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

Program Year 7

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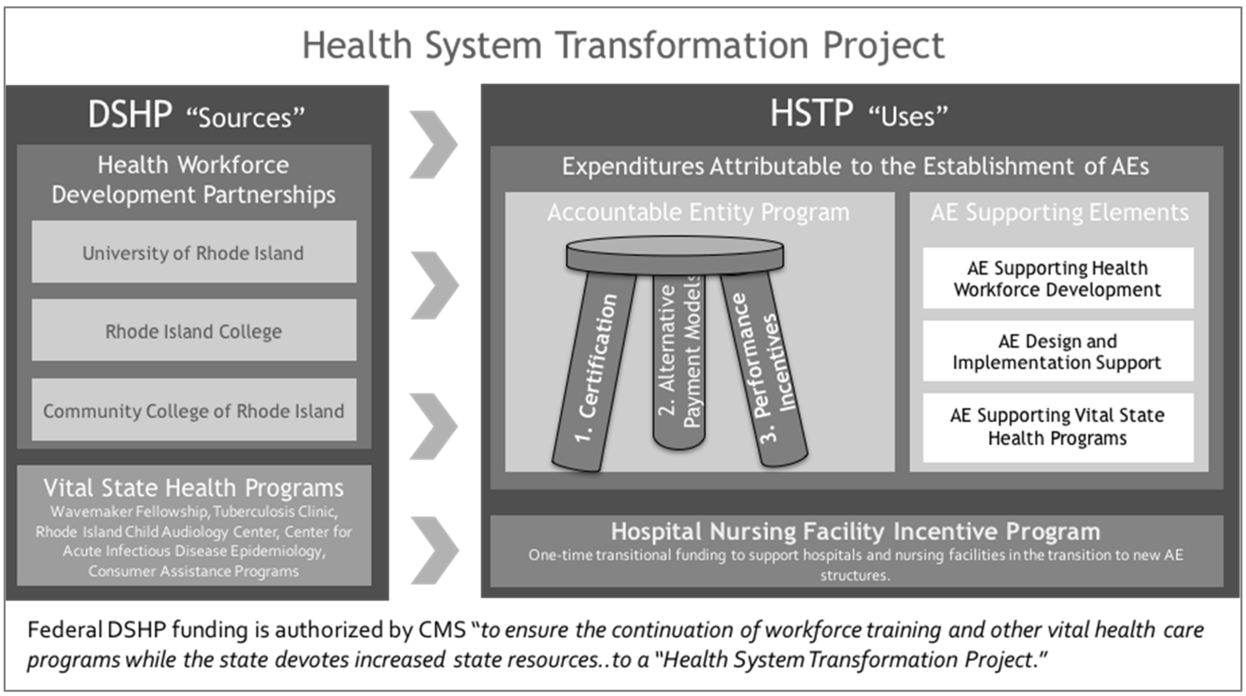
EOHHS INCENTIVE PROGRAM REQUIREMENTS

I. BACKGROUND AND CONTEXT

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



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

- Investments in partnerships with Institutions of Higher Education (IHEs) for statewide health workforce development and technical assistance to AEs
- One-time funding to support hospitals and nursing facilities with the transition to new AE structures[1]

[1] The STCs limit this program to be one-time only and to not exceed $20.5 million, paid on or before December 31, 2017.

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

II. DETERMINING MAXIMUM INCENTIVE POOLS

1. Accountable Entity Incentive Pools (AEIP)

AEs certified for Program Year 7, (7/1/24-6/30/2025), that demonstrate completion of the TCOC Financial Solvency Filing process, and participation in a qualified Alternative Payment Methodology (APM) contract consistent with EOHHS requirements, are eligible to participate in the Medicaid AE Incentive Program.[2] In PY7, EOHHS shall establish an AE-specific Incentive Pool that establishes the total incentive dollars that may be earned by each AE for PY7. The MCO shall verify whether an AE achieves the milestones and/or metrics to earn incentive funding and implement and operate the AE Incentive Pool in coordination with EOHHS.

AE specific incentive pools shall be derived by multiplying a per member per month (PMPM) multiplier times the number of AE attributed lives, in accordance with the following formula.

Program Year 7:AE-Specific Incentive Pool (AEIP) Calculation		
PMPM Multiplier	**x Attributed Lives**	**x 12**
TBD	At the start of each Program Year in accordance with EOHHS defined requirements	Translate to Member Month

For PY7 the PMPM Multiplier will be determined by the amount of unearned incentive funds from prior program years that can be rolled over to form a PY7 incentive pool. EOHHS will establish the PY7 incentive multiplier once the aggregate incentive pool is finalized.

2. MCO Specific Incentive Pools (MCOIP)

MCO specific incentive pools shall be derived from multiplying a per member per month (PMPM) multiplier times the number of attributed lives, in accordance with the following formula.

