

- 4.4.1. Defined set of business process metrics meaningfully targeted to both operational and total cost of care efficiency.
- 4.4.2. Actions to Enhance Ability to Manage Care processes. Reshaping workflows for: availability and access, high impact interventions, reduce variance in quality/outcomes
- 4.4.3. Defined tools in place for tracking and monitoring level of performance in meeting contact and follow up objectives in implementation of the care model; established protocols for review of performance and feedback loops for quality improvement.

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

- 4.5.1. HIT tools to provide clinical decision support to providers to help ensure they follow the evidence-based care pathways
- 4.5.2. Define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care.
- 4.5.3. Provision of actionable information to providers within the system
 - 4.5.3.1. Analysis of gaps, needs, risks based on evidence based practice. Gaps in care reports based on deviations from evidence based practice.
 - 4.5.3.2. To help enhance, help direct care coordination/care management. E.g. Medications management – information on the pharmacy claims. Whether prescriptions have been filled? Whether follow up appointments with referrals have occurred.
- 4.5.4. Early warning system
 - Established methods to alert, engage the care management team to critical changes in utilization. Alerted before bearing the full burden of costs.
 - 4.5.4.1. Employ a Care Management Dashboard (real time dashboard of patient-admissions and discharges to EDs and hospitals)
 - 4.5.4.2. Employ Care Management Alerts (ADT notification via direct messaging of ED and hospital admissions and discharges)

- 4.5.4.3. Contribute provider files on own AE organization and providers to statewide common provider directory

4.6. Staff Development – Training

- 4.6.1. Training in, and expectation for, using data systems effectively, using data to manage patients care.
- 4.6.2. Ongoing aggregate reporting with individual/team drill-downs re: Conformance with accepted standards of care, deviations from best practice, identified breakdowns in process

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 and family 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 BH and PH/primary care
- 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 approach key social determinants of health. These can include social factors such as housing, food security, family and social support, safety and

domestic violence, education and literacy, employment, transportation, criminal justice involvement, and neighborhood stress levels.

5.2.2. Population Health and SDOH Assessment

Evaluate the social needs of their members and take actions to maximize the degree that Attributed Members receive appropriate care and follow-up based on their identified social needs.

- 5.2.2.1. 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 protocol shall identify what triggers a screening and may be based on such factors as diagnosis, care utilization pattern or patient self-identification. Procedures shall address approach to completing an initial SDOH Care Needs Screening minimally for persons identified as rising risk and high risk attributed members within 90 days of the Effective Date of Enrollment or of the identification of the individual as rising risk or high risk and annually for each attributed member.
- 5.2.2.2. The SDOH Care Needs Screening shall be an instrument defined by the AE and reviewed by EOHHS. 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; and
- 5.2.2.3. Evaluate Attributed Members' SDOH screening needs through regular analysis of available claims, encounter, & clinical data on diagnoses and patterns of care, in partnership with participating MCOs;
- 5.2.2.4. Develop reporting or claiming mechanism to allow social needs diagnostic codes to be provided to MCO.

5.2.3. Tracking and Follow-up Referrals. Ensure that Attributed Members receive warm-transfers for appropriate care and follow-up based on their identified SDOH needs. May be done in direct coordination with MCOs.

- 5.2.3.1. Develop a standard protocol for referral for social needs using evidence and experience-based learning and for tracking referrals and follow-up. Social needs assistance shall include:
 - Referring to providers, social service agencies, or other community-based organizations that address the Attributed Member's needs

- Providing support to maximize successful referrals, which may include:
 - Actions to maximize the outcome that the Member attends the referred appointment or activity, including activities such as coordinating transportation assistance & following up after missed appointments;
 - The Attributed Member’s PCP or care team member communicating and sharing records with the provider being referred to, as appropriate to coordinate care; and
 - The Attributed Member’s PCP or care team member directly introduces the Attributed Member to the service provider, if co-located, during a medical visit (i.e., a “warm hand-off”);
 - Providing information and navigation to the Attributed Member regarding community providers of social services that address the Attributed Member’s health-related social needs, as appropriate;
 - Providing the Attributed Member with information and counseling about available options; and
 - Coordinating with community providers of social services to improve integration of care.

