

**Rhode Island Executive Office of Health and Human Services
Transitioning to Alternative Payment Methodologies:
Requirements for Medicaid Managed Care Partners**

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Rhode Island Comprehensive Demonstration
Demonstration Approval Period: January 1, 2019 through December 31, 2023

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1. EOHHS Requirements for Transitioning to Alternative Payment Methodologies

1.1. Background and Purpose of This Document

The purpose of this document is to set forth the requirements for managed care organizations contracted with EOHHS as Medicaid Managed Care Organizations (MCOs). Executed agreements with MCOs include contractual terms setting targets for payments to providers that are to be made utilizing an EOHHS approved Alternative Payment Methodology (APM). EOHHS approved Alternative Payment methodologies that MCOs may pursue to achieve compliance with the targeted requirements are identified in Section 2.1 of this document.

The primary pathway for MCO compliance for Medicaid-only community-based beneficiaries is through Alternative Payment Methodology #1, **Total cost of care (TCOC) models with EOHHS-certified Comprehensive Accountable Entities (AEs)**. The Accountable Entity program is a core component of Governor Raimondo's Reinventing Medicaid initiative and of the CMS approved Health System Transformation Program (HSTP).

In October 2016, through an amendment to the 1115 waiver, Rhode Island reached an agreement with Centers for Medicare & Medicaid Services (CMS) providing substantial regulatory and financial support for EOHHS' Health System Transformation Program. HSTP incentive funds for certified AEs are a core component of this program.

This document provides further specification as to requirements for Alternative Payment Methodologies including:

- MCO Contract Requirements: Alternative Payment Methodologies
- EOHHS Approved Alternative Payment Methodology
- Specifications for Total Cost of Care (TCOC) Arrangements
 - Additional APM Specifications
- EOHHS Certified Accountable Entities
- Contracting with EOHHS Approved, Rhode Island Office of the Health Insurance Commissioner (OHIC) Recognized PCMHs

The primary text of this document provides an overview of the program requirements. The attachments contain considerable technical detail as to EOHHS program requirements and constitute essential components of this requirements document.

Transformation to a value-based health care delivery system is a fundamental policy goal for the State of Rhode Island. This is an iterative process and EOHHS reserves the right to periodically modify these Requirements as it deems appropriate.

1.2. Reinventing Medicaid and Alternative Payment Methodologies (APMs)

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In March 2015 Governor Gina Raimondo issued Executive Order 15-08, establishing the “Working Group to Reinvent Medicaid” to provide recommendations for a restructuring of the Medicaid program. The Governor charged the Working Group to Reinvent Medicaid to:

- Submit a report on or about April 30, 2015, of its findings and recommendations for consideration in the Fiscal Year 2016 budget
- Submit recommendations, no later than July 1, 2015, for a plan for a multi-year transformation of the Medicaid program and all state publicly financed health care in Rhode Island.

The Reinventing Medicaid Act of 2015 set into law the fundamental recommendations of the Working Group¹. The final report of the Working Group was issued on July 8, 2015, and its Executive Summary (excerpted below) highlights its findings:

Working with partners from the health care sector, the advocacy community, the business community at large, and the Executive Office of Health and Human Services, we now lay out a model for a reinvented publicly financed health care system in Rhode Island based on the following principles:

1. *Pay for value, not for volume*
2. *Coordinate physical, behavioral, and long-term health care*
3. *Rebalance the delivery system away from high-cost settings*
4. *Promote efficiency, transparency, and flexibility*

From these principles, we derive ten goals for Rhode Island’s Medicaid program:

- *Goal 1: Substantially transition away from fee-for-service models to a system where members get their care through provider organizations that are accountable for the quality, health outcomes and total costs of care for their members.*
- *Goal 2: Define Medicaid-wide population health targets, and, where possible, tie them to payments.*
- *Goal 3: Maintain and expand on our record of excellence—including our #1 ranking—on delivering care to children.*
- *Goal 4: Maximize enrollment in integrated care delivery systems.*
- *Goal 5: Implement coordinated, accountable care for high-cost/high-need populations.*
- *Goal 6: Ensure access to high-quality primary care.*
- *Goal 7: Leverage health information systems to ensure quality, coordinated care.*
- *Goal 8: Shift Medicaid expenditures from high-cost institutional settings to community-based settings.*
- *Goal 9: Encourage the development of accountable entities for integrated long-term care.*
- *Goal 10: Improve operational efficiency.*²

¹ See <http://reinventingmedicaid.ri.gov> for additional documentation.

² Report of the Working Group to Reinvent Medicaid: Recommendations for a Plan for a Multi-Year Transformation of the Medicaid Program and All State Publicly Financed Healthcare in Rhode Island, July 8, 2015. <http://reinventingmedicaid.ri.gov>

EOHHS' contracts with MCOs require that managed care partners have the capability and commitment to achieve these critical goals for a sustainable and superior Medicaid program for Rhode Island. Through this document EOHHS is setting forth specifications for meeting Alternative Payment Methodology requirements as is delineated in the Medicaid Managed Care contract.

2. MCO Contract Requirements: Alternative Payment Methodologies

EOHHS seeks to significantly reduce the use of fee-for-service payment as a payment methodology and to replace fee-for-service payment with alternative payment methodologies that provide incentives for better quality and more efficient delivery of health services.

Managed Care contractors will incorporate value-based purchasing initiatives into their provider contracts. EOHHS is committed to facilitating the creation of partnerships or organizations using accountable delivery models that integrate medical care, mental health, substance abuse disorders, community health, social services and LTSS, supported by innovative payment and care delivery models that establish shared financial accountability across all partners, with a demonstrated approach to continue to grow and develop the model of integration and accountability.

Pursuant to this commitment, during FY 2016 EOHHS certified Accountable Entity Coordinated Care Pilots (AE) and MCOs were required to execute "total cost of care" payment arrangements with certified Pilots.

In FY 2018 EOHHS moved beyond the pilot phase of this initiative by issuing certification standards for fully qualified comprehensive Accountable Entities, as described in Section 4 of this document.

EOHHS' contracts with MCOs include defined targets for implementing contracts with alternative payment arrangements. Targets for alternative payment arrangements are as follows:

Requirements for agreements between EOHHS and Managed Care Organizations for the five contract periods beginning on or after March 1, 2017 are:

For Contract Period 3 (July 1, 2019 – June 30, 2020)

- At least 50% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology or the percent of Managed Care Organization payments to providers made through an EOHHS approved Alternative Payment Methodology shall be 5% higher than the percent required for Contract Period #2.

For example, if for Contract Period #2 45% of Managed Care Organization payments to providers were made through an EOHHS approved Alternative Payment Methodology, for Contract Period #3 at least 50% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology.

For Contract Period 4 (July 1, 2020 – June 30, 2021)

- At least 60% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology **or** the percent of Managed Care Organization payments to providers made through an EOHHS approved Alternative Payment Methodology shall be 5% higher than the percent required for Contract Period #3.

For example, if for Contract Period #3 the required level was 45% of Managed Care Organization payments to providers were made through an EOHHS approved Alternative Payment Methodology, for Contract Period #4 at least 55% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology.

For Contract Period 5 (July 1, 2021 – June 30, 2022)

- At least 65% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology **or** the percent of Managed Care Organization payments to providers made through an EOHHS approved Alternative Payment Methodology shall be 10% higher than the percent required for Contract Period #4.

For example, if for Contract Period #4 the required level was 45% of Managed Care Organization payments to providers were made through an EOHHS approved Alternative Payment Methodology, for Contract Period #5 at least 55% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology.

At least 10% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology that includes provisions for both shared savings and shared risk.

For Contract Period 6 (July 1, 2022 – June 30, 2023)

- At least 65% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology **or** the percent of Managed Care Organization payments to providers made through an EOHHS approved Alternative Payment Methodology shall be 10% higher than the percent required for Contract Period #4.

For example, if for Contract Period #4 the required level was 45% of Managed Care Organization payments to providers were made through an EOHHS approved Alternative Payment Methodology, for Contract Period #6 at least 55% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology.

At least 10% of Managed Care Organization payments to providers shall be made through an EOHHS approved Alternative Payment Methodology that includes provisions for both shared savings and shared risk.

MCOs will be required to complete the APM Reporting Template (see Attachment E) to show their status against these measures. The APM Reporting Template is to be submitted to EOHHS not later than sixty (60) days after the end of each calendar quarter. For the Contract Period beginning July 1, 2018 EOHHS' contracts with MCOs specify that EOHHS shall withhold 0.05% from capitation payments to

MCOs pending demonstration of compliance with these requirements. Upon demonstration of compliance with these targets for the respective quarters, the withheld amount will be paid to the MCOs.

2.1. EOHHS Approved Alternative Payment Methodologies

An Alternative Payment Methodology means a payment methodology structured such that it provides economic incentives, rather than focusing on volume of services provided, focus upon such key areas as:

- A. Improving quality of care;
- B. Improving population health;
- C. Impacting cost of care and/or cost of care growth;
- D. Improving patient experience and engagement; and/or
- E. Improving access to care.

Progressively, a qualified APM will include the following elements:

- The payment methodology must define and evaluate actual cost experience during the contracted performance period as compared to a projected total cost of care for the performance period.
- Providers must be rewarded for managing costs below the projected total cost of care through shared savings, should quality performance be acceptable.
 - The total value of a shared savings pool shall be derived through a quality multiplier (e.g. $\text{Observed total savings (Projected TCOC} - \text{Actual TCOC} > \text{zero}) \times \text{quality multiplier} = \text{actual shared savings pool}$). The quality multiplier can range from low of 0 to a maximum value of 1.0.)
- When determined qualified to accept downside risk, Providers may also be responsible for some or all the costs that exceed the budget.

For the purpose of meeting this requirement in the respective Contract Periods the following will be recognized as qualified Alternative Payment Methodologies:

Table 2: Qualified Alternative Payment Methodologies	Applicable Timeframe	Payments Included in APM Target Calculation
1. Total cost of care (TCOC) based contracts with EOHHS certified Comprehensive Accountable Entities	All Contract Years	All Payments as set forth in Attachment J, "EOHHS Total Cost of Care (TCOC) Requirements for the AE Program"
2. Other Population Based Total Cost of Care models (inclusive, for example, all covered services in EOHHS-MCO contract and global capitation payments or a limited scope model such as a PCP capitation). Savings and/or risk arrangements shall not exceed the limits as	All Contract Years	All payments for services as defined in TCOC arrangement and compliant with EOHHS requirements

set forth in Attachment J unless directly approved by EOHHS.		
4. Episode Based Bundled Payments either prospectively paid or retrospectively reconciled, with a risk component	All Contract Years	All Payments included within the bundle
5. PCMH - Care Transformation PMPM*	Thru June 30, 2023	PMPM Payment only
6. Supplemental infrastructure and Pay-for-performance payments** for non-LTSS providers	Thru June 30, 2023	P4P Payment only
7. Supplemental infrastructure and Pay-for-performance payments** for LTSS providers	Thru June 30, 2023	P4P Payment only
8. Other non-FFS payments that meet the definition of an Alternative Payment Methodology as approved by EOHHS.	All Contract Years	All Payments
9. Other payments that meet the definition of an Alternative Payment Methodology as approved by EOHHS	All Contract Years	Determined on an individual basis

*Care Transformation: Such payments include PMPM payment to support development and maintenance of a care management function within that practice and is not limited to supporting a care manager, per se. The purpose of the infrastructure payment is to compensate practices for the time and effort involved in achieving PCMH recognition and establishing basic policies and procedures necessary for PCMH function, including developing clinical data capture, reporting and analysis capacity.

**Pay-for-performance payments, supplemental infrastructure payments for person centered integrated care functions, including care management, paid to PCPs, ACOs and other providers, and supplemental infrastructure payments to specialists and other providers to provide incentives to improve communications and coordination among care providers.

The Alternative Payment Methodology (APM) target means the aggregate use of the above defined methodologies as a percentage of a Managed Care Organization’s medical expenditures during a contract period.

2.2 Qualifying APM Medical Expenditures for Purposes of the APM Target

Qualifying APM medical expenditures for purposes of the APM target shall include:

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- a) All fee-for-service or non-fee-for-service payments made by the MCO under a population based total cost of care (TCOC) contract with shared savings and/or shared risk.
- b) Episode based (bundled) payments; primary care, specialty care or other limited scope-of-service capitation payments, and global capitation payments.
- c) Quality payments that are associated with a non-fee-for-service payment (e.g. a quality payment on top of a bundled payment or PCP capitation).
- d) Supplemental payments for infrastructure development and/or Care Manager services to PCMHs and to Accountable Entities, **through June 30, 2020**.
- e) Shared savings distributions or payments.

Note that shared risk arrangements with providers must comply with EOHHS requirements for risk as set forth in Attachment B, *EOHHS Total Cost of Care (TCOC) Requirements for the AE Program*.