Program Year 7: MCO-Specific Incentive Pool (MCOIP) Calculation		
PMPM Multiplier	**x Attributed Lives**	**x 12**
TBD~~1.05~~	At the start of each Program Year in accordance with EOHHS defined requirements	Translate from Member Month to annual

[2] Note that FQHC-based AEs may remain in shared savings-only contracts if they demonstrate a progression to value-based care through participation in the Return on Investment Project described below.

For PY7 the PMPM Multiplier will be determined by the amount of unearned incentive funds from prior program years that can be rolled over to form a PY7 incentive pool. EOHHS will establish the PY7 incentive multiplier once the aggregate incentive pool is finalized. .

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

III. EOHHS Priorities

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

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

IV. HSTP PROJECT BASED METRICS

Incentive funds will not be allocated to HSTP Project Based Metrics in PY7.

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

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

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

Required Performance Areas and Milestones		
Performance Area	**Minimum Milestones**	**PY 7 Allocation**
Fixed Percentage Allocations Based on Specific Achievements:	• FQHC-based AEs that remain in shared savings-only contracts: Return on Investment (ROI) Project. In partnership with a contracted MCO, identify a type of utilization to target for reduction, the targeted amount of reduction and the associated cost saving, and an intervention that is expected to achieve this reduction. FQHC-based AEs may designate the activities performed pursuant to one of the HSTP Projects below as the intervention for the ROI Project. It is the responsibility of the MCO to utilize data analytics and predictive modeling tools to assist the AE to identify an area of utilization to target, based on current avoidable utilization gaps/opportunities and to identify the cost savings associated with the reduction. • AEs that participate in downside risk contracts: Evidence of participation in contracts that include shared losses, including evidence of RBPO certification per OHIC.	**5%**
FQHC ROI Project: Pay for Performance	• At the end of the Performance Year, FQHC-based AEs that remain in shared savings-only contracts and MCOs are eligible to receive Incentive Funds in the amount that the intervention saved by reducing the target utilization, up to 5% of the AEIP/MCO-IP. See guidance document for further detail.	**5%**
Pay for Reporting Measures: RELD	• AEs and MCOs may earn up to 30% of any remaining AEIP/MCO-IP funds based on submission of performance for select AE Common Measure Slate measures stratified by race, ethnicity, language and/or disability status. (RELD): o Measure #1: Comprehensive Diabetes Care: Eye Exam o Measure #2: Comprehensive Diabetes Care: HbA1c Control o Measure #3: Controlling High Blood Pressure o Measure #4: Developmental Screening in the First Three Years of Life • Accountable Entities (AEs) should use their own EHR-based clinical data, patient age and sex data, and REL data and disability status data	**30%**

	obtained from managed care organizations (MCOs) to report stratified performance for all measures. • There is no RELD data completeness threshold for reporting performance stratified by RELD. Organizations should report on all patients for whom they have RELD data. • See the Quality and Outcome Implementation Manual for full measure specifications.	

Annual Outcome Metrics Pay for Performance	• **Outcome Metrics Pay for Performance Allocation: EOHHS will work with MCOs and AE to determine appropriate performance-based targets for the following metrics.**
	  ○ Plan All-Cause Readmissions(30%)
	  ○ Potentially Avoidable ED Visits (30%)
	• See the Quality and Outcome Implementation Manual for full measure specifications and information on reporting.
		65% (60% for FQHC-based AEs remaining in shared savings only contracts)

Total		**100%**

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

VI. AEIP Funding Requirements

Under the terms of EOHHS' agreement with the federal government, this is not a grant program. AEs must earn payments by meeting metrics defined by EOHHS, as described herein and approved by CMS, to secure full funding.

Certified AEs must develop individual Health System Transformation Project Plans (HSTP Project Plans) that identify clear project objectives and specify the activities, measures, and timelines for achieving the proposed objectives. Certified AEs will develop HSTP Project Plans in collaboration with MCOs and submit to EOHHS following review and approval by the MCOs. EOHHS will provide an HSTP Project Plan Template in early CY 2022 that includes further instructions and deadlines.

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

- Be subject to EOHHS review and approval
- Incorporate the central elements of the approved AE submission, including:
  - Performance schedule and performance metrics
  - Payment terms – basis for earning incentive payment(s) commensurate with the value and level of effort required.
- A defined process and timeline to evaluate whether AE performance warrants incentive payments. The AE's failure to fully meet a performance metric within the timeframe specified will result in forfeiture of the associated incentive payment. **There will be no payment for partial fulfillment.**

- Stipulate that the AE earns payments through demonstrated performance. The MCO must certify that an AE has met the performance metric target as a condition for the release of associated HSTP funds to the AE. AEs submit quarterly reports to the MCO using a standard reporting form to document progress in meeting identified performance metrics and targets that would entitle the AE to qualify to receive HSTP payments; such reports will be provided to EOHHS by the MCO.
- AE performance metrics in the "Fixed Percentage Allocations Based on Specific Achievements" category is specific to the performance period and must be met by the close of the performance year for an AE to earn the associated incentive payment.

