ATTACHMENT C: Proposal Narrative Template

I. Domain 1: Breadth and Characteristics of Participating Providers

1. Attest that the applicant has an attributable population of at least 5,000 members in accordance with AE Certification Standards section 1.1 and state the basis for the applicant's attestation (e.g., provide the number of patients who are currently assigned to participating for primary care or other evidence).

2. Describe why the applicant believes its provider base is adequate to serve the intended population (children and/or adults) as well as relevant sub-populations and specific needs in accordance with AE Certification Standards section 1.1. Include a description of how the applicant may deliver this full continuum of services through ensuring smooth transitions to other providers as applicable:
    a. Primary care
    b. Specialty care
    c. Inpatient care
    d. Behavioral health, including preventive, routine, and high-end behavioral health services and including integration of behavioral health services with physical health services
    e. Substance use services, including integrated services
    f. Social determinants of health
        i. Specify three areas of critical need for social supports for the population serviced (children and/or adults) and describe the in-house capacity and/or relationships with social support providers that will allow the applicant to meet these needs.

3. In accordance with AE Certification Standards section 1.2, attest that all providers listed as participating in the applicant's proposed AE have agreed to participate in and be accountable for healthcare transformation efforts, including participating in a total cost of care contract.

4. In accordance with AE Certification Standards section 1.3, describe and as applicable attach copies of protocols that guide care delivery across providers within and outside the AE to deliver integrated care.

5. In accordance with AE Certification Standards section 1.4, describe how the applicant currently does or plans to identify and take action to address rising risk and high-risk populations.

6. In accordance with AE Certification Standards section 1.4, describe how the applicant currently cares or plans to care for patients with multiple co-occurring chronic conditions, including chronic behavioral health conditions.

7. In accordance with AE Certification Standards section 1.4, describe how the applicant currently works to improve transitions of care or plans to do so. Include both transitions among different levels of care within health care as well as at key points of life transitions such as discharge from corrections, engagement with DCYF, etc.

8. In accordance with AE Certification Standards section 1.5, describe how the AE assures timely access to care as described below. Provide evidence from within the previous six months to demonstrate compliance:

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

II. Domain 2: Corporate Structure and Governance

In accordance with AE Certification Standards section 2, attest that the applicant's governance structure as described in Attachment C and accompanying attachments is compliant with each of the following requirements. If the applicant does not yet meet the requirement, please state the applicant's plan and timeline to achieve compliance:

1. Board of Directors membership meeting the minimum requirements:
    a. Most voting members are primary care providers and behavioral health providers and at least three members are primary care providers and at least three are behavioral health providers. This means the members are representatives appointed by participating primary care providers and behavioral health providers who are listed on the Provider Base tab of Attachment C.
    b. If the applicant is applying to serve children:
        i. Pediatric primary care provider
        ii. Pediatric behavioral health provider
        iii. Pediatric member of Consumer Advisory Committee, who is a Medicaid member attributed to the AE or a representative of an attributed member.
        iv. Community-based organization provider of age-appropriate social supports
    c. If the applicant is applying to serve adults:
        i. Internal medicine primary care provider
        ii. Adult behavioral health provider
        iii. Adult member of Consumer Advisory Committee, who is a Medicaid member attributed to the AE
        iv. Community-based organization provider of age-appropriate social supports
    d. There is a Board-level Governing Committee with a distinct focus on Medicaid that includes an Integrated Care Committee, a Quality Oversight Committee, and a Finance Committee. The Governing Committee is responsible for designing the distribution plan

for any shared savings earned and, as applicable, the plan for distributing responsibility for any shared losses.

e. There is a Compliance Officer with an unimpeded line of communication with the Board who is not legal counsel for the Board.
f. There is a Community Advisory Committee that includes at least four persons who are Medicaid beneficiaries attributed to the AE, or who are appropriate family representatives of those beneficiaries, and who are representative of the populations served by the AE (children and/or adults).
g. The Community Advisory Committee also includes at least one representative from a Health Equity Zone organization that operates in the AE's geographic service area.

2. In accordance with AE Certification Standards section 2.4, identify any MCOs with which the applicant has begun discussions in preparation for potential contracting. Does the applicant currently have an executed contract, an MOU, or a jointly executed Letter of Intent to contract with a Medicaid MCO using an Alternative Payment Methodology such as a total cost of care model? Please briefly describe the applicant's plan to meet the requirement of having a total cost of care contract with at least once MCO.