Methodologies #5, #6, and #7, in Table 2 above, while generally not employing the aforementioned budget methodology, **will be included in the calculation of the APM target through June 30, 2020**.

3. Specifications for Total Cost of Care (TCOC) Calculation

The total cost of care calculation (TCOC) is a fundamental element in any shared savings and/or risk arrangement and requires careful analysis. Most fundamentally it will include a baseline or benchmark historical cost of care carried forward to the performance period. Actual costs during the performance period are then compared to those projections to identify a potential shared savings or risk pool, depending on the terms of the arrangement.

For All Methodology #1 the TCOC calculation, must be compliant with the TCOC guidelines for EOHHS certified Accountable Entities included as Attachment B (“EOHHS Total Cost of Care (TCOC) Requirements for the AE Program”) of this document. As described in that guidance, EOHHS will review the MCO’s TCOC methodologies and reserves the right to require modifications before granting approval.³ Although other TCOC based APMs are not required to strictly adhere to the requirements set forth in Attachment B, such arrangements must incorporate core features of such a model including clear methodology for calculation of total cost of care targets vis a vis actual costs for the performance period, method for recognizing changes in the risk profiles of attributed populations, and additional APM specifications as described below:

- **Required Quality Score Factor**

All Alternative Payment Methodologies must include both a defined set of metrics and a

quality performance score that must be met for payments to be made. Attachment C to this document provides the Quality Framework and TCOC Quality Multiplier for contracts with certified AEs and should be used as a reference for any other APMs.

- **Limits on Downside Risk³**

EOHHS has established certain limits on downside risk. These limits are identified in Attachment B (“EOHHS Total Cost of Care (TCOC) Requirements for the AE Program”)

- **Attribution Method**

For all budget-based Methodology #1 APMs Managed Care Organizations will conform with the attribution guidance established by EOHHS (see Attachment A to this document: EOHHS Attribution Guidance for the AE Program). For other related APMs clear attribution methodology must be established.

- **Individual members or enrollees can only be recognized in one Accountable Entity at a time.** This is to ensure that TCOC calculations and shared savings are not “double counted” across multiple entities.

4. EOHHS Certified Accountable Entities

Contractual arrangements with Accountable Entities must be compliant with the requirements set forth in Attachment B, Medicaid Accountable Entity Total Cost of Care (TCOC) Requirements, including Quality Framework and Measures.

Certification standards have been designed to ensure that qualified Accountable Entities either have or are developing the capacity and authority to integrate and manage the full continuum of physical and behavioral health care, from preventive services to hospital-based services and to long term services and supports and nursing home care. Such entities must also demonstrate their capacity and authority to address members’ “social determinants”; that is, non-medical services that impact a member’s health and ability to access care (e.g., housing, food), in a way that is acceptable to CMS and the State.

For additional detail on certification standards for AEs see:

- Rhode Island Accountable Entity Program: Accountable Entity Certification Standards. (https://eohhs.ri.gov/sites/g/files/xkqbur226/files/2021-03/Attachment_H_PY4_AE_Certification_Standards_.pdf)

³ In addition to this EOHHS requirement, note that depending on circumstances transparency in such arrangements is specifically required in CFR42 §438.6 Contract requirements: 438.6(g) Inspection and audit of financial records – Risk contracts must provide that the state agency and the Department may inspect and audit any financial records of the entity or its subcontractors. 438.6(h) Physician Incentive plans – MCO contracts must provide for compliance with the requirements set forth in 422.208 and 422.210 of this chapter. 438.6(l) All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

For additional information on Rhode Island’s Health System Transformation see:

- Rhode Island Accountable Entity Roadmap (https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/11.18%20Attachment%20L_Accountable%20Entity%20Roadmap_Final_%202020_Nov_16.pdf)

5. Contracting with EOHHS Recognized PCMHs

Fundamental to health care system transformation is a strong foundation of high performing primary care practices. EOHHS is committed to continued support for primary care practice transformation and is aligning in this effort with the RI Office of the Health Insurance Commissioner.

For participating MCOs:

In Periods ending June 30, 2020 the MCO shall take such actions as are necessary so that 55% of members are assigned to a PCP in a practice that functions as a Patient-Centered Medical Home as recognized by the Rhode Island Office of the Health Insurance Commissioner and by EOHHS. For the Contract Periods ending June 30, 2021 and June 30, 2022 the PCMH target is 60%.

For the purposes of this provision EOHHS accepts OHICs determination of a qualified Patient- Centered Medical Home. Pursuant to Section 10(c)(2)(A) of OHIC Regulation 2, the Care Transformation Advisory Committee developed the following three-part definition of PCMH against which RI primary care practices will be evaluated and defined:

- a. Practice is participating in or has completed a formal transformation initiative⁴** (e.g., CTC-RI, PCMH-Kids, RIQI’S TCPI, or a payer- or ACO-sponsored program) or practice has obtained NCQA Level 3 recognition. Practice meeting this requirement through achievement of NCQA Level 3 recognition may do so independent of participating in a formal transformation initiative.
- b. Practice has implemented the following specific cost-management strategies** according to the implementation timeline included in the Plan as Attachment A (strategy development and implementation at the practice level rather than the practice site level is permissible):
 - i. develops and maintains a high-risk patient registry that tracks patients identified as being at risk of avoidable intensive service use in the near future;
 - ii. practice uses data to implement care management⁵, focusing on high-risk patients and interventions that will impact ED and inpatient utilization;
 - iii. implements strategies to improve access to and coordination with behavioral health services;

⁴ A formal PCMH transformation initiative is a structured training program for primary care providers and support staff with a pre-defined curriculum and technical assistance based on an evidence-based PCMH transformation model and designed to systematically build the skills within the practice to function as a PCMH.

⁵ Practices shall implement “care coordination” for children, which is a broader set of services not exclusively focused on high-risk patients. See R Antonelli, J McAllister, J. Popp. “Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework.” The Commonwealth Fund, publication number 1277, May 2009.

- iv. *expands access to services both during and after office hours;*
- v. *develops service referral protocols informed by cost and quality data provided by payers; and*
- vi. *develops/maintains an avoidable ED use reduction strategy.*

c. *Practice has demonstrated meaningful performance improvement.*

During 2016 OHIC shall define the measures for assessing performance and the precise definition of “meaningful performance improvement” in consultation with the Advisory Committee. To promote measure alignment across statewide initiatives, measures selected to measure performance improvement will be selected from the multi-payer measure set adopted pursuant to CMS State Innovation Model (SIM) grant activity.

OHIC takes the lead in determining qualified practices. Annually, OHIC coordinates with CTC, PCMH-Kids, RIQI, and payers to create a list of practices that payers should include in PCMH target calculations. OHIC posts this list on its website.

Also note that the MCO contract requires that the MCO auto-assign members to a qualified PCMH practice prior to assigning to a non-qualifying site.

Rhode Island Medicaid Accountable Entity Program
ATTACHMENT M: ACCOUNTABLE ENTITY ATTRIBUTION
PROGRAM YEAR FOUR REQUIREMENTS

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Attachments

- Attachment A: Excerpts from EOHHS-MCO Contracts Regarding Assignment of Primary Care Providers
- Attachment B: Qualifying Primary Care Services as Identified by CPT Codes

Attribution Overview

In the Comprehensive Accountable Entity (AE) program, AEs are responsible for the cost and quality of care for the Medicaid members who are patients of primary care providers affiliated with the AE. “Attribution” refers to the identification of those members for whom each AE is responsible. Attribution does not affect consumers’ freedom to choose or change their providers at any point.

Attribution is generally used for five purposes:

1. To inform AEs which members they are responsible for at a given time, to aid in care management and population health management;
2. To estimate the number of member months that will be attributed to each AE during a performance year in order to calculate the Incentive Fund Pool, which is based on the plurality of months a member receives care at an AE;
3. To identify the members whose health outcomes the AE is responsible for, in order to evaluate AE performance on the outcome metrics measured in the Incentive Fund Pool.
4. To identify the members whose healthcare quality the AE is responsible for, in order to evaluate AE performance on quality measures.
5. To identify the members whose cost and quality outcomes the AE was responsible for during the baseline and performance years, in order to evaluate AE performance on total cost of care (TCOC) and quality.

This document sets forth the process by which Medicaid members are attributed to AEs for each of these purposes.

Population Eligible for Attribution to a Comprehensive AE

The population eligible for attribution to an AE consists of Medicaid-only beneficiaries with full Medicaid benefits who are enrolled in managed care. Members who have dual Medicare and Medicaid coverage are not eligible for attribution to a Comprehensive AE. Members eligible and enrolled in Extended Family Planning are not eligible for attribution to a Comprehensive AE.

Primary Care Providers Whose Assigned Patients are Eligible for Attribution to a Comprehensive AE

Members assigned to the following Primary Care Providers (PCPs) are eligible for attribution to a Comprehensive AE: An individual physician, nurse practitioner, physician assistant, team, or FQHC selected by or assigned to the member to provide and coordinate the member’s health care needs and to manage referrals for specialized services. PCPs who are Medical Doctors, Doctors of Osteopathy, nurse practitioners, or physician assistants in the following specialties: family and general practice, pediatrics, internal medicine, or geriatrics who have a demonstrated clinical relationship as the principal coordinator of care for children or adults and who have contracted with the MCO to undertake the responsibilities of serving as a PCP as stipulated in the MCO’s primary care agreements. PCPs shall also meet the credentialing criteria established by the MCO and approved by EOHHS. The provider roster shall identify PCPs by TIN and by NPI.

Each PCP bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with at most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs.

Methodology to Attribute Members to AEs

Step 1: Member selection or assignment by the MCO at the point of enrollment with the MCO

The managed care contract sets forth certain requirements for PCP assignment that are intended to promote PCP assignment as appropriate (per MCO-submitted and EOHHS-approved PCP assignment algorithm) for the member in the case that the member does not affirmatively select a PCP (see Attachment A).

Upon enrollment with the MCO, the member will be attributed to the AE with which their selected/assigned PCP is affiliated. This is the AE that member will remain attributed to until Step 2, unless the member requests to change to a different PCP. When a member has requested that the MCO change their PCP to one that is not participating in the AE to which the member is currently attributed, the MCO shall update the member's AE attribution no later than on the next attribution report that incorporates quarterly reconciliation.

Step 2: Quarterly attribution reconciliation based on claims-based utilization analysis and member-requested changes to assigned PCP.

By performing the analyses of utilization outlined in "Attribution Reconciliation Logic" below, a member's attribution may change if it is demonstrated that the member uses a different PCP than the one assigned by the MCO.

Not later than thirty days after the close of each calendar quarter, MCO shall analyze claims for eligible members to identify the presence of visits to a PCP with qualifying primary care services as identified by CPT codes and/or FQHC encounter codes for the preceding twelve-month period (see Attachment B for qualifying CPT codes). The provider specialty must be a PCP eligible for attribution.

Note that while this document refers to "PCPs on the roster of an AE," whether a PCP is "on the roster" of an AE is determined by whether the tax identification number (TIN) through which the PCP billed the claim is on the roster of that AE.

Attribution Reconciliation Logic:

- 1.1. For members who have received all their qualified primary care services from a qualified provider on the roster of the AE to which the member is currently attributed, the AE attribution will be unchanged.
- 1.2. For members who have not received any primary care services during the period, AE attribution will be unchanged.
- 1.3. The MCO will identify beneficiaries who have received at least one primary care service from a PCP who is not on the roster of the AE to which the member is currently attributed. For those beneficiaries, the attribution hierarchy will then be as follows:
 - 3.1 Where the member's only PCP visits for qualifying primary care services were to a PCP not participating in the AE program, the member will not be attributed to an AE.
 - 3.2 Where the member has only had one visit to a PCP for qualifying primary care services and that PCP is participating in a different AE from the AE to which the member is currently attributed, the member will be attributed to the AE where they received their primary care services.
 - 3.3 Where a member has had two or more visits for qualifying primary care services and these visits are not all to PCPs on the roster of the same AE (or include visits to PCPs not on the roster of any AE), the sum of the visits

provided by PCPs on the roster of each AE are compared to the number of visits provided at any non-AE PCP with the highest number of visits.

- 3.3.1 If a non-AE PCP, aggregated by TIN, has the highest number of visits, the member will not be attributed to an AE.
- 3.3.2 If any AE has the highest number of visits, the member will be attributed to that AE, even if it does not align with their PCP of record.
- 3.3.3 If two or more AEs, including the AE to which the member is currently attributed, are tied for the highest number of visits, attribution will be unchanged.
- 3.3.4 If two or more AEs are tied for the highest number of visits and the member is not currently attributed to any of these AEs, the member will be assigned to the AE that aligns with the PCP that the member visited most recently.