AEs shall be required to demonstrate that at least 10% of Program Year 7 incentive funds are allocated to partners who provide specialized services to support behavioral health care, substance abuse treatment and/or social determinants. Funds that are not completely exhausted in the program year can be earmarked for other contracts in support of SDOH and BH integration and/or for the following program year. The intent is that these funds be explicitly used to support the CBO for their role, function and infrastructure and capacity building in the effort to further integrate such services. Partnerships with social service organization (SSO), behavioral health and/or opioid health home should be driven based on an AEs analytic profile inclusive of identified community needs and gaps, outcome of SDOH Screenings and a geographic analysis. These funds are to be used to build capacity for such community-based organization to enter into financial arrangements with a health care system. Capacity building efforts may include infrastructure support related to information technology, analytics, systems, care coordination/integration of services, with attention to on non-Medicaid billable services such as housing and food insecurity.

Payment and Reconciliation

AEIP and MCOIP funds will be distributed on a quarterly basis. Within thirty (30) calendar days of the end of each quarter, the MCOs shall submit to EOHHS a request for the release of any earned AEIP and MCOIP funds through the Milestone Performance Report (MPR). MCOs shall also submit all evidence of completion of any milestones by the AE. EOHHS shall process this submission and distribute earned AEIP and MCOIP funds to the MCO within thirty (30) calendar days of receiving an accurate MPR. MCOs shall make associated payments to AEs within thirty (30) calendar days of receiving the earned incentive funds from EOHHS. The MCO will maintain a report of funds received and disbursed by transaction in a format and in the level of detail specified by EOHHS.

Actual AEIP incentive payment amounts to AEs will be based on demonstrated AE performance; accordingly, incentive payments earned by the AE may be less than the amount they are eligible to earn.

VII. ALLOWABLE & DISALLOWABLE USE OF AEIP FUNDS

EOHHS/Medicaid will oversee the MCOs administration and management of the HSTP incentive program. In accordance with requirements, MCOs shall directly report to EOHHS on a quarterly basis each AEs achievement of HSTP incentive milestones/metrics and earned funds. Incentive funds should be used to directly support the goals and objectives of the Medicaid

Accountable Entity program. However, EOHHS is not prescriptive on how earned incentive funds are overtly used, however EOHHS does require each Medicaid AE and MCO to attest that earned HSTP incentive funds **will not** be used for specific expenditures as outlined below. This attestation is required to remain eligible to earn HSTP incentive funds. These non-allowable expenditures have been developed in alignment with Section 2 CFR 200 which outlines Financial Management and Internal Control Requirements for receipt, tracking and use of federal funds by non-Federal awardees, and shall be updated by EOHHS as appropriate.

General Disallowable Uses:

- To directly mitigate against downside risk for the AE, the AE Partner of an AE, the AEs participating primary care physicians (PCPs), or for an AEs Safety Net Hospital(s)
- To offset revenue from reduced hospital utilization
- To pay for any costs incurred in the process of responding to the EOHHS AE Application, or during contract negotiations with Medicaid MCOs
- To pay for initiatives, goods, or services that are duplicative with initiatives, goods, and services that the AE, including any participating entities of the AE, currently fund with other federal, state, and/or local funding
- To pay for any RI Medicaid service (whether covered by the MCO or covered as a wrap service)
- To support personnel FTE allocation in a duplicative manner with payments provided for Covered Services
- To provide goods or services not allocable to approved project plans and budgets
- To pay for malpractice insurance

Expenditures cannot include the following:

- Alcoholic beverages
- Medical Marijuana
- Copayments/Premiums
- Capital expenditures (unless approved in advance by EOHHS)
- Credit Card Payments Interest
- Debt restructuring and bad debt
- Student Loan Repayment
- Defense and prosecution of criminal and civil proceedings, and claims
- Donations, fund raising, and investment management costs
- Social activities (good and services intended for leisure or recreation), Hobbies (materials or courses)
- Fines and penalties
- Goods or services for personal use, including but not limited to entertainment, gift cards

or other cash equivalents

- Idle facilities and idle capacity
- Insurance and indemnification
- Licenses (drivers, professional or vocational)
- Lobbying
- Marketing/member communication expense, unless approved in advance by EOHHS
- Memberships and subscription costs
- Patent costs

Duplication Disallowable Uses

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

- RI Medicaid Covered Services including, State Plan services and 1115 demonstration services
- Services that are duplicative of services a member is already receiving
- Services where other funding sources are available such as services that a member is eligible for, and able to receive from a federal agency, another state agency. In certain cases, a member may not be "able to" access certain programs and thus HSTP funds may be utilized. Such cases may include, but are not limited to, a program that has:

  Run out of funds or lacks capacity (e.g., organization does not have the resources to assist with additional enrollment)
  Delayed access to services or goods (e.g., wait list, waiting for a determination on eligibility and availability).

