

**EOHHS Total Cost of Care (TCOC) Guidance**

**Rhode Island Medicaid Accountable Entity Program**  
**Attachment L 1: Accountable Entity Total Cost of**  
**Care Requirements**

**Rhode Island Executive Office of Health and Human Services**  
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DRAFT

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## A. TCOC Definition

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

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

## B. TCOC Methodology Goals

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

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

- **Establish consistent core components of the TCOC methodology while still allowing some innovation and flexibility**

Balance these competing goals. Allow for some variation in TCOC methodology within uniform state guidelines/criteria, with recognition of the importance of alignment in the methodology for the managed care and fee-for-service populations attributed to ~~Specialized~~specialized LTSS AEs.

## C. General Requirements for Program Participants

### 1. Minimum Membership and Population Size

For comprehensive AEs, MCOs may utilize TCOC-based payment models only with AEs ~~with~~ which ~~the MCO has~~have at least 5,000 attributed Medicaid members, across all MCOs. For specialized LTSS AEs, there must be at least 500 attributed lives in Medicaid managed care and/or Medicaid fee-for-service.

### 2. State/MCO Capitation Arrangement

The MCO retains the base contract with the State, ~~and~~; the MCO medical capitation will be adjusted for savings/risk associated with the program. ~~There will be no gain share between as described in the State and the /MCO on the Shared Savings/(Loss) Pool (after required adjustments)-contract.~~ This does not preclude MCOs from creating value-based purchasing arrangements with non-AE providers; however, those contracts would still be subject to the State gain-share and would not be included in the State's assessment of the MCO's value-based payment performance standards related to AEs.

### 3. Exclusivity of Approved TCOC Methodologies

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

### 4. Other Approved Alternative Payment Methodologies for LTSS Providers

The MCO and Medicaid fee-for-service may also implement other approved alternative payment methodologies (APMs) (as described in Section G), in addition to TCOC arrangements, for providers in ~~Specialized~~specialized LTSS AEs. Participation in those APMs is voluntary for providers.

### 5. Attribution

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

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

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

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

### 1. Defining a Historical Base

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

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

#### b. Covered Services

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

- I. Exclude services currently covered under stop-loss provisions between EOHHS and the MCO, as outlined below:
  - Long-term care in an intermediate or skilled facility in excess of 30 days.
  - Costs associated with the transplant of a bodily organ. Includes costs incurred from the date of admission through the date of discharge associated with the specific hospital stay in which an organ is implanted. The AE TCOC calculation will include all costs up to the transplant of a bodily organ.
  - Early Intervention Services in excess of \$5,000 for an individual.
  - Hepatitis C Pharmacy Costs: Costs in excess of the per member per month level as set forth in the *Provisions for Stop Loss Claiming for Pharmacy Expenditure in Treatment of Enrollees with Hepatitis C*.
- II. Exclude HSTP performance incentive payments- ~~and CTC payments~~.

III.—Include and define any other infrastructure payments made by MCOs to AEs and AE-affiliated providers, ~~including but not limited to any patient-centered medical home (PCMH), care management, and utilization management payments.—~~

IV.III. . . .

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

TCOC ~~calculations~~expenditure data shall be adjusted ~~for outlier to exclude~~ costs ~~by defining a threshold ceiling in excess of \$100,000 per member per year.~~ However, the ~~historical base~~TCOC expenditures must include 10% of any annualized spending per member above the ~~spending threshold shown below. This threshold is based on the 95.5<sup>th</sup> percentile of Rhode Island Medicaid per member annual claims cost for the AE-eligible population and for AE allowable TCOC Expenditures, as calculated by EOHHS and shown below. This threshold shall be established across all members (not by rate cell). Upon AE request, an alternative threshold of 99.7% may be applied, as shown below.—~~truncation threshold.

Percentile	Annualized per member spending threshold
95.5 percentile	\$xx TBD
99.7 percentile	\$xx TBD

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

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

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

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

EOHHS.

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

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

**2. Required Adjustments to the Historical Base**

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

**a. Adjustment for Prior Year Savings**

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

**b. Adjustment for Historically Low-Cost AEs**

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

~~Note that reconciliation payments made to FQHCs must be accounted for in the risk-adjusted per capita spending for FQHCs over the assessed historical time period. Reconciliation payments are also to be subsequently included in the TCOC calculations for the performance period.~~

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

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

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



than 12 months if necessary.

**a. Required Cost Trend Assumptions**

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

**b. Final Target Adjusted for Changes in the Attributed Population’s Risk Profile**

The MCO must apply a risk adjustment methodology to assess any changes in an attributed population’s risk profile from the risk-adjusted historical base to the contractual performance period. This methodology must be consistent with the risk adjustment methodology used in developing the adjusted historical base as described in Section D.1.d of this document.

**4. Actual Expenditures for the Performance Period**

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

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

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

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

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

TCOC methodologies shall account for statistical uncertainty in performance measurement due to the effect of random variation in utilization and spending in small populations. MCOs shall address the impact of random variation upon cost savings results through the application of a shared savings adjustment factor, defined by performance year AE attributed population size (calculated as attributed member months divided by 12).

The shared savings adjustment factor adjusts the AE’s shared savings/(loss) pool proportionately by the probability of true savings (1 minus the probability of achieving shared savings as a result of chance). The proportion of savings for which an AE is eligible shall be adjusted along a sliding scale by AE size, based on the parameters below. AEs with fewer than 5,000 attributed members with an MCO shall be classified as Small AEs.

**Shared Savings/Loss Adjustment Factor Parameters**

Shared Savings/Loss Adjustment Factor Parameters by AE Size and Savings Rate				Probability of Achieving Shared Savings/Loss as a Result of Chance*			
Savings %	Small AE (5-9,999)	Medium AE (10-19,999)	Large AE (20,000+)	Savings %	5,000 members	10,000 members	20,000 members

1%	73%	79%	89%	1%	27%	21%	11%
2%	82%	92%	97%	2%	18%	8%	3%
3%	91%	97%	99%	3%	9%	3%	1%
4%	95%	99%	100%	4%	5%	1%	0%
5%	98%	100%	100%	5%	2%	0%	0%
6%	99%	100%	100%	6%	1%	0%	0%

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

**b. Impact of Quality and Outcomes**

The Shared Savings/(Loss) Pool shall be adjusted based on an assessment of performance relative to a set of quality measures for the attributed population. ~~A detailed quality scoring methodology is under development~~ An Overall Quality Score will be generated for each AE, according to the methodology detailed in Attachment B: Quality Framework and Methodology for Comprehensive and Specialized LTSS Accountable Entities. The Shared Savings/(Loss) Pool must be multiplied by the Overall Quality Score.

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

In any given performance year, the Shared Savings Pool must not exceed 10% of the ~~TCOC Expenditure Target, as calculated in Section D.3 of this document~~ AE's contract revenue. In instances where the AE is responsible for downside risk, the Shared Loss Pool must not exceed 5% of the ~~TCOC Expenditure Target~~ AE's contract revenue.

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

In Year 1, AEs may be eligible to retain up to 40% of the Shared Savings Pool, as defined in Section D.5 above. AEs assuming downside risk may be eligible for up to 60% of the Shared Savings Pool, and may be responsible for up to 60% of the Shared Loss Pool.

AE Shared Savings Model	AE Share of Savings	Maximum Allowable Shared Savings Pool	Maximum Allowable Shared Loss Pool	AE Share of Losses
<b>Option 1: Shared savings only</b>	Up to 40% of Savings Pool	10% of <del>the TCOC Expenditure Target</del> <u>AE contract revenue</u>	NA	NA
<b>Option 2: Shared savings + risk</b>	Up to 60% of Savings Pool	10% of <del>the TCOC Expenditure Target</del> <u>AE contract revenue</u>	5% of <del>the TCOC Expenditure Target</del> <u>AE contract revenue</u>	Up to 60% of Loss Pool

~~Any MCO/AE downside risk arrangement must be implemented with a minimum withhold, capturing at least 75 percent of the maximum shared loss pool.~~

**7. Required Progression to Risk Based Arrangements**

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

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

	Marginal Risk AE Share of Losses	Loss Cap Maximum Shared Loss Pool	Total Potential Risk
Definition	The percentage of any Shared Loss Pool for which the AE is financially at risk.	The maximum percentage loss over of the TCOC Expenditure Target AE’s contract revenue for which the AE is financially at risk.	The maximum potential loss for which the AE is financially at risk.
Year 1	0	NA	0
Year 2	0	NA	0
Year 3	At least 15 - 30% of any Shared Loss Pool	At least 2% No more than 510%	15% x 2% x Adjustment Factor (82% to 97%) = -2% to -3%
Year 4	At least 30 - 50% of any Shared Loss Pool	At least 2% No more than 10%	30% x 2% x Adjustment Factor (82% to 97%) = -5% to -6%
Year 5	At least 50 - 60% of any Shared Loss Pool	At least 2% No more than 10%	50% x 2% x Adjustment Factor (82% to 97%) = -8% to -1.0%