Attribution to Inform AEs Which Patients They Are Accountable For

For the purposes of informing AEs which members they are accountable for, MCOs shall submit to AEs and to EOHHS electronic lists of attributed members on a monthly basis per the reporting requirements and file specifications outlined in the Managed Care Reporting Calendar

This monthly report will be updated to reflect changes that have taken place since the previous monthly list, including new Medicaid members, persons who have lost Medicaid eligibility, persons who have requested a PCP not included in the AE, persons who have requested a PCP included in the AE, and the results of quarterly reconciliation.

MCOs shall base the list of attributed members on attribution as of the last day of the month to which the attribution list applies, i.e., incorporating any changes that took place up to the final day of that month.

In creating the monthly attribution lists, MCOs shall use the AE rosters that are in effect for the month in question, including any changes in those rosters that have been communicated to the MCOs by any AE.

Other Purposes of Monthly Attribution Data:

- To the extent that MCOs give AEs information about utilization patterns for attributed members, EOHHS expects that MCOs will use the monthly attribution data to generate this information.
- EOHHS performs its own analysis of claims data to confirm members whose attribution changed based on MCO analysis of member utilization have been attributed correctly.

Attribution for Setting Incentive Fund Pools:

HSTP Incentive Fund Pools for each AE are set based on estimated member months for the program year. EOHHS estimates the member months that will be attributed to each AE for each MCO contract based on the number of attributed MCO members attributed to the AE in a single month at the end of the preceding program year or the beginning of the performance year to which the Incentive Fund Pool will apply. For example, depending on the timing of data availability, EOHHS may use attribution data from May, June, or July 2021 to estimate member months for the performance year beginning July 1, 2021.

Attribution to Evaluate AE Performance on Outcome Metrics Measured for the Incentive Fund Pool

Outcome measure performance is evaluated on an annual, calendar year basis.

As described in detail in the *Total Cost of Care Quality and Outcome Measures and Associated Incentive Methodologies for Comprehensive Accountable Entities: Implementation Manual Requirements for Program Years 1 through 4*, MCOs are responsible for calculating AE performance for one outcome measure, All-Cause Readmissions, while EOHHS is responsible for calculating AE performance for two outcome measures, Emergency Department Utilization for Individuals Experiencing Mental Illness and Potentially Avoidable Emergency Department Visits. In calculating outcome measure performance, MCOs and EOHHS will use the same attribution methodology for all outcome measures.

For purposes of evaluating annual outcome measure performance, each member will be attributed to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, the member will not be attributed to any AE for outcome measurement purposes. EOHHS and MCOs shall determine attribution using the AE provider rosters that are in place as of December of the performance year.

MCOs are responsible for providing AEs with quarterly reports on their performance on all three outcome measures. In calculating quarterly outcome measure performance, the MCO shall attribute members to the AE to which the member is attributed in the final month of each quarter, using the AE rosters that apply in the final month of each quarter. For example, for the January through March quarter, attribution will be based on attribution in March using the March AE rosters.

Attribution to Evaluate AE performance on Quality Measures

Quality measure performance is evaluated on an annual, calendar year basis.

For purposes of evaluating annual quality measure performance, each member will be attributed to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, the member will not be attributed to any AE for quality measurement purposes. MCOs shall determine attribution using the AE provider rosters that are in place as of December of the performance year.

Attribution for Total Cost of Care Analysis:

For purposes of TCOC calculations, each member should be assigned to a single AE in each baseline and performance year. That is, each member's costs during a given baseline or performance year should only be attributed to a single AE. The AE to which these costs should be attributed is based on the AE to which the member is attributed in the member's latest month of enrollment during each baseline or performance year in the MCO's Medicaid plan.

For example, consider a member enrolled with MCO #1:

- If the member is attributed to AE X from July 2020 through February 2021 and attributed to AE Y from March 2021 through June 2021, then the member's costs from July 2020 through June 2021 are attributed to AE Y.
- If this member loses Medicaid eligibility as of June 1, 2021, the member's costs from July 2020 through May 31, 2021 would be attributed to AE Y.
- If the member is attributed to AE X from July 2020 through February 2021, then is attributed to "no AE" from March 2021 through June 2021 due to switching to a PCP that does not participate in an AE, the member's costs from July 2020 through June 2021 would not be attributed to any AE.

Please see Attachment C, "Illustrative Attribution and Rate Cell Examples" for more details on the TCOC attribution methodology.

TCOC calculations for the baseline and performance years should be based on very similar provider networks in each AE in order to ensure that changes between the baseline and performance year are based on performance rather than the AE's composition. Therefore, attribution to set baseline year TCOC should be based on the TINs on the roster of each AE as of the date baseline year cost data is submitted, and when quarterly and final performance is calculated, attribution should use this same set of TINs for each AE.

Over the course of the performance year, it is possible that some TINs will change AEs or leave or enter the AE program. These changes will be reflected in the TINs used for calculating baseline data applicable in the following program year. For example, performance year costs in Program Year 3 (PY3) will be attributed using the TINs on each AE roster when the MCO submitted the baseline data used to generate PY3 TCOC targets. Then, in the spring of 2021, the TINs on AE rosters at that time (including any changes that took place between July 2020 and March or April 2021) will be used to calculate baseline data for PY4 TCOC targets, and performance year cost attribution for PY4 will use the TINs on the AE rosters from the spring of 2021.

Note that during each Performance Year, MCOs will submit data on a quarterly basis in response to the Performance Year Data Request. For these submissions, MCOs should attribute costs in the same manner described above and using the same AE rosters. Members and member costs should be attributed to the AE to which the member was attributed in the member's latest month of enrollment during the period for which data is reported. The Performance Year Data Request Template includes more detailed instructions regarding calculation of specific values in that submission.

Attachment A: Excerpts from EOHHS-MCO Contracts Regarding Assignment of Primary Care Providers

PCP assignment by the MCOs must comply with EOHHS contractual requirements. The following excerpts from Sections 2.05.07 and 2.05.08 of EOHHS' Medicaid Managed Care Services contracts with the MCOs describe the MCOs' contractual requirements related to PCP assignment:

2.05.07 Assignment of Primary Care Providers (PCPs)

The Contractor will have written policies and procedures for assigning each of its members who have not selected a primary care provider (PCP) at the time of enrollment to a PCP. The process must include at least the following features:

- The Contractor must allow each enrollee to choose his or her health professional to the extent possible and appropriate.
- If a Medicaid-only member does not select a PCP during enrollment, the Contractor will make an automatic assignment, taking into consideration such factors as current provider relationships, language needs (to the extent they are known), member's area of residence and the relative proximity of the PCP to the member's area of residence. The Contractor then must notify the member in a timely manner by telephone or in writing of his/her PCP's name, location, and office telephone number, and how to change PCPs if desired. The Contractor will auto assign members to a NCQA recognized Patient Centered Medical Home, where possible.
- In addition to the above, EOHHS recognizes the importance of members being enrolled in a certified AE and a Patient Centered Medical Home (PCMH). EOHHS expects that, as applicable to the eligible populations, the Contractor will prioritize auto-assignment (a) first, to PCPs in a PCMH practice that is also a participating provider in a certified and contracted AE; second, to PCPs in a PCMH practice that are not in a contracted AE; third to non-PCMH PCP participating in a contracted AE; and fourth to PCPs in a non-PCMH and non- AE participating practice.

The Contractor is responsible for creating an auto-assignment algorithm and submitting this algorithm to EOHHS for review and approval within ninety (90) days of the execution of this contract. Once this logic is approved by EOHHS, the health plan should operationalize this within sixty (60) days. The Contractor should consider the following when creating the algorithm: a) When auto assignment is being utilized, the Contractor must regularly monitor member panel size to ensure that providers have not exceeded their panel size; b) The provider's ability to comply with EOHHS's specified access standards, as well as the provider's ability to accommodate persons with disabilities or other special health needs must be considered during the auto-assignment process; c) In the event of a full panel or access issue, the algorithm for auto assignment must allow a provider to be skipped until the situation is resolved. Additionally, the Contractor will be required to provide registries of patients to each PCP facility where the patients are assigned, no less frequent than quarterly or at an interval defined by EOHHS.

- The Contractor will notify PCPs of newly assigned members in a timely manner.
- If a Medicaid-only member requests a change in his or her PCP, the Contractor agrees to grant the request to the extent reasonable and practical and in accordance with its policies for other enrolled groups. It is EOHHS's preference that a member's reasonable request to change his or her PCP be effective the next business day.

The Contractor will make every effort to ensure a PCP is selected during the period between the notification to the Contractor by EOHHS and the effective date of the enrollee's enrollment in the Contractor's Health Plan. If a PCP

has not been selected by the enrollee's effective date of enrollment, the Contractor will assign a PCP. In doing so, the Contractor will review its records to determine whether the enrollee has a family member enrolled in the Contractor's Health Plan and, if so and appropriate, the family member's PCP will be assigned to the enrollee. If the enrollee does not have a family member enrolled in the Health Plan but the enrollee was previously a member of the Health Plan, the enrollee's previous PCP will be assigned by the Contractor to the enrollee, if appropriate.

2.04.01 Changing PCPs

The Contractor will have written policies and procedures for allowing members to select or be assigned to a new PCP including when a PCP is terminated from the Health Plan, or when a PCP change is ordered as part of the resolution to a formal grievance proceeding. In cases where a PCP has been terminated, the Contractor must allow members to select another PCP or make a re-assignment within ten (10) calendar days of the termination effective date.

Attachment B: Qualifying Primary Care Services as Identified by CPT Codes

Evaluation/Management CPT Codes: 99201-99205, 99211-99215

Consultation CPT Codes: 99241-99245

Preventive Medicine CPT Codes: 99381-99387, 99391-99397

Rhode Island Medicaid Accountable Entity Program

Attachment J: Accountable Entity Total Cost of Care- Program Year 4 Requirements

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A. TCOC Definition

Total cost of care (TCOC) is a fundamental element to the Accountable Entity (AE) program. It includes a historical baseline cost of care projected forward to the performance period. Actual costs during the performance period are then compared to this baseline to identify a potential shared savings or risk pool.

Effective TCOC methodologies incentivize AEs to invest in care management and other services that address member needs and reduce duplication of services. In doing so, AEs improve health outcomes, lower costs, and earn savings. Savings in this program are also determined by performance against quality and outcomes metrics.

B. TCOC Methodology Goals

These TCOC guidelines support meaningful performance measurement and create financial incentives to reduce costs and improve quality. In order to accomplish meaningful performance measurement, this methodology:

- **Provides opportunity for a sustainable business model**
This methodology creates ongoing opportunity for effective AEs by: (1) recognizing efficient historical performers; (2) allowing for shared savings to be retained for system investment; (3) creating greater financial incentives for being inside the AE program than for being outside the program
- **This methodology creates financial flexibility for AEs to** improve clinical pathways for Medicaid high utilizers and to address social drivers of health outcomes and costs
- **Is fiscally responsible for all participating parties** and adequately protect the solvency of the AEs and managed care organizations (MCOs) and the financial interests of the RI Medicaid Program
- **Specifically recognizes and addresses the challenge of small populations** through strategies that minimize the impact of small numbers, given the state's small size
- **Incorporates quality metrics** related to increased access and improved member outcomes
- **Requires timely data exchange and performance improvement reporting between MCOs and AEs.**
- **Includes a progression toward meaningful provider risk**

C. General Requirements for Program Participants

1. Minimum Membership and Population Size

MCOs may utilize TCOC-based payment models only with AEs that have at least 5,000 attributed Medicaid members across all MCOs and at least 2,000 members per MCO-AE contract.

2. State/MCO Capitation Arrangement

The MCO retains the base contract with the State; the MCO medical capitation will be adjusted for savings/risk associated with the program as described in the State/MCO contract. This does not preclude MCOs from creating value-based purchasing arrangements with non-AE providers; however, those contracts would still be subject to the State gain-share and would not be included in the State's assessment of the MCO's value-based payment performance standards related to AEs.

3. Exclusivity of Approved TCOC Methodologies

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

4. Attribution

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

D. TCOC Methodology

For PY4, EOHHS has established a standard methodology for total cost of care. An overview of the methodology is presented here. The full methodology is detailed in the *Total Cost of Care Technical Guidance*.

1. Establishing TCOC targets

For PY4, TCOC targets will include the following components:

- a. Historical cost data, including covered services that align with those included in EOHHS's contract with MCOs
- b. Adjustment for the changing risk profile of the population
- c. Adjustment for trend assumptions
- d. Adjustment to historical base relative to market average

2. Measuring Expenditures for the Performance Period

a. Calculate Actual Expenditures Consistent with the Historical Base Methodology

MCOs will calculate and report actual expenditures for the Performance Period consistent with the base methodology as described above.

