ATTACHMENT H - Accountable Entities Certification Standards – Comprehensive AE (Program Year 5)

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I. Certification Standards Overview and Purpose

This Accountable Entity (AE) Certification Standards Document was submitted by the RI Executive Office of Health and Human Services (EOHHS), as the single state Medicaid agency in Rhode Island, to CMS for review and approval in accordance with Special Terms and Conditions (STC) 43 of the Rhode Island Comprehensive 1115 Demonstration Waiver. The purpose of this document is to formalize the Certification Standards for Accountable Entities. Interested parties are invited to submit applications for certification and participation in the program. The issuance of AE Certification Standards, as well as the application and approval process, through the various stages, is managed directly by EOHHS.

The AE Certification standards and the corresponding application and approval process are intended to promote the development of new forms of organization, care integration, payment, equity considerations, and accountability for an attributed population. Successful organizations are multi-disciplinary in composition, inter-disciplinary in practice and focused on population health, with programs tailored to address varying levels and types of needs. Participants are demonstrably engaged in a common enterprise with incentives to work together to better meet the needs of attributed populations. There is a strong emphasis on integration of behavioral health, social determinants of health and equitable care for all Medicaid recipients, inclusive of all races, ethnicities, ages, abilities, cultural beliefs and sexual orientation. EOHHS is committed to working within our organization and collaborating with partners outside of our organization to address institutional racism. The health care industry has the power to improve health equity, and improved health equity will improve health outcomes. Community partners have the power to improve the community conditions that so profoundly impact the health of our Medicaid population. Together, health care providers, the community, and state agencies will work in concert towards this end.

Certification standards may be updated annually, and modifications may be required during implementation to ensure that best practices and lessons that are learned throughout implementation can be leveraged and incorporated into the program design. Any such revisions shall be formally posted on the EOHHS website and shall allow for a 30-day public comment period prior to implementation.

II. Background and Context

EOHHS, is implementing the RI Medicaid Accountable Entity (AE) Program **through its contracted Medicaid Managed Care Organizations (MCOs).** This program is intended to align incentives across the health care delivery and financing systems. The program also seeks to enable health system engagement with upstream determinants of health, including through collaboration with the Health Equity Zones (HEZ).

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

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

Certified AEs are responsible for coordinating the full continuum of health care services for defined populations**.** An effective AE must be able to meet the needs of the full population but must also have distinct competencies to recognize and address the special needs of high risk and "rising risk" subgroups. Applicants who are designated as "Certified" will immediately be eligible to enter into a contractual arrangement with the Medicaid MCOs to manage a population of Medicaid members under a total cost of care arrangement. Please refer to the Medicaid Managed Care contracts via the following link for detail regarding the full continuum of health services and benefits for Medicaid managed care members and MCO requirements for participating in value-based purchasing and accountable care: http://www.eohhs.ri.gov/ProvidersPartners/MedicaidManagedCare.aspx.

Certified AEs are eligible to participate in the Medicaid Infrastructure Incentive Program, which is intended to support Accountable Entities in building capacity – the processes and technology – required for effective system transformation.

EOHHS recognizes that AE applicants may be in differing stages of readiness and anticipates that most AEs will initially be "Certified with Conditions." AEs must address any conditions in accordance with an agreed upon project plan to be eligible to receive incentive funds while "Certified with Conditions." AEs who demonstrate that all the domain requirements are fully met

are designated as "Fully Certified." All AEs must be re-certified annually. AEs that had been "Certified with Conditions" must demonstrate the agreed-upon progress toward meeting stated conditions in order to be re-certified for the following year.

Certification Period and Continued Compliance with Certification Standards

Certification takes place annually, in compliance with CMS requirements. AEs are required to comply with all standards and requirements throughout the certification period. A certified AE shall provide notification to EOHHS of any potential changes that may impact performance or represent material modifications to the AE in relation to their certification and associated approval for participation in the AE program (e.g. change in ownership; change in contracted status with a MCO; change in the AE's legal or financial status such as but not limited to changes due to a merger, acquisition, or any other change in legal status; withdrawal or change in legal status of key partners; requests to add additional partners, or other material change.) Upon notice, and with reasonable opportunity for the AE to address identified deficiencies, EOHHS reserves the right to suspend or terminate certification.

The AE shall not assign or transfer any right, interest, or obligation under this certification to any successor entity or other entity without the prior written consent of EOHHS.

III. Public Input Process

The process for developing these Certification Standards includes substantive public input. EOHHS recognizes the value of ongoing stakeholder engagement, collaboration and consensus building and is committed to ensuring a transparent and open public process. EOHHS has and will continue to meet with stakeholders, including MCOs and AEs, providers, and other community and advocacy groups to receive comments/feedback on upcoming guidance documents.

IV. Certification Standards: Comprehensive Accountable Entity

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

Summary of Domains for Certification:

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

Within each of the domains, considerable attention is given to the integration of activities focused on behavioral health, social determinants of health, and equitable care.[2] AEs are expected to work directly with partner organizations to address all of these needs within a care plan.

[1] Participating Providers are all providers within an AE network including but not limited to medical, behavioral health, and social service providers.

[2] Ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, no one should be disadvantaged from achieving this potential, if it can be avoided.", Whitehead M, Dahlgren G. *Concepts and Principles for Tackling Social Inequities in Health: Levelling up, Part 1*. World Health Organization, Regional Office for Europe; 2006.

For each requirement, applicants must either demonstrate specific compliance or identify how they will achieve compliance and a timeline for doing so. The AE is expected to demonstrate the ability to address the requirements described in the domains for certification. The AE may not have a particular capacity internally, and requirements may be partially met by an engaged partner, such as an MCO. The certification process should demonstrate an effective and robust partnership between the AE and MCO to leverage the capabilities that each brings to the relationship and to avoid duplication.

1. Breadth and Characteristics of Participating Providers

An AE needs to have a critical mass of providers and community partners that are inter-disciplinary with core expertise/direct service capacity in primary care and in behavioral health, inclusive of substance use services. The AE further needs to demonstrate defined relationships with providers of social services and community-based organizations in order to meet the needs of the member so that the member may live the most productive and meaningful life within their community.

For each population (children and/or adults) that is to be attributed to the AE, the applicant must demonstrate that it has the capability to address and coordinate the needs of populations at all levels and the ability to coordinate and direct a significant portion of care for those populations. AEs should not only have a strong foundation in primary care but also be able to effectively coordinate care beyond the scope of primary medical care. An AE shall identify participating behavioral health and social service partners and the role and expectation of such organizations as provider partners in their delivery system. Total cost of care calculations are based on the full range of benefits and services included within EOHHS's contract with managed care organizations. Note, for reference, Appendix A provides excerpts from the contracts between EOHHS and the MCOs that describe the scope of benefits covered within the managed care contracts, including required areas of behavioral health services coverage for children and adults.[3]

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

- Serving as the member's Primary Care Provider (PCP) and medical home
- Provide the level of care and range of services necessary to address the medical and behavioral needs of members, including those members with chronic conditions
- Provide overall clinical direction and serve as the central point for the integration and

[3] http://www.eohhs.ri.gov/ProvidersPartners/MedicaidManagedCare.aspx

coordination of care

- Make and track referrals for specialty care, other medically necessary services such as dental care, and services to address social determinants of health

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

Mental Health and Substance Use Disorder (Behavioral health (BH)) capacity must be demonstrated through evidence of Provider Partnerships with BH Service providers.