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

In

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

Should an MCO and AE wish to share risk on a more accelerated schedule than that

outlined above, the MCO and AE shall submit written documentation to EOHHS, including:

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

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

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

~~In order to monitor AE financial performance, AEs and MCOs will be required to furnish financial reports regarding risk performance on a semi-annual basis to EOHHS.~~

## E. TCOC Methodology: Required Elements for Specialized LTSS AEs

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

1. Defining a Historical Base
2. Required Adjustments to the Historical Base
3. TCOC Expenditure Target for the Performance Period
4. Actual Expenditures for the Performance Period
5. Shared Savings/(Loss) Pool Calculations

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

<sup>2</sup> Note that CMS has issued guidance for shared savings programs for both Medicaid and for Medicare Shared Savings Programs. For ease of reference links to relevant State Medicaid Director Letters are provided: [www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf](http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf); [www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-002.pdf](http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-002.pdf). Links for the Medicare Shared Savings Program final rule and a CMS Factsheet are also provided:

[www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO\\_Methodology\\_Factsheet\\_ICN907405.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Methodology_Factsheet_ICN907405.pdf). The Shared Savings Program final rule can be downloaded at [www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf](http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf) on the Government Printing Office (GPO) website

6. AE Share of Shared Savings/(Loss) Pool
7. Required Progression to Risk Based Arrangements

Note that the specialized LTSS AE Program is a pilot program and as such, EOHHS intends to engage in a systematic review of the guidelines established below as the program develops.

## 1. Defining a Historical Base

### a. AE Specific Historical Cost Data

The TCOC historical base shall include three years of AE-specific historical cost data with ~~more recent years weighted more heavily than more distant years equal weighting applied to each year.~~ MCOs are strongly encouraged to use three years of historic data in creating the benchmark in order to stabilize the historic base; at a minimum, all existing AE experience must be utilized. For newly established AEs, the TCOC historical base can be created on a simulated attributed population identified using historical utilization data, as historical authorization data for the AE may not be available.

### b. Covered Services

TCOC methodologies shall include all Medicaid costs associated with covered services listed in Attachment BA that are included in ~~EOHHS's EOHHS'~~ contract with MCOs, ~~as well as with the clarifications/exceptions listed below. In addition, EOHHS intends to include~~ equivalent Medicaid fee-for-service covered services for people not enrolled in managed care, for the performance year, ~~with the following clarifications/exceptions.~~ Any further adjustments to covered services outside of those listed below must be requested in writing and pre-approved by EOHHS prior to MCO-AE contract execution for the affected contractual performance year:

- I. Exclude services currently covered under stop-loss provisions between EOHHS and the MCO;
- II. Exclude services managed by BHDDH for people with intellectual and development disabilities;
- III. Exclude long-stay/custodial nursing facility costs in excess of six consecutive months (disregarding any short-term acute hospital or skilled nursing facility stays that interrupt an otherwise continuous long-stay/custodial nursing facility stay);
- IV. Exclude HSTP performance incentive payments; and CTC payments.
- V. Include and define any other infrastructure payments made by MCOs or EOHHS to AEs and AE-affiliated providers, ~~including but not limited to care-management and utilization management payments.~~

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

TCOC ~~calculations are data shall be~~ adjusted ~~for outlier to exclude~~ costs ~~by defining a threshold ceiling in excess of \$100,000 per member per year.~~ However, ~~the historical base~~ TCOC expenditures must include 10% of any annualized spending per member

above the ~~spending threshold shown below. This threshold is based on the 95.5<sup>th</sup>-percentile of Rhode Island Medicaid per member annual claims cost for the AE-eligible population and for AE allowable TCOC Expenditures, as calculated by EOHHS and shown below. This threshold shall be established across all members. Upon AE-request, an alternative threshold of 99.7% may be applied, as shown below.~~  
truncation threshold.

Percentile	Annualized per-member spending threshold
95.5 percentile	<del>\$\$\$ TBD</del>
99.7 percentile	<del>\$\$\$ TBD</del>

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

To account for possible changes in the risk profile of an AE’s attributed patient population over the historical base years, a risk adjustment methodology, using a clinical risk adjustment software, shall be applied. Under such an approach, risk calculations and any adjustments shall be applied at the total attributed population and not the EOHHS rate cell level. The TCOC methodology must describe the risk-adjustment method including underlying software parameters set by the MCO/payer. With EOHHS approval, adjustments using clinical and social risk factor data exogenous to the risk adjustment methodologies described above may be used. The MCO/payer may also propose an alternative approach to risk adjustment. The risk adjustment method must be equivalently provided to the MCO-enrolled and Medicaid fee-for-service populations within the AE. Information on risk adjustment methodologies shall be disclosed to contracting AEs.

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

When projecting (or trending) historical costs forward into the performance year, TCOC methodologies shall appropriately account for trends in nursing facility and home and community-based LTSS spending. Unless otherwise approved by EOHHS, trends assigned to TCOC baselines shall not exceed the final cumulative trends to the medical portion of Rhody Health Options rates for the nursing facility and the community LTSS capitation cells for Medicaid-only and Medicare-Medicaid populations contained in the EOHHS data books. The trends shall be applied to the AE in aggregate based on the AE’s member mix.

**2. Required Adjustments to the Historical Base**

In order to prospectively establish an AE’s TCOC Expenditure Target, the following adjustments to the historical base must be applied. ~~Note that no~~No additional adjustments are allowed without prior approval from EOHHS. EOHHS anticipates that historic costs for members enrolled in the Medicare-Medicaid plan may require adjustment.

**a. Adjustment for Prior Year Savings**

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

**a-b. Adjustment for Historically Low-Cost AEs**

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

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

Once an AE-specific, adjusted historical base is established, this base must be trended forward into the performance period to create an AE-specific TCOC Expenditure Target. TCOC methodologies shall be based on a performance time period of 12 months aligned with the state fiscal year. Initial contractual performance time periods may extend longer than 12 months if necessary.

**a. Required Cost Trend Assumptions**

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

**b. Final Target Adjusted for Changes in the Attributed Population's Risk Profile**

A risk adjustment methodology must be applied to assess any changes in an attributed population's risk profile from the risk-adjusted historical base to the contractual performance period, provided it can be equally applied to the MCO-enrolled and Medicaid fee-for-service populations within the AE. This methodology must be consistent with the LTSS risk adjustment methodology used in developing the adjusted historical base as described in Section E.1.d of this document.

**4. Actual Expenditures for the Performance Period**

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

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

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

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

**a. Small Sample Size Adjustment for Random Variation: Minimum Savings (Loss) Rate**

Shared savings calculations are intended to provide an incentive for outcomes based on performance. There is a methodological challenge posed in differentiating results based on performance versus random variation. In the calculations for comprehensive AE TCOC projections, an accommodation is made to adjust for the impact of random variation in small populations. Given the smaller sizes in the attributed populations of the specialized LTSS AEs, there is a higher likelihood of volatility in shared savings pool calculations. EOHHS is continuing to review potential approaches to stabilizing the shared savings pool calculations. The method outlined here is preliminary pending further examination and input.

Given the smaller attributed populations expected to be attributed to specialized LTSS AEs, it is necessary to account for statistical uncertainty in performance measurement due to the effect of random variation in utilization and spending. Specialized LTSS AEs will be subject to a 4% Minimum Savings (Loss) Rate. A specialized LTSS AE must achieve shared savings of greater than or equal to 4% of the TCOC Expenditure Target in order to be eligible for shared savings. Where the AE is responsible for downside risk, the AE will share in losses if the shared loss rate is greater than or equal to 4% of TCOC Expenditure Target. During the pilot, EOHHS will assess the effectiveness of the Minimum Savings (Loss) Rate for the specialized LTSS AE program and may make changes to the adjustment or develop an alternative approach to better account for random variation. These approaches may include, but are not limited to, exclusion of low frequency high-cost services and separate calculations for higher cost conditions.

**b. Impact of Quality and Outcomes**

The Shared Savings/(Loss) Pool shall be adjusted based on an assessment of performance relative to a set of quality measures for the attributed population. ~~A detailed quality scoring methodology is under development.~~ An Overall Quality Score will be generated for each AE, according to the methodology detailed in Attachment B: Quality Framework and Methodology for Comprehensive and Specialized LTSS Accountable Entities. The Shared Savings/(Loss) Pool must be multiplied by the Overall Quality Score.