- b. Actual expenditures shall include all performance year costs for those members attributed to an AE

3. Shared Savings/(Loss) Pool Calculations

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

- a. **Minimum Savings Rate**

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. The MSR by AE size is detailed in the *Total Cost of Care Technical Guidance*.

b. Impact of Quality and Outcomes

The Shared Savings Pool shall 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 A: Quality Framework and Methodology for Comprehensive Accountable Entities*. The Total Shared Savings Pool (inclusive of both the AE and MCO portions) must 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.

In PY4, 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. Note that EOHHS intends for the Shared Loss Pool adjustment based on the Overall Quality Score to be applied in PY4 only.

c. Risk Exposure Cap

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 Target or as a percentage of the AE's revenue. 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.

For AEs assuming downside risk, the Maximum Shared Loss Pool will be defined by the Risk Exposure Cap agreed to by AE and MCO as part of the downside risk arrangement. The Risk Exposure Cap must meet the minimum requirement for transitioning to risk-based arrangements as specified below.

4. AE Share of Savings/(Loss) Pool

In Program Year 4, AEs assuming downside risk 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.

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	At least 60% of Shared Savings Pool	At least 30% of Shared Loss Pool

5. Required Progression to Risk-Based and Value-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 was not counted towards these three years due to the COVID-19 emergency. New participants in the AE program begin this progression at Year 1 levels of risk exposure and risk sharing.

EOHHS has defined “meaningful risk” based on learnings from other states, OHIC requirements and federal MACRA rules. 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	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	At least 40%

		TCOC; or 6% of AE Revenue	
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For Program Year 4, EOHHS has aligned minimum downside risk requirements proportionally with the most marginal risk standards established by the Office of the Health Insurance Commissioner (OHIC). Alternative risk requirements for larger organizations may be considered in the future as AEs develop risk-bearing capacity.

Additionally, approved TCOC contracts for Program Year 4 that include downside risk 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. Details of OHIC’s pre-qualification process for risk-bearing provider organizations is found in *Attachment B: Pre-Qualification of Accountable Entities Bearing Financial Risk*.

b. AEs not eligible to assume downside risk

In accordance with CMS guidance, EOHHS must ensure that Federally Qualified Health Centers receive and retain 100% of the Medicaid payments and cannot be put at risk for receiving less than PPS for FQHC services. Therefore, FQHC AEs may remain in shared savings-only contracts if they progress towards value-based care and alternative payments as evidenced by an EOHHS-approved proposal demonstrating a positive ROI. Such proposals may include the development of evidence-based processes, incentives for cost reduction, and the establishment of sustainability for interventions currently funded by grants; these proposals are also outlined in “*ATTACHMENT K – INFRASTRUCTURE INCENTIVE PROGRAM: REQUIREMENTS FOR MANAGED CARE ORGANIZATIONS AND CERTIFIED ACCOUNTABLE ENTITIES*.” Due to the COVID-19 emergency, these requirements will be postponed until PY4.

E. TCOC Reporting Requirements

In order to monitor AE financial performance, MCOs are required to furnish to EOHHS and AEs on a quarterly basis reports regarding TCOC performance. The reports must include, by rate cell, summarized TCOC expenditures and member months for attributed members over a recent 12-month period. See Accountable Entity Program Total Cost of Care Technical Guidance for Program Year 4 for reporting dates.

Attachment A: Quality Framework and Methodology for Comprehensive Accountable Entities

A. Principles and Quality Framework

A fundamental element of the EOHHS Accountable Entity (AE) program, and specifically the transition to alternative payment models, is a focus on quality and outcomes. Measuring and rewarding quality as part of a value-based model is critical to ensuring that quality is maintained and/or improved while cost efficiency is increased. As such, the payment model must be designed to both recognize and reward historically high-quality AEs while also creating meaningful opportunities and rewards for quality improvement. This model must be measurable, transparent and consistent, such that participants and stakeholders can view and recognize meaningful improvements in quality as this program unfolds. The Program requirements are intended to provide structure that permits baseline measurement and assessment, while allowing for future refinements that continuously “raise the bar” toward critical improvements in quality and outcomes.

B. Impact of Quality Performance on Shared Savings and Losses

Medicaid AEs are eligible to share in earned savings and will contribute toward shared losses based on a quality multiplier (the “Overall Quality Score”) to be determined as follows:

- AE performance on total cost of care (TCOC) as determined using the EOHHS approved TCOC methodology will determine whether the AE is eligible for shared savings or must contribute to shared losses.
- In accordance with 42 CFR §438.6(c)(2)(ii)(B)⁶, quality performance measurement must be based on the Medicaid Accountable Entity Common Measure Slate. EOHHS expects that performance on each measure be reported annually for the full quality measure performance year.
- For comprehensive AEs, all admin (claims-based) measures must be generated and reported by the MCO. AEs must provide the necessary data to the MCO to generate any hybrid or EHR-only measures. Any EHR-only non-HEDIS measure is defined to include only active patients in the denominator. Active patients are individuals seen by a primary care clinician associated with the AE anytime within the last 12 months.
- An Overall Quality Score must be generated for each AE. The Overall Quality Score will be used as a multiplier to determine the percentage of any shared savings pool the AE and MCO are eligible to receive. In PY4, the Overall Quality Score will also be used to determine the percentage of any Shared Loss Pool the AE and MCO will have to pay. 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

⁶ https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438_16&rqn=div8.

Shared Loss Pool of \$100,000 would be reduced by \$22,000, yielding a final Shared Loss Pool of \$78,000. Overall Quality Scores must be calculated distinctly for each MCO with which the AE is contracted.

- Performance year periods, which are aligned with the state fiscal year calendar, will be tied to the calendar year quality performance period ending within the performance year period. The prior calendar year quality performance period will serve as the benchmark period, as shown below.

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

C. Medicaid AE Common Measure Slate for Comprehensive AEs

In accordance with 42 CFR §438.6(c)(2)(ii)(B)⁷, quality performance measurement must be based on the Medicaid Comprehensive AE Common Measure Slate (see Section F below). The 12 core measures must be reported for all measure that meet the eligible denominator sizes. The Common Measure Slate for comprehensive AEs has been developed with the following considerations:

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

D. Comprehensive AE Overall Quality Score Determination

As articulated in the Rhode Island Accountable Entity Program Total Cost of Care Quality and Outcome Measures Implementation Manual hereafter referenced as “Implementation

⁷ https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438_16&rgn=div8.

Manual”, EOHHS developed a standard quality score methodology to be used by all AEs and MCOs.

The required TCOC Overall Quality Score methodology is as follows:

- a. **Target Structure:** The Overall Quality Score recognizes AEs that either attain a high-achievement target or demonstrate a required level of improvement over prior performance. MCOs will assess AE performance on each Common Measure Slate P4P measure for both achievement and improvement. For each Common Measure Slate P4P measure except SDOH Screening, AEs will be awarded whichever score yields the greatest performance points. The maximum earnable score for each measure will be “1”, and each measure will be weighted equally.
 - a. Achievement targets:
 - i. EOHHS will establish two achievement targets: “threshold” and “high.”
 - ii. Achievement points will be scored on a sliding scale for performance between the threshold and high values.
 1. If performance is below or equal to the threshold-performance target: 0 achievement points
 2. If performance is between the threshold-performance and the high-performance target, achievement points earned (between 0 and 1) will be determined based on the following formula: $(\text{Performance Score} - \text{Threshold Performance}) / (\text{High-Performance Target} - \text{Threshold Performance})$
 3. If performance is above the high-performance target: 1 achievement point
 - b. Improvement target:
 - i. The improvement target will be a fixed number of percentage points, with three percentage points as the default value.
 1. The value may vary from three percentage points if deemed appropriate by EOHHS.
 2. The value may be less than what would be required to demonstrate statistical significance in a given year.
 - ii. QPY2 performance will be the basis of assessing improvement for QPY4.
 - iii. Improvement will not be recognized by the MCO if the rate is statistically significantly below the rate of two calendar years prior⁸.
 - iv. Improvement as defined by 1.b.i-iii will earn the AE a score of “1.”
- b. **Scoring SDOH Screening:** This measure will be scored differently than the other Common Measure Slate measures for QPY4. Given that this measure changed significantly in QPY3,

⁸ For Weight Assessment and Counseling for Children and Adolescents, statistical significance is determined using the average of numerators across component scores.

there is no QPY2 rate against which EOHHS can assess improvement in QPY4. Therefore, AEs will only be assessed based on achievement for this measure in QPY4, as described in 1.a above.

E. Calculation of the Overall Quality Score and TCOC Quality Benchmarks

Each MCO will sum the points earned across all measures for which the AE has an adequate denominator size and divide that sum by the number of measures for which there is an adequate denominator size. For example, if an AE has an adequate denominator size for all AE Common Measure Slate measures, then the MCO would sum the scores for each of the ten measures and divide the result by 10.⁹ This resulting quotient is the “Overall Quality Score.” The MCO shall multiply the annual savings or loss generated by the AE by the Overall Quality Score to determine the shared savings to be distributed to the AE, or loss to be shared with the AE. See Appendix E: Example Overall Quality Score Calculation for QPY 4, in the accompanying, Implementation Manual, for illustration of this calculation and further details.

EOHHS will define the percentage of quality measures from the common measure slate needed to achieve full shared savings (or to fully share losses) once QPY1 AE performance data and NCQA HEDIS benchmarks for CY2018 are available. EOHHS anticipates completing this process by November 30, 2019. Please refer to the Implementation Manual for further details. **In setting this parameter, EOHHS’ general principle is that AEs should be allowed to achieve the full share of shared savings (or losses) without having to earn the maximum possible points, i.e., through hitting the high achievement or improvement targets for all ten measures.** EOHHS will also define the impact of quality performance on mitigation of shared losses. **In setting this parameter, EOHHS’s general principle is that AEs should have any losses mitigated, but not eliminated, based on quality performance.**

EOHHS modified the Overall Quality Score methodology for PY 3 in an effort to hold providers harmless for QPY3 quality performance due to the COVID-19 pandemic. MCOs should use their existing QPY2 measures and methodology (inclusive of measure targets and weights), except that:

- 1) For any measure designated as P4P in a QPY2 contract for which an AE’s QPY3 value is superior to the QPY2 value, MCOs should use the QPY3 rate instead of the QPY2 rate in the calculation of the Overall Quality Score; and
- 2) For Social Determinants of Health Screening, a QPY3 value may not be substituted for QPY2 since there were significant specification changes. Social Determinants of Health Screening is considered a reporting-only measure for QPY3.

For further details please reference the Quality and Outcome Implementation manual.

⁹ Weight Assessment and Counseling for Children and Adolescents is assessed as one measure. The measure is a composite, created by averaging the scores of the three individual measure components 1) BMI percentile, 2) counseling for nutrition, and 3) counseling for physical activity.

EOHHS has adopted different approaches to set TCOC quality benchmarks based on the performance year.

For QPY3, negotiated AE and MCO QPY2 benchmarks shall be used to evaluate AE performance and inform the negotiated formula for distribution of shared savings and losses.

For QPY4, EOHHS will employ a combination of internal and external sources to set achievement targets. EOHHS will set targets for Quality Performance Year 4 using Quality Performance Year 2 data, Quality Compass, Office of the Health Insurance Commissioner (OHIC) Patient Centered Medical Home (PCMH) Measure Survey Data in advance of Quality Performance Year 4. It will share its proposed targets and rationale with the AE/MCO Work Group in mid-December 2020 before finalizing the benchmarks by December 31, 2020.

AE Quality Performance Year 2 data will be used to ensure the following guiding principles are met: 1) the high achievement target should be attainable for at least some AEs; 2) the high achievement target should not exceed a value that represents a reasonable understanding of “high performance”; and 3) the high achievement target should not be below the current performance of every single AE.

EOHHS will also consider the following benchmark sources:

- a. HEDIS measures
 - i. NCQA’s Quality Compass benchmarks will be used whenever possible, for QPY4, HEDIS 2020 (CY2019) will be used. The benchmark (e.g., 75th percentile for Medicaid managed care) used to set achievement targets will vary by measure based on EOHHS assessment of past MCO or AE performance.
- b. Non-HEDIS measures
 - ii. Alternative sources to NCQA’s Quality Compass will be used for non-HEDIS measures as available for the measure (e.g., CMS Child Core Set data for Developmental Screening in the First Three Years of Life).
 - iii. For QPY4, EOHHS will use OHIC-gathered Rhode Island PCMH 10/18-9/19 performance measure data for benchmarking purposes. While more recent data will become available (i.e., 10/19-10/20), these data will likely be impacted by COVID 19 and therefore EOHHS will utilize data from this prior performance period. These data are collected annually by OHIC from primary care practices seeking OHIC PCMH designation (186 practices submitted in 2019). OHIC data can be stratified to identify Medicaid-focused practices (i.e., self-reported to have >50% of patients covered by Medicaid or be uninsured), although the absolute number of such practices has historically been low.