- 5.2.3.2. Within one year of certification by EOHHS, provide EOHHS with documented plan for the tracking and reporting of referrals for social needs to MCO. The plan should include:
- Standardized protocol for referral to social service provider
 - Methods for tracking referrals
 - Development of metrics to define a successful referral
 - Development of reporting of metrics and referral information to MCO

- 5.2.4. Commit to participate in collaborative process with EOHHS to develop standards for:
- Development of metrics for successful social service interventions;
 - Data sharing between AE and social service providers to facilitate successful interventions;
 - Best practices for formal and informal relationships between AEs and social service providers to support successful interventions;
 - Identification of social needs intervention gaps in Rhode Island; and
 - Future infrastructure needs to support social needs intervention for Rhode Islanders.

- Require that the CBO track and report on all referrals from the AE, through a monthly list of all attributed AE members who have been referred, and the status of interventions

5.2.5. 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 partner with EOHHS, URI, RI College, CCRI, and other education and training providers to support RI's workforce transformation efforts. Such efforts shall include, but not be limited to, the following activities:

- 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
 - 5.3.2.1. Develop Memoranda of Understanding with URI, RIC, CCRI and/or other education and training providers to assist in educational planning, curriculum development, instruction, clinical training, research, and/or other educational activities related to healthcare workforce transformation.
 - 5.3.2.2. Develop partnerships with URI, RIC, CCRI and/or other education and training providers to expand clinical rotations and/or internships to prepare health professional students with new knowledge and skills, for new occupations and roles, in new settings and new models of care to achieve RI's health system transformation goals.
 - 5.3.2.3. Develop partnerships with URI, RIC, CCRI and/or other education and training providers to expand continuing education for current employees of AE partners to provide them with new knowledge and skills, for new occupations and roles, in new settings and new models of care, to achieve RI's health system transformation goals.
 - 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-divers 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 strategy to integrate person-centered medical, behavioral, and social services for individuals at 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. An effective AE must have a systematic process to target the top 1% - 5% most complex patients in each relevant subpopulation for care management and support. The AE will have tools to systematically track and coordinate care across specialty care, facility- based care and community organizations, as well as the ability to rapidly recognize and effectively respond to changes in a condition.

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 services

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

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

6.1. Systematic Processes to Identify Patients for Care Management

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

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

6.2. Defined Care Management Team with Specialized Expertise Pertinent to Characteristics of Rising Risk and High Risk Target population

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

6.3. Individualized Person Centered Care Plan - Care Management for Rising Risk, High-Risk Targeted Members

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

- 6.3.4.3. Engagement with CBOs, providers of social support services as part of the implementation of the care plan
 - 6.3.4.4. AE pays close attention to effective, warm handoffs where they occur.
 - 6.3.4.5. Specific attention to transitions of care (between settings, between youth/adult services)
 - 6.3.4.6. Person Centered Care plan developed in collaboration with the member or caregiver and is driven by the member's priorities, motivations, and goals, ensures that the member is engaged in and understands the care she will receive.
 - 6.3.4.7. Begins by looking at the person. Motivational interviewing. Care plan built around the person, not around services.
 - 6.3.4.8. The Care Plan is readily available to the member
 - 6.3.4.9. Strength based. Provides for continuity
 - 6.3.4.10. Processes for working closely with members, family members and caregivers, range of providers to assure adherence to the care plan
 - 6.3.4.11. Encourage patient and/or family health education and promotion
 - 6.3.4.12. Leverage Home-based services, and telephonic and web-based communications, group care, and the use of culturally and linguistically appropriate care;
 - 6.3.4.13. Programs to promote healthy lifestyles, developing skills in self-care. Sees intermittent failure as part of the pathway.
- 6.3.5. Educates and trains providers across the full continuum of care regarding the care integration strategy and provider requirements for participation.

7. Member Engagement

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

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

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

- 7.1.1. Communication approach that recognizes highly complex, multi-condition high cost members Recognizes that the roots of many problems are based in childhood trauma; that

many of the highest need individuals have a basic mistrust of the health care system. Often does not have a primary existing affiliation with a PCP.

