DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
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State Demonstrations Group

NOV 17 2017

Patrick M. Tigue
Medicaid Program Director
Rhode Island Executive Office of Health & Human Services
Hazard Building #74, 1st Floor
74 West Road
Cranston, RI 02920

Dear Mr. Tigue:

This letter is to inform you that the following attachment to the Special Terms and Conditions (STCs) for Rhode Island's section 1115(a) demonstration (11-W-00242/1), entitled "Rhode Island Comprehensive Demonstration," is approved as submitted by the state and as modified through our discussions.

- Accountable Entity Roadmap (Attachment N)

CMS finds this protocol to be in accordance with the STCs for the demonstration, and has no further questions or comments at this time. A copy of the approved attachment is enclosed and will be added into the STCs.

We look forward to continuing to work with you and your staff on the Rhode Island Demonstration. Your CMS project officer, Mrs. Heather Ross, is available to address any questions you may have related to this correspondence. Mrs. Ross can be reached at (410)786-3666, or Heather.Ross@cms.hhs.gov.

Official communications regarding official matters should be sent simultaneously to Mrs. Ross and Mr. Richard McGreal, Associate Regional Administrator in our Boston Regional Office. Mr. McGreal can be reached at (617)565-1226, or Richard.McGreal@cms.hhs.gov.

Sincerely,

Angela D. Garner
Director
Division of Systems Reforms Demonstrations

Enclosure

cc: Richard McGreal, ARA, Region I

Rhode Island Executive Office of Health and Human Services (EOHHS)

Medicaid Program Accountable Entity Roadmap Document

Date of Submission for Center for Medicare and Medicaid Services (CMS) Review and Approval: Thursday, April 13, 2017

Table of Contents

I. Roadmap Overview and Purpose

This Accountable Entity (AE) Roadmap 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) 48 of Rhode Island's Health System Transformation Project (HSTP) Amendment to the state's 1115 Medicaid Demonstration Waiver.

The purpose of this document is to:

- Document the State's vision, goals and objectives under the Waiver Amendment.
- 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.
- Request review and approval by CMS, as is required before the state can begin payments of Medicaid Incentive Funds under the Waiver Amendment

The Accountable Entity "Roadmap" is a requirement of the Special Terms and Conditions (STCs) of RI's Health System Transformation Waiver (STC 48). The State must develop an Accountable Entity Roadmap for the Health System Transformation Project to be submitted to CMS for CMS's 60-day process of review and approval. The State may not claim FFP for Health System Transformation Projects until after CMS has approved the Roadmap. Once approved by CMS, this document will be incorporated as Attachment N of the STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved waivers, expenditure authorities and STCs. (Changes to the protocol will apply prospectively, unless otherwise indicated in the protocols.)

The Accountable Entity Roadmap will be a conceptualized living document that will be 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 systems 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 draft roadmap was posted for public input in December 2016. Twenty-four (24) comments were received from a variety of stakeholders representing provider, insurers, and advocates. Thirteen (13) public input sessions were held between January and March 2017 to inform the final roadmap. A full list of public sessions can be found in **Appendix B**.

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

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 in a given year and closer to thirty percent over a three- year period. 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, the current system of care, both in Rhode Island and nationally, focuses predominantly on high quality medical care treatment of individual conditions – as is encouraged and reinforced by our fee for service (FFS) payment model. As a result of this model, there is often siloed and/or fragmented care, with high readmissions and missed opportunities for intervention. Specifically:

- *Within Medical Care:* There is limited focus on transitions, discharges, care coordination, and medication management across and between hospitals, specialists and primary care providers.
- *Between Medical Care and Behavioral Health care:* There is limited effective coordination between medical and behavioral providers, often acting as two distinct systems of care.
- *Complicated by growing needs of an aging population*: This will challenge medical models of care and require broader definitions of care (e.g., dementia, cognitive issues).
- *Between Medical Care and Social Determinants:* There is limited recognition and adaptation of a medical model that recognizes common factors impacting health of Medicaid populations – such as childhood trauma and its long-term impacts, mistrust of the health care system, etc. There is also limited capacity to address broader social needs, which often overshadow and exacerbate medical needs – e.g., housing/housing security, food security, domestic violence/sexual violence.

As a result, although individual providers are often high performing, no single entity "owns" service integration, and no single entity is accountable for overall outcomes - only specific services. Effective interventions must "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.

These issues are particularly problematic when serving the most complex Medicaid populations -- the six percent of Medicaid users with the most complex needs and highest costs that account for almost two thirds (65%) of Medicaid claims expenditure. Specifically:

- **Populations receiving institutional and residential services**
  Nearly half (45%) of claims expenditure on high cost users is on nursing facilities for the elderly and disabled, and on residential and rehabilitation services for persons with developmental disabilities.
- **Populations with integrated physical and behavioral health care needs**
  Forty percent (40%) of claims expenditure on high cost users is for individuals living in the community, most (82%) of whom have multiple co-morbidities, with both physical and mental health or substance abuse needs that require an integrated approach.

The vision, as expressed in the Reinventing Medicaid report is for *"...a reinvented Medicaid in which our Medicaid managed care organizations (MCOs) contract with Accountable Entities (AEs), integrated provider organizations that will be responsible for the total cost of care and healthcare quality and outcomes of an attributed population."*

The goals are consistent with initiatives taking hold across the country – a movement toward Accountable Care Organizations, including value based payment, new forms of organization, and increased care integration. Specific goals of this initiative, developed in alignment with SIM and other ongoing initiatives in our RI environment include:[1]

- Transition from fee for service to value based purchasing
- Focus on Total Cost of Care (TCOC)
- Create population based accountability for an attributed population
- Build interdisciplinary care capacity that extends beyond traditional health care providers
- Deploy new forms of organization to create shared incentives across a common enterprise
- Apply emerging data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs

As a result of this transformation of the Rhode Island Medicaid program (and in partnership with other efforts such as SIM), RI anticipates that by 2022, Rhode Island will have achieved the following objectives:

- 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
- Increase in the provision of coordinated primary care and behavioral health services in the same setting.

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

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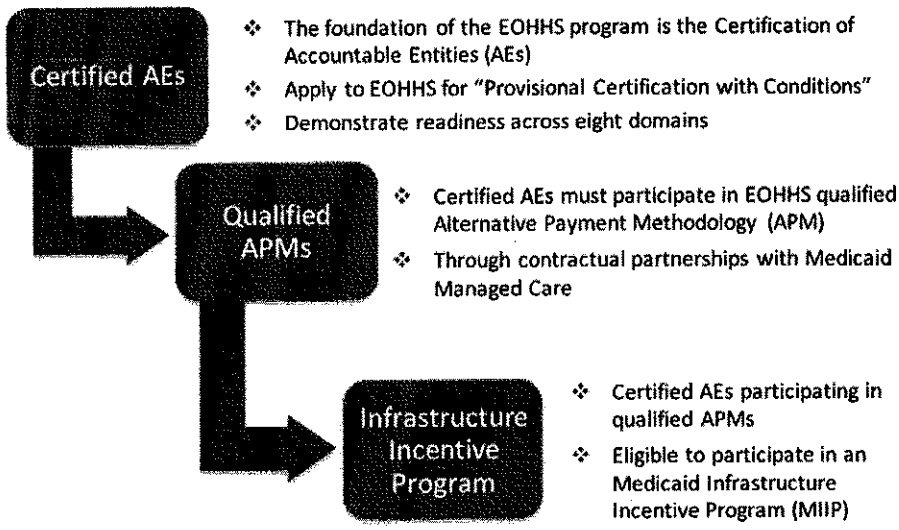
[1] RI's Office of the Health Insurance Commissioner (OHIC) received a SIM (State Innovation Model) grant from CMS to test health care payment and service delivery reform models over the next four years, in a project called Healthy Rhode Island.

III. Our Approach

As stated above, the Rhode Island Accountable Entity 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."*

The Accountable Entity program shall be developed within, and in partnership with, Rhode Island's existing managed care model, building on its existing strengths. The AE program will enhance the capacity of MCOs to serve high-risk populations by increasing delivery system integration and improving information exchange/clinical integration across the continuum.

Structurally, the Accountable Entity program includes three core "pillars":
(1) EOHHS **Certified Accountable Entities** and Population Health,
(2) Progressive Movement toward EOHHS approved **Alternative Payment Methodologies,**
(3) **Incentive Payments** for EOHHS Certified AEs, as depicted below:



Not all providers are at the same level of readiness for the interdisciplinary integration and transition to alternative payment methodologies envisioned by this program. As such, EOHHS is taking a multi-pronged strategy, in order to effectively "meet providers where they are" and enable the necessary system transformation. EOHHS anticipates at least three specific programs:

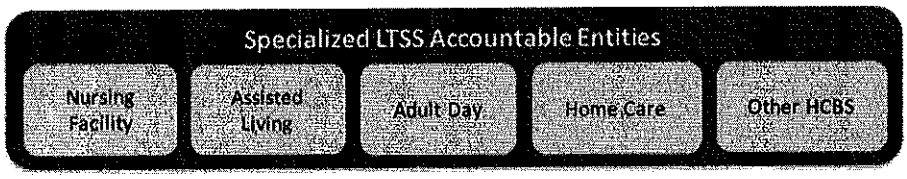
Phase 1: Comprehensive AE Program
EOHHS views the full development of high performing Comprehensive AEs as the core objective of its Health System Transformation Program. The Comprehensive AE Pilot already underway shall be expanded and enhanced for full implementation. The Comprehensive AE

represents 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. The AE will be accountable for the coordination of care for attributed populations and will be required to adopt a defined population health approach.

