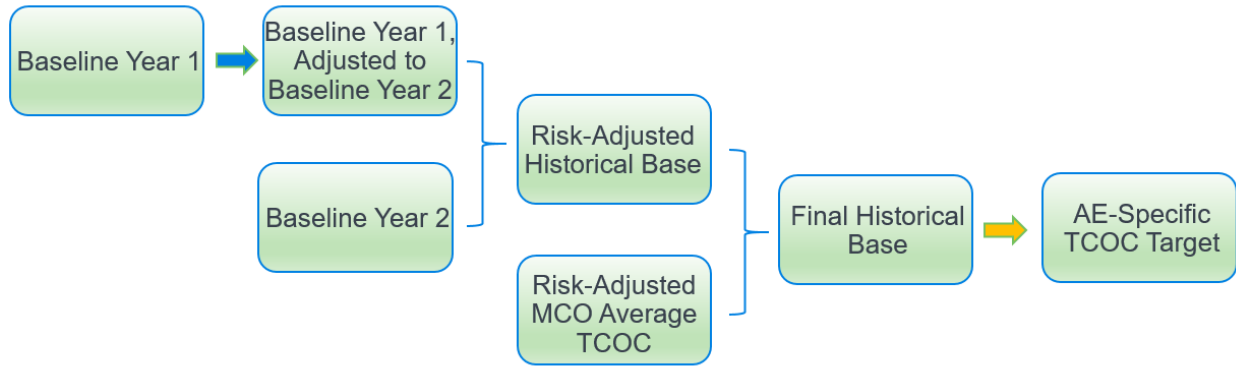




**RHODE ISLAND ACCOUNTABLE ENTITY PROGRAM
TOTAL COST OF CARE TECHNICAL GUIDANCE**

Program Year 5

Program Year 5: Total Cost of Care Technical Guidance

The process for determining the TCOC Expenditure Target involves a series of adjustments. These adjustments are illustrated at a high level in the figure below. The adjustments are described in detail in Sections 1 through 3.



-  Adjustments for trend, risk adjustment, and rate cell mix changes from Baseline Year 1 to Baseline Year 2
-  Adjustments for trend, risk adjustment, and rate cell mix changes from Baseline Year 2 to Performance Period

1. Calculate Historical Base

a. AE-Specific Historical Cost Data

The TCOC Historical Base will generally include two years of AE-specific historical cost data. Claims and enrollment in each year will be limited to members attributed to the AE in the final month of the member's enrollment in that year (see Attachment M for further attribution guidance). The AE's provider roster as of March 31 of the year preceding the start of the Performance Year should be used when determining claims and enrollment in the Baseline Years. The Baseline Years will be aligned with the baseline years used to calculate MCO capitation rates for the state fiscal year that covers the same period as the Performance Year. For example, the baseline years used to calculate MCO capitation rates for state fiscal year 2022 were the Baseline Years used to calculate the TCOC Historical Base for Program Year 4.

In most cases, the Baseline Years will be:

- I. **Baseline Year 1:** 12-month period ending 2 years before the start of the performance period.
- II. **Baseline Year 2:** 12-month period ending 1 year before the start of the performance period.

However, in cases where EOHHS uses a different time period for MCO capitation rate-setting, this may differ. For example, to avoid including months affected by the COVID-19 pandemic in MCO rate-setting for SFY 2023, EOHHS used a single baseline year of CY 2019.

Claims will be excluded if they were paid more than 6 months after the end of the

Baseline Year in which they were incurred. No adjustments will be made for claims incurred but not paid (IBNP).

Member months will include all months during the year for attributed members in which a capitation payment was made to the MCO. If the MCO-AE contract does not have at least an average of 2,000 members attributed during each of the historical Baseline Years (i.e. 24,000 member months in each year), EOHHS will evaluate whether the MCO-AE contract will be eligible for shared savings/(losses) in the Performance Period and may prescribe an alternative TCOC methodology. If the MCO-AE contract does meet the minimum attributed membership in the historical base period, the MCO-AE contract will still be eligible for shared savings/(losses) even if the average attributed members fall below 2,000 in the Performance Period.

b. Covered Services

The TCOC expenditures in the Historical Base and Performance Period will include all costs associated with covered services that are included in EOHHS's contract with MCOs for the Performance Period. This does include maternity delivery services, which are capitated through kick payments rather than per member capitation. At the conclusion of the performance year, AE TCOC targets will be adjusted to account for changes in the statewide number of maternity events that occurred between the Baseline Years and the Performance Period. Additionally, the risk adjustment mechanism (described later) will account for differences in rates of maternity events between AEs and MCOs.

