ATTACHMENT L - Accountable Entity Roadmap Document

Table of Contents

I. Accountable Entity Roadmap Overview and Purpose

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

The purpose of this document is to:

- Document the State's vision, goals and objectives under the Waiver.
- Detail the State's intended path toward achieving the transformation to an accountable, comprehensive, integrated cross-provider health care delivery system for Medicaid enrollees, and detail the intended outcomes of that transformed delivery system.
- Provide an update to the State's previously submitted and approved Roadmap, as is required annually under STC 44.

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

This roadmap has been developed with input from participating managed care organizations (MCOs), AEs, and community and industry stakeholders.

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

II. Rhode Island's Vision, Goals and Objectives

Rhode Island's Medicaid program is an essential part of the fabric of Rhode Island's health care system now serving one out of three Rhode Islanders. The program has achieved national recognition for the quality of services provided, with Medicaid MCOs that are consistently ranked in the top ten in national NCQA rankings for Medicaid MCOs. While these achievements are valuable, prior to the implementation of AEs the system of care had certain limitations that were recognized here in Rhode Island and nationally:

- It was generally fee based rather than value based;
- It did not generally focus on accountability for health outcomes;
- There was limited emphasis on a Population Health approach; and
- There was an opportunity to better meet the needs of those with complex health needs and exacerbating social determinants.

Rhode Island's system of care did not consistently provide whole-person care, because, as encouraged and reinforced by our fee-for-service (FFS) payment model, it focused predominantly on medical care of particular health conditions. As a result of this model, care was often siloed and/or fragmented rather than coordinated, with high hospital readmissions, avoidable emergency room visits and missed opportunities for intervention. Although individual providers were performing well**,** no single provider "owned" service integration or was accountable for the overall outcomes of a patient. This made it more likely that a patient would experience fragmented rather than coordinated care, leading to duplicative services, unsuccessful referrals, and unmet needs. These issues were particularly problematic when serving the most complex Medicaid populations - six percent of Medicaid users account for almost two thirds (65%) of Medicaid claims expenditures. Disproportionately high expenditures are often associated with populations receiving institutional and residential services, those with co-occurring physical, behavioral health, and members with unmet social determinant of health needs.

While EOHHS has taken steps to alleviate many of these issues, there is further work to be done. Effective delivery system transformations must continue to build partnerships and align financial incentives across payment, delivery and social support systems in order to meet the real life needs of individuals and their families.

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

The Managed Care Program's Strategic Goals are:

1. Maintain historical program strengths focused on health outcomes, cost containment, and the satisfaction of the Rhode Islanders served.

[1] These strategic goals were presented at an EOHHS AE Advisory Committee meeting on June 19, 2019; refinements to the AE Program strategic goals were presented at an EOHHS AE Advisory Committee meeting on August 7, 2019.

2. Improve engagement in and satisfaction with care received among Rhode Islanders on Medicaid, particularly for those with complex healthcare needs.
3. Implement value-based payment models that create incentive structures to orient the system to better respond to individual's comprehensive needs and reward models of accountable care delivery that demonstrate improved health outcomes and cost containment.
4. Improve health outcomes for Rhode Islanders on Medicaid by orienting the health care delivery system to:
    a. Better integrate medical and behavioral health care in a way that is particularly supportive of those with complex or chronic care needs
    b. Respond to upstream determinants of health to address individual's health related social needs and consider community factors that impact population health, with an emphasis on housing and homelessness
    c. Meet unique needs of elderly and members with disabilities and those in need of long-term services and supports (LTSS) in a way that prioritizes choice and empowers individuals to remain in the community
    d. Support optimal health, development, and well-being of Medicaid covered children, with a focus on the prevention of child maltreatment
5. Achieve the specific strategic goals of the Health System Transformation Project that is focused on the establishment and implementation of the AE Program:
    a. Transition the Medicaid payment system away from fee-for-service to alternative payment models
    b. Drive delivery system accountability to improve quality, member satisfaction and health outcomes, while reducing total cost of care
    c. Develop targeted provider partnerships that apply emerging data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs
    d. Improve health equity and address Social Determinants of Health (SDOH) and Behavioral Health (BH) by building on a strong primary care foundation to develop interdisciplinary care capacity that extends beyond traditional health care providers
    e. Enable vulnerable populations to live successfully in the community

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

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

III. Our Approach

The AE program was developed in the context of Rhode Island's existing managed care model. The program is expected to enhance MCO and AE capacity to serve high-risk populations by increasing delivery system integration and improving information exchange/clinical integration across the continuum.

EOHHS Envisions Two Specific AE Programs:

Phase 1: Comprehensive AE Program

EOHHS views the development of Comprehensive AEs as the core objective of its Health System Transformation Project. The Comprehensive AE is an interdisciplinary partnership of providers with a strong primary care base that ensures coordinated access to other services, including specialty care, behavioral health care, and social support services. AEs are accountable for healthcare costs and quality of care for attributed populations and must adopt a population health approach that is population-based, data-driven, evidence-based, person- and family-centered, recognizes and addresses social determinants of health, includes care management and care coordination, and integrates behavioral and physical healthcare.

After the completion of a two-year pilot program, the Comprehensive AE Program launched July 1, 2018. As a core part of the program EOHHS conducts a certification process through which prospective Comprehensive AEs demonstrate that they meet the AE Certification Standards issued by EOHHS. From Program Year 1 to Program Year 6 AEs were re-certified annually. Starting in Program Year 7 AEs will be required to recertify every two (2) years. As of state fiscal year 2023, EOHHS has certified seven Comprehensive AEs for participation in the program. Six AEs contracted with MCOs and entered into Total Cost of Care (TCOC) and AE Incentive Program arrangements for Program Year 2 and Program Year 3, and a seventh contracted with MCOs and entered into TCOC and AE Incentive Program arrangements for Program Year 4 and Program Year 5. In Program Year 6 seven AEs entered into TCOC and AE Incentive Program arrangements with MCOs; six AEs took on downside risk.

Phase 2: Specialized AE: LTSS APM Program

In July 2022, EOHHS, in partnership with CMS, extended its three-way contract with the state's participating Medicare-Medicaid Plan (MMP) through CY 2023. In addition to the MMP program, Rhode Island has four coordination-only Dual Eligible Special Need Plans (D-SNP) that serve the state's dual eligible population. EOHHS is piloting a specialized AE program, (henceforth referred to as a LTSS APM) through the MMP program. D-SNPs operating in the state are not eligible to participate in the LTSS APM program. It has been EOHHS' long-standing objective to encourage and enable LTSS eligible and aging populations to live successfully in their communities. The impacts of the COVID-19 Public Health Emergency (PHE) make this goal of successful home and community-based services all the more important as we construct our recovery. The HSTP program provides EOHHS with an opportunity to implement an APM model focused specifically on home and community-based services needed to prevent the Medicaid-eligible population from needing institutional LTSS. This requires a

"Specialized" approach and focus that acknowledges the unique challenges including but not limited to:

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

The design of this LTSS APM model was informed by a robust stakeholder engagement process. Feedback was initially solicited as part of the broader stakeholder engagement process surrounding the HSTP program that EOHHS contracted with Day Health Strategies to provide project management support for this effort in 2019. Planning was interrupted due to the PHE, however, throughout the summer of 2021, EOHHS reconvened engaged stakeholders in discussions to inform the program design for the LTSS APM model. As a result of those discussions, EOHHS worked to develop a quality pay-for-performance model focused on improving equitable access to HCBS services that enable LTSS eligible populations to live successfully in their communities. EOHHS drafted LTSS APM Program Requirements that were posted for public comment in November of 2021 and continued to engage stakeholders throughout the initial program development process.

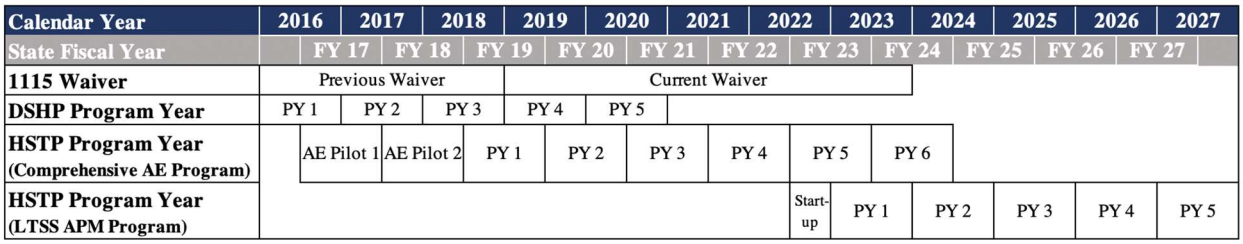
The development and design of the LTSS APM model began in PY3 and continued through PY4. The program launched in July 2022 as an 18-month pilot. While EOHHS hoped to implement the full "pay for performance" phase of the APM in January 2024, the identified funding to support this program will not be available. For this reason, the LTSS APM will conclude with the end of the program pilot on June 30, 2024. EOHHS remains hopeful that we will be able to use the insights gained from this pilot program to formulate, develop, and implement innovative payment models for home health services. EOHHS remains committed to supporting home care providers through other supports and alternative payment models that support Medicaid beneficiaries and strengthen our continuum care.

