ATTACHMENT L - Accountable Entity Roadmap Document

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I. Roadmap Overview and Purpose

This Accountable Entity (AE) Roadmap is being submitted by the Rhode Island Executive Office of Health and Human Services (RI EOHHS), as the single state Medicaid agency in Rhode Island, to CMS in accordance with Special Term and Condition (STC) 44 of Rhode Island's 1115 Medicaid Demonstration Waiver.

The purpose of this document is to:

- Document the State's vision, goals and objectives under the Waiver.
- Detail the State's intended path toward achieving the transformation to an accountable, comprehensive, integrated cross-provider health care delivery system for Medicaid enrollees, and detail the intended outcomes of that transformed delivery system.
- Provide an update to the State's previously submitted and approved Roadmap, as is required annually under STC 44.

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

This roadmap has been developed with input from participating MCOs, Accountable Entities and stakeholders. A stakeholder process was conducted through the summer of 2019 to inform the amendments made to this document. Stakeholders included twenty-six organizations representing providers, insurers, and advocates. A full list of participating stakeholders can be found in **Appendix A**.

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

II. Rhode Island's Vision, Goals and Objectives

Rhode Island's Medicaid program is an essential part of the fabric of Rhode Island's health care system serving one out of four Rhode Islanders. The program has achieved national recognition for the quality of services provided, with Medicaid MCOs that are consistently ranked in the top ten in national NCQA rankings for Medicaid MCOs. However, there are important limitations to our current system of care – recognized here in Rhode Island and nationally:

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

As such, Rhode Island's current system of care focuses predominantly on medical care of individual conditions – as is encouraged and reinforced by our fee for service (FFS) payment model. As a result of this model, care is often siloed and/or fragmented, with high hospital readmissions and missed opportunities for intervention. Although individual providers are performing well**,** no single provider "owns" service integration or is accountable for the overall patient. These issues are particularly problematic when serving the most complex Medicaid populations - the six percent of Medicaid users who account for almost two thirds (65%) of Medicaid claims expenditure. Specifically**,** populations receiving institutional and residential services and populations with co-occurring physical and behavioral health care needs.

Effective transformations must build partnerships across payment, delivery and social support systems, and must align financial incentives, in order to meet the real life needs of individuals and their families.

In the spring of 2019, EOHHS embarked upon a strategic planning process to establish a set of strategic goals to govern both the Managed Care Program and the AE Program.[1]

The Managed Care Program's strategic goals are:

1. Maintain historical program strengths focused on health outcomes, cost containment, and the satisfaction of the Rhode Islanders served
2. Improve engagement in and satisfaction with care received among Rhode Islanders on Medicaid, particularly for those with complex healthcare needs
3. Implement value-based payment models that create incentive structures to orient the system to better respond to individual's comprehensive needs and reward models of accountable care delivery that demonstrate improved health outcomes and cost containment

[1] These strategic goals were presented at an EOHHS AE Advisory Committee meeting on June 19, 2019; refinements to the AE Program strategic goals were presented at an EOHHS AE Advisory Committee meeting on August 7, 2019; these goals are currently being refined based on feedback, and are not yet final.

4. Improve health outcomes for Rhode Islanders on Medicaid by orienting the health care delivery system to:
    a. Better integrate medical and behavioral health care in a way that is particularly supportive of those with complex or chronic care needs
    b. Respond to upstream determinants of health to address individual's health related social needs and consider community factors that impact population health, with an emphasis on housing and homelessness
    c. Meet unique needs of elderly and members with disabilities and those in need of long-term services and supports (LTSS) in a way that prioritizes choice and empowers individuals to remain in the community
    d. Support optimal health, development, and well-being of Medicaid covered children, with a particular focus on the prevention of child maltreatment
5. Achieve the specific strategic goals of the Health System Transformation Project that is focused on the establishment and implementation of the AE Program:
    a. Transition the Medicaid payment system away from fee-for-service to alternative payment models
    b. Drive delivery system accountability to improve quality, member satisfaction and health outcomes, while reducing total cost of care
    c. Develop targeted provider partnerships that apply emerging data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs
    d. Improve health equity and address Social Determinants of Health (SDOH) and Behavioral Health (BH) by building on a strong primary care foundation to develop interdisciplinary care capacity that extends beyond traditional health care providers
    e. Enable vulnerable populations to live successfully in the community

As a result of this transformation of the Rhode Island Medicaid program, RI anticipates achieving: improvements in the balance of long-term care utilization and expenditures, away from institutional and into community-based care; decreases in readmission rates, preventable hospitalizations and preventable ED visits; and increases in the coordination of primary and behavioral health services.

