Solicitation Information
August 13, 2015

RFI# 7549802

TITLE: EOHHS –Certified Medicaid Accountable Entities

Submission Deadline: September 10, 2015 at 10:00 AM (ET)

Questions concerning this solicitation must be received by the Division of Purchases at david.francis@purchasing.ri.gov no later than **Monday, August 24th at 10:00 AM (ET).** Questions should be submitted in a *Microsoft Word attachment.* Please reference the RFP# on all correspondence. Questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

SURETY REQUIRED: No

BOND REQUIRED: No

David J. Francis
Interdepartmental Project Manager

Applicants must register on-line at the State Purchasing Website at www.purchasing.ri.gov

Note to Applicants:

Offers received without the entire completed three-page RIVIP Generated Bidder Certification Form attached may result in disqualification.

THIS PAGE IS NOT A BIDDER CERTIFICATION FORM

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1.0 Introduction

The Rhode Island Department of Administration/Division of Purchases, on behalf of the Rhode Island's Executive Office of Health and Human Services (EOHHS), is soliciting responses from the provider community, insurers and interested stakeholders to explore the implementation of new accountable provider organizations as part of the Reinventing Medicaid initiative.

This is a Request for Information (RFI). No award will be made as a result of this solicitation

INSTRUCTIONS AND NOTIFICATIONS TO OFFERORS:

1.1 INSTRUCTIONS AND NOTIFICATIONS TO OFFERORS:

1. Potential vendors are advised to review all sections of this RFI carefully and to follow instructions completely, as failure to make a complete submission as described elsewhere herein may result in rejection of the proposal.
2. The State invites feedback from the community on any questions posed in this RFI. Please note it is not a requirement to answer all questions.
3. Alternative approaches and/or methodologies to accomplish the desired or intended results of this RFI are solicited.
4. This is a Request for Information (RFI), and as such no award will be made as a result of this solicitation.
5. All costs associated with developing or submitting responses to this RFI or to provide oral or written clarification of its content shall be borne by the vendor. The State assumes no responsibility for any costs.
6. Responses misdirected to other state locations, or which are otherwise not present in the Division at the time of opening for any cause will be determined to be late and will not be considered. For the purposes of this requirement, the official time and date shall be that of the time clock in the reception area of the Division.
7. Respondents are advised that all materials submitted to the State for consideration in response to this RFI will not be considered to be Public Records as defined in Title 38, Chapter 2 of the General Laws of Rhode Island. The responses may only be released for inspection upon RFI once an award of a subsequent procurement has been made, as long as the release will not place the State at a competitive disadvantage in its sole discretion.
8. Interested parties are instructed to peruse the Division of Purchases website on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this RFI.

9. Equal Employment Opportunity (G.L. 1956 § 28-5.1-1, et seq.) – § 28-5.1-1 Declaration of policy – (a) Equal opportunity and affirmative action toward its achievement is the policy of all units of Rhode Island state government, including all public and quasi-public agencies, commissions, boards and authorities, and in the classified, unclassified, and non-classified services of state employment. This policy applies to all areas where State dollars are spent, in employment, public services, grants and financial assistance, and in state licensing and regulation. For further information, contact the Rhode Island Equal Opportunity Office at (401) 222-3090.

10. In accordance with Title 7, Chapter 1.2 of the General Laws of Rhode Island, no foreign corporation, a corporation without a Rhode Island business address, shall have the right to transact business in the State until it shall have procured a Certificate of Authority to do so from the Rhode Island Secretary of State (401-222-3040). This is a requirement only of the successful vendor(s).

11. The vendor should be aware of the State's Minority Business Enterprise (MBE) requirements, which address the State's goal of ten percent (10%) participation by MBE's in all State procurements. For further information, visit the website www.mbe.ri.gov or contact charles.newton@doa.ri.gov.

2.0 RFI for Information

This RFI outlines the type of information being solicited from potential respondents and includes guidelines for content and format of responses.

2.1 Requirements and Deadlines for Questions and Responses

Questions concerning this RFI may be e-mailed to the Division of Purchases at david.francis@purchasing.ri.gov no later than the date and time indicated on page one of this RFI. Please reference RFI # 7549802 on all correspondence. Questions should be submitted in a Microsoft Word attachment. Answers to questions received, if any, will be posted on the Internet as an addendum to this RFI. It is the responsibility of all interested parties to download this information. If technical assistance is required to download, call the Help Desk at (401) 574-9709.

Offerors are encouraged to submit written questions to the Division of Purchases. **No other contact with State parties regarding this RFI should be attempted**. Responses to this RFI should be submitted on or before the date listed on the cover page. Responses received after this date and time as registered by the official time clock in the reception area of the Division of Purchases may not be considered.

Note: Responses received after the above-referenced due date and time may not be considered. Responses misdirected to other State locations or which otherwise not presented in the Division of Purchases by the scheduled due date and time will be determined to be late and may not be considered. Responses faxed or emailed, to the Division of Purchases will not be considered. The official time clock is in the reception area of the Division of Purchases.

2.1.2 RESPONSES

The "official" time clock for this solicitation is located in the Reception Area of the Department of Administration/Division of Purchases, One Capitol Hill, Providence, RI.

Submit one (1) original and two (2) copies, and one electronic copy of responses by the date and time stated on page one of this RFI. Submissions should be single spaced on 8 ½" by 11" pages with 1" margins using Times Roman 12 font.

Responses (an original plus two (2) copies/one electronic copy) must be mailed or hand-delivered in a sealed envelope marked "**RFI# 7549802 EOHHS –Certified Medicaid Accountable Entities**" to:

RI Department of Administration
Division of Purchases, 2nd floor
One Capitol Hill
Providence, RI 02908-5855

Based on the responses, Rhode Island may invite a vendor to present their feedback and recommendations to key state officials.

2.2 Introduction

The Rhode Island Division of Purchases ("Division"), on behalf of the State of Rhode Island ("State", "Rhode Island", or "RI"), is issuing this Request for Information ("RFI") to solicit specific information about Certified Accountable Entities.

2.3 Purpose of the Request for Information

This Request for Information (RFI) is being issued to solicit specific information from health plans, provider networks, hospital organizations, consumers, patient advocates and other provider entities with respect to the establishment of accountable entities (AEs) that will be able to contract with Medicaid Managed Care Organizations (MMCOs) to provide care to Medicaid managed care enrollees.

