

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

**Program Year 4**

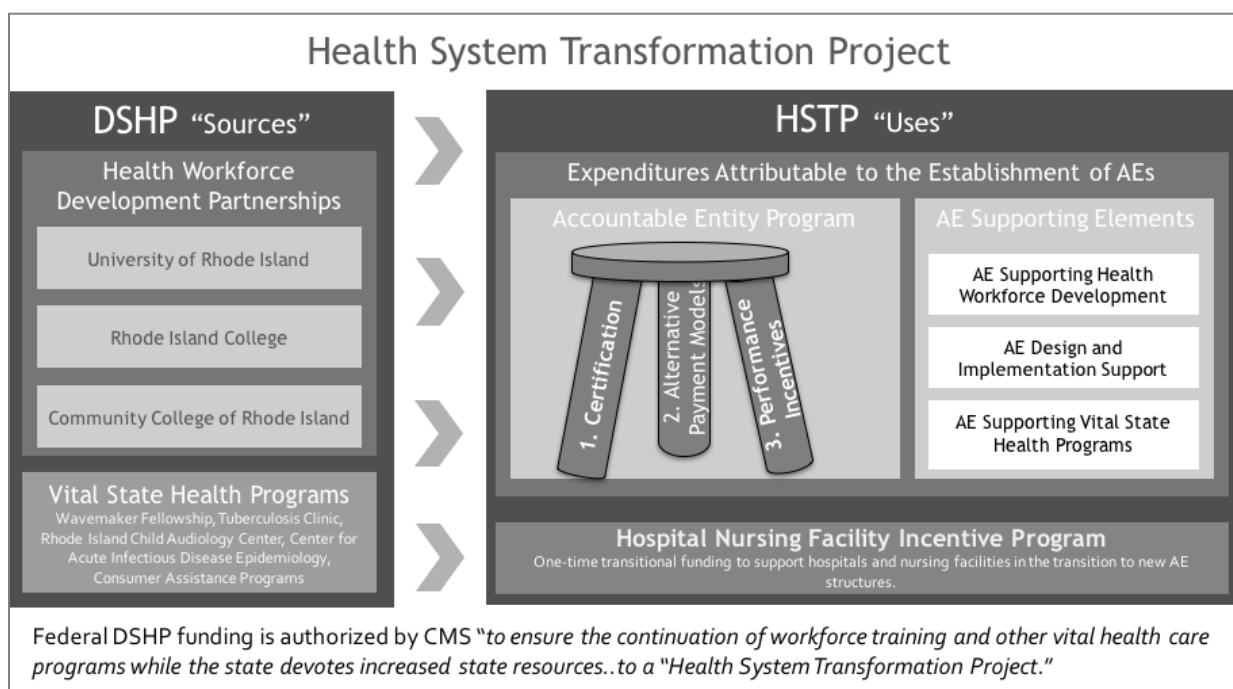
**Table of Contents**

- I. Background and Context**
- II. Determining Maximum Incentive Pool Funds**
- III. EOHHS Priorities**
- IV. HSTP Projects Eligible for Award of AEIP Funds**
- V. Accountable Entity Incentive Pool (AEIP) & Managed Care Organization Incentive Pool (MCO IP) Required Performance Areas and Milestones**
- VI. AEIP Funding Requirements**
- VII. Allowable & Disallowable Use of AEIP Funds**
- VIII. Appendix A: Guidance for Return on Investment Projects for Federally Qualified Health Centers Not Taking Downside Risk**

# 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<sup>1</sup>
- Project management support to ensure effective and timely design, development and implementation of this program
- Project demonstration pilots and project evaluation funding to support continuous program learning, advancement and refinement
- Other supporting programs, including Consumer Assistance, Wavemaker Fellowship, TB Clinic, RI Child Audiology Center, and Center for Acute Infectious Disease Epidemiology