LTSS APM Program Timeline

Phase	Timeline	Key Elements
Phase 1 *Design and Development*	PY 3-4 October 2020-June 2022	• Design an APM model for MMP contract • Develop critical systems and operational capacities to support the implementation of an APM model in managed care starting with a quality performance program Stakeholder engagement, partner discussions
Phase 2 *Pilot Implementation*	PY 5-6 July 2022-December 2023	• Pilot key elements of LTSS APM program within existing MMP contract • Use lessons learned to modify model as needed and determine if model can be replicated as part of integrated D-SNP contracts that go into effect January 2026.

EOHHS is committed to supporting the Comprehensive AE Program through the Medicaid Infrastructure Incentive Program (MIIP). Beginning in late 2015, EOHHS began pursuing Medicaid waiver financing to provide support for AEs by creating a pool of funds primarily focused on assisting in the development and implementation of the infrastructure needed to support Accountable Entities. RI applied for such funding in early 2016 as an amendment to RI's current Global Medicaid 1115 Waiver. In October 2016, the Centers for Medicare & Medicaid Services (CMS) approved this waiver amendment, bringing $129.8 million in Federal Financial Participation (FFP) to RI from November 2016 through December 2020. The Medicaid Infrastructure Incentive Program continues through June 30, 2024. If unearned funds remain at that time, the state will continue the Program through June 30, 2025 to complete the expenditures.

The overall timeline for this project is depicted below:



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

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

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

- EOHHS holds public input sessions and participant working sessions with key stakeholders and interested public participants
- Draft requirements documents are posted for public comment, and documents are revised in consideration of public comments before final submission to CMS
- On-going/ad-hoc Partner Meetings with MCOs and AEs are held to cover emerging topics.

IV. Program Structure

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

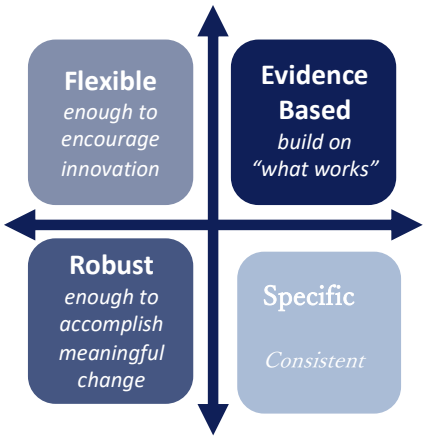
Core Pillars of EOHHS Accountable Entity Program

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

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

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

Note that these pillars were developed with an effort to balance the following key principles:



- **Evidence Based,** leveraging learnings from our pilot, other Medicaid ACOs and national Medicare/Commercial experience
- **Flexible enough to encourage innovation,** ACOs, and particularly Medicaid ACOs, are relatively new, and in many developmental areas clear evidence is not available
- **Robust enough to accomplish meaningful change**, and foster organizational commitments and true investments
- **Specific enough to ensure clarity and consistency**, recognizing that consistent guidelines provide clarity to participants

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

V. Certification Requirements

Comprehensive Accountable Entities

Attachment H: AE Certification Standards articulate detailed requirements for AE certification. These standards were developed and are reviewed and updated based on the following:

- Learnings from the AE Pilot program and prior program years
- National/emerging lessons from other states implementing Medicaid ACOs
- EOHHS multi-year participation in a Medicaid ACO Learning Collaborative facilitated by the Center for Health Care Strategies (CHCS) and sponsored by the Commonwealth Foundation
- Lessons learned from the existing Medicare and Medicaid ACO programs
- Alignment with Value Based and Quality Measure ACO standards as developed by the Rhode Island Office of the Health Insurance Commissioner (OHIC)
- Feedback and comments from stakeholders on annual draft AE Roadmap
- Discussion with stakeholders on features and details of AE Roadmap
- Ongoing Feedback and comments from stakeholders gathered in public meetings/discussions

The AE certification standards and the corresponding application and approval process are intended to promote the development of new forms of organization, care integration, payment,

and accountability. AE certification standards are organized into eight domains in two categories, as shown below:

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

EOHHS considers fulfillment of the AE Certification Standards in the Readiness category (A. Readiness, Domains 1-3) to be fundamental to an AE's ability to affect system transformation and achieve the broader goals of the AE Program. Readiness was appropriately a significant focus for AEs in the initial years of the program. However, as AEs mature, EOHHS expects they will focus increasingly on advancements in the System Transformation category (B. System Transformation Domains 4-8). Into Program Year 4 and beyond, EOHHS incorporated additional elements in the Certification Standards on Health Equity.

In Program Years 3 through 6 AEs were required to complete an application and/or re-certification process for ongoing Medicaid AE certification. EOHHS plans to continue this requirement in Program Year 7. Within the application and/or re-certification, AEs are expected to identify concrete ways in which their MCO contracts and partnerships are being leveraged to assist the AE in achievement of the advanced standards in domains 4-8. AEs submit an AE-specific application/re-application for certification to the State that includes a description of the AE's governance structure and budget and a description of how a new applicant will comply with the certification standards or, for an existing AE, any changes from the previous year's submission. If an AE had any certification conditions from the previous year, progress towards meeting these conditions will be part of the re-certification application.

Applicants demonstrating that they meet the specified standards are designated as "Certified." EOHHS recognized that AE applicants would have differing stages of readiness. As such, EOHHS anticipated that most AEs would be "Certified with Conditions" initially. The outstanding need areas or "conditions" identified in initial program years highlighted the gaps in AE capacities and capabilities that have been and will be funded through the AE Incentive Program. These identified gaps have been addressed in accordance with agreed upon project plans, timelines, and measures for each AE to continue to be eligible for incentive funds. Over the course of the first four program years, the AEs have enhanced their capacity such that going into Program Year 5, all AEs were fully certified.

LTSS APM

The *LTSS APM Program Requirements* document articulates requirements for providers participating in the LTSS APM program. Home care agencies providing homemaker and CNA services are eligible to participate in the pilot. Any home care agency contracted with participating managed care programs can enter into an agreement with that managed care entity to participate in the LTSS APM. Through this APM, we aim to:

- Encourage and enable LTSS eligible and aging populations to live successfully in their communities
- Improve and ensure equitable access to home and community-based services (HCBS) that prevent LTSS eligible populations from needing institutional LTSS
- Foster a sustainable network of high quality HCBS providers that are equipped to meet the diverse needs of LTSS members

VI. Alternative Payment Methodologies

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

Comprehensive Accountable Entities

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

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

The specific terms of the savings and risk transfer to the AE are at the discretion of the contracting parties, however EOHHS has set minimum standards for risk sharing and a specific Total Cost of Care methodology. EOHHS does not intend to stipulate the terms of these arrangements but expects they will operate within the bounds of EOHHS defined APM Requirements and AE Incentive Program Requirements. In addition, EOHHS reserves the right

to review and approve such arrangements.[2, 3]

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

Qualified TCOC contracts must incorporate the EOHHS Quality Framework and Methodology. Under this framework, shared savings from TCOC contracts will be adjusted based on performance on EOHHS defined common set of quality measures as articulated in Attachment A of Attachment J.

LTSS APM

In recognition of the challenges to implementing a TCOC model for LTSS providers, the LTSS APM model was designed for initial implementation as a Category 2 APM per the HCP-LAN framework.[4] The LTSS APM was designed as a first step towards linking payment to quality and value and was intended to build on and advance broader state efforts to address the impacts of the PHE and critical HCBS workforce shortages.

During the pilot, EOHHS provided up-front funding to home care agencies to build the capacity to participate in this measurement-based incentive program. The program included a readiness phase and a pay for reporting phase. As mentioned, EOHHS was not able to identify funding for the LTSS APM beyond the program pilot. Therefore, the planned pay-for-performance phase of the program will not be implemented at this time. While the program is set to end, the pilot helped home health agencies develop the capacity to track important workforce retention and quality measures. EOHHS anticipates that these lessons learned will help inform future alternative payment models for this provider type.

Similar to the Comprehensive AE program, the LTSS APM has been administered through Managed Care. EOHHS established performance measures for participating home health agency providers as well as participating MCOs, to bring incentives into alignment and foster partnership between payers and providers.

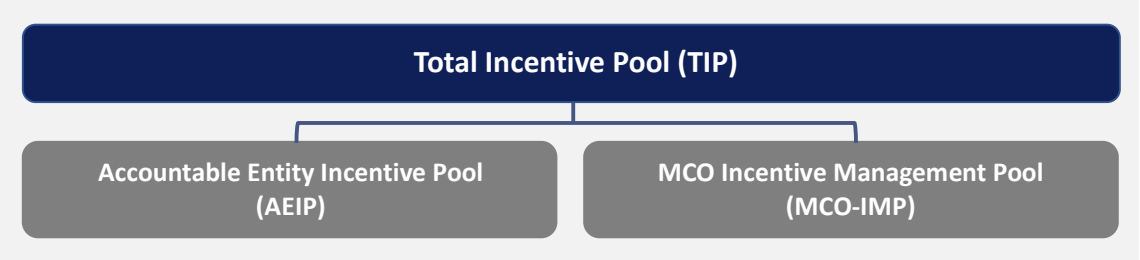
[2] In addition to this EOHHS requirement, note that in certain circumstances transparency in such arrangements is specifically required in CFR42 §438.6.
[3] CMS has issued guidance for shared savings programs for both Medicaid and for Medicare Shared Savings Programs. See https://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html and https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/sharedsavingsprogram
[4] Health Care Payment Learning & Action Network (HCP-LAN): 2017 Updated APM Framework, http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

VII. Medicaid Accountable Entity Incentive Program

Comprehensive Accountable Entities

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

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



These Incentive Pools are not grants, but rather are earned by AEs and MCOs based on their specific performance relative to a set of metrics. The allocation of funds based on different metrics is defined in detail annually in the *Attachment K: Incentive Program Requirements* .