The Executive Office of Health and Human Services (EOHHS) intends to establish a process by which these organizations will be certified by the state as eligible for participation in Medicaid. EOHHS will use findings generated by this RFI in conjunction with other available information to define the certification standards and contractual requirements for these accountable entities.

This RFI is specifically seeking input for setting AE certification standards, including issues such as

required provider representation, governance requirements, required scope of services and capacity. Additionally, contractual parameters such as payment models, attribution methods, and measurements standards will be explored. In order to facilitate meaningful feedback, a proposed set of potential certification standards and contractual parameters are provided in this RFI. Please note that these proposed standards are intended as a starting point only, for purposes of encouraging meaningful and specific input. These standards are intended to be substantially amended as a result of the learnings from this Request for Information and other ongoing processes.

The intended audience for this RFI is the Rhode Island insurer and provider community, as well as other interested parties, especially those currently providing care to Medicaid enrollees, those interested in or actively engaged in accountable care models of payment and service, and those who might consider becoming or participating in certified accountable entities serving RI Medicaid members.

2.4 Background

Premise for Reform

Rhode Island has a strong history of successful Medicaid managed care implementation with an established MCO infrastructure and a strong multi-payer medical home infrastructure (CSI). Medicaid managed care members have access to broad networks of care, robust member services and supports and high levels of beneficiary responsiveness/coordination. RI MCOs are nationally recognized as among the highest quality MCOs in the United States.

Given this important starting point, a key premise for Medicaid MCO reform in Rhode Island is that the existing MCO contract structure is "necessary but not sufficient". That is, the current model has some critically important strengths, but may not be structured to adequately address the next generation of managed care. A second key premise guiding this reform is that the program can better meet the triple aim -- enhanced care experience, improved health, and reduced cost of care -- <u>if</u> we establish and support an intermediate structure for financial alignment of incentives across providers. The proposed certification standards and contracting requirements described below are therefore intended to define and guide the development and implementation of such intermediate structures.

Current Program Characteristics

Effective certification standards and contracting requirements must also consider the following characteristics of the current Rhode Island Medicaid program, as described in the Rhode Island Annual Medicaid expenditure report for SFY 2014. Specifically:

- *Populations Served*
  The Rhode Island Medicaid program served 221,000 average eligibles in SFY 2014. Including the Medicaid expansion population more than one-quarter of Rhode Islanders were enrolled in Medicaid for some part of SFY 2014. Over half of Medicaid SFY 2014 expenditures (59.7%) were for Elders and Adults with Disabilities. Children & families, children with special health care needs and Medicaid Expansion Populations accounted for 24.8%, 8.7% and 6.8% of Medicaid

expenditures respectively.

- *Medicaid Program Expenditures*
  The Rhode Island Medicaid program is a $2,005 million program. Over the past five years, RI Medicaid expenditures have increased by 1.1% per year on average, which is notably low as compared to national Medicaid and regional commercial experience.
- *Participating Providers*
  Medicaid program funds are used to reimburse a variety of providers. Together, hospitals and nursing facilities account for nearly half of program expenditure.
- *Long-term Services and Supports*
  Long-term services and supports, including both institutional care and home and community based services, accounted for about 40% of Medicaid expenditures.
- *Managed Care*
  Eighty percent of Medicaid average eligibles are enrolled in managed care programs, and these managed care enrollees account for 58% of Medicaid expenditures. Both of Rhode Island's participating Medicaid Managed Care Organizations (MMCOs) ranked in the top 10 Medicaid plans in the nation in CY 2014.
- *High Utilizers*
  The 6% of Medicaid users with the highest costs account for almost two thirds (65%) of Medicaid claims expenditure. Nearly half (45%) of claims expenditure on high cost users is on nursing facilities and residential and rehabilitation services for persons with developmental disabilities.

Authority and Governance

The effort to establish and certify accountable entities is grounded in the broader reform health care reform efforts of the state. In March of 2015, Governor Gina Raimondo issued Executive Order 15-08, establishing the "Working Group to Reinvent Medicaid." The working group delivered an initial report to the Governor in April, outlining a series of short-term payment and delivery system steps for fiscal year 2015 designed to lay the groundwork for longer-term reform. In June, the RI General Assembly passed the Reinventing Medicaid Act of 2015, placing in law the Working Group's initial recommendations. In July, the Working Group delivered their final report, articulating a multi-year plan for transformation of the Medicaid program.

The final Reinventing Medicaid report articulates the following principles:

1. Pay for value, not for volume
2. Coordinate physical, behavioral, and long-term health care
3. Rebalance the delivery system away from high-cost settings
4. Promote efficiency, transparency, and flexibility

From these principles, the Working Group derived ten goals:

- **Goal 1:** Substantially transition away from fee-for-service models to a system where members get their care through provider organizations that are accountable for the quality, health outcomes and total cost of care for their members.
- **Goal 2:** Define Medicaid-wide population health targets, and, where possible, tie them to payments.
- **Goal 3:** Maintain and expand on our record of excellence on delivering care to children.
- **Goal 4:** Maximize enrollment in integrated care delivery systems
- **Goal 5:** Coordinated, accountable care for high-cost/high-need populations
- **Goal 6:** Ensure access to high-quality primary care
- **Goal 7:** Leverage health information systems to ensure quality, coordinated care
- **Goal 8:** Shift Medicaid expenditures from high-cost institutional settings to community-based settings
- **Goal 9:** Encourage the development of accountable entities for integrated long-term care
- **Goal 10:** Improve operational efficiency

Based on these principles and goals, the Working Group recommended several initiatives grouped into three overarching themes:

- **Payment and Delivery System Reforms**: initiatives that transform Rhode Island's Medicaid system into one that pays for quality and value, rather than volume, and promotes better quality of care and patient experience.
- **Targeting Fraud, Waste, and Abuse**: initiatives that ensure Medicaid programs operate in compliance with state and federal law and regulation, and root out wasteful, unnecessary, or fraudulent spending and utilization.
- **Administrative and Operational Efficiencies**: initiatives that streamline and improve state oversight of the Medicaid program.