**c. Adjustment for MCO Enrollment<sup>3</sup>**

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<sup>3</sup> The TCOC methodology ~~includes~~may include MCO-enrolled and Medicaid fee-for-service populations to increase the reliability and validity of the TCOC calculations for the specialized LTSS AEs. However, EOHHS does not have federal authority to distribute shared savings payments to AEs for Medicaid beneficiaries who are not enrolled in managed care. As a result, the TCOC methodology adjusts for the proportion of a specialized LTSS AE's attributed population that is enrolled in managed care. In contrast, specialized LTSS AEs will be eligible to earn ~~Infrastructure~~ Incentive Payments based on the AE's performance relative to the AE's TCOC Expenditure Target for its total attributed population, which includes MCO-enrolled and Medicaid fee-for-service beneficiaries. As articulated in the Incentive Program ~~Guidance~~Requirements, 20% of the specialized LTSS AE Specific Incentive Pool shall be set aside to support potential shared savings achieved by an AE relative to the AE's TCOC Expenditure Target, without adjustment for MCO Enrollment.



The Shared Savings/(Loss) Pool will be adjusted based on the percentage of member months that the AE’s attributed population is enrolled in managed care. With EOHHS approval, an MCO may apply a risk adjustment methodology to account for differences in the risk of the MCO-enrolled and Medicaid fee-for-service populations.

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

~~To establish the Shared Savings Pool for specialized LTSS AEs, the TCOC Expenditure Target, as calculated in Section E.3 of this document, will be adjusted based on the percentage of member months that the AE’s attributed population is enrolled in managed care.~~ In any given performance year, the Shared Savings Pool must not exceed 10% of the adjusted TCOC Expenditure Target-AE’s contract revenue. In instances where the AE is responsible for downside risk, the Shared Loss Pool must not exceed 5% of the adjusted TCOC Expenditure Target-AE’s contract revenue.

**6. AE Share of Savings (Loss) Pool**

In Year 1, AEs may be eligible to retain up to 40% of the Shared Savings Pool, as defined in Section E.5 above. AEs assuming downside risk may be eligible for up to 60% of the Shared Savings Pool, and may be responsible for up to 60% of the Shared Loss Pool. However, no ~~Specialized~~specialized LTSS AEs will be eligible to assume downside risk in the first year of the AE program. EOHHS will issue additional guidance requirements in the future on downside risk arrangements for specialized LTSS AEs.

Specialized LTSS AE Shared Savings Model	AE Share of Savings	Maximum Allowable Shared Savings Pool	Maximum Allowable Shared Loss Pool	AE Share of Losses
Shared savings only	Up to 40% of Savings Pool	<del>10% of the TCOC Expenditure Target adjusted for MCO enrollment</del> <u>10% of AE contract revenue</u>	NA	NA

**7. Required Progression to Risk Based Arrangements**

It is anticipated that, over time, shared savings and incentive opportunities will be in relation to shared risk. AEs will be expected to move into downside risk arrangements within four to five years of the launch of the specialized LTSS AE program. After five years, development and implementation funding will end, and AEs will be sustained going forward based on their successful performance and associated financial rewards in accordance with their MCO contract(s).

EOHHS has defined “meaningful risk” based on learnings from other states, Office of the Health Insurance Commissioner (OHIC) requirements, and federal MACRA rules. Marginal risk and loss caps are defined with a range, EOHHS anticipates that smaller organizations will fall on the lower end of that range. The required progression of increasing risk for all specialized LTSS AEs is as follows:

	Marginal Risk AE Share of Losses	Loss Cap Maximum Shared Loss Pool	Total Potential Risk
Definition	The percentage of any Shared Loss Pool for which the AE is financially at risk.	The maximum percentage <del>less-over</del> of the <del>TCOC Expenditure-Target</del> AE's contract revenue for which the AE is financially at risk.	The maximum potential <del>loss for which the AE is financially at risk-</del>
Year 1	0	NA	0
Year 2	0	NA	0
Year 3	0	NA	0
Year 4	<del>At least 15-30%</del> of any Shared Loss Pool	At least 2% No more than <del>510%</del>	<del>15% x 2% = .3%</del>
Year 5	<del>At least 30-50%</del> of any Shared Loss Pool	At least 2% No more than 10%	<del>30% x 2% = .6%</del>

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

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

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

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

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

Additionally, if an AE enters into an arrangement that provides for shared losses with a total potential risk that equals or exceeds 10% of expected expenditures, the AE must meet all of the financial reserve and risk-based capital requirements required of an MCO, with oversight by the Department of Business Regulation.<sup>4</sup> EOHHS anticipates that any AEs taking on such risk must, at a minimum, demonstrate adequate capitalization to cover three months of claims.<sup>5</sup>

~~In order to monitor AE financial performance, AEs and MCOs will be required to furnish financial reports regarding risk performance on a semi-annual basis to EOHHS.~~

## F. TCOC Development ~~and Approval~~ ~~and Reporting~~ Process

### 1. TCOC Development Approval

Medicaid MCOs and AEs ~~will~~must establish TCOC calculation methodologies ~~that in~~ accordance with these requirements to serve as the basis for their shared savings and/or risk arrangements. These methodologies must be approved by EOHHS. EOHHS will review the MCO's TCOC methodologies and reserves the right to ask for modifications before granting approval.<sup>6</sup> EOHHS also reserves the right to review these methodologies on an annual basis. ~~EHOHHS' approval, denial, or requests for amendment will also be transmitted in writing, without unreasonable delay. Further, for specialized LTSS AEs, the TCOC calculation methodologies will~~must be equivalently applied to the MCO-enrolled and Medicaid fee-for-service populations ~~within if both are included in~~ the AE.

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

#### 1. Benchmark Time Period

<sup>4</sup> As specified in the standards for minimum risk-based capital (RBC) requirements for health organizations in Chapter 27-4.7 of the RI general statute. <http://webserver.rilin.state.ri.us/Statutes/Title27/27-4.7/INDEX.HTM>

<sup>5</sup> Note that CMS has issued guidance for shared savings programs for both Medicaid and for Medicare Shared Savings Programs. For ease of reference links to relevant State Medicaid Director Letters are provided: [www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf](http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf); [www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-002.pdf](http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-002.pdf). Links for the Medicare Shared Savings Program final rule and a CMS Factsheet are also provided: [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO\\_Methodology\\_Factsheet\\_ICN907405.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Methodology_Factsheet_ICN907405.pdf). The Shared Savings Program final rule can be downloaded at [www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf](http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf) on the Government Printing Office (GPO) website

<sup>6</sup> In addition to this EOHHS requirement, note that depending on circumstances transparency in such arrangements is specifically required in CFR42 §438.6 Contract requirements 438.6(g): Inspection and audit of financial records – Risk contracts must provide that the state agency and the Department may inspect and audit any financial records of the entity or its subcontractors. 438.6(h) Physician Incentive plans – MCO contracts must provide for compliance with the requirements set forth in 422.208 and 422.210 of this chapter. 436.6(k)- All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

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

**2. Benchmark Data Source**

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

**3. Mid-Year Changes**

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

**4. Risk Adjustment**

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

**4.5. Shared Savings/Loss Distribution Rate and Calculation**

What portion of the eligible shared savings pool (after accounting for scaling based on quality and outcomes metrics) will be distributed to the AE?

**5.6. Shared Savings/Loss Distribution Timing**

At what time are shared savings distributions made to qualifying AEs? If distributions are made more frequently than annually, please also describe any true-up processes.

**6.7. Alignment between MCO and FFS populations (Specialized AEs only)**

Can the TCOC methodology be applied equally to MCO and Medicaid fee-for-service populations within a single specialized LTSS AE?

Where appropriate, MCOs should respond separately to the questions for comprehensive and specialized LTSS AEs. ~~MCOs must also submit to EOHHS a completed attached template (Attachment A) for each AE within 15 days, at the latest, of concluding any AE contract. If any entity is certified and contracted as both a comprehensive AE and a specialized LTSS AE, separate comprehensive AE and specialized LTSS AE templates must be completed for the entity.~~

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

MCOs must complete and submit the MCO/AE TCOC Reporting Template as defined by EOHHS for each AE within 15 days, at the latest, of executing any AE contract. If any entity is certified and contracted as both a comprehensive AE and a specialized LTSS AE, separate

comprehensive AE and specialized LTSS AE templates must be completed for the entity.