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

-

1. **Required Structure for Implementation**
   The AEIP will be established **via a Contract or Contract Amendment** between the MCO and the AE. EOHHS reserves the right to review and approve the terms of incentive contracts with AEs. Incentive contracts will specify performance requirements and metrics to be achieved for AEs to earn incentive payments. The Contract or Contract Amendment will:
   - Incorporate the central elements of the approved HSTP Project Plan and project-based metrics, including:
     - Stipulation of program objective
     - Scope of activity to achieve
     - Performance schedule for milestones and metrics

        - A review process and timeline to evaluate AE progress in meeting milestones and metrics in its HSTP Project Plan and determine whether AE performance warrants incentive payments.
        - The MCO must certify that an AE has met its approved metrics as a condition for the release of associated AEIP funds to the AE.
    - Set payment terms and schedule including approved metrics selected for each AE that assures that the basis for earning incentive payment(s) is commensurate with the value and level of effort required and in accord with the allocation of incentive payments.
    - Delineate responsibilities and define areas of collaboration between the AE and the MCO. Areas of collaboration may be based on findings from the certification process and address such areas as health care data analytics in service utilization, developing and executing plans for performance improvement, quality measurement and management, and building care coordination and care management capabilities.
    - Minimally require that AEs submit quarterly reports to the MCO using a standard reporting form to document progress in meeting quality and cost objectives that would entitle the AE to qualify to receive AEIP payments. Such reports will be shared directly by the MCO with EOHHS.
    - Stipulate that the AE earn payments through demonstrated performance. The AE's failure to fully meet a performance milestone under its AE Health System Transformation Project Plan within the timeframe specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment).
    - State that in the event that an AE fails to meet a performance metric in a timely fashion (and thereby forfeits the associated AEIP payment), an AE can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric.
    - Note: AE performance metrics in the "Fixed Percentage and Outcome Measure Allocations" category are specific to the performance period and must be met by the close of the performance year in order for an AE to earn the associated incentive payment.

EOHHS regularly convenes and works with the HSTP/AE Advisory Committee. This advisory committee is made up of a diverse group of stakeholders representing community-based organizations, AEs, MCOs, and other state agencies. Through this public advisory process, EOHHS received input on the opportunity to centralize infrastructure and capacity building investments in specific areas that support all parties in their efforts to transform the current delivery system to that of a valued based population health model. Specific investment areas include but are not limited to the following:

- Health Information Technology
- Social Determinants of Health

- Behavioral Health

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

VIII. Program Monitoring, Reporting, & Evaluation Plan

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

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

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

1. MCO Compliance and Performance Reporting Requirements

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

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

MCO Required Reports	Description
1. AE Population Extract File	This monthly report provides EOHHS with a member level detail report of all Medicaid MCO members attributed to each AE. This

MCO Required Reports	Description
	data will be used by EOHHS for data validation purposes as well as for the purposes of ad-hoc analysis.
2. AE Provider Roster	This monthly provider report provides EOHHS with an ongoing roster of the AE provider network, inclusive of provider type/specialty and affiliation (participating, affiliated, referral etc.) to the Accountable Entity.
3. AE Quality Measure Report	This report consists of the set of NCQA HEDIS and other clinical and quality measures that are used to determine the quality multiplier for total cost of care.
4.	
5.	
6. MCO & AE Milestone Performance Report (PY5 & PY6)	The Milestone Performance Report (MPR) is completed quarterly by the MCO to demonstrate compliance with the MCO and AE incentive reward program.
7. AE Quarterly Outcome Metric Performance	As part of the HSTP incentive program and per the incentive funding requirements, AEs have an opportunity to earn a percentage of HSTP incentive dollars based on annual performance on three identified outcome metrics. Each MCO is responsible for providing quarterly performance data.
8. AE Annual Outcome Metric Performance	As part of the HSTP incentive program and per the incentive funding requirements, AEs have an opportunity to earn a percentage of HSTP incentive dollars based on annual performance on three identified outcome metrics. Each MCO is responsible for providing annual performance data.
9. TCOC Historical Base Data	This report provides data to support development of total cost of care targets for the following AE Performance Year.
10. AE Quarterly TCOC Performance Report	This report provides data to support development of quarterly total cost of care performance reports.
11. AE Final TCOC Performance Report	This report provides data to support development of annual total cost of care performance reports.
12. AE Base Contract Checklist	To accompany the annual AE-MCO base contract, this checklist identifies the elements with which the base contract must comply to be approved.
13. Final ROI Project Report	As part of the HSTP incentive program, FQHC-based AEs that choose not to take on downside risk can earn 5% of their incentive funds through an "ROI Project." This report is how the MCO will report to EOHHS on the results of these projects.

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

2. Oversight Meetings with MCOs

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

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

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

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

2. State Reporting Requirements

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

The state will provide quarterly expenditure reports to CMS using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority subject to budget neutrality. This project is approved for expenditures applicable to allowable

costs incurred during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only if they do not exceed the pre-defined limits on the expenditures as specified in Section XVI of the STCs.

The state will also separately report these expenditures by quarter for each FFY on the Form CMS-37 (narrative section) for all expenditures under the demonstration, including HSTP Project Payments, administrative costs associated with the demonstration, and any other expenditures specifically authorized under this demonstration. The report will include:

- A description of any issues within any of the Medicaid AEs that are impacting the AE's ability to meet the measures/metrics.
- A description of any negative impacts to enrollee access, quality of care or beneficiary rights within any of the Medicaid AEs.

3. Evaluation Plan

EOHHS Evaluation Design, includes a discussion of the goals, objectives, and evaluation questions specific to the entire delivery system reform demonstration. Specifically, the design of the evaluation approach focuses on three key research domains based on Medicaid waiver priorities 1) pay for value, not volume 2) coordinate physical, behavioral and long-term health care and 3) re-balance the delivery system away from high-cost settings.

Key areas of attention in the evaluation will tie to the goals and objectives set forth in this Roadmap. The Evaluation Plan shall list findings such as impact on core outcome measures, program measures, and member and provider experience. The latter will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. The Evaluation Plan will include a detailed description of how the effects of the demonstration will be isolated from other initiatives that have occurred or are occurring within the state. The Evaluation Plan includes documentation of a data strategy which identify data sources, and analytic methodology.

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

The state submitted a draft Interim Evaluation Report of the Accountable Entities program to CMS on December 22, 2022 and expects to submit a final Interim Evaluation Report on September 15, 2023. The purpose of the Interim Evaluation Report is to present preliminary evaluation findings and describe plans for completing the evaluation plan. The state also plans to submit a Summative Evaluation Report after the completion of the demonstration.

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

Background and Context

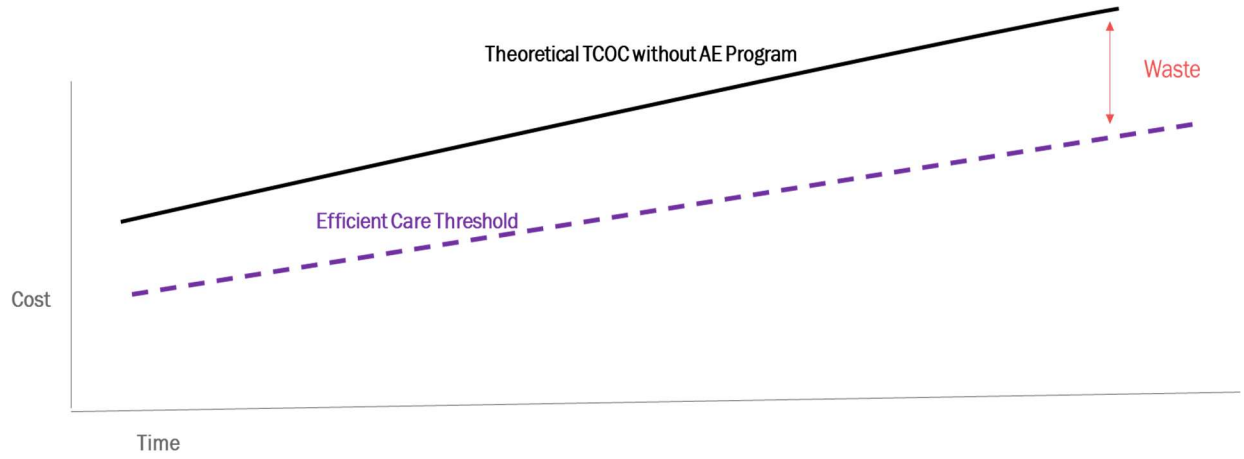
Rhode Island Medicaid's Designated State Health Program (DSHP) funds are intended to support the establishment of Accountable Entities (AEs) by providing incentive-based infrastructure funding for MCOs and AEs. Additional supporting investments in partnership with the Institutions of Higher Education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

Sustainability Conceptual Framework

The long-term objective of the AE program is to incentivize AEs to take action to reduce low-value care in the healthcare system, while investing in care and SDOH that leads to improved health outcomes. This objective is built on the knowledge that our current healthcare system includes a substantial amount of wasteful spending and is aligned with the Rhode Island Foundation's Long Term Health Planning Committee's 10-year plan for a healthier Rhode Island.[5] Low-value care or "waste" may include care that is not necessary at the time it is delivered (e.g., a duplicative lab test) as well as care that would not have been needed if the patient had received care to prevent and manage chronic disease. For example, if a patient with a mental illness like major depression receives regular treatment, it is less likely that they will experience a psychiatric emergency requiring emergency department care. They would also be more likely to have capacity to manage any other health problems they might have. Similarly, if a patient with type 2 diabetes receives support to keep their blood glucose levels steady and healthy (including education and training related to the use of insulin if needed, education and coaching on nutrition, and support to increase physical activity) they are much less likely to experience either a diabetic emergency or expensive and painful long-term consequences such as neuropathy and kidney disease.

