ATTACHMENT L - Accountable Entity Roadmap Document

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I.   Roadmap Overview and Purpose

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

The purpose of this document is to:

- Document the State's vision, goals and objectives under the Waiver.

- Detail the State's intended path toward achieving the transformation to an accountable, comprehensive, integrated cross-provider health care delivery system for Medicaid enrollees, and detail the intended outcomes of that transformed delivery system.

- Provide an update to the State's previously submitted and approved Roadmap, as is required annually under STC 44.

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

This roadmap has been developed with input from participating MCOs, Accountable Entities and stakeholders. A stakeholder process was conducted through the summer of 2020 to inform the amendments made to this document.

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

II.   Rhode Island's Vision, Goals and Objectives

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

- It is generally fee based rather than value based,

- It does not generally focus on accountability for health outcomes,

- There is limited emphasis on a Population Health approach, and

- There is an opportunity to better meet the needs of those with complex health needs and exacerbating social determinants.

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

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

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

The Managed Care Program's strategic goals are:
1. Maintain historical program strengths focused on health outcomes, cost containment, and the satisfaction of the Rhode Islanders served

2. Improve engagement in and satisfaction with care received among Rhode Islanders on Medicaid, particularly for those with complex healthcare needs

3. Implement value-based payment models that create incentive structures to orient the system to better respond to individual's comprehensive needs and reward models of

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

accountable care delivery that demonstrate improved health outcomes and cost containment

4. Improve health outcomes for Rhode Islanders on Medicaid by orienting the health care delivery system to:

   a. Better integrate medical and behavioral health care in a way that is particularly supportive of those with complex or chronic care needs

   b. Respond to upstream determinants of health to address individual's health related social needs and consider community factors that impact population health, with an emphasis on housing and homelessness

   c. Meet unique needs of elderly and members with disabilities and those in need of long-term services and supports (LTSS) in a way that prioritizes choice and empowers individuals to remain in the community

   d. Support optimal health, development, and well-being of Medicaid covered children, with a focus on the prevention of child maltreatment

5. Achieve the specific strategic goals of the Health System Transformation Project that is focused on the establishment and implementation of the AE Program:

   a. Transition the Medicaid payment system away from fee-for-service to alternative payment models

   b. Drive delivery system accountability to improve quality, member satisfaction and health outcomes, while reducing total cost of care

   c. Develop targeted provider partnerships that apply emerging data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs

   d. Improve health equity and address Social Determinants of Health (SDOH) and Behavioral Health (BH) by building on a strong primary care foundation to develop interdisciplinary care capacity that extends beyond traditional health care providers

   e. Enable vulnerable populations to live successfully in the community

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

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

III.   Our Approach

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

EOHHS envisions two specific AE programs:

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

After the completion of a two-year pilot program, the Comprehensive AE Program launched July 1, 2018. EOHHS has certified six Comprehensive AEs for participation in the program. Six AEs contracted with MCOs and entered into Total Cost of Care and AE Incentive Program arrangements for Program Year 2.

Phase 2: Specialized AE Program
 In July 2020, EOHHS received an extension of its Medicare-Medicaid Program (MMP) through CY 2023. In addition to the MMP program, EOHHS has executed contracts with two Dual Eligible Special Need Plans (D-SNP). Both the MMP and D-SNP are managed care programs specifically for the dual-eligible population. EOHHS has an opportunity to pilot a Specialized APM model through the MMP program and, depending on initial results, extend the pilot offering to the D-SNP plans in Rhode Island.

It has been EOHHS' long-standing objective to encourage and enable LTSS eligible and aging populations to live successfully in their communities. The HSTP program provides EOHHS with an opportunity to implement an APM model focused specifically on preventative care and services needed to prevent the Medicaid-eligible population from needing institutional LTSS. This requires a "Specialized" approach and focus that acknowledges the unique challenges including but not limited to:

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

The design of this Specialized APM model shall be actively informed by a robust stakeholder engagement process. This process is already underway; as part of the broader stakeholder engagement process surrounding the HSTP program. EOHHS contracted with Day

Health Strategies in 2019 seeking feedback from stakeholders regarding the strategic goals for the HSTP and the Specialized AE program. EOHHS shall continue to seek public input and comment on a proposed Specialized APM model for the MMP program. The initial proposal is to implement a quality pay-for-performance model focused on incentivizing transitions of care from hospitals and nursing homes to either an individual's home with supportive outpatient services or home- and community-based care.

EOHHS intends to start the development of this new Specialized APM model in PY3, with the full program implementation, likely to begin in Program Year 4. Please note this timeline is highly dependent on the timeline associated with amending the MMP contract.

Specialized AE Program Timeline

Phase	Timeline	Key Elements
Phase 1 *Design and Development*	PY 3 October 2020- June 2021	• Design an APM model for MMP contract • Develop critical systems and operational capacities to support the implementation of an APM model in managed care starting with a quality performance program focused on transitions of care using a cross setting (hospital, nursing home, homecare/community) approach. • Stakeholder engagement, partner discussions
Phase 2 *Pilot Implementation*	PY 4 July 2021- June 2022	• Pilot key elements of new APM program within existing MMP contract • Use lessons learned to modify model as needed and determine if can be replicated as part of D-SNP contracts
Phase 3 *Specialized APM program implementation*	PY 5 July 2022 + ongoing	• Implement new APM quality performance model payment model.

EOHHS is committed to supporting the AE Program through the Medicaid Infrastructure Incentive Program (MIIP). Beginning in late 2015, EOHHS began pursuing Medicaid waiver financing to provide support for AEs by creating a pool of funds primarily focused on assisting in the development and implementation of the infrastructure needed to support Accountable Entities. RI applied for such funding in early 2016 as an amendment to RI's current Global Medicaid 1115 Waiver. In October 2016, the Centers for Medicare & Medicaid Services (CMS) approved this waiver amendment, bringing $129.8 million in Federal Financial Participation (FFP) to RI from November 2016 through December 2020. The Medicaid Infrastructure Incentive Program continues through June 30,2024.

The overall timeline for this project is depicted below:

Calendar Year	2016	2017	2018	2019	2020	2021	2022	2023	

State Fiscal Year	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24
1115 Waiver	Previous Waiver			Current Waiver				
DSHP Program Year	PY1	PY2	PY3	PY4	PY5			
HSTP Program Year	AE Pilot 1	AE Pilot 2	PY1	PY2	PY3	PY4	PY5	PY6

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

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

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

- EOHHS holds public input sessions and participant working sessions with key stakeholders and interested public participants

- Draft requirements documents are posted for public comment, and documents are revised in consideration of public comments before final submission to CMS

- On-going/ad-hoc Partner Meetings with MCOs and AEs are held to cover emerging topics.