## **2. Required Ongoing Reporting**

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

<u>Performance Period 1: Performance Quarters</u>	<u>Quarterly Report Due to EOHHS</u>
<u>Q1: Jan 1<sup>st</sup> – Mar 31<sup>st</sup> 2018</u>	<u>July 29<sup>th</sup> 2018</u>
<u>Q2: Apr 1<sup>st</sup> – Jun 30<sup>th</sup> 2018</u>	<u>October 28<sup>th</sup> 2018</u>
<u>Q3: Jul 1<sup>st</sup> – Sep 30<sup>th</sup> 2018</u>	<u>January 28<sup>th</sup> 2018</u>
<u>Q4: Oct 1<sup>st</sup> – Dec 31<sup>st</sup> 2018</u>	<u>April 29<sup>th</sup> 2018</u>
<u>Q5: Jan 1<sup>st</sup> – Mar 31<sup>st</sup> 2019</u>	<u>July 29<sup>th</sup> 2019</u>
<u>Q6: Apr 1<sup>st</sup> – Jun 30<sup>th</sup> 2019</u>	<u>October 28<sup>th</sup> 2019</u>

## **G. Other APMs for Specialized LTSS AEs**

Currently, most Medicaid nursing facility and home and community-based LTSS in Rhode Island are reimbursed using encounter-based and other fee-for-service payment models that do not reward quality, efficiency, or value. EOHHS seeks to move away from fee-for-service payment models toward alternative payment models (APMs) that incentivize providers to be more accountable for Medicaid patients' care and outcomes. EOHHS intends to pilot test APMs, including bundled payments, per member per month (PMPM) payments, episodic payments, and other value-based payment (VBP) models, on a voluntary basis with Partner and Affiliate Providers in specialized LTSS AEs. EOHHS anticipates requesting expenditure authority under Section 1115(a)(2) of the Social Security Act to implement APMs for nursing facility and home and community-based LTSS. Additional guidance on requirements around the APMs and ~~on~~ the APM pilot opportunities will be provided separately.

## H. Comprehensive AE TCOC Methodology Example

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

\*Note: All data is illustrative only

		SFY2014	SFY2015	SFY2016	Historical Base		Performance Year	
AE Specific Historical Data Input: Membership and Cost		Year1	Year2	Year3	\$	pmpm	\$	pmpm
INPUT>	Attributed Lives (Members)	5,000	5,000	5,250	5,150	5,250		
INPUT>	PMPM	\$345.00	\$347.00	\$320.00	\$330.29	\$350.00		
<b>1 Calculating the Historical Base and Initial TCOC Target</b>					<b>Historical Base</b>		<b>Performance Year Target</b>	
		Year1	Year2	Year3	\$	pmpm	\$	pmpm
A Total Cost of Care (Unadjusted)		\$20,700,000	\$20,820,000	\$20,160,000	\$20,412,000	\$330.29		
B Base Year Weight		10%	30%	60%				
C Trend Factor			2%	2%				
D Trend Adjustment		\$836,280	\$416,400	\$0	\$208,548	\$3.37		
Details below	E Risk Adjustment	\$871,579	\$429,278	\$0	\$215,941	\$3.49		
F Total Cost of Care (Adjusted)		\$22,407,859	\$21,665,678	\$20,160,000	\$20,836,489	\$337.16		
Details below	G Prior Year Savings Adjustment			\$176,400	\$176,400	\$2.85		
Details below	H Historical Performance Adjustment			\$408,240	\$408,240	\$6.61	Projected Trend	Time Period (Yrs)
Total Cost of Care (Adjusted, with Sustainability Adjustments)					\$21,421,129	\$346.62	2%	2
Total Cost of Care (Initial Target)							\$22,286,543	\$360.62
							TCOC Initial PY Target	
<b>2 Calculating the Final TCOC Target</b>								
A Risk Adjustment							\$458,976	\$7.29
B * Final Target based on risk-adjusted PMPM with performance year membership							\$432,748	\$0.00
Total Cost of Care (Final Target)							\$23,178,267	\$367.91
							TCOC Final PY Target	
<b>3 Calculating and Distributing the Shared Savings (Loss) Pool</b>							<b>Performance Year</b>	
					\$	pmpm		
A Total Cost of Care (Actual Expenditures)					\$22,050,000	\$350.00		
							TCOC Actual	
B Shared Savings (Loss) Pool					\$1,128,267	\$17.91		
Details below	C Random Variation Adjustment				-\$22,565	-\$0.36		
Details below	D Quality and Outcomes Adjustment				\$0	\$0.00		
E Shared Savings (Loss) Pool (Adjusted)					\$1,105,702	\$17.55		
F Eligible Shared Savings Pool					\$1,105,702	\$17.55		
G Eligible Shared Loss Pool					NO	NO		
Cap: 10% Target	H Maximum Allowable Shared Savings Pool				\$2,317,827	\$36.79		
Cap: 5% Target	I Maximum Allowable Shared Loss Pool				-\$1,158,913	-\$18.40		
J Final Shared Savings Pool					\$1,105,702	\$17.55		
K Final Shared Loss Pool					NO	NO		
<b>L AE Share of Shared Savings (Loss) Pool</b>								
M Option 1: AE's Shared Savings Only		AE Share	20%	30%	40%			
		\$	pmpm	\$	pmpm	\$	pmpm	
Shared Savings		\$221,140	\$3.51	\$331,711	\$5.27	\$442,281	\$7.02	
N Option 2: AE's Shared Savings and Risk		AE Share	40%	50%	60%			
		\$	pmpm	\$	pmpm	\$	pmpm	
Shared Savings		\$442,281	\$7.02	\$552,851	\$8.78	\$663,421	\$10.53	
Shared Loss		NO	NO	NO	NO	NO	NO	

**Adjustment Details**

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

Risk Adj	E Average Risk Score	Year1	Year2	Year3	Historical Base	<-INPUT
		0.95	0.97	0.99	0.98	
	COC (Dollars) Years and Risk-Adjusted to Year Risk Mix	\$359.53	\$354.15	\$320.00	\$334.20	
	Risk Adjustment	\$14.53	\$7.15	\$0.00	\$3.60	

Adjustment for Prior Year Savings	G Prior Year Savings Target Actual COC (ppm)		\$7.00	<-INPUT
	Eligible Adjustment: AE Share		\$2.80	40% AE Share
	Eligible Adjustment: Total Dollars		\$176,400	
	Maximum Adjustment for Prior Year Savings (2%)		\$408,240	2% Max Allowable
	Eligible Adjustment: Max Allowable		\$176,400	

Historical Performance Adjustment	H MCO Average Cost (ppm)		\$334.00	<-INPUT
	MCO Average Risk Score		1.00	
	AE Average Risk Score		0.99	
	AE Cost (ppm)		\$320.00	
	AE Cost with FQHC PPS Adjustment (ppm)		\$320.00	\$0.00 FQHC PPS Adjustment (ppm), if applicable
	AE Average Risk Normalized Cost (ppm)		\$323.23	
	Cost Score (% above/below MCO average)		-4%	
	Eligible Adjustment		\$13.84	
	Eligible Adjustment: Total Dollars		\$855,593	
	Max Allowable Adjustment		\$408,240	2% Max Allowable
	Eligible Adjustment: Max Allowable		\$408,240	

**2 Final COC Target Adjustments**

Risk Adj	A Average Risk Score	PY	1.01	<-INPUT
	Risk Adjustment		\$7.29	

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

Small Sample Size and Random Variation Adjustment	C Shared Savings (Loss) Adjustment Factor Parameters by AE Size and Savings Rate			
	Savings %	Small AE (5-9,999)	Medium AE (10-19,999)	Large AE (20,000+)
	1%	73%	79%	89%
	2%	82%	92%	97%
	3%	91%	97%	99%
	4%	95%	99%	100%
	5%	98%	100%	100%
	6%	99%	100%	100%
	Parameter Lookup			
	Savings %	4.87%	5.00%	5.00%
Small AE	98%			
Medium AE	100%			
Large AE	100%			
Random Variation Adjustment	98%			Small AE AE Size Classification

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

1 COC inputs must account for covered service exclusions and claims cap truncation  
 2 Base Year Weights are flexible, example uses MSSP methodology  
 3 Placeholder trend, to populate DHS data book trends, Year1 trend to Year2/Year1  
 4 Change compounding formula based on time period between Base Year and Performance Year (assumes 2 year period)