Should benchmark data be unavailable for a given measure, EOHHS will convene a meeting of AEs, MCOs, and clinicians to review the measure and determine appropriate benchmarks. As MCOs and AEs began transitioning in QPY3 to using electronic clinical data exchange for

generation of those Common Measure Slate measures requiring clinical data, EOHHS anticipates that MCOs will use different data collection techniques with different AEs (see “Data Collection and Reporting Responsibilities” in the accompanying Implementation Manual). EOHHS will assess the impact of different data collection techniques on AE performance on Common Measure Slate measure results. Should different data collection techniques appear to have substantive systemic effects on AE performance on some or all of those measures requiring clinical data, EOHHS will modify benchmarks for affected AEs using its best judgement.

F. Comprehensive AE Common Measure Slate*

Measures ¹⁰	Steward	Data Source ¹¹	Specifications	AE Common Measure Slate				
				QPY1 Reporting and Incentive Use	QPY2 Reporting and Incentive Use and QPY3 Incentive Use Per 5/8/20 EOHHS Memo	QPY3 Intended Incentive Use Pre 5/8/20 EOHHS Memo ¹²	QPY3 Reporting	
HEDIS Measures								
Adult BMI Assessment	NCQA	Admin/Clinical	Current HEDIS specifications: QPY1: HEDIS 2019 QPY2: HEDIS 2020 QPY3: HEDIS MY 2020 QPY4: HEDIS MY 2021* *The AE/MCO Work Group will approve adoption of the HEDIS MY 2021 specifications when they are released in March 2021.	P4R	P4P/P4R			
Adolescent Well-Care Visits	NCQA	Admin/Clinical				P4P	Yes	
Breast Cancer Screening	NCQA	Admin			P4R	P4P	P4P	Yes
Child and Adolescent Well-Care Visits (adolescent age stratifications only)	NCQA	Admin						
Child and Adolescent Well-Care Visits (2 components: 3-11 years and total)	NCQA	Admin						
Comp. Diabetes Care: Eye Exam	NCQA	Admin/Clinical					P4P	Yes
Comp. Diabetes Care: HbA1c Control (<8.0%)	NCQA	Admin/Clinical			P4R	P4P/P4R	P4P	Yes
Controlling High Blood Pressure	NCQA	Admin/Clinical			P4R	P4P/P4R	P4P	Yes
Follow-up after Hospitalization for Mental Illness	NCQA	Admin			P4R – 7 or 30 days	P4P – 7 or 30 days	P4P – 7 days	Yes – 7 days
Weight Assessment & Counseling for Physical Activity, Nutrition for Children & Adolescents	NCQA	Admin/Clinical			P4R	P4P/P4R	P4P	Yes

¹⁰ Attachments L1 for Program Years 1 and 2 included Self-Assessment/Rating of Health Status as developed by EOHHS. This measure is no longer part of the AE Common Measure Slate for QPY1-4. EOHHS communicated its decision to drop this measure from Program Year 2 in its 4/30/19 amended Attachment L1.

¹¹ “Admin/Clinical” indicates that the measure requires use of both administrative and clinical data.

¹² For QPY3, QPY2 measure categorization will be used for calculation of the QPY3 Overall Quality Score.

Measures ¹⁰	Steward	Data Source ¹¹	Specifications	AE Common Measure Slate			
				QPY1 Reporting and Incentive Use	QPY2 Reporting and Incentive Use and QPY3 Incentive Use Per 5/8/20 EOHHS Memo	QPY3 Intended Incentive Use Pre 5/8/20 EOHHS Memo ¹²	QPY3 Reporting
Non-HEDIS Measures (Externally Developed)							
Developmental Screening in the 1st Three Years of Life	OHSU	Admin/Clinical	QPY1-4: CTC-RI/OHIC (December 2018 version) ¹³	P4R	P4P/P4R	P4P	Yes
Screening for Clinical Depression and Follow-up Plan	CMS	Admin/Clinical	QPY1: CMS MIPS 2018 ¹⁴ QPY2: CMS MIPS 2019 ¹⁵ QPY3: CMS MIPS 2020 ¹⁶ , September 15, 2020 version modified by EOHHS and included as Appendix A in the Implementation Manual QPY4: CMS MIPS 2021, modified by EOHHS* *The AE/MCO Work Group will approve adoption of the CMS MIPS 2021 specifications when they are released in winter 2021.	P4R	P4P/P4R	P4R	Yes
Tobacco Use: Screening and Cessation Intervention	AMA-PCPI	Admin/Clinical	QPY1-4: CMS MIPS 2018 ¹⁷	P4R	P4P/P4R	Reporting-only	Yes
Non-HEDIS Measures (EOHHS-developed)							
Social Determinants of Health Infrastructure Development	EOHHS	Admin/Clinical	QPY3-4: EOHHS (August 6, 2020 version – included as Appendix B in the Implementation Manual)			P4P	Yes
Social Determinants of Health Screening	EOHHS	Admin/Clinical	QPY1-2: EOHHS February 15, 2018 version ¹⁸	P4R	P4R	Reporting-only	Yes

¹³ <http://www.ohic.ri.gov/documents/Revised-Measure-Specifications-Adult-and-Pedi-CTC-OHIC-Dec-2018-FINAL.pdf>

¹⁴ <https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2018#measures>

¹⁵ <https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2019#measures>

¹⁶ <https://qpp.cms.gov/mips/explore-measures/quality-measures?tab=qualityMeasures&py=2020>

¹⁷ Tobacco Use: Screening and Cessation Intervention had substantive changes in the CMS MIPS 2019 version.

¹⁸

<http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/Final%20Documents/SDOH%20Guidance%20Document%202018-02-15.pdf>

Measures ¹⁰	Steward	Data Source ¹¹	Specifications	AE Common Measure Slate			
				QPY1 Reporting and Incentive Use	QPY2 Reporting and Incentive Use and QPY3 Incentive Use Per 5/8/20 EOHHS Memo	QPY3 Intended Incentive Use Pre 5/8/20 EOHHS Memo ¹²	QPY3 Reporting
			QPY3-4: EOHHS August 6, 2020 version – included as Appendix C in the Implementation Manual				
Optional Measure Slates (for QPY1 and QPY2 EOHHS permits selection of up to 4 optional measures)¹⁹							
OHIC Aligned Measure Set Menu			QPY1: OHIC 2018 ²⁰ QPY2: OHIC 2019 ²¹	P4R/P4P	P4R/P4P		
CMS Medicaid Adult Core Set			QPY1: CMS 2018 ²² QPY2: CMS 2019 ²³	P4R/P4P	P4R/P4P		
CMS Medicaid Child Core Set			QPY1: CMS 2018 ²⁴ QPY2: CMS 2019 ²⁵	P4R/P4P	P4R/P4P		

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

¹⁹ Optional Admin measures could be pay-for-performance in QPY1. Optional Admin/Clinical or Clinical-only measures could be pay-for-performance or pay-for-reporting in QPY1.

²⁰ <http://www.ohic.ri.gov/documents/Crosswalk%20of%20RI%20Aligned%20Measure%20Sets%202017%2011-2.xlsx>

²¹ <http://www.ohic.ri.gov/documents/Crosswalk-of-RI-Aligned-Measure-Sets--For-2019-2018-10-13.xlsx>

²² <https://www.medicare.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-adult-core-set.pdf>

²³ <https://www.medicare.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-adult-core-set.pdf>

²⁴ <https://www.medicare.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-core-set.pdf>

²⁵ <https://www.medicare.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-core-set.pdf>

Attachment B: Pre-Qualification of Accountable Entities Bearing Financial Risk

1. Background

During early 2020, EOHHS required Accountable Entities (AEs) that were anticipating downside risk in their future PY3 contracts with Medicaid MCOs to submit a pre-qualification application and supporting documentation to Office of the Health Insurance Commissioner (OHIC) by January 15, 2020. (PY3 is the period July 1, 2020 through June 30, 2021.) OHIC reviewed each submission to determine if an AE was “pre-qualified” as having the financial capacity to bear an estimated amount of downside risk across all of its Rhode Island Medicaid MCO contracts for PY3. Because AEs ultimately did not execute PY3 contracts with downside risk, EOHHS will again require AEs to submit a pre-qualification application in advance of PY4 downside risk contracts.

To ensure that AEs assuming downside risk in their executed contracts with Medicaid MCOs are able to cover any financial losses, EOHHS and OHIC have also established an annual TCOC Financial Solvency Filing process to certify AEs for downside risk assumption. This Attachment B lays out both the Pre-Qualification process and the Financial Solvency Filing process for PY4 (July 1, 2021 through June 30, 2022). OHIC will perform the Pre-Qualification and TCOC Financial Solvency Filing reviews on behalf of EOHHS. In so doing, OHIC will review and assess the financial impact of downside risk associated across all of an AE’s Medicaid MCO risk contracts.

i. Pre-Qualification Process

a. AEs that must file for pre-qualification

OHIC will maintain a single pre-qualification review process for all AEs that will be entering into arrangements that include shared losses. This review will estimate the amount of downside risk the AE anticipates assuming in PY4 and whether the AE has an adequate combination of assets and insurance to cover the maximum risk exposure.

b. Requirements for Pre-Qualification

EOHHS will allow for flexibility in AEs’ approaches to managing their risk exposure as long as the AE can document a thorough strategy for obtaining protection from estimated maximum potential losses. If an AE has a strong balance sheet, its strategy for covering maximum potential losses due to downside risk could include documenting that it has sufficient existing secured liquid assets and reinsurance to cover the maximum potential losses, with evidence that these funds are secured in a controlled or custodial account. Other organizations without available liquid assets to cover the maximum potential losses may need to develop a risk strategy portfolio consisting of several different approaches. Strategies could include, for example, aggregate and individual stop loss insurance, corporate investors, provider partner organization contributions, insurer withholds, delegation of risk to contracted provider organizations,

insurer-provided capital, securities in trust, and letters of credit.²⁶

For AEs without the necessary secured liquid assets to cover their estimated maximum potential loss, OHIC will require provision of copies of any agreements with organizations assuming some or all of the risk on behalf of the AE. Such agreements should, at a minimum, detail the financial arrangement, and the amount of risk being assumed by each organization. OHIC will require that each AE submit documentation that it has taken adequate steps to cover the risk using a) secured assets in a custodial or controlled account(s), and/or b) a reinsurance policy which can be used to protect the interests of enrolled Medicaid members, and/or c) delegation of risk to one or more parties. Taken together, the value of these strategies should not be less than the potential maximum losses due to all downside risk contracts with Medicaid MCOs.

As part of the pre-qualification application, AEs will also be required to submit a planned process for ongoing monitoring of performance against the downside financial risk arrangements for the AE and any subcontracted entities assuming delegated risk.

c. Process for pre-qualification review

The process that OHIC will follow in its pre-qualification review is outlined below in i-viii.

- i.** The AE submits its application to OHIC with all supporting documentation by January 15, 2021.
- ii.** OHIC determines the AE's actual and/or estimated maximum risk exposure for MCO contracts for PY4.
- iii.** OHIC determines whether the AE has an adequate current or planned process for ensuring sufficient financial resources to protect it, and those entities with which it has a contracting affiliation and is sharing or intends to share downside risk, from the estimated maximum potential losses from all Medicaid MCO contracts with downside risk with one or more financial mechanisms (e.g., liquid assets, stop-loss insurance, working capital and reserves, withhold arrangements or other financial mechanisms).
- iv.** OHIC ensures that if the AE has liquid assets as part of its current or planned process to protect itself from the maximum potential losses, that the liquid assets are in a custodial or controlled account, which can be used exclusively to protect the interests of attributed Medicaid patients.
- v.** OHIC reviews the AE's current and/or planned process for ongoing monitoring of performance against downside financial risk arrangements and assurance of financial solvency and ensures that the process is acceptable.

²⁶ The AE should be the beneficiary of a surety bond or letter of credit.

vi. OHIC reviews the AE’s current and/or planned process for ongoing monitoring of any subcontracted provider entities assuming AE-delegated downside risk and ensures that process is acceptable.

viii. EOHHS notifies the AE by March 15, 2021 of its pre-qualification status. AEs can appeal the decision, in writing to EOHHS, within 30 days of its notification. AEs that choose not to appeal the decision but who would like to reapply for pre-qualification can do so by re-submitting the application and supporting documents addressing the concerns highlighted by OHIC in the original application.

If at any time during its review OHIC determines that it requires additional documentation, it will notify the AE in writing specifying the additional documentation needed.

d. Pre-Qualification Application Materials

Medicaid Accountable Entity Pre-Qualification Application

1. AE Descriptive Information

Rhode Island Medicaid Accountable Entity Organization Information

Name of Applicant: _____

The following information is required of the individual (within the Accountable Entity) who is designated to be the AE’s primary contact for the pre-qualification process:

Title: _____

First Name: _____ Last Name: _____

Position: _____

Street or PO Address: _____

City: _____ State: _____ Zip Code: _____

E-mail Address: _____

Telephone: _____

2. Provide a list of the names of the Medicaid MCOs with which the applicant will be entering into an arrangement to assume financial accountability for the full range, or nearly the full range, of an attributed MCO member population’s health care needs.