## II. DETERMINING MAXIMUM INCENTIVE POOL FUNDS

### 1. MCO Specific Incentive Pools (MCOIP)

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

Program Year 4: MCO-Specific Incentive Pool (MCOIP) Calculation		
PMPM Multiplier	x Attributed Lives	x 12
\$1.30	At the start of each Program Year in accordance with EOHHS defined requirements	Translate from Member Month to annual

### 2. Accountable Entity Incentive Pools (AEIP)

AEs certified for Program Year 4, 7/1/21-6/30/2022), that demonstrate completion of the Office of the Health Insurance Commissioner (OHIC) pre-certification process, and in a qualified Alternative Payment Methodology (APM) contract consistent with EOHHS requirements, are eligible to participate in the Medicaid AE Incentive Program<sup>2</sup>. In PY 4, EOHHS shall establish an AE-Specific Incentive Pool that establishes the total incentive dollars that may be earned by each AE during the PY period. The MCO shall implement and operate the AE Incentive Pool and determine whether an AE achieves the milestones and/or metrics to earn incentive funding.

---

<sup>1</sup> The STCs limit this program to be one-time only and to not exceed \$20.5 million, paid on or before December 31, 2017. \*Note that the PMPM Multiplier shown above has been established by EOHHS for Program Year 3; the PMPM Multiplier will be defined and released on a yearly basis by EOHHS.

<sup>2</sup> In accordance with CMS guidance, EOHHS must ensure that Federally Qualified Health Centers receive and retain 100% of the Medicaid payments and cannot be put at risk for receiving less than PPS for FQHC services. Therefore, FQHC AEs may remain in shared savings-only contracts if they demonstrate a progression to value-based care. Such progression may include but is not limited to the development of evidence-based processes, incentives for cost reduction, and the establishment of sustainability for interventions currently funded by grants.

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

Program Year 4: AEIP AE-Specific Incentive Pool (AEIP) Calculation		
PMPM Multiplier	x Attributed Lives	x 12
\$6.84	At the start of each Program Year in accordance with EOHHS defined requirements	Translate to Member Month

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

### III. EOHHS Priorities

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

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

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

HSTP Project based metrics shall be based on tangible projects within the AE Certification Standards and must be linked to one or more of the eight domains described below. For Program Year 4 and beyond, HSTP projects must shift toward system transformation capacities (domains 4-8).

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

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

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

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

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

Required Performance Areas and Milestones		
Performance Area	Minimum Milestones	PY 4 Allocation
<b>Fixed Percentage Allocations Based on Specific Achievements:</b>	<ul style="list-style-type: none"> <li>FQHC AEs: Return on Investment (ROI) Project. In partnership with a contracted MCO, identify a type of utilization to target for reduction, the targeted amount of reduction and the associated cost saving, and an intervention that is expected to achieve this reduction. FQHC-based AEs may designate the activities performed pursuant to one of the HSTP Projects below as the intervention for the ROI Project. It is the responsibility of the MCO to utilize data analytics and predictive modeling tools to assist the AE to identify an area of utilization to target, based on current avoidable utilization gaps/opportunities and to identify the cost savings associated with the reduction.</li> <li>Non-FQHC AEs: Evidence of participation in contracts that include shared losses, including evidence of RBPO certification per OHIC.</li> </ul>	<b>5%</b>
<b>FQHC ROI Project Pay for Performance</b>	<ul style="list-style-type: none"> <li>At the end of the Performance Year, FQHC-based AEs and MCOs are eligible to receive Incentive Funds in the amount that their intervention saved by reducing the target utilization, up to 5% of the Incentive Fund Pool. See guidance document for further detail.</li> </ul>	<b>5%</b>
<b>New Pay for Reporting Measures</b>	<ul style="list-style-type: none"> <li>Percentage of AE attributed lives with a primary care visit for whom their attributed primary care provider possesses their race, ethnicity and language data.</li> </ul>	<b>5%</b>