**OHHS Comprehensive AE Total Cost of Care (TCOC) Guidance**

\*Note: All data is illustrative only

Comprehensive AE COC Calculation Pool				AE Specific Variables Calculation Variables		
		SFY 2014	SFY 2015	SFY 2016	SFY 2018	
INPUT B>	AE Specific Historical Data Input: Membership and Cost	Year 1	Year 2	Year 3	Historical Base	Performance Year
INPUT B>	Attributed Lives (Members)	5,000	5,000	5,250	5,150	5,250
INPUT B>	PMPM	\$345.00	\$347.00	\$320.00	\$330.29	\$350.00
<b>1 Calculating the Historical Base and Initial TCOC Target</b>					<b>Historical Base</b>	
					\$	pmpm
A Total Cost of Care (Unadjusted)		\$20,700,000	\$20,820,000	\$20,160,000	\$20,412,000	\$330.29
B Base Year Weight		10%	30%	60%		
C Trend Factor			2%	2%		
D Trend Adjustment		\$836,280	\$416,400	\$0	\$208,548	\$3.37
E Risk Adjustment		\$871,579	\$429,278	\$0	\$215,941	\$3.49
F Total Cost of Care (Adjusted)		\$22,407,859	\$21,665,678	\$20,160,000	\$20,836,489	\$337.16
G Prior Year Savings Adjustment				\$176,400	\$176,400	\$2.85
H Historical Performance Adjustment				\$408,240	\$408,240	\$6.61
I Total Cost of Care (Adjusted, with Sustainability Adjustments)					\$21,421,129	\$346.62
J Total Cost of Care (Initial Target)						
					Projected Trend	Time Period (Yrs)
					2%	2
					\$22,286,843	\$360.62
					TCOC Initial PY Target	
<b>2 Calculating the Final COC Target</b>						
A Risk Adjustment					\$458,976	\$7.29
B *Final Target Based on Risk-adjusted PMPM with performance year membership					\$432,748	\$0.00
C Total Cost of Care (Final Target)					\$23,178,267	\$367.91
					TCOC Final PY Target	
<b>3 Calculating and Distributing the Shared Savings (Loss) Pool</b>					<b>Performance Year</b>	
					\$	pmpm
A Total Cost of Care (Actual Expenditures)					\$22,050,000	\$350.00
					TCOC Actual	
B Shared Savings (Loss) Pool					\$1,128,267	\$17.91
C Random Variation Adjustment					-\$22,565	-\$0.36
D Quality and Outcomes Adjustment					\$0	\$0.00
E Shared Savings (Loss) Pool (Adjusted)					\$1,105,702	\$17.55
F Eligible Shared Savings Pool					\$1,105,702	\$17.55
G Eligible Shared Loss Pool					NO	NO
H Maximum Allowable Shared Savings Pool					\$2,317,827	\$36.79
I Maximum Allowable Shared Loss Pool					-\$1,158,913	-\$18.40
J Final Shared Savings Pool					\$1,105,702	\$17.55
K Final Shared Loss Pool					NO	NO
<b>L AE Share of Shared Savings (Loss) Pool</b>						
M Option 1: AE's Shared Savings Only		AE Share	20%	30%	40%	
		\$	pmpm	\$	pmpm	\$
Shared Savings		\$221,140	\$3.51	\$331,711	\$5.27	\$442,281
Shared Loss						
N Option 2: AE's Shared Savings and Risk		AE Share	40%	50%	60%	
		\$	pmpm	\$	pmpm	\$
Shared Savings		\$442,281	\$7.02	\$552,851	\$8.78	\$663,421
Shared Loss		NO	NO	NO	NO	NO



**Adjustment Details**

**1 Historical Base and Initial Target Adjustments**

Risk Adj	E	Average Risk Score	Year 1	Year 2	Year 3	Historical Base	<-INPUT
		TCOC (Dollars) / Year and Risk-Adjusted to Year Risk Mix	\$359.53	\$354.15	\$320.00	\$334.20	
		Risk Adjustment	\$14.53	\$7.15	\$0.00	\$3.60	
Adjustment for Prior Year Savings	G	Prior Year Savings Target (Actual COC) (ppm)			\$7.00	<-INPUT	
		Eligible Adjustment (AE) Share			\$2.80	40%	AE Share
		Eligible Adjustment (Total Dollars)			\$176,400		
		Maximum Adjustment for Prior Year Savings (2%)			\$408,240		2% Max Allowable
		Eligible Adjustment (Max Allowable)			\$176,400		
Historical Performance Adjustment	H	MCO Average Cost (ppm)			\$334.00	<-INPUT	
		MCO Average Risk Score			1.00		
		AE Average Risk Score			0.99		
		AE Cost (ppm)			\$320.00		
		AE Cost with QHCPSP Adjustment (ppm)			\$320.00	\$0.00	FQHC/PPS Adjustment (ppm), if applicable
		AE Average Risk Normalized Cost (ppm)			\$323.23		
		Cost Score (% above/below MCO average)			-4%		
		Eligible Adjustment			\$13.84		
		Eligible Adjustment (Total Dollars)			\$855,593		
		Max Allowable Adjustment			\$408,240		2% Max Allowable
		Eligible Adjustment (Max Allowable)			\$408,240		

**2 Final COC Target Adjustments**

Risk Adj	A	Average Risk Score	PY	<-INPUT
		Risk Adjustment	\$7.29	

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

Small Sample Size Random Variation Adjustment	C	Shared Savings (Loss) Adjustment Factor Parameters by AE Size and Savings Rate			
		Savings %	Small AE (\$-9,999)	Medium AE (10-19,999)	Large AE (20,000+)
		1%	73%	79%	89%
		2%	82%	92%	97%
		3%	91%	97%	99%
		4%	95%	99%	100%
		5%	98%	100%	100%
		6%	99%	100%	100%
		<b>Parameter Lookup</b>			
		Savings %	4.87%	5.00%	5.00%
	Small AE	98%			
	Medium AE	100%			
	Large AE	100%			
	Random Variation Adjustment	98%			
			Small AE	AE Size Classification	

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

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

I. Specialized LTSS AE TCOC Methodology Example

DRAFT

**OHHS Specialized AE Total Cost of Care (TCOC) Guidance**

\*Note: All Data is Illustrative Only

		SFY2014	SFY2015	SFY2016	Historical Base	SFY2018
INPUT>	AE Specific Historical Data Input: Membership and Cost					
INPUT>	Attributed Lives (Members)	1,000	1,000	1,000	1,000	1,000
INPUT>	PMPM	\$1,125.00	\$1,200.00	\$1,275.00	\$1,237.50	\$1,225.00

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

	Year 1	Year 2	Year 3	Historical Base		Performance Year Target	
				\$	pmpm	\$	pmpm
A Total Cost of Care (Unadjusted)	\$13,500,000	\$14,400,000	\$15,300,000	\$14,850,000	\$1,237.50		
B Base Year Weight	10%	30%	60%				
C Trend Factor		2%	2%				
D Trend Adjustment	\$545,400	\$288,000	\$0	\$140,940	\$11.75		
E Risk Adjustment	\$0	\$0	\$0	\$0	\$0.00		
F Total Cost of Care (Adjusted)	\$14,045,400	\$14,688,000	\$15,300,000	\$14,990,940	\$1,249.25		
G Prior Year Savings Adjustment			\$0	\$0	\$0.00		
H Historical Performance Adjustment			\$0	\$0	\$0.00	Projected Trend	me Period (Yrs)
I Total Cost of Care (Adjusted, with Sustainability Adjustments)				\$14,990,940	\$1,249.25	2%	2
J Total Cost of Care (Initial Target)						\$15,596,574	\$1,299.71

**2 Calculating the Final TCOC Target**

A Risk Adjustment	\$0	\$0.00
B *Final Target based on risk-adjusted PMPM with performance year membership	Impact of change in membership	\$0 \$0.00
Total Cost of Care (Final Target)	\$15,596,574	\$1,299.71
TCOC (Final PY Target)		

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

	Performance Year	
	\$	pmpm
A Total Cost of Care (Actual Expenditures)	\$14,700,000	\$1,225.00
TCOC (Actual)		

B Shared Savings (Loss) Pool	\$896,574	\$74.71
C Shared Savings Pool	\$896,574	\$74.71
D Shared Loss Pool	NO	NO
E Shared Savings Pool After MSR	\$896,574	\$74.71
F Shared Loss Pool After MLR	NO	NO
G Quality and Outcomes Adjustment: Quality Score Multiplier	1.00	<-INPUT
H Shared Savings Pool (Adjusted)	\$896,574	\$74.71
I Shared Loss Pool (Adjusted)	NO	NO
J Adjustment for MCO Enrollment (% MCO Member Months)	50%	<-INPUT
K Eligible MCO-Adjusted Shared Savings Pool	\$448,287	\$37.36
L Eligible MCO-Adjusted Shared Loss Pool	NO	NO
M Maximum Allowable MCO Shared Savings Pool	\$779,829	\$64.99
N Maximum Allowable MCO Shared Loss Pool	-\$389,914	-\$32.49
O Final MCO Shared Savings Pool	\$448,287	\$37.36
P Final MCO Shared Loss Pool	NO	NO

