DOCUMENT HISTORY

STATUS	DOCUMENT REVISION	EFFECTIVE DATE	DESCRIPTION
Baseline	1.0	7/1/2023	Initial version, EOHHS Medicaid Managed Care Manual Chapter 8.1, Accountable Entity Program Requirements
Revision			

Administration of the AE Program

Managed Care Contractors are required to sub-contract with Accountable Entities and carry out the necessary functions to effectively administer the AE Program in partnership with EOHHS. Contractors shall comply with guidance set forth in the AE program requirements documents, including attachments to EOHHS' 1115 waiver special terms and conditions that are updated annually as well as other technical guidance documents that are drafted by EOHHS and published online. Managed Care Contractors shall also comply with the reporting requirements detailed in the Managed Care Reporting calendar, which includes several reports that are meant to support AE program implementation. On a monthly basis, EOHHS will meet with Managed Care Contractors to review progress, identify and mitigate risks or compliance issues, and discuss any other pertinent topics to AE program implementation.

Guidance Document Name	Cadence for Updating
Accountable Entity Attribution Requirements	Annually, due to CMS in December of preceding year
Accountable Entity Total Cost of Care Requirements	Annually, due to CMS in December of preceding year
Accountable Entity Infrastructure Incentive Program: Requirements for Managed Care Organizations and Certified Accountable Entities	Annually, due to CMS in December of preceding year
Accountable Entity Certification Standards – Comprehensive AE	Annually, due to CMS in December of preceding year
Rhode Island Accountable Entity Program Total Cost of Care Technical Guidance	Ad hoc
Rhode Island Accountable Entity Program Total Cost of Care Quality and Outcome Measures and Associated Incentive Methodologies for Comprehensive Accountable Entities: Implementation Manual	Ad hoc

1. Contracting with Certified AEs

In order to attain the AE APM Target, Managed Care Contractors must execute contracts with certified AEs. EOHHS plans to continue to invest in AEs' capacity development under the Health System Transformation Project through state fiscal year 2024, and throughout this period, EOHHS will retain the function of certifying new AEs and annually re-certifying incumbent AEs who meet the Accountable Entity Certification Standards. Per the Accountable Entity Total Cost of Care Requirements, MCOs may contract with certified AEs that have at least 5,000 attributed Medicaid members across AE contracts and at least 2,000 attributed Medicaid members per MCO-AE contract.

Contracts with certified AEs must comply with the Accountable Entity Total Cost of Care Requirements and all other contract standards established by EOHHS. EOHHS generates an AE Contract Checklist

annually, which lists the operative components that must be included in the contract in compliance with all guidance documents. On the last business day of March each year, Managed Care Contractors shall submit a base contract and copy of the AE Contract Checklist indicating the location in the contract of each required component. The base contract must receive EOHHS approval before the Managed Care Contractor executes contracts with certified Accountable Entities. Only expenditures made pursuant to compliant, approved contracts will be counted toward the AE APM target.

2. Attribution

Managed Care Contractors shall implement AE attribution and quarterly reconciliation in compliance with the Accountable Entity Attribution Requirements. This includes producing attribution reports for AE and EOHHS use, as described in the Accountable Entity Attribution Requirements.

EOHHS will generate a report on a monthly basis to monitor attribution and reconciliation for accuracy.

3. Total Cost of Care

Managed Care Contractors shall execute and implement AE total cost of care contracts in compliance with the Accountable Entity Total Cost of Care Requirements, Rhode Island Accountable Entity Program Total Cost of Care Technical Guidance, and Accountable Entity Attribution Requirements**.**

Managed Care Contractors are responsible for providing cost and member attribution data to EOHHS to support a) setting total cost of care targets and b) calculating quarterly and final total cost care performance. The cost and attribution data must comply with instructions in the requirements documents noted above as well as with instructions in any reporting templates provided by EOHHS. Reporting requirements for this data are reflected in the Rhode Island Accountable Entity Program Total Cost of Care Technical Guidance as well as the Managed Care Reporting Calendar. EOHHS, through its contracted actuarial vendor, is responsible for implementing the TCOC methodology to set TCOC targets and calculate quarterly and final TCOC performance. As described in detail in the Rhode Island Accountable Entity Program Total Cost of Care Technical Guidance, this methodology includes adjustments for risk, trend, and each AE's efficiency relative to the market average, as well as PBM spread (where applicable) and steps to accurately attribute costs incurred through visits to federally-qualified health centers.

Note that the Accountable Entity Total Cost of Care Requirements also describes the process by which AEs must be qualified to enter into contracts with downside risk.