The Reinventing Medicaid Amendment passed by the legislature included the following provisions for implementation of this initiative:

SECTION 19. Rhode Island Medicaid Reform Act of 2008
(c) Pilot Coordinated Care Program. The executive office of health and human services proposes to establish a coordinated care program with a community provider that uses a shared savings model. Creating a new service delivery option may require authority under the Medicaid waiver demonstration and may necessitate amendments to the state plan. The adoption of new or amended rules may also be required.

(o) *Alternative Payment Arrangements* – The EOHHS proposes to develop and implement alternative payment arrangements that maximize value and cost-effectiveness, and tie payments to improvements in service quality and health outcomes. Amendments to the section 1115 waiver and/or the Medicaid state plan may be required to implement any alternative payment arrangements the EOHHS is authorized to pursue.

2.5 Project Overview

Using the specifications of the initiative above as a starting point, the state is pursuing a model of setting certification standards for ACOs and then requiring Medicaid managed care organizations to contract with these certified ACOs in accordance with state specified contracting terms.

More immediately, in SFY 2016, the state will seek to certify a pilot Accountable Entity, capable of managing a fully delegated global capitation contract no later than January 1, 2016. As such, the state is seeking feedback on the immediate certification standards and contractual requirements associated with this pilot.

Additional documents for review with background information and context include:

1. Publications and reports from the Reinventing Medicaid Task Force and full text of the Reinventing Medicaid Act of 2015. http://reinventingmedicaid.ri.gov

2. EOHHS Medicaid Expenditure Report – SFY 2014
http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/RI_Medicaid_Expend_SFY2014_FINAL_2.pdf

3. Code of Federal Regulations, Part 425 – Medicare Shared Savings Program
http://www.gpo.gov/fdsys/pkg/CFR-2013-title42-vol3/xml/CFR-2013-title42-vol3-part425.xml#seqnum425.108

4. Vermont Medicaid ACO Shared Savings Program (SSP) Pilot Compilation of Pilot Standards
http://gmcboard.vermont.gov/sites/gmcboard/files/Medicaid_ACO_Standards_Draft.pdf

3.0 Content of Response

The following outline (and suggested page counts) is intended to minimize the effort of the respondent and structure the response for ease of analysis. The listed questions can be used to guide responses, but it is not required that each be answered. All responses will be equally valued, regardless of page length. **Concise responses** are appreciated. All responses must be limited to a maximum of 18 pages in total, excluding appendices.

Part A Organization Profile (3 pages)

In order to establish certification standards, it is helpful to understand the existing organizational structures and affiliations in our community that would likely form the basis for future certified accountable entities.

Please provide a brief description of your organization, including listing other organizations that you have formal or informal relationships with, whether you currently serve Medicaid recipients, and

what types of services you provide. Please emphasize specific organizational affiliations (current and planned) that would support a fully integrated, coordinated care model serving the population of Medicaid eligibles.

Part B Accountable Entity Objectives and Critical Success Factors (3 pages)

A key premise for Medicaid MCO reform in Rhode Island is that the program can better meet the triple aim -- enhanced care experience, improved health, and reduced cost of care -- if we can accomplish the following four principles, as articulated in the final Reinventing Medicaid report and described above:

- Pay for value, not for volume
- Coordinate physical, behavioral, and long-term health care
- Rebalance the delivery system away from high-cost settings
- Promote efficiency, transparency, and flexibility

This proposed accountable entity structure is therefore intended to establish an intermediate structure for financial alignment of incentives across providers that could better accomplish these four principles, and therefore better meet the triple aim.

EOHHS seeks comments on this objective; specifically:

- What is the opportunity here in Rhode Island for accountable entities to enhance the care experience, improve health and reduce the cost of care for Medicaid eligible populations.
- What are the most critical delivery system features of an effective AE model – that is likely to accomplish the principles above and therefore better meet the triple aim?
- How can/should EOHHS hold these new entities accountable so as to ensure that our goals are achieved. What specific measures/metrics do you recommend?
- Should EOHHS consider/allow specialized, population specific accountable entities? If so, should all accountable entities be held to the the same certification standards? Or should standards and contracting requirements be different for different populations?

Note that EOHHS is also in the process of developing a new model for integrated health homes for the SPMI population. As such, the state seeks comments on how best to coordinate and/or integrate these two important initiatives.

Part C Feedback on Draft Accountable Entity Certification Standards (3 pages)

In this section, the state has included draft certification standards for accountable entities. Please note that these proposed standards are intended as a starting point, for purposes of encouraging meaningful and specific input. These standards are intended to be substantially amended as a result of the learnings from this Request for Information and other ongoing processes.

For Sections 1 through 5 below, please provide feedback on the proposed certification standards. Specifically, consider the following three questions and the above described premise for reform:

1. Which criteria are most critical to achieving an accountable care model that is prepared to meet the challenges of the next generation of managed care and the triple aim? Which are less critical, and might be excluded? What is missing?
2. Are these criteria currently drafted in sufficient detail to achieve the desired outcome? Can/should EOHHS consider more detailed or specific criteria? Less detailed/specific?
3. Are any of these criteria likely to act as barriers to local providers considering becoming Certified Accountable Entities and how might we refine these criteria to reduce such barriers?

Note that these draft certification standards for Level 1, 2 and 3 Certified Entities are also summarized in table form in Appendix A.

Part C Section 1 Definition of an Accountable Entity

The preliminary working definition of Certified Accountable Entities borrows from the Dartmouth Institute as follows:

> *A Group of primary care providers, specialists and/or hospital and other health professionals who manage the full continuum of care and are accountable for the total costs and quality of care for a defined population.*[1]

More specifically, EOHHS is considering the following definitional requirements for Certified Accountable Entities:

- **Price and utilization sensitive**
  All participating parties would need to benefit when total cost of care is reduced, and provider payments must incentivize coordination of total cost of care of a member.
- **Ability to manage the full continuum of care, including "social determinants"**
  Accountable entity should have the capacity, tools, authority to integrate and manage the full continuum of physical and behavioral health care, from preventive services to hospital based and long term/nursing home care. Such entities should incorporate "social determinants"; that is, non-medical services that impact a member's health and ability to access care (e.g., housing, food), in a way that is acceptable to CMS.
- **Capacity for data driven decision-making**
  Accountable entity could be required to demonstrate the ability to measure, collect and be held to specific and detailed performance metrics to include clinical process measures, member experience and cost of care measures, and ultimately population health outcomes measures – and have the necessary data and analytic capacity to impact these outcomes.