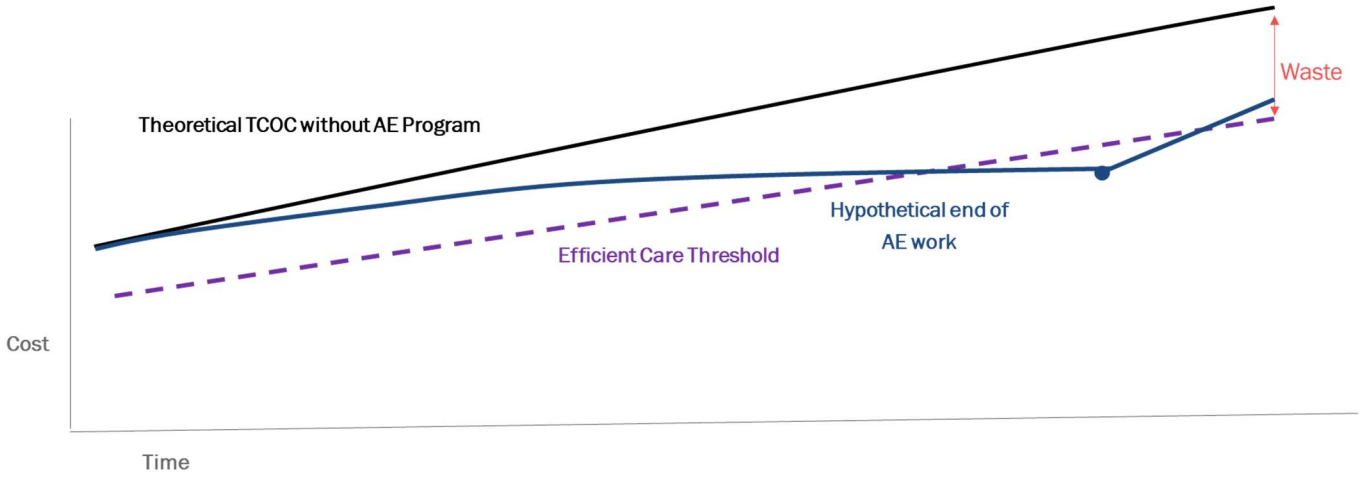
If waste were eliminated, the system could reach an "efficient care threshold." Such an "efficient care threshold" is of course theoretical only, both because elimination of *all* waste is likely not attainable and because we do not know what that cost level would be, especially considering the potential for unforeseen innovations in care delivery. Nevertheless, the concept is useful for discussion and is illustrated in the graph below:

[5] Health in Rhode Island, A Long Term Vision, Rhode Island Foundation, *available at* https://assets.rifoundation.org/documents/Health_in_Rhode_Island_Jan2020.pdf



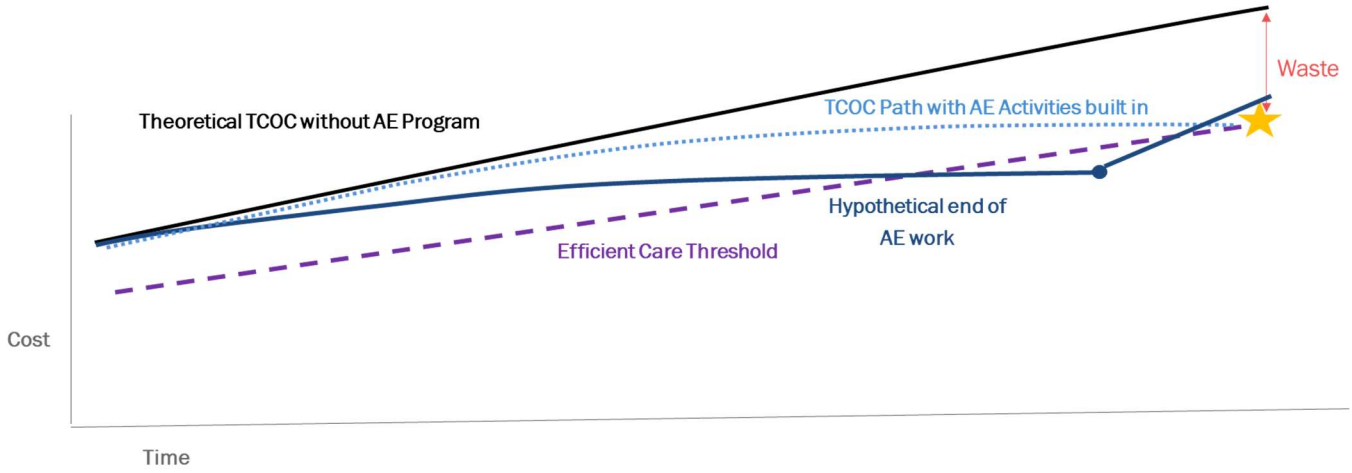
Note that even under the "efficient care threshold" scenario, costs will continue to grow over time. The goal is to slow the rate of growth, not necessarily to reduce the actual dollars spent on health care.

AE actions to bring total cost of care closer to the efficient care threshold include changing practice patterns to be more efficient as well as making investments to improve healthcare outcomes for higher-risk patients. The potential impact of these AE efforts is illustrated by the dark blue line below – the TCOC path without AE activities built in.



The dark blue line shows how TCOC growth is driven down by AE investment in activities that reduce high-cost utilization that doesn't improve health outcomes. Currently, much of this activity is paid for separately by HSTP Incentive Funds (and shared savings payments) rather than by fee-for-service claims, and that cost is not currently counted in TCOC. At some point in the future, TCOC as currently calculated could dip below the efficient care threshold as more and more waste is eliminated but investments remain uncounted. This could make TCOC targets impossible to meet without cutting necessary care and sacrificing quality. Further, when HSTP funds are exhausted, if AEs cannot fund the interventions that yield cost savings, then we would expect TCOC to rebound as high-cost utilization returns. Avoiding this outcome is the purpose of establishing an effective Sustainability Plan, so that we ensure the continuation of these effective activities.

EOHHS envisions that over time, TCOC calculations will include an ever-increasing share of the cost of the investments needed to achieve the desired return (lower unnecessary utilization and healthier members). This vision is aligned with the work of the Office of the Health Insurance Commissioner (OHIC) and Cost Trends Steering Committee to support the Compact to Reduce the Growth in Health Care Costs and State Health Care Spending in Rhode Island. The Compact sets a cost growth target for commercial, Medicaid, and Medicare spending, and includes claims and non-claims spending.[6] Medicaid can align TCOC more closely with this measurement model by ensuring that certain spending that is currently in the "non-claims" category is still counted in TCOC, just as it is counted in the cost growth target. The concept of a TCOC that includes the cost of AE activities is illustrated by the light blue dotted line below.



Theoretically, the light blue dotted line should, at some point, come close to and perhaps meet the efficient care threshold. For much of the time between now and that point, EOHHS expects AEs will earn shared savings that they can invest in their work to improve care delivery, including ongoing innovation that can generate yet more efficient care. The impact of the COVID-19 pandemic is an added complexity; while the exact impact on utilization and TCOC is unclear, directionally we expect that it has depressed utilization, at least in the short-term.

As AEs approach the efficient care threshold, we would expect the shared savings opportunities to shrink, because each year's TCOC targets are based on actual spending from a recent baseline period. As actual spending growth decreases and targets reflect that improved performance, the opportunity to reduce costs below targets will decline. That is, there will be less and less waste to eliminate in the system. At this point, the goal will be to have AEs maintain their performance and have sustainable sources of funds to continue to perform the activities that keep unnecessary high-cost utilization low.

To plan for this future state, EOHHS has established the following sustainability framework:

[6] Compact to Reduce the Growth in Health Care Costs and State Health Care Spending in Rhode Island, Rhode Island Health Care Cost Trends Steering Committee, *available at* http://www.ohic.ri.gov/documents/cost%20trends%20project/Compact-to-Reduce-the-Growth-in-Health-Care-Costs-and-State-Health-Care-Spending-in-RI.pdf.

1. Understanding AE activities and costs: Some AE work is short-term by its nature, composed of investments that do not require substantial permanent costs but that improve AE capacity for the longer term. Investments in health information technology often work this way; upfront payments in a population health or care management dashboard can make care delivery more efficient and ongoing costs after the initially implementation are relatively low. By contrast, other work is ongoing and must continue to be funded to continue to reap the return on the investment. Paying care management staff is an example of this kind of ongoing cost. It is important to understand both the cost and nature of these activities to determine funding alternatives.

2. Identifying strategies for AE sustainability: As information is gathered to better understand the costs associated with the activities that must continue in order to reach the efficient care threshold, EOHHS must identify a set of strategies to sustain them.

While the focus of this document is on the sustainability of AEs, it should be noted that EOHHS views this program in the context of broader efforts to advance value-based payment across payers and provider types in Rhode Island and address cost drivers that may not be in an AE's direct control. As such, EOHHS is committed to the broader advancement of value-based payment in Medicaid and partnering with the Office of the Health Insurance Commissioner and key stakeholders within the state to advance policies aimed at containing costs, improving quality of care, and improving population health.