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

III. Our Approach

The Accountable Entity program is being developed within, and in partnership with, Rhode Island's existing managed care model, enhancing the capacity of MCOs to serve high-risk populations by increasing delivery system integration and improving information exchange/clinical integration across the continuum.

EOHHS envisions two specific AE programs:

Phase 1: Comprehensive AE Program
EOHHS views the development of Comprehensive AEs as the core objective of its Health System Transformation. The Comprehensive AE-is an interdisciplinary partnership of providers with a strong foundation in primary care and inclusive of other services, most notably behavioral health and social support services. AEs are accountable for the coordination of care for attributed populations and must adopt a defined population health approach.

After the completion of a two-year pilot program, the Comprehensive AE Program launched July 1, 2018. EOHHS has certified six Comprehensive AEs for participation in the program. Five AEs contracted with MCOs and entered into Total Cost of Care and AE Incentive Program arrangements for Program Year 1.

Phase 2: Specialized AE Program
For Program Years 1 and 2, the AE Program specifically excluded dual eligible populations. However, EOHHS is committed to including the dual eligible population in the AE program in order to encourage and enable LTSS eligible and aging populations to live successfully in their communities. This population requires a "Specialized" approach that acknowledges the unique challenges in program design for APM design. These include:

- multiple payers (Medicare, Medicaid)
- small populations subject to highly volatile cost experience
- highly fragmented delivery systems

This Specialized AE program must be built within a specified payment system. As such, in 2018, this Specialized AE design effort was placed on hold as the state considered, and began design efforts toward an overall, longer term dual eligible payment system model.[2] Once this process is complete, EOHHS shall implement a Specialized AE program within the overarching dual-eligibles payment system.

[2] Note that the authority for the current Medicare-Medicaid Plan (or MMP) as implemented via Neighborhood's Integrity Program, comes to an end in December 2020. The state must decide whether to retain this payment arrangement, modify the arrangement, or implement an alternative payment model. Options under consideration for this overarching payment model include a Modified MMP program, an Aligned DSNP model, and an ASO-based model

The design of this Specialized AE program shall be actively informed by a robust stakeholder engagement process. This process is already underway; as part of the broader stakeholder engagement process surrounding the HSTP program, EOHHS contracted with Day Health Strategies seeking feedback from stakeholders regarding the strategic goals for the Specialized AE program and the dual eligible population. EOHHS anticipates significant additional stakeholder input throughout the design of both the overarching dual eligible payment system and the specific Specialized AE program structure.

EOHHS shall develop and implement this new Specialized AE program in PY3, with components that leverage existing payment models. Once the new payment model is in place, the full program implementation will begin, likely in Program Year 5.

Specialized AE Program Design Timeline

Phase	Timeline	Key Elements
Phase 1 *Planning and Design*	PY 2 July 2019- June 2020	• Plan, design new overarching payment system for dual eligible population • Stakeholder engagement, partner discussions • Design targeted Specialized AE program within the new payment system
Phase 2 *Specialized AE Infrastructure Development + Pilot Implementation*	PY 3/4 July 2020- June 2022	Develop critical supporting systems and operational capacities to support the targeted population and the dual eligible AE program. Pilot key elements of new AE program within existing, interim models.
New Overarching Payment Model Implemented *Jan 2021: Interim Model* *Jan 2022: Transition to New Dual Eligibles Payment Model*		
Phase 3 *Specialized AE program implementation*	PY 5 July 2022 + ongoing	Implement AE program within the new payment model to support dual eligible population.

EOHHS is committed to supporting the AE Program through the Medicaid Infrastructure Incentive Program (MIIP). Beginning in late 2015, EOHHS began pursuing Medicaid waiver financing to provide support for AEs by creating a pool of funds primarily focused on assisting in the development and implementation of the infrastructure needed to support Accountable Entities. RI submitted an application for such funding in early 2016 as an amendment to RI's current Global Medicaid 1115 Waiver. In October 2016, the Centers for Medicare & Medicaid Services (CMS) approved this waiver amendment, bringing $129.8 million in Federal Financial Participation (FFP) to RI from November 2016 through December 2020.

