

---

May 20, 2026

Kristin Sousa, Assistant Secretary and Medicaid Director  
State of Rhode Island Department of Human Services, Executive Office  
3 West Road, Virks Building  
Cranston, RI 02920

Dear Ms. Kristin Sousa:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Rhode Island's submission of a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on June 23, 2025, and a final revised preprint was received on May 20, 2026. The proposal has a control name of RI\_VBP\_Oth\_Renewal\_20250701-20260630.

CMS has completed our review of the following Medicaid managed care SDP(s):

- The Total Cost of Care payment arrangement for the state's Accountable Entities, as authorized in the state's section 1115 demonstration for the rating period covering July 1, 2025 through June 30, 2026, incorporated in the capitation rates through a risk-based rate adjustment of up to \$109,000,000.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the [Medicaid Managed Care Rate Development Guide](#). The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

If you have any questions concerning this letter, please contact [StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov).

Sincerely,

John Giles  
Director, Managed Care Group  
Center for Medicaid and CHIP Services

---

## Section 438.6(c) Preprint

---

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to:  
[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov).

### SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):  
-
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.*
3. Identify the managed care program(s) to which this payment arrangement will apply:
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment:
  - a. Identify the estimated federal share of this state directed payment:
  - b. Identify the estimated non-federal share of this state directed payment:

*Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.*

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement?  Yes  No

6. If this is not the initial submission for this state directed payment, please indicate if:
- a.  The State is seeking approval of an amendment to an already approved state directed payment.
  - b.  The State is seeking approval for a renewal of a state directed payment for a new rating period.
    - i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
  - c. Please identify the types of changes in this state directed payment that differ from what was previously approved.
    - Payment Type Change
    - Provider Type Change
    - Quality Metric(s) / Benchmark(s) Change
    - Other; please describe:
- No changes from previously approved preprint other than rating period(s).
7.  Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

## SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).
- a.  Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).
  - b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

- a.  **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

*If checked, please answer all questions in Subsection IIA.*

- b.  **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

*If checked, please answer all questions in Subsection IIB.*

#### **SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):**

*This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.*

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- Quality Payment/Pay for Performance (Category 2 APM, or similar)
- Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- Multi-Payer Delivery System Reform
- Medicaid-Specific Delivery System Reform
- Performance Improvement Initiative
- Other Value-Based Purchasing Model

**11.** Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If “other” was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

**12.** In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the [CMS Adult and Child Core Set Measures](#) when applicable. If the state needs more space, please use Addendum Table 1.A and check this box:

**TABLE 1: Payment Arrangement Provider Performance Measures**

Measure Name and NQF # (if applicable)	Measure Steward/ Developer <sup>1</sup>	Baseline <sup>2</sup> Year	Baseline <sup>2</sup> Statistic	Performance Measurement Period <sup>3</sup>	Performance Target	Notes <sup>4</sup>
<i>Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay</i>	<i>CMS</i>	<i>CY 2018</i>	<i>9.23%</i>	<i>Year 2</i>	<i>8%</i>	<i>Example notes</i>
<b>a.</b>						
<b>b.</b>						
<b>c.</b>						
<b>d.</b>						
<b>e.</b>						

1. Baseline data must be added after the first year of the payment arrangement  
 2. If state-developed, list State name for Steward/Developer.  
 3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.  
 4. If the State is using an established measure and will deviate from the measure steward’s measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.



14. Is the State seeking a multi-year approval of the state directed payment arrangement?  
 Yes  No
- a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.
- b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.
15. Use the checkboxes below to make the following assurances:
- a.  In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.
- b.  In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.
- c.  In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.
- d.  In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

**SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:**

*This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.*

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*
- a.  Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates*<sup>1</sup> (42 C.F.R. § 438.6(c)(1)(iii)(B))
- b.  Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))
- c.  Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

---

<sup>1</sup> Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

- a. Check the basis for the fee schedule selected above.
  - i.  The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a).<sup>2</sup>
  - ii.  The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.
  - iii.  The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.
    1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)
- b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

- a.  Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.
- b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.
- c. Indicate the number of exemptions to the requirement:
  - i. Expected in this contract rating period (estimate)
  - ii. Granted in past years of this payment arrangement
- d. Describe how such exemptions will be considered in rate development.