EOHHS seeks comments on the appropriate glidepath toward a fully accountable entity. Draft certification standards suggest that Accountable Entities could be certified as Level 1, Level 2, and Level 3 depending on the readiness of the participating entities. The state intends that all Accountable Entities will make substantial progress toward becoming Level 3 certified within 3

[1] The Dartmouth Institute for Health Policy and Clinical Practice
http://tdi.dartmouth.edu/research/evaluating/health-system-focus/accountable-care-organizations/about-us

years, and may reserve the right to reconsider certification decisions absent such progress, as experience in other states and Medicare would suggest that such a commitment to substantial progress is critical to ongoing program development and success. The state will consider setting specific milestones along this path of development, and would appreciate comments as to the nature and timing of such milestones.

Part C Section 2 Required scope of services

A key premise of this reform is that all parties must benefit when **total cost of care is reduced**. EOHHS therefore intends that the entities be held accountable to total cost of care including a full spectrum of services, including primary, specialty, behavioral health, dental, and long term care services as appropriate to serve the specified population. Under such a model, carve outs would be limited.

Based on this objective, EOHHS is considering a requirement that certified accountable entities should capture at least 60 percent of Medicaid costs for attributed members at Level 1, increasing to 75% at Level 2 and 90 percent of cost at Level 3. Additionally these Certified Accountable Entities might be required to:

- Include primary, specialty, behavioral health, dental, and long term care services and support/coordinate the full integration of primary and behavioral healthcare and care management services. Long term care services could be required to include developmentally disabled services, group homes, home and community based services and nursing home care as appropriate.
- Be patient centered medical home based: all participating primary care providers might be required to be qualified patient centered medical homes, and at least 75% of an Accountable Entity's attributed members might be required to be enrolled in a qualified PCMH.
- Integrate with community organizations that can address social determinants of health: housing, employment, food security, transportation and substance use disorder recovery.

The state would specifically appreciate comments as to the benefits and challenges of including developmentally disabled services, group homes, home and community based services and nursing home care in the required scope of services for the accountable entity. Comments on the inclusion of social determinants are also of specific interest.

Part C Section 3 Governance

The state acknowledges the importance of an effective governance model. Experience in other states suggest that absent specific and detailed governance requirements, the participants with the most significant investments may be anticipated to end up with the most significant financial incentives, and critical community participants (primary care providers, home care providers, community health workers) may be unable to make the necessary investments to earn the desired rewards.

As such, the objective of these draft governance rules is to ensure that critical community participants are included in the leadership team of the accountable entity and that such participants have the ability to influence or direct clinical practice to improve outcomes. The state would appreciate comments as to the importance of such governance standards, the specific nature of the draft standards proposed below, and the impact such requirements might have on the existing structures already in place or under development in Rhode Island.

Draft Governance standards for certified accountable entities are as follows:

- **Corporate Structure**
  An Accountable Entity may be a single corporate structure or a network of providers organized through contractual relationships. Each Accountable Entity may be required to convene a Community Advisory Council.
- **Governing Board**
  An Accountable Entity may be required to establish and maintain a governing board with adequate authority to execute the required services and functions of a certified accountable entity.
  - The governing board may be required to be separate and unique to the accountable entity and not the same as a governing board of any specific accountable entity participant. However, individuals may be allowed to serve on the governing board of both the accountable entity and an AE participant.
  - EOHHS is considering a requirement that 75% of the governing board must be chosen by AE participants.
  - The governing board may be required to possess broad responsibility for the ACO's administrative, fiduciary and clinical operations.
  - The governing board may be required to have a conflict of interest policy calling for disclosure of relevant financial interests and for a procedure to determine whether conflicts exist and an appropriate process to resolve conflicts.
  - Participants in the governing board might be specified as follows:
    - Need not be proportional to AE participants, but may be required to be representative of a variety of participating practitioners (e.g., primary care, specialties, behavioral health, waiver services).
    - May be required to include at least two health care providers in active practice, including: A physician or a nurse practitioner whose area of practice is primary care; and a mental health or chemical dependency treatment provider;
    - May be required to include at least two members from the community at large to ensure that the organizations decision-making is consistent with the values of the members and the community; at least one of which must be Medicaid beneficiary served by the AE.
    - May be required to include at least one member of the community advisory council.

- **Leadership and Management Structure**
  Level 2 and 3 Accountable Entities may be required to have a leadership and management structure that includes clinical and administrative systems. Level 1 AEs may need to demonstrate progress toward the leadership and management structure described below.
  - Operations are managed by an executive who must certify that all AE participants are willing to become accountable to and report on quality, cost and overall care of the Medicaid beneficiaries assigned to the AE.
  - The appointment and removal of the executive might specifically be required to be under the control of the organization's governing board.
  - The AE may be required to establish and maintain an ongoing quality assurance and process improvement program overseen by an appropriately qualified health care professional.
  - The AE may be required to have a medical director, who is an AE physician, who may be part-time, but must be physically present at one of the AE's locations on a regular basis, must be board-certified and licensed in the State of Rhode Island.
  - The AE may be required to have a compliance officer who reports directly to the governing board. The compliance officer cannot be legal counsel to the AE.

- **Transparency**
  Each Accountable Entity governing board may be required to establish standards for publicizing the activities of the Accountable Entity and the organization's community advisory council, as necessary, to keep the community informed.

- **Financial Requirements**
  The state may require the AE to furnish financial reports regarding risk performance on a monthly, quarterly or annual basis. The AE may need to demonstrate experience and capacity for managing financial risk and establishing financial reserves, and meeting the following minimum financial requirements:
  - Maintaining restricted reserves of $250,000 plus an amount equal to 50 percent of the Accountable Entity's total actual or projected liabilities above $250,000.
  - Maintaining a net worth in an amount equal to at least five percent of the average combined revenue in the prior two quarters of the participating health care entities.
  - Demonstrated experience and capacity to operate within a fixed global budget.
  - Demonstrated experience in developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes.