- 7.1.2. Identified population specific strategies, methods to actively develop a trusting relationship through the use of evidence-based and patient-centered engagement methods
- 7.1.3. Use culturally competent communication methods and materials with appropriate reading level and communication approaches.
 - 7.1.3.1. Uses methods adapted to recognize that compliance with patient notification requirements is not the same as effective communication with members
 - 7.1.3.2. Tools are understandable, and culturally and linguistically appropriate

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

- 7.2.1. Established capabilities to educate members/promote the use of technologies for member engagement. This includes technologies that may not be covered by Medicaid but might support/enable people to be better able to manage health conditions.
 - 7.2.1.1. Demonstrated use of Products that support monitoring and management of an individual's physiological status and mental health (e.g. vital sign monitors, activity/sleep monitors, mobile PERS with GPS)
 - 7.2.1.2. Demonstrated use of Products that support monitoring and maintaining the functional status of vulnerable adults in their homes (Fall detection technologies, environmental sensors, video monitoring)
 - 7.2.1.3. Technologies, products that support both informal and formal caregivers providing timely, effective assistance.
- 7.2.2. Established capabilities to leverage relevant, cost effective technologies including, but not limited to:
 - 7.2.2.1. Social media applications to promote adherence to treatment
 - 7.2.2.2. Use of technologies that enable vulnerable adults to stay socially connected (Social communication/PC mobile apps for remote caregivers, cognitive gaming & training, social contribution)
 - 7.2.2.3. Demonstrated use of telemedicine

8. Quality Management

8.1. Quality Committee and Quality Program

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

- 8.1.1. Members of the AE Quality Committee will minimally include an identified board certified physician licensed in the State of Rhode Island who is an AE participating clinician, a behavioral health clinician at the independent practice level who is licensed in Rhode

island and who is an AE participating clinician, and an individual from a community based service organization that provides key social supports to attributed members of the AE.

8.2. Methodology for the Integration of Medical, Behavioral, and Social Supports

AE will develop defined methods and processes to advance the integration of medical, behavioral, and social supports for AE members. Such methodology will include internal capacity at an AE plus Partners, Affiliates, Associates and other providers/suppliers as pertinent to the structure of the AE. Methods and processes to advance integration will be evidenced through executed Policies and Procedures and Operational Protocols

8.2.1. The AE will be able to identify how it will require AE participants and providers/suppliers to comply with and implement each process, including the remedial processes and penalties (including the potential for expulsion) applicable to AE participants and AE providers/suppliers for failure to comply with and implement the required process; and explain how it will employ its internal assessments of cost and quality of care to continuously improve-the AE's care practices

8.3. Clinical Pathways, Care Management Pathways, and Evidence Based Practice

AE will identify a method for (a) promoting evidence-based practice and (b) integration and review of clinical pathways, care management pathways based on evidence-based practice. The minutes of, and reports to, the Quality Committee as to the performance of the Quality Program will report on implementation and tracking of defined strategies for promoting the introduction and utilization of evidence based practices in clinical and care management pathways.

8.4. Quality Performance Measures

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

8.4.1. 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.

V. Certification Standards: Specialized LTSS Accountable Entity

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 Partner or Affiliated provider:

Table A: Attributable Services

Attributable Service*	Adults	Children
Attributable Home and Community Based Services	<ul style="list-style-type: none"> • Homemaker • Personal Care Services • Adult Day Services • Assisted Living • Supported Living Arrangements/ Shared Living 	<ul style="list-style-type: none"> • Certified Nursing Assistant Services • Pediatric Private Duty Nursing
Attributable Institutional Services	<ul style="list-style-type: none"> • 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.

LTSS Pilot AEs serving adults must demonstrate direct home care (including homemaker and personal care assistance) and adult day care capacity within the participating LTSS AE provider base (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 are 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. 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.

LTSS Pilot AEs serving children must demonstrate direct certified nursing assistant (CNA) services and pediatric private duty nursing capacity within the participating LTSS AE provider base (partner or affiliated providers) as specified below:

- **Direct Certified Nursing Assistant (CNA) 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 skills — 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.