**Q AE Share of Final Shared Savings (Loss) Pool**

Option: AE's Shared Savings Only	20%		30%		40%	
	\$	pmpm	\$	pmpm	\$	pmpm
Shared Savings	\$89,657	\$7.47	\$134,486	\$11.21	\$179,315	\$14.94

Cap: 10% MCO-Adj. Target  
Cap: 5% MCO-Adj. Target

Adjustment Details						
<b>1 Historical Base and Initial COC Target Adjustments</b>						
Risk Adj	E	Average Risk Score	Year1	Year2	Year3	Historical Base
			1.0	1.0	1.0	1.00 <-INPUT
		TCC (Dollars) Years and Risk-Adjusted to Year Risk Mix	\$1,125.00	\$1,200.00	\$1,275.00	\$1,237.50
		Risk Adjustment	\$0.00	\$0.00	\$0.00	\$0.00
Adjustment for Prior Year Savings	G	Prior Year Savings: Target Actual TCC (ppm)			\$0.00	<-INPUT
		Eligible Adjustment: AE Share			\$0	40% AE Share
		Eligible Adjustment: Total Dollars			\$0	
		Maximum Adjustment for Prior Year Savings (2%)			\$297,000	2% Max Allowable
		Eligible Adjustment to Max Allowable			\$0	
Historical Performance Adjustment	H	MCO Average Cost (ppm)			\$1,100.00	<-INPUT
		MCO Average Risk Score			1.0	
		AE Average Risk Score			1.0	
		AE Cost (ppm)			\$1,275.00	
		AE Average Risk Normalized Cost (ppm)			\$1,275.00	
		Cost Score (% above/below MCO Average)			16%	
		Eligible Adjustment			-\$196.88	
		Eligible Adjustment: Total Dollars			-\$2,362,500	
		Max Allowable Adjustment			\$297,000	2% Max Allowable
		Eligible Adjustment to Max Allowable			\$0	
<b>2 Final COC Target Adjustments</b>						
Risk Adj	A	Average Risk Score	PY		1.00	<-INPUT
		Risk Adjustment			\$0.00	
<b>3 Shared Savings (Loss) Pool Adjustments</b>						
MSR/MLR	E/F	Application of Minimum Shared Savings (Loss) Rate				
		Minimum Savings (Loss) Rate	4.0%	Targeted Expenditures		
		Minimum Savings	\$623,863	\$51.99		
		Minimum Loss	-\$623,863	-\$51.99		
<p>1 TCC inputs must account for covered service exclusions and claims cap truncation</p> <p>2 Base Year Weights are flexible, example uses MSSP methodology</p> <p>3 Placeholder trend, to populate DHHS data book trends, Year 2 trend = Year 2 / Year 1</p> <p>4 Change compounding formula based on time period between Base Year 3 and Performance Year (assumes 2 year period)</p>						

Adjustment Details						
<b>1 Historical Base and Initial COC Target Adjustments</b>						
Risk Adj	E	Average Risk Score	Year 1	Year 2	Year 3	Historical Base
			1.0	1.0	1.0	1.00 <-INPUT
		TCC (Dollars) Years 1 and 2 Risk-Adjusted to Year 3 Risk Mix	\$1,125.00	\$1,200.00	\$1,275.00	\$1,237.50
		Risk Adjustment	\$0.00	\$0.00	\$0.00	\$0.00
Adjustment for Prior Year Savings	G	Prior Year Savings Target Actual COC (ppm)			\$0.00	<-INPUT
		Eligible Adjustment: AE Share			\$0	40% AE Share
		Eligible Adjustment: Total Dollars			\$0	
		Maximum Adjustment for Prior Year Savings (2%)			\$297,000	2% Max Allowable
		Eligible Adjustment to Max Allowable			\$0	
Historical Performance Adjustment	H	MCO Average Cost (ppm)			\$1,100.00	<-INPUT
		MCO Average Risk Score			1.0	
		AE Average Risk Score			1.0	
		AE Cost (ppm)			\$1,275.00	
		AE Average Risk Normalized Cost (ppm)			\$1,275.00	
		Cost Score (% above/below MCO Average)			16%	
		Eligible Adjustment			-\$196.88	
		Eligible Adjustment: Total Dollars			-\$2,362,500	
		Max Allowable Adjustment			\$297,000	2% Max Allowable
		Eligible Adjustment to Max Allowable			\$0	
<b>2 Final COC Target Adjustments</b>						
Risk Adj	A	Average Risk Score	PY		1.00	<-INPUT
		Risk Adjustment			\$0.00	
<b>3 Shared Savings (Loss) Pool Adjustments</b>						
MSR/MLR	F	Application of Minimum Shared Savings (Loss) Rate				
		Minimum Savings (Loss) Rate	4.0%	Targeted Expenditures		
		Minimum Savings	\$623,863	\$51.99		
		Minimum Loss	-\$623,863	-\$51.99		
<p>1 TCC inputs must account for covered service exclusions and claims cap truncation</p> <p>2 Base Year Weights are flexible, example uses MSSP methodology</p> <p>3 Placeholder trend, to populate DHHS data book trends, Year 2 trend = Year 2 / Year 1</p> <p>4 Change compounding formula based on time period between Base Year 3 and Performance Year (assumes 2 year period)</p>						

OHHHS Specialized AETCOE Total Cost of Care (TCOC) Guidance  
 Specialized AETCOE Calculation Tool

\*Note: All data is illustrative only

		SFY2014	SFY2015	SFY2016	Historical Base	SFY2018
INPUTS>	AETCOE Historical Data Input: Membership and Cost					Performance Year
INPUTS>	Attributed Lives (Members)	1,000	1,000	1,000	1,000	1,000
	PMPM	\$1,225.00	\$1,250.00	\$1,275.00	\$1,262.50	\$1,225.00
<b>1 Calculating the Historical Base and Initial TCOC Target</b>						
		Year 1	Year 2	Year 3	Historical Base	Performance Year Target
A	Total Cost of Care (Unadjusted)	\$14,700,000	\$15,000,000	\$15,300,000	\$15,150,000	\$1,262.50
B	Base Year Weight	10%	30%	60%		
C	Trend Factor		2%	2%		
D	Trend Adjustment	\$593,880	\$300,000	\$0	\$149,888	\$12.45
E	Risk Adjustment	\$0	\$0	\$0	\$0	\$0.00
F	Total Cost of Care (Adjusted)	\$15,293,880	\$15,300,000	\$15,300,000	\$15,299,388	\$1,274.95
G	Prior Year Savings Adjustment			\$303,000	\$303,000	\$25.25
H	Historical Performance Adjustment			\$303,000	\$303,000	\$25.25
I	Total Cost of Care (Adjusted, with Sustainability Adjustments)				\$15,905,388	\$1,325.45
J	Total Cost of Care (Initial Target)					\$16,547,966
						\$1,379.00
<b>2 Calculating the Final TCOC Target</b>						
A	Risk Adjustment				\$0	\$0.00
B	*Final Target based on risk-adjusted PMPM with performance year membership				Impact of change in membership	\$0
	Total Cost of Care (Final Target)					\$16,547,966
						\$1,379.00
<b>3 Calculating and Distributing the Shared Savings (Loss) Pool</b>						
					Performance Year	
A	Total Cost of Care (Actual Expenditures)				\$14,700,000	\$1,225.00
					TCOC Actual	
B	Shared Savings (Loss) Pool				\$1,847,966	\$154.00
C	Shared Savings Pool				\$1,847,966	\$154.00
D	Shared Loss Pool				NO	NO
E	Shared Savings Pool After MSR				\$1,847,966	\$154.00
F	Shared Loss Pool After MLR				NO	NO
G	Quality and Outcomes Adjustment: Quality Score Multiplier				1.00	
H	Shared Savings Pool (Adjusted)				\$1,847,966	\$154.00
I	Shared Loss Pool (Adjusted)				NO	NO
J	Adjustment for MCO Enrollment (% MCO Member Months)				50%	
K	Eligible MCO-Adjusted Shared Savings Pool				\$923,983	\$77.00
L	Eligible MCO-Adjusted Shared Loss Pool				NO	NO
M	Maximum Allowable MCO Shared Savings Pool				\$827,398	\$68.95
N	Maximum Allowable MCO Shared Loss Pool				-\$413,699	-\$34.47
O	Final MCO Shared Savings Pool				\$827,398	\$68.95
P	Final MCO Shared Loss Pool				NO	NO
Q	AETCOE Final Shared Savings (Loss) Pool					
R	Options: Shared Savings Only	AETShare	20%	30%	40%	
		\$	pmpm	\$	pmpm	\$
	Shared Savings	\$165,480	\$13.79	\$248,219	\$20.68	\$330,959
						\$27.58