The service cost will be measured using fee-for-service claims paid by the MCO and encounter expenditures for sub-capitated vendors contracted by the MCO. Payment amounts associated with sub-capitated vendor encounters will be consistent with the amounts included on the encounters sent to EOHHS. The following items will be explicitly excluded from the covered services definition:

- i. Expenditures for services paid outside the MCO fee-for-service payment system or sub-capitated vendor claims payment system (e.g. offline payments or other services invoiced).
- ii. Payment for non-claims-based case management programs.
- iii. Services covered under stop-loss provisions between EOHHS and the MCO in the Performance Period, as specified in the EOHHS/MCO Contract for Medicaid Managed Care Services.
- iv. Health System Transformation Project (HSTP) performance incentive payments and Care Transformation Collaborative (CTC) payments.
- v. Value-added services provided by the MCO.
- vi. Recoveries made outside the MCO or sub-capitated vendor claims payment system, such as reinsurance, pharmacy rebates, or pay-and-chase third party liability recoveries.
- vii. Amounts attributable to pharmacy benefit manager (PBM) administrative spread, i.e. the difference between the amount paid by the MCO to the PBM and the amount paid by the PBM to the pharmacy. To the extent that an MCO is unable to utilize the amount paid to the pharmacy, an adjustment will be

made as described in section 1.f.

- viii. Services included in the managed care program in the Baseline Years that are not covered under the MCO contract in the Performance Period.

The MCOs will report expenditures for the above services excluded from the TCOC calculation for the Baseline Years and Performance Period for review by EOHHS for reasonableness and to determine whether an adjustment is required for these services as described in section 1.f below.

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

The TCOC expenditures in the Historical Base and Performance Period will be adjusted to exclude costs in excess of a defined threshold for an individual member in a single year. The threshold is applied after removal of covered services described above, but prior to any other adjustments, such as risk adjustment and trend. In the event a member is included in more than one rate cell during the Historical Base or Performance Period, the claims threshold will be applied separately to each rate cell. This threshold will not be pro-rated for members with less than 12 months of enrollment in a given year. The threshold will be \$100,000 for SFY 2018 and will be indexed in future years to reflect trends, program and policy changes, and managed care efficiency adjustments. The thresholds for SFY 2018-SFY2022 are shown below. The thresholds for SFY 2023 and subsequent years will be provided prior to the start of each year.

- SFY 2018: \$100,000
- SFY 2019: \$104,800
- SFY 2020: \$109,800
- SFY 2021: \$113,500
- SFY 2022: \$119,600

After this adjustment, the TCOC expenditures in each rate cell and year will be divided by applicable member months in the same year to arrive at a TCOC Per Member Per Month (PMPM) Expenditures.

d. Adjust for Trend Assumptions

Baseline Year 1 will also be adjusted to account for trends, program and policy changes, and managed care efficiency adjustments, consistent with the development of the medical component of capitation rates being paid to MCOs by EOHHS. These adjustments will align generally with the cumulative adjustments made to Baseline Year 1 in the medical portion of capitation rates by rate cell. As needed, EOHHS will modify these adjustments to reflect only services included in TCOC expenditures; therefore, the adjustment factors by rate cell may differ from the values included in the capitation rate certification. The adjustments will be applied separately by rate cell.

e. Adjust for a Changing Risk Profile

To account for changes in the risk profile of an AE's attributed patient population over the two years in the Historical Base, a risk adjustment methodology will be applied. This adjustment is intended to make the TCOC PMPM expenditures in Baseline Year 1 more comparable to Baseline Year 2; therefore, the adjustment will be applied to Baseline Year 1 only. A separate risk adjustment, described later in this document, will be applied to the entire Historical Base to reflect changes in risk profile from Baseline Year 2 to the Performance Period.