IV.   AE Program Structure

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

to be eligible to receive incentive-based infrastructure payments.

Core Pillars of EOHHS Accountable Entity Program

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

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

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

Note that these pillars were developed with an effort to balance the following key principles:
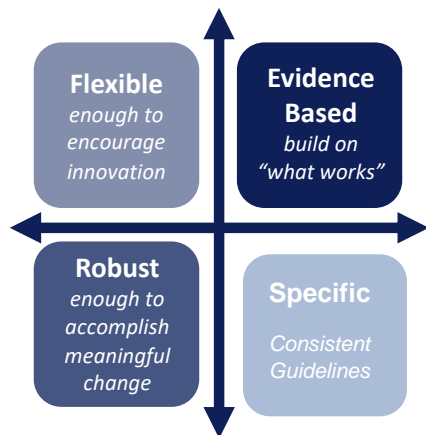
- **Evidence Based,** leveraging learnings from our pilot, other Medicaid ACOs and national Medicare/Commercial experience

- **Flexible enough to encourage innovation,** ACOs, and particularly Medicaid ACOs, are relatively new, and in many developmental areas clear evidence is not available

- **Robust enough to accomplish meaningful change**, and foster organizational commitments and true investments

- **Specific enough to ensure clarity and consistency**, recognizing that consistent guidelines provide clarity to participants

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

V. AE Certification Requirements

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

- Learnings from the AE Pilot program and to date

- 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 Value Based and Quality Measure ACO standards as developed by the Rhode Island Office of the Health Insurance Commissioner (OHIC)

- Feedback and comments from stakeholders on annual draft AE Roadmap

- Discussion with stakeholders on features and details of AE Roadmap

- Ongoing Feedback and comments from stakeholders gathered in public meetings/discussions

The AE certification standards and the corresponding application and approval process are intended to promote the development of new forms of organization, care integration, payment, and accountability. AE certification standards are organized into eight domains in two categories, as shown below:

	Certification Domains
A. Readiness	1. Breadth and Characteristics of Participating Providers
	2. Corporate Structure and Governance
	3. Leadership and Management
B. System Transformation	4. IT Infrastructure - Data Analytic Capacity and Deployment
	5. Commitment to Population Health and System Transformation
	6. Integrated Care Management
	7. Member Engagement and Access
	8. Quality Management

EOHHS considers fulfillment of the certification standards in the Readiness category (domains 1-3) to be fundamental to an AE's ability to affect system transformation and achieve the broader goals of the AE Program. Readiness was appropriately a significant focus for AEs in the initial years of the program. However, as AEs mature, EOHHS expects they will focus increasingly on advancements in the System Transformation category (domains 4-8). Given that AEs have different starting points and will be addressing different gaps in the System Transformation domains using different strategies, EOHHS will implement the standards articulated in this category via the HSTP Project Plan. As such, for Program Year 3 and beyond, AEs will be certified relative to the Readiness certification standards (domains 1-3) and will demonstrate progress towards achieving the advanced standards in domains 4-8 via their HSTP projects. Into Program Year 4 and beyond, EOHHS is considering an additional element to the Certification process on Health Equity.

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

- AE Application for Readiness Certification

- *Note: On an annual basis, already certified AEs must report progress towards fulfilling their certification conditions, any changes in structure relative to their submitted application, or an attestation that no change has occurred.*

- AE developed HSTP Project Plan

- OHIC RBPO Certification Application

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

VI.   Alternative Payment Methodologies

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

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

Each AE Program will specify qualifying APMs that will be based on a specified population of attributed lives. Attribution to an AE shall be implemented in a consistent manner by all participating MCOs based upon EOHHS requirements.

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

such arrangements.[2, 3]

Additional program specific APM requirements are as follows:

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

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

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

2. **Specialized AE Alternative Payment Methodology**
    A total cost of care model may be inappropriate for LTSS Medicaid eligible due to factors
    such as small population size, and provider readiness. Any APM model incorporated in the
    Specialized AE LTSS APM program will consider these challenges and be appropriate for
    application to the LTSS population. EOHHS anticipates initially implementing a Category 2
    APM per the HCP-LAN framework.[4] Such a model would introduce a link to quality and
    value; for example, Specialized APMs might measure an LTSS provider such as home health
    agencies on a set of performance measures with identified providers eligible to earn
    performance payments for achievements in priority areas.

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

[3] 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

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

VII.   Medicaid Accountable Entity Incentive Program

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

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

Total Incentive Pool (TIP)	
Accountable Entity Incentive Pool (AEIP)	MCO Incentive Management Pool (MCO-IMP)
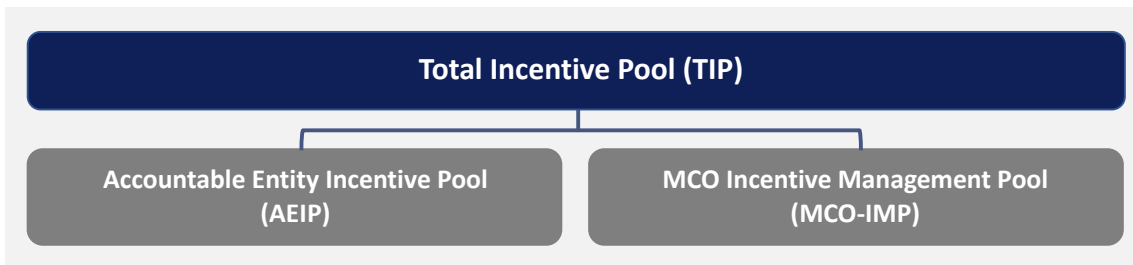
These Incentive Pools are not grants. The incentive dollars that AEs and MCOs shall earn is based on their specific performance relative to a set of milestones that are listed below and defined in detail annually in the *EOHHS Medicaid Accountable Entity Incentive Program Requirements*.