Cap: 0% AETCOE Contract  
 Cap: 5% AETCOE Contract

Adjustment Details							
1 Historical Base and Initial COC Target Adjustments							
Risk Adj	E	Average Risk Score	1.0	1.0	1.0	Historical Base	<-INPUT
		TCOC (Dollars) Years 1 and 2 Risk-Adjusted to Year 3 Risk Mix	\$1,225.00	\$1,250.00	\$1,275.00	\$1,262.50	
		Risk Adjustment	\$0.00	\$0.00	\$0.00	\$0.00	
Adjustment for Prior Year Savings	G	Prior Year Savings Target Actual COC (ppm)			\$65.00	<-INPUT	
		Eligible Adjustment AE Share			\$26.00	40%	AE Share
		Eligible Adjustment Total Dollars			\$312,000		
		Maximum Adjustment for Prior Year Savings (2%)			\$303,000		2% Max Allowable
		Eligible Adjustment Max Allowable			\$303,000		
Historical Performance Adjustment	H	MCO Average Cost (ppm)			\$1,350.00	<-INPUT	
		MCO Average Risk Score			1.0		
		AE Average Risk Score			1.0		
		AE Cost (ppm)			\$1,275.00		
		AE Average Risk Normalized Cost (ppm)			\$1,275.00		
		Cost Score (% above/below MCO average)			-6%		
		Eligible Adjustment			\$70.14		
		Eligible Adjustment Total Dollars			\$841,667		
		Max Allowable Adjustment			\$303,000		2% Max Allowable
		Eligible Adjustment Max Allowable			\$303,000		
2 Final COC Target Adjustments							
Risk Adj	A	Average Risk Score	1.00				<-INPUT
		Risk Adjustment					
3 Shared Savings (Loss) Pool Adjustments							
MSR/MLR	F	Application of Minimum Shared Savings (Loss) Rate					
		Minimum Savings (Loss) Rate	4.0%		Targeted Expenditures		
		Minimum Savings	\$661,919		\$55.16		
	Minimum Loss	-\$661,919		-\$55.16			

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

DRAFT





**Attachment B: Services Included in Specialized LTSS AE TCOC Analyses**

Homemaker  
Environmental Modifications  
Special Medical Equipment  
Minor Environmental Modifications  
Meals on Wheels  
Personal Emergency Response (PERS)  
LPN Services (Skilled Nursing)  
Home Health Services (skilled)  
Skilled Therapies (PT, OT, Speech)  
Community Transition Services  
Residential Supports  
Day Supports  
Supported Employment  
Supported Living Arrangements/Shared Living  
Private Duty Nursing  
Adult Companion  
Assisted Living  
Personal Care Assistance/Certified Nursing Assistant (CNA)/Attendant Care Services  
Respite  
Habilitative Services  
Adult Day Services  
Long Stay Nursing Facility  
Hospice  
Skilled Nursing Facility (SNF)

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## Attachment B: Quality Framework and Methodology for Comprehensive and Specialized LTSS Accountable Entities

### **A. Principles and Quality Framework**

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

As a starting point, the Year 1 requirements described below are intended to provide an interim structure that permits baseline measurement and assessment, while allowing for future refinements that continuously “raise the bar” toward critical improvements in quality and outcomes.

### **B. Shared Savings Opportunity**

Medicaid AEs are eligible to share in earned savings based on a quality multiplier to be determined as follows:

- o The AE must meet the established total cost of care (TCOC) threshold as determined using the EOHHS approved TCOC methodology to be eligible for shared savings.
- o The quality measures included as part of the Medicaid Accountable Entity Common Measure Slate (including up to 4 additional optional menu measures for comprehensive AEs) will be used to determine a quality score for each AE.
- o For comprehensive AEs, all admin (claims-based) measures must be generated and reported by the MCO. AEs must provide the necessary data to the MCO to generate any hybrid or EHR-only measures. Any EHR-only measures generated by an AE may be reported for the AE’s full attributed population.
- o For specialized LTSS AEs, measures must be generated for an AE’s entire Medicaid attributed population, including MCO-enrolled and not enrolled beneficiaries.
- o The quality score will be used as a multiplier to determine the percentage of the shared savings pool the AE is eligible to receive. Quality scores will be calculated distinctly for each MCO with which the AE is contracted.
- o Performance year periods, which are aligned with the state fiscal year calendar, will be tied to the calendar year quality performance period ending within the performance year period. The prior calendar year quality performance period will serve as the benchmark period, as shown below.

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

\*Performance Year 1 may be an extended performance period to allow for differential start dates; as such it must begin no earlier than January 1, 2018 and no later than July 1, 2018 and must end on June 30, 2019.

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

For comprehensive AEs, EOHHS requires the use of the measures included in the Medicaid Comprehensive AE Common Measure Slate (see below). In addition to the 11 required core measures, each MCO and AE may include up to 4 additional optional measures identified by the MCO and AE from the RI State Innovation Model (SIM) menu measure set and/or Medicaid Child and/or Adult Core Set.

Note that EOHHS may define an additional member retention measure for piloting in Year 1, and full implementation beginning in Year 2.

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

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

### **D. Comprehensive AE Quality Score Determination**

#### **Part 1: Relative Weight of Individual Measures for Comprehensive AEs**

The Quality Score is to be developed based on assigning a weight to each individual measure. Measure weighting is subject to negotiation between the MCO and AE, but must meet the following requirements:

- Measures for which the AE's baseline meets or exceeds the current Medium benchmark cannot exceed 10% weight.

- Measures with no baseline cannot exceed 10% weight, and
- The Social Determinants of Health (SDOH) Screen measure must be assigned a 10% weight.

Mandatory measures for which baseline data can be calculated will be pay for performance in Year 1. A Measure Score will be generated for each measure according to the criteria specified below in Section E Part 2.

The following four mandatory measures, for which baseline data is not available, will be pay for reporting in Year 1:

- Measure 5. Tobacco Use: Screening and Cessation Intervention
- Measure 9. Screening for Clinical Depression & Follow-up Plan
- Measure 10. Social Determinants of Health (SDOH) Screen
- Measure 11. Self-assessment/rating of health status

A pass/fail score (either 100% or 0%) will be awarded for these measures, based on timely submission of required data in accordance with agreed upon formats. There will be no partial credit for reporting. Year 1 data will be used to establish a baseline for these measures.

Optional admin (claims-based) measures must be pay for performance in Year 1. Optional hybrid or EHR-only measures may be pay for performance or pay for reporting in Year 1.

The overall Quality Score must be a sum of the Measure Specific Quality Score times the Measure Weight for each measure.

Example:

<u>List of Measures</u>	<u>Measure Specific Quality Score</u>	<u>Measure Weight</u>	<u>Measure Specific Quality Score * Measure Weight</u>
<u>Measure 1</u>	<u>100%</u>	<u>20%</u>	<u>20%</u>
<u>Measure 2</u>	<u>100%</u>	<u>20%</u>	<u>20%</u>
<u>Measure 3</u>	<u>75%</u>	<u>20%</u>	<u>15%</u>
<u>Measure 4</u>	<u>50%</u>	<u>30%</u>	<u>15%</u>
<u>Measure 5</u>	<u>0%</u>	<u>10%</u>	<u>0%</u>
<b><u>Overall Quality Score</u></b>			<b><u>70%</u></b>

**Part 2) Comprehensive AE Measure Specific Performance**

Measure specific performance is intended to both reward historically high-quality providers and create opportunities for low performers to benefit from improvement.