Applicants **may also choose to include direct capacity in the other attributed services listed in Table A (Assisted Living, Supportive Living Arrangements/Shared Living, and/or Long-Stay Nursing Facility Care)** as part of their LTSS Pilot AE, as specified below. Note that demonstrated direct service capacity in these areas is not required, but would be included in the determination of attributed lives.

- **Assisted Living** capacity, including 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** capacity includes any 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** capacity includes 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.

Although direct service capacity in nursing facility care is not a requirement, a successful LTSS Pilot AE must 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 B. The “Included Services” listed in Table B, 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 B: Service List by Population

LTSS Services	Children <i>w/Special Health Care Needs</i>		Adults <i>including nonelderly adults with disabilities and elderly</i>	
	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 (CNA) 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 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 for services to patients based on 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 a 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:

1.1.2.1 **Adults: Direct service capacity** within 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 with co-occurring physical and behavioral health needs including Alzheimer’s and related dementias. For purposes of attribution, applicants may also include direct capacity in Assisted Living, Supportive Living Arrangements/Shared Living, and/or Long-Stay Nursing Facility Care as part of their LTSS Pilot AE, as defined above.

1.1.2.2 **Children: Direct service capacity** within 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

1.1.2.3 **Population specific capability to facilitate smooth and timely transitions** to, and follow up with nursing facilities and hospitals.

1.1.2.4 **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 B 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, such as senior centers)
- 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 to 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 their relationship to the Entity: Partner vs. affiliate vs associated/contracted providers. Note that 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 Governing Committee with distinct obligations and authorities in management of the AE program. The composition of the Governing Committee must include participation of various constituencies as set forth below. The Governing 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 members or their caregivers or advocates who are representative of the populations served by the AE.
- 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 **the following Board Level Governing Committees** with a distinct focus on Medicaid: 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 members or their caregivers 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 of 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 governing 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 members or their caregivers 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 Governing 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 B. 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 member 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 warm transfers for 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 B 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, developed in collaboration with the member and their caregiver, should reflect the member's priorities and goals, ensure that the member is engaged in and understands the care he/she will receive, and include 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 of 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 A: Scope of Benefits Included In EOHHS Contracts with Managed Care Organizations

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Inpatient Hospital Care	As medically necessary. EOHHS shall be responsible for inpatient admissions or authorizations while Member was in Medicaid fee-for-service, prior to Member's enrollment in Health Plan. Contractor shall be responsible for inpatient admissions or authorizations, even after the Member has been dis-enrolled from Contractor's Health Plan and enrolled in another Health Plan or re-enrolled into Medicaid fee-for-service, until the management of the Member's care is formally
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting
Therapies	Covered as medically necessary, includes physical therapy, occupational therapy, speech therapy, hearing therapy, respiratory therapy and other related therapies.
Physician/Provider Services	Covered as needed, based on medical necessity, including primary care, specialty care, and obstetric and newborn care.
Family Planning Services	Enrolled female members have freedom of choice of providers for family planning services.
Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Generic substitution only unless provided for otherwise as described in the <i>Managed Care Pharmacy Benefit Plan Protocols</i> .
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider. Limited to non-prescription drugs, as described in the <i>Medicaid Managed Care Pharmacy Benefit Plan Protocols</i> . Includes nicotine cessation supplies ordered by a Health Plan physician. Includes medically necessary nutritional supplements ordered by a Health Plan physician.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Laboratory Services	Covered when ordered by a Health Plan physician/provider including urine drug screens.
Radiology Services	Covered when ordered by a Health Plan physician/provider.
Diagnostic Services	Covered when ordered by a Health Plan physician/provider.
Mental Health and Substance Use –Outpatient& Inpatient	Covered as needed for all members, including residential substance use treatment for youth. Covered services include a full continuum of Mental Health and Substance Use Disorder treatment, including but not limited to, community- based narcotic treatment, methadone, and community detox. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). Also includes, DCYF ordered administratively necessary days (See Attachments O & P for further details), or hospital-based detox, MH/SUD residential treatment (including minimum 6 month SSTAR birth residential services), Mental Health Psychiatric Rehabilitative Residence (MHPRR), psychiatric rehabilitation day programs, Community Psychiatric Supportive Treatment (CPST), Crisis Intervention for individuals with severe and persistent mental illness (SPMI) enrolled in the Community Support Program (CSP), Opioid Treatment Program Health Homes (OTP), Assertive Community Treatment (ACT), Integrated Health Home (IHH), and services for individuals at CMHCs.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Home Health Services	Covered services include those services provided under a written plan of care authorized by a physician/provider including full-time, part-time, or intermittent skilled nursing care and certified nursing assistant services as well as physical therapy, occupational therapy, respiratory therapy and speech-language pathology, as ordered by a health plan physician. This service also includes medical social services, durable medical equipment and medical supplies for use at home. Home Health Services do not include respite care, relief care or day care.
Home Care Services	Covered services include those provided under a written plan of care authorized by a physician/provider including full-time, part-time or intermittent care by a licensed nurse or certified nursing assistant as well as; physical therapy, occupational therapy, respiratory therapy and speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. Home care services do not include respite care, relief care or day care.
Preventive Services	Covered when ordered by a health plan physician/provider. Services include homemaker services, minor environmental modifications, physical therapy evaluation and services, Respite Services, personal care services and Habilitative Services.