---

<sup>2</sup> Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

**19.** If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

- a. Will the state require plans to pay a  uniform dollar amount **or** a  uniform percentage increase? (*Please select only one.*)
- b. What is the magnitude of the increase (e.g., \$4 per claim or 3% increase per claim?)
- c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).
- d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

### **SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS**

**20.** In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

- a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- inpatient hospital service
- outpatient hospital service
- professional services at an academic medical center
- primary care services
- specialty physician services
- nursing facility services
- HCBS/personal care services
- behavioral health inpatient services
- behavioral health outpatient services
- dental services
- Other:

- b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

- c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.
- 21.** In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.
- 22.** For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:
- a.  Replace the negotiated rate(s) between the plan(s) and provider(s).
  - b.  Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).
  - c.  Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).
- 23.** For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.). This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*
- If the state needs more space, please use Addendum 2.A and check this box:

**TABLE 2: Provider Payment Analysis**

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
<i>Ex: Rural Inpatient Hospital Services</i>	80%	20%	N/A	N/A	100%
a.					
b.					
c.					
d.					
e.					
f.					
g.					

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- a.  Medicare payment/cost
- b.  State-plan approved rates as defined in 42 C.F.R. § 438.6(a) (*Please note, this rate cannot include supplemental payments.*)
- c.  Other; Please define:

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b?  Yes  No

*If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.*

- 26.** Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b?  Yes  No

*If yes, please provide information requested under the column “Pass-Through Payments” in Table 2.*

- 27.** Please describe the data sources and methodology used for the analysis provided in response to Question 23.

- 28.** Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

#### **SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS**

- 29.** States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment?  Yes  No

**a.** If yes:

- i.** What is/are the state-assigned identifier(s) of the contract actions provided to CMS?
- ii.** Please indicate where (page or section) the state directed payment is captured in the contract action(s).

**b.** If no, please estimate when the state will be submitting the contract actions for review.

**SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION**

*Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.*

**30.** Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS?  Yes  No

**a.** If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

**b.** If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

**Table 3: Actuarial Rate Certification(s)**

<b>Control Name Provided by CMS (List each actuarial rate certification separately)</b>	<b>Date Submitted to CMS</b>	<b>Does the certification incorporate the SDP?</b>	<b>If so, indicate where the state directed payment is captured in the certification (page or section)</b>
<b>i.</b>			
<b>ii.</b>			
<b>iii.</b>			
<b>iv.</b>			
<b>v.</b>			

*Please note, states and actuaries should consult the most recent [Medicaid Managed Care Rate Development Guide](#) for how to document state directed payments in actuarial rate certification(s). The actuary’s certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)*

**c.** If not currently captured in the State’s actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State’s actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

**31.** Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- a.  An adjustment applied in the development of the monthly base capitation rates paid to plans.
- b.  Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- c.  Other, please describe:

**32.** States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

**33.**  In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

## **SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE**

**34.** Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- a.  State general revenue
- b.  Intergovernmental transfers (IGTs) from a State or local government entity
- c.  Health Care-Related Provider tax(es) / assessment(s)
- d.  Provider donation(s)
- e.  Other, specify:

**35.** For any payment funded by **IGTs (option b in Question 34)**,

- a. Provide the following (respond to each column for all entities transferring funds). If the state needs more space, please use Addendum Table 4.A and check this box:

**Table 4: IGT Transferring Entities**

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

- b.  Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.
- c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

**36. For any state directed payments funded by provider taxes/assessments (option c in Question 34),**

- a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

**Table 5: Health Care-Related Provider Tax/Assessment(s)**

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i.						
ii.						
iii.						
iv.						
v.						

- b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

**Table 6: Health Care-Related Provider Tax/Assessment Waivers**

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

- a. Is the donation bona-fide?  Yes  No
- b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?  
 Yes  No

38.  **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

## **SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS**

- 39.**  Use the checkbox below to make the following assurance, “In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340.”
- 40.** Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:
- a.** A hyperlink to State’s most recent quality strategy:
  - b.** The effective date of quality strategy.
- 41.** If the State is currently updating the quality strategy, please submit a draft version, and provide:
- a.** A target date for submission of the revised quality strategy (month and year):
  - b.** Note any potential changes that might be made to the goals and objectives.

*Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.*

**42.** To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

**Table 7: Payment Arrangement Quality Strategy Goals and Objectives**

Goal(s)	Objective(s)	Quality strategy page
<i>Example: Improve care coordination for enrollees with behavioral health conditions</i>	<i>Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%</i>	5
a.		
b.		
c.		
d.		

**43.** Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year’s payment arrangement and in terms of that of the multi-year payment arrangement.

**44.** Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the [CMS Adult and Child Core Set Measures](#), when applicable.

- a.**  In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

- b. Describe how and when the State will review progress on the advancement of the State’s goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State’s goals and objectives. Please attach the State’s evaluation plan for this payment arrangement.