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

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

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

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

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

	Certification Domains
A. Readiness	1. Breadth and Characteristics of Participating Providers
	2. Corporate Structure and Governance
	3. Leadership and Management
B. System Transformation	4. IT Infrastructure - Data Analytic Capacity and Deployment
	5. Commitment to Population Health and System Transformation
	6. Integrated Care Management
	7. Member Engagement and Access
	8. Quality Management

   - **Project merits Incentive Funding**
     Projects must include the following:
     - Clear statement of understanding regarding the intent of incentive dollars
     - Rationale for this opportunity, including a clear description of objective for the project and how achieving that objective will promote health system transformation for that AE
     - Confirmation that project does not supplant funding from any other source
     - The inclusion of a gap analysis and an explanation of how the workplan and associated project work plan and budget address these gaps
     - Clear interim and final project metrics and projected impacts, as well as criteria for recognizing achievement of these milestones and quantifying these impacts

2. **Required Structure for Implementation**
   The AEIP will be established **via a Contract or Contract Amendment** between the MCO and the AE. EOHHS reserves the right to review and approve the terms of incentive contracts

with AEs. Incentive contracts will specify performance requirements and metrics to be achieved for AEs to earn incentive payments. The Contract or Contract Amendment will:

- Incorporate the central elements of the approved HSTP Project Plan and project based metrics, including:
  - Stipulation of program objective
  - Scope of activity to achieve
  - Performance schedule for milestones and metrics
  - A review process and timeline to evaluate AE progress in meeting milestones and metrics in its HSTP Project Plan and determine whether AE performance warrants incentive payments.
  - The MCO must certify that an AE has met its approved metrics as a condition for the release of associated AEIP funds to the AE.

- Set payment terms and schedule including approved metrics selected for each AE that assures that the basis for earning incentive payment(s) commensurate with the value and level of effort required and in accord with the allocation of incentive payments.

- Delineate responsibilities and define areas of collaboration between the AE and the MCO. Areas of collaboration may be based on findings from the certification process and address such areas as health care data analytics in service utilization, developing and executing plans for performance improvement, quality measurement and management, and building care coordination and care management capabilities.

- Minimally require that AEs submit quarterly reports to the MCO using a standard reporting form to document progress in meeting quality and cost objectives that would entitle the AE to qualify to receive AEIP payments. Such reports will be shared directly by the MCO with EOHHS.

- Stipulate that the AE earn payments through demonstrated performance. The AE's failure to fully meet a performance milestone under its AE Health System Transformation Project Plan within the timeframe specified will result in forfeiture of the associated incentive payment (i.e. no payment for partial fulfillment).

- State that in the event that an AE fails to meet a performance metric in a timely fashion (and thereby forfeits the associated AEIP payment), an AE can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric.

- Note: AE performance metrics in the "Fixed Percentage and Outcome Measure Allocations" category are specific to the performance period and must be met by the close of the performance year in order for an AE to earn the associated incentive payment.

Over the last year, EOHHS has been convening and working with the HSTP/AE Advisory Committee. This advisory committee is made up of a diverse group of stakeholders representing

community-based organizations, AEs, MCOs, and other state agencies. Through this advisory process, EOHHS received input on the opportunity to centralize infrastructure and capacity building investments in specific areas that support all parties in their efforts to transform the current delivery system to that of a valued based population health model. Specific investment areas include but are not limited to the following:

- Health Information Technology
- Social Determinants of Health
- Behavioral Health

In addition to the Medicaid Accountable Entity and Managed Care Incentive program, EOHHS has started to make centralized investments in these three areas. Details of these investments are further outlined in the accompanying Sustainability Plan.

VIII. Program Monitoring, Reporting, & Evaluation Plan

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

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

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

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

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

MCO Required Reports	Description
1. Quarterly Provider Access Report	Report completed by each Health Plan by the following provider types: primary care, specialty care, and behavioral health for routine and urgent care. This report measures whether appointments made are meeting Medicaid accessibility standards.
2. Quarterly Appeals Report	An aggregate report of clinical and administrative denials and appeals by each Health Plan, including External Review.
3. Quarterly Grievances Report	An aggregate report of grievances by each Health Plan.
4. Informal Complaints Report	An aggregate report of the clinical and administrative complaints specified by category and major provider sub-groups for each Health Plan
5. Accountable Entity TCOC Performance Report	This report provides data to support development of quarterly and final program year total cost of care performance reports
6. TCOC Historical Base Data	This report provides data to support development of total cost of care targets for the following AE Performance Year
7. AE Quality Measure Report	This report consists of the set of NCQA HEDIS and other clinical and quality measures that are used to determine the quality multiplier for total cost of care.
8. MCO & AE Performance Incentive Pool Report	Detailed budgeted and actual MCO & AE expenditures in accordance with EOHHS defined templates
9. AE Population Extract File	This monthly report provides EOHHS with a member level detail report of all Medicaid MCO members attributed to each AE. This data will be used by EOHHS for data validation purposes as well as for the purposes of ad-hoc analysis.
10. AE Provider Roster	This monthly provider report provides EOHHS with an ongoing roster of the AE provider network, inclusive of provider type/specialty and affiliation (participating, affiliated, referral etc.) to the Accountable Entity.

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

2. In-Person Meetings with MCOs

As part of its ongoing monitoring and oversight of its MCOs, EOHHS conducts an in-person meeting on a monthly basis with each contracted MCO. These meetings provide an opportunity

for a more focused review of specific topics and areas of concerns. Additionally, they provide a venue for a review of defined areas of program performance such as quality, finance, and operations. These meetings also provide an important forum to identify and address statewide AE performance, emerging issues, and trends that may be impacting the AE program. In addition to the reporting noted above, these meetings support EOHHS' ability to report to CMS (in quarterly waiver reports) issues that may impact AE's abilities to meet metrics or identify factors that may be negatively impacting the program.

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

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

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

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

The state will provide quarterly expenditure reports to CMS using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority subject to budget neutrality. This project is approved for expenditures applicable to allowable costs incurred during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only if 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 Evaluation Design, includes a discussion of the goals, objectives, and evaluation questions specific to the entire delivery system reform demonstration. Specifically, the design of the evaluation approach focuses on three key research domains based on Medicaid waiver priorities 1) pay for value, not volume 2) coordinate physical, behavioral and long term health care and 3) re-balance the delivery system away from high cost settings.

Key areas of attention in the evaluation will tie to the goals and objectives set forth in this Roadmap. The Evaluation Plan shall list findings such as impact on core outcome measures, program measures, and member and provider experience. The latter 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 that have occurred or are occurring within the state. The Evaluation Plan includes documentation of a data strategy which identify data sources, and analytic methodology.