Understanding AE Activities and Costs

In the spring and early summer of 2020, EOHHS conducted interviews with all AEs regarding the expenses involved in activities undertaken as part of HSTP, as well their ability to track these expenses. AEs shared that they can track expenses effectively and identified the areas where their resources are generally spent.

AEs have made significant investments in longer-term capacity in care coordination and population health management using Incentive Funds that should, over time, generate shared savings that will help sustain AEs. These investments include development of technology solutions; staff training; new internal structures; and establishment of community-clinical partnerships. Some of these investments will not require permanent funding at the same levels the AEs initially expended, although others may require ongoing funding, such as certain technology investments that require significant annual license payments. Several examples of each type of investment that have occurred over the course of the program are listed below:

- Technology:
    - Blackstone Valley Community Health Center employs a population health tool (NextGen Population Health) to compile claims and NextGen EMR data for all attributed members. The platform is capable of risk segmentation, condition cohort identification, pre-visit planning, and comprehensive quality measure reporting.

- Blackstone Valley Community Health Center is continuing to increase use of virtual (telehealth) visits to increase access to behavioral health care for high-acuity patients who are otherwise unengaged.
- Coastal is leveraging the CHADIS system to allow patients to complete behavioral health screenings on smart phones or tablets in the waiting room before appointments.
- Integrated Healthcare Partners is working with URI's DataSpark to execute a gap analysis assessment for mental health and substance use services rendered to their patients. Integrated Healthcare Partners can currently see where patients live and where they receive primary care and behavioral health care. By integrating claims data to gain a comprehensive view of its population, Integrated Healthcare Partners expects to be able draw conclusions related to access adequacy by geography. A later phase of the project will focus on where patients live and receive social services.
- Prospect Health Services is implementing Cerner HealtheIntent, a comprehensive population health management tool.
- Providence Community Health Centers launched a texting platform for patient engagement, including outreach campaigns to close quality gaps.
- Providence Community Health Centers has developed analytics to identify lists of patients with whom providers should follow up each day; monthly statistics on panel management; and quarterly governance oversight metrics.

- Staff training:
  - Integra participates in the Rhode Island Health Education Exchange (RIHEE) Advisory Group's Rhode Island Department of Health Academic Institute Accountable Entity Continuing Education Needs Assessment activities to facilitate continuing education opportunities for staff.
  - Integrated Health Partners will provide staff with additional training regarding social determinants of health.
  - Providence Community Health Centers has created online learning management system content to educate staff in advance of new projects and to educate providers regarding population health principles and practices, especially in the context of the AE program.
  - Coastal Medical enrolled approximately 60 staff members from practices and clinical programs in the Mental Health First Aid training to better support our patients in crisis during PY4.
- New internal structures and processes:

- Blackstone Valley Community Health Center began offering nurse care manager telehealth and expanded walk-in hours at its new Central Falls facility and the Blackstone Valley Neighborhood Health Station, expanding its ability to deliver care to more patients.
- Blackstone Valley Community Health Center added a more experienced psychiatric nurse practitioner in a clinical leadership role to strengthen the behavioral health component of care teams while offering frontline expertise to the AE governance team.
- Coastal Medical has implemented universal screenings across all practices to assess and identify needs around depression, anxiety, and social determinants of health, and is currently implementing SUD screening. Regular reporting around screenings and the associated needs are reviewed and acted upon in a variety of ways. Care management and behavioral health teams conduct outreach and make referrals to both internal and external resources and established interdisciplinary care conferences also provide a forum for surfacing these issues.
- Coastal Medical implemented an abbreviated SDOH screening, performed during transition of care appointments in PY4, when patients are the most vulnerable.
- Coastal Medical has implemented AE Care Conferences to identify and coordinate care for rising-risk and high-risk Medicaid AE patients. These care conferences include community-based organization partners. The care team members proactively review the identified patients before upcoming appointments. The established interdisciplinary care conferences across practices and teams are intended to identify, monitor and coordinate care for patients. During PY4, Coastal also initiated monthly care conferences with members of the MCO care management team to coordinate efforts for hard to reach or rising risk patients.
- Integra has launched an Integrated Behavioral Health pilot program in select pediatric and adult practices.
- Integra has invested in infrastructure for pediatric practices to support early evaluation and screening for members under age 18.
- Integrated Health Partners will develop a comprehensive workflow across its practices to engage members in housing support services.
- Integrated Health Partners has established a designated “triage line” in partnership with the state’s BH Link program, through which the AE is able to promptly connect members to behavioral health services at the AE, preventing hospital visits in appropriate cases.
- Prospect Health Services is working to integrate behavioral health/ substance use disorder expertise into all aspects of its AE program, including through expanding integrated behavioral health in primary care; expanding telehealth consulting, and

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

  - Providence Community Health Centers has added a psychiatric nurse practitioner to health center staff to provide comprehensive mental health and substance abuse treatment targeting the homeless population, which includes the organization's highest-cost and most complex patients.
  - Providence Community Health Centers has redesigned and implemented complex care protocols to manage the highest-cost and highest-risk patients. This includes integrating primary care, behavioral health, nurse case management, and clinical pharmacy services.
  - Providence Community Health Centers has implemented a mechanism called FastPass to ensure that high-utilizer, low-engagement patients receive access to nursing staff and same-day appointments.
  - Thundermist Health Center implemented a comprehensive Adverse Childhood Experience Screening (ACES) into the care of attributed pediatric members of their AE. This process has included the training of a large portion of their staff on how to perform ACES.

- Community-Clinical Partnerships: Note that these partnerships may include some funding for staff that would need to be sustained. However, the changes in workflow among clinical and community-based service providers are less likely to require ongoing funding.
  - Blackstone Valley Community Health Center currently shares a care coordinator with The Providence Center, a major provider of mental health and substance abuse services in Rhode Island.
  - Blackstone Valley Community Health Center is establishing a Mobile Integrated Health unit through a new partnership with the Pawtucket Fire Department, which will support diversion from hospital emergency departments to an express health care clinic where appropriate.
  - Integra has partnered with The Providence Center to embed a peer recovery coach with its Complex Care Management team. The coach will work closely with other team members to support patients who are dealing with complex medical, behavioral health and/or substance issues as well as social determinants of health, and who require a more intensive home and community-based intervention.
  - Providence Community Health Centers has worked with Family Services of Rhode Island to integrate a behavioral health care manager, licensed social worker, and community advocate into the PCHC team of nurse case manager to identify and manage the care of high-risk patients with behavioral health diagnoses and medical co-morbidities.

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

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

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

In addition, there are non-staff costs that are also ongoing expenses. These include certain IT infrastructure costs, annual licensing fees, and vendor costs.

Submission of AE Budgets through Recertification

To enhance our understanding of AE costs, EOHHS prepared a budget template that AEs completed as part of Program Year 4 certification. EOHHS has used the data AEs provide through this template to refine expectations for the resources AEs will need on an annual basis to continue current activities. EOHHS updated the budget template as part of Program Year 5 certification, to allow the agency to continue to evaluate long-term costs over time and incorporate feedback from AEs on additional areas to assess for sustainability. Specifically, EOHHS refined the template to collect more detail and specificity on types of expenses as we observed a wide range and level of reported costs in Program Year 4. EOHHS understood from AE feedback that it was challenging to translate their internal budget frameworks to the Program Year 4 budget template and added the specificity to make this easier for AEs to accomplish. Even with the updates, natural variation exists in the level of detail and categorization of expenses provided across the AEs. This updated budget template was continued for Program Year 6.

EOHHS aggregated and summarized financial data submitted by the seven AEs starting in Program Year 4. The total budgeted costs per member reported ranged from $46 to $208, with an average of $89. Personnel expenditures account for the majority of all costs (70%), followed by Community-Based Organization (CBO) contracts (13%), and information technology expenses (12%). The remaining 5% fall into other categories, including general overhead. The AEs

budgeted considerable expenses for care management, behavioral health, and SDOH screening and referral services.

In Program Year 5, the total budgeted costs per member reported ranged from $36 to $185, with an average of $87, representing a $2 reduction from Program Year 4 reported costs. Personnel expenditures account for the majority of all costs (72%), followed by Community-Based Organization (CBO) contracts (11%), and information technology expenses (8%). The remaining 9% fall into other categories, including general overhead. The AEs budgeted considerable expenses for care management, behavioral health, and SDOH services, including population health management and data analysis tools.

In Program Year 6, the total budgeted costs per member reported ranged from $36 to $200, with an average of $84, representing a $3 reduction from Program Year 5 reported costs (from $87 to $84). Personnel expenditures account for the majority of costs (72%), followed by Community-Based Organization (CBO) contracts (14%), and information technology expenses (7%). The remaining 8% fall into other categories, including general overhead. Similar to Program Year 5, the AEs budgeted considerable expenses for care management, behavioral health, and SDOH services.

	Total Attributed Members	**Total Budgeted Costs Reported**	**Average Cost Per Member Per Year**
PY 4	199,322 (April 2021)	$17,694,353	$89
PY 5	212,595 (April 2022)	$18,502,540	$87
PY 6	225,640 (April 2023)	$18,995,244	$84

Because staff compose a substantial share of AE costs and there are also annual fees associated with many of the population health management tools the AEs use, EOHHS expects that the expenses associated with the work that AEs have undertaken to improve care coordination and population health will not decline in a meaningful way over time. Note, regarding reported expenditures associated with community health workers, funding has fluctuated over the past three years, including 6% ($5 per member per year) in Program Year 4, 7.6% (or $6.90 per member per year) in Program Year 5, and 4.8% ($4.28 per member per year) in Program Year 6. As discussed further below, this is now a covered Medicaid service. This coverage should lead to savings for AEs, and the share of costs covered may be higher than estimated here because not all AEs separately reported CHW costs in their budgets. Some additional savings may also be achieved as AEs gain experience and develop more efficient ways to deploy staff.