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
EPSDT Services	<p>Provided to all children and young adults up to age 21. Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes inter-periodic screens as <i>medically</i> indicated. Includes multi-disciplinary evaluations and treatment for children with significant disabilities or developmental delays.</p>
Emergency Room Service and Emergency Transportation Services	<p>Covered both in- and out-of-State, for Emergency Services, or when authorized by a Health Plan Provider, or in order to assess whether a condition warrants treatment as an emergency service.</p>
Nursing Home Care and Skilled Nursing Facility Care	<p>Covered when ordered by a Health Plan physician/provider. For Rhody Health Partners members limited to thirty (30) consecutive days. All skilled and custodial care covered. Rlte Care member are subject to stop loss. Rhody Health Partners and Medicaid Expansion members should be dis-enrolled after 30 days. After 15-day admission, Contractor is responsible for notifying the State to begin dis-enrollment process.</p>
School-Based Clinic Services	<p>Covered as Medically Necessary at all designate sites.</p>
Services of Other Practitioners	<p>Covered if referred by a Health Plan physician. Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.</p>

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
<p>Court-ordered mental health and substance use services – criminal court</p>	<p>Covered for all members. Treatment must be provided in totality, as directed by the Court or other State official or body (i.e. a Probation Officer, The Rhode Island State Parole Board). If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. The following are examples of Criminal Court Ordered Benefits that must be provided in totality as an in-plan benefit:</p> <ul style="list-style-type: none"> • Bail Ordered: Treatment is prescribed as a condition of bail/bond by the court. • Condition of Parole: Treatment is prescribed as a condition of parole by the Parole Board. • Condition of Probation: Treatment is prescribed as a condition of probation • Recommendation by a Probation State Official: Treatment is recommended by a State official (Probation Officer, Clinical social worker, etc.). • Condition of Medical Parole: Person is released to treatment as a condition of their parole, by the Parole Board.