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

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

IX. Rhode Island Health System Transformation Project Accountable Entity Sustainability Plan

The DSHP funds are intended to support the establishment of Accountable Entities (AEs) by providing incentive-based infrastructure funding for MCOs and AEs. Additional supporting investments in partnership with the Institutions of Higher Education are intended to build critical supporting workforce capacities to enable system transformation. It is important that the changes made and programs developed utilizing the DSHP funds are continued even after the incentive funding ceases, in order to sustain the progress that has been made in transforming the healthcare delivery system. The purpose of this document is to describe EOHHS' strategies to ensuring that the AEs are sustained without DSHP funds.

EOHHS and Accountable Entities Have Made Major Investments That Will Support Sustainability

All AEs are required to design and implement, in collaboration with their MCO partners, at least three (3) Core Projects to earn HSTP Incentive Funds. AEs have made significant investments in longer-term capacity in care coordination and population health management using Incentive Funds that should, over time, generate shared savings that will help sustain AEs. These investments include development of technology solutions; staff training; new internal structures; and establishment of community-clinical partnerships. Several examples of each type of investment are listed below:

- Technology:
    - Providence Community Health Centers launched a texting platform for patient engagement, including outreach campaigns to close quality gaps.
    - Providence Community Health Centers has developed analytics to identify lists of patients with whom providers should follow up each day; monthly statistics on panel management; and quarterly governance oversight metrics.
    - Integrated Healthcare Partners (IHP) is working with URI DataSpark to execute a gap analysis assessment for mental health and substance use services rendered to their patients. IHP can currently see where patients live and where they receive primary care and behavioral health care. By integrating claims data to gain a comprehensive view of its population, IHP expects to be able draw conclusions related to access adequacy by geography. A later phase of the project will focus on where patients live an receive social services.
    - Prospect Health Services is implementing Cerner HealtheIntent, a comprehensive population health management tool.
    - Blackstone Valley Community Health Center employs a population health tool (NextGen Population Health) to compile claims and NextGen EMR data for all

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attributed members. The platform is capable of risk segmentation, condition cohort identification, pre-visit planning, and comprehensive quality measure reporting.

- Staff training:

  - Providence Community Health Centers has created online learning management system content to educate staff in advance of new projects and to educate providers regarding population health principles and practices, especially in the context of the AE program.

  - Integra participates in the Rhode Island Health Education Exchange (RIHEE) Advisory Group's Rhode Island Department of Health Academic Institute Accountable Entity Continuing Education Needs Assessment activities to facilitate continuing education opportunities for staff.

- New internal structures and processes:

  - Coastal Medical has implemented universal screenings across all practices to assess and identify needs around depression, anxiety, and social determinants of health, and is currently implementing SUD screening. Regular reporting around screenings and the associated needs are reviewed and acted upon in a variety of ways. Care management and behavioral health teams conduct outreach and make referrals to both internal and external resources, and established interdisciplinary care conferences also provide a forum for surfacing these issues.

  - Coastal Medical has implemented AE Care Conferences to identify and coordinate care for rising-risk and high-risk Medicaid AE patients. These care conferences include community-based organization partners. The care team members proactively review the identified patients before upcoming appointments. The established interdisciplinary care conferences across practices and teams are intended to identify, monitor and coordinate care for patients.

  - Providence Community Health Centers has added a psychiatric nurse practitioner to health center staff to provide comprehensive mental health and substance abuse treatment targeting the homeless population, which includes the organization's highest-cost and most complex patients.

  - Providence Community Health Centers has redesigned and implemented complex care protocols to manage the highest-cost and highest-risk patients. This includes integrating primary care, behavioral health, nurse case management, and clinical pharmacy services.

  - Integra has launched an Integrated Behavioral Health pilot program in select pediatric and adult practices.

  - Prospect Health Services is working to integrate behavioral health/ substance use disorder expertise into all aspects of its AE program, including through expanding integrated behavioral health in primary care; expanding tele-health consulting,

and incorporating behavioral health into its care management program through the regular participation of behavioral health leadership in High Intensity Care Management rounds.

- o Blackstone Valley Community Health Center began offering nurse care manager telehealth and expanded walk-in hours at its new Central Falls facility and the Blackstone Valley Neighborhood Health Station, expanding its ability to deliver care to more patients.

- o Blackstone Valley Community Health Center added a more experienced psychiatric nurse practitioner in a clinical leadership role to strengthen the behavioral health component of care teams while offering frontline expertise to the AE governance team.

- Community-Clinical Partnerships:

  - o Providence Community Health Centers has worked with Family Services of Rhode Island to integrate a behavioral health care manager, licensed social worker, and community advocate into the PCHC team of nurse case manager to identify and manage the care of high-risk patients with behavioral health diagnoses and medical co-morbidities.

  - o Providence Community Health Centers has partnered with ONE Neighborhood Builders to support tenants in units designated at Permanent Supportive Housing.

  - o Integra has partnered with The Providence Center to embed a peer recovery coach with its Complex Care Management team. The coach will work closely with other team members to support patients who are dealing with complex medical, behavioral health and/or substance issues as well as social determinants of health, and who require a more intensive home and community-based intervention.

  - o Blackstone Valley Community Health Center currently shares a care coordinator with The Providence Center, a major provider of mental health and substance abuse services in Rhode Island.

<u>EOHHS has begun a process to identify long-term (as opposed to one-time) funding needs.</u>

EOHHS conducted interviews with all AEs regarding the expenses involved in activities undertaken as part of HSTP, as well their ability to track these expenses. AEs shared that they are able to track expenses effectively and identified the areas where their resources are generally spent.

AEs have invested in health information technology, which has ongoing operating costs that are substantially lower than the initial investment to purchase and implement technology.

By contrast, expenses for staff to implement programs are ongoing for the life of the new activities AEs are conducting. Many AEs have hired staff to perform both administrative and clinical services that are necessary for their programs. This increased staffing includes:

- Administrative and management staff
  - Administrative oversight and program management, including reporting
  - Quality coordinator
  - Utilization management staff
- Direct service staff:
  - Community Health Workers
  - Peer Recovery Specialists
  - Pharmacists (performing clinical pharmacy work)
  - Behavioral health clinicians
  - Social workers (performing non-billable services such as supporting housing applications)
- Data analytics staff:
  - Information technology management staff

EOHHS will continue to track information on costs as the program develops, with the goal of helping AEs to more fully capture costs that are specific to the program. For example, some staff perform services that can be billed to Medicaid as well as services that are paid through HSTP Incentive Funds. Determining what staff costs are ultimately Medicaid-billable is critical to sustainability.