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

- High benchmark target: NCQA Medicaid Quality Compass percentile measure score defined by measure based on current MCO performance (see Common Measure Slate for measure specific benchmarks)
- Medium benchmark target: NCQA Medicaid Quality Compass 66<sup>th</sup> percentile measure score for all measures

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

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

**Comprehensive AE Measure Specific Scoring**

<u>Measure Performance Category</u>	<u>Measure Score</u>	<u>Performance Category Criteria</u>
<u>High Performance</u>	<u>100%</u>	<u>AE score meets or exceeds the High benchmark target</u>
<u>Medium Performance</u>	<u>75%</u>	<u>AE score meets or exceeds the Medium benchmark target (but is below the High benchmark target)</u>
<u>Improvement</u>	<u>50%</u>	<u>AE score is below the Medium benchmark target but shows meaningful improvement over the prior year's performance. Meaningful improvement is defined as improvement half way from the AE's baseline to the Medium performance target, or 10 percentage point improvement, whichever is lower, with a minimum required improvement of at least 3 percentage points.</u>
<u>Fail</u>	<u>0%</u>	<u>AE score is below the Medium benchmark target and does not show meaningful improvement over the prior year's performance, as defined above.</u>

*Example: Comprehensive AE Measure 1. Breast Cancer Screening*

High Benchmark = 65.06 (75<sup>th</sup> Percentile NCQA Quality Compass)

Medium Benchmark = 63.10 (66<sup>th</sup> Percentile NCQA Quality Compass)

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

**Proposed Comprehensive AE Common Measure Slate\***

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

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

Measure Name	NQF #	Measure Steward	Measure Domain	Measure Source	Measure Description	Age Cohort	High Benchmark	Medium Benchmark
<u>5. Tobacco Use: Screening and Cessation Intervention</u>	<u>0028</u>	<u>AMA-PCPI</u>	<u>Preventive Care</u>	<u>Admin or Hybrid</u>	<u>Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user</u>	<u>Adult</u>	<u>N/A Reporting only in Y1</u>	<u>N/A Reporting only in Y1</u>
<u>6. Comp. Diabetes Care: HbA1c Control (&lt;8.0%)</u>	<u>0575</u>	<u>HEDIS®</u>	<u>Chronic Illness</u>	<u>Hybrid</u>	<u>The percentage of members 18-75 years of age with diabetes (type 1 and 2) w/HbA1C control &lt;8.0%</u>	<u>Adult</u>	<u>QC 75<sup>th</sup> percentile</u>	<u>QC 66<sup>th</sup> percentile</u>
<u>7. Controlling High Blood Pressure</u>	<u>0018</u>	<u>HEDIS®</u>	<u>Chronic Illness</u>	<u>Hybrid</u>	<u>The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year based on the following criteria:</u> <ul style="list-style-type: none"> <li><u>• 18-59 years of age whose BP was &lt;140/90 mm Hg</u></li> <li><u>• 60-85 years of age with a dx of diabetes whose BP was &lt;140/90 mm Hg</u></li> <li><u>• 60-85 years of age without a dx of diabetes whose BP was &lt;150/90 mm Hg</u></li> </ul>	<u>Adult</u>	<u>QC 90<sup>th</sup> percentile</u>	<u>QC 66<sup>th</sup> percentile</u>
<u>8. Follow-up after Hospitalization for Mental Illness (7 Days)</u>	<u>0576</u>	<u>HEDIS®</u>	<u>Behavioral Health</u>	<u>Admin</u>	<u>The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnosis and who had a follow-up visit with a mental health practitioner</u>	<u>Adult and Pediatric</u>	<u>QC 90<sup>th</sup> percentile</u>	<u>QC 66<sup>th</sup> percentile</u>



Measure Name	NQF #	Measure Steward	Measure Domain	Measure Source	Measure Description	Age Cohort	High Benchmark	Medium Benchmark
<a href="#">9. Screening for Clinical Depression &amp; Follow-up Plan</a>	0418	CMS	Behavioral Health	Practice-reported	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	Adult and Pediatric	N/A Reporting only in Y1	N/A Reporting only in Y1
<a href="#">10. Social Determinants of Health (SDOH) Screen</a>	N/A	N/A	Social Determinants		% of members screened as defined per the SDOH elements in the Medicaid AE certification standards*	Adult and Pediatric	N/A	N/A
<a href="#">11. Self-Assessment/Rating of Health Status</a>	N/A	N/A			Measure to be defined and submitted to EOHHHS for approval (e.g., Institute for Healthcare Improvement)	Adult and Pediatric	N/A	N/A

Technical specifications for the measures above will be provided separately.

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

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

**Optional Menu Metrics for Comprehensive AEs**

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



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



2017-adult-core-set .pdf



Crosswalk Aligned Measure Set

Field Code Changed

Field Code Changed

Field Code Changed

### **E. Medicaid AE Common Measure Slate for Specialized LTSS AEs**

For specialized LTSS AEs, EOHHS requires the use of all measures included in the Medicaid Specialized LTSS AE Common Measure Slate (see below). The Common Measure Slate for specialized LTSS AEs has been developed with the following considerations:

- o Cross cutting measures across multiple domains with a focus on LTSS, healthy aging, behavioral health, and social determinants of health.
- o Feasibility of data collection and measurement and minimization of administrative burden.
- o A focused set of measures that will enable a concentrated effort and meaningful assessment of quality.
- o Focus on statewide strategic priorities outlined by EOHHS and the RI Division of Elderly Affairs.

### **F. Specialized LTSS AE Quality Score Determination**

**Year 1:** Unlike the Comprehensive AEs, the SIM measure set does not specifically include a set of LTSS-related measures. As such, there is a strong emphasis on reporting and establishing baseline data for the measures in the first year of the specialized LTSS AE program. All measures must be reported using EOHHS measure specifications (to be released separately). For Year 1, all measures included in the Measure Slate will be assigned a weight and included in the Overall AE Quality Score for each AE. The Quality Weight will be determined in the contract between the MCO and AE. However, the minimum Quality Weight for the SDOH measure is 10%. Each measure will also be given a Reporting Score, which will be a pass/fail score (either 100% or 0%), based on timely submission of required data in accordance with agreed upon formats; there will be no partial credit for reporting. The Measure Specific Quality Score will be calculated as the product of the Quality Weight and the Reporting Score for the measure (i.e., Measure Specific Quality Score = Quality Weight x Reporting Score). The Overall AE Quality Score will be calculated as the sum of the Measure Specific Quality Scores for each measure.

Example: Overall AE Quality Score Calculation for a Specialized LTSS AE in Year 1

<u>Measure</u>	<u>Quality Weight</u>	<u>Reporting Score</u>	<u>Quality Score</u>
<u>Measure 1</u>	<u>5%</u>	<u>100%</u>	<u>5%</u>
<u>Measure 2</u>	<u>15%</u>	<u>100%</u>	<u>15%</u>
<u>Measure 3</u>	<u>10%</u>	<u>100%</u>	<u>10%</u>
<u>Measure 4</u>	<u>10%</u>	<u>100%</u>	<u>10%</u>
<u>Measure 5</u>	<u>20%</u>	<u>0%</u>	<u>0%</u>
<u>Measure 6</u>	<u>5%</u>	<u>100%</u>	<u>5%</u>
<u>Measure 7 (SDOH Screening)</u>	<u>10%</u>	<u>100%</u>	<u>10%</u>
<u>Measure 8</u>	<u>5%</u>	<u>0%</u>	<u>0%</u>
<u>Measure 9</u>	<u>10%</u>	<u>100%</u>	<u>10%</u>
<u>Measure 10</u>	<u>10%</u>	<u>100%</u>	<u>10%</u>
<b><u>Overall AE Quality Score</u></b>			<b><u>75%</u></b>

**After Year 1:** After Year 1, the Quality Score Determination for specialized LTSS AEs will be designed to both reward high-quality providers and create opportunities for low performers to benefit from improvement. It will also shift the emphasis from reporting to performance. The requirements will be updated in the future to describe how the Overall AE Quality Score will be calculated. However, the approach will be aligned with the comprehensive AE approach to the extent feasible and practical.

**Proposed Medicaid Specialized LTSS AE Common Measure Slate**

<b><u>Measure Name</u></b>	<b><u>Preliminary Measure Description</u></b>
<b><u>1. Depression Screening and Follow-up</u></b>	<b><u>% of attributed population who were screened for clinical depression using a standardized tool, and received appropriate follow-up care within 30 days if positive</u></b>
<b><u>2. Falls with Major Injury</u></b>	<b><u>% of attributed population experiencing one or more falls with major injury</u></b>
<b><u>3. Advanced Care Planning</u></b>	<b><u>% of attributed population 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan</u></b>
<b><u>4. Discharge to the Community from Nursing Home</u></b>	<b><u>% of short-stay residents attributed to the AE who were successfully discharged to the community</u></b>
<b><u>5. ED Utilization</u></b>	<b><u>Rate of emergency department visits (that do not result in inpatient stays) among the attributed population</u></b>
<b><u>6. 30-Day All-Cause Readmission</u></b>	<b><u>% of acute inpatient stays among the attributed population that were followed by an unplanned acute readmission for any diagnosis within 30 days</u></b>
<b><u>7. Social Determinants of Health (SDOH) Screening</u></b>	<b><u>% of attributed population screened as defined per the SDOH elements in the Medicaid AE certification standards*</u></b>
<b><u>8. Patient/Client Satisfaction</u></b>	<b><u>Average patient/client satisfaction rating among the attributed population</u></b>
<b><u>9. Caregiver Support/ Caregiver Burden</u></b>	<b><u>To be determined</u></b>
<b><u>10. Social Isolation</u></b>	<b><u>To be determined</u></b>

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

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

DRAFT