EOHHS compared Program Year 4 budgeted costs to actual Program Year 2 shared savings to better understand the magnitude of program expenses and as a preliminary exploration to guide sustainability planning. While this is an imperfect comparison, since AE investments have increased over time, it is a useful exercise to compare the size of investment against the size of savings generated. Among AEs that achieved overall savings across their MCO contracts in Program Year 2, shared savings payments received by the AEs were less than the AEs' budgeted expenses. Note, however, that the AEs generally received 50% of the shared savings pools they generated. When EOHHS looked at the *total* shared savings pools, we found that the total (shared between the MCO and AE) did exceed the AEs' costs, which indicates that the AEs' work did yield a return on the investment in terms of reducing total cost of care. EOHHS also

observed that the two AEs with the highest reported cost per member in Program Year 4 observed the highest shared savings in Program Year 2.

EOHHS made this same comparison with Program Year 5 budgeted costs and actual Program Year 3 shared savings. In aggregate, both the shared savings payments received by the AEs and the total shared savings pools generated exceeded the AE's costs. Details on comparison between AE costs and shared savings payments to the AE are presented below. In Program Year 5, the AE with the highest reported cost per member observed the highest shared savings in Program Year 3. This merits further exploration of the association between investments and overall TCOC savings. Details on comparison between AE costs and shared savings payments to the AE are presented below.

Note, there was variation in the level of detail and categorization of expenses provided across the AEs. For the purposes of summarizing these financial data, EOHHS included all costs and attributed members when evaluating the total per member per year costs and removed AEs as needed from category-level analyses to reduce overall limitations to interpreting the results.

The annual comparison of budget costs to shared saving was continued, Program Year 6 budget vs Program Year 4 savings. In aggregate, the reported cost per member continues to be lower than the shared savings payment, a continued trend compared to the previous annual comparison (Program Year 5 budget compared to Program Year 3 savings). Additionally, the relationship between budgeted costs and anticipated savings varies across the AEs, with no AE's cost being higher than the savings per member. This is a positive indicator of the current sustainability of the AE model.

In Program Year 7, EOHHS will continue to gather budgetary information from AEs to inform more rigorous analysis into the costs necessary to implement a successful AE program. This information will continue to shape EOHHS' approach to sustainability.

Strategies for Sustainability

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

The five strategies for sustainability are:

A. Centralize key investments to achieve efficiencies that will reduce AE costs and enhance shared savings opportunities.
B. Support achievement of shared savings through the TCOC arrangements that AEs have with MCOs to provide some support for AE costs.
C. Obtain the authorities needed to provide reimbursement for high value services that require consistent support (e.g., Community Health Workers).
D. Leverage contractual relationship with MCOs to increase the support of care management and social determinants of health (SDOH) activities.
E. Leverage multi-payer statewide policies to support AEs.

A. By centralizing key investments, EOHHS expects to achieve efficiencies that will reduce AE costs and enhance shared savings opportunities.

EOHHS has made, and plans to continue to make, investments in healthcare infrastructure that are more cost-effective to build in a centralized way. In several cases, these investments prevent AEs from needing to incur higher costs on their own to reap the benefits of the investment. As a result, these may not be investments that will directly offset existing AE costs in the budgets described above, as the AEs have not had to budget for these costs. In some cases, however, new EOHHS investments will directly offset costs that AEs currently incur on their own. In all cases, these investments are expected to aid AEs in their work to better manage population health and reduce total cost of care. EOHHS has contracted to develop and enhance several health information technology (HIT) resources for statewide use, including:

- Event Notification Services–Event Notification Services is a dashboard that provides near real-time patient information on which patients from the practice's panel has been admitted to or discharged from a hospital or skilled nursing facility (SNF). This information, substantially reduces the staff time needed to track patients across the continuum of care, especially when patients receive care outside the AE's network. EOHHS's investment in Event Notification Services has allowed the creation of a system that AEs can use for substantially lower cost than they would incur to coordinate care without such a system.

  EOHHS will continue to support and encourage AEs to work with local hospitals on receiving admission, discharge, and transfer event notifications for attributed members per the CMS Interoperability and Patient Access Final Rule and resulting Conditions of Participation for hospitals (42 CFR 482.24(d)). EOHHS believes that greater efficiencies can be obtained by coordinating notifications through a central service such as the statewide Health Information Exchange. .

- Quality Reporting System – The Quality Reporting System (QRS) simplifies quality data reporting for state programs and across health plans, creating a single solution for quality measurement needs to reduce administrative burden and increase availability of outcome data to support health system transformation efforts. AEs can report quality data from their electronic health records to the QRS once rather than reporting separately to several managed care organizations. The QRS does not eliminate the need for data from MCO claims and care management systems, or for supplemental data such as the KIDSNET immunization registry. While the QRS does not offset existing AE costs, it protects AEs from more burdensome reporting costs and the need to invest in separate electronic reporting systems. All AEs representing over 80 individual practice sites currently utilize the QRS to submit electronic clinical data to the MCOs.

- CurrentCare - CurrentCare is a health information exchange that supports information sharing across the state and provides secure access to longitudinal health records and crucial health care information to authorized users. By facilitating access to patient records, CurrentCare reduces the administrative burden that AEs have to spend to request patient records from different providers and makes it easier to quickly learn essential

information about new patients. This is another example of an investment that would be unreasonable for an AE to make independently, and which should support efficient care delivery, but which does not offset the existing AE budget costs. EOHHS is in the process of transitioning to an opt-out model for CurrentCare, which is expected to increase patient participation. EOHHS recently worked with the Rhode Island Quality Institute to add AE attribution flags to CurrentCare Viewer and Event Notification Services to facilitate care coordination. This flag will allow for providers to know when they are treating a patient who is attributed to an AE (including the attributed AE name). In addition, development is underway to issue an "AE admissions" report to hospitals, particularly those with inpatient psychiatric services, to alert them when a recent admission is affiliated with an AE.

In 2020, EOHHS conducted interviews with AEs regarding potential EOHHS investments in other centralized activities, and learned that a more systematic, coordinated approach to addressing social determinants of health would be valuable, and that in particular it was important to develop more robust collaborations between AEs and community-based organizations (CBOs) to serve AE members with health-related social needs.

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

The SDOH strategy consists of two interrelated initiatives:

Community Resource Platform:

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

EOHHS procured a statewide community resource platform (CRP) to facilitate closed-loop referrals among healthcare and community-based providers. Some AEs had already budgeted for CRP services, so for those entities the statewide platform will reduce budgeted costs.

Following a competitive procurement, EOHHS contracted with Unite Us from April 2021 through April 2024 to provide the CRP. Under this agreement, Unite Us operates a web-based portal to: 1) improve coordination between CBOs and healthcare organizations, with member consent; and 2) improve standardized data capture, data-sharing, and data use for screenings and assessments, diagnosis and interventions, and aggregation for analytics. Upon the expiration of EOHHS' contract with Unite Us MCOs and AEs may continue to utilize the platform through purchase of individual licenses.

The CRP:

- Records member responses to a social determinants of health questionnaire and identify their social needs;
- Generates and sends electronic referrals to the most appropriate CBO(s);

- Allows CBOs to send referral responses back to the referring provider;
- Allows CBOs to generate and receive referrals to and from each other;
- Creates a longitudinal client record that can be shared with organizations participating in the member's care (with consent);
- Interfaces or integrate with other IT systems used by healthcare providers and CBOs;
- Protects individual privacy; and
- Provides a dashboard that will generate network-level data and reports in real time and track agreed-upon metrics.

.

Rhode to Equity:

As described in the Program Year 4 Roadmap, in 2020 and the first six months of 2021, the Rhode Island Department of Health (RIDOH) supported a project called the Diabetes Health Equity Challenge. The project was a learning collaborative to build clinical-community linkages to support people living with diabetes who might be especially vulnerable to equity gaps in the context of COVID-19. Under the program, geographically-based teams applied to collaboratively work to improve outcomes for people with diabetes who are at risk of poor outcomes in the context of the pandemic. EOHHS and RIDOH have collaborated to expand and enhance this program as the Rhode to Equity project, which launched in July 2021 and has now completed its second and final year.

Rhode to Equity was a learning and action collaborative that supported six cross-sector teams consisting of 1) AEs and a primary care clinic participating in that AE, 2) Health Equity Zones (including "backbone agencies" and CBO partners), 3) Community Health Teams, and 4) persons with lived experience of inequity (PLE). Managed care organizations are resources for teams.

Team participants committed to a common aim, a place-based population of focus, a set of measures, and collaborative actions to improve downstream, midstream, and upstream care and conditions. Through Rhode to Equity, participating teams:

- Received funding that assists with covering the costs of team participation;
- Obtained customized technical assistance from national health equity content experts;
- Were supported in applying well designed, evidence-based population health tools;
- Engaged with peers through learning sessions to explore "cross pollination" of ideas and understanding; and
- Were positioned to scale the team's work to further advance community and clinical solutions and policy.