Phase 2: Specialized LTSS AE Pilot Program

EOHHS is committed to improving the balance of long term care utilization and expenditures, away from institutional and into community-based care. Encouraging and enabling LTSS eligible and aging populations to live successfully in the community requires a focused approach. As such, we have defined two interim Specialized AE models: LTSS Pilot AEs and Medicaid Pre-Eligibles. Ultimately, EOHHS anticipates that specialized AEs will become integrated with Comprehensive AEs.

The long- term services and supports system in Rhode Island is fragmented and dominated by specialized providers who are geographically and/or service specific, and may have differing stages of readiness to engage in accountable systems of care. As such, the Specialized LTSS Pilot AE program is intended to encourage the development of critical partnerships across the LTSS spectrum of services to develop and enhance the necessary infrastructure to support a population management approach, as shown below. These specialized LTSS Pilot AEs will participate in alternative payment models that create appropriate financial incentives for participating providers to enable LTSS eligible populations to overcome barriers to live successfully in the community. The ability of an LTSS AE to address persons with behavioral health needs and dementia will be critical.



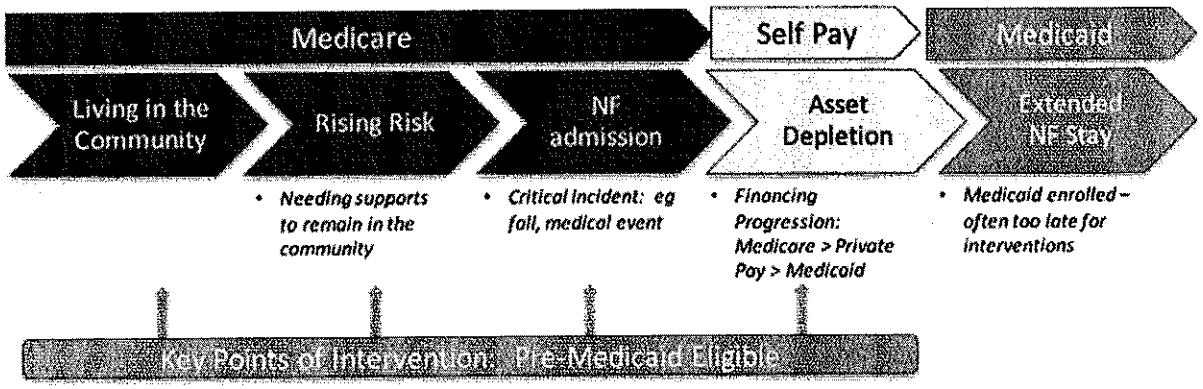
Multiple providers and groups of providers of LTSS services have expressed strong interest in this pilot. However, Rhode Island's LTSS system of care is fragmented and dominated by specialized providers who are geographically and/or service specific. Significant infrastructure development is required to build the necessary capacity and capabilities for these providers to effectively manage a population under a total cost of care model.

Phase 3: Medicaid Pre-Eligibles Pilot Program

Note that authority for this program shall be requested under the RI Medicaid Waiver renewal, to be submitted in December 2017 and effective January 1, 2019. EOHHS seeks to implement this program once it is approved under the waiver extension.

EOHHS is seeking Medicaid prevention/deferral strategies to enable and encourage aging populations to live successfully in the community. To be effective, EOHHS must work "upstream", and support people in the community who are not yet Medicaid eligible but are at high risk of becoming so when/if faced with a critical incident or depletion of

resources. Effective programs in this arena must "break through" the financing system disconnects shown below to create financial incentives for participating providers.



As such, EOHHS will be in the process of developing a pilot program intended to engage high volume Medicare providers in the development and implementation of targeted interventions for Medicaid Pre-eligibles, especially at-risk populations residing in the community. This pilot is still in the design phase – to be implemented subject to approval by CMS under the 1115 Waiver Demonstration.

EOHHS anticipates that additional programs may be added over time, based on learnings from the current programs and pilots.

EOHHS is taking a phased approach to implementation, with a process and timeline that allows for the incorporation of ongoing learnings, as shown below:

AE Type	Primary Target Population	Program Phase	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Comprehensive AE	Medicaid only	Program Design and Pilot Certification								
		Pilot Performance Period		***						
		Certification Renewal/ Full Certification								
		Full program performance period								
Specialized LTSS	LTSS Eligibles*	Program Design and Pilot Certification								
		Pilot Performance Period				***				
		Certification Renewal/ Full Certification								
		Full program performance period								
Medicaid Pre-Eligibles subject to CMS approval**	Medicaid LTSS Prevention: *Medicare eligibles at risk of becoming duals*	Program Design and Pilot Certification								
		Pilot Performance Period					***			
		Certification Renewal/ Full Certification								
		Full program performance period								

*** Initial pilot performance period begins

* Includes duals and nonduals eligible for LTSS

** Authority for this program shall be requested under the RI Medicaid Waiver renewal, to be submitted in Dec 2017 and effective 1/1/19.

Note that the Comprehensive AE program is already underway, as Pilot AEs were certified in the fall of 2015 and APM contracts were in place between MCOs and Pilot AEs in 2016. EOHHS plans to move the Comprehensive AE program to full certification in CY 2017 with the first full program performance period beginning in CY 2018. The two new pilot programs (Specialized LTSS AE and Medicaid Pre-Eligibles) will follow a similar trajectory, with staged implementation dates and targeted pilot performance periods in CY 2018 and CY2019 respectively.

EOHHS is committed to supporting this system transformation through our Medicaid Incentive Program (MIIP). An estimated $76.8 Million in Health System Transformation Funds will be allocated to the MIIP, supporting MCOs and AEs in building the capacity and tools required for effective system transformation.[2] These funds must be used to support state defined priorities, in specified allowable expenditure areas, and will be tied to the achievement of AE and MCO specific projects, deliverables and milestones.

Effective implementation of this program will mean that by 2022 at least one third (33%) of Medicaid eligibles will be attributed to an EOHHS Accountable Entity, participating in an EOHHS approved Alternative Payment Methodology (APM). This goal will be accomplished in accordance with the following progression:

Percent of Medicaid covered lives attributed to an EOHHS approved APM

Performance Year	Target
DY 10 CY 2018	10%
CY 2019	15%
CY 2020	20%
CY 2021	25%
CY 2022	33%

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

Core Documents	Targeted CMS Submission	Description
1. AE Application and Certification Standards	Spring 2017	• AE certification standards • Applicant evaluation and selection criteria • Submission guidelines
2. APM Guidance	Fall 2017	• Required components and specifications for each allowable APM structure • AE Scorecard • Areas of required consistency, flexibility
3. Attribution Guidance	Fall 2017	• Required processes for AE attribution, hierarchy

[2] Subject to available funds captured in accordance with CMS approved claiming protocols.

4. Medicaid Incentive Program Guidance	Fall 2017	• Additional details on funding allocation, required priorities, allowable areas of expenditure, milestones

Note that EOHHS is continuously seeking input on these core programmatic guidance documents as follows:

- EOHHS shall hold public input sessions and participant working sessions with key stakeholders and interested public participants to refine each guidance document.
- Draft guidance shall be posted, comments received will be reviewed, and documents will be revised in consideration of public comments before final submission to CMS for approval.
  For example, this Roadmap, including draft elements of each of these additional core documents, was posted in December 2016 and Stakeholders and participants provided many valuable comments which will be included in the final guidance
- The 1115 Waiver Taskforce provides an additional forum for public input. It is a statutorily defined (RIGL Chapter 42-12.4-9) committee, co-chaired by a senior state official of EOHHS/DHS and a member of the community and including representation from each population receiving Medicaid services. This group meets monthly. Medicaid AE's are a standing agenda item on the 1115 Waiver Task Force, thereby providing opportunity for a brief update on the status of the design and implementation.
- **On-going and ad-hoc Partner Meetings with MCOs and potential AE providers are held to cover emerging topics.**
- EOHHS holds AE Office Hours for stakeholders every other week. These meetings are scheduled through September, 2017; however, they will be continued past September, if needed.

IV. Progress to Date

EOHHS has made significant progress along several aspects of the Accountable Entity strategy. Key actions taken to date include:

1. Comprehensive AE Pilot Program Implementation
2. Specialized AE Pilot Program Development
3. Establishment of funding mechanism for Incentive payments

Key action steps to date in each of these areas are highlighted below.