- **Provider Selection and Exclusivity**
  The state may require that providers are selected by Accountable Entities using universal application and credentialing procedures based on objective quality information, and are removed if the providers fail to meet objective quality standards.

EOHHS is specifically seeking comments on provider exclusivity requirements. Should providers who are financially accountable members, participating in the risk/reward of the accountable entities be permitted to participate in the networks of multiple accountable entities? Should primary care providers be required to be exclusive to a specific accountable entity?

Part C Section 4 Data/Analytics Capacity

Expert guidance suggests that In order to move to a more accountable model of care, accountable entities must have access to real time or near real time data and have the analytic capacity to effectively use that data to inform care. As such, the state may require that certified AEs demonstrate the following minimal data and analytic capacity:

- Ability to submit claims/encounter data to the state and receive aggregated performance data
- Meet "stage 1 meaningful use" conditions according to the CMS EHR Incentive program as a Level 1 or Level 2 AE.[2] Meet "stage 2 meaningful use" conditions according to the CMS EHR Incentive program as a Level 3 AE.
- May be required to comply with the enhanced certification standards for EHRs promoted through the CMS EHR Incentive Payment Program and the HHS Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program that require EHRs to capture clinical data necessary for quality measurement as part of care delivery and calculate and report electronic clinical quality for all patients treated by individual providers.

Part C Section 5 Organizational Capacity

Minimum volume thresholds are important to ensure that entities can reasonably be held accountable to the total cost of care. Absent a minimum volume of Medicaid eligibles, variations in cost associated with individual high cost cases cannot be adequately managed. As such, EOHHS may require that certified Accountable Entities be responsible for the total cost of care associated with a minimum of 5,000 Medicaid enrollees.

Please comment on the necessary minimum number of enrollees for successful care management and risk. Also comment on whether alternative standards should be considered for accountable entities focused on a specialized, high cost population subgroups (e.g., SPMI).

Part D Feedback on Draft Contractual Requirements (3 pages)

In this section, the state has included draft contractual requirements for accountable entites. Please note that these proposed requirements are intended as a starting point, for purposes of encouraging meaningful and specific input. They will be significantly amended as a result of learnings from this request for information and other ongoing processes.

[2] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html

For Sections 1, 2 and 3 below, please provide feedback on the proposed AE contractual requirements. Specifically, consider the following three questions and the "Premise for Reform" described above:

1. Which requirements are most critical to achieving an accountable care model that is prepared to meet the challenges of the next generation of managed care and the triple aim? Which are less critical, and might be excluded? What is missing?
2. Are these requirements drafted in sufficient detail to achieve the desired outcome? Can/ should EOHHS consider more detailed or specific requirements? Less detailed/specific?
3. Are any of these requirements likely to act as barriers to local providers considering becoming Certified Accountable Entities and how might we refine these requirements to reduce such barriers?

Note that these draft contractual requirements for the interaction between the state, participating Medicaid MCOs and certified Level 1, 2 and 3 accountable entities, are also summarized in table form in Appendix B.

Part D Section 1 Interaction with Health Plans

In this new model, the state may continue to contract with MCOs to provide care to Medicaid enrollees in a capitated model. The MCOs might then be required to contract with Accountable Entities (AEs), which have been certified by the state. Payments to and enrollment in these AEs could then be one of the main mechanisms by which the Reinventing goals of transitioning to value-based care delivery would be accomplished. The state seeks comments as to the advantages and risks of such an approach.

The state also seeks comments as to the appropriate and respective roles of the two parties. Currently, MCOs perform a variety of important functions on behalf of EOHHS and Medicaid enrollees, including utilization review/utilization management, claims processing, network contracting, grievances/appeals and member services. Should these traditional roles of MCOs change with these new accountable entity structures in place? If so, in what ways?

The state intends that over time this new program structure will become the primary contracting model in the Medicaid program. As such, EOHHS intends that MCOs contract with Accountable Entities to serve at least 30 percent of Medicaid membership in Year 1 of the program, increasing to 60 percent in Year 3. In order to limit carve outs (and ensure that the Accountable Entities are truly accountable for total cost of care) these contracts must also capture 60 percent of Medicaid cost of these members for Level 1 AEs, and 90% for Level 3 AEs.

Part D Section 2 Payment Model

The contractual requirements must also consider the appropriate risk arrangement between the AEs and the MCO. How much risk should the MCO retain? How much risk should be transferred to the new entity in order to align financial incentives?

Considering these questions, the proposed payment model requirements are based on three preliminary principles of payment:

- All parties need some financial incentives to manage care – MCOs, AEs, State
- Partnership creates common priorities
- Risk potential must be adjusted based on meeting performance standards/quality metrics

The proposed payment model includes three levels financial accountability, consistent with the level 1, 2, and 3 AE certification standards described in Part C, with higher levels of financial accountability for more advanced AE structures. Under such a model, organizations could move from level one to level three, moving toward a "level three equal partnership" by year 3; however, we recognize that some organizations may have the expertise, experience and capacity to establish a Level 3 arrangement more immediately. Moving toward an "equal partnership" model is intended to allow for both the AEs and the MCO to have appropriate incentives to manage the total cost of care:

- **Level 1: Shared Savings**
  Begin with a model whereby the MCO and AEs build the necessary governance model, data/analytic infrastructure and metrics to share risk. AEs would be eligible for small amount of shared savings.
- **Level 2: Moderate Risk Sharing**
  Increased financial accountability for both the MCO and the AEs, higher savings potential for AEs and assumption of downside risk.
- **Level 3: Equal partnership**
  Equal partnership, where the vast majority of financial accountability is transferred from the state to the MCOs, and the MCO and AE partner equally in the risk and rewards of effective care management.

A potential financial model that captures such an approach is summarized in Figure 1 and described in additional detail below. The state seeks comments on both the high level directives for Level 1, 2 and 3 described above, as well as the level of specificity included in Figure 1, and the appropriate amount of risk and reward for both MCOs and AEs at different levels of maturity.