EOHHS and RIDOH anticipated this work would enable AEs to greatly enhance their capacity to address attributed patients' health-related social needs, by strengthening connections with local social service resources, and increase AEs' engagement in place-based efforts to improve upstream conditions. This improved capacity was expected to enhance AEs' ability to improve

their patients' health outcomes and as a result, reduce their health costs and increase AEs' shared savings.

EOHHS and RIDOH worked with national experts, The Dawn Chorus Group, to evaluate the impact of the Rhode to Equity on the strength and efficacy of community-clinical linkages in its first year and second year of implementation. The Dawn Chorus Group surveyed the R2E Team members at multiple times throughout Year 1, utilizing the Kirkpatrick Framework approach, which looks at how people change during adult learning encounters. The four levels to the Kirkpatrick Framework that the team members were surveyed on were: Experiences and Emotions, Changes in Knowledge, Changes in Behavior, and Changes in Outcomes. The same survey questions were asked at the start of Year 1 and again at the end of Year 1 in order to make a quantifiable comparison. First-year evaluation data showed that growth occurred across a wide range of skills and portfolios, specifically in both equity and collaboration. This was consistent with general feedback from the AEs that having the opportunity for close collaboration with community organizations has strengthened those relationships and supports partnerships. The evaluation trends identified in both the Year 1 goals and the distribution of the use of data, that the teams were moving in a positive direction. Year 2 evaluation focused on the progress the teams made over time within the 24 month project duration. Year 2 evaluation drew on insights from a detailed analysis of the six distinct R2E teams; using surveys, qualitative data through monthly questions and interviews, as well as a review of final action plans to report on specific changes that were implemented by the teams.

Key findings from the data revealed that:

- The collaborative nature of the R2E project, notably involving community partners and focusing on community needs, yielded valuable insights for patient care.
- Each community team demonstrated a robust commitment to addressing local disparities. Notably, Community Health Workers (CHWs) played a pivotal role in the project's success, positively responding to interventions and valuably contributing to the project.
- In terms of health equity, teams recognized the significance of tackling social determinants of health, which are contributions to health disparities. The teams saw the value of adopting a participatory strategy that incorporates the insights of people with lived experience, thus promoting inclusiveness.
- Furthermore, the teams developed skills in tailoring health approaches to individuals, while simultaneously devising strategies for the overall populace.

Evaluation trends through the duration of the project identified tangible improvements across all portfolios of work, indicating transformative efforts were successful.

<u>Behavioral Health Investment:</u>

Applying a similar approach to the SDOH investment strategy, EOHHS has earmarked $3.5 million in HSTP funds to invest in infrastructure to support AEs in addressing their attributed

populations' behavioral health needs. EOHHS conducted a series of interviews between September 2021 and February 2022 to identify opportunities for appropriate uses of these funds.

Under the AE Program's TCOC model, AEs have a significant interest in improving care for members living with a BH condition, to both improve outcomes and avoid spending on services that fail to improve outcomes. Because these members have unmet health needs that may lead to unhelpful service utilization, targeting interventions to provide them more efficiently and effectively with the needed care can have a significant impact on spending and outcomes. EOHHS understands that, in response to the incentives implicit in the TCOC model and explicit in the AE program's quality and outcome measures, AEs have sought to implement strategies to better serve members with BH needs.

EOHHS interviewed all seven AEs and participating MCOs, along with many community BH stakeholders. During this process EOHHS identified several recurring themes and barriers that remain:

1. Workforce Shortages
2. Housing Access
3. Care Transitions
4. BH Data Sharing
5. Attributed But Not Seen Population
6. Mid-Acuity Patients

EOHHS has developed a series of investment plans to facilitate improvement of the quality of care provided to AE members with BH diagnoses. For Part 1 of the investment, EOHHS implemented a series of Health Information Technology initiatives to facilitate more efficient communication between AEs and BH providers that care for AE patients. An AE Flag was added to the CurrentCare viewer to allow providers to know when they are treating a patient that is attributed to an AE and which AE they should coordinate care with.. .

B. EOHHS anticipates that shared savings from the TCOC arrangements that AEs have with MCOs will provide some support for AEs.

The HSTP model is intended to support AEs in care delivery transformation work that will reduce or, at a minimum, reduce the growth of TCOC of the attributed population. As AEs generate savings relative to their TCOC target budgets, they will receive a share of these savings. These shared savings are expected to provide a meaningful amount of revenue to support ongoing AE activities within additional reimbursement. In advance of Program Year 3, EOHHS further developed the TCOC model to:

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

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

TCOC Model Developments:

As described in the Program Year 4 Roadmap, the TCOC model included a market adjustment of 10% for Program Year 3, so more efficient AEs will be in a position to earn more savings than in years past. Under this adjustment, 10% of the difference between the total cost of care achieved by the AE and the average total cost of care for that MCO's Medicaid members is added back to the AE's TCOC target. It will be easier for the AE to generate savings relative to a higher target, so the AE will earn more shared savings than otherwise. In Program Year 3, AEs with above-average spending did not have a negative market adjustment, to allow them time to improve. In Program Year 4, however, the market adjustment for more efficient AEs was 20%, while AEs with above-average spending had a 10% negative adjustment. The benefit for more efficient AEs is greater, which will enhance their sustainability. In Program Year 5, the above market weight was 15% and the below market weight was 30% and in Program Year 6, the weights are 20% and 35%, respectively. This structure allows the program to continue generating savings overall while striking a balance between rewarding existing efficiency and future improvement.

EOHHS implemented one technical change to the market adjustment in Program Year 5. The adjustment is now statewide, comparing each AE to its peers across all MCOs in the AE program, opposed to comparing to its peers within the same MCO. This change was made to create further alignment with the managed care capitation rate development process as capitation rates are set based on statewide experience and not individual MCO experience. Also beginning in Program Year 5, EOHHS implemented a technical update to how delivery costs are accounted for in the TCOC model, which also creates further alignment with managed care capitation rate development.

In Program Year 6 EOHHS implemented a Global Shared Savings/Loss Cap. In instances where, in aggregate, the AEs Shared Savings/(Loss) Pool for a particular MCO is materially misaligned with the MCO's financial gains or losses related to benefit expenses, the Shared Savings/(Loss) Pool for the AEs may be adjusted. Each year, a Global Cap on the Shared Savings/(Loss) Pool for each MCO will be established based on the MCO's financial gain/loss on benefit expense, plus the risk margin related to benefit expenses that is incorporated in the capitation rates for that year. In Program Years 1 and 2, only one AE-MCO contract included "downside" risk, meaning that in the event of shared losses, the AE would be responsible to pay a portion of the deficit. All other AEs were in "upside-only" contracts, in which AEs had an opportunity to share in savings, but in the event of shared losses, the AE would not be responsible to pay a portion of the deficit. These upside-only contracts generally provided that AEs and MCOs would share any savings equally, with AEs receiving 50% of any savings. EOHHS planned to require AEs to take on downside risk in Program Year 3, but due to COVID-19, rescinded this requirement, and only one AE took on downside risk in that year. Program Year 4 was the first year that AEs eligible to take on downside risk were required to do so.

Beginning in Program Year 4, AEs had the potential to earn 60% of any savings they generated, rather than the 50% permitted under upside-only contracts. Notably, while the TCOC

methodology provides a standard framework for calculating TCOC, the standards for taking on risk allow for AEs and MCOs to negotiate contracts with higher levels of risk (and potential shared savings) as AEs become ready to do so. Starting in Program Year 5, all AEs had the opportunity to take on downside risk, but downside risk was not a requirement for FQHC-based AEs.

In Program Year 5 six (6) out of seven (7) certified AEs had contracts with MCOs that included downside-risk. FQHC-based AEs were not required to take on downside risk; however, three (3) out of the four (4) FQHC-based AEs took on downside risk for the first time in Program Year 5.

In Program Year 6 the TCOC methodology was updated to include the Global Shared Savings/Loss Cap. This change is intended to ensure that no MCO is left with a major gap between their total benefit expense plus surplus and the amount they are required to pay out in shared savings. Each year, the Global shared Savings/Loss Cap will be established based on the MCO's financial gain/(loss) on benefit expense, plus the risk margin related to benefit expense that is incorporated in the capitation rates for that year. The Global Shared Savings/Loss Cap also works in the opposite direction, limiting the AEs' aggregate shared losses in excess of the MCO's actual benefit loss.

Preliminary TCOC Performance and Expectations:

In Program Year 1, three AEs earned shared savings.

	MCO 1	MCO 2
AE 1	Total PMPM saved: $2.37 Shared savings payment: $154,591	Did not have a contract
AE 2	Not yet participating in program	
AE 3	No savings	No savings
AE 4	No savings	Total PMPM saved: $4.33 Shared savings payment: $572,032
AE 5	No savings	No savings
AE 6	Total PMPM saved: $2.62 Shared savings payment: $457,006	Total PMPM saved: $20.90 Shared savings payment: $1,846,999

EOHHS compared these results to the Program Year 4 AE budget information received for Program Year 4 certification applications. The three AEs that earned shared savings in Program Year 1 received shared savings payments equal to 9.6% to 76.5% of their Program Year 4 expenses. In Program Year 1, AEs were only just starting to earn Incentive Funds, and thus were in the initial stages of developing infrastructure and capacity to address total cost of care.

In Program Year 2, most AEs earned shared savings in at least one contract.