To that end, EOHHS has prepared a budget template that AEs will complete as part of Program Year 4 certification (see exhibit A). EOHHS will use the data AEs provide through this template to refine expectations for the resources AEs will need on an annual basis to continue current activities.

Because staff compose a substantial share of AE costs (over 80% in some cases), EOHHS expects that the expenses associated with the work that AEs have undertaken to improve care coordination and population health will not decline in a meaningful way over time. However, some savings may be achieved as AEs develop more efficient ways to deploy staff, and EOHHS plans to create opportunities for AEs to share best practices with one another, such as through monthly meetings facilitated by a technical assistance consultant.

HSTP Sustainability Plan

The HSTP Sustainability Plan seeks to support the continued growth and development of AEs by reducing AE administrative and infrastructure costs where possible, supporting and expanding AEs' ability to earn shared savings to fund their work, and leveraging other sources of support for AE activities that improve population health and reduce overall healthcare spending.

The HSTP Sustainability Plan is composed of the following elements:

A. By centralizing key investments, EOHHS expects to achieve efficiencies that will reduce AE costs.
B. EOHHS anticipates that shared savings from the total cost of care arrangements that AEs have with MCOs will provide some support for AEs.
C. EOHHS will work with AEs to obtain the authorities needed to provide reimbursement for high value services.

D. EOHHS will leverage its contractual relationship with MCOs to increase the support of care management and social determinants of health (SDOH) activities

E. EOHHS will leverage multi-payer statewide policies to support AEs

HSTP Sustainability Plan Details

A. **By centralizing key investments, EOHHS expects to achieve efficiencies that will reduce AE costs.**

EOHHS has made, and plans to continue to make, investments in healthcare infrastructure that is more cost-effective to build in a centralized way. These investments reduce AEs' costs in two ways. First, in cases where AEs do have to contribute financially to engage with the infrastructure, the costs are much lower than they would be if each AE developed the infrastructure on its own. Second, this infrastructure directly reduces AEs costs to achieve care coordination and quality reporting.

EOHHS has already contracted to develop and enhance several health information technology (HIT) resources for statewide use, including:

- Care Management Alerts and Dashboards – Care Management Alerts are secure email notifications sent to a primary care practice when a patient from the practice's panel is admitted to or discharged from a hospital or skilled nursing facility (SNF). The Care Management Dashboard provides near real-time patient information on which patients are currently in a hospital/SNF or have been recently discharged. All AEs have signed up to receive Alerts and Dashboard information, which substantially reduce the staff time needed to track patients across the continuum of care, especially when patients receive care outside the AE's network. EOHHS's investment in the Care Management Alerts and Dashboards has allowed the creation of a system that AEs can use for substantially lower cost than they would incur to set up similar infrastructure independently or coordinate care without such a system.

- Quality Reporting System – The Quality Reporting System (QRS) simplifies quality data reporting for state programs and across health plans, creating a single solution for quality measurement needs to reduce administrative burden and increase availability of outcome data to support health system transformation efforts. AEs can report quality data from their electronic health records to the QRS once rather than reporting separately to several managed care organizations. The QRS does not eliminate the need for data from MCO claims and care management systems, or for supplemental data such as the KIDSNET immunization registry.

- CurrentCare - CurrentCare is a health information exchange that supports information sharing across the state and provides secure access to longitudinal health records and crucial health care information to authorized users. By facilitating access to patient records, CurrentCare reduces the staff time that AEs have to spend to request patient records from different providers and makes it easier to quickly learn essential information about new patients. EOHHS is aware that CurrentCare may be more effective if patients

have the opportunity to opt out of participation rather than needing to opt in and will continue to explore this possibility.

EOHHS has conducted an initial round of interviews with AEs regarding potential EOHHS investments in other centralized activities, and learned that a more systematic, coordinated approach to addressing social determinants of health would be valuable.

Therefore, EOHHS has designed an investment strategy to support and improve the coordination between AEs and community-based organizations (CBOs) to address SDOH. This strategy is intended to reduce the costs and administrative burden AEs experience as they work on these issues individually.

The SDOH strategy consists of two interrelated initiatives:

Community Referral Platform:

AEs were nearly unanimous in their view that a single statewide community information and referral platform would be extremely valuable. This would reduce each AE's expenses in procuring such a system individually, and greatly enhance AEs' capacity to refer patients to community-based organizations to address health-related social needs.

EOHHS plans to purchase a statewide community information and referral platform that all AEs and CBOs can utilize. EOHHS anticipates that this system will be available by mid-2021.

Health Equity Challenge:

The Rhode Island Department of Health (RIDOH) is currently supporting a project called the Diabetes Health Equity Challenge. The project is a short-term learning collaborative to build clinical-community linkages to support people living with diabetes who might be especially vulnerable to equity gaps in the context of COVID-19. Under the program, geographically-based teams applied to collaboratively work to improve outcomes for people with diabetes who are at risk of poor outcomes in the context of the pandemic. Teams consist of an AE; a Health Equity Zone; a Community Health Team; and a community member with lived experience. There are currently two teams participating in the Challenge. Teams receive coaching in applying Pathways to Population Health tools from national experts through a Learning Collaborative, as well as technical assistance in implementing local practice/organization changes and working towards upstream solutions to solve systemic health inequities.

EOHHS and RIDOH will collaborate to expand the Health Equity Challenge so that all six (6) AEs can participate. Teams will receive facilitation and coaching through a Learning Collaborative structure. Limited financial support will be available to support organizations and individuals in spending time engaging in the Learning Collaborative. Teams will identify health outcomes on which to focus (e.g., diabetes in the current model), as well as the social needs/risk factors that they will address in order to improve the focal health outcome.

The Health Equity Challenge includes Community Health Teams (CHTs) as a core program element. Community Health Teams consist of community health workers, a behavioral health provider, a peer recovery specialist, a "Screening, Brief Intervention, and Referral to Treatment" screener, and access to specialty consultants and referrals to non-medical services. The network

of Rhode Island CHTs is an extension of primary care, working to facilitate access to community-based services to address complex environmental, medical, and behavioral health needs. CHTs are supported by the Care Transformation Collaborative. Rhode Island has invested in CHTs through HSTP, and EOHHS expects to continue to support AEs by leveraging this resource in the Health Equity Challenge and other ongoing work.