III. Domain 3: Leadership and Management

1. In accordance with AE Certification Standards section 3.1, identify the Chief Executive and/or Medicaid AE Program Director responsible to the Board of Directors and responsible for AE operations. If this person has not yet been hired, describe the plan and timeline to do so.

2. In accordance with AE Certification Standards section 3.1, describe the management structure and staffing profile that the AE will deploy to ensure the component parts of the AE will be integrated into a coordinated system of care. This structure can include management services agreements with MCOs or subcontracts with other vendors. Component parts/activities that should be included in this structure/profile include:
    a. Integrated care management
    b. IT infrastructure and data analytics
    c. Quality assurance and tracking
    d. Unified financial leadership and systems
    e. Financial modeling capabilities and indicators
    f. Designing financial incentives to encourage coordinated, effective, efficient care.

3. In accordance with AE Certification Standards section 3.1, describe the applicant's approach to deploy interventions to reduce total cost of care (TCOC), including interventions to address utilization of healthcare services that the applicant does not directly provide itself.

IV. Domain 4: IT Infrastructure – Data Analytic Capacity and Deployment

1. In accordance with AE Certification Standards section 4.1, describe the applicant's ability to receive, collect, integrate, and utilize person-specific demographic, clinical, and health status information. Include the following elements:

a. Able to ensure data quality, completeness, consistency of fields, definitions.
b. EHR capacity: Ability to share information with providers and partner organizations.
    i. Use EHR systems to document medical, behavioral, and social needs in one common medical record that can be shared across the network within HIPAA guidelines. Use EHRs that comply with ONC certification standards, particularly for USCDI and interoperability requirements Require use of EHRs to capture clinical data necessary for quality measurement as part of care delivery and submit these data to QRS system.
c. Patient registries – shared patient lists (e.g., PCP, BH provider, Care management) to ensure providers are aware of patient engagements.
d. Demonstrate that patients are offered an opportunity to opt out of CurrentCare disclosures for care coordination. This condition can be met by submitting a copy of a Notice of Privacy Practices or a comparable document that is in compliance with 216-RICR-10-10-6.
e. AE provider participants must contribute data from their EHRs to CurrentCare in a Clinical Care Document Format (CCD). AE provider participants must have the ability to receive data from CurrentCare or CurrentCare enrolled patients either through bidirectional interfaces with CurrentCare, where EHR vendor capacity exists, or by ensuring all pertinent staff have appropriate access to CurrentCare Viewer or CurrentCare data within their EHR.
f. AE provider participants must demonstrate capacity to exchange clinical quality data electronically via the QRS for all practice sites with over 1,000 attributed AE members. Alternate approaches to submitting electronic clinical data to MCOs will be considered on a case-by-case basis but must be approved by EOHHS prior to implementation. This will enable data and reporting capability necessary to identify and monitor quality and performance opportunities. AEs are expected to submit full panel submissions as part of this CDE process. The appropriate quality improvement and clinical staff should have access and use of the QRS as needed.
g. Participate in primary source verification activities, (chart reviews, supplying EHR screenshots, correcting data submission errors as needed, etc.) as necessary for the Quality Reporting System (QRS) to obtain Data Aggregator Validation (DAV) program certification from the National Committee for Quality Assurance (NCQA).

2. In accordance with AE Certification Standards section 4.2, describe the applicant's methodology to stratify attributed members to identify those with the highest complexity and those in the rising/imminent risk groups, including how social determinants of health are incorporated into the stratification model. Identify the tools used for this purpose. Include the approach for the populations served (children and/or adults). If the applicant does not yet have this capacity, describe the plan to achieve it, including proposed timeline.

3. In accordance with AE Certification Standards section 4.3, describe the business process metrics that the applicant will use to meaningfully evaluate operational efficiency and total cost of care efficiency.

a. Defined set of business process metrics meaningfully targeted to both operational and total cost of care efficiency.
b. Actions to Enhance Ability to Manage Care processes. Reshaping workflows for: availability and access, high impact interventions, reduce variance in quality/outcomes.
c. Defined tools in place for tracking and monitoring level of performance in meeting contact and follow up objectives in implementation of the care model; established protocols for review of performance and feedback loops for quality improvement.