1. Comprehensive AE Pilot Program Implementation

Rhode Island has already begun moving forward with the creation and support of Accountable Entities (AEs), while simultaneously testing critical program design elements. To approach the

task of how to best advance such models in Rhode Island, EOHHS issued an RFI in August 2015 and received 14 responses with many thoughtful comments and recommendations. Based on feedback from the RFI and experience in other states, the state implemented an Accountable Entity Pilot Program as a fast-track path and an opportunity for early learnings in late fall 2015. EOHHS then provisionally certified Pilot AEs and issued companion documents specifying attribution rules and total cost of care guidance.

Pilots were certified with the understanding that:

- The state would be proceeding to move past the Pilot phase and, based on experiences and learnings from RI and across the country, would develop more extensive and refined certification standards. Applicants for pilot certification would be expected to comply with those new standards.
- The state would pursue opportunities with the federal government that, if successful, would enable state investments in the further development of AE capabilities.

To date, there have been three rounds of pilot AE applications. Applicants had to demonstrate readiness across three key design domains, including governance, organizational capability, and data/analytic capability. Qualified pilot applicants were "Provisionally Certified with Conditions", which specified limitations to their contracting authority and confirmed required developmental steps and timelines.

The following six provider-based entities have been designated as Provisionally Certified Pilot AEs, eligible to enter into Total Cost of Care-based shared savings programs with Medicaid MCOs beginning in January 2016:

- Blackstone Valley Community Health Center's HealthKey Accountable Entity
- Coastal Medical, Inc.
- Community Health Center Accountable Care Organization (CHC ACO)[3]
- Integra Community Care Network, LLC
- Providence Community Health Centers, Inc.'s Providence ChoiceCare AE
- Prospect Health Services Rhode Island, Inc. (PHSRI)

These six AEs were certified as "Type 1" AEs, meaning they are certified to contract for all services for a total attributed population. As of July 2016, more than one third (1/3) of total Medicaid lives were attributed to participating pilot AEs under Total Cost of Care pilot terms, as shown below:

AE Pilot: Attributed Lives

[3] Community Health Center Accountable Care Organization (CHC ACO) currently includes East Bay Community Action Program (EBCAP), Comprehensive Community Action, Inc. (CCAP), Thundermist Health Center, Tri-Town Community Action Agency, WellOne Primary Medical & Dental Care, and Wood River Health Services.

Type 1 Attributed Lives	United	NHP	Total MCOs
Blackstone Valley (BVCHC)		8,933	8,933
Integra (CNE, SCH &RIPCP)	19,011	20,140	39,151
PHSRI	5,350	5,411	10,761
PCHC Providence ChoiceCare AE		25,037	25,037
CHC ACO+		28,160	28,160
Total Type 1	**24,361**	**87,681**	**112,042**

Sources and Notes: United and NHP attributed lives from Q4 2016 snapshot reports. Coastal was provisionally certified in July 2016 and has not yet contracted with the MCOs.

These AE pilot participants provide three different models of Comprehensive Accountable Care, which will allow significant opportunities for evaluation going forward. There are two hospital based entities, one multispecialty group practice, and three FQHC based models, all of which demonstrate a commitment to primary care infrastructure and an interdisciplinary approach.

2. Specialized AE Pilot Program Development

"Specialized" AEs are generally intended as an interim arrangement to enable providers to form networks that will build the capacity and infrastructure needed to manage specialized populations across providers. Over time, EOHHS intends that these Specialized AEs would partner with a Comprehensive AE.

In conjunction with the Comprehensive AE Pilot Program implemented in late fall, 2015, EOHHS included an opportunity for provisional certification of specialized "Type 2" Accountable Entities. Specifically, the Specialized Pilot Type 2 AEs was intended to encourage and enhance integrated care for persons with SPMI/SMI (Serious & Persistent Mental Illness/Serious Mental Illness), consistent with EOHHS' goal of integrating physical and behavioral health services. As such, organizations with attributed SPMI/SMI populations were eligible to become "Type 2" AEs, eligible to participate in a total cost of care based shared savings arrangement with participating Medicaid MCOs.

In practice, the implementation of this type of Specialized AE resulted in the alignment of Specialized AEs with Comprehensive AEs. As such, EOHHS intends to sunset the Type 2 SPMI Specialized Accountable Entity, instead encouraging integration of SPMI populations with comprehensive AEs, as has already occurred in the market. EOHHS remains committed to continued improvements and enhancements in integrated care for persons with SPMI/SMI.

EOHHS is also working closely with stakeholders to develop a Specialized LTSS AE Pilot Program to focus on providers of long term services and supports (LTSS). Activities to support this initiative so far include:

- Establishment of key program goals
- Multiple discussions with key stakeholders and public meetings

- Research and evaluation of similar programs in other states
- Detailed discussions with key stakeholders regarding potential program structure, including attribution methods, APM models and performance metrics

Specialized LTSS-focused AEs are intended to achieve the rebalancing goals of Reinventing Medicaid by effectively enabling and encouraging aging populations to live successfully in the community. This requires creating sufficient financial incentives for current LTSS providers – nursing facilities, home and community based providers -- to work together to change the way care is delivered to our aging population. As such, the Specialized LTSS focused AE program shall:

- Support focused investments to build capacity and fill in gaps in infrastructure to more effectively address the needs of vulnerable seniors, supporting their ability to successfully remain in the community.
- Encourage and invest in the development of integrated care delivery models, such that providers build collaborative LTSS focused integrated care delivery systems that include a continuum of care. Ability to address persons with behavioral health needs and dementia will be critical.
- Encourage/require alternative payment methodologies that support this integrated system and that align financial incentives both across payors and between the state, MCOs and providers.
- Change financial incentives for Nursing Facilities – encourage them to reduce length of stay, increase quality, and send people home quicker.

EOHHS is also beginning to design a Medicaid Pre-Eligibles Pilot Program. The conceptual design as tested with stakeholders in the draft roadmap in January 2017 was met with strong interest and positive feedback, and initial design discussions have already begun with interested stakeholders. Over the coming months, EOHHS intends to work with CMS and local parties to design potential pathways for this innovative approach.

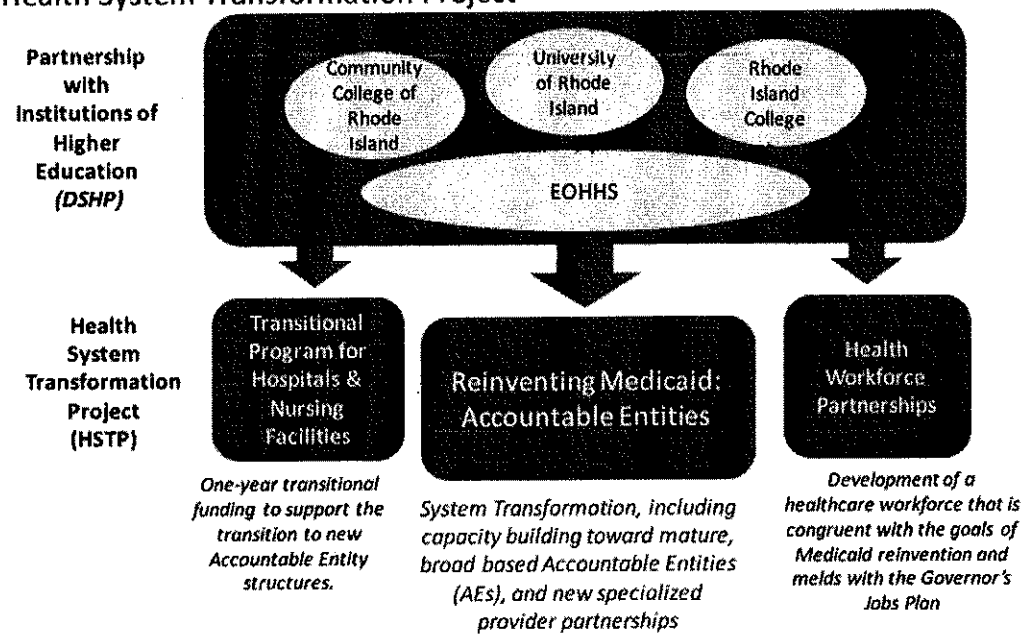
3. Establishment of funding mechanism for Incentive payments

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 design, development implementation, and administration 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 Comprehensive Medicaid 1115 Waiver Demonstration. In October 2016 CMS approved

this waiver amendment, for a federal share of $129.8 million in federal financial participation (FFP) to RI from November 2016 through December 2020.[4]

This funding is based on the establishment of an innovative Health Workforce Partnership with RI's three public higher education institutions: University of Rhode Island (URI), Rhode Island College (RIC), and the Community College of Rhode Island (CCRI), as illustrated below.