The overall timeline for this project is depicted below:

Calendar Year	2016	2017	2018	2019	2020	2021	2022	2023	
State Fiscal Year		FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24
1115 Waiver	Previous Waiver				Current Waiver				
DSHP Program Year	PY1	PY2	PY3	PY4	PY5				
HSTP Program Year		AE Pilot 1	AE Pilot 2	PY1	PY2	PY3	PY4	PY5	

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

Core Documents	**Description**
1. AE Application and Certification Standards	• AE certification standards • Applicant evaluation and selection criteria • Submission guidelines
2. APM Requirements	• Required components, specifications for each allowable APM structure • AE Quality Framework and Methodology • Areas of required consistency, flexibility
3. Attribution Requirements	• Required processes for AE attribution, hierarchy
4. Medicaid Infrastructure Incentive Program Requirements	• Specifications re: HSTP Project Plan, required incentive funding allocation, priorities, allowable areas of expenditure, performance milestones

The AE Requirements documents are updated and submitted to CMS on an annual basis. EOHHS seeks input on these core programmatic requirements as follows:

- EOHHS holds public input sessions and participant working sessions with key stakeholders and interested public participants
- Draft requirements documents are posted for public comment, and documents are revised in consideration of public comments before final submission to CMS
- On-going/ad-hoc Partner Meetings with MCOs and AEs are held to cover emerging topics.

IV. AE Program Structure

The core of the AE program is a contractual relationship between the AE and Medicaid's Managed Care partners. EOHHS, with stakeholder input, has established requirements for Accountable Entity certification as well as Managed Care performance requirements for AE contracts. Certified AEs must enter into value based APM contracts in compliance with EOHHS requirements in order to participate in member attribution, shared savings/risk arrangements, and to be eligible to receive incentive-based infrastructure payments.

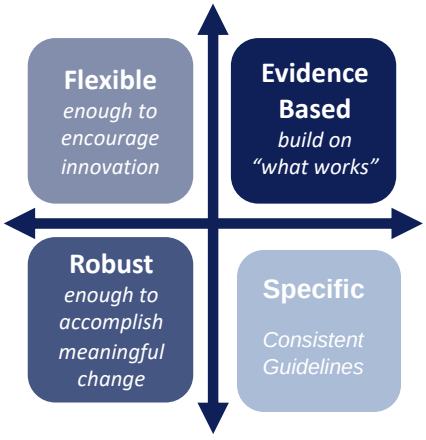
Core Pillars of EOHHS Accountable Entity Program

1. **EOHHS Certified Accountable Entities and Population Health (Section V)**
   The foundation of the EOHHS program is the certification of AEs responsible for the health of a population.

2. **Progressive Movement toward EOHHS approved APMs (Section VI)**
   Fundamental to EOHHS' initiative is progressive movement from volume-based to value-based payment arrangements and to increased risk and responsibility for cost and quality of care. The program therefore requires certified AEs enter in to Alternative Payment Methodologies (APMs) with managed care partners in accordance with EOHHS defined requirements.

3. **Incentive Payments for EOHHS Certified AEs (Section VII)**
   Incentive-based infrastructure funding is available to state certified AEs who have entered into qualifying APM contracts with managed care partners.

Note that these pillars were developed with an effort to balance the following key principles:



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

The following sections describe each of the three pillars. Detailed specifications for the implementation of each pillar are articulated in EOHHS AE Program Requirements documents.

V. AE Certification Requirements

The *RI Medicaid Accountable Entity Program AE Certification Standards* articulate detailed requirements for AE certification. These standards were developed based on the following:

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

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. AE certification standards are organized into eight domains in two categories, as shown below:

	Certification Domains
A. Readiness	1. Breadth and Characteristics of Participating Providers
	2. Corporate Structure and Governance
	3. Leadership and Management
B. System Transformation	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

EOHHS considers fulfillment of the certification standards in the Readiness category (domains 1-3) to be fundamental to an AE's ability to affect system transformation and achieve the broader goals of the AE Program. Readiness was appropriately a significant focus for AEs in the initial years of the program. However, as AEs mature, EOHHS expects they will focus increasingly on

advancements in the System Transformation category (domains 4-8). Given that AEs have different starting points and will be addressing different gaps in the System Transformation domains using different strategies, EOHHS will implement the standards articulated in this category via the HSTP Project Plan. As such, for Program Year 3 and beyond, AEs will be certified relative to the Readiness certification standards (domains 1-3) and will demonstrate progress towards achieving the advanced standards in domains 4-8.