<p>Court-ordered mental health and substance use treatment – civil court</p>	<p>All Civil Mental Health Court Ordered Treatment must be provided in totality as an in-plan benefit. All regulations in the State of Rhode Island and Providence Plantations, Title 40.1, Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1- 5, Mental Health Law, Section 40.1-5.5 must be followed. If the length of stay is not prescribed on the court order, the Health Plans may conduct Utilization Review on the length of stay. The Managed Care Organizations must offer appropriate transitional care management to persons upon discharge and coordinate and/or arrange for in-plan medically necessary services to be in place after a court order expires. Note the following are facilities where treatment may be ordered: The Eleanor Slater Hospital, Our Lady of Fatima Hospital, Rhode Island Hospital (including Hasbro), Landmark Medical Center, Newport Hospital, Roger Williams Medical Center, Butler Hospital (including the Kent Unit), Bradley Hospital, Community Mental Health Centers, Riverwood, and Fellowship. Any persons ordered to Eleanor Slater Hospital for more than 7 calendar days, will be dis-enrolled from the Health Plan at the end of the month, and be re- assigned into Medicaid FFS. Civil Court Ordered Treatment can be from the result of:</p> <ul style="list-style-type: none"> a) Voluntary Admission b) Emergency Certification c) Civil Court Certification <p>Court-ordered treatment that is not an in-plan benefit or to a non-network provider, is not the responsibility of the Contractor. Court ordered treatment is exempt from the 30-day prior authorization requirement for residential treatment as defined in SECTION 2.12.03.02.</p>
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SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
Podiatry Services	Covered as ordered by Health Plan physician/provider.
Optometry Services	<p><i>For children under 21:</i> Covered as medically necessary with no other limits.</p> <p><i>For adults 21 and older:</i> Benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years. Eyeglass lenses are covered more than once in 2 years only if medically necessary. Eyeglass frames are covered only every 2 years. Annual eye exams are covered for members who have diabetes. Other medically necessary treatment visits for illness or injury to the eye are covered.</p>
Oral Health	<p><i>Inpatient:</i> Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an inpatient setting.</p> <p><i>Outpatient:</i> Contractor is responsible for operating room charges and anesthesia services related to dental treatment received by a Medicaid beneficiary in an outpatient hospital setting.</p> <p><i>Oral Surgery:</i> Treatment covered as medically necessary. As detailed in the <i>Schedule of In-Plan Oral Health Benefits updated January 2017</i>.</p>
Hospice Services	Covered as ordered by a Health Plan physician/provider. Services limited to those covered by Medicare.
Durable Medical Equipment	Covered as ordered by a Health Plan physician/provider as medically necessary.
Adult Day Health	Day programs 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,

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
	meals, and other services in a community group setting. Adult Day Health programs are for adults who return to their homes and caregivers at the end of the day.
Children’s Evaluations	Covered as needed, child sexual abuse evaluations (victim and perpetrator); parent child evaluations; fire setter evaluations; PANDA clinic evaluations; and other evaluations deemed medically necessary.
Nutrition Services	Covered as delivered by a licensed dietitian for certain medical conditions as defined in http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7065.pdf and as referred by a Health Plan physician.
Group/Individual Education Programs	Including childbirth education classes, parenting classes, wellness/weight loss and tobacco cessation programs and services.
Interpreter Services	Covered as needed.
Transplant Services	Covered when ordered by a Health Plan physician.
HIV/AIDS Non-Medical Targeted Case Management for People Living with HIV/AIDS (PLWH/As) and those at High Risk for acquiring HIV	This program may be provided for people living with HIV/AIDS and for those at high risk for acquiring HIV (see provider manual for distinct eligibility criteria for beneficiaries to qualify for this service). These services provide a series of consistent and required “steps” such that all clients are provided with and Intake, Assessment, Care Plan. All providers must utilize an acuity index to monitor client severity. Case management services are specifically defined as services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation. Targeted case management can be furnished without regard to Medicaid’s state-wideness or comparability requirements. This means that case management services may be limited to a specific group of individuals (e.g., HIV/AIDS, by age or health/mental health condition) or a specific area of the state. (Under EPSDT, of course, all children who

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
	<p>require case management are entitled to receive it.) May include:</p> <ul style="list-style-type: none"> • Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible • All types of case management encounters and communications (face-to-face, telephone contact, other) • Categorical populations designated as high risk, such as, transitional case management for incarcerated persons as they prepare to exit the correctional system; adolescents who have a behavioral health condition; sex workers; etc. • A series of metrics and quality performance measures for both HIV case management for PLWH/s and those at high risk for HIV will be collected by providers and are required outcomes for delivering this service. <p>Note: Does not involve coordination and follow up of medical treatments.</p>
<p>AIDS Medical Case Management</p>	<p>Medical Case Management services (including treatment adherence) are a range of client – centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include 1) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) monitoring the care; 5) Periodic re-evaluation and adaptation of the plan as necessary over the time client is enrolled in services.</p>