Risk adjustment will be applied separately to each rate cell, accounting for changes in the average risk score in that rate cell between Baseline Year 1 and Baseline Year 2. For instance, if the average risk score for attributed members in the Medicaid Expansion Females 19-24 rate cell is 1.100 in Baseline Year 1 and 1.200 in Baseline Year 2, the TCOC PMPM Expenditures in Baseline Year 1 will be multiplied by a factor of $(1.200 / 1.100) = 1.091$. After this risk adjustment factor is applied, the Historical Base TCOC by rate cell will be aggregated using the mix of rate cells for attributed members in Baseline Year 2.

Encounter data will be used for the development of average risk scores by rate cell. A concurrent risk adjustment algorithm will be used, meaning that the time period used to collect diagnosis codes and/or prescription drug claims will align with the time period being risk-adjusted. The risk adjustment software for this adjustment will be determined by EOHHS at the start of each Performance Period. The same software and version will be used in both Baseline Years and the Performance Period.

Within each program year, risk scores will be normalized in each Baseline Year and Performance Period such that the average statewide risk score (including all MCOs) in each rate cell remains constant over time. Risk scores may be recalibrated before calculating Baseline Year and Performance Period risk scores in the following program year.

f. Special adjustments for changes in payment mechanisms or reporting

EOHHS reserves the right to make an additional adjustment to account for changes in MCO payment mechanisms or expenditure reporting between the Baseline Years and Performance Period. EOHHS will review the expenditures excluded from the TCOC calculation, as outlined in section 1.b, to ensure consistent treatment in the Baseline Years and Performance Year. The need for an adjustment will be considered on a case-by-case basis, and if determined to be necessary, will be developed by EOHHS.

Examples of situations that may require this adjustment include:

- i. A change in services covered by sub-capitation arrangements materially impacts the reporting of those services.
- ii. A material amount of offline or lump sum payments were made in the Baseline Years and not the Performance Period, or vice versa.
- iii. A change in reporting of recoveries outside of the claims payment system impacts the reported expenditures in the Baseline Years or Performance Years.
- iv. The MCO is unable to remove PBM administrative spread from the experience at the member level.

- v. Claims completion after six months of run-out is estimated to vary significantly between the Baseline Years and Performance Period in a manner that materially impacts the TCOC target and/or savings calculations.

g. Blend Baseline Years

After applying the trend adjustment and risk adjustment to Baseline Year 1, the TCOC PMPM Expenditures for both Baseline Years will be combined to arrive at the Risk-Adjusted Historical Base. The Baseline Years will be weighted consistently with the MCO rate setting for the State Fiscal Year aligning with the Performance Period.

2. Adjust Historical Base Relative to Market Average

In order to prospectively establish an AE’s TCOC Expenditure Target, an additional adjustment will be made to the Historical Base to reflect the AE’s historical experience relative to peers. This adjustment is required because AEs that have already achieved high levels of efficiency will have difficulty continuously achieving trends below the market rate. However, these AEs provide value to the MCOs by maintaining low expenditures relative to the market.

This adjustment will be determined by comparing the AE’s Risk-Adjusted Historical Base to the Risk-Adjusted Historical Base for all members across the MCOs participating in the AE program. This includes members attributed to other providers who are not included in any AE. The Risk-Adjusted Historical Base for all of the participating MCOs’ members will be calculated using the same methodology as the AE’s Risk-Adjusted Historical Base.

The adjustment will be a multiplicative factor applied to all rate cells in the Historical Base. The factor will be calculated as follows:

- a. Calculate Risk-Adjusted Historical Base for the AE.
- b. Calculate Risk-Adjusted Historical Base for all members across the MCOs participating in the AE program.
- c. For each rate cell, adjust the result of (b) by a factor equal to the average Baseline Year 2 risk score for the AE’s members divided by the average Baseline Year 2 risk score for all members across the MCOs participating in the AE program. This is intended to normalize the statewide average costs in each rate cell to be comparable to the AE’s attributed members.
- d. Aggregate the result of (c) by using the AE’s mix of members by rate cell in Baseline Year 2. This is intended to normalize the statewide aggregate risk-adjusted costs to be comparable to the AE’s attributed member mix.
- e. Subtract the result of (a) from the result of (d). If this difference is positive, multiply by the Below Market Weight. If this difference is negative, multiply by the Above Market Weight. These weights will vary by Program Year, as shown in the table below.