4. Incentive Program

Through the duration of the Accountable Entity Incentive Program, Managed Care Contractor shall administer the incentive program in accordance with Accountable Entity Infrastructure Incentive Program: Requirements for Managed Care Organizations and Certified Accountable Entities.

The Managed Care Contractor shall partner with certified AEs to provide support and guidance in the development and approval of AEs' HSTP Project Plans, to ensure that HSTP funds are tied to ambitious project targets prior to the Contractor's submission to EOHHS for final approval. The Managed Care Contractor shall continue to support AEs as they implement the interventions described in the HSTP Project Plans, to set AEs up for successful achievement of targets. Support and guidance may include sharing of relevant data or reports, provision of technical assistance, and/or sharing of evidence based best practices.

Similarly, the Managed Care Contractor shall also provide support and guidance to AEs in the development and implementation of ROI Projects, or other activities as prescribed in Accountable Entity Infrastructure Incentive Program: Requirements for Managed Care Organizations and Certified Accountable Entities.

The Managed Care Contractor shall complete and submit the MCO-AE Milestone Performance Report according to the schedule defined in the Managed Care Reporting Calendar to enable timely payment for AE achievement of milestones.

5. Quality Improvement

The AE total cost of care methodology includes an important role for quality measurement, as the amount of shared savings an AE is eligible to receive depends on the AE's quality performance. The Managed Care Contractor shall implement quality measurement in accordance with the Accountable Entity Total Cost of Care Requirements and the Rhode Island Accountable Entity Program Total Cost of Care Quality and Outcome Measures and Associated Incentive Methodologies for Comprehensive Accountable Entities: Implementation Manual. These requirements identify the quality measures that are included in the total cost of care methodology; the way quality performance affects shared savings/losses; quality measure specifications; and performance targets. The Managed Care Reporting Calendar describes the annual reporting requirement for quality measures and includes the reporting template. Note that the quality measures, targets, and certain measure specifications are determined annually by EOHHS through a collaborative process involving an MCO-AE working group. The selected quality measures are closely tied to the measures in the OHIC Aligned Measure Set.

Managed Care Contractors shall provide support and guidance for AEs in achieving high performance on quality measures, including through technical assistance, sharing best practices, and facilitating shared learning among AEs.

6. Joint Operating Committee, Care Continuum, and Delegation

Managed Care Contractors shall establish a Joint Operating Committee (JOC) with each contracted AE. This JOC shall serve as a shared management structure through which the Managed Care Contractor and AE will promote communication, support collaborative activities, engage in problem-solving, and review ongoing progress toward performance goals.

Managed Care Contractors shall develop and submit to EOHHS a Care Program Strategy that includes the following elements:

1. A comprehensive assessment of each AE's capacity to perform care management and complex case management functions as identified in Accountable Entity Certification Standards – Comprehensive AE section 6.
2. A list of the care management and complex case management functions that will be delegated to each AE. This should include distinct, delineated roles for the AE and the Managed Care Contractor for sub-populations and programs as appropriate. Note that the Managed Care Contractor shall delegate those functions that the AE has capacity to perform.
3. An actuarially validated framework for financing delegated care management and complex case management functions. This framework must begin the financing mechanism the first year of delegation and increase funding commensurate with increased AE capacity. Increased financing may be tied to AE attainment of NCQA accreditation or bearing increased downside risk.

Managed Care Contractors shall also serve as vital partners to advance health equity across several different axes of current inequity.

1. Health disparities across race, ethnicity, language, and disability status must be addressed to achieve EOHHS' vision for an equitable healthcare system. Managed Care Contractors and AEs shall take coordinated actions to address these disparities. Managed Care Contractors may support AE-led equity efforts by supporting data collection and identification of disparities, member engagement strategies, technical assistance, etc.
2. EOHHS is aware that Medicaid members living with serious mental illness, serious and persistent mental illness, and/or substance use disorder are likely to also struggle to manage medical co-morbidities and experience substantially worse health outcomes as a result. This inequity calls for coordinated efforts by behavioral and medical providers, which Managed Care Contractors shall facilitate for Network Providers through, e.g., enhanced data sharing, collaborative learning opportunities, technical assistance, etc.
3. A high share of Medicaid members can benefit from community resources to address unmet health-related social needs, and Managed Care Contractors shall facilitate coordination among Network Providers and community-based organizations to help address these needs.