Health System Transformation Project



The majority of the financing from this waiver amendment will be provided to AEs as incentive-based infrastructure funding via the state's managed care contracts. Other CMS-funded components include:

- Investments in partnerships with Institutions of Higher Education (IHEs) for statewide health workforce development and technical assistance to AEs
- One-time transitional funding to support hospitals and nursing facilities in the transition to new AE structures[5]
- Project management support to ensure effective and timely design, development, implementation, and administration of this program
- Project demonstration pilots and project evaluation funding to support continuous program learning, advancement and refinement
- Other supporting programs, including Consumer Assistance, Wavemaker Fellowship, TB Clinic, RI Child Audiology Center, and Center for Acute Infectious Disease Epidemiology

[4] The current Rhode Island 1115 Waiver is a 5-year demonstration, ending in 2018. The STCs include DSHP funding authority through 2018, with a commitment articulated in the cover letter to extend this authority thru 2020 upon waiver renewal for a total funding opportunity for a federal share of $129 Million in federal financial participation (FFP).

[5] The STCs limit this program to be one-time only and to not exceed $20.5 million, paid on or before December 31, 2017.

As mentioned above, the current RI 1115 Waiver expires December 31, 2018. The STCs of the waiver amendment include expenditure authority for this program up to $79.9 million FFP through the end date of the current waiver.

V. AE Program Structure

EOHHS intends to expand and refine the current Pilot Accountable Entity Program to further support and encourage the development of Accountable Entities. As such, the Accountable Entity Program will include three core "pillars" as shown and described below. Each of these pillars will be articulated through specified arrangements with certified AEs. These three pillars are noted briefly here and described more fully later in this Roadmap.

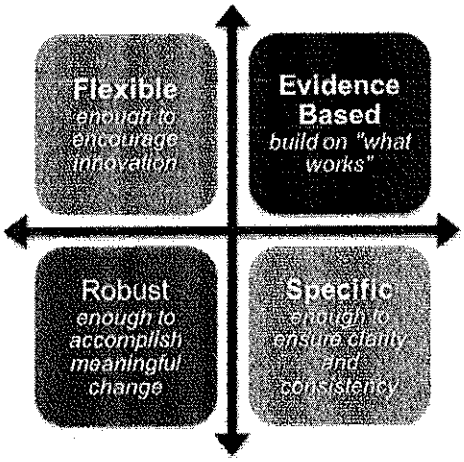
The vehicle for implementing the AE initiative will be contractual relationships between the AE and Medicaid's Managed Care partners. EOHHS, with stakeholder input, has established requirements for Accountable Entity certification as well as Managed Care performance requirements for AE contracts. Once an AE is certified by EOHHS, the AE is now eligible to enter a value based Alternate Payment contract (i.e. total cost of care/shared savings and/or risk model) with any of the State's Medicaid MCOs based on the methodology established by EOHHS (total cost of care model, including quality measures, attribution, and incentive funding distribution) and in conformance with EOHHS contractual requirements as set forth in the contract between EOHHS and the MCO. The MCO and AE contract establishes the specific requirements and milestones associated with the administration of the AE program.
Medicaid MCOs are contractually required to increasingly enter into EOHHS approved value based APM contract arrangements. Certified AEs must enter into value based APM contracts in compliance with EOHHS guidelines in order to participate in member attribution, shared savings arrangements, and to be eligible to receive incentive-based infrastructure payments through the Health System Transformation Program.

Core Pillars of EOHHS Accountable Entity Program

1. **EOHHS Certified Accountable Entities and Population Health**
   The foundation of the EOHHS program is the certification of Accountable Entities (AEs) responsible for the health of a population of members.
2. **Progressive Movement toward EOHHS approved Alternative Payment Methodologies**
   Fundamental to EOHHS' initiative is progressive movement from volume based to value based payment arrangements and movement from shared savings to increased risk and responsibility. Once an AE is certified, the AE must pursue value-based Alternative Payment Methodologies (APMs) with managed care partners in accordance with EOHHS defined guidance.
3. **Incentive Payments for EOHHS Certified AEs**
   Incentive-based infrastructure funding will be available to state certified AEs who have entered into qualifying APM contractual agreements with managed care partners. As part of these agreements, AEs may earn incentive-based infrastructure funding under state-specified requirements. Note that Certified Specialized LTSS AE pilots may be eligible to participate in the Incentive Program for an initial six months prior to entering into qualifying APM contractual agreements with managed care partners, in order to support the

immediate development of business critical partnerships and technical capacities needed to support an effective Alternative Payment Model.

Note that each of these pillars was 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 provide further detail on each of the three pillars.

VI. AE Certification Requirements

During the spring/summer of 2017, EOHHS will be formalizing 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 various stages of the application and approval process, will be managed directly by EOHHS. The final certification standards and application requirements will be 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 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

EOHHS recognizes that potential applicants may have differing stages of readiness. The HSTP Program is intended as a catalyst for health system change, to induce these emerging organizations to develop new capacities and capabilities toward a new system of care that cares for the whole person and is accountable for both the outcome and cost of care.

As such, AEs will be annually certified, and EOHHS anticipates that most will be "Provisionally Certified with Conditions" initially. A provisionally certified entity means that the AE may not be fully compliant with all the organizational capabilities set forth in the certification requirements at the point of application but the AE has a strong application and a plan and commitment to further develop capabilities in key areas. The outstanding need area or "conditions" shall highlight the gaps in AE capacities and capabilities that will be funded through the Medicaid 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 Medicaid Incentive funds. Eventually, AEs who have demonstrated that all of the domain requirements were fully met will be designated as "Fully Certified". "Full" certification is not required to be eligible for Medicaid Incentive funds.

EOHHS intends to certify three types of AEs:

1. **Comprehensive AEs**
2. **Specialized LTSS Pilot AEs**

3. Specialized Medicaid Pre-Eligibles Pilot AEs

Note that these AEs will serve distinct populations. As such, entities may apply to participate in one or more programs, as long as readiness can be appropriately and specifically demonstrated.

1. Comprehensive AE Certification Standards

EOHHS has identified the critical domains considered instrumental to the success of Comprehensive AEs in meeting the needs of the Medicaid population through system transformation. Note that these requirements do not specify a particular organizational structure. EOHHS values multiple models of AE and encourages entities with different structures to apply (under the current pilot there are FQHC based, hospital based and primary care based Pilot AEs).

AE Applicants must meet minimum requirements in order to be considered for certification. Preliminary minimum requirements include:

- Minimum attributed lives
- Minimum Medicaid share of lives
- Demonstrated ability to collect, share, and report data
- Demonstrated level of behavioral health integration with primary care, with an established behavioral health provider organization
- Demonstrated affiliation or working arrangement with an SUD treatment provider
- Demonstrated affiliation or working arrangement with community based organizations to address broader social contexts impacting health, outcomes

Final requirements for qualified applicants shall be included in the AE application.

Qualified AE applicants will then be required to demonstrate their specific capacity to serve the requested populations by meeting requirements across the following domains. Preliminary detailed requirements for each of these domains are included in **Appendix A**.

- **Domain 1: Breadth and Characteristics of Participating Providers**
  Interdisciplinary with demonstrated ability to serve a broad continuum of needs including social determinants for attributed populations. Must include a defined affiliation or working arrangement with community based organizations to address broader social contexts impacting health, outcomes.
- **Domain 2: Corporate Structure and Governance**
  An adequate and appropriate governance structure to accomplish the program goals
- **Domain 3: Leadership and Management**
  A leadership structure, with commitment of senior leaders, backed by the required resources to implement and support a single, unified vision
- **Domain 4: IT Infrastructure: Data Analytic Capacity & Deployment**

A core functional IT capacity to receive, collect, integrate, and utilize information

- **Domain 5: Commitment to Population Health and System Transformation**
  A concerted program built on population health principles and systematically focused on the health of the entire attributed population. 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.
- **Domain 6: Integrated Care Management**
  A comprehensive integrated care management program, including systematic processes and specialized expertise to identify and target populations. An organizational approach and strategy to integrate person-centered medical, behavioral, and social services for individuals at risk for poor outcomes and avoidable high costs.
- **Domain 7: Member Engagement & Access**
  Capacity for effective member engagement, including strategies to maximize outreach, engagement, and communication with members in a culturally competent manner
- **Domain 8: Quality Management**
  Ability to internally report on quality and cost metrics; to use those metrics to monitor performance, emerging trends, and quality of care issues; and to use results to improve care

It is EOHHS' expectation is that the AE shall be structured and organized to provide care for all populations, including adults and children. However, EOHHS recognizes that the necessary skills and capacities of an AE will vary considerably across populations. Specifically,

- **Children,** including children with special health care needs (CSHCN) and children with high, rising and low risk
- **Adults**, including adults with complex medical needs, co-occurring Behavioral Health/Medical, Homelessness, Substance Use Disorders, Other Disabilities, Intellectual and Developmental Disabilities.

As such, AE Certification may be specific to an approved population – Children, Adults – with attribution limited to the approved population. AE applicants will need to demonstrate the ability to meet the broad range of needs present in each identified population. Note that in some instances these capacities may be demonstrated by the AE itself, or through its relationship with participating MCOs.

To ensure that incentives are meaningfully and adequately sized, this will be a competitive program, with stricter requirements for certification beginning in year two.

Preliminary evaluation and selection criteria are as follows:

- **Demonstrated commitment to EOHHS priorities and Medicaid populations**
  Demonstrated capabilities and capacities to serve the unique needs of the Medicaid population, and to address the goals and priorities described in Section 2.