**TABLE 8: Evaluation Measures, Baseline and Performance Targets**

Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Performance Target	Notes <sup>1</sup>
<i>Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039</i>	<i>CY 2019</i>	<i>34%</i>	<i>Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year</i>	<i>Example notes</i>
<b>i.</b>				
<b>ii.</b>				
<b>iii.</b>				
<b>iv.</b>				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

- c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

**ATTACHMENT J - Accountable Entity Total Cost of Care Requirements  
(Program Year 8)**

**Table of Contents**

---

**A. TCOC Definition**

**B. TCOC Methodology Goals**

**C. General Requirements for Program Participation**

1. Minimum Membership and Population Size
2. State/MCO Capitation Arrangement
3. Exclusivity of Approved TCOC Methodologies
4. Attribution

**D. TCOC Methodology: Required Elements for Comprehensive AEs**

1. Establishing TCOC Targets
2. Measuring Expenditures for the Performance Period
3. Shared Savings/(Loss) Pool Calculations
4. AE Share of Savings/(Loss) Pool
5. Required Progression to Risk Based Arrangements

**E. TCOC Reporting Requirements**

**Attachments**

- **Attachment A:** Quality Framework and Methodology for Comprehensive Accountable Entities
- **Attachment B:** TCOC Financial Solvency Filing for Accountable Entities Bearing Financial Risk

## A. TCOC Definition

Total cost of care (TCOC) is a fundamental element to the Accountable Entity (AE) program. It includes a historical baseline cost of care projected forward to the performance period. Actual costs during the performance period are then compared to this baseline to identify a potential shared savings or risk pool.

Effective TCOC methodologies incentivize AEs to invest in care management and other services that address member needs and reduce duplication of services. In doing so, AEs improve health outcomes, lower costs, and earn savings. Savings in this program are also determined by performance against quality and outcomes metrics.

## B. TCOC Methodology Goals

These TCOC guidelines support meaningful performance measurement and create financial incentives to reduce costs and improve quality. In order to accomplish meaningful performance measurement, this methodology:

- **Provides opportunity for a sustainable business model**  
This methodology creates ongoing opportunity for effective AEs by: (1) recognizing efficient historical performers; (2) allowing for shared savings to be retained for system investment; (3) creating greater financial incentives for being inside the AE program than for being outside the program
- **This methodology creates financial flexibility for AEs to improve clinical pathways for Medicaid high utilizers and to address social drivers of health outcomes and costs**
- **Is fiscally responsible for all participating parties** and adequately protect the solvency of the AEs and managed care organizations (MCOs) and the financial interests of the RI Medicaid Program
- **Specifically recognizes and addresses the challenge of small populations** through strategies that minimize the impact of small numbers, given the state's small size
- **Incorporates quality metrics** related to increased access and improved member outcomes
- **Requires timely data exchange and performance improvement reporting between MCOs and AEs**
- **Includes a progression toward meaningful provider risk**

## C. General Requirements for Program Participants

### 1. Minimum Membership and Population Size

MCOs may utilize TCOC-based payment models only with AEs that have at least 5,000 attributed Medicaid members across all MCOs and at least 2,000 members per MCO-AE contract.

## 2. State/MCO Capitation Arrangement

The MCO retains the base contract with the State; the MCO medical capitation will be adjusted for savings/risk associated with the program as described in the State/MCO contract. This does not preclude MCOs from creating value-based purchasing arrangements with non-AE providers; however, those contracts would still be subject to the State gain-share and would not be included in the State's assessment of the MCO's value-based payment performance standards related to AEs.

## 3. Exclusivity of Approved TCOC Methodologies

MCO TCOC arrangements shall supersede and be exclusive of any other TCOC-related shared savings arrangements with an AE or any of its constituent providers for Medicaid members.

## 4. Attribution

AE specific historic base data must be based on the AE's attributed lives for a given period, in accordance with EOHHS defined attribution requirements, as defined separately. TCOC performance period data must account for and be aligned with the list of attributed members MCOs are required to generate on a monthly basis, as described in the attribution requirements.

# D. TCOC Methodology

EOHHS has established a standard methodology for total cost of care. An overview of the methodology is presented here. The full methodology is detailed in the *Total Cost of Care Technical Guidance*.

## 1. Establishing TCOC targets

For PY8, TCOC targets will include the following components:

- a. Historical cost data, including covered services that align with those included in EOHHS's contract with MCOs
- b. Adjustment for the changing risk profile of the population
- c. Adjustment for trend assumptions
- d. Adjustment to historical base relative to market average

## 2. Measuring Expenditures for the Performance Period

- a. **Calculate Actual Expenditures Consistent with the Historical Base Methodology**  
MCOs will calculate and report actual expenditures for the Performance Period consistent with the base methodology as described above.
- b. **Actual expenditures shall include all performance year costs for those members attributed to an AE**

## 3. Shared Savings/(Loss) Pool Calculations

The Shared Savings/(Loss) Pool shall be calculated as the difference between Actual

Expenditures and TCOC Expenditure Target after the following adjustments:

**a. Minimum Savings Rate**

EOHHS requires a minimum savings rate (MSR) to limit the potential for Shared Savings payments related to cost reductions generated strictly due to the effect of random variation in utilization and spending in small populations. The MSR by AE size is detailed in the *Total Cost of Care Technical Guidance*. The MSR only applies to shared-savings only contracts; there is no MSR in “two-sided” contracts where the AE takes on downside risk.