<b>Annual Outcome Metrics Pay for Performance</b>	<ul style="list-style-type: none"> <li>• <b>Outcome Metrics Pay for Performance Allocation: EOHHS will work with MCOs and AE to determine appropriate performance-based targets for the following metrics.</b>  <a href="http://www.eohhs.ri.gov/Initiatives/AccountableEntities/ResourceDocuments.aspx">http://www.eohhs.ri.gov/Initiatives/AccountableEntities/ResourceDocuments.aspx</a> <ul style="list-style-type: none"> <li>○ All-Cause Readmissions (15%)</li> <li>○ Potentially Avoidable ED Visits (10%)</li> <li>○ ED Utilization Among Members with Mental Illness (20%)</li> </ul> </li> </ul>	<b>45%</b>
<b>Variable Allocation HSTP Project Based MCO and AE defined performance measures<sup>3</sup></b>	<ul style="list-style-type: none"> <li>• MCO and AE defined performance measures and targets for at minimum 3 AE core projects</li> <li>• Each project should have at minimum 2 measures per project<sup>4</sup> If an FQHC-based AE chooses to designate a project as its ROI Project intervention, the AE will be eligible to earn Incentive Funds through achievement of project measures as with any other project and will separately be eligible to earn up to 5% of Incentive Funds through achieving an ROI.</li> <li>• At a minimum, one project must focus on behavioral health integration and one project must focus on social determinants of health.</li> </ul>	<b>45% (40% for FQHC-based AEs)</b>
<b>Total</b>		<b>100%</b>

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

## VI. AEIP Funding Requirements

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

Certified AEs must develop individual Health System Transformation Project Plans (HSTP Project Plans) that identify clear project objectives and specify the activities, measures, and timelines for achieving the proposed objectives. HSTP project plans will be submitted as part of the Program Year 4 Certification/Re-certification application. EOHHS will review and approve each HSTP project plan as part of the certification process. Further detail regarding the HSTP project plan is in the Medicaid Accountable Entity Application for Certification.

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

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

<sup>3</sup> Both the MCO and AE have up to one (1) year to achieve the HSTP project-based metric.

<sup>4</sup> Percentage of incentive funds and weighting for each of these measures are to be determined by MCO and AE and approved by EOHHS.

- 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.<sup>5</sup>
- AE performance metrics in the “Fixed Percentage Allocations Based on Specific Achievements” category is specific to the performance period and must be met by the close of the performance year for an AE to earn the associated incentive payment.
- AE performance metrics in the “ Variable Allocation HSTP Project Based Measures” require a process by which an AE that fails to meet a performance metric in a timely manner can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric.

AEs shall be required to demonstrate that at least 10% of Program Year 4 incentive funds are allocated to partners who provide specialized services to support behavioral health care, substance abuse treatment and/or social determinants. Funds that are not completely exhausted in the program year can be earmarked for other contracts in support of SDOH and BH integration and/or for the following program year. The intent is that these funds be explicitly used to support the CBO for their role, function and infrastructure and capacity building in the effort to further integrate such services. Partnerships with social service organization (SSO), behavioral health and/or opioid health home should be driven based on an AEs analytic profile inclusive of identified community needs and gaps, outcome of SDOH Screenings and a geographic analysis. These funds are to be used to build capacity for such community-based organization to enter into financial arrangements with a health care system. Capacity building efforts may include infrastructure support related to information technology, analytics, systems, care coordination/integration of services, with attention to on non-Medicaid billable services such as housing and food insecurity.

### **Payment and Reconciliation**

In advance of the MCOs payments to AEs, the MCO shall receive payment from EOHHS in the amount and schedule agreed upon with EOHHS. AEIP and MCOIP milestones will be paid on a quarterly basis. MCOs shall make associated payments to AEs within thirty (30) calendar days of approving AE performance metric achievement based on satisfactory evidence. The MCO will maintain a report of funds received and disbursed by transaction in a format and in the level of detail specified by EOHHS. Within thirty (30) calendar days of the end of each calendar quarter, the MCO will provide the report to EOHHS for internal tracking of funds. The MCO will work

---

<sup>5</sup> Reporting templates will be developed in partnership with EOHHS



with EOHHS to resolve any reporting discrepancies within fifteen (15) calendar days of notification of such discrepancy.