Behavioral health capacity shall be commensurate with the size and needs of the attributed population and based on a geographic analysis conducted by the AE. An AE may identify specific gaps and needs in care that inform the enhancement and referral arrangements of their AE network. BH service capacity shall include, through direct service provision or through established relationships with other providers, the ability to ensure that a broad range of treatment options representing a continuum of care is available to members of each population for which certification is sought (children, adults, older adults, perinatal and postpartum women etc.).

Direct service capacity within the AE shall be evidenced by the participation of Rhode Island licensed providers. This can include programs licensed by the Office of Facilities and Program Standards within the R.I. Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) for the provision of services to individuals who are developmentally disabled and/or experiencing a mental health and/or substance use disorder and can include programs licensed by the Department of Children, Youth, and Families.

AEs serving individuals 16 years of age and older who are at risk for or diagnosed with an opioid use disorder must make available community-based treatment utilizing all federally approved Medication Assisted Therapies, Opioid Treatment Program (OTP) Health Homes, and American Society of Addiction Medicine (ASAM) levels 3.1, 3.3, 3.5 and 3.7 of SUD residential treatment. These programs are provided by organizations licensed by BHDDH. Direct services for substance use treatment can also be demonstrated through the participation of treatment providers licensed by the Rhode Island Department of Health who are permitted to practice and bill Medicare or Medicaid autonomously, whether in a private practice or in association with a private agency or institution. Direct service capacity can also be demonstrated through the participation of Licensed Chemical Dependency Professionals who are permitted to practice under approved licensed provider agencies.

AEs serving individuals living with or at risk for developing a serious mental illness (SMI) or serious and persistent mental illness (SPMI) must ensure that Assertive Community Treatment (ACT) and Integrated Health Home (IHH) services are available to their members, either directly or through a Provider Partnership with a Community Mental Health Center (CMHC). CMHCs are licensed by BHDDH. Direct service capacity can also be demonstrated through the

participation of BH providers who are licensed by the Rhode Island Department of Health and who are permitted to practice and bill Medicare or Medicaid autonomously, whether in private practice or in association with a private agency or institution. This can include but is not limited to licensed psychologists, psychiatrists, licensed psychiatric nurses, and licensed mental health counselors (LMHC), licensed marriage and family therapists (LMFT), and licensed independent clinical social workers (LICSW). Approved licensed provider agencies may expand their BH capacity through clinical supervision to a defined staff of BH practitioners not otherwise licensed to perform at the independent level.

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

Improving health equity through enhancing capacity to address social determinants of health and health-related social needs

Health-related social needs can play a crucial role in the health status and outcomes of Medicaid recipients. These include unstable housing/poor housing conditions, food insecurity, and exposure to safety risks and domestic violence, as well as many other factors. When unmet, health-related social needs raise stress levels and allostatic load, impact the progression of health conditions, impact the ability to procure meaningful employment, impact the ability to mitigate health risks, and impact the ability to access health care. A core objective of the AE initiative is to advance the systematic integration of efforts to improve health-related social needs/social determinants of health and medical/BH care. The applicant must identify three key domains of social need for each population for which certification is being sought (children and/or adults) and identify arrangements in place for the provision of pertinent services.

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

Capacity to address health-related social needs/social determinants of health shall be evidenced by the participation of providers of pertinent social supports within the AE. An AE may demonstrate in-house capacity to provide social supports, but it is not required that AEs be able to provide the full range of social supports that may be appropriate to meet the needs of the attributed population. It is expected that AEs form defined affiliations and working arrangements with Community-Based Organization (CBOs) that address members' health-related social needs, such as Health Equity Zones, to address identified social contexts impacting health and outcomes. Investments described in the HSTP Social Determinants of Health Investment Strategy Proposal are meant to support AEs' capacity development in this area.

1.1. Provider Base

1.1.1. Critical Mass for attribution. For the purposes of these certification standards,

provider is differentiated from individual clinicians and is defined as a corporate entity with an identifiable tax identification number for services to patients based on the work of individual clinicians working with or for the corporate entity.

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

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

1.1.2.1 Population-specific primary care and behavioral health capacity to serve children, including adequate pediatricians, family practice clinicians, and advanced nurse practitioners, physician assistants, and pediatric behavioral health providers.

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

1.1.2.3 Population-specific substance use service capacity

1.1.2.4 Population-specific social determinants service capacity

AEs will identify social determinants of health needs for the populations they serve. AEs will identify three areas of critical need for social supports for each population served and describe in-house capacity and/or relationships with providers of social supports to address those needs. For illustration, the community-based services that can have critical impacts in promoting improved health outcomes may include the following:

- Housing stabilization and support services;
- Housing search and placement;
- Utility assistance;
- Food security;
- Support for attributed members who have experienced violence.

AEs may identify other areas deemed to be of critical impact. Note that incentive funds through the HSTP program are available to help strengthen relationships with CBOs and develop internal capacity for screening, referral, and service provision.

1.2. Relationship of Providers to the AE

1.2.1. Certification that all AE participating providers have agreed to participate in, and be accountable for health care transformation efforts, as set forth in these certification standards, including use of a total cost of care based Alternative Payment Methodology, in accordance with EOHHS APM requirements.

1.2.2. Description of types of member providers and clinicians and their relationship to the Entity: Note that clinicians employed by a participating provider entity are, by definition, participating in and accountable for health care transformation efforts of their employer.

1.2.2.1. Providers (primary care, behavioral health, and community based) are the core organizational and corporate partners in the AE, with voting rights on the AE Board of Directors, who participate in shared savings, movement to risk, participate in written mutual requirements

and protocols for collaborative practice (e.g., data sharing, care management) to promote and support integrated care, as applicable.

1.2.2.2. Primary care providers are recognized providers in attribution methodologies. Although not necessarily represented as voting members of the AE, PCPs provide the direct core capacity the AE brings to the organization of care, have meaningful direct and contractually defined participation in shared savings arrangements and progression to risk, and participate in written mutual requirements and protocols for collaborative practice (e.g., data sharing, care management) to promote and support integrated care.

1.2.2.3. Specialty and community-based providers have established referral, coordination, and working relationships with the AE but do not provide a basis for attribution. These include, but are not limited to, arrangements to fulfill the "breadth of provider base" requirements related to providers of behavioral health, substance use services, or social supports to address social determinants of health. Relationships with such providers are essential to demonstrate the ability to coordinate care for the full continuum of needs for attributed populations, particularly rising and high-risk individuals. Depending on the nature of the agreement between the parties, the AE may or may not have shared savings or incentive arrangements with those providers.

1.3. Ability to Coordinate for All Levels of Need for any Attributed Population

1.3.1. Demonstrate that the AE can meet all AE requirements to deliver the full continuum of needs for attributed populations by either providing services directly or through accountable care management to ensure smooth transitions. (For reference, see Attachment A)

1.3.1.1. Physical Health: service delivery/coordination capacity beyond the scope of PCP medical care, including specialty and inpatient care.

1.3.1.2. Behavioral Health: meet preventive, routine, and high-end behavioral health needs.

1.3.1.3. Integrated PH/BH: Evidence of direct participation or identified working relationships with a full continuum of BH providers as shown in Attachment A, including recognized CMHO providers and providers recognized by Office of the Health Insurance Commissioner (OHIC) as certified Integrated Behavioral Health providers.

1.3.1.4. Integrated SUD treatment, across the spectrum of need including opioid addiction services

1.3.1.5. Social Determinants: Community Health Team and/or Social Service Organization (SSO) CBO/HEZ partner addressing targeted social determinant area (e.g., focus on housing/housing security).