**b. Impact of Quality and Outcomes**

The Shared Savings Pool shall be adjusted based on an assessment of performance relative to a set of quality measures for the attributed population. An Overall Quality Score will be generated for each AE, according to the methodology detailed in *Attachment A: Quality Framework and Methodology for Comprehensive Accountable Entities*. The Total Shared Savings Pool (inclusive of both the AE and MCO portions) must be multiplied by the Overall Quality Score. The Overall Quality Score must function as a multiplier, and may not include a gate; as such, any quality points earned must be associated with a share of the Shared Savings Pool.

In PY8, the Shared Loss Pool shall also be adjusted based on the Overall Quality Score generated for each AE according to the methodology detailed in *Attachment A: Quality Framework and Methodology for Comprehensive Accountable Entities*. The Overall Quality Score will be divided by 4 and multiplied by the total Shared Loss Pool. The resulting product will be subtracted from the total Shared Loss Pool. For example, if the Overall Quality Score is 0.88, the multiplier will be 0.22. A Shared Loss Pool of \$100,000 would be multiplied by 0.22, yielding \$22,000, and the shared loss pool of \$100,000 would be reduced by \$22,000, yielding a final Shared Loss Pool of \$78,000.

**c. Risk Exposure Cap**

The Risk Exposure Cap cannot be lower than specified minimum thresholds. The Risk Exposure cap can be expressed as a percentage of the AE-specific TCOC Expenditure Target<sup>1</sup> or as a percentage of the AE’s revenue.<sup>2</sup> Savings or losses that exceed 10% in any program year will trigger a review by EOHHS to determine if all Performance

---

<sup>1</sup> The percentage of total cost of care is calculated based on the Final TCOC Target established by EOHHS as part of the final Program Year TCOC reporting. See the Total Cost of Care Technical Guidance for details on how the Final TCOC Target is established.

<sup>2</sup> Revenue of AE providers from the insurer under the contract refers to revenue paid by the insurer (MCO) to any Tax Identification Number that the AE identifies as participating in the AE. This is not limited to primary care practices or providers through whom Medicaid members are attributed to the AE, but rather refers to all providers that have signed AE participation agreements for the Program Year in question. The revenue for these providers is all revenue for services rendered to any Medicaid patient covered by the insurer and is not limited to members attributed to the AE. This does not include revenue for services rendered to patients covered by the Medicare-Medicaid Plan or any non-Medicaid product offered by the same insurer.

Period TCOC and target TCOC calculations are accurate. If the Risk Exposure Cap is greater than or equal to 10%, the AE must present an actuarial analysis that estimates maximum potential loss. The actuarial analysis must be performed by an independent actuary and the results of the analysis be provided in a letter signed by the responsible actuary. This analysis will be used to substantiate the risk mitigation plan proposed by the AE. EOHHS reserves the right to revise any errors and adjust for unforeseen programmatic or data issues that may be contributing to overstated losses or savings.

For AEs assuming downside risk, the Maximum Shared Loss Pool will be defined by the Risk Exposure Cap agreed to by AE and MCO as part of the downside risk arrangement. The Risk Exposure Cap must meet the minimum requirement for transitioning to risk-based arrangements as specified below.

**d. Global Shared Savings/Loss Cap**

In instances where, in aggregate, the AEs Shared Savings/(Loss) Pool for a particular MCO is materially misaligned with the MCO’s financial gains or losses related to benefit expenses, the Shared Savings/(Loss) Pool for the AEs may be adjusted. Each year, a global cap on the Shared Savings/(Loss) Pool for each MCO will be established based on the MCO’s financial gain/loss on benefit expense, plus the risk margin related to benefit expenses that is incorporated in the capitation rates for that year. The calculation of the Global Shared Savings/Loss Cap and further details on the timing of this adjustment are outlined in the Total Cost of Care Technical Guidance for Program Year 8, Section 5.d.

**4. AE Share of Savings/(Loss) Pool**

In Program Year 8, AEs who assumed downside risk in Program Year 7 must be eligible to retain at least 60% of the Shared Savings Pool and must be responsible for at least 40% of any Shared Loss Pool. AEs new to downside risk in Program Year 8 must be eligible to retain at least 60% of the Shared Savings Pool and must be responsible for at least 30% of any Shared Loss Pool. AEs in shared savings-only models must be eligible to retain up to 50% of the Shared Savings Pool.