B. EOHHS anticipates that shared savings from the total cost of care arrangements that AEs have with MCOs will provide some support for AEs.

The HSTP model is intended to support AEs in care delivery transformation work that will reduce or, at a minimum, reduce the growth of the Total Cost of Care (TCOC) of the attributed population. As AEs generate savings relative to their TCOC target budgets, they will receive a share of these savings. These shared savings are expected to provide a meaningful amount of revenue to support ongoing AE activities within additional reimbursement. EOHHS has further developed the TCOC model to:

- Reduce AE administrative burden;
- Align with the MCO capitation rate development process and thereby align incentives;
- Introduce an improved risk adjustment methodology; and
- Support more efficient providers through a higher market adjustment.

In addition, as more AEs adopt downside risk contracts over time, EOHHS expects AEs to receive a higher proportion of shared savings.

TCOC Model Developments:

In Program Years 1 and 2, MCOs designed their own TCOC models pursuant to EOHHS requirements. This meant that AEs had to expend time and effort to understand and adapt their processes to more than one model. In Program Year 3, EOHHS developed a single TCOC methodology that will be used for all AE-MCO contracts and centralized the technical work to establish TCOC budget targets, utilizing the agency's managed care actuarial support vendor. By controlling the TCOC target development, EOHHS reduced AE costs to engage with the process, because AE staff need only spend time on one model. This also created greater alignment with the MCO capitation rate development process, for which EOHHS uses the same actuarial support vendor. Alignment with the MCO capitation rate process promotes future sustainability of the AE program as both AEs and MCOs are properly incentivized to achieve savings.

The new TCOC model includes an improved risk adjustment methodology that accounts for local Rhode Island conditions (including the relative costs associated with different health conditions in Rhode Island and the terms of the TCOC methodology), which EOHHS expects to better support AEs caring for more complex patients, especially those with serious mental illness. The revised risk adjustment methodology accounts for AE program carve-outs, such as Hepatitis C drugs and transplants; the cap on claims for individual members (approximately $100,000); and reimbursement and utilization rates specific to Rhode Island. The revised methodology yielded risk scores that better accounted for actual spending differences across members, indicating that it has better predictive accuracy. Specifically, the R-squared results show that the revised methodology accounted for 3.9 to 5.9 percent more of the variation in cost

than the original model for able children, able adults, and disabled children. EOHHS expects that the revised risk adjustment methodology will more accurately reflect changes in an AE's population over time as well as improving comparisons of risk-adjusted costs between an AE and the MCO average.

The Program Year 3 methodology was also modified to allow for a higher market adjustment. In previous years, different MCOs took different approaches to the concept of the market adjustment. For example, under one MCO's methodology, an AE that had lower risk-adjusted spending compared to the MCO average would receive 6% of the difference as a TCOC budget increase, such that if the AE continues to outperform the market average, it will generate more savings relative to its budget. EOHHS understands that another MCO did not utilize a market adjustment at all. In PY3, the market adjustment is 10%, so more efficient AEs will be in a position to earn more savings than in years past. In future years, EOHHS expects to increase the market adjustment to further reward efficient providers. In Program Year 3, AEs with above-average spending do not have a negative market adjustment, to allow them time to improve. In future years, as the market adjustment for efficient providers grows, EOHHS will impose a negative adjustment on less efficient providers. This will allow the program to continue generating savings overall while striking a balance between rewarding existing efficiency and future improvement.

In Program Years 1 and 2, only one AE-MCO contract included "downside" risk, meaning that in the event of shared losses, the AE would be responsible to pay a portion of the deficit. All other AEs were in "upside-only" contracts, in which AEs had an opportunity to share in savings, but in the event of shared losses, the AE would not be responsible to pay a portion of the deficit. These upside-only contracts generally provided that AEs and MCOs would share any savings equally, with AEs receiving 50% of any savings. EOHHS expected to require AEs to take on downside risk beginning in Program Year 3. Downside risk is expected to increase provider incentive to reduce TCOC, and these contracts would also have required the AE share of any savings to be higher – at least 60% - in recognition of the risk they would take on. However, due to the substantial uncertainty regarding healthcare spending driven by COVID-19, EOHHS chose not to require that AEs take on downside risk in Program Year 3. AEs may choose to take on downside risk, and EOHHS expects that those that do so will be eligible for higher shares of any savings, while others will continue to be eligible for 50% shared savings. EOHHS expects to require downside risk beginning in Program Year 4, at which point AEs will have the potential to earn a higher share of any savings they generate. Notably, while the TCOC methodology provides a standard framework for calculating TCOC, the standards for taking on risk allow for AEs and MCOs to negotiate contracts with higher levels of risk (and potential shared savings) as AEs become ready to do so.

Preliminary TCOC Performance and Expectations:

In Program Year 1, two AEs earned shared savings. EOHHS is optimistic that improvements in methodology and AE capacity to manage high-cost patients will yield shared savings for more, if not all, AEs in coming years. In addition, the record of the Medicaid Shared Savings Program is consistent with expecting improvement; Medicare Accountable Care Organizations have earned more shared savings over time, both in the sense that savings across the program have increased

and in the sense that a higher proportion of the participating organizations generate savings rather than deficits.[5]

Final data on Program Year 2 performance will be available in early 2021. EOHHS is aware that, more than in typical years, TCOC performance is difficult to predict due to COVID-19. Many providers experienced declining utilization in March through June 2020, but the COVID-19 cases themselves were very high cost. Further, rapid expansion and usage of telehealth introduces a new care modality not seen in other program years. As more data becomes available, EOHHS will continue to work with its actuarial vendor to analyze shared savings results from each Program Year to strengthen projections for the remaining duration of the AE program and subsequent years. This analysis will incorporate any changes to the TCOC methodology as well as projections regarding future TCOC budget levels (i.e., if budgets decline as a result of lower spending levels, this would affect future savings potential).

C. EOHHS will work with AEs to obtain the authorities needed to provide reimbursement for high value services.

Currently, HSTP Incentive Funds are used to support a range of AE activities that are expected to help reduce TCOC. To the extent that these activities are effective, over the long term, TCOC budgets will be lower than would otherwise be the case, trending toward a level that captures the cost for the most efficient care delivery possible. If the activities required to deliver this efficient care are not properly accounted for in the TCOC budget, it is possible that the budget could become too low to cover the cost of these activities. To avoid this outcome, EOHHS seeks to incorporate these costs into the underlying reimbursement structure where appropriate, so that they can be appropriately accounted for in the TCOC calculations. EOHHS is actively providing technical assistance to AEs to ensure that they are taking full advantage of billing for Medicaid-covered services. In particular, several AEs identified that there are barriers to billing for peer recovery coach services. EOHHS and AEs are working together to understand and address the barriers to billing for these services. In addition, EOHHS understands that billing for behavioral health services delivered outside the health care setting, such as care provided in the community by Community Health Teams, can be more complex to bill and is working with providers to identify creative solutions.