7. Data Sharing

Managed Care Contractors shall share data with AEs to facilitate AE efforts to manage population health and succeed under total cost of care contracts. On a monthly basis, the Managed Care contractor must provide timely, member specific utilization and cost data to AEs, as described in the minimum data sets below. Managed Care contractors shall also provide AEs with reports to identify high risk, high utilizer members, provider outlier analysis of high/low performing providers within an AE panel, person-level lists generated by EOHHS for specific quality or outcome measures, any additional reports as prescribed in the AE Quality and Outcome Implementation Manual, and any other data reports that are mutually agreed upon to be useful in managing population health and costs.

The Managed Care contractor is required to share a minimum data set (or sets) of claims and attribution information with the contracted AE for its attributed members at a beneficiary-identifiable level. Managed Care contractors must use the monthly AE attribution roster to determine the population eligible for the claims extract. Claims for a given performance year should be provided to the AE for attributed members until the contractual paid lag is complete. A full refresh of data going back to the beginning of the performance year, including any retroactive adjustment shall be provided at the beginning and/or end of each Program Year. To enable AEs to validate that their systems are integrating data accurately, control totals should be supplied to the AE with each monthly data set indicating: number of records, total allowed amount for medical and pharmacy claims data set, and number of records and total member months for the eligibility data set. Claim paid amount should be provided on all claims in the data set. Such minimum data set is as applicable to Claims and Non-Claims Based data files as set forth in the tables below.

The Managed Care contractor is required to develop a methodology for mitigating duplicative claims and coordinate with contracted AEs to ensure duplicative claims are removed from data. The Managed Care contractor must work with their contracted AEs to determine the most effective methodology for their unique data systems and interoperability needs for program efficiency.

Prior to transmitting data to AEs, the Managed Care contractor must complete the necessary quality checks and review data privacy of members to ensure integrity of data transmitted to the AE for a member's attributed months, including checks for completeness.

Claims-Based Data Elements

Field Name/Description		Source/Field Number	
MEMBER FIELDS	**DESCRIPTION**	**1500****	**UB-04/CMS 1450**
Member ID ()	Payer-defined, internal member ID for subscriber ID and insurance product changes	Box 1a	Box 60
Insurance Product		Box 9d	Box 50
Subscriber ID		Box 4	Box 8a
Last Name		Box 2	Box 8b, 58, 60
First Name		Box 2	Box 8b, 58, 60
Middle Name		Box 2	Box 8b
DOB		Box 3	Box 10
Gender		Box 3	Box 11
SDOH	Any documented social determinants of health, for example, documented as Z-codes		
CLAIMS FIELDS		1500	UB-04
Claim Line ID	Unique claim identifier		

Field Name/Description		Source/Field Number	
Claim Line Payment Status	Most up to date status of claim (as available)		
Claim Type	Code - usually a letter - that identifies the "general" type of claim (e.g., Outpatient, Inpatient, Dental, Professional)		
Paid Amount	Final amount that was paid by the plans for the services provided on the claim		
Payer Authorization ID		Box 23	
Date of Service		Box 24A	Box 45
Admission Date	Date of admission to a facility	Box 18	Box 12
Discharge Date	Date of physical discharge to community or other facility (e.g., rehab, nursing home)	Box 18	Box 6
From Date	Date of which the services were provided	Box 24A	Box 6
Thru Date		Box 24A	Box 6
Days	Represents Length of Stay for applicable claims		
Effective Date		Box 24A	
Line Number/ Line ID (including unique claim ID and data definition)	Claim detail number	Box 24A	
Line From Date	First date of which the services were provided	Box 24A	
Line Thru Date	Last date of which the services were provided		
Facility Type			Box 4
Place of Service Code	Code that describes the type of place or facility for which the service occurred (e.g., Federally Qualified Health Center, Urgent Care Facility)		
Outpatient Type			Box 4
Admission Flag			Box 66A
Readmission Flag			
Admission Type	Urgent, elective, etc.		Box 14
Revenue Code	4-digit numbers that are used on bills/claims to tell the insurance		Box 42

Field Name/Description		Source/Field Number	
	companies either where the patient was when they received treatment, or what type of item a patient might have received as a patient		
Discharge Status Code	Status code describing where the patient was discharged to		
Discharge Status Description	Description of the discharge status code		
Type of Bill Code	identifies the type of bill being submitted to a payer		Box 4
Paid Date	Date of which the services on the claim were paid by the plans		
Facility Name	The name of the facility where services were rendered	Box 32	Box 1
Rendering Provider NPI	Also referred to as "Attending Provider"; the National Provider Identifier who administers the service on the claim	Box 32 A	Box 56
Rendering Provider Name	Also referred to as "Attending Provider"; the name of the provider who administers the service on the claim		Box 01
Billing Provider NPI	The National Provider Identifier of the provider who bills for the service on the claim		
Billing Provider Name	The name of the provider or practice who bills for the service on the claim		
Billing Provider TIN	Employer Identification Number (EIN) /Taxpayer Identification Number (TIN) that identifies the physician/practice/supplier to whom payment is made for the line-item service		
Attributed PCP NPI	NPI of the member's attributed PCP, as part of the AE program		
Attributed PCP Name (Last)	Last name of the member's attributed PCP, as part of the AE program		
Attributed PCP Name (First)	First name of the member's attributed PCP, as part of the AE program		