<b>AE Shared Savings Model</b>	<b>AE Share of Savings</b>	<b>AE Share of Losses</b>
<b>Shared savings only</b>	Up to 50% of Shared Savings Pool	N/A
<b>Shared savings and risk: AEs that assumed downside risk in PY7</b>	At least 60% of Shared Savings Pool	At least 40% of Shared Loss Pool
<b>Shared savings and risk: AEs that did not assume downside risk in PY7</b>	At least 60% of Shared Savings Pool	At least 30% of Shared Loss Pool

## 5. Required Progression to Risk-Based and Value-Based Arrangements

### a. AEs qualified to assume downside risk

Certified AEs qualified to assume downside risk must demonstrate a progression of risk to include meaningful downside shared risk within three years of AE program participation, however PY3 was not counted towards these three years due to the COVID-19 emergency. New participants in the AE program will begin this progression at Year 1 levels of risk exposure and risk sharing. Federally Qualified Health Centers (FQHC)-based AEs new to downside risk in PY8 will assume risk consistent with the Year 4 standards described in the table below, even if they are in their sixth year in the program.

EOHHS has defined “meaningful risk” based on learnings from other states, OHIC requirements, and federal MACRA rules. The required progression of increasing risk for AEs qualified to assume downside risk is as follows:

	<b>Shared Savings Cap</b> <i>Maximum Shared Savings Pool</i>	<b>Minimum Risk Exposure Cap</b> <i>Maximum Shared Loss Pool</i>	<b>Risk Sharing Rate</b> <i>AE Share of Losses</i>
<i>Definition</i>	<i>A cap on the Shared Savings Pool, expressed as a percentage of the total cost of care</i>	<i>A cap on the Shared Loss Pool, expressed as a percentage of a) the total cost of care, or b) the annual revenue of AE providers from the insurer under the contract</i>	<i>The percentage of the Shared Loss Pool shared by the provider with the insurer under the contract after the application of the Risk Exposure Cap</i>
Year 1	At least 10% of TCOC	N/A	0
Year 2	At least 10% of TCOC	N/A	0
Year 3	At least 10% of TCOC	N/A	0
Year 4/ AEs taking downside risk for the first time	At least 10% of TCOC	<b>At least</b> the lesser of 1% of TCOC; or 3% of AE Revenue	At least 30%
Year 5 and beyond	At least 10% of TCOC	<b>At least</b> the lesser of 2% of TCOC; or 6% of AE Revenue	At least 40%

All AEs that agree to bear downside risk under Program Year 8 TCOC contracts must satisfy requirements of the (complete TCOC Financial Solvency Filing process) risk-bearing provider organization process to ensure that the AE has a risk mitigation plan sufficient to cover its maximum possible loss under such a contract. **All AEs that agree to bear downside risk under PY8 TCOC contracts must complete the PY8 TCOC Financial Solvency Filing process.** Details of the TCOC Financial Solvency Filing process for risk-bearing provider organizations is found in *Attachment B: TCOC Financial*

### *Solvency Filing for Accountable Entities Bearing Financial Risk.*

The Medicaid prospective payment system (PPS) established a methodology assuring FQHCs a minimum per visit reimbursement rate when providing care to Medicaid beneficiaries. States also have the option of using an alternative payment methodology (APM) so long as the medical payment rate is not lower than what would be paid under PPS. In Rhode Island, FQHCs are paid pursuant to an APM. EOHHS believes that FQHC-based AEs in Rhode Island can choose to engage in contracts with a level of risk pursuant to these requirements while remaining compliant with Federal rules.

An FQHC-based AE that enters into a downside risk contract would be subject to the same requirements as other AEs taking on downside risk with respect to the Shared Saving Cap and the process described in *Attachment B: TCOC Financial Solvency Filing for Accountable Entities Bearing Financial Risk*. However, FQHC-based AEs who take risk for the first time in PY8 will be subject to the Risk Exposure Cap and minimum Risk Sharing Rate that applied to other AEs in PY4. As noted above, this means a Risk Exposure Cap of 1% of TCOC or 3% of AE revenue, and a minimum Risk Sharing Rate of 30%.

#### **b. AEs not assuming downside risk**

FQHCs are not required to take on the downside risk option described above. FQHC-based AEs may remain in shared savings-only contracts if they progress towards value-based care and alternative payments.

Non-FQHC based AEs that are experiencing financial hardship and are not able to participate in taking on downside risk for PY8, may enter in shared savings-only contracts, effective PY8, with the following conditions:

- Submission of a detailed project plan the AE develops that includes:
  - Identification of the financial conditions that prevent the AE from taking on downside risk.
  - Identification of metrics that the AE will use to determine that they are able to take on downside risk the following program year, as well as a description of the steps they will take, and a complete timeline, to achieve the necessary performance on those metrics
- Following the contracting process with the AEs, MCOs are required to submit copies of the executed contracts along with the project plan, as described above, to EOHHS. Executed contracts are due on the first business day of August each year.