In Program Year 3, AEs will be required to complete an application and/or re-certification process for ongoing Medicaid AE certification. Within the application and/or re-certification, AEs are expected to identify concrete ways in which their MCO contracts and partnerships are being leveraged to assist the AE in achievement of the advanced standards in domains 4-8. The AE will submit an AE-specific application for certification to the State that includes:

- AE Application for Readiness Certification
- *Note: On an annual basis, already certified AEs must report progress towards fulfilling their certification conditions, any changes in structure relative to their submitted application, or an attestation that no change has occurred.*
- AE developed HSTP Project Plan
- AE/MCO co-signed Attribution Report
- OHIC RBPO Certification Application

Applicants demonstrating that they meet the specified standards are designated as "Certified." EOHHS recognizes that AE applicants may have differing stages of readiness. As such, EOHHS anticipates that most AEs will be "Certified with Conditions" initially. The outstanding need areas or "conditions" shall highlight the gaps in AE capacities and capabilities that will be funded through the AE Incentive Program. These identified gaps will need to be addressed in accordance with an agreed upon project plan and timeline in order for the AE to continue to be eligible for incentive funds.

VI. Alternative Payment Methodologies

Fundamental to EOHHS' initiative is progressive movement to EOHHS-approved Alternative Payment Methodologies (APMs), incorporating clear migration from volume based to value-based payment arrangements and movement from shared savings to increased risk and responsibility. The *RI Medicaid Accountable Entity Program APM Requirements* articulate detailed specifications for EOHHS compliant APMs.

The AE initiative will be implemented through Managed Care. AEs must enter into Managed Care contracts in order to participate in member attribution and EOHHS-approved APMs. These AEs are eligible to receive incentive payments from their Managed Care partner through the AE Incentive Program. Correspondingly, MCOs must enter into qualified APM contracts (consistent with EOHHS defined APM Requirements) with Certified AEs under the terms of their contracts with EOHHS.

Each AE Program will specify qualifying APMs that will be based on a specified population of attributed lives, as defined in the table below. Within these respective populations, attribution to an AE shall be implemented in a consistent manner by all participating MCOs based upon EOHHS requirements.

AE Attributable Populations

Program	Attributable Populations
1. Comprehensive AEs	Medicaid-only eligibles
2. Specialized AEs	Medicaid/Medicare dual eligibles

The specific terms of the savings and risk transfer to the AE are at the discretion of the contracting parties. EOHHS does not intend to stipulate the terms of these arrangements but expects they will operate within the bounds of EOHHS defined APM Requirements and AE Incentive Program Requirements. In addition, EOHHS reserves the right to review and approve such arrangements.[3, 4]

Additional program specific APM requirements are as follows:

1. **Comprehensive AE Alternative Payment Methodology: Total Cost of Care**
   Managed Care Contracts with Comprehensive Accountable Entities must be based on total

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

[4] CMS has issued guidance for shared savings programs for both Medicaid and for Medicare Shared Savings Programs. See

https://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html and https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/sharedsavingsprogram

cost of care (TCOC), as defined in EOHHS APM Requirements. These TCOC arrangements shall supersede and be exclusive of any other TCOC-related shared savings arrangements with an AE or any of its constituent providers. TCOC contracting between MCOs and AEs must meet requirements set forth by EOHHS. MCOs are responsible to EOHHS for compliance in this matter. The MCOs will report to EOHHS outcomes on quality and financial performance by AEs on a schedule set forth in the Managed Care contract.

Qualified total cost of care (TCOC) contracts must incorporate the EOHHS Quality Framework and Methodology. Under this framework, shared savings from TCOC contracts will be adjusted based on performance on EOHHS defined common set of quality measures as articulated in the EOHHS APM Requirements.

Qualified TCOC-based contractual arrangements must also demonstrate a progression of risk to include meaningful downside shared risk or full risk. As AE incentive funding is phased out, AEs will be sustained based on their successful performance and associated financial rewards in accordance with their contract with MCOs.