Program Year	Below Market Weight	Above Market Weight
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3	10%	0%
4	20%	10%
5	30%	15%

- f. Divide the result of (e) by the Risk-Adjusted Historical Base for the AE (a) and add 1.00. This results in a factor that will be applied to the AE’s Historical Base.

Applying this multiplicative factor to the all rate cells in the Risk-Adjusted Historical Base will result in the Final Historical Base.

3. Calculate TCOC Expenditure Target for the Performance Period

Once the Final Historical Base is established, this base will be trended forward into the performance period to create an AE-specific TCOC Expenditure Target.

a. Historical Base with Required Trend Assumptions

The Final Historical Base will be adjusted to account for trends, program and policy changes, and managed care efficiency adjustments, consistent with the development of the medical component of capitation rates being paid to MCOs by EOHHS. These adjustments will align generally with the cumulative adjustments to the medical portion of capitation rates by rate cell. As needed, EOHHS will modify these adjustments to reflect only services included in TCOC expenditures; therefore, the adjustment factors by rate cell may differ from the values included in the capitation rate certification. Consistent with Section 1.f, EOHHS may also make special adjustments for payment mechanisms or reporting between the Historical Base and the Performance Period.

The adjustments will be applied to the AE separately by rate cell. Prior to the start of the Performance Period, a Preliminary AE-specific TCOC Expenditure Target will be established using the AE’s mix of rate cells in Baseline Year 2. The Final AE-specific TCOC Expenditure Target will be adjusted for changes in risk profile and rate cell mix between Baseline Year 2 and the Performance Period, as described below. As needed, EOHHS will also adjust the prospective adjustments for trends, program and policy changes, and managed care efficiency adjustments for any capitation rate amendments made after the Preliminary AE-specific TCOC Expenditure Target was established.

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

A risk adjustment methodology will be applied to account for changes in the risk profile of an AE’s attributed patient from Baseline Year 2 to the Performance Period. The methodology will be consistent with the risk adjustment methodology used in developing the adjusted historical base as described in Section 1.e of this document. Risk adjustment will be applied separately to each rate cell, accounting for changes in the average risk score in that rate cell between Baseline Year 2 and the Performance Period. For instance, if the average risk score for attributed members in the Medicaid Expansion Females 19-24 rate cell is 1.200 in Baseline Year 2 and 1.300 in the Performance Period, the TCOC expenditures in the Historical Base will be multiplied by a factor of $(1.300 / 1.200) = 1.083$. After this risk adjustment factor is applied, the Historical Base TCOC by rate cell will be aggregated using the mix of rate cells for

attributed members in the Performance Period. The result of this step is the Final AE-specific TCOC Expenditure Target.

EOHHS reserves the right to modify the Final AE-specific TCOC Expenditure Target after the Performance Period for extraordinary and unforeseen circumstances. For instance, if MCO reimbursement for non-AE providers materially changes, it may have unintended consequences on the TCOC Expenditure Target.

4. Calculate Actual Expenditures for the Performance Period

a. Calculate Actual Expenditures Consistent with the Historical Base Methodology

The TCOC methodology will be based on a Performance Period of 12 months aligned with the State Fiscal Year. Actual Expenditures for the Performance Period will be calculated consistent with the Historical Base methodology as described in Sections 1.b and 1.c of this document. Claims will be excluded if they were paid more than 6 months after the end of the Performance Period.

5. Calculate Shared Savings/(Loss) Pool

The Shared Savings/(Loss) Pool will be calculated as the difference between Actual Expenditures (Section 4) and Final AE-specific TCOC Expenditure Target (Section 3), after the following adjustments:

a. Minimum Savings Rate (One-Sided Model Only)

EOHHS requires a minimum savings rate (MSR) to limit the potential for Shared Savings payments related to cost reductions generated strictly due to the effect of random variation in utilization and spending in small populations. If the AE is in a “one-sided” model (described in Section 6), the Shared Savings Pool will be \$0 if the difference between Actual Expenditures and TCOC Expenditure Target does not exceed the MSR. There is no MSR or minimum loss rate (MLR) for AEs participating in a “two-sided” model.