## E. TCOC Reporting Requirements

In order to monitor AE financial performance, MCOs are required to furnish to EOHHS and AEs on a quarterly basis reports regarding TCOC performance. The reports must include, by rate cell, summarized TCOC expenditures and member months for attributed members over a recent 12-month period. See *Accountable Entity Program Total Cost of Care Technical Guidance* for Program Year 8 for reporting dates.

## Attachment A: Quality Framework and Methodology for Comprehensive Accountable Entities

### A. Principles and Quality Framework

A fundamental element of the EOHHS Accountable Entity (AE) program, and specifically the transition to alternative payment models, is a focus on quality and outcomes. Measuring and rewarding quality as part of a value-based model is critical to ensuring that quality is maintained and/or improved while cost efficiency is increased. As such, the payment model must be designed to both recognize and reward historically high-quality AEs while also creating meaningful opportunities and rewards for quality improvement. This model must be measurable, transparent, and consistent, such that participants and stakeholders can view and recognize meaningful improvements in quality as this program unfolds. The program requirements are intended to provide structure that permits baseline measurement and assessment, while allowing for future refinements that continuously “raise the bar” toward critical improvements in quality and outcomes.

### B. Impact of Quality Performance on Shared Savings and Losses

Medicaid AEs are eligible to share in earned savings and will contribute toward shared losses based on a quality multiplier (the “Overall Quality Score”) to be determined as follows:

- AE performance on total cost of care (TCOC) as determined using the EOHHS approved TCOC methodology will determine whether the AE is eligible for shared savings or must contribute to shared losses.
- In accordance with 42 CFR §438.6(c)(2)(ii)(B)<sup>3</sup>, quality performance measurement must be based on the Medicaid Accountable Entity Common Measure Slate. EOHHS expects that performance on each measure be reported annually for the full quality measure performance year.
- For comprehensive AEs, all admin (claims-based) measures must be generated and reported by the MCO. AEs must provide the necessary data to the State Quality Reporting System (QRS) to generate any hybrid or EHR-only measures. Any EHR-only non-HEDIS measure is defined to include only active patients in the denominator. Active patients are individuals seen (either through an in-person office visit or telephone visit, e-visit or virtual check-in) by a primary care clinician associated with the AE anytime within the last 12 months.
- An Overall Quality Score must be generated for each AE. The Overall Quality Score will be used as a multiplier to determine the percentage of any Shared Savings Pool the AE and MCO are eligible to receive. In PY8, the Overall Quality Score will also be used to determine the percentage of any Shared Loss Pool the AE and MCO will have to pay. The Overall Quality Score will be divided by 4 and multiplied by the total Shared Loss Pool. The resulting product will be subtracted from the total Shared Loss Pool. For example, if the Overall Quality Score is 0.88, the multiplier will be 0.22. A Shared Loss Pool of \$100,000 would be multiplied by 0.22, yielding \$22,000,

---

<sup>3</sup> [https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438\\_16&rgn=div8](https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438_16&rgn=div8).

and the Shared Loss Pool of \$100,000 would be reduced by \$22,000, yielding a final Shared Loss Pool of \$78,000. Overall Quality Scores must be calculated distinctly for each MCO with which the AE is contracted.

- Performance year periods, which are aligned with the state fiscal year calendar, will be tied to the calendar year quality performance period ending within the performance year period. Benchmark periods used to set targets for achievement and improvement will depend on data availability and appropriateness and may be adjusted in case of unusual circumstances such as the COVID-19 pandemic.

Performance Year	Performance Time Period	Quality Measurement Performance Period	Quality Measurement Benchmark Period	Payment
PY 1	SFY 2019	HEDIS 2019, CY 18	HEDIS 2018, CY 17	SFY 2020
PY 2	SFY 2020	HEDIS 2020, CY 19	HEDIS 2019, CY 18	SFY 2021
PY 3	SFY 2021	HEDIS Measurement Year (MY) 2020, CY 20	HEDIS 2020, CY 19	SFY 2022
PY 4	SFY 2022	HEDIS MY 2021, CY 21	HEDIS MY 2018 and 2019, CY 18 and 19	SFY 2023
PY5	SFY23	HEDIS MY 2022, CY 22	HEDIS MY 2019 and 2020, CY 19 and 20	SFY 2024
PY6	SFY24	HEDIS MY 2023, CY 23	HEDIS MY 2020 and 2021, CY 20 and 21	SFY 2025
PY7	SFY25	HEDIS MY 2024, CY 24	HEDIS MY 2021 and 2022, CY 21 and 22	SFY 2026
PY8	SFY26	HEDIS MY 2025, CY 25	HEDIS MY 2022 and 2023, CY 22 and 23	SFY 2027