4. In accordance with AE Certification Standards section 4.4, describe the health information technology tools the applicant uses or will use to provide screening and clinical decision support to providers to ensure they follow evidence-based pathways for physical health, behavioral health, and social determinants of health.
    a. HIT tools to provide screening and clinical decision support (e.g., Event notification services to providers to help ensure they follow the evidence-based care pathways, inclusive of behavioral health and social determinants of health.
    b. Define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care.
    c. Provision of actionable information to providers within the system
        i. Analysis of gaps, needs, risks based on evidence-based practice. Gaps in care reports based on deviations from evidence-based practice.
        ii. To help enhance and/or direct care coordination/care management. E.g., medication management.
    d. Establish early warning systems and methods to alert and engage the care management team to critical changes in utilization. o Employ notification services (real time dashboard of patient admissions and discharges to EDs and hospitals).

5. In accordance with AE Certification Standards section 4.5, describe the training staff receive and/or will receive in how to use data systems effectively and use data to manage patient care.
    a. Training in, and expectation for, using data systems effectively, using data to manage patients care.
    b. Ongoing aggregate reporting with individual/team drilldowns re: Conformance with accepted standards of care, deviations from best practice, identified breakdowns in process.

V. Domain 5: Commitment to Population Health and System Transformation

1. In accordance with AE Certification Standards section 5.1, describe the applicant's approach to population health management. Explain how the approach meets the following requirements:
    a. Is population-based.
    b. Is data-driven.
    c. Is evidence-based.

d. Is person and family-centered: providing strength based individual and family support and care plans that are reflective of member/family voice and preferences.
e. Recognizes and addresses SDOH. Creates programmatic interventions by sub-population.
f. Is team based and includes care management and care coordination, effective management of transitions of care, and collaboration with community health teams and community health workers as integral partners.
g. Integrates BH and PH/primary care, including the identification of modifiable, non-modifiable risk factors for poor behavioral health outcomes.

2. In accordance with AE Certification Standards section 5.2, describe the applicant's approach to address attributed member's Health Equity & Social Determinates of Health:
    a. An AE will seek methods to identify and alleviate key social determinants of health. These can include social factors such as housing, food security, safety, transportation, and domestic violence.
    b. An AE will perform a regular Population Health and SDOH Assessment, including evaluating the social needs of its members and taking actions to maximize the degree that Attributed Members receive appropriate care and follow-up based on their identified social needs.
        i. An AE will develop, implement, and maintain procedures for completing SDOH Care Needs Screening for Attributed Members based on a defined protocol. The protocol shall identify what triggers a screening and may be based on such factors as diagnosis, care utilization pattern or patient self-identification. Procedures shall address the approach to completing an initial SDOH Care Needs Screening for persons with a primary care visit. AEs may collaborate with MCOs to support these activities.
        ii. The AE's SDOH Care Needs Screening shall be an instrument defined by the AE and approved by EOHHS. EOHHS shall be informed of any changes to an AEs SDOH Care Needs Screening tool prior to implementation of changes. The screening shall evaluate Attributed Members' health-related social needs in order to determine the need for social service intervention. Such services shall include but not be limited to:
            - Housing insecurity
            - Food insecurity
            - Transportation
            - Interpersonal violence; and
            - Utility assistance

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

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

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

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

i. Develop a standard protocol for referral for social needs using evidence and experience-based learning and for tracking referrals and follow-up. Social needs assistance shall include: Referring to providers, social service agencies, or other community-based organizations that address the Attributed Member's needs.

ii. Providing support to maximize successful referrals, which may include:

- Actions to maximize the outcome that the Member attends the referred appointment or activity, including activities such as coordinating transportation assistance. Attending appointment with members & following up after missed appointments.
- The Attributed Member's PCP or care team member communicating and sharing records with the provider being referred to, as appropriate to coordinate care.
- The Attributed Member's PCP or care team member directly introduces the Attributed Member to the service provider, if co-located, during a medical visit (i.e., a "warm hand-off").
- Providing information and navigation to the Attributed Member regarding community providers of social services that address the Attributed Member's health-related social needs, as appropriate.
- Providing the Attributed Member with information and counseling about available options; and
- Coordinating with community providers of social services to improve integration of care.

d. AEs must have a documented plan for the tracking and reporting of referrals for social needs to MCO. The plan should include:

i. Standardized protocol for referral to social service provider.

ii. Methods for tracking referrals, including follow-up, until referral report has been received.

iii. Monitoring the timeliness and quality of the referral response

iv. Development of metrics to define a successful referral.

v. Development and implementation of standards and reporting of metrics and referral information to MCO.