The MSR levels are calculated as a percentage of the TCOC Expenditure Target. The percentage varies based on the average number of attributed members in the Performance Period, as shown in the table below. The MSR for the AE will be determined by interpolating between the upper and lower bounds for the range based on the AE’s number of attributed members. This table and methodology for “one-sided” models is consistent with the Medicare Shared Savings Program (MSSP)¹, with the exception that AEs with fewer than 5,000 members will have a 4.0% MSR.

Minimum Savings Rate by AE Size

Average Attributed Members, Performance Period		Minimum Savings Rate	
Low End	High End	Low End	High End
0	4,999	4.0%	4.0%
5,000	5,999	3.9%	3.6%
6,000	6,999	3.6%	3.4%

¹ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V7.pdf>, page 35

7,000	7,999	3.4%	3.2%
8,000	8,999	3.2%	3.1%
9,000	9,999	3.1%	3.0%
10,000	14,999	3.0%	2.7%
15,000	19,999	2.7%	2.5%
20,000	49,999	2.5%	2.2%
50,000	59,999	2.2%	2.0%
60,000	Max	2.0%	2.0%

b. Impact of Quality and Outcomes

In cases where there are shared savings – that is, the Shared Savings Pool is positive after the application of the MSR/MLR – the Pool will be adjusted based on an assessment of performance relative to a set of quality measures for the attributed population. An Overall Quality Score will be generated for each AE, according to the methodology detailed in *Attachment J – Accountable Entity Total Cost of Care Requirements Attachment A: Quality Framework and Methodology for Comprehensive Accountable Entities*. In cases where the Shared Savings Pool is positive, the total Shared Savings Pool (inclusive of both the AE and MCO portions) will be multiplied by the Overall Quality Score. The Overall Quality Score must function as a multiplier, and may not include a gate; as such, any quality points earned must be associated with a share of the Shared Savings Pool.

The Shared Loss Pool shall also be adjusted based on the Overall Quality Score generated for each AE according to the methodology detailed in *Attachment A: Quality Framework and Methodology for Comprehensive Accountable Entities*. The Overall Quality Score will be divided by 4 and multiplied by the total Shared Loss Pool. The resulting product will be subtracted from the total Shared Loss Pool. For example, if the Overall Quality Score is 0.88, the multiplier will be 0.22. A Shared Loss Pool of \$100,000 would be multiplied by 0.22, yielding \$22,000, and the shared loss pool of \$100,000 would be reduced by \$22,000, yielding a final Shared Loss Pool of \$78,000.

c. Risk Exposure Cap

In instances where the AE is responsible for downside risk, a Risk Exposure Cap may be established. The Risk Exposure Cap cannot be lower than specified minimum thresholds. The Risk Exposure cap can be expressed as a percentage of the AE-specific TCOC Expenditure Target² or as a percentage of the AE’s revenue.³

² The percentage of total cost of care is calculated based on the Final TCOC Target established by EOHHS as part of the final Program Year TCOC reporting. See Section 3 above for details on how the Final TCOC Target is established.

³ Revenue of AE providers from the insurer under the contract refers to revenue paid by the insurer (MCO) to any Tax Identification Number that the AE identifies as participating in the AE. This is not limited to primary care practices or providers through whom Medicaid members are attributed to the AE,

Savings or losses that exceed 10% in any program year will trigger a review by EOHHS to determine if all Performance Period TCOC and target TCOC calculations are accurate. If the risk exposure cap is greater than or equal to 10%, the AE must present an actuarial analysis that estimates maximum potential loss. The actuarial analysis must be performed by an independent actuary and the results of the analysis be provided in a letter signed by the responsible actuary. This analysis will be used to substantiate the risk mitigation plan proposed by the AE. EOHHS reserves the right to revise any errors and adjust for unforeseen programmatic or data issues that may be contributing to overstated losses or savings.

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

In Program Year 5, AEs who assumed downside risk in Program Year 4 must be eligible to retain at least 60% of the Shared Savings Pool and must be responsible for at least 40% of any Shared Loss Pool. AEs new to downside risk in Program Year 5 must be eligible to retain at least 60% of the Shared Savings Pool and must be responsible for at least 30% of any Shared Loss Pool. AEs in shared savings-only models must be eligible to retain up to 50% of the Shared Savings Pool. The Shared Savings Pool is defined above in Section 5.