2. **Specialized AE Alternative Payment Methodology**

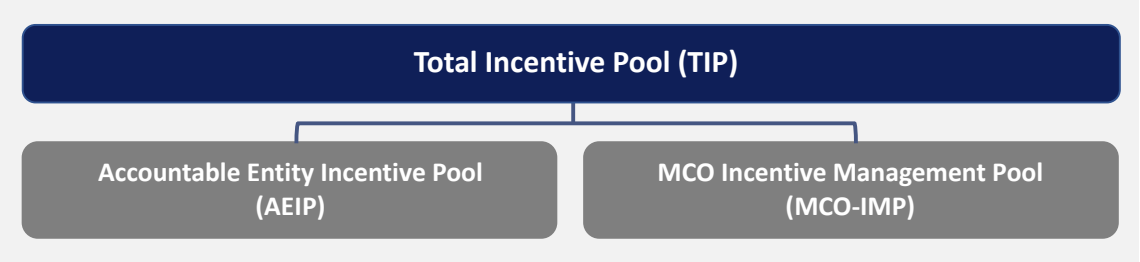
A total cost of care model may be inappropriate for dual eligible populations due to factors such as small population size, provider readiness, and the Medicaid/Medicare reimbursement structure (under which Medicare is the primary payer for many services). Any APM model incorporated in the Specialized AE program will consider these challenges and be appropriate for application to dual eligible populations. EOHHS anticipates initially implementing a Category 2 APM per the HCP-LAN framework.[5] Such a model would introduce a link to quality and value; for example, Specialized AEs might be measured on a set of performance measures with AEs eligible to earn performance payments for achievements in priority areas.

[5] Health Care Payment Learning & Action Network (HCP-LAN): 2017 Updated APM Framework, http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

VII. Medicaid Infrastructure Incentive Program (MIIP)

The Medicaid Infrastructure Incentive Program (MIIP) provides funding to support the design, development and implementation of the infrastructure needed to support Accountable Entities. The *EOHHS Medicaid Infrastructure Incentive Program Requirements* articulate detailed specifications for the incentive program.

The MIIP includes three dimensions:
the Total Incentive Pool (TIP), which is composed of the AE Incentive Pool (AEIP) and the MCO Incentive Management Pool (MCO-IMP), as depicted below.



These Incentive Pools are not grants. The incentive dollars that AEs and MCOs shall earn is based on their specific performance relative to a set of milestones that are listed below and defined in detail annually in the *EOHHS Medicaid Infrastructure Incentive Program Requirements*.

AEIP and MCO-IMP Milestone Performance Areas



Note that the fixed and developmental milestone performance areas are intended to allow AE/MCO partnerships to develop the foundational tools and human resources that will enable the development of system transformation competencies and capacity. Over the course of the AE Program, the required allocation of incentive funds will shift increasingly towards the performance-based milestone areas and away from the fixed and developmental milestones.

AE Specific Health System Transformation Project Plans (HSTP Project Plans)
Certified AEs must develop individual AE Health System Transformation Project Plans (HSTP Project Plans) that identify clear project objectives and include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken. Detailed specifications for the development, submission, and approval of HSTP Project Plans are articulated in the *EOHHS Medicaid Infrastructure Incentive Program Requirements.*

Note that HSTP Project Plans may only be modified with state approval, in accordance with the Material Modification specifications included in the *EOHHS Medicaid Infrastructure Incentive Program Requirements*. A Material Modification includes any change to the metrics, deadlines or funds associated with an HSTP Project Plan. EOHHS may also require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved.

1. **Guidelines for Evaluation**
   EOHHS shall review and approve each HSTP Project Plan developed and submitted by an AE in accordance with the following criteria and the annual requirements:

   - The HSTP project plan shall include the types of activities targeted for funds. HSTP Project Plans must focus on tangible projects within the AE Certification domain areas, linking recognized areas of need and opportunity to developmental tasks. HSTP projects eligible for award of AEIP funds must be linked to one or more of the eight domains below. EOHHS anticipates that in early program years HSTP projects may be weighted toward development in core readiness domains 1-3, as AEs build the capacity and tools required for effective system transformation. However, over time HSTP projects must shift toward system transformation capacities domains 4-8.

	Certification Domains
A. Readiness	1. Breadth and Characteristics of Participating Providers
	2. Corporate Structure and Governance
	3. Leadership and Management
B. System Transformation	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

   - **Project merits Incentive Funding**
     Projects must include the following:
     - Clear statement of understanding regarding the intent of incentive dollars

- Rationale for this incentive opportunity, including a clear description of objective for the project and how achieving that objective will promote health system transformation for that AE
- Confirmation that project does not supplant funding from any other source
- The inclusion of a gap analysis and an explanation of how the workplan and associated incentive plan and budget address these gaps
- Clear interim and final project milestones and projected impacts, as well as criteria for recognizing achievement of these milestones and quantifying these impacts