Figure 1: Summary of State/MCO/AE Risk Arrangement

	Level 1	Level 2	Level 3
	Shared Savings	**Shared Risk**	**Equal Partners**
Contract Scope	*30% of eligibles*	*45% of eligibles*	*60% of eligibles*
Share of Services	*60% of services/cost*	*75% of services/cost*	*90% of services/cost*
Shared Savings Limit	*5% of benchmark*	*10% of benchmark*	*10% of benchmark*
Max downside risk	*0% of benchmark*	*7.5% of benchmark*	*10% of benchmark*

Risk Arrangement	*Up*	*Down*	*Up*	*Down*	*Up*	*Down*
State/MCO Risk Arrangement						
State	60%	60%	40%	40%	10%	10%
MCO	40%	40%	60%	60%	90%	90%
	100%	100%	100%	100%	100%	100%
MCO/AEs Risk Share Within MCO Portion						
MCO	70%	100%	60%	60%	50%	50%
AE	30%	0%	40%	40%	50%	50%
Total	100%	100%	100%	100%	100%	100%
Resulting 3 Way Share of Risk						
State	60%	60%	40%	40%	10%	10%
MCO	28%	40%	36%	36%	45%	45%
AE	12%	0%	24%	24%	45%	45%
Total	100%	100%	100%	100%	100%	100%

- **Shared Savings**
  The MCO may earn a sharing rate of up to 90% percent of the difference between the capitation amount and actual cost of care (COC), adjusted for performance on quality metrics. A certified level 3 AE may earn a sharing rate of up to 45% of the difference between the BCOC and the actual COC, adjusted for performance on quality metrics. Shared savings would be limited to 5% of the total benchmark cost of care for Level 1 AEs and 10% for Level 2 and 3 AEs.

- **Shared Risk**
  If the actual cost of care is higher than the capitation, the MCO could be responsible for up to 90% of the shared losses. If the AE actual cost of care (COC) is more than 2% above the BCOC, the AE must be responsible for shared losses. The maximum loss rate for a Level 3 AE must not exceed 45% of the difference between the BCOC and actual COC.

  AE assumption of downside risk could vary by Level as follows:

  - Level 1: no downside risk
    Level 2: risk limited to 7.5% of total benchmark cost of care
    Level 3: risk limited to 10.0% of total benchmark cost of care

  The AE could be required to notify the state if it is transferring risk to any participating provider. AEs could be required to submit a Risk Mitigation Plan to the state that demonstrates that the AE has the ability to assume the appropriate levels of downside risk and receive state approval. The Risk Mitigation Plan could be required to include a downside risk distribution model that does not disproportionately punish any particular organization within the AE and maintains network adequacy in the event of a contract year in which the AE has experienced poor financial performance.

- **Risk Adjusted Capitation/Benchmark Cost of Care**
  The state could set a risk-adjusted capitation for each MCO depending on the Level of the AEs associated with that MCO. The capitation might be required to capture at least 60% of the total cost of care for the MCO population attributed to Level 1 AEs, 75% of the total cost of care for those attributed to the Level 2 AEs, and 90% of the cost of care for those attributed to Level 3 AEs. The capitations must be risk-adjusted using the CMS HCC model.[3] The MCO would then set a benchmark cost of care for the attributed population in each AE.

- **Member Attribution**
  MCOs may be required to attribute their MCO members to each of their participating AEs. This attribution may be required to be based on a methodology developed by the state in order to ensure consistency across the MCOs. The state is in the process of developing an attribution methodology for the Care Transformation Collaborative Initiative. The currently proposed CTC attribution standards include 5 specific hierarchical attribution criteria based on preventative and eligible PCP visits and pharmacy claims over a 27-month look back period. Please comment on whether EOHHS should leverage this same methodology for AE attribution or develop/build on an alternative model.

- **Performance Standards**
  The MCO and AE could be required to report on all required metrics to be eligible for shared savings. For Level One arrangements, MCOs may be required to report all metrics, but performance may not affect shared savings rate. For Level 2 and 3 AEs, sharing rates between the MCO and the state could be equal to the product of the MCOs quality score and maximum sharing rate of 60% for level 2 and 90% for level 3.

[3] http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html

Part D Section 3 Performance Metrics

The state recognizes that the incentive for accountable entities to focus on total cost of care must be balanced with specific, detailed performance metrics that are ultimately centered around population health outcomes measures.

As such, EOHHS intends to establish performance metrics for accountable entities that include both overall delivery system transformation metrics, and provider specific metrics of transformation. Access to care, quality of care, satisfaction with care, and health outcomes would be tracked at both the population and provider specific level. These measurement and incentive programs may vary by Accountable Entity certification level and providers should be prepared to be evaluated on different kinds of metrics as they progress toward a Level 3 AE certification.

Additionally, the accountable entity model is built on the premise that the program can better meet the triple aim -- enhanced care experience, improved health, and reduced cost of care -- if we can accomplish the following four principles, as articulated in the final Reinventing Medicaid report and described above:

- Pay for value, not for volume
- Coordinate physical, behavioral, and long-term health care
- Rebalance the delivery system away from high-cost settings
- Promote efficiency, transparency, and flexibility

The state seeks specific recommendations and comments on the performance metrics that are most critical to achieving these AE program goals.

The state also intends for these performance metrics to be aligned with a number of existing programs in order to maximize the likelihood of success, engage a broad range of Accountable Entity participants, and optimize the likelihood of successfully achieving the program goals. These programs include:

- CMS metrics for monitoring the implementation of value-based purchasing;
- Metrics established for all-payer reform in the SIM program, the SIM Population Health Plan
- Metrics developed to track and implement the Reinventing Medicaid program;

As an example, metrics used in the Medicare Shared Savings program and the CSI-RI program are listed in Appendix C and D respectively. The state also seeks comments on how best to align with these existing program metrics. Which of the specific metrics listed in appendix C and D are most critical to be aligned across programs and included in AE performance metrics?

Part E Year 1 Pilot Program (3 pages)

Over time all Medicaid members will be attributed to an Accountable Entity. More immediately, in SFY 2016 a pilot Accountable Entity must be certified as capable of enrolling or attributing at least 25,000 MMCO members under a fully delegated global capitation contract, with payments set at 95% of current MMCO payment rates.

This contract must be executed no later than January 1, 2016, and is intended to save $6 Million in SFY 2016 Medicaid expenditures. As such, the state is seeking feedback on the immediate

certification standards and contractual requirements associated with this pilot.

Please consider the following standards and requirements, and provide feedback on the content, timeline and process for pilot certification and contracting.