- **Evidence of Readiness** *(Domains 1-3)*
  Specific evidence of strong interdisciplinary network capacity, and an effective governance model and leadership team.
- **Data & Analytic Capacity** *(Domain 4)*
  Demonstrated capacity to collect, integrate and utilize data to support decision-making.
- **System Transformation** *(Domains 5-8)*
  Demonstrated commitment to, and capacity for, population health and system transformation, including a comprehensive, integrated and interdisciplinary care management program, effective member engagement strategies and a strong quality management program.

Final evaluation and selection criteria shall be included in the AE application.

2. Specialized AE Certification Standards: LTSS Pilot Certified AE

The objective of an LTSS Pilot AE 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. Eligible entities must demonstrate readiness across the same domains as listed above for Comprehensive AEs, with specific requirements within each domain that have been tailored to the specific needs of the LTSS eligible population and the current capacities of the LTSS provider community:

- Domain 1: Breadth and Characteristics of Participating Providers
- Domain 2: Organizational Structure and Governance
- Domain 3: Leadership and Management
- Domain 4: IT Infrastructure – Data Analytic Capacity and Deployment
- Domain 5: Commitment to Population Health and System Transformation
- Domain 6: Integrated Care Management
- Domain 7: Member Engagement and Access
- Domain 8: Quality Management

Note that the Pilot LTSS AE certification standards are intended as a starting point to engage individual providers in the challenging tasks of partnership development. EOHHS anticipates there may be multiple pilot LTSS AEs with different combinations of participating providers and different governance and care management models. Similar to the Comprehensive AE program, EOHHS intends to allow for multiple models under the pilot and will leverage learnings from the pilot to establish more rigorous standards for full implementation.

To ensure that incentives are meaningfully and adequately sized, this will be a competitive pilot program, with a limited number of selected participants, subject to available funding.

3. Specialized AE Certification Standards: Medicaid Pre-Eligibles Pilot Certified AEs

Certified Comprehensive AEs may also be eligible to participate in the Medicaid Pre-Eligibles Pilot program if they meet EOHHS specified criteria, to be developed in the coming months.

Comprehensive AEs who are already working with Medicare populations (either through Medicare Advantage or Medicare ACO arrangements) are likely to provide the foundation for such a program.

VII. 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 AE initiative will be implemented through Managed Care. AEs must enter into Managed Care contracts in order to participate in member attribution and shared savings within TCOC arrangements. These AEs will also be eligible to receive incentive payments from their Managed Care partner through the Health System Transformation Program.
Correspondingly, MCOs must enter into qualified APM contracts (consistent with EOHHS defined APM guidance) with Certified AEs under the terms of their contracts with EOHHS.

As the primary contractor with EOHHS, the MCOs will retain accountability for ensuring compliance with all contractual requirements and related Federal managed care regulations. It is anticipated that successful development of an AE will include a defined yet dynamic distribution of responsibilities between the MCO and the AE, and that these will be identified in the written agreement between the parties. The distribution of roles and responsibilities may vary among AEs and MCOs to achieve the most effective combination. Performance of certain functions can be delegated to a subcontracting AE, but delegation will be with the expressed obligation to abide by managed care regulations and must be reviewed and approved by the State.

EOHHS is committed to maintaining member choice within the AE program structure. Members must have access to the right care, at the right time, and in the right setting. AE provider relationships may not impact member choice and/or the member's ability to access providers contracted or affiliated with the MCO. While AE based network limits, restrictions and fees are prohibited, MCOs and AEs may encourage utilization of preferred networks provided that rewards or positive financial incentives used are nominal and specifically linked with health-promoting plans of care. All incentives and methods of encouragement of preferred networks must be consistent with CMS requirements for Medicaid.[6]

EOHHS is also committed to ensuring that the proposed AE will not limit Medicaid beneficiary access to providers on the basis of AE attribution. It is not the intent of the accountable entity program to create new siloes of care within each system. In particular, AE affiliated hospitals and/or specialists may not in any way limit access to only AE participating providers.

Qualified APM contracts shall be in accordance with EOHHS defined APM guidance. This guidance shall be developed:

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[6] Next Generation ACO summary on CMS website: https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/index.html. Next Generation ACO RFA, which includes section on beneficiary coordinated care rewards: https://innovation.cms.gov/Files/x/nextgenacorfa.pdf

- leveraging learnings from the current pilot program guidance documents as implemented in 2016,
- in alignment with Federal MACRA rules,
- in alignment with Rhode Island commercial requirements as established by the Office of the Health Insurance Commissioner, and,
- considering public and stakeholder input.

Note that the allowable APMs do NOT require a change to the underlying structure of payment between the MCOs and the AEs. Payment models that maintain the existing fee-for-service structure with a link to a set of quality indicators at risk, including a total cost of care overlay (thereby creating an opportunity for shared savings and risk between payors and providers) would qualify as an APM.

Each of the three AE Programs 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 defined guidance, to be developed with input from stakeholders this spring and submitted for approval by CMS.

AE Attributable Populations

Program	Attributable Populations
1. Comprehensive AEs	Medicaid-only eligibles
2. Specialized LTSS AEs	LTSS eligible, including duals and nonduals
3. Specialized Medicaid Pre-Eligibles AEs	Medicare-only eligible

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 Guidance. In addition, EOHHS does reserve the right to review and approve such arrangements.[7, 8]

Additional program specific APM requirements are as follows:

Comprehensive AE Alternative Payment Methodology: Total Cost of Care
Managed Care Contracts with Comprehensive Accountable Entities must be based on total cost of care (TCOC) to be defined in forthcoming APM guidance from the EOHHS. 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 guidelines set forth by EOHHS. MCOs are responsible to EOHHS for

[7] In addition to this EOHHS requirement, note that in certain circumstances transparency in such arrangements is specifically required in CFR42 §438.6.
[8] 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

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 Scorecard. A comprehensive quality score factor, based on the *Quality Scorecard*, must be applied to any shared savings and/or risk arrangements when calculating the total cost of care. A draft version of this *Quality Scorecard* has been posted for public comment. The final *Quality Scorecard* will be modified, based on stakeholder input, and will align with the quality measures for Accountable Care Organizations (ACOs), which were endorsed by RI SIM. In addition to the required core measures, each MCO and AE may also include a limited number of additional measures from the SIM menu set, Medicaid Adult and/or Child Core Set. The quality calculation construct must be based upon a quality multiplier with a minimum threshold of allocated shared savings.

Qualified TCOC-based contractual arrangements must also demonstrate a progression of risk to include meaningful downside shared risk or full risk. By the end of the anticipated five-year waiver period in October 2021, infrastructure funding will be phased out. AEs will be sustained going forward based on their successful performance and associated financial rewards in accordance with their contract with MCOs.

2. Specialized LTSS Pilot AE: LTSS Bundle

Participating AEs will be responsible for the total cost of care. However, for dual eligible populations Medicare is primary for many services, with different arrangements depending on the program structure. As such, this interim APM arrangement will project the total cost of care for services included within the identified "bundle" of Long Term Services and Supports for the attributed population. This calculation will provide the basis for comparing actual financial experience with the projected financial experience.

The LTSS APM will also include a performance bonus for Pilot LTSS AE performance across a set of agreed upon dimensions. Given that EOHHS anticipates significant challenges in both capturing key data elements and measuring performance across populations, EOHHS would likely begin with a pay for reporting period for some components.

3. Specialized Medicaid Pre-Eligibles Pilot AEs

EOHHS sees an important opportunity in creating a targeted program to address Medicaid pre-eligibles. Previous studies of Medicaid migration patterns for long term care recipients here in Rhode Island have shown that much of the extended stay nursing home population is already in a nursing home when becoming eligible for Medicaid, likely having entered a nursing home and then spent down their assets until they became Medicaid eligible. This suggests that strategies to "rebalance," away from expensive nursing home settings and toward more cost-effective community based care would benefit from a multi-payer approach, as these high risk individuals must be identified well before they spend down assets and become Medicaid

eligible – before they enter a nursing home.

As this program is not slated to begin during this DY approval period, EOHHS intends to work with interested entities in the coming months to develop a reporting and data sharing arrangement that effectively enables combined Medicare and Medicaid population reporting and tracking for populations transitioning from Medicare to Medicaid.

VIII. Medicaid 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 design, development and implementation of the infrastructure needed to support Accountable Entities.

CMS has approved up to $129.8 Million in HSTP program funds[9]. An estimated $76.8 M shall be allocated to the AE Program, subject to available funds captured in accordance with CMS approved claiming protocols, as shown below. Under the terms of Rhode Island's agreement with the federal government, this is not a grant program. AEs must earn payments by meeting metrics defined by EOHHS and its managed care partners and approved by CMS to secure full funding.