AEs are also engaged in some activities that could be reimbursable if EOHHS receives federal authority to do so. Community health worker services are the most significant example of this. During Program Year 3, EOHHS will research waivers approved in other states, identify options that could permit reimbursement for community health worker services, and consider whether any of these options should be proposed as additional investments in our state budget.

One way to reimburse services is through fee-for-service payment, which serves as the chassis underlying many alternative payment methodologies. However, EOHHS recognizes that for

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[5] Jonathan Gonzalez-Smith et al., *Medicare ACO Results for 2018: More Downside Risk Adoption, More Savings, and All ACO Types Now Averaging Savings*, HEALTH AFFAIRS BLOG (Oct. 25, 2019), *available at* https://www.healthaffairs.org/do/10.1377/hblog20191024.65681/full/ (last visited Aug. 11, 2020).

some services, a fee-for-service reimbursement level would likely be too low to be worth the administrative burden of filing claims for the service. Therefore, EOHHS plans to explore how primary care capitation and other alternative payment methods could be used to reimburse for services without requiring fee-for-service billing.

By ensuring that AEs can obtain reimbursement for high value services that are currently paid for through HSTP, EOHHS will allow AEs to be paid for all the expenses involved in providing the highest-quality, most efficient care possible.

D. Leverage its contractual relationship with MCOs to increase support of care management and social determinants of health (SDOH) activities

In fall 2020, EOHHS will facilitate a new managed care stakeholder process to help develop insight into the strengths and weaknesses of the model. As part of this stakeholder engagement process, EOHHS expects to explore the following policies that would support AEs if implemented:

- Full delegation of care management contractual obligations to AEs. Currently, EOHHS requires Medicaid MCOs to provide care management and care coordination services to members. In addition, a substantial part of the AE portfolio is also dedicated to care management and coordination. Because multiple levels of care management, including potentially for the same individual patient, is not efficient and goes against the goals of accountable care. EOHHS will take steps to require care management be delegated to AEs, with funds passing through MCOs to support this change, while gaining a deeper understanding of the role of the MCO in utilization management and utilization review to control costs.

- Further development of in-lieu of and value-based service provisions. Currently, MCOs are encouraged to offer both "in-lieu of" and value-added services, which can provide flexibility to pay for services that are not Medicaid benefits, but which will better serve the patient and reduce costs. Current MCO contracts identify several examples of permitted "in-lieu of" and value-added services, such as nutritional counseling, homecare hours beyond the usual maximum, and silver diamine fluoride for dental use. MCOs are also not limited to the services listed in the contract when considering "in-lieu of" and value-added services they may wish to offer. EOHHS expects to work with MCOs to identify other services that would appropriately be considered "in-lieu of" or value-added, as well as to consider a process by which AEs could recommend that MCOs cover a new service through one of these mechanisms.

- Explore opportunities for greater MCO engagement in community investment and social determinants of health.

  - Inclusion of SDOH investment in the numerator of the medical-loss ratio: By including SDOH investments made by MCOs in the MLR numerator as quality improvement activities, EOHHS will avoid penalizing MCOs for these investments, which could be the case if they were counted as administrative spending. Depending on each MCO's financial situation over time, this change

could also encourage MCOs to make these investments, to prevent their MLR from dropping too low. EOHHS would work with CMS to ensure that the investments eligible for inclusion in the MLR numerator are appropriate.

- Requiring that a share of MCO profits go towards community investment. EOHHS has learned that in some other states, MCOs are required to spend a share of their profits on community investment. These investments could include providing resources to AEs to use in contracting with CBOs to provide social services to AE patients. EOHHS expects to discuss this policy idea with MCOs.

- Rewarding MCOs that make community investments with more favorable member assignment. An alternative to requiring a certain level of community investment is to reward such investment with more favorable member assignment (i.e., all else equal, plans that make such investments would have a higher priority in being assigned new Medicaid members who have not affirmatively selected an MCO). These investments could include providing resources to AEs to use in contracting with CBOs to provide social services to AE patients. EOHHS expects to examine this policy idea with MCOs.

In addition, EOHHS expects to work with MCOs and AEs to identify opportunities for MCOs and AEs to collaborate on member engagement. For example, MCOs may be able to assist with outreach to increase member awareness that they are being served by an AE, describe the benefits and value of being served by an AE, and direct member to AEs for care management and coordination.

E. EOHHS will leverage multi-payer, statewide policies to support AEs

Most AEs receive a significant share of patient volume through Medicaid, but also have commercial and Medicare patients. To the extent that incentives, policies, and funding priorities are aligned across payers, EOHHS expects that AEs will be better able to leverage resources to serve their full patient population.

The Office of the Health Insurance Commissioner (OHIC) promulgates Affordability Standards for insurance companies. Affordability Standards include requirements for aligned quality measures, engagement in alternative payment methods, minimum share of spending to go to primary care, and specific payments to patient-centered medical homes.

EOHHS and OHIC have already worked to align incentives across the Medicaid and commercial markets. For example, Affordability Standards quality measures and expectations for health plan engagement in alternative payment methods and risk contracting are reflected in MCO and AE standards as well.

Additional opportunities for alignment may be possible in the future. The Affordability Standards require commercial plans to contribute to patient-centered medical homes, on a per-member-per-month basis. Currently, MCOs are not required to make these payments for adult (i.e., non-pediatric) practices that have graduated from the Care Transformation Collaborative PCMH program. However, if in the future they did contribute, AE practices would be able to use payments from commercial and Medicaid insurers to create and sustain programs that serve more

of their patients in the same program. Similarly, EOHHS may explore the potential for alignment with OHIC standards for requiring that a certain share of spending be for primary care. This would also increase overall support for AEs.

EOHHS is aware that OHIC and many healthcare stakeholders are increasingly focused on primary care capitation. This payment method may provide more flexibility for practices and AEs to pay for work that is not reimbursable. As OHIC and healthcare stakeholders continue discussing ways to expand use of this payment methodology, EOHHS expects to discuss the potential for alignment with MCOs.