- **Pilot certification standards**
  Pilot participants must commit to meeting all of the certification standards of a Level 3 Accountable Entity as described in Part B above and Appendix A by January 2016, or establish commitments to achieve these standards by a date that is agreed upon by the state and the entity.

- **Pilot timeline and process**
  An application to be certified as an accountable entity will be posted by the state on or before September 30. Pilot candidates must submit certification commitments within two weeks, no later than October 15, 2015. Pilot accountable entity(s) will be selected by the state no later than October 30, 2015. The partnering MMCO must establish a risk arrangement with an agreed upon pilot AE, effective January 1, 2016.

- **Pilot contractual requirements**
  Level 3 contractual requirements will apply, with the following modifications:
  - *Payment Model*
    This would be a full risk contract, whereby the partnering MMCO would establish a risk adjusted total cost of care for the agreed upon population, set at 95% of the estimated population cost. The Accountable Entity would then be responsible for any costs above the budgeted total cost of care, and would retain any savings for costs below this budget. Savings vs. risk adjusted budgets would be retained by the pilot accountable entity provided that specified performance metrics (access, member satisfaction and quality metrics) are met.
  - *Performance Standards and Metrics*
    Specific performance metrics (access, member satisfaction and quality metrics) shall be proposed by the MMCOs and approved by the state. These metrics must be met in order for any savings to be retained by the pilot. The state seeks feedback on the specific performance standards and metrics that could be reasonably established under the pilot to ensure that the financial incentives associated with the above payment model are sufficiently balanced by performance standards that ensure adequate access to care, quality of care, satisfaction with care, and health outcomes.

- **State Commitments**
  Certification as an Accountable Entity pilot would qualify these entities to participate in the hospital and nursing home incentive programs, if appropriate.

Part F Interest in becoming a Certified Accountable Entity (3 pages)

Please describe your organization's interest in becoming a certified accountable entity. If interested, please list any gating factors that would prevent your organization from being able to meet the criteria proposed in this RFI and suggest potential methods of addressing them. Also, please suggest state actions or incentives that might encourage additional participants.

Please also describe your organization's interest in participating in the Year 1 Pilot Program. Please specify any concerns with the draft pilot program requirements as documented above, the challenges these requirements pose for your organization, and any recommended state actions or incentives that might encourage additional participants in this pilot.

Response Protocols

Submit one (1) original and **five (5) complete** copies of responses by the date and time stated on page one of this RFI. Please also submit two (2) electronic copies (thumb drive, CD, etc.) All paper submissions should be single spaced on 8 ½" by 11" pages and printed double-sided.

Based on the responses, Rhode Island will invite a select group of respondents to be part of further discussions.

Disclaimer

This Request for Information is solely for information and planning purposes and does not constitute a Request for Proposal. All information received in response to the RFI and marked as "Proprietary" will be handled accordingly. Responses to the RFI cannot be accepted by the Government to form a binding contract. Responses to the RFI will not be returned. Respondents are solely responsible for all expenses associated with replying to this RFI.

Appendix A: Summary of DRAFT Accountable Entity Certification Standards

	Level 1	Level 2	Level 3
Definition	*A Group of primary care providers, specialists and/or hospital and other health professionals who manage the full continuum of care and are accountable for the total costs and quality of care for a defined population.*		
Required Scope of Services	Capture 60% of total cost of care for attributed members 75% of members enrolled in a PCMH	75% of total cost of care 75% of members enrolled in a PCMH	90% of total cost of care 75% of members enrolled in a PCMH
Governance	• Single corporate structure or network of providers with contractual relationships, must convene Community Advisory Council. • Governing board separate and unique, must be representative of participating practitioners, including 2 providers in active practice, 2 members of community at large, 1 member of Community Advisory Council. 75% of governing board to be chosen by AE participants.		
Leadership	Must demonstrate progress toward Level 2&3 structure.	• Must include clinical and administrative systems • Governing board controls appointment/removal of executive • Need medical director, compliance officer and ongoing QA/process improvement program	Same as Level 3
Financial Requirements	• Demonstrated experience/capacity for managing financial risk, establishing financial reserves, and implementing alternative payment methodologies. • Maintain restricted reserves of $250,000 plus an amount equal to 50% of AE's total actual or projected liabilities above $250,000. • Maintain net worth equal to at least 5% of the average combined revenue in the prior two quarters of the participating entities. • Demonstrated experience and capacity to operate within a fixed global budget.		
Provider Selection	• Providers may participate in the networks of multiple AEs, however primary care providers must be exclusive to a specific AE. • Selection must use universal application and credentialing procedures, and objective quality information. • Providers subject to removal if fail to meet objective quality standards.		
Data & Analytics Capacity	• Ability to submit claims/encounter data and receive aggregated performance data • Meet "stage 1 meaningful use" conditions according to CMS EHR Incentive program • Comply with CMS enhanced certification standards for EHRs	Same as Level 1	Same as Level 1&2, **Except** Must meet "stage 2 meaningful use" conditions according to CMS EHR Incentive Program
Organizational Capacity	• Minimum of 5,000 Medicaid enrollees		