Please include contracts that will start in 2021. If contract negotiations are underway at the time of the application or are anticipated to begin but have not yet, indicate the status of negotiations and report anticipated risk arrangement terms.

For each MCO contract, provide the nature of the reimbursement arrangement and the estimated number of attributed patient lives in PY4:

Name of MCO	Risk Arrangement Terms	Aggregate Number of Attributed Patients and Associated Date
	PMPM budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	
	PMPM Budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	
	PMPM budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	

3. Provide a statement that describes the applicant’s experience to date in managing population-based contracts that hold the applicant organization financially responsible for a negotiated portion of costs that exceed a predetermined population-based total cost of care (TCOC) budget.

4. Please attach a plan that provides details of the applicant’s processes and mechanism(s) for ensuring sufficient financial resources to protect a) the applicant and b) those provider entities with which it has subcontracted and intends to share downside risk, from the estimated potential maximum losses from downside risk associated with MCO contract(s)

and AE subcontracts, respectively. AEs should also provide supporting documentation to demonstrate adequate protection against financial loss.

- Explain in this plan any intention to obtain insurance coverage or other agreements that protect the applicant from maximum potential losses from current downside risk, and a description of any other planned risk mitigation mechanisms including any aggregate stop-loss insurance, security deposits, working capital and reserves, withhold arrangements, etc.
 - Distinguish current liquid assets from other mechanisms, including insurance coverage or other agreements that protect the applicant from potential maximum losses from future downside risk. If the AE is employing liquid assets as part of its plan to protect itself from maximum potential losses, those liquid assets must be in a controlled or custodial account to be used exclusively to protect the interests of attributed Medicaid patients. Applicant should provide evidence that the funds are in a controlled or custodial account. If the applicant intends to utilize a surety bond to protect the applicant from potential maximum losses from future downside risk, the bonding company must be certified by the U.S. Treasury.²⁷
 - If the applicant is planning a financial arrangement with any partner organization(s) that is assuming any of the applicant's downside risk, the partner(s) must execute a Parental Guarantee²⁸ document prior to applying for pre-qualification from OHIC. The partner organization with which the AE is executing a Parental Guarantee should have a custodial or controlled account to cover losses. The AE should furnish documentation of the Parental Guarantee's custodial or controlled account.
 - If the risk exposure cap is anticipated to be greater than or equal to 10%, the AE should address plans to 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.
5. Include a description of the applicant's current or planned process for ongoing monitoring of the applicant's financial risk arrangements and financial solvency. This process should include a timely review of the quarterly data reports received from the MCOs.

²⁷ <https://fiscal.treasury.gov/surety-bonds/list-certified-companies.html>.

²⁸ A Parental Guarantee is an agreement between an entity that controls a health care provider and the health care provider. It guarantees the performance of the provider's obligations under the financial risk transfer agreement including the payment of any amounts owed by the health care provider to participating providers for services rendered pursuant to a risk transfer agreement.

6. Include a description of mechanisms that are or will be put in place by the applicant to monitor the financial solvency of any provider entity(ies) with which it has a contracting affiliation and intends to share downside risk associated with MCO contract(s).

ii. PY4 TCOC Financial Solvency Filing, Review, and Assessment

a. AEs that Must File for Financial Solvency Review and Assessment

OHIC will maintain a single review process for all AEs that have entered into arrangements that include shared losses. This review will assess the amount of downside risk the AE assumed in PY4 and whether the AE has an adequate combination of assets and / or other financial mechanisms (e.g., reinsurance, letter of credit) to cover the maximum risk exposure. The PY4 review will also assess an AE's performance in its PY3 risk contracts, as best understood at the time, to ensure adequate financial protections for a combined PY3 loss (if applicable) and PY4 maximum potential loss.

b. Requirements

OHIC will allow for flexibility in AEs' approaches to managing their risk exposure as long as the AE can document a thorough strategy for obtaining protection from estimated maximum potential losses. If an AE has a strong balance sheet, its strategy for covering maximum potential losses due to downside risk could include documenting that it has sufficient existing secured liquid assets and reinsurance to cover the maximum potential losses, with evidence that these funds are secured in a controlled or custodial account. Other organizations without available liquid assets to cover the maximum potential losses may need to develop a risk strategy portfolio consisting of several different approaches. Strategies could include, for example, aggregate and individual stop loss insurance, corporate investors, provider partner organization contributions, insurer withholds, delegation of risk to contracted provider organizations, insurer-provided capital, securities in trust, and letters of credit.²⁹

For AEs without the necessary secured liquid assets to cover their estimated maximum potential loss, OHIC will require provision of copies of any agreements with organizations assuming some or all of the risk on behalf of the AE. Such agreements should, at a minimum, detail the financial arrangement, and the amount of risk being assumed by each organization. OHIC will require that each AE submit documentation that it has taken adequate steps to cover the risk using a) secured assets in a custodial or controlled account(s), and/or b) a reinsurance policy which can be used to protect the interests of enrolled Medicaid members, and/or c) delegation of risk to one or more parties. Taken together, the value of these strategies should not be less than the potential maximum losses due to all downside risk contracts with Medicaid MCOs.

AEs must also submit a planned process for ongoing monitoring of performance against the

²⁹ The AE should be the beneficiary of a surety bond or letter of credit.

downside financial risk arrangements for the AE and any subcontracted entities assuming delegated risk.

c. Process for Filing and Review

For PY4, AEs must submit to OHIC a completed filing application (see attached template) and documents requested in the application, including the following:

- a. Final executed AE/MCO contract for PY4 (July 1, 2021-June 30, 2022)
- b. AE descriptive information
- c. Final description of the financial risk arrangements (see Table 2 in the PY4 filing application)
- d. Final description of experience managing financial risk to date
- e. Current assessment of financial performance relative to PY3 risk arrangements, recognizing that claim runout and settlement processes will not yet be complete. AEs should report the extent of their financial exposure if a loss is projected.³⁰
- f. Final financial protection and risk mitigation processes / mechanisms
- g. Final monitoring processes

Following submission of the final terms of the PY4 contract, OHIC will review the financial risk arrangements, the AE's financial protections, and financial performance monitoring processes. Assuming contracts are submitted to OHIC no later than August 31, 2021, OHIC would notify AEs of their financial solvency certification status or communicate any concerns or additional information requests to AEs by November 1, 2021.

The process that OHIC will follow in its review is outlined below in i-vii.

- i. OHIC determines the AE's actual maximum risk exposure for MCO contracts for the Performance Year.
- ii. OHIC determines whether the AE has sufficient financial resources to protect itself from the estimated maximum potential losses from all Medicaid MCO contracts with downside risk using one or more financial mechanisms (e.g., liquid assets, stop-loss insurance, working capital and reserves, withhold arrangements or other financial mechanisms). This assessment will factor in the AE's financial performance in PY3 downside risk arrangements to ensure adequate financial protections to cover the combined projected PY3 losses (as applicable) **and** maximum potential losses in PY4.
- iii. OHIC also determines whether those AE subcontracted entities with which the AE is sharing TCOC downside risk have sufficient financial resources to protect themselves

³⁰AEs will need demonstrate the capacity to fund PY3 losses and protect against future TCOC financial losses.

from the estimated maximum potential losses from the AE's subcontract using one or more financial mechanisms.

- iv. OHIC ensures that if the AE has liquid assets as part of its current or planned process to protect itself from the maximum potential losses, that the liquid assets are in a custodial or controlled account, which can be used exclusively to protect the interests of attributed Rhode Island Medicaid patients.
- v. OHIC reviews the AE's current and/or planned process for ongoing monitoring of performance against downside financial risk arrangements and assurance of financial solvency and ensures that the process is acceptable.
- vi. OHIC reviews the AE's current and/or planned process for ongoing monitoring of any subcontracted provider entities assuming AE-delegated downside risk and ensures that process is acceptable.
- vii. Communication of status of review: By November 1, 2021, EOHHS notifies the AE of successful certification or communicates any concerns and/or an additional information request related to the AE's final risk terms. AEs can appeal the final decision, in writing to EOHHS, within 30 days of its notification. AEs that choose not to appeal the decision but would like to reapply for financial solvency certification can do so by re-submitting the application and supporting documents addressing the concerns highlighted by OHIC in the original application.

If at any time during its review OHIC determines that it requires additional documentation, it will notify the AE in writing specifying the additional documentation needed.

d. TCOC Financial Solvency Filing Application Materials

Medicaid Accountable Entity TCOC Financial Solvency Certification for PY4

Purpose: AEs should use this application to report the terms of their PY4 TCOC downside risk arrangements as executed in their contracts with Medicaid MCOs.

1. AE Descriptive Information

Rhode Island Medicaid Accountable Entity Organization Information

Name of Applicant: _____

The following information is required of the individual (within the Accountable Entity) who is

designated to be the AE’s primary contact for the pre-qualification process:

First Name: _____ Last Name: _____

Position: _____

Street or PO Address: _____

City: _____ State: _____ Zip Code: _____

E-mail Address: _____

Telephone: _____

2. Provide a list of the names of the Medicaid MCOs with which the applicant executed a contract to assume financial accountability for the full range, or nearly the full range, of an attributed MCO member population’s health care needs. Please include contracts for which the AE has accepted downside risk for any or all of PY4.

For each MCO contract, provide the nature of the reimbursement arrangement and the estimated number of attributed patient lives in PY4.

AE/MCO Contract Risk Arrangement Terms for PY4³¹

Name of MCO	Risk Arrangement Terms of Executed Contracts	Aggregate Number of Attributed Patients and Associated Date
	PMPM budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	
	PMPM Budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	
	PMPM budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	

³¹ See Glossary of Terms at the back of Attachment B for definitions of the terms used in this table.

3. Provide a statement that describes the applicant’s experience to date in managing population-based contracts that hold the applicant organization financially responsible for a negotiated portion of costs that exceed a predetermined population-based total cost of care (TCOC) budget.

- viii. Report financial performance relative to PY3 risk arrangements across all Medicaid MCO contracts identified in the 2020 certification application, as best known at the time of this filing.

Indicate if the applicant projects any losses under its PY3 risk arrangements.

Name of Medicaid MCO	Projected Risk Arrangement Loss for PY3 (Y/N)

- ix. Please attach a plan that provides details of the applicant’s processes and mechanism(s) for ensuring sufficient financial resources to protect a) the applicant and b) those provider entities with which it has subcontracted and intends to share downside risk, from the estimated potential maximum losses from downside risk associated with MCO contract(s) and AE subcontracts, respectively. AEs should also provide supporting documentation to demonstrate adequate protection against financial loss.

- Include in this plan evidence of any insurance coverage or other agreements that protect the applicant from maximum potential losses from current downside risk, and a description and evidence of the applicant’s other risk mitigation mechanisms including any aggregate stop-loss insurance, security deposits, working capital and reserves, withhold arrangements, etc.
- Distinguish current liquid assets from other mechanisms, including insurance coverage or other agreements that protect the applicant from potential maximum losses from future downside risk. If the AE is employing liquid assets as part of its plan to protect itself from maximum potential losses, those liquid assets must be in a controlled or custodial account to be used exclusively to protect the interests of attributed Medicaid patients. Applicant should provide evidence that the funds are in a controlled or custodial account. If the applicant intends to utilize a surety bond to protect the

applicant from potential maximum losses from future downside risk, the bonding company must be certified by the U.S. Treasury.³²

- If the applicant is planning a financial arrangement with any partner organization(s) that is assuming any of the applicant's downside risk, the partner(s) must execute a Parental Guarantee³³ document prior to applying for pre-qualification from OHIC. The partner organization with which the AE is executing a Parental Guarantee should have a custodial or controlled account to cover losses. The AE should furnish documentation of the Parental Guarantee's custodial or controlled account.
 - 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.
- x. Include a description of the applicant's current or planned process for ongoing monitoring of the applicant's financial risk arrangements and financial solvency. This process should include a timely review of the quarterly data reports received from the MCOs.
- xi. Include a description of mechanisms that are or will be put in place by the applicant to monitor the financial solvency of any provider entity(ies) with which it has a contracting affiliation and intends to share downside risk associated with MCO contract(s).

Glossary of Terms

Parental Guarantee - An agreement between an entity that controls a health care provider and the health care provider. It guarantees the performance of the provider's obligations under the financial risk transfer agreement including the payment of any amounts owed by the health care provider to participating providers for services rendered pursuant to a risk transfer agreement.

Partner Organization - An entity that will be assuming some of the AE's downside risk. It may be, but is not limited to, a corporate parent or otherwise related corporate entity, an investor, a business partner, or a delegated provider entity that delivers health care services to the AE's attributed patients. A delegated physician or other professional provider is not a partner organization if the totality of its assumption of AE risk is borne through a payment withhold.