	SFY 17	SFY 18	SFY 19	SFY 20	SFY 21	Total
Accountable Entity Program	$0.0	$10.0	$29.4	$23.9	$13.5	$76.8

An AE Program Advisory Committee shall be established by EOHHS. This committee shall be chaired by EOHHS, with a community Co-Chair and shall include representation from participating MCOs, AEs, and community stakeholders and shall:

- Support the development of AE infrastructure priorities,
- Help target Medicaid Incentive Program funds to specific priorities that maximize impact
- Review specific uses of funds by each AE and MCO, such that individual AE Project plans are designed and implemented to maximum effect
- Monitor ongoing MCO/AE program performance
- Support effective program evaluation and integrated learnings

Detailed guidance for this program shall be set forth by EOHHS, with assistance from the AE Program Advisory Committee, in the final HSTP Guidelines for Health System Transformation Project Plans. Draft guidance shall be posted, comments received will be reviewed, and

[9] The current Rhode Island 1115 Waiver is a 5-year demonstration, ending in 2018. The STCs include DSHP funding authority through 2018, with a commitment articulated in the cover letter to extend this authority thru 2020 upon waiver renewal for a DSHP funding opportunity for a federal share of $129 Million in federal financial participation (FFP).

documents will be revised in consideration of public comments before final submission to CMS for approval.

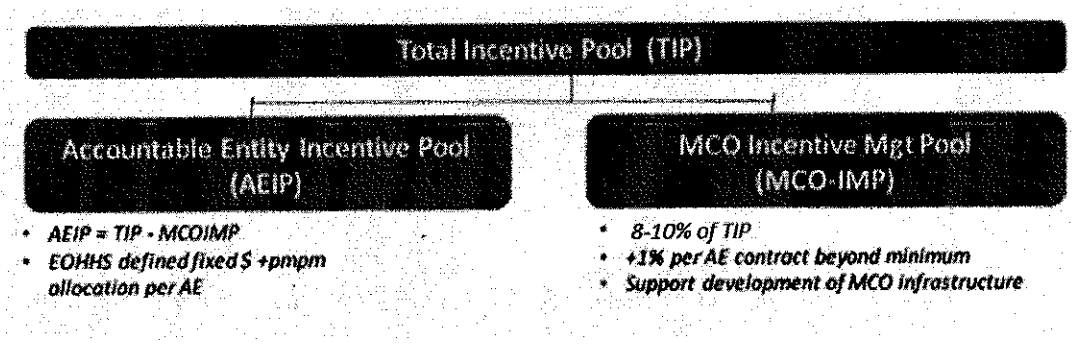
A. Program Structure

The Medicaid Incentive Program (MIIP) shall consist of three core programs: (1) Comprehensive AE Program; (2) Specialized LTSS AE Pilot Program; and (3) Specialized Pre-eligibles AE Pilot Program. EOHHS shall allocate available HSTP funds to these three programs as follows, subject to available funds and EOHHS identification of priority areas of focus and assessment of readiness. This allocation shall be revisited annually.

AE Programs	Share of Available AE Funds	
	Program Year 1	Full Program
Comprehensive AE Program	60-70%	60% - 70%
Specialized LTSS Pilot AE Program	30-40%	25% - 35%
Specialized Pre-eligibles Pilot AE Program		5%-15%*

*Authority for this program is dependent upon CMS approval under the RI Medicaid 1115 waiver extension, to be submitted to CMS in December 2017, effective January 1, 2019.

For each MCO the MIIP shall include three dimensions:



1. **Maximum Total Incentive Pool (TIP) for MCOs**
   The maximum TIP for each MCO shall be determined by EOHHS with consideration to the MCO share of AE attributed lives in accordance with EOHHS defined attribution guidelines and associated reports.

2. **MCO Incentive Program Management Pool (MCO-IMP)**
   Assuming satisfactory MCO performance, the MCO Incentive Program Management Pool shall minimally be eight percent (8%) of the Total Incentive Pool. To the degree that the MCO has more than the minimally required number of contracts with AEs, to be identified in a contract amendment, the MCO-IMP shall be increased by one percent for each AE contract to a maximum of ten percent. These funds are intended for use toward advancing program success, including program administration and oversight, assisting with the development of the necessary infrastructure to support a new business model, and

establishing shared responsibilities, information requirements and reporting between EOHHS, the MCO and the Accountable Entities.

3. **Accountable Entity Incentive Pool (AEIP)**
The Accountable Entity Incentive Pool shall equal the Total Incentive Pool minus the MCO Incentive Program Management Pool (AEIP =TIP – MCO-IMP). This pool shall be divided into the three distinct programs as specified above. In developing contracts with AEs, MCOs shall propose AE Infrastructure Payment Criteria and Methodology for EOHHS review and approval that are consistent with EOHHS defined guidance. This shall determine the total annual amount and schedule of incentive payments each participating AE may be eligible to receive from the Accountable Entity Incentive Pool.

3a. Accountable Entity Specific Incentive Pools
Certified AEs in qualified Alternative Payment Methodology (APM) contracts consistent with EOHHS guidance must be eligible for the Medicaid Incentive Program. Each MCO must create an AE Incentive Pool for each Certified AE to establish the total incentive dollars that may be earned by each AE during the period. The Pool calculation shall include a base amount plus a pmpm component based on attributed lives at the start of each contract year in accordance with EOHHS defined guidance. An example of an AE Incentive Pool calculation for a sample AE is shown below – please note the numbers shown here are illustrative only.

AE #1 Incentive pool Year 1: Illustrative Example Calculation
AE 1 has 15,000 attributed lives, 10,000 are with MCO 1, and 5,000 with MCO 2
Payments from each MCO are for distinct attributed populations and therefore not duplicative.

	MCO 1	MCO 2	Total
Attributed lives	10,000	5,000	15,000
Base Amount	$200,000	$200,000	$400,000
pmpm	$ 180,000	$ 90,000	$270,000
AE 1 Incentive Pool	**$380,000**	**$290,000**	**$670,000**

Illustrative Example Assumptions	
$200,000	base per MCO
$ 1.50	pmpm

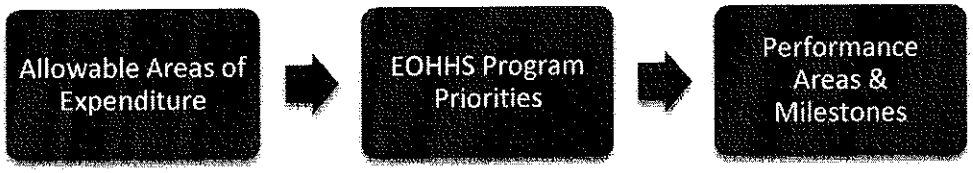
3b. Performance Based Incentive Payments
AEs must develop individual Health System Transformation project plans that identify clear project objectives and specify the activities and timelines for achieving the proposed objectives. Actual AEIP incentive payment amounts to AEs will be based on demonstrated AE performance. Incentive payments actually earned by the AE may be less than the amount they are potentially eligible to earn. MCOs shall not be entitled to any portion of funds from the Accountable Entity Incentive Pool that are not earned by the AE.

Reconciliation
In advance of the MCOs payments to AEs, the MCO shall receive payment from EOHHS in the amount and schedule agreed upon with EOHHS. Any Incentive Program funds that are not earned by EOHHS Certified AEs as planned during a given contract year shall be tracked and

retained by the MCO exclusively for future Accountable Entity Incentive Pool uses during the following contract year. Any funds not earned during the following contract year shall be returned to EOHHS within thirty days of such request by EOHHS. An AE's failure to fully meet a performance metric within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment). An AE that fails to meet a performance metric in a timely fashion can earn the incentive 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 on-time performance on the next metric in the performance sequence, in accordance with the requirements for Material Modifications described in Section VIII.C.3 of this document.

B. Program Spending Guidance

Incentive Program funds are designed to be used by AEs to prepare project plans and to build the capacity and tools required for effective system transformation. Allowable expenditures must align with EOHHS program priority areas and shall be distributed by the MCOs to the AEs in designated performance areas.



Allowable Areas of Expenditure

Allowable uses of funds include the following three core areas and eight domains. Costs must be reasonable for services rendered.