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

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

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

Appendix A: Guidance for Return on Investment Projects for Federally Qualified Health Centers Not Taking Downside Risk

The goal of the Health System Transformation Project is to transition from fee-for-service payment to a methodology that rewards quality and efficiency over volume of care. In lieu of downside risk arrangements that encourage and demonstrate this transformation, EOHHS requires that FQHC-based Accountable Entities remaining in upside-only contracts demonstrate how they are progressing from volume to value. EOHHS requires that FQHC-based Accountable Entities who do not enter into downside risk contracts collaborate with contracted Managed Care Organizations to identify a project targeted to demonstrate reduced healthcare spending for the AE's Medicaid Line of Business.

FQHC-based AEs who do not enter into downside risk contracts are eligible to earn 5% of their Incentive Fund Pool upon submitting a Return on Investment (ROI) Project Plan, which must include: 1) a description of the targeted area of utilization and utilization change; and 2) a description of the intervention and how it will impact the targeted utilization.

Note that the targeted area of utilization and utilization change may not be identical to the AE's target for any of the three AE Incentive Pool Outcome Metrics. To the extent that an AE chooses to address the same type of utilization addressed by one of the Outcome Metrics, the AE may only earn savings for utilization reduction over and above its Outcome Metric target.

At the end of Program Year 7 (SFY 2025), FQHC-based AEs are eligible to receive Incentive Funds in the amount that their intervention saved by changing the target utilization compared to the utilization in a baseline period, up to an amount equal to 5% of the AE's Incentive Fund Pool.

EOHHS anticipates that savings will be calculated in a manner similar to the following:

a. Identify an "expected" level of utilization that would occur without an intervention. This might be done by "trending" baseline year data forward to get a performance year projection, or the expected utilization level might be the same as the level in the baseline year, depending on whether the utilization in question is expected to remain the same or change over time;
b. Identify the cost of the targeted utilization that would have been incurred in Program Year 7 had the utilization been the same as the expected level;
c. Subtract the actual cost incurred in Program Year 7 from the expected cost calculated under b.[3]

FQHC-based AEs are eligible to earn up to 5% of their Incentive Fund Pool in this manner. Any difference between the amount saved and the amount equal to 5% of their Incentive Fund Pool will be considered unearned Incentive dollars.

[3] EOHHS acknowledges that this methodology will not necessarily identify reductions in utilization *caused* by the intervention and that this is a limitation.

Note that EOHHS expects the MCO to submit the ROI Project Plan and final report on performance, however the expectation is that the AE will take the lead in crafting the ROI Project Plan and intervention, in close partnership with the MCO.

<u>Timeline and Process:</u>

Activity	Responsible Party	Time
Develop and draft ROI Project Plan using the provided template.	AE, with support from MCO as described in this document	Spring 2024
Submit ROI Project Plan to Medicaid.	MCO	Aug. 1, 2024
Review ROI Project Plan. EOHHS will evaluate the methodologies used to set the baseline period and targets for utilization reduction to ensure they are reasonable. EOHHS will evaluate the ROI Project Plan to ensure that the intervention is described in sufficient detail to be ready to implement and reasonably related to the goal to target utilization reduction. EOHHS will identify any questions or areas that require revision and provide this feedback to the MCO and AE.	EOHHS	Aug. 15, 2024
Submit revised ROI Project Plan	MCO	Sept. 1, 2024
Approve ROI Project Plan. Approval will permit release of Incentive Funds equal to 5% of the AE's HSTP Incentive Fund Pool and a proportionate share of the MCO-IP as part of the next quarterly reporting/payment cycle following approval.	EOHHS	Sept. 15, 2024
Submit to EOHHS a final report showing the change in utilization from the baseline period to the performance year and estimating any savings resulting from reduced utilization.	MCO	Oct. 30, 2024
Approve final report showing the change in and associated savings. EOHHS will evaluate the methodology by which the MCO calculated the utilization reduction and savings to ensure it is reasonable. Approval will permit release of earned Incentive Funds up to 5% of the AE's HSTP Incentive Fund Pool and a proportionate share of the MCO-IP as part of the next quarterly reporting/payment cycle following approval.	EOHHS	Nov. 30, 2024