Field Name/Description		Source/Field Number	
IHH Name (if applicable)	Integrated Health Home that the member belongs to		
ICD Diagnosis Code(s)	International Classification of Diseases (ICD); provides a method of classifying diseases, injuries, and causes of death	Box 21A-L	Box 67
ICD Diagnosis Version	Identifies whether the type of ICD code is version 9 or 10	Box 21 ICD INC	
CPT Code(s)	Current Procedural Terminology (CPT)/Procedure Codes; describes what kind of procedure a patient has received	Box 24D	Box 74a-e
Modifier Code(s)	Indicate that a service or procedure performed has been altered by some specific circumstance, but not changed in its definition or code	Box 24D	
HCPCS Codes		Box 24D	
HCPCS Modifiers		Box 24D	
DRG Code	Diagnosis-related group (DRG); classifies cases according to certain groups, also referred to as DRGs, which are expected to have similar hospital resource use (cost)		Box 71
DRG Description	Describes the type of DRG (e.g., heart failure, pneumonia, and hip/knee replacement)	Other	other
DRG Code Type {MS|AP|APR}	A more detailed breakdown of DRG classifications	Other	other

Non-Claims Based Data Elements

ELIGIBILITY FIELDS	Description
Subscriber ID	Payer defined, internal member ID for subscriber ID and insurance product changes
Last Name	
First Name	
Middle Name	
DOB	
Gender	
Race	

ELIGIBILITY FIELDS	Description
Ethnicity	
Language	
Member Risk Score	Rolling 12-month score or PY score at the time of eligibility month
Member Year	Year of eligibility
Member Month {1..12}	Month of eligibility
Member ID	Payer defined, internal member ID
Insurance Product	Name of insurance product (Medicaid, Medicare)
Subscriber ID	The National Provider Identifier of the provider who is the attending PCP on the claim
PCP last name	
PCP first name	
PCP NPI	
IHH Name (if applicable)	
Member Risk Score	
RX FIELDS	**Description**
Prescriber NPI	The National Provider Identifier of the provider who prescribed the medication
Drug Class	Describes medications that are grouped together because of their similarity
Drug Name	Referring to the chemical makeup of a drug rather than to the advertised brand name under which the drug is sold
NDC Code	National Drug Code (NDC); a unique 10-digit or 11-digit, 3-segment number, and a universal product identifier for human drugs
Drug Type	{Generic|Brand|Specialty|Other}
Dispense as Written Code	A code indicating whether or not the prescription was dispensed as written by the prescribing provider
Days' Supply	Number of days which the drug was prescribed to the patient
Quantity Dispensed	Amount of prescription dispensed to patient
Therapeutic Class	This type of categorization of drugs is from a medical perspective and categorizes them by the pathology they are used to treat
Filled Date	Date which the prescription was filled by patient
Pharmacy Service Provider Name	Member's preferred pharmacy

Individual Level Data Files for AE Outcome Measures (to be generated by EOHHS)

File 1: Members Experiencing Mental Illness [MCO] [Time period].csv		
Field Description	**Field Name**	**Source**
Medicaid ID	MEDICAID_ID	AE population extract file
Member Name	MEMBER_NAME	AE population extract file
Member Date of Birth	MEMBER_DOB	AE population extract file
Attributed AE	MEMBER_AE	AE population extract file
Attributed PCP	MEMBER_PCP	AE population extract file

File 2: Preventable ED Visits [MCO] [Time period].csv		
Field Description	**Field Name**	**Source**
Medicaid ID	MEDICAID_ID	AE population extract file
Member Name	MEMBER_NAME	AE population extract file
Member Date of Birth	MEMBER_DOB	AE population extract file
Attributed AE	MEMBER_AE	AE population extract file
Attributed PCP	MEMBER_PCP	AE population extract file
Primary Diagnosis Code	DIAG_CDE_1	MMIS
Probability Visit was Avoidable	PREVENT_PROB	MMIS + NYU algorithm
Date of Service	FROM_SVC_DTE	MMIS
Billing Provider NPI	BLNG_PR_NPI	MMIS
Claim ICN	CL_ICN	MMIS