Domains	Allowable Uses of Funds	Allowable Expenditure Mix		
		Yr 1	Yr 2-3	Yr 4
A. Readiness		**<50%**	**<25%**	**<10%**
1. Breadth and Characteristics of Participating Providers	• Building provider base, population specific provider capacity, interdisciplinary partnerships, developing a defined affiliation with community based organizations (CBOs) • Developing full continuum of services, Integrated PH/BH, Social determinants			
2. Corporate Structure and Governance	• Establishing a distinct corporation, with interdisciplinary partners Joined in a common enterprise			
3. Leadership and Management	• Establishing an initial management structure/staffing profile			

	• Developing ability to manage care under Total Cost of Care (TCOC) arrangement, with increased risk and responsibility			
B. IT Infrastructure		**30%**	**30%**	**30%**
4. Data Analytic Capacity and Deployment	• Building core infrastructure: EHR capacity, patient registries, Current Care • Provider/care managers' access to information: Lookup capability, medication lists, shared messaging, referral management, alerts • Patient portal • Analytics for population segmentation, risk stratification, predictive modeling • Integrating analytic work with clinical care: Clinical decision support tools, early warning systems, dashboard, alerts • Staff development and training – individual/team drill downs re: conformance with accepted standards of care, deviations from best practice			
C. System Transformation		**20%**	**45%**	**70%**
5. Commitment to Population Health and System Transformation	• Developing an integrated strategic plan for population health that is population based, data driven, evidence based, client centered, recognizes Social Determinants of Health, team based, integrates BH, IDs risk factors • Healthcare workforce planning and programming			
6. Integrated Care Management	• Systematic process to ID patients for care management • Defined Coordinated Care Team, with specialized expertise and staff for distinct subpopulations • Individualized person centered care plan for high risk members			
7. Member Engagement and Access	• Defined strategies to maximize effective member contact and engagement • Use of new technologies for member engagement, health status monitoring and health promotion			
8. Quality Management	• Defined quality assessment & improvement plan, overseen by quality committee			

EOHHS anticipates that spending may be heavily weighted toward the Readiness Core Area (domains 1-3) in year one, as AEs build the capacity and tools required for effective system transformation. However, over time the allowable areas of expenditure will be required to shift toward system transformation (domains 5-8). A preliminary allowable mix of expenditures is shown above.

Program Priorities

Each MCO's AE Incentive Pool budget and actual spending must align with the priorities of EOHHS as developed with the support of the Advisory Committee and shown below. Note: This is a draft set of priorities – a final set of priorities shall be reviewed and confirmed by the Advisory Committee, and specified in the final APM guidance document.

Program	Priorities

Comprehensive AEs	• Planning and core infrastructure development
	• Medical enhancements: enhanced systems of care, workforce development
	  o For children
	  o For Adults
	• Integration and innovation in behavioral health care
	  o For children
	  o For Adults
	• Integration and innovation in SUD treatment
	• Integration and intervention in social determinants, including cross system impacts

Specialized Pilot LTSS AEs	• Building partnerships, including governance, leadership and financial arrangements, between LTSS providers. • Developing programs and care coordination processes towards effective and timely care transitions and reduced institutional/ED utilization • Repurposing skilled nursing capacity for acute psychiatric transitions and/or adult day capacity • Home and Community based Behavioral Health capacity development for behavioral health specialized adult day care, home care, and alternative living arrangements.
Specialized Medicaid Pre-Eligibles AEs	• Developing processes, tools and protocols for identification of at risk Medicaid pre-eligible populations • Developing effective and evidence based interventions to support community based care for these populations. EOHHS is committed to working with these entities to define and develop opportunities (mechanisms to pay for) for the specific services needed for identified Medicaid pre-eligible populations that may not currently be Medicare covered services – e.g., home based primary care, palliative care, community health workers, etc. *Note that authority for this program shall be requested under the RI Medicaid Waiver renewal, to be submitted in March of 2018 and effective January 1, 2019. EOHHS seeks to implement this program once it is approved under the waiver extension.*

Performance Areas

AEs must develop AE Specific Health System Transformation Project Plans. These plans shall specify the performance that would qualify an AE to earn incentive payments. Earned funds shall be distributed by the MCO to the AE in accordance with the distribution by performance area defined in the AE specific Health System Transformation Plan, consistent with the requirements defined below:

Performance Area	Minimum Milestones	Year 1	Year 2	Year 3	Year 4
Planning and Design	• Execution of Contract, Initial Workplan & budget for developing an AE Project Plan, including completed EOHHS Budget Template • Detailed AE Gap Analysis, with specified impacts by domain and population	**70%**	**15%**	**0%**	**0%**
Developmental Milestones	• Detailed **Health System Transformation Project Plan, including** proposed	**30%**	**85%**	**75%**	**50%**

	Infrastructure Development Budget by Project, Domain and population, in accordance with state specified template • Quarterly Progress Report in accordance with state defined template • Quarterly financial report, in accordance with state defined template, including documented evidence of expenditures • Developmental milestones MCO/AE Defined (at least 3 unique developmental milestones per year)				
Value based purchasing metrics	• Demonstrated APM Progression • Marginal Risk Requirements • Minimum required share of marginal risk for which the AE is liable, in accordance with EOHHS define APM guidelines	**0%**	**0%**	**20%**	**30%**
System Performance Metrics	• Preventable Admissions • Readmissions • Avoidable ED Use • MCO/AE Specific Performance Targets (up to 3)	**0%**	**0%**	**5%**	**10%**
Final Deliverable		**0%**	**0%**	**0%**	**10%**

The early milestones are intended to allow AEs to develop the foundational tools and human resources that will enable AEs to build core competencies and capacity. In accordance with EOHHS' agreement with CMS, participating AEs must fully meet milestones established in the AE specific health system transformation plan prior to payment. EOHHS recognizes the financial constraints of many participating AEs, and that timely payment for the achievement of early milestones will be critical to program success.

These AE-specific HSTP project plans may only be modified with state approval, in accordance with the Material Modification requirements outlined in section C.3 below, and further specified in the EOHHS Guidelines. EOHHS 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.

C. Implementation and Oversight

As described above, the Medicaid Incentive Program (MIIP) includes EOHHS **program priority areas, allowable areas of expenditure, and AE specific performance areas** that qualify an AE to earn incentive payments. With the assistance of the Advisory Committee EOHHS will develop "EOHHS Guidelines for Health System Transformation Project Plans" that will further specify each of these program elements. This guidance will define specific implementation requirements that must be adhered to by AEs and MCOs to ensure that incentive programs are designed and implemented to maximum effect.

Four key elements of these implementation requirements to be further stipulated in the guidelines are as follows:

1. **Specifications Regarding Allowable HSTP Project Plans**
   Specifications shall delineate additional details regarding:
   - Core Goals
   - Allowable Priority areas
   - Allowable Areas of Expenditure
   - Required Performance Areas
   - Characteristics of approvable project plans:
     - Approvable project plans must demonstrate how the project will advance the core goals and identify clear objectives and steps for achieving the goals.
     - Approvable project plans must set timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance.

2. **MCO Review Committee Guidelines for Evaluation**
   The MCO shall convene a review committee to evaluate each proposal. EOHHS shall have a designee that participates on the MCO submission evaluation committee to ensure the state's engagement in the process to evaluate the project plan and associated recommendations for approval or disapproval. The MCO Review Committee, in accordance with EOHHS guidelines, shall determine whether:
   - **Project as submitted is eligible for award**
     Eligible projects will include a project plan that clearly address EOHHS priority areas and clearly includes the types of activities targeted for funds.
   - **Project merits Incentive Funding**
     Projects must show appropriateness for submission for this program by including 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 and is non-duplicative of submission that may be made to another MCO
     - High quality proposal that includes a gap analysis, explains how the workplan and budget addresses these gaps, and describes the AE's current strengths and weaknesses in this area
     - Clear interim and final project milestones and projected impacts, as well as criteria for recognizing achievement of these milestones and quantifying these impacts
   - **Incentive Funding request is reasonable and appropriate**
     The funding request must be reasonable for the project identified, with funds clearly dedicated to this project. The level and apportionment of the incentive funding request

must be commensurate with value and level of effort required.

3. Material Modification of HSTP Project Plans
   EOHHS guidelines shall delineate additional details regarding material modification requests, to include:
   - Definition
     A Material Modification includes any change to the metrics, deadlines or funds associated with an HSTP Project Plan. Failure to meet performance metrics shall be considered a material modification.
   - Material Modification Request Submission
     An official request must be submitted in writing by the AE to the MCO, including the following:
     - A brief description of the requested change
     - A clear statement of purpose, or justification for the modification
     - A brief statement of the anticipated impact the change will have on the project plan, timeline and goals
     - A listing of any proposed changes in specific metrics or deadlines
   - Review Process and Criteria
     Any material modification to the HSTP Project Plans must be reviewed and approved by the MCO Review Committee. Material modifications that either delay the project by more than 3 months or impact more than 15% of HSTP funding must also be approved by the AE Advisory Committee. Material modification requests must be reasonable for the project identified, with clear revisions to the project milestones, metrics and timelines commensurate with the scope of the modification. In instances where an AE fails to meet (or anticipates that it will not meet) a performance metric, fully achieving the original metric (within one year of the original performance deadline) in combination with on-time performance on the next metric in the performance sequence shall qualify as an acceptable modification.

4. Required Structure for Implementation
   The Incentive Funding Request must be awarded to the AE via a Contract Amendment between the MCO and the AE. The Contract Amendment shall:
   - Be subject to EOHHS review and approval
   - Incorporate the central elements of the approved AE submission, including:
     - Stipulation of program objective
     - Scope of activity to achieve
     - Performance schedule
     - Payment terms – basis for earning incentive payment(s) commensurate with the value and level of effort required.
   - Define a review process and timeline to evaluate progress 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 Health System Transformation Project funds to the AE.