2. Required Structure for Implementation

The AEIP will be established **via a Contract or Contract Amendment** between the MCO and the AE. EOHHS reserves the right to review and approve the terms of incentive contracts with AEs. Incentive contracts will specify performance requirements and milestones to be achieved for AEs to earn incentive payments. The Contract or Contract Amendment will:

- Incorporate the central elements of the approved HSTP Project Plan and project based metrics, including:
  - Stipulation of program objective
  - Scope of activity to achieve
  - Performance schedule for milestones
  - A review process and timeline to evaluate AE progress in meeting milestones in its HSTP Project Plan and determine whether AE performance warrants incentive payments.
  - The MCO must certify that an AE has met its approved metrics as a condition for the release of associated AEIP funds to the AE.
- Set payment terms and schedule including approved metrics selected for each AE that assures that the basis for earning incentive payment(s) commensurate with the value and level of effort required and in accord with the allocation of incentive payments.
- Delineate responsibilities and define areas of collaboration between the AE and the MCO. Areas of collaboration may be based on findings from the certification process and address such areas as health care data analytics in service utilization, developing and executing plans for performance improvement, quality measurement and management, and building care coordination and care management capabilities.
- Minimally require that AEs submit quarterly reports to the MCO using a standard reporting form to document progress in meeting quality and cost objectives that would entitle the AE to qualify to receive AEIP payments. Such reports will be shared directly by the MCO with EOHHS.
- Stipulate that the AE earn payments through demonstrated performance. The AE's failure to fully meet a performance milestone under its AE Health System Transformation Project Plan within the timeframe specified will result in

forfeiture of the associated incentive payment (i.e. no payment for partial fulfillment).

- State that in the event that an AE fails to meet a performance metric in a timely fashion (and thereby forfeits the associated AEIP payment), an AE can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric.
- Note: AE performance metrics in the "Fixed Percentage Allocations Based on Specific Achievements" category are specific to the performance period and must be met by the close of the performance year in order for an AE to earn the associated incentive payment.

VIII. Program Monitoring, Reporting, & Evaluation Plan

As the primary contractors with EOHHS, the MCOs will be directly accountable for the performance of their subcontractors. EOHHS is responsible for overseeing compliance and performance of the MCOs in accordance with EOHHS contractual requirements and federal regulation, including performance of subcontractors.

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

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

1. MCO Compliance and Performance Reporting Requirements

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

For this initiative, MCO reporting requirements that have more typically been provided by the MCOs and reviewed by EOHHS at the plan-level have been extended to also require reporting at the AE level. A menu of metrics and measures that will be used by the MCOs to assess the performance of the AEs and that will be reported to EOHHS is further specified in the APM requirements document. MCOs are required to submit the reports below on an ongoing basis in support of the AE Program:

MCO Required Reports	Description
1. Quarterly Provider Access Report	Report completed by each Health Plan by the following provider types: primary care, specialty care, and behavioral health for routine and urgent care. This report measures whether appointments made are meeting Medicaid accessibility standards.
2. Quarterly Appeals Report	An aggregate report of clinical and administrative denials and appeals by each Health Plan, including External Review.
3. Quarterly Grievances Report	An aggregate report of grievances by each Health Plan.

MCO Required Reports	Description
4. Informal Complaints Report	An aggregate report of the clinical and administrative complaints specified by category and major provider sub-groups for each Health Plan
5. Accountable Entity Shared Savings Financial Performance Report	This financial report is included as part of each Health Plan's risk share report and provides financial data and information as to how each Accountable Entity is performing relative to their total cost of care benchmark.
6. AE Quality Measure Report	This report consists of the set of NCQA HEDIS and other clinical and quality measures that are used to determine the quality multiplier for total cost of care.
7. MCO Performance Incentive Pool Report	Detailed budgeted and actual MCO expenditures in accordance with EOHHS defined templates
8. AEIP Milestone Performance Report	Detailed budgeted and actual AEIP expenditures report documenting the achievement of AEIP milestones in accordance with EOHHS defined templates

In addition to enhancement of current reports, the Medicaid MCOs are required to submit an Alternative Payment Methodology (APM) Data Report on a quarterly basis, reporting on their performance in moving towards value-based payment models.

Pertaining more directly to AE program operations, the Medicaid MCOs are required to submit Accountable Entity specific reports, including the following:

- AE Population Extract File
  This monthly report provides EOHHS with a member level detail report of all Medicaid MCO members attributed to each AE. This data will be used by EOHHS for data validation purposes as well as for the purposes of ad-hoc analysis.
- AE Participating Provider Roster
  This monthly provider report provides EOHHS with an ongoing roster of the AE provider network, inclusive of provider type/specialty and affiliation (participating, affiliated, referral etc.) to the Accountable Entity.