### C. Medicaid AE Common Measure Slate for Comprehensive AEs

In accordance with 42 CFR §438.6(c)(2)(ii)(B)<sup>4</sup>, quality performance measurement must be based on the Medicaid Comprehensive AE Common Measure Slate (see Section F below). The core measures must be reported for all measure that meet the eligible denominator sizes. The Common Measure Slate for comprehensive AEs has been developed with the following considerations:

<sup>4</sup> [https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438\\_16&rgn=div8](https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438_16&rgn=div8).

- Alignment with the RI OHIC core measure set.
- Cross cutting measures across multiple domains with a focus on clinical/chronic care, behavioral health, and social determinants of health.
- Feasibility of data collection and measurement and minimization of administrative burden.
- A minimum number of measures necessary to enable a concentrated effort and meaningful assessment of quality.
- Focus on statewide strategic priorities outlined by EOHHS, RI Department of Health, RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, and the Office of the Health Insurance Commissioner.

#### D. Comprehensive AE Overall Quality Score Determination

As articulated in the Rhode Island Accountable Entity Program Total Cost of Care Quality and Outcome Measures Implementation Manual hereafter referenced as “Implementation Manual”, EOHHS developed a standard quality score methodology to be used by all AEs and MCOs. The required TCOC Overall Quality Score methodology is as follows:

- a. **Target Structure:** The Overall Quality Score recognizes AEs that either attain a high-achievement target or demonstrate a required level of improvement over prior performance. MCOs will assess AE performance on each Common Measure Slate P4P measure for both achievement and improvement. For each Common Measure Slate P4P measure, AEs will be awarded whichever score yields the greatest performance points. The maximum earnable score for each measure will be “1”, and each measure will be weighted equally.
  - a. Achievement targets:
    - i. EOHHS will establish two achievement targets: “threshold” and “high.”
    - ii. Achievement points will be scored on a sliding scale for performance between the threshold and high values.
      1. If performance is below or equal to the threshold-performance target: 0 achievement points
      2. If performance is between the threshold-performance and the high-performance target, achievement points earned (between 0 and 1) will be determined based on the following formula:  $(\text{Performance Score} - \text{Threshold Performance}) / (\text{High-Performance Target} - \text{Threshold Performance})$
      3. If performance is above the high-performance target: 1 achievement point
  - b. Improvement target:
    - i. The improvement target will be measured at the AE/MCO dyad level and will be a fixed number of percentage points, with three percentage points as the default value.
      1. The value may vary from three percentage points if deemed appropriate by EOHHS.
      2. The value may be less than what would be required to demonstrate statistical significance in a given year.

- ii. Improvement as defined by 1.b.i will earn the AE a score of “1.”

## **E. Calculation of the Overall Quality Score and TCOC Quality Benchmarks**

Each MCO will sum the points earned across all measures for which the AE has an adequate denominator size and divide that sum by the number of measures for which there is an adequate denominator size.<sup>5</sup> For example, if an AE has an adequate denominator size for all AE Common Measure Slate measures, then the MCO would sum the scores for each of the nine measures and divide the result by 9.<sup>6</sup> This resulting quotient is the “Overall Quality Score.” The MCO shall multiply the annual savings generated by the AE by the Overall Quality Score to determine the shared savings to be distributed to the AE. See Appendix F: Example Overall Quality Score Calculation for QPY8, in the accompanying, Implementation Manual, for illustration of this calculation and further details.

EOHHS will define the percentage of quality measures from the common measure slate needed to achieve full shared savings. In setting this parameter, EOHHS’ general principle is that AEs should be allowed to achieve the full share of shared savings without having to earn the maximum possible points, i.e., through hitting the high achievement or improvement targets for all ten measures. EOHHS will also define the impact of quality performance on mitigation of shared losses. In setting this parameter, EOHHS’s general principle is that AEs should have any losses mitigated, but not eliminated, based on quality performance.

EOHHS has adopted different approaches to set TCOC quality benchmarks based on the performance year.

**For QPY3**, negotiated AE and MCO QPY2 benchmarks were used to evaluate AE performance and inform the negotiated formula for distribution of shared savings.

**For QPY4**, EOHHS employed a combination of internal and external sources to set achievement targets. EOHHS set targets for Quality Performance Year 4 using Quality Performance Year 2 data, Quality Compass, Office of the Health Insurance Commissioner (OHIC) Patient Centered Medical Home (PCMH) Measure Survey Data in advance of Quality Performance Year 4.