	MCO 1	MCO 2
AE 1	No savings	Did not have a contract
AE 2	Total PMPM saved: $19.72 Shared savings payment: $670,191	Total PMPM saved: $12.16 Shared savings payment: $337,961
AE 3	No savings	Total PMPM saved: $16.94

		Shared savings payment: $1,211,366
AE 4	No savings	Total PMPM saved: $17.80 Shared savings payment: $2,467,659
AE 5	Total PMPM saved: $12.32 Shared savings payment: $513,541	Total PMPM saved: $2.05 Shared savings payment: $56,511
AE 6	Total PMPM saved: $2.93 Shared savings payment: $505,235	Total PMPM saved: $15.44 Shared savings payment: $1,161,257

In addition, AE 5 had a contract with a third MCO in PY2 and earned $209,706 in shared savings.

The five AEs that earned shared savings in Program Year 2 received shared savings payments (generally 50% of the shared savings pools they generated) equal to 26.4% to 90.7% of their Program Year 4 expenses.

In Program Year 3, each AE earned shared savings in all of their contracts.

	MCO 1	MCO 2
AE 1	Total PMPM saved: $21.51 Shared savings payment: $1,518,986	Did not have a contract
AE 2	Total PMPM saved: $69.25 Shared savings payment: $2,002,151	Total PMPM saved: $40.24 Shared savings payment: $1,666,936
AE 3	Total PMPM saved: $37.44 Shared savings payment: $7,106,284	Total PMPM saved: $45.23 Shared savings payment: $3,692,894
AE 4	Total PMPM saved: $30.76 Shared savings payment: $4,397,578	Total PMPM saved: $36.58 Shared savings payment: $5,185,416
AE 5	Total PMPM saved: $42.07 Shared savings payment: $8,225,047	Total PMPM saved: $27.61 Shared savings payment: $2,078,674
AE 6	Total PMPM saved: $18.73 Shared savings payment: $864,318	Total PMPM saved: $39.18 Shared savings payment: $2,140,188

Five out of the six AEs that earned shared savings in Program Year 3 received shared savings payments (generally 50% or 60% of the shared savings pools they generated) in excess of their reported Program Year 5 expenses.

In Program Year 4 each AE earned shared savings in all of their contracts.

	MCO 1	MCO 2
AE 1	Total PMPM saved: $37.10 Shared savings payment: $2,723,619	Did not have a contract
AE 2	Total PMPM saved: $61.68 Shared savings payment: $2,435,774	Total PMPM saved: $58.22 Shared savings payment: $1,772,464
AE 3	Total PMPM saved: $53.78 Shared savings payment: $2,929,373	Total PMPM saved: $68.28 Shared savings payment: $1,637,740
AE 4	Total PMPM saved: $44.63 Shared savings payment: $6,313,240	Total PMPM saved: $51.43 Shared savings payment: $7,466,829
AE 5	Total PMPM saved: $49.81	Total PMPM saved: $49.29

	Shared savings payment: $9,203,325	Shared savings payment: $3,019,261
AE 6	Total PMPM saved: $68.65 Shared savings payment: $4,318,227	Total PMPM saved: $76.38 Shared savings payment: $3,993,080
AE 7	Total PMPM saved: $79.17 Shared savings payment: $6,114,501	Total PMPM saved: $86.60 Shared savings payment: $2,791,212

In FY 2024, AEs are estimated to receive a total net-benefit of $35.7 million when comparing the estimated budget of Program Year 6 ($19.0 million) to the savings received attributable to Program Year 4 ($54.7 million). As noted in the sustainability section, this is based on an imperfect comparison, yet remains useful exercise to compare the size of investment against the size of savings generated.

EOHHS has expected that AE capacity to generate savings would generally increase over time as they continue to improve their infrastructure and partner with MCOs on ways to improve population health.

EOHHS is optimistic that improvements in methodology and AE capacity to manage high-cost patients will continue to yield shared savings for AEs in coming years. In addition, the record of the Medicare Shared Savings Program is consistent with expecting improvement. The total savings generated by all Medicare Accountable Care Organizations has increased over time, and more participating ACOs have moved from generating deficits to generating savings over time.[7] However, EOHHS also recognizes that the level of shared savings in Program Years 3 and 4 may have been affected by the COVID-19 pandemic and that future year's savings made be more modest as utilization return to more typical levels.

As more data become available, EOHHS will continue to work with its actuarial vendor to analyze shared savings results from each Program Year to strengthen projections for the remaining duration of the AE program and subsequent years. This analysis will incorporate any changes to the TCOC methodology as well as projections regarding future TCOC budget levels (i.e., if budgets decline as a result of lower spending levels, this would affect future savings potential).

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

Currently, HSTP Incentive Funds are used to support a range of AE activities that are expected to help reduce TCOC. To the extent that these activities are effective, over the long term, TCOC budgets will be lower than would otherwise be the case, trending toward a level that captures the cost for the most efficient care delivery possible. If the activities required to deliver this efficient care are not properly accounted for in the TCOC budget, it is possible that the budget could become too low to cover the cost of these activities. To avoid this outcome, EOHHS is attentive

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

to opportunities to incorporate these costs into the underlying reimbursement structure where appropriate, so that they can be appropriately accounted for in the TCOC calculations.

Community health worker services are a prime example of an AE activity that became a reimbursable Medicaid benefit. Rhode Island's SFY 2022 state budget added community health worker services as a Medicaid benefit, and EOHHS submitted a State Plan Amendment to add community health worker services to the Medicaid State Plan to the Centers for Medicare & Medicaid Services (CMS). The State Plan Amendment was approved by CMS in May 2022. EOHHS expects that this addition will generate a significant return on investment for the state; a recent Health Affairs report conducted a robust financial analysis of a CHW program and found that every dollar invested in the intervention would return $2.47 to an average Medicaid payer within the fiscal year.[8]

EOHHS is initially reimbursing for community health worker services using fee-for-service methodology. In the coming years, however, EOHHS plans to include CHW services in managed care contracts and work with providers and MCOs to incorporate these services into alternative payment methodologies such as primary care capitation.

Based on budgets submitted by AEs as part of Program Year's 4 and 5 re-certification, EOHHS estimates that reimbursement for these services will cover at least 6%-8% of AE costs that were historically funded through the Incentive program or shared savings. The estimated range is likely low because not all AEs reported spending on CHW services separately from other prevention and care management activities.

By ensuring that AEs can obtain reimbursement for high value services that are currently paid for through HSTP, EOHHS will allow AEs to be paid for all the expenses involved in providing the highest-quality, most efficient care possible, while still reducing total cost of care and in turn state and federal expenses in Medicaid. EOHHS will continue to explore opportunities to add other services and activities as covered benefits, including through value-added services, and will work with AEs and MCOs to identify such services. **EOHHS will leverage multi-payer, statewide policies to support AEs**

Most AEs receive a significant share of patient volume through Medicaid, but also have commercial and Medicare patients. To the extent that incentives, policies, and funding priorities are aligned across payers, EOHHS expects that AEs will be better able to leverage resources to serve their full patient population. Additionally, alignment of incentives across provider types, as Medicaid and other payers continue to increase the proportion of medical spending that falls under value-based contracts will facilitate AE success under TCOC arrangements and advance quality, affordability, and population health across payers.

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

[8] Health Affairs. "Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment" https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00981.

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

EOHHS will also explore opportunities to develop new, multi-payer alternative payment methodologies (APMs) in partnership with OHIC, including efforts to bring incentive structures into alignment across different provider types. EOHHS was also an active participant in the Cost Trends Project Value-Based Payment Subcommittee, which developed and issued a set of recommendations to accelerate the addition of advanced value-based payment methodologies in the state.[12]

One opportunity to better align incentives across payers and support AEs is primary care capitation. This payment method may provide more flexibility for practices and AEs to pay for work that is not reimbursable, as well as greater revenue stability. For example, EOHHS and OHIC implemented a Pediatric Primary Care Rate Supplement through the end of calendar year 2020, to provide monthly financial incentives to ensure all children were up to date with the full array of essential, preventive healthcare services by overcoming COVID-19 related barriers to access. Payments were contingent upon providers demonstrating measurable improvement in access to care. As OHIC and healthcare stakeholders continue discussing ways to expand use of this payment methodology, EOHHS expects to discuss the potential for alignment with MCOs.

EOHHS and MCOs will also examine other APMs under consideration for multi-payer adoption and will carefully consider how these can operate in conjunction with the AE TCOC model. The Value-Based Payment Subcommittee is identifying strategies to expand prospective total cost of care payment methods, for example. EOHHS supports this direction and intends to pursue it in alignment with statewide goals. As EOHHS develops plans for advanced value-based payment, it is necessary to remain careful stewards and administrators of the AE program, including through careful planning that accounts for the wide differences among providers.

EOHHS expects that by aligning with multi-payer efforts, AEs will benefit from having similar incentives and structures across their patient populations, because the same programs and policies will benefit them across multiple lines of business and less effort will be needed to analyze different APMs.

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

Ongoing Sustainability Planning

EOHHS considers sustainability planning an ongoing project throughout the Demonstration. However, as we enter the final few years of the Demonstration-supported AE program, the above-described strategies will support the continuation of the AE program beyond the conclusion of the current demonstration period. EOHHS' vision is that the AE program will

[12] https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-04/RI%20Advanced%20VBP%20Compact%202022%2004-20%20FINAL%20%2B%20Signed.pdf

continue to focus on the same goal of driving delivery system accountability to improve quality, member satisfaction, and health outcomes, while reducing total cost of care.

Finally, EOHHS expects that sustainability considerations will inform a range of policy decisions in the coming years. EOHHS will continue regular discussions with AEs, MCOs, CMS, and other stakeholders to inform the ongoing strategy.

Appendix A: Roadmap Required Components

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

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

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