3. In accordance with AE Certification Standards section 5.3, System Transformation and the Healthcare Workforce:

a. Healthcare workforce transformation planning

i. Participate on EOHHS, DLT, or other committees as requested to provide ongoing assessment of healthcare workforce transformation needs and strategies.
ii. Participate in periodic employer surveys of healthcare workforce development needs and opportunities.

b. Healthcare workforce transformation programming
i. Collaborate with URI, RIC, CCRI and/or other education and training providers to assist in educational planning, curriculum development, instruction, clinical training, research, and/or other educational activities related to healthcare workforce transformation.
ii. Develop partnerships with URI, RIC, CCRI and/or other education and training providers to expand clinical rotations and/or internships to prepare health professional students with knowledge and skills needed to achieve RI's health system transformation goals.
iii. Develop partnerships with URI, RIC, CCRI and/or other education and training providers to expand continuing education for current employees of AE partners to acquire the knowledge and skills needed to achieve RI's health system transformation goals.
iv. Develop partnerships with secondary schools, public workforce development agencies, and/or community-based organizations to develop career pathways that prepare culturally and linguistically diverse students and adults for entry level jobs leading to career advancement in health-related employment.

VI. Domain 6: Care Continuum

1. In accordance with AE Certification Standard 6.1.1, indicate whether the AE has an optional Joint Operating Committee (JOC) management structure with each plan the AE contracts with.

2. In accordance with AE Certification Standard 6.1.2, describe the methodology and tools that the applicant will use to identify/target attributed members for care management. This method should involve systematic use of analytics and risk segmentation.

3. In accordance with AE Certification Standard 6.1.3, describe the applicant's current or planned future activities to educate and train providers across the full continuum of care regarding the continuum of care programming offered by or through the applicant and the expectations that providers must meet to implement these programs.

4. If the applicant has chosen to conduct the optional health promotion activities described in AE Certification Standard 6.2, please describe the applicant's approach to these activities, including:

a. The applicant's approach to identifying/targeting members for health promotion activities.
b. Which health promotion activities the applicant plans to conduct independently and which the applicant plans to conduct jointly (or explore conducting jointly) with contracted MCOs (pending agreement with the MCO(s) in the contracting process)
c. The applicant's planned approach to accomplishing the health promotion efforts in PY7 and beyond.

The description may also include examples of health promotion activities the applicant conducted, independently and/or jointly, from the past 12 months, if applicable.

5. Describe the applicant's approach to care coordination standards under Certification Standard 6.3, including the applicant's approach to the following:
    a. Tracking and coordinating care across specialty care, facility-based care, and care delivered by community-based organizations
    b. Rapidly identifying and effectively responding to changes in a member's condition to activate care coordination.

6. If the applicant has chosen to adopt the optional care coordination activities under Certification Standard 6.3, describe the applicant's approach to any of these standards, including the following as applicable:
    a. Systematically identifying members suitable for care coordination
    b. Supporting members in navigating care by scheduling appointments, arranging transportation, engaging in special programs, and providing health coaching
    c. Coordinating communication and care between all providers and care coordinators/managers (within and outside of the applicant) engaged in a member's care. Include how the applicant will support transitions of care, hospital discharge planning, integration of BH, chronic disease management, and addressing social determinants of health/ health-related social needs.
    d. Exchanging member lists (i.e., exchange between the AE and MCO) for transitions of care, chronic disease management, social determinants of health information, etc.
    e. Conducting prenatal risk assessment
    f. Providing nutrition assessment, education, and counseling

7. Describe the applicant's approach to care management standards under Certification Standard 6.4, including the following information:
    a. The applicant's systematic methods to identify, conduct outreach to, and enroll individuals at high risk for poor outcomes in care management.

b. How the applicant ensures that care management programs/activities employ evidence-based practices
c. How the applicant ensures that care management programs/activities are culturally and linguistically appropriate for the populations served.
d. The applicant's approach to transitions of care for individuals moving between healthcare settings, including an approach to coordinate with hospitals on discharge planning and follow-up. The approach should be evidence-based.
e. Rapidly identifying and effectively responding to changes in a member's condition to activate care management.

8. If the applicant has chosen to adopt the optional care management standards under Certification Standard 6.4, describe the applicant's approach to any of these standards, including the following as applicable:
    a. The applicant's systematic methods to identify, conduct outreach to, and enroll individuals at high risk for poor outcomes in care management.
    b. Whether and to what extent the applicant uses or plans to use community health workers as extenders for licensed care management staff
    c. The applicant's approach to care management collaboration with community and provider-based care coordinators/care managers to arrange, assure delivery of, monitor, and evaluate member care
    d. The applicant's approach to care management coordination with non-covered health/social service providers
    e. The applicant's approach to supporting access to and coordination with broad-based services such as NEMT, DHS services, RIDOH programs, Rite Smiles as part of care management.