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

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

## **VII. ALLOWABLE & DISALLOWABLE USE OF AEIP FUNDS**

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

### **General Disallowable Uses:**

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

- To pay for construction or renovations
- To pay for malpractice insurance

Expenditures cannot include the following:

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

### **Duplication Disallowable Uses**

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

- RI Medicaid Covered Services including, State Plan services and 1115 demonstration services

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

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

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

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

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

In accordance with CMS guidance, EOHHS must ensure that Federally Qualified Health Centers receive and retain 100% of Medicaid Prospective Payment System (PPS) payments and cannot put any FQHC payment for services at 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 will require that FQHC-based AEs remaining in upside-only contracts demonstrate how they are progressing from volume to value.

Starting in PY4, progress from volume to value will be demonstrated by generating a positive return on investment for the AE's Medicaid Line of Business.

FQHC AEs and MCOs must collaborate to identify an investment that is targeted to reduce utilization or otherwise demonstrate a return on investment for the AE's Medicaid Line of Business.

FQHC AEs and MCOs are eligible to earn 5% of their Incentive Fund Pool upon submitting a description of the targeted area of utilization and targeted amount of utilization reduction (or other measure(s) and target(s)); work plan; and budget.

At the end of the Performance Year, FQHCs and MCOs are eligible to receive Incentive Funds in the amount that their intervention saved by reducing the target utilization (or achieving other measure(s)). FQHC AEs and MCOs 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.

### AE responsibilities:

- Work with MCOs to identify a specific type of utilization to target with an investment or another measure that, if achieved, will yield a return on investment for the AE's Medicaid Line of Business.
- Design a work plan and budget for the intervention. The work plan may reflect an intervention that the AE is pursuing through a project under "Variable Allocation HSTP Project Based MCO and AE defined performance measures."
- Implement the intervention. Again, the intervention may be, or be part of, a project the AE is pursuing as part of the AE's "Variable Allocation HSTP Project Based MCO and AE defined performance measures."
- Review MCO reports on progress and adjust the work plan as appropriate to improve performance based on progress and learning.

### MCO responsibilities:

- Prepare data regarding cost drivers specific to each FQHC AE.
- Assist AEs in identifying specific types of utilization (or other measures) that the AE could

target with an investment. For example, an MCO might share data indicating that:

- A high proportion of the AE’s members who need lab work go to a hospital setting for blood draws rather than receiving this service at the FQHC itself;
  - A high proportion of members are referred for low-value care (e.g., MRI for lower-back pain);
  - A high proportion of members are experiencing inpatient admissions for a specific chronic condition; or
  - A high share of members utilizing emergency departments do so during specific hours when the FQHC is closed.
- Identify an appropriate baseline period for comparison. This could be Program Year 2 or 3, depending on data availability. EOHHS encourages MCOs to try to account for unusual utilization patterns driven by COVID-19, whether by taking an average of two or more previous years or other appropriate methodology.
  - Identify the amount of utilization reduction the intervention will seek to achieve and the savings associated with achieving this goal (or the target for another measure and associated savings). For example, if the AE and MCO plan to reduce MRIs for lower-back pain by 50 compared to the baseline period and each MRI for lower-back pain costs \$500, then this intervention is expected to save \$25,000. Note that this process includes measuring the amount of utilization (or performance on another measure) in the baseline period.
  - Provide monthly updates on utilization/performance so that the AE can evaluate whether it is on target to reduce utilization by the targeted amount (or achieve performance on another measure).
  - Provide final results estimating savings achieved from utilization relative to the baseline period (or performance relative to baseline on another measure).