AE Shared Savings Model	AE Share of Savings	AE Share of Losses
Shared savings only	Up to 50% of Shared Savings Pool	N/A
Shared savings and risk: AEs that assumed downside risk in PY4	At least 60% of Shared Savings Pool	At least 40% of Shared Loss Pool
Shared savings and risk: AEs that did not assume downside risk in PY4	At least 60% of Shared Savings Pool	At least 30% of Shared Loss Pool

7. Required Progression to Risk Based Arrangements

a. AEs qualified to assume downside risk

Certified AEs qualified to assume downside risk must demonstrate a progression of risk to include meaningful downside shared risk within three years of AE program participation, however PY3 will not be counted towards these three years due to the COVID-19 emergency. FQHC-based AEs new to downside risk in PY5 will assume risk consistent with the Year 4 standards below even if they are in their fifth year in the program. After development and implementation funding ends, AEs will be sustained 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

but rather refers to all providers that have signed AE participation agreements for the Program Year in question. The revenue for these providers is all revenue for services rendered to any Medicaid patient covered by the insurer and is not limited to members attributed to the AE. This does not include revenue for services rendered to patients covered by the Medicare-Medicaid Plan or any non-Medicaid product offered by the same insurer.

Health Insurance Commissioner (OHIC) requirements and rules under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The required progression of increasing risk for AEs qualified to assume downside risk is as follows:

	Shared Savings Cap <i>Maximum Shared Savings Pool</i>	Risk Exposure Cap <i>Maximum Shared Loss Pool</i>	Risk Sharing Rate <i>AE Share of Losses</i>
<i>Definition</i>	<i>A cap on the Shared Savings Pool, expressed as a percentage of the total cost of care</i>	<i>A cap on the Shared Loss Pool, expressed as a percentage of a) the total cost of care, or b) the annual provider revenue from the insurer under the contract</i>	<i>The percentage of the Shared Loss Pool shared by the provider with the insurer under the contract after the application of the risk exposure cap</i>
Year 1	At least 10% of TCOC	N/A	0
Year 2	At least 10% of TCOC	N/A	0
Year 3	At least 10% of TCOC	N/A	0
Year 4/ AEs taking downside risk for the first time	At least 10% of TCOC	At least the lesser of 1% of TCOC; or 3% of AE Revenue	At least 30%
Year 5	At least 10% of TCOC	At least the lesser of 2% of TCOC; or 6% of AE Revenue	At least 40%
Year 6	At least 10% of TCOC	At least the lesser of 2% of TCOC; or 6% of AE Revenue	At least 40%

Additionally, AEs that agree to bear downside risk under Program Year 5 TCOC contracts must be pre-qualified by OHIC to ensure that an AE has a risk mitigation plan sufficient to cover its maximum possible loss under such a contract. AEs that completed the TCOC Financial Solvency Filing process for PY4 are considered pre-qualified by OHIC for PY5. All AEs that agree to bear downside risk under PY5 TCOC contracts must complete the PY5 TCOC Financial Solvency Filing process. Details of OHIC’s pre-qualification process for risk-bearing provider organizations is found in *Attachment B: Pre-Qualification of and TCOC Financial Solvency Filing for Accountable Entities Bearing Financial Risk*.

b. FQHC-based AEs and downside risk

The Medicaid prospective payment system (PPS) established a methodology assuring FQHCs a minimum per visit reimbursement rate when providing care to Medicaid beneficiaries. States also have the option of using an alternative payment methodology (APM) so long as the medical payment rate is not lower than what would be paid under PPS. In Rhode Island, FQHCs are paid pursuant to an APM. EOHHS believes that FQHC-based AEs in Rhode Island can choose to engage in contracts with a level of risk pursuant to these requirements while remaining compliant with Federal rules.