2. In-Person Meetings with MCOs

As part of its ongoing monitoring and oversight of its MCOs, EOHHS conducts an in-person meeting on a monthly basis with each contracted MCO. These meetings provide an opportunity for a more focused review of specific topics and areas of concerns. Additionally, they provide a venue for a review of defined areas of program performance such as quality, finance, and operations. These meetings also provide an important forum to identify and address statewide AE performance, emerging issues, and trends that may be impacting the AE program. In addition to the reporting noted above, these meetings support EOHHS' ability to report to CMS

(in quarterly waiver reports) issues that may impact AE's abilities to meet metrics or identify factors that may be negatively impacting the program.

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

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

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

3. State Reporting Requirements

The state will incorporate information about the Health System Transformation waiver amendment into its existing requirements for waiver reports, including quarterly, annual, and final waiver program reports, and financial/expenditure reports. In addition, the state shall supply separate sections of such reports to meet the reporting requirements in the STCs that are specific to the Health Systems Transformation waiver amendment.

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

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

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

4. Evaluation Plan

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

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

The state has contracted a qualified independent entity to conduct the evaluation.

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

Appendix A: Stakeholder Meetings and Feedback

Summer 2019 AE Program Strategic Planning Project

Participating Stakeholders

1. Blackstone Valley Community Health Center
2. Brown University School of Public Health
3. Care New England
4. Coastal Medical
5. CODAC Behavioral Healthcare
6. Economic Progress Institute
7. Family Services of RI
8. Integrated Healthcare Partners
9. LeadingAge RI
10. Lifespan
11. Long Term Care Coordinating Council (LTCCC)
12. Neighborhood Health Plan of RI
13. Prospect Health Services RI
14. Providence Community Health Center
15. Rhode Island Health Care
16. RI Assisted Living Association (RIALA)
17. RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH)
18. RI Department of Health (DOH)
19. RI Office of the Health Insurance Commissioner (OHIC)
20. RI Parent Information Network (RIPIN)
21. RI Partnership for Home Care
22. The Substance Use and Mental Health Leadership Council of RI
23. Tufts Health Public Plan
24. United Healthcare
25. Women's Resource Center

2016 – 2017 AE Program Planning and Design Stakeholder Process

Stakeholder Meetings

1. HSTP/AE Presentation to ICI Provider Council
2. HSTP/AE presentation to 1115 Task Force
3. AE/MCO meetings on AE initiative (2 sessions)
4. Broad Stakeholder meeting/presentation on Comprehensive AEs (2 sessions)
5. Stakeholder meeting on Specialized AEs
6. HSTP/AE meeting to home care/child service providers
7. NASW Aging Committee meeting
8. Coalition for Children presentation
9. Governor BH council
10. BHDDH Health Transition team

11. DEA Home and Community Care Advisory Committee

Stakeholder Comments

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

Appendix B: Roadmap Required Components

	STC Required Elements of Roadmap	Where Addressed
A	Specify that the APM guidance document will define a menu of metrics and measures that will be used by the MCOs to assess the performance of the AEs through the activities of the AE subcontractors.	*Section IX. Program Monitoring, Reporting, & Evaluation Plan* • Page 18, *1. MCO Compliance and Performance Reporting Requirements*, 2nd paragraph
B	Include guidelines requiring AEs to develop individual AE Health System Transformation Project Plans, which shall include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance.	*Section VIII. Medicaid Infrastructure Incentive Program (MIIP)* • Page 15, *AE Specific Health System Transformation Project Plans*, 1st paragraph
C	Report to CMS any issues within the AEs that are impacting the AE's ability to meet the measures/metrics, or any negative impacts to enrollee access, quality of care or beneficiary rights. The state, working with the MCOs, shall monitor statewide AE performance, trends, and emerging issues within and among AEs on a monthly basis, and provide reports to CMS on a quarterly basis.	*Section IX. Program Monitoring, Reporting, & Evaluation Plan* • Page 20, *2. In-Person Meetings with MCOs*
D	Provide minimum standards for the process by which EOHHS seek public input in the development of the AE Certification Standards;	*Section V. AE Certification Requirements* • Page 10, 1st paragraph
E	Specify a State review process and criteria to evaluate each AE's individual Health System Transformation Project Plan and develop its recommendation for approval or disapproval;	*Section VIII. Medicaid Incentive Program (MIIP)* • Page 15, *1. Guidelines for Evaluation*
F	Describe, and specify the role and function, of a standardized, AE-specific application to be submitted to the State on an annual basis for participation in the AE Incentive Program, as well as any data books or reports that AEs may be required to submit to report baseline information or substantiate progress;	*Section V. AE Certification Requirements* • Page 11, 1st paragraph *Section IX: Program Monitoring, Reporting, & Evaluation Plan* • Page 18-19, *1. MCO Compliance and Performance Reporting Requirements*
G	Specify that AEs must submit semi-annual reports to the MCO using a standardized reporting form to document its progress in achieving quality and cost objectives, that would entitle the AE to qualify to receive AE Incentive Program Payments.	*Section VIII. Medicaid Incentive Program (MIIP)* • Page 16, *2. Required Structure for Implementation*, 4th bullet
H	Specify that each MCO must contract with Certified AEs in accordance with state defined	*Section VII: Alternative Payment Methodologies*