1.3.2. Develop and implement agreed upon protocols that guide the interaction between providers across the continuum of care and to integrate care delivery.

1.4. Defined Methods to Care for People with Complex Needs

1.4.1. Ability to identify and address rising risk, high risk populations

1.4.2. Improve care at points of transition from low to intensive levels of care

1.4.3. Ability to work effectively at key points of life transition or impact, as appropriate for the population served, such as discharge from corrections, engagement with DCYF protective custody, risk of loss of housing, homelessness, substance use, domestic violence/sexual violence

1.4.4. Ability to care for people with co-occurring chronic conditions, especially BH

1.5. Able to Ensure Timely Access to Care

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

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

1.5.1.1. Minimum Access Standards:

Appointment	***Access Standard***
After Hours Care Telephone	24 hours 7 days a week
Emergency Care	Immediately or referred to an emergency facility
Urgent Care Appointment	Within 24 hours
Routine Care Appointment	Within 30 calendar days
New Member Appointment	30 calendar days
Physical Exam	180 calendar days
EPSDT appointment	Within 6 weeks
Non-emergent, non-urgent mental health or substance use condition	Within ten (10) calendar days for diagnosis or treatment

2. Corporate Structure and Governance

A fundamental EOHHS objective is to develop a new type of organization in Rhode Island Medicaid to promote a population health focused and person-centered system of care, both within a racial equity lens. Such an organization must meet a core set of corporate requirements set forth in these requirements. The intent of these requirements include: (1) To ensure multi-disciplinary providers are actively engaged in a shared enterprise and have a stake in both financial opportunities and decision-making of the organization; (2) to ensure that assets and resources intended to support RI Medicaid are appropriately allocated, protected, and retained in Rhode Island; (3) to ensure that the mission and goals of the new entity align with the goals of EOHHS and the needs of the Medicaid population; (4) to ensure a structured means of accountability to the population served (5) to make health equity a strategic priority.

A qualified AE applicant must demonstrate its ability to meet the requirements of these certification standards including corporate structure and governance. A qualified applicant must be a legal entity incorporated within Rhode Island and with a federal tax identification number. The AE applicant may be formed by two or more entities joining together for the purpose of forming an AE, or it may be a single entity that includes all required capabilities of an AE.

If two or more parties form the AE applicant, it must be a distinct corporation and meet all the requirements for corporate structure and governance. It must have an identifiable governing body with authority to execute the functions and make final decisions on behalf of the AE. The governing body must be separate and unique to the AE and must not be the same as the governing body of any other entity participating in the AE.

If the applicant is a single entity the AE's board of directors may be the same as that of the single entity. However, the single entity applicant must establish a Governing Committee with distinct obligations and authorities in management of the AE program. The composition of the Governing Committee must include participation of various constituencies as set forth below. The Governing Committee must have authority to make binding decisions regarding the distribution of any shared savings or losses to providers (primary, behavioral health & social service), or other contracted parties, as applicable.

Whether the applicant is a single entity or a multiple entity AE:

- There shall be an established means for shared governance that provides all AE Providers participating in savings and/or risk arrangements with an appropriate, meaningful proportionate participation in the AE's decision-making processes. The structure of the AE must ensure that Governing Board or Governing Committee members have shared and aligned incentives to drive efficiencies, improve health outcomes, work together to manage and coordinate care for Medicaid beneficiaries, and share in savings and in risk.
- The AE must have a mission statement that aligns with EOHHS goals – a focus on population health, a commitment to an integrated and accountable system of care, a primary concern for the health outcomes of attributed members, the progressive use of outcome-based metrics, particular concern for those with the most complex set of medical, behavioral health, and social needs, and a health equity lens as part of the AEs governance structure.
- Governing Board of Directors or Governing Committee shall meet regularly, not less than quarterly.

These requirements are further defined in sections 2.1 -2.4. For each requirement, new applicants must either demonstrate specific compliance or propose an approach and timeline not to exceed nine months from the date of provisional certification to come into full compliance.

2.1 Multiple and Single Entity Applicants

2.1.1. By-Laws/ charter that sets forth Membership on the Board of Directors with voting rights that is inclusive of the minimum requirements set forth by EOHHS

2.1.2. Inclusion of a Board Level Governing Committee with a distinct focus on Medicaid, and inclusive of an Integrated Care Committee, a Quality Oversight Committee, and a Finance Committee

2.1.3. Include quarterly progress dashboards to monitor quality and cost effectiveness to support MCO and AE ability to monitor and improve performance.

2.1.4. A Compliance Officer with an unimpeded line of communication with the Board and who is not the legal counsel for the Board

2.1.5. Community Advisory Committee (CAC)

2.1.5.1. CAC consisting of at least four persons who are Medicaid beneficiaries attributed to the AE, or who are appropriate family representatives of those beneficiaries, and who are representative of the populations served by the AE (children and/or adults). Alternative structures for meaningful engagement with Medicaid members and families as well as the community may be proposed and must be approved by EOHHS.

2.1.5.2. CAC shall include at least one representative from a Health Equity Zone organization that operates in the AE's geographic service area.

2.1.6. Fiduciary and Administrative Responsibility Resides with BOD

2.1.6.1. The AE's administration must report exclusively to the governing Board through the AE's chief executive officer

2.1.7. Defined conflict of interest provisions that:

2.1.7.1. Require each member of the governing body, sub-committees, employees, and consultants to disclose relevant financial interests

2.1.7.2. Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise

2.1.7.3. Address remedial action for members of the governing body that fail to comply with the policy

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

2.2.1. Core Premises

Shared governance provides all AE participants with an appropriate, meaningful, proportionate control over the AE's decision-making processes. The Governing Board/Committee will have oversight of the quality of the AE's services to attributed members, provide guidance on decisions related to program design and implementation, and have authority to make binding decisions regarding the distribution of any shared savings or losses to Providers (primary care, behavioral health, and social service/HEZ) or other contracted partners, as applicable. The Governing Board/Committee will:

2.2.1.1. Be multi-disciplinary in composition and inter-disciplinary in practice

2.2.1.2. Have a defined, transparent structure, ensuring partners have shared and aligned incentives

2.2.1.3. Leverage strengths of partners toward an integrated person-centered system of care

2.2.2. Board or Governing Committee Membership

2.2.2.1. Most voting members of the Board or the Governing Committee shall be primary care providers (i.e., representatives appointed by the respective provider) behavioral health providers (i.e. representatives appointed by the respective provider) from participating provider organizations, provided that at least three members shall be primary care providers and three members shall be behavioral health providers. The meaning of the term provider is as set forth in Section 1.1.1

2.2.2.2. Minimal representation requirements, for each population certified to serve:

2.2.2.2.1. **Children:** Pediatric primary care provider, Pediatric BH provider, Pediatric representative member of Consumer Advisory Committee (must be a member or representative of an attributed member of the AE), CBO provider of age-appropriate social supports (i.e., representatives appointed by the respective provider)

2.2.2.2.2. **Adults:** Internal Medicine primary care provider, Adult BH provider, Adult representative member of Consumer Advisory Committee (must be an attributed member of the AE), CBO provider of age-appropriate social supports (i.e., representatives appointed by the respective provider)

2.3. Compliance

2.3.1. Provisions for assuring compliance with State, Federal law re: Medicaid, Medicare.

2.3.2. Policies and Procedures related to debarred providers, discrimination, protection of privacy, use of electronic records.

2.3.3. Policies and procedures for compliance with anti-trust rules and regulations

2.3.4. AE compliance program includes a designated compliance official who is not legal counsel and a mechanism to identify and address compliance problems including fraud, waste, and abuse.