An FQHC-based AE that enters into a downside risk contract would be subject to the same requirements as other AEs taking on downside risk with respect to the Shared Saving Cap and the process described in *Attachment J: Accountable Entity Total Cost of Care Requirements: Attachment B: Pre-Qualification of and TCOC Financial Solvency Filing for Accountable Entities Bearing Financial Risk*. However, FQHCs who take risk for the first time in PY5 will be subject to the Risk Exposure Cap and minimum Risk Sharing Rate that applied to other AEs in PY4. As noted above, this means a Risk Exposure Cap of 1% of TCOC or 3% of AE revenue, and a minimum Risk Sharing Rate of 30%.

c. AEs not assuming downside risk

FQHC-based AEs are not required to take on the downside risk option described above. FQHC-based AEs may remain in shared savings-only contracts if they progress from volume to value as demonstrated by participation in an EOHHS-approved project designed to generate healthcare cost savings.

For details on this option, see Attachment K, Infrastructure Incentive Program: Requirements for Managed Care Organizations and Certified Accountable Entities.

Division of responsibilities between MCOs and EOHHS

MCOs are required to provide a copy of their proposed “base” AE TCOC contract (i.e., the template total cost of care contract with terms that will apply to all AEs) to EOHHS by the last business day of March for the program year beginning the following July. For example, PY5 base contracts are due to EOHHS by March 31, 2022. EOHHS will review and identify any corrections needed to comply with program requirements, following which MCOs will submit a final base contract.

Following the contracting process with the AEs, MCOs are required to submit copies of the executed contracts to EOHHS. Executed contracts are due on the first business day of August each year.

The calculations to determine shared savings/(losses) will be a collaborative effort between EOHHS and the MCOs. Below, please find a summary of MCO and EOHHS responsibilities for determining shared savings/(losses), including target dates for completion.

MCO Responsibilities:

- Three months before the start of the performance period, MCOs shall submit to EOHHS AE-specific historical cost data by rate cell for each baseline year. MCOs shall also submit data on TCOC PMPM expenditures for all MCO members, to support application of the market adjustment. These tasks are described in 1.a-c and 2.a above.
- Eight months after the end of the Performance Period, MCOs shall calculate actual TCOC by rate cell. This task is described in 4.a. above.
- Eight months after the end of the performance Period, MCOs shall determine the impact

of quality on any Shared Savings Pool or Shared Loss Pool. This task is described in 5.b above.

- On an ongoing basis, MCOs shall ensure AEs follow the required progression to risk-based arrangements. This task is described in 7.a above.

EOHHS Responsibilities

- One month before the start of the performance period, EOHHS will use the historical cost data from MCOs to calculate Preliminary TCOC Targets for the Performance Period, by adjusting for trend assumptions, changing risk profile, blending baseline years, and making the market adjustment. These tasks are described in 1.d-g and 3.a above.
- Ten months after the end of the Performance Period, EOHHS will:
 - Calculate Final TCOC Targets, including risk adjustment and any changes necessary due to extraordinary and unforeseen circumstances. This task is described in 3.b above.
 - Apply the Minimum Savings Rate. This task is described in 5.a above.
 - Apply the Risk Exposure Cap. This task is described in 5.c above.
 - Determine AE share of Shared Savings/(Loss) Pool. This task is described in 6.a above.

In addition to the above steps to determine shared savings/(losses), MCOs and EOHHS will collaborate to provide quarterly updates to each AE on its Performance Period TCOC expenditures. These quarterly updates are intended to provide AEs with information about emerging experience that they can use to track performance and assess any material deviations from expectations. It is not expected that quarterly updates can be used to project full year results with a high degree of precision.

MCOs will provide to EOHHS actual TCOC by rate cell on the following schedule:

Report	Due Date
TCOC Quarterly Report covering claims incurred July 2022 through September 2022 and paid through December 31, 2022	January 31, 2023
TCOC Quarterly Report covering claims incurred July 2022 through December 2022 and paid through March 31, 2023	April 30, 2023
TCOC Quarterly Report covering claims incurred July 2022 through March 2023 and paid through June 30, 2023	July 31, 2023
TCOC Quarterly Report covering claims incurred July 2022 through June 2023 and paid through September 30, 2023	October 31, 2023
TCOC Final Report covering claims incurred July 2022 through June 2023 and paid through December 31, 2023	February 28, 2024

EOHHS will adjust quarterly data for rate cell mix and PBM spread and provide MCOs with a TCOC Quarterly Report for each AE. EOHHS reserves the right to include other adjustments as part of quarterly reports as necessary based on program changes or emerging issues. However, currently EOHHS does not anticipate including a risk adjustment in quarterly reports.