³² <https://fiscal.treasury.gov/surety-bonds/list-certified-companies.html>.

³³ A Parental Guarantee is an agreement between an entity that controls a health care provider and the health care provider. It guarantees the performance of the provider's obligations under the financial risk transfer agreement including the payment of any amounts owed by the health care provider to participating providers for services rendered pursuant to a risk transfer agreement.

PMPM (Per Member Per Month) Budget – A prospectively defined spending target associated with an Accountable Entity’s (AE) attributed population, wherein spending is defined on an average monthly per capita basis, or “per member per month.”

Provider Revenue – This is the total annual service revenue, care management and infrastructure payments accruing to the provider for attributed members under the contract. This should be reported for those contracts that employ a risk exposure care based on provider revenue.

Risk Exposure Cap - Also called Maximum Shared Loss Pool. This is a cap on the losses the organization may incur under the contract, expressed as a percentage of a) the total cost of care or b) the annual service revenue from the insurer under the contract. It is the maximum percentage of the organization’s contract revenue for which the organization is financially at risk.

Risk Sharing Rate - Also called the Marginal Risk. This is the percentage of total losses shared by the organization with the insurer under the contract after the application of any risk exposure cap and/or minimum loss rate. It is the percentage of any Shared Loss Pool for which the organization is financially at risk.

Stop Loss Insurance (aggregate/specific) - Aggregate stop-loss insurance is a policy designed to limit claim coverage (losses) to a specific amount. This coverage ensures that a catastrophic claim (specific stop-loss) or numerous claims (aggregate stop-loss) do not drain the financial reserves of the organization.

Total Cost of Care - A historical baseline or benchmark cost of care specifically tied to an Accountable Entity’s (AE) attributed population projected forward to the performance period.

Withhold Arrangement - A withhold arrangement is characterized by the insurer withholding the amount of money at risk until the contracting organization furnishes services to the members and meets certain quality and/or cost standards.

ATTACHMENT K – INFRASTRUCTURE INCENTIVE PROGRAM: REQUIREMENTS FOR MANAGED CARE ORGANIZATIONS AND CERTIFIED ACCOUNTABLE ENTITIES

Program Year 4

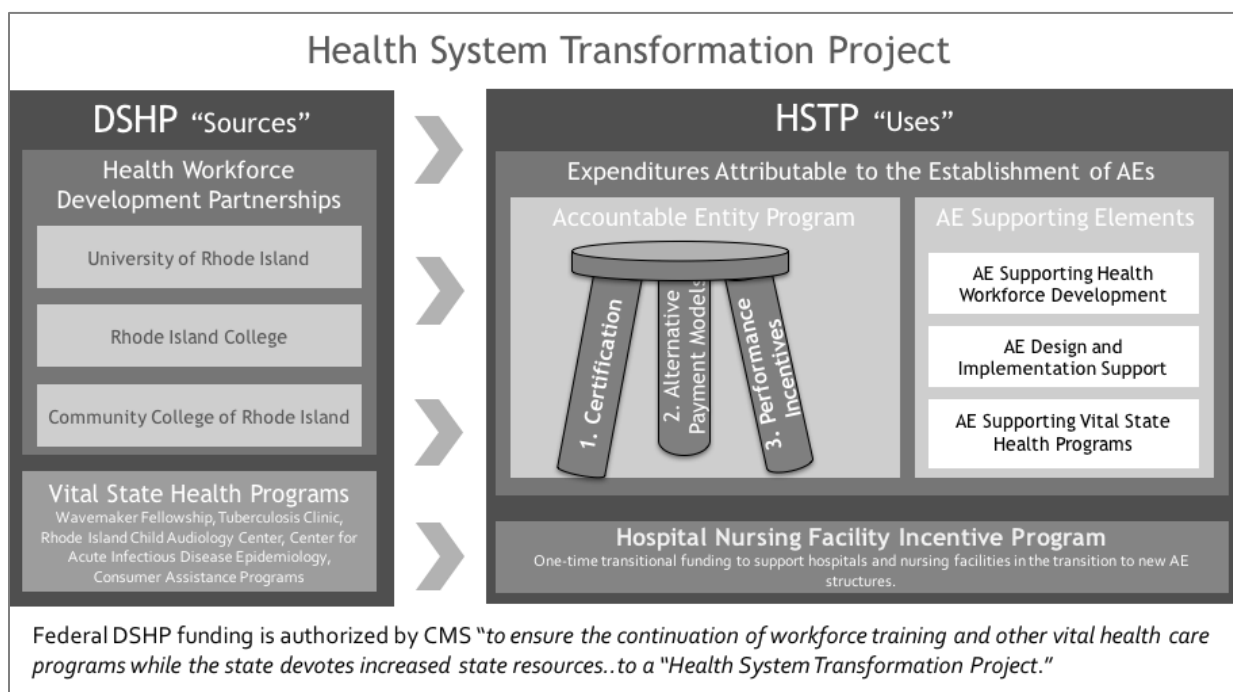
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EOHHS INCENTIVE PROGRAM REQUIREMENTS

I. BACKGROUND AND CONTEXT

In October 2016, the Centers for Medicare & Medicaid Services (CMS) approved the request made by the Rhode Island (RI) Executive Office of Health and Human Services (EOHHS) to amend the Rhode Island Comprehensive 1115 Waiver Demonstration to create a pool of funds focused on the design, development and implementation of the infrastructure needed to support Accountable Entities. This funding is based on the establishment of an innovative **Health Workforce Partnership** with RI’s three public institutions of higher education (IHE): University of Rhode Island (URI), Rhode Island College (RIC), and the Community College of Rhode Island (CCRI), as illustrated below.



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

- Investments in partnerships with Institutions of Higher Education (IHEs) for statewide health workforce development and technical assistance to AEs
 - One-time funding to support hospitals and nursing facilities with the transition to new AE structures³⁴

³⁴ The STCs limit this program to be one-time only and to not exceed \$20.5 million, paid on or before December 31, 2017. *Note that the PMPM

- Project management support to ensure effective and timely design, development and implementation of this program
- Project demonstration pilots and project evaluation funding to support continuous program learning, advancement and refinement
- Other supporting programs, including Consumer Assistance, Wavemaker Fellowship, TB Clinic, RI Child Audiology Center, and Center for Acute Infectious Disease Epidemiology

II. DETERMINING MAXIMUM INCENTIVE POOL FUNDS

1. MCO Specific Incentive Pools (MCOIP)

For Program Year 4, the MCO-Specific Incentive Pool amount shall be derived from multiplying a per member per month (PMPM) multiplier times the number of Medicaid attributed lives, in accordance with the following formula.

Program Year 3: MCO-Specific Incentive Pool (MCOIP) Calculation		
PMPM Multiplier	x Attributed Lives	x 12
\$1.30	At the start of each Program Year in accordance with EOHHS defined requirements	Translate from Member Month to annual

2. Accountable Entity Incentive Pools (AEIP)

AEs certified for Program Year 4, 7/1/21-6/30/2022), that demonstrate completion of the Office of the Health Insurance Commissioner (OHIC) pre-certification process, and in a qualified Alternative Payment Methodology (APM) contract consistent with EOHHS requirements, are eligible to participate in the Medicaid AE Incentive Program³⁵. In PY 4, EOHHS shall establish an AE-Specific Incentive Pool that establishes the total incentive dollars that may be earned by each AE during the PY period. The MCO shall implement and operate the AE Incentive Pool and determine whether an AE achieves the milestones and/or metrics to earn incentive funding.

For Program Year 4, the AE-Specific Incentive Pool amount shall be derived from multiplying a per member per month (PMPM) multiplier times the number of Medicaid attributed lives, in accordance with the following formula.

Program Year 3: AEIP AE-Specific Incentive Pool (AEIP) Calculation		
PMPM Multiplier	x Attributed Lives	x 12

Multiplier shown above has been established by EOHHS for Program Year 3; the PMPM Multiplier will be defined and released on a yearly basis by EOHHS.

³⁵ In accordance with CMS guidance, EOHHS must ensure that Federally Qualified Health Centers receive and retain 100% of the Medicaid payments and cannot be put at risk for receiving less than PPS for FQHC services. Therefore, FQHC AEs may remain in shared savings-only contracts if they demonstrate a progression to value-based care. Such progression may include but is not limited to the development of evidence-based processes, incentives for cost reduction, and the establishment of sustainability for interventions currently funded by grants.

\$6.84	At the start of each Program Year in accordance with EOHHS defined requirements	Translate to Member Month
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EOHHS recognizes that over the term of the performance period there will be fluctuations in the number of attributed members. Such changes will not alter the value of the AEIP or MCOIP for the performance period unless there is a material reduction in the number of attributable lives. A material reduction shall be a reduction of 15% or more sustained over two quarters. In such case that a material reduction is experienced, the AEIP and MCOIP will be reduced accordingly with appropriate reductions made to any remaining incentive payments within the AEIP and MCOIP. The AEIP and MCOIP will not be increased if there is a growth in the attributed lives as to not exceed the HSTP funds available to EOHHS for this initiative. However, changes in the number of attributed lives will continue to be a factor in calculations in TCOC related contracts with MCOs. EOHHS' determination of the value of the AEIP and MCOIP shall be based upon the number of Medicaid AE attributed lives. Such determination shall be consistent with attribution requirements set forth by EOHHS.

III. EOHHS Priorities

Each MCO's AE Incentive Pool budget and actual spending must align with the AE Program Goals of EOHHS as developed with the support of the HSTP AE Advisory Committee and shown below.

- Transition the Medicaid payment system away from fee-for-service to alternative payment models.
- Drive delivery system accountability to improve quality, member satisfaction and health outcomes, while reducing total cost of care.
- Develop targeted provider partnerships that apply emerging data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs.
- Improve health equity and address SDOH and behavioral health by building on a strong primary care foundation to develop interdisciplinary care capacity that extends beyond traditional health care providers.
- Enable vulnerable populations to live successfully in the community.

IV. HSTP PROJECT BASED METRICS ELIGIBLE FOR AWARD OF AEIP FUNDS

HSTP Project based metrics shall be based on tangible projects within the AE Certification Standards and must be linked to one or more of the eight domains described below. For Program Year 4 and beyond, HSTP projects must shift toward system transformation capacities

(domains 4-8).

	Domains	Allowable Uses of AEIP Funds
A. Readiness	1. Breadth and Characteristics of Participating Providers	<ul style="list-style-type: none"> Building provider base, population specific provider capacity, interdisciplinary partnerships, developing a defined affiliation with community-based organizations (CBOs) Developing full continuum of services, Integrated PH/BH, Social determinants , including robust referral process and workflow for complex and high need patients
	2. Corporate Structure and Governance	<ul style="list-style-type: none"> Establishing a distinct corporation, with interdisciplinary partners joined in a common enterprise
	3. Leadership and Management	<ul style="list-style-type: none"> Establishing an initial management structure/staffing profile Developing ability to manage care under Total Cost of Care (TCOC) arrangement with increased risk and responsibility
B. IT Infrastructure*	4. Data Analytic Capacity and Deployment	<ul style="list-style-type: none"> Building core infrastructure: EHR capacity, patient registries, Current Care Provider/care managers' access to information: Lookup capability, medication lists, shared messaging, referral management, alerts Analytics for population segmentation, risk stratification, predictive modeling Integrating analytic work with clinical care: Clinical decision support tools, early warning systems, dashboard, alerts Staff development and training – individual/team drill downs re: conformance with accepted standards of care, deviations from best practice
C. System Transformation	5. Commitment to Population Health and System Transformation	<ul style="list-style-type: none"> Developing an integrated strategic plan for population health that is population based, data driven, evidence based, client centered, recognizes Social Determinants of Health, team based, integrates BH, IDs risk factors Implementation of contracts with social service organizations to address key SDOH gaps and needs Implementation of evidence based BH integration and consultation services Healthcare workforce planning and programming
	6. Integrated Care Management	<ul style="list-style-type: none"> Systematic process to ID patients for care management Defined Coordinated Care Team, with specialized expertise and staff for distinct subpopulations Individualized person-centered care plan for high risk members
	7. Member Engagement and Access	<ul style="list-style-type: none"> Defined strategies to maximize effective member contact and engagement Use of new technologies for member engagement, health status monitoring and health promotion Implementation of tele-health
	8. Quality Management	<ul style="list-style-type: none"> Defined quality assessment & improvement plan, overseen by quality committee Implementation of clinical data exchange and aggregation for quality measure (hybrid and EHR based measures).

* The state may make direct investments in certain technology to support provider to provider EHR communication, such as dashboards and alerts. This investment would be made directly by the state with

vendor(s) which would have the capacity and expertise to create and implement this technology in AEs statewide. This may be done in certain technology areas where direct purchasing by the state would result in significant efficiencies and cost savings. The products and tools resulting from this direct state technology investment would be made available to all AEs at no upfront charge. AEs would have the choice to either utilize the statewide tool at no charge or pay for their own tool. In this case, HSTP funds would not be available for the AE to separately purchase such a tool.