2.3.5. Compliance Officer. A single entity AE may use an existing Corporate Compliance Officer in this role provided that the Compliance Officer's scope of activities includes compliance with AE program requirements and at least twice annual reporting to the Governing Body/Committee.

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

2.4.1. Required for attribution, shared savings/risk contract, and to be eligible for Health System Transformation Program (HSTP) incentive funds.

2.4.2. Comport with EOHHS defined delegation rules re: AE/MCO distribution of functions.

3. Leadership and Management

3.1. Leadership Structure

There must be a single, unified leadership structure, with commitment of senior leaders, backed by the required resources to implement and support the vision. AE organizational leadership must explicitly demonstrate that improving health equity is an organizational priority (at all levels of the organization). Health equity goals should inform resource allocation and drive AE efforts to improve community conditions for Medicaid recipients. The AE shall describe how its current structure meets these requirements or set forth a defined plan with fixed dates and deliverables as to how compliance will be progressively achieved. The leadership structure must include:

3.1.1. For a multiple or single entity AE, a Chief Executive and/or a Medicaid AE Program Director responsible to the BOD and for AE operations.

3.1.2. Management structure/staffing profile describing how the various component parts of the AE will be integrated into a coordinated system of care. This may include specific management services agreements with MCOs or subcontracts under the direction of the AE. Pertinent areas include:

- 3.1.2.1. Integrated Care Management
- 3.1.2.2. IT Infrastructure/Data Analytics
- 3.1.2.3. Quality Assurance and Tracking
- 3.1.2.4. Finance - Description of infrastructure for
  - 3.1.2.4.1. Unified financial leadership and systems
  - 3.1.2.4.2. Financial modeling capabilities and indicators
  - 3.1.2.4.3. Designing incentives that encourage coordinated, effective, efficient care

3.1.3. Leadership and management structure/ staffing profile describing how the AE will deploy interventions to reduce total cost of care (TCOC), including interventions to address utilization of healthcare services that the AE does not directly provide itself. In addition to general program certification requirements, certified AEs entering into downside risk contracts with MCOs will be required to obtain a Risk Bearing Provider Organization (RBPO) certification from the Office of the Health Insurance Commissioner (OHIC). Such OHIC certification will require AEs to document how they plan to cover downside losses and demonstrate the financial capacity to bear an estimated amount of downside risk.

4. IT Infrastructure – Data Analytic Capacity and Deployment

IT infrastructure and data analytic capabilities are widely recognized as critical to effective AE performance. The high performing AE must make use of comprehensive health assessment and evidence-based decision support systems based on complete patient information and clinical data across life domains. This data will be used to inform and facilitate Integrated Care Management across disciplines, including strategies to address social determinants of health care.

It is not necessary that an AE use limited resources to independently invest in and develop “big data” capabilities. There are many efforts underway in Rhode Island to standardize data collection and take advantage of emerging technologies, such as all payer data systems to enable

access to an up-to-date comprehensive clinical care record across providers (e.g., CurrentCare, care management dashboards & Quality Report System (QRS)), and to forge system connections that go beyond traditional medical claims and eligibility systems (e.g. SNAP, homelessness, census tract data on such factors as poverty level, percent of adults who are unemployed, percent of people over age 25 without a high school degree, etc.). In addition, building partnerships with community-based organizations can also be achieved through IT infrastructure and implementation of a Community Resource Platform (CRP), as described in the HSTP Social Determinants of Health Investment Strategy. AEs shall be included in system planning and preparedness (user testing) and expected to leverage their arrangement with their community-based partners for this purpose. MCOs have long established administrative claims data and eligibility files. **As such, many of these required capacities and capabilities might best be achieved in partnerships with MCOs and others to avoid duplicative infrastructure.**

A successful AE will be able to draw upon and integrate multiple information sources that use validated and credible analytic profiling tools to conduct regular risk stratification/predictive modeling to segment the population into risk groups and to identify those beneficiaries who would benefit most from care coordination and management. The goal of analytical tools is to define processes to advance population health, to support risk segmentation to better target efforts to rising risk and high-risk groups, to critical points of transition, to strengthen clinical practice, to promote evidence-based care, to report on quality and cost measures, to use data in improvement initiatives related to physical and/or behavioral health, to be able to identify and intervene upon health disparities, and to better coordinate care.

4.1. Core Data Infrastructure and Provider and Patient Portals

4.1.1. Able to receive, collect, integrate, utilize person specific demographic (race, ethnicity, language, disability (RELD)), clinical, and health status information.

4.1.1.1. Able to ensure data quality, completeness, consistency of fields, definitions

4.1.1.2. EHR capacity: Ability to share information with providers and partner organizations.

4.1.1.2.1. Use EHR systems to document medical, behavioral, and social needs in one common medical record that can be shared across the network within HIPAA guidelines. Use EHRs that comply with Office of the National HIT Coordinator (ONC) certification standards. Require use of EHRs to capture clinical data necessary for quality measurement as part of care delivery and submit these data to QRS system.

4.1.1.3. Patient registries – shared patient lists (e.g., PCP, BH provider, Care management) to ensure providers are aware of patient engagements.

4.1.1.4. Demonstrate that at least 60% of AE patients are enrolled in CurrentCare and/or document a plan to increase CurrentCare enrollment.

4.1.1.5. AE provider participants must contribute data from their EHRs to CurrentCare (AE office-based providers will send encounter data in a Clinical Care Document Format (CCD) via “Direct” secure

messages). AE provider participants must have the ability to receive data from CurrentCare or CurrentCare enrolled patients in at least one of the following ways: Through bi-directional interfaces with CurrentCare, or where RIQI and AE provider participants' EHR vendor capacity exists, ensure staff have appropriate access to CurrentCare viewer or CurrentCare data within their EHR.

4.1.1.6. AE provider participants must demonstrate capacity to exchange clinical quality data electronically via the QRS. This will enable data and reporting capability necessary to identify and monitor quality and performance opportunities. AEs are expected to submit full panel submissions as part of this CDE process. The appropriate quality improvement and clinical staff should have access and use of the QRS as needed. Participation in the QRS is vital to fulfill quality measure implementation for the AE program as well as other electronical clinical data exchange requirements.

4.1.1.7. Participate in primary source verification activities (chart reviews, supplying EHR screenshots, correcting data submission errors as-needed, etc.) as necessary for the Quality Reporting System (QRS) to obtain Data Aggregator Validation (DAV) program certification from the National Committee for Quality Assurance (NCQA).

4.2. Using Data Analytics for Population Segmentation, Risk stratification, Predictive Modeling

Able to draw upon and integrate multiple information sources to conduct regular risk stratification/predictive modeling to segment the population into risk groups, identify the specific people that will benefit the most from care coordination and management. Such tools should incorporate social risk factors. (e.g., neighborhood, race, ethnicity, preferred language, housing, family supports into risk profiling, by population). This is a critical aspect of health equity efforts.

4.2.1. Identified methodology and tools for attributed member risk stratification to identify highest complexity, rising/imminent risk groups

4.2.2. By population groups included in certification: Children, adults

4.2.3. Incorporating social determinants (e.g., housing, family support systems) into risk profiling, by population

4.2.4. Able to identify the use of validated, effective, credible tools for analytic profiling

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

Development of defined strategic focus on the AE processes and outcomes that impact costs.

4.3.1. Defined set of business process metrics meaningfully targeted to both operational and total cost of care efficiency.