Appendix B: Summary of DRAFT Accountable Entity Contractual Requirements

	Level 1	Level 2	Level 3
Interaction with Health Plans	Cost of care benchmarks must include at least 60% of the total cost of care	Include 75% of total cost of care	Include 90% of the total cost of care
Payment Model	**Shared Savings** • State/MCO: 60/40 risk share • MCO/AE: 70/30 upside risk share • Resulting 3-way risk share state/MCO/AE of 60/28/12% respectively Shared savings of up to 12% of the difference between the benchmark cost of care (BCOC) and the actual cost of care.	**Moderate Risk Sharing** • State/MCO: 40/60 risk share • MCO/AE: 60/40 risk share • Resulting 3-way risk share state/MCO/AE of 40/36/24% respectively Shared savings/risk up to 24% of difference between BCOC and the actual cost of care, adjusted for performance levels.	**Equal Partnership** • State/MCO: 10/90 risk share • MCO/AE: 50/50 risk share • Resulting 3-way risk share state/MCO/AE of 10/45/45% respectively Shared savings/risk of up to 45% of the difference between the BCOC and the actual cost of care, adjusted for performance levels.
Shared Savings Limit	Shared savings limited to 5% of BCOC	Shared savings limited to 10% of BCOC	Shared savings limited to 10% of BCOC
Downside Risk Limit	No downside risk	• Risk limited to 7.5% of BCOC • Must submit Risk Mitigation Plan and notify state if transferring risk to providers.	• Risk limited to 10.0% of BCOC • Must submit Risk Mitigation Plan and notify state if transferring risk to providers.
Performance Standards	**Reporting Only** • Reporting required, but performance will not affect the shared savings rate. • Two-tiered: MCO must report to state, and AE must report to MCO	**Performance Based** • For both MCOs and AEs, quality score on benchmarks will affect the shared savings and risk. • MCOs: Actual sharing rate will be product of MCO quality score and maximum sharing rate of 60% • AEs: Actual sharing rate will be product of AE quality score and max sharing rate of 24%.	**Enhanced Performance Requirements** • For both MCOs and AEs, quality score on benchmarks will affect the shared savings and risk. • MCOs: Actual sharing rate will be product of MCO quality score and maximum sharing rate of 90% • AEs: Actual sharing rate will be product of AE quality score and max sharing rate of 45%.
Risk adjusted capitation - BCOC	• The capitations must be risk-adjusted using the CMS HCC model. • The MCO then sets a benchmark cost of care (BCOC) for the attributed population in each AE.		
Attribution method	MCOs must attribute their MCO members to each of their participating AEs. • Attribution methodology to be developed by state to ensure consistency, may use CSI-RI methodology now under development • Proposed CSI-RI attribution standards include 5 specific hierarchical attribution criteria based on preventative and eligible PCP visits and pharmacy claims over a 27-month look back period.		
Metrics of Performance	• TBD based on MSSP program, CSI-RI, and SIM. • Structure based	• TBD based on MSSP program, CSI-RI, and SIM. • Process based	• TBD based on MSSP program, CSI-RI, and SIM. • Outcome based

Appendix C: Sample Performance Metrics

Medicare Shared Savings Program:

Table: 33 ACO Quality Measures

Domain	Measure	Description	Pay-for-Performance Phase In R= Reporting P= Performance		
			PY1	PY2	PY3
Patient/Caregiver Experience	ACO #1	Getting Timely Care, Appointments, and Information	R	P	P
Patient/Caregiver Experience	ACO #2	How Well Your Doctors Communicate	R	P	P
Patient/Caregiver Experience	ACO #3	Patients' Rating of Doctor	R	P	P
Patient/Caregiver Experience	ACO #4	Access to Specialists	R	P	P
Patient/Caregiver Experience	ACO #5	Health Promotion and Education	R	P	P
Patient/Caregiver Experience	ACO #6	Shared Decision Making	R	P	P
Patient/Caregiver Experience	ACO #7	Health Status/Functional Status	R	R	R
Care Coordination/Patient Safety	ACO #8	Risk Standardized, All Condition Readmissions	R	R	P
Care Coordination/Patient Safety	ACO #9	ASC Admissions: COPD or Asthma in Older Adults	R	P	P
Care Coordination/Patient Safety	ACO #10	ASC Admission: Heart Failure	R	P	P
Care Coordination/Patient Safety	ACO #11	Percent of PCPs who Qualified for EHR Incentive Payment	R	P	P
Care Coordination/Patient Safety	ACO #12	Medication Reconciliation	R	P	P
Care Coordination/Patient Safety	ACO #13	Falls: Screening for Fall Risk	R	P	P
Preventive Health	ACO #14	Influenza Immunization	R	P	P
Preventive Health	ACO #15	Pneumococcal Vaccination	R	P	P
Preventive Health	ACO #16	Adult Weight Screening and Follow-up	R	P	P
Preventive Health	ACO #17	Tobacco Use Assessment and Cessation Intervention	R	P	P
Preventive Health	ACO #18	Depression Screening	R	P	P
Preventive Health	ACO #19	Colorectal Cancer Screening	R	R	P
Preventive Health	ACO #20	Mammography Screening	R	R	P
Preventive Health	ACO #21	Proportion of Adults who had blood pressure screened in past 2 years	R	R	P
At-Risk Population Diabetes	Diabetes Composite ACO #22 – 26	ACO #22. Hemoglobin A1c Control (HbA1c) (<8 percent) ACO #23. Low Density Lipoprotein (LDL) (<100 mg/dL) ACO #24. Blood Pressure (BP) < 140/90 ACO #25. Tobacco Non Use ACO #26. Aspirin Use	R	P	P
At-Risk Population Diabetes	ACO #27	Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)	R	P	P
At-Risk Population Hypertension	ACO #28	Percent of beneficiaries with hypertension whose BP < 140/90	R	P	P
At-Risk Population IVD	ACO #29	Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl	R	P	P
At-Risk Population IVD	ACO #30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	R	P	P
At-Risk Population HF	ACO #31	Beta-Blocker Therapy for LVSD	R	R	P
At-Risk Population CAD	CAD Composite ACO #32 – 33	ACO #32. Drug Therapy for Lowering LDL Cholesterol ACO #33. ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	R	R	P

Notes: PY = Performance Year

Appendix D: CSI Clinical Quality Measures

CSI RI Clinical Quality Measures: 2014 Contractual Performance Standards for Contract Adjudication on 4/1/15

Measure	Contractual performance metric	2013 Target	2014 Target	Comments
Adult BMI (18-64)	✓	57%	70%	
Adult BMI (65+)	✓	69%	75%	
DM A1c Good Control (<8)	✓	69%	70%	
DM BP Control (<140/90)	✓	76%	78%	
DM LDL Good Control		50%	N/A	Retiring measure
Hypertension BP Control (<140/90)	✓	72%	76%	Updating measure according to HEDIS updates
Tobacco Cessation	✓	85%	90%	
Depression Screen		91%		
DM A1c Poor Control		21%		
DM BP Good Control		41%		
DM-BP Pts w/ Measurement		97%		Retiring measure
DM-HbA1c Pts w/ Result		89%		
DM-LDL Pts w/ Result		79%		Retiring measure
Hypertension BP Measurement		100%		Retiring measure
Tobacco Assessment		98%		
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis		N/A		
Chlamydia Screening – Sexual History		N/A		
Chlamydia Screening – Testing		N/A		
Fall Risk Management		N/A		