SERVICE	SCOPE OF BENEFIT (ANNUAL) Including but not limited to:
	It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other form of communication.
Treatment for Gender Dysphoria	Comprehensive benefit package.
Early Intervention	Covered for Rlte Care members as included within the Individual Family Service Plan (IFSP), consistent with the 2005 Article 22 of the General Laws of Rhode Island.
Habilitative Services	Covered as ordered by a health plan physician.
Rehabilitation Services	Physical, Occupational and Speech therapy services may be provided with physician orders by RI DOH licensed outpatient Rehabilitation Centers. These services supplement home health and outpatient hospital clinical rehabilitation services when the individual requires specialized rehabilitation services not available from a home health or outpatient hospital provider.
In Lieu of Service	All services as provided in Attachment A can be utilized as an in Lieu of Service if alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting.
Value Add Services	Services/equipment which are not in the State Plan but are cost effective, improve health and clinically appropriate.
Neonatal Intensive Care Unit (NICU)	Covered under the following circumstances: Admitted to Women and Infants (W&I) from home after discharge, admitted to W&I NICU from home after discharge from W&I Normal Newborn Nursery, Admission to non-W&I level 2 Nursery, Admission to W&I NICU from home following delivery at and discharge from non-W&I facility or discharge from non-W&I NICU with admission to W&I for continued care.

Attachment A, continued
Additional Specification of Required Continuum of Behavioral Health Services

Children

○ Acute Services

- Emergency/Crisis Intervention
- Observation/Crisis Stabilization/Holding Bed
- Inpatient Acute
- Residential Treatment

○ Substance Use Services

- Residential Treatment
- Outpatient/ Intermediate Services

○ Outpatient Mental Health Services

- Traditional Outpatient Services
 - Diagnostic evaluation
 - Developmental evaluations
 - Psychological testing
 - Individual therapy
 - Family therapy
 - Group therapy
 - Specialty Group therapy (Special populations)
 - Medication management

Intermediate Mental Health Services

- Evidence of the ability to coordinate with providers for the following intermediate mental health services for children:
 - Partial Hospitalization
 - Day/Evening treatment
 - Intensive Outpatient treatment (IOP)
 - Enhanced Outpatient Service

- Home Based Therapeutic Services
- Evidence Based Practices
- Adolescent Residential Substance Use Treatment
- Personal Assistance Services and Supports (PASS)
- Respite

Adults

Acute Services

- Evidence of the availability of the following mental health services for adults:
 - Emergency /Crisis Intervention

- Observation/Crisis Stabilization/Holding Bed
- Inpatient Acute
- Inpatient Detoxification (ASAM Level 4.0)
- Acute Crisis Stabilization Unit

- Inpatient (non-hospital) detoxification (ASAM Level 3.7)

Substance use Services

- Services of the Opioid Treatment Program Health Home Program

- Evidence of the availability of the following substance use services for adults:
 - ASAM Level 3.5 Clinically Managed High - Intensity Residential
 - ASAM Level 3.3 Short- Term Clinically Managed - Medium Intensity Residential
 - ASAM Level 3.1 Clinically Managed Low - Intensity Residential Services

- Evidence of the availability of the following intermediate/outpatient substance use disorder services for adults:
 - Partial Hospitalization
 - Day/Evening
 - Intensive Outpatient treatment (IOP)
 - Enhanced Outpatient Services
 - General outpatient
 - Medication Assisted Treatment including Methadone Maintenance and Suboxone treatment.

- Evidence of the availability of the following intermediate/outpatient mental health services for adults:
 - Partial hospitalization
 - Day/evening
 - Intensive Outpatient treatment (IOP)
 - Enhance Outpatient Services
 - Assertive Community Treatment (ACT)
 - Integrated Health Home (IHH)
 - Clubhouse
 - Integrated Dual Diagnosis Treatment for substance use disorders
 - General Outpatient
 - Mental Health Psychiatric Rehabilitative Residence (MHPRR)
 - Supervised apartments

Integrated Health Home (IHH) and the Assertive Community Treatment Programs (ACT)

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 are 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 skills — all under the supervision of a Registered Nurse.