4.3.2. Actions to Enhance Ability to Manage Care processes. Reshaping workflows for: availability and access, high impact interventions, reduce variance in quality/outcomes

4.3.3. Defined tools in place for tracking and monitoring level of performance in meeting contact and follow up objectives in implementation of the care model; established protocols for review of performance and feedback loops for quality improvement.

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

4.4.1. HIT tools to provide screening and clinical decision support (e.g., RIQI care management dashboards) to providers to help ensure they follow the evidence-based care pathways, inclusive of behavioral health and social determinants of health.

4.4.2. Define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care.

4.4.3. Provision of actionable information to providers within the system

4.4.3.1. Analysis of gaps, needs, risks based on evidence-based practice. Gaps in care reports based on deviations from evidence-based practice.

4.4.3.2. To help enhance and/or direct care coordination/care management. E.g., medication management.

4.4.4. Early warning system

Established methods to alert, engage the care management team to critical changes in utilization. Alerted before bearing the full burden of costs.

4.4.4.1. Employ a Care Management Dashboard (real time dashboard of patient-admissions and discharges to EDs and hospitals)

4.4.4.2. Employ Care Management Alerts (ADT notification via direct messaging of ED and hospital admissions and discharges)

4.5. Staff Development – Training

4.5.1. Training in, and expectation for, using data systems effectively, using data to manage patients care.

4.5.2. Ongoing aggregate reporting with individual/team drill-downs re: Conformance with accepted standards of care, deviations from best practice, identified breakdowns in process

5. Commitment to Population Health and System Transformation

Central to the AE model is progression to a systematic population health model that works to improve the health status of the entire attributed population while systematically segmenting subpopulation risk groups with complex needs in order to implement focused strategies to improve their health status; ensuring that the gap between subpopulation's health outcomes does not widen. An effective system recognizes interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and develops a road map to address social determinants of health (SDOH) based on recognized best practices locally and nationally. Along with clinical and claims data, the entity identifies population needs in collaboration with state and local agencies (for example, the HEZ) using publicly available data to develop a plan.

5.1. Key Population Health Elements

An applicant will describe its approach to population health management, including how their approach:

5.1.1. Is population-based
5.1.2. Is data-driven
5.1.3. Is evidence-based
5.1.4. Is person and family-centered: Provides strength based individual and family support and care plans that are reflective of member/family voice and preferences.
5.1.5. Recognizes and addresses SDOH. Creates programmatic interventions by sub-population.
5.1.6. Is team based and includes care management and care coordination, effective management of transitions of care, and collaboration with community health teams and community health workers as integral partners
5.1.7. Integrates BH and PH/primary care, including the identification of modifiable, non-modifiable risk factors for poor behavioral health outcomes.

5.2. Health Equity & Social Determinants of Health

5.2.1. An applicant will demonstrate that it recognizes and seeks methods to approach key social determinants of health. These can include social factors such as housing, food security, safety, transportation, and domestic violence.

5.2.2. An applicant will demonstrate that it has capacity to perform a Population Health and SDOH Assessment, including evaluating the social needs of its members and taking actions to maximize the degree that Attributed Members receive appropriate care and follow-up based on their identified social needs.

5.2.2.1. Develop, implement, and maintain procedures for completing an initial SDOH Care Needs Screening for Attributed Members based on a defined protocol. The protocol shall identify what triggers a screening and may be based on such factors as diagnosis, care utilization pattern or patient self-identification. Procedures shall address approach to completing an initial SDOH Care Needs Screening for persons with a primary care visit. AEs may collaborate with MCOs to support these activities.

5.2.2.2. The SDOH Care Needs Screening shall be an instrument defined by the AE and reviewed by EOHHS. The screening shall evaluate Attributed Members' health-related social needs in order to determine the need for social service intervention. Such services shall include but not be limited to:

- Housing insecurity;
- Food insecurity;
- Interpersonal violence; and
- Utility assistance;

Note: If SDOH screen is conducted during a telephone visit, e-visit or virtual check in or independent of a visit, providers may use their discretion whether to ask questions related to interpersonal violence. The interpersonal violence domain must, however, be included for screens administered during in-person visits.

5.2.2.3. Evaluate Attributed Members' SDOH screening needs through regular analysis of available claims, encounter, & clinical data on diagnoses and patterns of care, in partnership with participating MCOs;

5.2.2.4. Develop electronic reporting (electronic data exchange/QRS) or claiming mechanism through the use of diagnostic Z codes to allow social needs data to be systematically provided to MCOs/EOHHS.

5.2.3. Coordination with CBOs. Establish protocols with CBOs to ensure that attributed members receive supportive services to address indicated social needs, such as: warm-transfers, closed-looped referrals, navigation, case management, and/or care coordination for appropriate care and follow-up. May be done in direct coordination with MCOs.

5.2.3.1. Develop a standard protocol for referral for social needs using evidence and experience-based learning and for tracking referrals and follow-up. AEs may leverage the Unite Us tool procured by the state to satisfy this requirement. Social needs assistance shall include:

- Referring to providers, social service agencies, or other community-based organizations that address the Attributed Member's needs

- Providing support to maximize successful referrals, which may include:

    - Actions to maximize the outcome that the Member attends the referred appointment or activity, including activities such as coordinating transportation assistance. Attending appointment with members & following up after missed appointments;

    - The Attributed Member's PCP or care team member communicating and sharing records with the provider being referred to, as appropriate to coordinate care;

    - The Attributed Member's PCP or care team member directly introduces the Attributed Member to the service provider, if co-located, during a medical visit (i.e., a "warm hand-off");

    - Providing information and navigation to the Attributed Member regarding community providers of social services that address the Attributed Member's health-related social

needs, as appropriate;

- Providing the Attributed Member with information and counseling about available options; and

- Coordinating with community providers of social services to improve integration of care.

5.2.3.2. AE should have a documented plan for the tracking and reporting of referrals for social needs to MCO. The plan should include:
- Standardized protocol for referral to social service provider
- Methods for tracking referrals
- Development of metrics to define a successful referral
- Development and implementation of standards and reporting of metrics and referral information to MCO

AEs may leverage the Unite Us tool procured by the state to satisfy this requirement.

5.3. System Transformation and the Healthcare Workforce

In consideration of the essential role that AEs will play in RI's health system transformation, AEs will be expected to partner with EOHHS, DLT, URI, RI College, CCRI, and other education and training providers to support RI's workforce transformation efforts. Such efforts shall include, but not be limited to, the following activities:

5.3.1. Healthcare workforce transformation planning

5.3.1.1. Participate on EOHHS, DLT, or other committees as requested to provide ongoing assessment of healthcare workforce transformation needs and strategies.

5.3.1.2. Participate in periodic employer surveys of healthcare workforce development needs and opportunities

5.3.2. Healthcare workforce transformation programming

5.3.2.1. Collaborate with URI, RIC, CCRI and/or other education and training providers to assist in educational planning, curriculum development, instruction, clinical training, research, and/or other educational activities related to healthcare workforce transformation.

5.3.2.2. Develop partnerships with URI, RIC, CCRI and/or other education and training providers to expand clinical rotations and/or internships to prepare health professional students with knowledge and skills needed to achieve RI's health system transformation goals.

5.3.2.3. Develop partnerships with URI, RIC, CCRI and/or other education and training providers to expand continuing education for current employees of AE partners to acquire the knowledge and skills needed to achieve RI's health system transformation goals.