	STC Required Elements of Roadmap	Where Addressed
	APM guidance and state defined AE Incentive Program guidance. The APM guidance will include a Total Cost of Care (TCOC) methodology and quality benchmarks. For specialized AEs (Type 2 AE) where TCOC methodologies may not be appropriate, other APM models will be specified. Describe the process for the state to review and approve each MCO's APM methodologies and associated quality gates to ensure compliance with the standards and for CMS review of the APM guidance as stated in STC 43(e).	• Page 12-13, "AE Attributable Populations" table through end of section
I	Specify the role and function of the AE Incentive Program guidance to specify the methodology MCOs must use to determine the total annual amount of AE Incentive Program payments each participating AE may be eligible to receive during implementation. Such determinations described within the APM guidance document shall be associated with the specific activities and metrics selected of each AE, such that the amount of incentive payment is commensurate with the value and level of effort required; these elements are included in the AE incentive plans referenced in STC 43(f). Each year, the state will submit an updated APM guidance document, including APM Program guidance and the AE Incentive Program Guidance.	*Section VIII. Medicaid Incentive Program (MIIP)* • Page 14, 1st paragraph *Section VIII. Medicaid Incentive Program (MIIP)* • Page 16, *2. Required Structure for Implementation*, 2nd bullet
J	Specify a review process and timeline to evaluate AE progress on its AE Incentive Program metrics in which the MCO must certify that an AE has met its approved metrics as a condition for the release of associated AE Incentive Program funds to the AE;	*Section VIII. Medicaid Incentive Program (MIIP)* • Page 16, *2. Required Structure for Implementation*, 1st bullet
K	Specify that an AE's failure to fully meet a performance metric under its AE Incentive Program within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment)	*Section VIII. Medicaid Incentive Program (MIIP)* • Page 17, *2. Required Structure for Implementation*, 5th bullet
L	Describe a process by which an AE that fails to meet a performance metric in a timely fashion (and thereby forfeits the associated AE Incentive Program Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving	*Section VIII. Medicaid Incentive Program (MIIP)* • Page 17, *2. Required Structre for Implementation*, 6th bullet

	STC Required Elements of Roadmap	Where Addressed
	the original metric and, where appropriate, in combination with timely performance on a subsequent related metric defined as demonstrating continued progress on an existing metric. For example, if the failed metric was related to developing a defined affiliation with a Community Business Organization or CBO, and that deliverable was late, the AE might then also be required to show it has adapted its governance model by incorporating into its bylaws and board protocols the requirement to develop a defined relationship with a CBO.	
M	Include a process that allows for potential AE Health System Transformation Project Plan modification (including possible reclamation, or redistribution of incentive payments pending State approval).	*Section VIII. Medicaid Incentive Program (MIIP)* • Page 15, *AE Specific Health System Transformation Project Plans*, 2nd paragraph
N	Include a process to identify circumstances under which a plan modification may be considered, which shall stipulate that CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved.	*Section VIII. Medicaid Incentive Program (MIIP)* • Page 15, *AE Specific Health System Transformation Project Plans*, 2nd paragraph
O	Include a State process of developing an evaluation of Health System Transformation Project as a component of the draft evaluation design as required by STC 127.	*Section IX. Program Monitoring, Reporting, & Evaluation Plan* • Page 21, *4. Evaluation Plan*