- Minimally require that AEs must submit semi-annual 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 Health System Transformation Project payments, and that such reports will be shared directly by the MCO with EOHHS.
- Stipulate that the AE must earn payments through demonstrated performance. The AE's failure to fully meet a performance metric 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).
  Provide a process by which an AE that fails to meet a performance metric in a timely fashion (and thereby forfeits the associated Health System Transformation Project Payment) 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 on-time timely performance on the next metric in the performance sequence.

IX. Program Monitoring, Reporting, & Evaluation Plan

Rhode Island has an established track record of expansions and improvements to its managed care programs as well as a systematic and active program of oversight of our contracted MCOs. The development of the Accountable Entities program provides a new and significant opportunity to further transform the performance of our delivery systems and improve health outcomes for Rhode Island's Medicaid population.

Rhode Island initiated its first managed care program in 1994 with the enrollment of children and families into its RIte Care program. In the years following there have been many changes in the structure of the program so that it now includes the large majority of Medicaid covered beneficiaries, a broad range of Medicaid covered services with very few service "carve outs", and an array of program initiatives intended to advance program effectiveness and cost efficiencies. At each step along the way we have adapted and expanded our program oversight activities to promote high quality performance and ensure program compliance.

Rhode Island's Accountable Entity program is designed to work within and in partnership with our managed care program. Certification of AEs is performed directly by EOHHS, establishing their eligibility to participate in the program. Annual certification ensures continued compliance with requirements to retain eligibility. Eligible AEs will then contract with managed care organizations within the requirements set forth by EOHHS. 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 will be 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, consumer experience, program operations and others. EOHHS reserves the right to review performance in any area of contractual performance, including flow down requirements to 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 will be 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 EHOHHS will be further specified in the final APM guidance document. Areas of current reporting that are under review as requirements for MCOs to report on data aggregated at the Accountable Entity level include:

MCO Required Reports	Description
1. Provider Access Survey 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. Provider Panel Report	A report of which provider panels by each Health Plan are at capacity and/or closed to enrollees.
3. Appeal and Grievance Report	An aggregate report of clinical and administrative denials and appeals by each Health Plan, including External Review.
4. Informal Complaint 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 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. Quality Scorecard	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

In addition to enhancement of current reports, the Medicaid MCOs will be required to submit reports on a quarterly basis that demonstrate their performance in moving towards value based payment models, including:

- Alternate Payment Methodology (APM) Data Report
- Value Based Payment Report

Pertaining more directly to AE program operations, the Medicaid MCOs will be required to submit Accountable Entity specific reports, including the following.

- AE Attributed Lives
  This quarterly report will provide EOHHS with the number of Medicaid MCO lives attributed to each specific Accountable Entity as well as in total.
- AE Population Extract File
  This monthly report will provide EOHHS with a member level detailed 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 will provide 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 more defined areas of program performance such as quality, finance, and operations. During the initial pilot phase with comprehensive AEs and as the program moves forward, these meetings 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 will be 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, as specified in Section II. 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 will issue an RFP, based on the CMS-approved evaluation plan, for a qualified independent entity to conduct the evaluation. The Evaluation Plan will describe the minimum qualifications of the evaluation contractor, a budget, and a plan to assure no conflict of interest.

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

EOHHS has presented to thirteen (13) stakeholder meetings regarding the HSTP/AE Program.

- HSTP/AE Presentation to ICI Provider Council
- HSTP/AE presentation to 1115 Task Force
- AE/MCO meetings on AE initiative (2 sessions)
- Broad Stakeholder meeting/presentation on Comprehensive AEs (2 sessions)
- Stakeholder meeting on Specialized AEs
- HSTP/AE meeting to home care/child service providers
- NASW Aging Committee meeting
- Coalition for Children presentation
- Governor BH council (scheduled)
- BHDDH Health Transition team (scheduled)
- DEA Home and Community Care Advisory Committee (scheduled)

Additionally, twenty-four (24) comments were received by EOHHS from the following interested parties:

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

Many of these comments provided valuable input to the final roadmap as documented here. Some required additional discussion, and were further refined through public input sessions in March 2017, prior to finalizing the roadmap.

Note that the draft roadmap that was posted in January 2017 for comments included both an in-depth discussion of Rhode Island's vision, goals and objectives of Rhode Island's AE program, as well as appendices that outlined initial details of programmatic guidance for AEs. As such, many of the comments received were more directly related to future anticipated guidance – either APM guidance, Incentive Program Guidance or Attribution guidance, and shall be addressed as part of that public input process.

The following is a summary of the comments received by thematic areas.

State Policy Alignment

A number of comments spoke to the need to ensure that state policy outside of the Accountable Entity program was aligned to ensure success. Detailed points of alignment included:

- Statutory authority for data sharing
- Budgetary support for the Integrated Care Initiative, Rhode Island's dual-eligible demonstration program
- Flexibility in Long Term Care Facility Bed Licensing
- Integration of Public Health Initiatives

Overall Program Strategy

Commenters also spoke to the general program strategy and vision as outlined in the roadmap. Frequent comments focused on the following topics:

- *Timeline and milestone expectations* – Many commenters expressed concern at the speed with which the state was proposing to implement the program.
- *Flexibility* – A number of comments spoke with varying degrees of support for the granting of flexibility from the state to MCOs and from MCOs to AEs.
- *Consumer Choice and Access* – Commenters highlighted the need to ensure the protection of consumer choice in the Medicaid program and to protect access to services given the preferred network structure that some AEs may consider developing.

Program Operational Details

Commenters provided significant feedback on operational details that EOHHS will develop further through upcoming guidance documents. Specific areas of feedback included:

- AE Certification
- Alternative Payment Methodologies
- Attribution

- Delegation of Responsibilities
- Incentive Payment Program
- Quality Scorecard
- Reporting and Data Sharing
- Social Service Integration
- Specialized AEs (LTSS)

Appendix C: Roadmap Required Components

	STC Required Elements of Roadmap	Where Addressed
A	(a) Specify that 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 shall be defined in the APM guidance document.	*Section IX. Program Monitoring, Reporting, & Evaluation Plan* • Page 35, 1st paragraph
B	(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 Incentive Program (MIIP)* *Section C. Implementation & Oversight* • Page 31, in bullets under paragraph titled *1. Specifications*
C	(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 36, in paragraph titled *2. In-Person Meetings with MCOs*
D	(d) Provide minimum standards for the process by which EOHHS seek public input in the development of the AE Certification Standards;	*Section VI. AE Certification Requirements* • Page 18, 1st and 2nd paragraphs
E	(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)* *Section C. Implementation & Oversight* • Page 31-32, in paragraph titled *2. MCO Review Committee*
F	(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	*Section VI. AE Certification Requirements* • Page 18, 1st paragraph *Section IX: Program Monitoring, Reporting, & Evaluation Plan* • Page 35-36, in paragraph beginning with "Pertaining more directly to

	or substantiate progress;	AE program operations..."
G	(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 Health System Transformation Project Payments;	*Section VIII. Medicaid Incentive Program (MIIP)* *Section C. Implementation & Oversight* • Page 32, in paragraph titled *3. Required Structure for Implementation,* 4th bullet
H	(h) Specify that each MCO must contract with Certified AEs in accordance with state defined 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 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 47(e).	*Section VII: Alternative Payment Methodologies* • Page 23, in paragraph titled AE Attributable Populations
I	(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 Health System Transformation Project incentive 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 47 (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)* *Section A. Program Structure* • Page 26, in paragraph titled *3. Accountable Entity Incentive Pool* *Section VIII. Medicaid Incentive Program (MIIP)* *Section C. Implementation & Oversight* • Page 31-32, in paragraph titled *2. MCO Review Committee,* 3rd bullet • Page 32, in paragraph titled *3. Required Structure for Implementation*, in 2nd bullet, 4th sub-bullet
J	(j) Specify a review process and timeline to evaluate AE progress on its Health System	*Section VIII. Medicaid Incentive Program (MIIP)*

	Transformation Project Plan metrics in which the MCO must certify that an AE has met its approved metrics as a condition for the release of associated Health System Transformation Project funds to the AE;	*Section C. Implementation & Oversight* • Page 32, in paragraph titled *3. Required Structure for Implementation*, in 3rd bullet
K	(k) Specify that AE's failure to fully meet a performance metric under its AE Health System Transformation Project Plan 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)* *Section C. Implementation & Oversight* • Page 32-33, in paragraph titled *3. Required Structure for Implementation,* 5th bullet
L	(l) Describe a process by which an AE that fails to meet a performance metric in a timely fashion (and thereby forfeits the associated Health System Transformation Project Payment) 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,	*Section VIII. Medicaid Incentive Program (MIIP)* *Section C. Implementation & Oversight* • Page 32-33, in paragraph titled *3. Required Structure for Implementation,* 6th bullet
M	(m) Include a process that allows for potential AE Health System Transformation Project Plan modification (including possible reclamation, or redistribution, pending State approval) and an identification of 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; and	*Section VIII. Medicaid Incentive Program (MIIP)* *Section B. Program Spending Guidance* • Page 31, 2nd paragraph
N	(n) 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 132.	*Section IX. Program Monitoring, Reporting, & Evaluation Plan* • Page 37, in paragraph titled *4. Evaluation Plan*