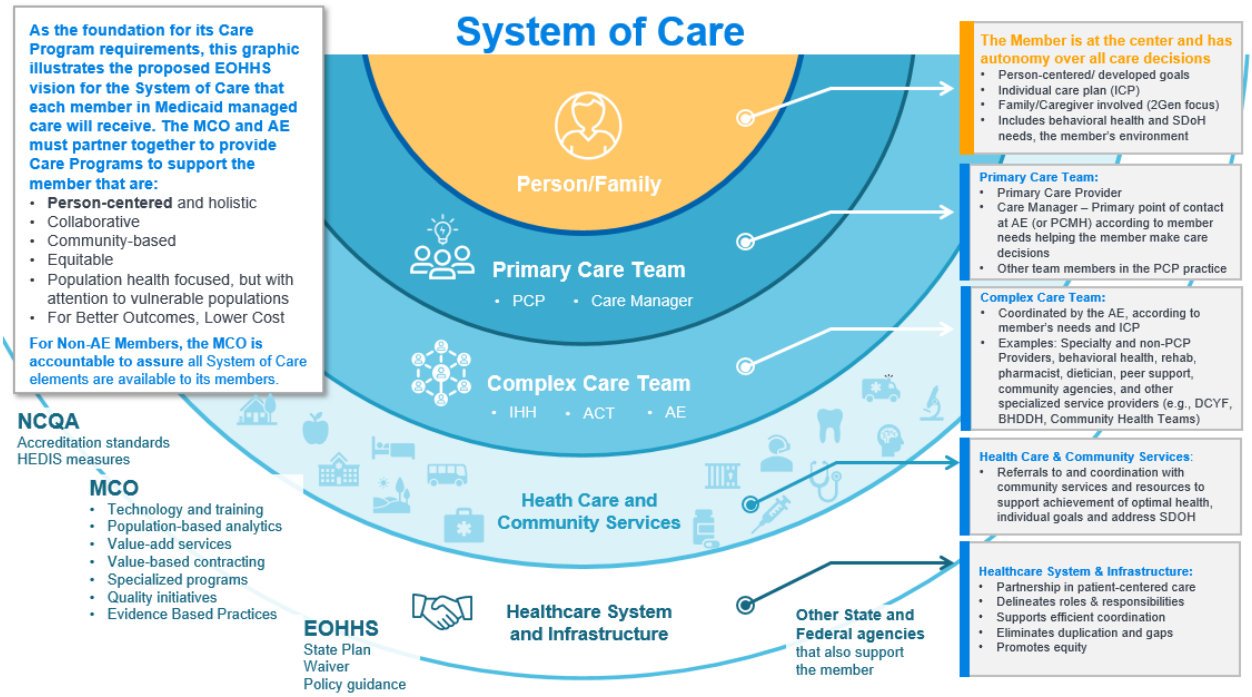
5.3.2.4. Develop partnerships with secondary schools, public workforce development agencies, and/or community-based organizations to

develop career pathways that prepare culturally and linguistically diverse students and adults for entry level jobs leading to career advancement in health-related employment.

6. Care Programs

EOHHS envisions a system of care in which the member (or family) is at the center of all care planning and has autonomy over all care decisions, meaning that members are active participants in the development of care plans and identification of care goals. This person-centered system is holistic and integrated, meaning that a person's health is viewed as inclusive of medical, behavioral health, and social needs. In this system of care, the primary care team is the closest to the member, and therefore acts as the primary point of contact for the member as they navigate their care. As members' needs grow in complexity, additional, tailored supports are provided as extensions of the primary care team, such as AE-deployed complex case management, Integrated Health Home (IHH) and Assertive Community Treatment (ACT) teams, or other specialized programming for particular sub-populations. In this system of care, the AE is envisioned as the primary source of referral, navigation, and coordination between primary care and other healthcare and community-based services within and outside of the AE's network. AEs are expected to coordinate closely with their contracted MCO partners to ensure that care management programming and system navigation for all attributed members are coordinated. The graphic below further depicts EOHHS' vision for a comprehensive, person/family centered system of care.

Figure 1: Rhode Island System of Care



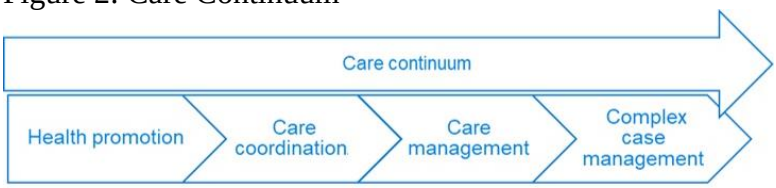
To achieve this vision in the context of the AE program, AEs must have the ability to manage and coordinate the care of their attributed populations in such a way that meets the unique needs of members, integrating medical, behavioral, and social care across a distribution of acuity and complexity. To meet the full range of needs, AEs must be able to offer a set of care programs that falls across a care continuum, as shown in figure 2 below.

It is EOHHS' expectation that the planning and implementation of these programs is done in close coordination with an AE's contracted MCO partners, to prevent duplication or fragmentation of care, to leverage the unique strengths of the AE and MCO respectively, and to ensure that whichever entity is providing the direct member care has the tools necessary to best serve the member and respond to their needs holistically.

Implementation of the array of care programs should feature multidisciplinary teams with specialized expertise pertinent to the characteristics of each targeted sub-population. It is expected that AEs formalize working partnerships with providers and institutions outside of the AE to enable coordination across care settings and to facilitate collaboration and information sharing with a focus on improved clinical outcomes and efficiencies.

A key feature of care programs for high and rising risk members is the Individualized Care Plan (ICP). The ICP must be developed with active member/family participation and reflect the results of a comprehensive assessment of care needs, including plans to mitigate impacts of social determinants of health. The ICP should reflect the patient's cultural background, language preferences, priorities and goals, ensures that the member is engaged in and understands the care he/she/they will receive, and includes empowerment strategies to achieve those goals.

Figure 2: Care Continuum



AE certification requirements in this section have been amended to align with this framework. Working definitions for each component along the care continuum have been developed to reflect national best practices:

- **Health Promotion** includes innovative and evidence-based educational resources, prevention and self-management tools, and information for members in formats that meet the needs of all members, promote self-care, and empower members. Health Promotion includes but is not limited to strategies for prevention, wellness care and immunizations, as well as general health promotion and prevention, and behavioral health rehabilitation and recovery. Health Promotion provides condition and disease-specific information and educational materials to members based on their individual condition or disease.
- **Care Coordination** is defined as the deliberate organization of member care activities between two or more participants (including the member) involved in a members' care to

facilitate the appropriate delivery of health care services. Care Coordination involves the marshaling of personnel and other resources needed to carry out all medically necessary member care activities and is often managed by the exchange of information among participants responsible for different aspects of care. Examples include help scheduling appointments, arranging transportation, and referrals to community services, programs, and resources. Care Coordination services should include connection with SDOH resources, utilizing a 2Gen approach where appropriate.