EOHHS Responsibility:

- As part of the initial approval process in July 2021, EOHHS will examine the methodologies by which the MCO set the baseline period for comparison identified the target amount of utilization reduction/ other measure. This includes the steps the MCO took to account for the impact of COVID-19, both in setting the baseline period and in identifying the target amount of utilization reduction/ other measure. EOHHS will evaluate these methodologies to ensure that they are reasonable.
- As part of the process to approve the final report in July and August 2022, EOHHS will examine the process by which the MCO calculated the utilization reduction/ other measure and savings. EOHHS requires that the MCO use the same methodology for both the baseline period and PY4.
- It is EOHHS’s responsibility to release earned Incentive Fund payments.

Timeline:

Activity	Responsible Party	Time
Submit description of targeted utilization and targeted amount of utilization reduction (or other measure), work plan and budget to Medicaid	MCO and AE	July 1, 2021

Approve targeted utilization, targeted utilization reduction (or other measure), work plan, and budget. Approval will permit release of Incentive Funds equal to 5% of the AE's HSTP Incentive Fund Pool	EOHHS	August 1, 2021
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 (or other measure)	MCO and AE	July 1, 2022
Approve final report showing the change in utilization (or other measure) and associated savings. Approval will permit release of earned Incentive Funds up to 5% of the AE's HSTP Incentive Fund Pool.	EOHHS	September 1, 2022

Description of Targeted Utilization and Utilization Reduction Template:

Service Type	E.g., MRI; blood test; emergency department visit; etc.
Specific circumstances of utilization	E.g., Site of service (hospital); time of service (during business hours); Patient condition (e.g., lower-back pain, mental illness)
Other elements to define the targeted utilization	
Amount of utilization targeted to be reduced/changed compared to prior year	E.g., 5% (50 count) fewer MRIs for lower-back pain compared to the number performed for attributed members in the previous year.
Estimated amount of reduced spending from the amount of reduced utilization	E.g., \$25,000 (assuming 50 fewer MRIs for lower-back pain, each of which would have cost \$500)

Description of Work Plan Template:

What is the intervention?	E.g., physicians will refer patients to a non-hospital setting for blood tests.
Why/ how will the intervention reduce the targeted utilization?	
Describe the steps required to implement the intervention and the timeline of implementation	
Which staff will be responsible for implementing the intervention and what will be each person's role?	
How will you monitor progress toward the target utilization reduction and how will you	

adjust the intervention if you are not on track to succeed in reaching the target?	
--	--

Budget Template is attached.

**FQHC AE ROI PROJECT BUDGET  
TEMPLATE**

<b>Personnel</b>	<b>ROI Project Role</b>	<b>Allocation to ROI Project</b>	<b>Total Cost <i>Estimated</i></b>	<b>ROI Project- Allocated Total Cost <i>Estimated</i></b>	<b>Notes</b>
				\$ -	
				\$ -	
				\$ -	
				\$ -	
				\$ -	
				\$ -	
<b>Total - Personnel</b>			\$0	\$0	

<b>IT</b>	<b>Contribution to ROI Project</b>	<b>Allocation to ROI Project</b>			<b>Notes</b>
				\$ -	
				\$ -	
				\$ -	
<b>Total - IT</b>			\$0	\$0	

<b>Vendor Contracts</b>	<b>ROI Project Role</b>	<b>Allocation to ROI Project</b>			<b>Notes</b>
				\$ -	



			\$	
			-	
			\$	
			-	
<b>Total Vendor Contracts</b>		\$0	\$0	
<b>Other</b>	<b>Contribution to ROI Project</b>	<b>Allocation to ROI Project</b>		<b>Notes</b>
			\$	
			-	
			\$	
			-	
			\$	
			-	
<b>Total Other</b>		\$0	\$0	

<b>TOTAL ROI PROJECT-ALLOCATED COSTS</b>	<b>\$0</b>
--	------------