Finally, as EOHHS explores opportunities for MCO investment in SDOH, EOHHS and OHIC could explore ways to increase multi-payer engagement in these investments.

Ongoing Sustainability Planning

EOHHS considers sustainability planning an ongoing project throughout the Demonstration. As described above, a major piece of this is gathering more data about AE revenue, expenses, the potential for shared savings to cover expenses, and the potential for additional revenue from Medicaid billing.

Finally, EOHHS expects that sustainability considerations will inform a range of policy decisions in the coming years, including but not limited to MCO procurement. EOHHS will continue regular discussions with AEs, MCOs, CMS, and other stakeholders to inform the ongoing strategy.

Appendix A: Roadmap Required Components

	STC Required Elements of Roadmap	Where Addressed
A	Specify that the APM guidance document will define a menu of metrics and measures that will be used by the MCOs to assess the performance of the AEs through the activities of the AE subcontractors.	*Section VIII. Program Monitoring, Reporting, & Evaluation Plan* • Page 20, *1. MCO Compliance and Performance Reporting Requirements,* 2nd paragraph
B	Include guidelines requiring AEs to develop individual AE Health System Transformation Project Plans, which shall include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance.	*Section VII. Medicaid Infrastructure Incentive Program (MIIP)* • Page 17, *AE Specific Health System Transformation Project Plans,* 1st paragraph
C	Report to CMS any issues within the AEs that are impacting the AE's ability to meet the measures/metrics, or any negative impacts to enrollee access, quality of care or beneficiary rights. The state, working with the MCOs, shall monitor statewide AE performance, trends, and emerging issues within and among AEs on a monthly basis, and provide reports to CMS on a quarterly basis.	*Section VIII. Program Monitoring, Reporting, & Evaluation Plan* • Page 21, *2. In-Person Meetings with MCOs*
D	Provide minimum standards for the process by which EOHHS seek public input in the development of the AE Certification Standards;	*Section V. AE Certification Requirements* • Page 12, 1st paragraph
E	Specify a State review process and criteria to evaluate each AE's individual Health System Transformation Project Plan and develop its recommendation for approval or disapproval;	*Section VII. Medicaid Incentive Program (MIIP)* • Page 17, *1. Guidelines for Evaluation*
F	Describe, and specify the role and function, of a standardized, AE-specific application to be submitted to the State on an annual basis for participation in the AE Incentive Program, as well as any data books or reports that AEs may be required to submit to report baseline information or substantiate progress;	*Section V. AE Certification Requirements* • Page 12, 1st paragraph *Section VIII: Program Monitoring, Reporting, & Evaluation Plan* • Page 20-21, *1. MCO Compliance and Performance Reporting Requirements*
G	Specify that AEs must submit semi-annual reports to the MCO using a standardized reporting form to document its progress in achieving quality and cost objectives, that would entitle the AE to qualify to receive AE Incentive Program Payments.	*Section VII. Medicaid Incentive Program (MIIP)* • Page 18, *2. Required Structure for Implementation*, 4th bullet
H	Specify that each MCO must contract with Certified AEs in accordance with state defined	*Section VI: Alternative Payment Methodologies*

	STC Required Elements of Roadmap	Where Addressed
	APM guidance and state defined AE Incentive Program guidance. The APM guidance will include a Total Cost of Care (TCOC) methodology and quality benchmarks. For specialized AEs (Type 2 AE) where TCOC methodologies may not be appropriate, other APM models will be specified. Describe the process for the state to review and approve each MCO's APM methodologies and associated quality gates to ensure compliance with the standards and for CMS review of the APM guidance as stated in STC 43(e).	• Page 14, "AE Attributable Populations" table through end of section
I	Specify the role and function of the AE Incentive Program guidance to specify the methodology MCOs must use to determine the total annual amount of AE Incentive Program payments each participating AE may be eligible to receive during implementation. Such determinations described within the APM guidance document shall be associated with the specific activities and metrics selected of each AE, such that the amount of incentive payment is commensurate with the value and level of effort required; these elements are included in the AE incentive plans referenced in STC 43(f). Each year, the state will submit an updated APM guidance document, including APM Program guidance and the AE Incentive Program Guidance.	*Section VII. Medicaid Incentive Program (MIIP)* • Page 16 1st paragraph *Section VIII. Medicaid Incentive Program (MIIP)* • Page 18, *2. Required Structure for Implementation*, 2nd bullet
J	Specify a review process and timeline to evaluate AE progress on its AE Incentive Program metrics in which the MCO must certify that an AE has met its approved metrics as a condition for the release of associated AE Incentive Program funds to the AE;	*Section VII. Medicaid Incentive Program (MIIP)* • Page 18, *2. Required Structure for Implementation*, 1st bullet
K	Specify that an AE's failure to fully meet a performance metric under its AE Incentive Program within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment)	*Section VII. Medicaid Incentive Program (MIIP)* • Page 18, *2. Required Structure for Implementation*, 5th bullet
L	Describe a process by which an AE that fails to meet a performance metric in a timely fashion (and thereby forfeits the associated AE Incentive Program Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving	*Section VII. Medicaid Incentive Program (MIIP)* • Page 18, *2. Required Structre for Implementation*, 6th bullet

	STC Required Elements of Roadmap	Where Addressed
	the original metric and, where appropriate, in combination with timely performance on a subsequent related metric defined as demonstrating continued progress on an existing metric. For example, if the failed metric was related to developing a defined affiliation with a Community Business Organization or CBO, and that deliverable was late, the AE might then also be required to show it has adapted its governance model by incorporating into its bylaws and board protocols the requirement to develop a defined relationship with a CBO.	
M	Include a process that allows for potential AE Health System Transformation Project Plan modification (including possible reclamation, or redistribution of incentive payments pending State approval).	*Section VII. Medicaid Incentive Program (MIIP)* • Page 7, *AE Specific Health System Transformation Project Plans*, 2nd paragraph
N	Include a process to identify circumstances under which a plan modification may be considered, which shall stipulate that CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved.	*Section VII. Medicaid Incentive Program (MIIP)* • Page 7, *AE Specific Health System Transformation Project Plans*, 2nd paragraph
O	Include a State process of developing an evaluation of Health System Transformation Project as a component of the draft evaluation design as required by STC 127.	*Section VIII. Program Monitoring, Reporting, & Evaluation Plan* • Page 23, *4. Evaluation Plan*