- **Care Management (CM)** is a team-based, person-centered approach designed to improve the health of members. CM is a set of activities tailored to meet a member's situational health-related needs according to their individual goals and as documented in the Individualized Care Plan (ICP). The member/family must be involved in the development of the ICP. Situational health needs can be defined as time-limited episodes of instability, such as following an acute medical event (e.g., heart attack, sepsis), surgery, or gaining self-care skills following a new diagnosis (e.g., diabetes). Care managers will facilitate access to services, both clinical and non-clinical, by connecting the member to resources that support him/her in playing an active role in the self-direction of his/her health care needs. CM activities also emphasize prevention, continuity of care, and coordination of care. Care activities are driven by quality-based outcomes such as: improved/maintained functional status; enhanced quality of life; increased member satisfaction; adherence to the care plan; improved member safety; and to the extent possible, increased member self-direction. "The goal of CM is to achieve an optimal level of wellness and improve coordination of care while providing cost-effective, non-duplicative services".
- **Complex Case Management (CCM)** means applying evidence-based care management services delivered to members with multiple or complex conditions to obtain access to care and services and coordination of their care. CCM is provided to highest risk members with complex conditions and to high-risk populations such as but not limited to children with complex medical needs and/or multiple ACEs (adverse childhood experiences), individuals with HIV/AIDS, mental illness, addiction issues or those recently discharged from correctional institutions. CCM functions, at a minimum, include a comprehensive initial assessment; delineation of available benefits and resources; development of an Individualized Care Plan (ICP) and prioritized goals, and monitoring and follow-up, and should address preventative care in addition to complex condition treatment. The member/family must be involved in the development of the ICP.

6.1. Care Program Design and Planning

6.1.1. AEs are encouraged to implement a Joint Operating Committee (JOC) management structure with each contracted MCO to facilitate coordination as care programs are planned and implemented

6.1.2. AEs are encouraged to demonstrate capacity to systematically utilize analytics and risk segmentation to identify/target individuals for health promotion care

coordination, and complex case management and must conduct these analytics and risk segmentation to identify/target individuals for care management. The analysis may include indicators such as poly-pharmacy, behavioral health diagnosis, limits to physical mobility, release from corrections, neighborhood stress index, depression, hospitalization, clinical indicators (e.g. diabetes), gaps in care, etc.

6.1.3. AEs must demonstrate that they educate and train providers across the full continuum of care regarding the continuum of care programming and provider expectations in the implementation of programs.

6.2. Health Promotion

AEs are encouraged to conduct the following health promotion efforts, either independently or jointly with contracted MCO(s):

6.2.1. Provide member educational health and wellness materials relevant to the AEs' attributed populations.

6.2.2. Conduct health fairs and events to engage with attributed members and/or the broader community to advance wellness and prevention

6.2.3. Create member lists (or receive member lists from MCO) to systematically engage in outreach and follow up activities

6.2.4. Educate and support members in accessing evidence-based programs and preventive services recommended by the US Preventive Services Task Force (USPSTF) that may be offered by the AE, MCO, RIDOH, or other community-based settings, such as, but not limited to:

6.2.4.1. Evidence-based preventive services for adults 35 to 70 diagnosed with prediabetes, such as the National Diabetes Prevention Program (DPP)[4] offered by RIDOH's Community Health Network (CHN) and other healthcare and community-based settings;

6.2.4.2. Evidence-based fall prevention exercise interventions/programs for adults living in the community over age 65 at risk for falls, such as "Matter of Balance, Managing Concerns about Falls"[5] (Boston University developed and tested), offered through CHN and other healthcare and community-based settings;

6.2.4.3. Evidence-based healthy diet and physical activity programs for adults with cardiovascular disease risk factors, such as the "Chronic Disease Self-Management Program"[6] (Stanford University developed and tested), offered through CHN and other healthcare and community-based settings.

[4] See Recommendation: Prediabetes and Type 2 Diabetes: Screening | United States Preventive Services Taskforce at https://uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes.
[5] See Recommendation: Falls Prevention in Community-Dwelling Older Adults: Interventions | United States Preventive Services Taskforce at https://uspreventiveservicestaskforce.org/uspstf/recommendation/falls-prevention-in-older-adults-interventions.
[6] See Recommendation: Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling Interventions | United States Preventive Services Taskforce at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd#citation10.

6.2.4.4. Evidence-based pediatric asthma control programs such as "Asthma: Home-Based Multi-Trigger, Multicomponent Environmental Interventions for Children and Adolescents with Asthma" recommended by the Community Preventive Task Force to improve asthma control.[7]

6.2.4.5. Other evidence-based prevention and health promotion programs that may be offered through CHN related to tobacco cessation, weight control, prenatal preventive care and perinatal supports, behavioral health, or chronic conditions including Alzheimer's, asthma, arthritis, cancer, COPD, and chronic pain.

6.3. Care Coordination

The AE must deploy the following care coordination activities, at a minimum, for members with chronic, acute, specialty, BH, and social needs

6.3.1. Systematically track and coordinate care across specialty care, facility- based care and community organizations

6.3.2. Rapidly identify and effectively respond to changes in a member's condition to activate care coordination or enrollment in care management/complex case management programming and help avoid use of unnecessary services, particularly emergency department visits or hospitalizations

The AE may also deploy the following care coordination activities as agreed to by the AE and MCO:

6.3.3. Exchange member lists (i.e., exchange between the AE and MCO) for transitions of care, chronic disease management, social determinants of health information, etc.

6.3.4. Administer prenatal risk assessment

6.3.5. Nutrition assessment, education, and counseling

6.3.6. Systematically identify members suitable for care coordination using member lists generated by internal analytics, MCO generated high risk lists, results from Health Risk Assessments and other screening tools, dashboards, and/or other tools

6.3.7. Support members in navigating care by scheduling appointments, arranging transportation, initiating, tracking, and following up on referrals (including referrals to community-based services), engaging in special programs, discharge and transitions of care planning, and providing health coaching

6.3.8. Coordinate communication and care between all providers and care coordinators/managers (within and outside of the AE) engaged in a member's care, particularly to support transitions of care, hospital discharge planning, integration of BH, chronic disease management, and addressing social determinants of health/ health-related social needs

6.4. Care Management

[7] See Asthma: School-Based Self-Management | The Community Guide at https://www.thecommunityguide.org/findings/asthma-school-based-self-management-interventions-children-and-adolescents-asthma.

6.4.1. **Core Care Management Capabilities:** AEs must deploy care management teams and offer care management services tailored to meet high and rising risk members' situational health-related needs.

Care management programming includes:

6.4.1.1. Application of evidence-based best practices
6.4.1.2. Demonstrated cultural and linguistic appropriateness
6.4.1.3. Systematic methods to identify, conduct outreach to, and enroll individuals at high risk for poor outcomes in care management
6.4.1.4. A transitions of care approach for individuals who are moving between healthcare settings, applying evidence-based best practices. Should include an approach to coordinate with hospitals on discharge planning and follow up

Care management programming *may* also include:

6.4.1.5. Collaboration with community and provider-based care coordinators/care managers to arrange, assure delivery of, monitor, and evaluate member care. This may include providers from multiple organizations with delineation of roles
6.4.1.6. Coordination with non-covered health/social service providers
6.4.1.7. Support in accessing and coordination with broad based services, including, but not limited to:
- Non-Emergency Medical Transportation (NEMT)
- DHS services (e.g., Office of Rehabilitative Services, Supplemental Nutrition Assistance Program)
- RIDOH programs (e.g., Community Health Network programs, Women, Infants, and Children services, Family Outreach, Lead program)
- RIte Smiles services

6.4.2. **Care Planning**: AEs must develop Individualized Care Plans (ICP) for all members in care management, with active involvement of the member/family in identifying care goals and interventions. The ICP shall be driven by the member's priorities, motivations, and goals, and ensure that the member is engaged in and understands the care they will receive. The ICP must be readily available to the member/family. The ICP must include the following:

6.4.2.1. A list of all entities and service providers involved in member's care, including contact information
6.4.2.2. Identification of a lead care manager by name and inclusive of contact information
6.4.2.3. Detail on how care will be coordinated between medical, behavioral health, and social support providers

6.4.2.4. Comprehensive assessment of care needs and gaps, such as: symptom severity, functional status, potentially avoidable hospital readmission strategies and improvement plan

6.4.2.5. Consideration of gaps in care, functional status, behavioral health and social service needs, managing transitions, increased patient medication adherence and use of medication therapy

6.4.2.6. Consideration of and, as appropriate, coordination with, an individual's caregiver/social support resources

6.4.2.7. Description of mitigation strategies for social determinants of health (e.g., housing security, food security, physical activity and nutrition, safety, safe environment; involvement with criminal justice/ parole, etc.)