V. ACCOUNTABLE ENTITY INCENTIVE POOL (AEIP) & MANAGED CARE ORGANIZATION INCENTIVE POOL (MCOIP) REQUIRED PERFORMANCE AREAS AND MILESTONES

Earned AEIP funds shall be awarded by the MCO to the AE in accordance with the distribution by performance area and metrics defined below. Earned AEIP funds are intended to advance AE program success through capacity building based on identified gaps and needs. Capacity building efforts may include implementation of project specific interventions, business models, and data requirements necessary for an AEs to manage the total cost of care and quality for an attributed population.

The MCO-IP shall be awarded from EOHHS to MCOs based on the same set of performance areas and metrics. This ensures that both the MCO and AE are collaborating towards achievement of similar objectives. MCOIP funds are intended for use toward advancing AE program success, including program administration and oversight, assisting with the development of the necessary infrastructure to support a new business model, and establishing shared responsibilities, information requirements and reporting between MCOs and AEs.

Required Performance Areas and Milestones		
Performance Area	Minimum Milestones	PY 3 Allocation
Fixed Percentage Allocations Based on Specific Achievements:	<ul style="list-style-type: none"> FQHC AEs: Return on Investment (ROI) Project. In partnership with a contracted MCO, identify a type of utilization to target for reduction, the targeted amount of reduction and the associated cost saving, and an intervention that is expected to achieve this reduction. FQHC-based AEs may designate the activities performed pursuant to one of the HSTP Projects below as the intervention for the ROI Project. It is the responsibility of the MCO to utilize data analytics and predictive modeling tools to assist the AE to identify an area of utilization to target, based on current avoidable utilization gaps/opportunities and to identify the cost savings associated with the reduction. Non-FQHC AEs: Evidence of participation in contracts that include shared losses, including evidence of RBPO certification per OHIC. 	5%
FQHC ROI Project Pay for Performance	<ul style="list-style-type: none"> At the end of the Performance Year, FQHC-based AEs and MCOs are eligible to receive Incentive Funds in the amount that their intervention saved by reducing the target utilization, up to 5% of the Incentive Fund Pool. See guidance document for further detail. 	5%

New Pay for Reporting Measures	<ul style="list-style-type: none"> Percentage of AE attributed lives with a primary care visit for whom their attributed primary care provider possesses their race, ethnicity and language data. 	5%
Annual Reporting on Outcome Metrics	<ul style="list-style-type: none"> Outcome Metrics Pay for Performance Allocation: EOHHS will work with MCOs and AE to determine appropriate performance-based targets for the following metrics. http://www.eohhs.ri.gov/Initiatives/AccountableEntities/ResourceDocuments.aspx <ul style="list-style-type: none"> All-Cause Readmissions (15%) Potentially Avoidable ED Visits (10%) ED Utilization Among Members with Mental Illness (20%) 	45%
Variable Allocation HSTP Project Based MCO and AE defined performance measures³⁶	<ul style="list-style-type: none"> MCO and AE defined performance measures and targets for at minimum 3 AE core projects Each project should have at minimum 2 measures per project³⁷ If an FQHC-based AE chooses to designate a project as its ROI Project intervention, the AE will be eligible to earn Incentive Funds through achievement of project measures as with any other project and will separately be eligible to earn up to 5% of Incentive Funds through achieving an ROI. At a minimum, one project must focus on behavioral health integration and one project must focus on social determinants of health. 	45% (40% for FQHC-based AEs)
Total		100%

In accordance with EOHHS’ agreement with CMS, participating AEs must fully meet performance metrics prior to payment. EOHHS recognizes the financial constraints of many participating AEs and that timely payment for the achievement of milestones will be critical to program success.

VI. AEIP Funding Requirements

Under the terms of EOHHS’ agreement with the federal government, this is not a grant program. AEs must earn payments by meeting metrics defined by EOHHS and its managed care partners, and approved by CMS, to secure full funding.

Certified AEs must develop individual Health System Transformation Project Plans (HSTP Project Plans) that identify clear project objectives and specify the activities, measures, and timelines for achieving the proposed objectives. HSTP project plans will be submitted as part of the Program Year 3 Certification/Re-certification application. EOHHS will review and approve each HSTP project plan as part of the certification process. Further detail regarding the HSTP project plan is in the Medicaid Accountable Entity Application for Certification.

Incentive Funding **must be earned and awarded to the AE via a Contract Amendment** between the MCO and the AE. The Contract Amendment shall:

- Be subject to EOHHS review and approval
- Incorporate the central elements of the approved AE submission, including:

³⁶ Both the MCO and AE have up to one (1) year to achieve the HSTP project-based metric.

³⁷ Percentage of incentive funds and weighting for each of these measures are to be determined by MCO and AE and approved by EOHHS.

- Performance schedule and performance metrics
 - Payment terms – basis for earning incentive payment(s) commensurate with the value and level of effort required.
- A defined process and timeline to evaluate whether AE performance warrants incentive payments. The AE's failure to fully meet a performance metric within the timeframe specified will result in forfeiture of the associated incentive payment. **There will be no payment for partial fulfillment.**
 - Stipulate that the AE earns payments through demonstrated performance. The MCO must certify that an AE has met the performance metric target as a condition for the release of associated HSTP funds to the AE. AEs submit quarterly reports to the MCO using a standard reporting form to document progress in meeting identified performance metrics and targets that would entitle the AE to qualify to receive HSTP payments; such reports will be provided to EOHHS by the MCO.³⁸
 - AE performance metrics in the “Fixed Percentage Allocations Based on Specific Achievements” category is specific to the performance period and must be met by the close of the performance year for an AE to earn the associated incentive payment.
 - AE performance metrics in the “Variable Allocation HSTP Project Based Measures” require a process by which an AE that fails to meet a performance metric in a timely manner can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric.

AEs shall be required to demonstrate that at least 10% of Program Year 3 incentive funds are allocated to partners who provide specialized services to support behavioral health care, substance abuse treatment and/or social determinants. Funds that are not completely exhausted in the program year can be earmarked for other contracts in support of SDOH and BH integration and/or for the following program year. The intent is that these funds be explicitly used to support the CBO for their role, function and infrastructure and capacity building in the effort to further integrate such services. Partnerships with social service organization (SSO), behavioral health and/or opioid health home should be driven based on an AEs analytic profile inclusive of identified community needs and gaps, outcome of SDOH Screenings and a geographic analysis. These funds are to be used to build capacity for such community-based organization to enter into financial arrangements with a health care system. Capacity building efforts may include infrastructure support related to information technology, analytics, systems, care coordination/integration of services, with attention to on non-Medicaid billable services such as housing and food insecurity.

Payment and Reconciliation

In advance of the MCOs payments to AEs, the MCO shall receive payment from EOHHS in the amount and schedule agreed upon with EOHHS. AEIP and MCOIP milestones will be paid on a

³⁸ Reporting templates will be developed in partnership with EOHHS

quarterly basis. MCOs shall make associated payments to AEs within thirty (30) calendar days of approving AE performance metric achievement based on satisfactory evidence. The MCO will maintain a report of funds received and disbursed by transaction in a format and in the level of detail specified by EOHHS. Within thirty (30) calendar days of the end of each calendar quarter, the MCO will provide the report to EOHHS for internal tracking of funds. The MCO will work with EOHHS to resolve any reporting discrepancies within fifteen (15) calendar days of notification of such discrepancy.

Actual AEIP incentive payment amounts to AEs will be based on demonstrated AE performance, accordingly, incentive payments earned by the AE may be less than the amount they are eligible to earn. MCOs shall not be entitled to any portion of funds from the Accountable Entity Incentive Pool that are not earned by the AE. Any monies not remitted to an AE from the Accountable Entity Incentive Pool must be returned to EOHHS.

Within forty-five (45) calendar days after the close of each quarter, EOHHS will review the budgeted AEIP funds retained by the MCO and deduct or recoup associated AEIP funds from the next quarterly payment if an AE has not met their performance milestone or metric within 365 days of target date. At the conclusion of the program and/or termination of an agreement, any Incentive Program funds that are not earned by EOHHS Certified AEs as planned will be returned to EOHHS within thirty (30) calendar days of such request by EOHHS.

VII. ALLOWABLE & DISALLOWABLE USE OF AEIP FUNDS

EOHHS/Medicaid will oversee the MCOs administration and management of the HSTP incentive program. In accordance with requirements, MCOs shall directly report to EOHHS on a quarterly basis each AEs achievement of HSTP incentive milestones/metrics and earned funds. Incentive funds should be used to directly support the goals and objectives of the Medicaid Accountable Entity program. However, EOHHS is not prescriptive on how earned incentive funds are overtly used, however EOHHS does require each Medicaid AE and MCO to attest that earned HSTP incentive funds **will not** be used for specific expenditures as outlined below. This attestation is required to remain eligible to earn HSTP incentive funds. These non-allowable expenditures have been developed in alignment with Section 2 CFR 200 which outlines Financial Management and Internal Control Requirements for receipt, tracking and use of federal funds by non-Federal awardees, and shall be updated by EOHHS as appropriate.

General Disallowable Uses:

- To directly mitigate against downside risk for the AE, the AE Partner of an AE, the AEs participating primary care physicians (PCPs), or for an AEs Safety Net Hospital(s)
- To offset revenue from reduced hospital utilization
- To pay for any costs incurred in the process of responding to the EOHHS AE Application, or during contract negotiations with Medicaid MCOs

- To pay for initiatives, goods, or services that are duplicative with initiatives, goods, and services that the AE, including any participating entities of the AE, currently fund with other federal, state, and/or local funding
- To pay for any RI Medicaid service (whether covered by the MCO or covered as a wrap service)
- To support personnel FTE allocation in a duplicative manner with payments provided for Covered Services
- To provide goods or services not allocable to approved project plans and budgets
- To pay for construction or renovations
- To pay for malpractice insurance

Expenditures cannot include the following:

- Alcoholic beverages
- Medical Marijuana
- Copayments/Premiums
- Capital expenditures (unless approved in advance by EOHHS)
- Credit Card Payments Interest
- Debt restructuring and bad debt
- Student Loan Repayment
- Defense and prosecution of criminal and civil proceedings, and claims
- Donations, fund raising, and investment management costs
- Social activities (good and services intended for leisure or recreation), Hobbies (materials or courses)
- Fines and penalties
- Goods or services for personal use, including but not limited to entertainment, gift cards or other cash equivalents
- Idle facilities and idle capacity
- Insurance and indemnification
- Licenses (drivers, professional or vocational)
- Lobbying
- Marketing/member communication expense, unless approved in advance by EOHHS
- Memberships and subscription costs

- Patent costs

Duplication Disallowable Uses

HSTP funding cannot substitute, duplicate, or replace services or goods that are available through other state or federal programs (e.g., Supplemental Nutrition Assistance Program (SNAP), SNAP Nutritional Education (SNAP-Ed), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)) or other RI Medicaid MCO and FFS (wrap) Covered Services. Medicaid MCOs and AEs are responsible for ensuring non-duplication. Potential areas of duplication include, but are not limited to:

- RI Medicaid Covered Services including, State Plan services and 1115 demonstration services
- Services that are duplicative of services a member is already receiving
- Services where other funding sources are available such as services that a member is eligible for, and able to receive from a federal agency, another state agency. In certain cases, a member may not be “able to” access certain programs and thus HSTP funds may be utilized. Such cases may include, but are not limited to, a program that has:
 - Run out of funds or lacks capacity (e.g., organization does not have the resources to assist with additional enrollment)
 - Delayed access to services or goods (e.g., wait list, waiting for a determination on eligibility and availability).

In such cases, the AE may provide services until the member is able to receive the public services. While HSTP funds cannot duplicate federal or state benefits or services, they can supplement such programs. In such cases, AEs must ensure that members are receiving the benefits or services, or, if applicable and appropriate, concurrently work to help members receive the benefits or services in conjunction with supplementing that program.

AEs may determine if the member’s needs are being addressed by existing programs and ensure non-duplication through mechanisms including, but not limited to, member attestation or information from a professional providing services to the member (e.g., care manager).

AEs may be required to demonstrate earned HSTP funds are not duplicative of the existing benefits or services their target population is already receiving or eligible for as well as demonstrate such funds appropriately meet that need without exceeding it. For example: An AE develops a program to increase access to food for a target population and identifies SNAP and WIC as potentially duplicative but finds, that SNAP and WIC will not provide enough nutritional value for the target population and generally a certain additional amount of food is needed; thus the AE is supplementing SNAP and WIC, and not duplicating those programs.

ATTACHMENT D - Alternative Payment Methodology Reporting Template



APMReport_Template_v.3 (1).xlsx