9. Describe how the applicant will ensure that all members in care management have Individualized Care Plans, developed with active involvement of the member/family to identify care goals and interventions, that meets all the requirements of AE Certification Standards Section 6.4.2.

10. Describe how the applicant will deploy care management staff with specialized expertise and skills for work with distinct sub-populations:
    a. Members requiring integration of BH care (including treatment for both mental illness and substance use disorder) and medical care
    b. Members with chronic diseases who require medical management and/or coordination of transitions of care (e.g., among emergency department, hospital inpatient, skilled nursing facility, home, etc.)
    c. Members requiring home and community-based services
    d. Members requiring supportive social services

11. If the applicant has chosen to adopt the optional case management standards as described in AE Certification Standard 6.5, describe the applicant's approach to any of these standards, including the following as applicable:
    a. Whether the applicant provides or plans to provide complex case management to any members directly, or instead facilitates or plans to facilitate access to this service for members who require the service. If the applicant will facilitate access for all members, note the entity or entities that will provide the service.
    b. The lead entity charged with delivering complex case management for specific subpopulations, including but not limited to children with complex medical needs and/or multiple ACEs (adverse childhood experiences); individuals with HIV/AIDS, mental illness, or SUD; individuals recently discharged from correctional institutions; individuals experiencing high risk pregnancies.
    c. If the applicant is providing complex case management, the applicant's staffing plan, including the qualifications/licensure of staff, behavioral health staffing or contracting, and any plans to include community health workers as extenders for complex case management licensed case managers.

VII. Domain 7: Member Engagement

1. In accordance with AE Certification Standards section 7.1, describe the applicant's current or planned future strategy to conduct outreach to and connect with hard-to-reach, high-need populations. Include the following information:
    a. How does the applicant ensure that its communications are culturally and linguistically appropriate?
    b. How does the applicant ensure that written communication is understandable and written at an appropriate reading level?
    c. How does the applicant address the potential mistrust of the healthcare system that many hard-to-reach members may experience?
    d. How does the applicant develop population-specific strategies and methods to develop trusting relationships with patients and engage them in their care?

2. In accordance with AE Certification Standards section 7.2, describe the tools/technologies the applicant uses or plans to use to promote member engagement and provide care. Include any information on how the applicant collaborates or plans to collaborate with MCOs to leverage existing technologies. Include the following information:

    a. How the applicant uses or plans to use remote monitoring tools to manage physiological and mental health and/or to support monitoring and maintaining functional status of vulnerable adults in their homes

    b. How the applicant uses or plans to use technologies to support formal and informal caregivers providing timely and effective assistance to members.

c. How the applicant uses or plans to use social media, applications that enable vulnerable adults to stay socially connected, Patient Portals, and other applications to promote adherence to treatment and engagement in care.

d. How the applicant uses or plans to use telemedicine to increase engagement.

VIII. Domain 8: Quality Management

1. In accordance with AE Certification Standards section 8.1, attest that the AE Quality Committee includes a board-certified physician licensed in the State of Rhode Island who is an AE participating clinician, a behavioral health clinician at the independent practice level who is licensed in Rhode Island and who is an AE participating clinician, and an individual from a community-based service organization that provides key social supports to attributed members of the AE.

2. In accordance with AE Certification Standards section 8.1, describe the Quality Program that the applicant operates or plans to operate. The Quality Program must have equity as an integral component and must be overseen by the individual responsible for the applicant's quality assurance and improvement program.

3. In accordance with AE Certification Standards section 8.2, describe how the applicant currently works to integrate medical, behavioral, and social supports through a health equity lens or how the applicant plans to implement efforts to achieve this integration.
    a. Attach executed Policies and Procedures that evidence the methods and processes used to advance integration.
    b. Describe how the applicant ensures or plans to ensure that AE participants and providers/suppliers comply with each process described above, including the remedial processes and penalties for failure to comply.
    c. Describe how the applicant employs or plans to employ internal assessments of cost and quality to continuously improve care practices.

4. In accordance with AE Certification Standards section 8.3, describe the applicant's method to promote evidence-based practice and integration and review of clinical and care management pathways based on evidence.

    a. Attach the most recent minutes of and reports to the Quality Committee regarding the performance of the Quality Program to demonstrate how the Quality Committee reviews information on implementation and tracks the effect of defined strategies to promote evidence-based pathways.

5. In accordance with AE Certification Standards section 8.4, describe how the applicant currently tracks and reports on key performance metrics, including consumer-reported quality measures, or how the applicant plans to develop this capacity.