6.4.2.8. Plan for engagement with CBOs and providers of social support services as part of the implementation of the care plan.

6.4.2.9. Description of plans for transitions of care (between settings, between youth/adult services)

6.4.2.10. Description of processes for working closely with members, family members and caregivers to ensure holistic approach to care, person/family centeredness.

6.4.2.11. Description of plan to leverage home-based services, tele-health, telephonic and web-based communications, group care, and of the plan to ensure provision of culturally and linguistically appropriate care.

6.4.3. **Staffing:** Care management staff must be able to provide care management for diverse populations and to render culturally and linguistically appropriate services. AEs shall have care management staff with specialized expertise and skills for work with distinct sub-populations and may also deploy non-licensed staff such as, but not limited to, community health workers and peer recovery specialists on the care management team:

6.4.3.1. Members (children and/or adults) requiring integration of BH care (including treatment for both mental illness and substance use disorder) and medical care

6.4.3.2. Members (children and/or adults) with chronic diseases who require medical management and/or coordination of transitions of care (e.g., among emergency department, hospital inpatient, skilled nursing facility, home, etc.)

6.4.3.3. Members (children and/or adults) requiring home and community-based services

6.4.3.4. Members (children and/or adults) requiring supportive social services

6.5. Complex Case Management

6.5.1. AEs are encouraged to provide or otherwise facilitate access to Complex Case Management services for the highest risk members with complex or multiple conditions and to high-risk populations, based on AEs' assessment of population risk and needs. The AE may facilitate access to Complex Case Management by working with contracted MCO(s) and/or IHH/ACT providers, for example, to

ensure that members identified by the AE as needing Complex Case Management are engaged with services offered by the MCO and/or IHH/ACT provider.

6.5.2. Even for AEs that do provide Complex Case Management directly, AEs may not have the capacity or specialized expertise to assume Complex Case Management functions for all specialized sub-populations. As such, the AE are encouraged to define the lead entity (e.g., MCO or IHH/ACT) for specific subpopulations and have clear protocols for referral, tracking, and shared management of care as appropriate. These sub-populations may include but are not limited to: children with complex medical needs and/or multiple ACEs (adverse childhood experiences); individuals with HIV/AIDS, mental illness, or SUD; individuals recently discharged from correctional institutions; individuals experiencing high risk pregnancies.

6.5.2.1. The AE and contracted MCO(s) must identify any sub-populations for which the AE is providing Complex Case Management.

6.5.2.2. For members enrolled in IHH/ACT, the coordinator for that program should be the lead care manager. The AE should establish formal agreements detailing protocols for shared care/case management, and the AE case manager should closely communicate and partner with the ACT or IHH team to wrap around the ACT/IHH services with additional support services.

6.5.3. Complex Case Management includes the core activities listed under care management (6.4.1)

6.5.4. Complex Case Management includes the care planning activities and standards listed under care management (6.4.2)

6.5.5. The AE must include BH staffing or contracts with BH providers to address the BH needs of members in CCM.

6.5.6. Community health workers may also serve as "extenders" of the licensed CCM case manager and may support the plan of care but may not serve as the primary case manager for members in CCM.

7. Member Engagement

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

Recognizing that many of these new technologies for health status monitoring and health promotion are not currently covered benefits, EOHHS anticipates that successful AEs will begin by promoting such products and encouraging their use and anticipates that infrastructure investments (including HSTP incentive funds) may be utilized to develop such capacities.

7.1. Defined Strategies to Maximize Effective Member Contact and Engagement

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

7.1.1. Communication approach that is culturally/linguistically appropriate and recognizes highly complex, multi-condition high-cost members. Recognizes that the roots of many problems are based in childhood trauma; that many of the highest need individuals have a basic mistrust of the health care system and may not have a primary existing affiliation with a PCP.

7.1.2. Identified population specific strategies, methods to actively develop a trusting relationship through evidence-based and patient-centered engagement methods.

7.1.2.1. Use culturally competent communication methods and materials with appropriate reading level and communication approaches. Tools are understandable, and culturally and linguistically appropriate.

7.1.2.2. Uses methods adapted to recognize that compliance with patient notification requirements is not the same as effective communication with members

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

7.2.1. Established capabilities to educate members/promote the use of technologies for member engagement and provision of care. This includes technologies that may not be covered by Medicaid but can support member engagement in care (e.g., online tools, apps, education resources) or management of health conditions (e.g., telemedicine, monitoring devices). AEs should coordinate with contracted MCO(s) to leverage currently available technologies.

7.2.1.1. Demonstrated use of Products that support monitoring and management of an individual's physiological status and mental health (e.g., vital sign monitors such as home blood pressure monitoring devices, activity/sleep monitors, mobile PERS with GPS)

7.2.1.2. Demonstrated use of Products that support monitoring and maintaining the functional status of vulnerable adults in their homes (Fall detection technologies, environmental sensors, video monitoring)

7.2.1.3. Technologies, products that support both informal and formal caregivers providing timely, effective assistance.

7.2.2. Established capabilities to leverage relevant, cost effective technologies including, but not limited to:

7.2.2.1. Social media applications to promote adherence to treatment

7.2.2.2. Use of technologies that enable vulnerable adults to stay socially connected (Social communication/PC mobile apps for remote caregivers, cognitive gaming & training, social contribution)

7.2.2.3. Demonstrated use of telemedicine and remote tele-monitoring

7.2.2.4. Patient Portals to enhance engagement, awareness, and self-management opportunities.

8. Quality Management

8.1. Quality Committee and Quality Program

The AE will maintain an ongoing Quality Committee that reports to the Governing Board or to the Governing Committee. The AE shall have a defined Quality Program with equity as integral component of the framework overseen by qualified healthcare professional responsible for the AE's quality assurance and improvement program. Members of the AE Quality Committee will minimally include an identified board-certified physician licensed in the State of Rhode Island who is an AE participating clinician, a behavioral health clinician at the independent practice level who is licensed in Rhode Island and who is an AE participating clinician, and an individual from a community-based service organization that provides key social supports to attributed members of the AE.

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

AE will develop defined methods and processes to advance the integration of medical, behavioral, and social supports through a health equity lens. Methods and processes to advance integration will be evidenced through executed Policies and Procedures and Operational Protocols. The AE will be able to identify how it will require AE participants and providers/suppliers to comply with and implement each process, including the remedial processes and penalties (including the potential for expulsion) applicable to AE participants and AE providers/suppliers for failure to comply with and implement the required process; and explain how it will employ its internal assessments of cost and quality of care to continuously improve-the AE's care practices

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

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

8.4. Quality Performance Measures

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

In accordance with 42 CFR §438.6(c)(2)(ii)(B) [8], AE quality performance must be measured and reported to EOHHS using the Medicaid Comprehensive AE Common Measure Slate. These measures shall be used to inform the distribution of any shared savings.

[8] https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438_16&rgn=div8

For QPY4, MCOs are responsible for reporting performance on all AE Common Measure Slate measures to EOHHS. All Admin measures must be generated and reported by the MCO. AEs and MCOs must work together to establish clinical data exchange capabilities via the State's Quality Reporting System