**For QPY5**, EOHHS employed a combination of internal and external sources to set achievement targets. This includes, but is not limited to, (1) AE data from QPY2-QPY4, (2) national and New England Medicaid (HMO) data from NCQA Quality Compass 2020 (CY 2019 or CY 2018 data) and 2021 (CY 2020 data), (3) national and Rhode Island state data from CMS’ 2019 and 2020

---

<sup>5</sup> An adequate denominator size is defined as a minimum denominator of 30. This is consistent with NCQA guidelines per the HEDIS MY 2020 and MY 2021 Volume 2: Technical Update.

<sup>6</sup> Weight Assessment and Counseling for Children and Adolescents is assessed as one measure. The measure is a composite, created by averaging the scores of the three individual measure components 1) BMI percentile, 2) counseling for nutrition, and 3) counseling for physical activity.

Child and Adult Health Care Quality Measures report and (4) Rhode Island practice-reported data for October 1, 2018 – September 30, 2019, October 1, 2019 – September 30, 2020 and October 1, 2020 – September 30, 2021 from the OHIC PCMH Measures Survey.

AE Quality Performance Year 2-4 data will be used to ensure the following guiding principles are met: 1) the high achievement target should be attainable for at least some AEs; 2) the high achievement target should not exceed a value that represents a reasonable understanding of “high performance”; and 3) the high achievement target should not be below the current performance of every single AE.

**For QPY6**, EOHHS employed a combination of internal and external data sources to set achievement targets for QPY6. EOHHS will set targets for QPY6 by January 2023 using (1) AE data, as reported by MCOs, from QPY4 (2021), (2) national and New England Medicaid (HMO) data from NCQA Quality Compass 2022 (CY 2021 data), (3) national and Rhode Island state data from CMS’ 2021 Child and Adult Health Care Quality Measures report and (4) Rhode Island practice-reported data for October 1, 2020 – September 30, 2021 from the OHIC PCMH Measures Survey.

**For QPY7**, EOHHS employed a combination of internal and external data sources to set achievement targets. EOHHS set targets for QPY7 by January 2024 using (1) AE data, as reported by MCOs, from QPY5 (2022), (2) national and New England Medicaid (HMO) data from NCQA Quality Compass 2023 (CY 2022 data) and (3) national and Rhode Island state data from CMS’ 2022 Child and Adult Health Care Quality Measures report.

**For QPY8**, EOHHS employed a combination of internal and external data sources to set achievement targets. EOHHS sets targets for QPY8 by January 2025 using (1) AE data, as reported by MCOs, from QPY6 (2023), (2) AE REL completeness data, as reported by AEs, from QPY5 (2022) and QPY6 (2023), (3) national and New England Medicaid (HMO) data from NCQA Quality Compass 2024 (CY 2023 data) and (4) national and Rhode Island state data from CMS’ 2023 Child and Adult Health Care Quality Measures report.

Should benchmark data be unavailable for a given measure, EOHHS will convene a meeting of AEs, MCOs, and clinicians to review the measure and determine appropriate benchmarks. As MCOs and AEs began transitioning in QPY3 to using electronic clinical data exchange for generation of those Common Measure Slate measures requiring clinical data, EOHHS anticipates that MCOs will use different data collection techniques with different AEs (see “Data Collection and Reporting Responsibilities” in the accompanying Implementation Manual). EOHHS will assess the impact of different data collection techniques on AE performance on Common Measure Slate measure results. Should different data collection techniques appear to have substantive systemic effects on AE performance on some or all of those measures requiring clinical data, EOHHS will modify benchmarks for affected AEs using its best judgement.

**F. Comprehensive AE Common Measure Slate\***

Measures	Steward	Data Source <sup>7</sup>	Specifications	AE Common Measure Slate <sup>8</sup>	
				QPY7 Reporting and Incentive Use	QPY8 Reporting and Incentive Use
<b>HEDIS Measures</b>					
Breast Cancer Screening	NCQA	ECDE <sup>9</sup>	Current HEDIS specifications: QPY7: HEDIS MY 2024 QPY8: HEDIS MY 2025	P4P	P4P
Child and Adolescent Well-Care Visits (Total)	NCQA	Admin		P4P	P4P
Chlamydia Screening in Women (Total)	NCQA	Admin		Reporting-only	P4P
Colorectal Cancer Screening	NCQA	ECDE <sup>10</sup>		Reporting-only	Reporting-only
Controlling High Blood Pressure	NCQA	Admin/ Clinical		P4P	P4P
Eye Exam for Patients with Diabetes	NCQA	Admin/ Clinical		P4P	Reporting-only
Follow-up After Hospitalization for Mental Illness	NCQA	Admin		P4P – 7 days	Reporting-only – 7 days
Glycemic Status Assessment for Patients with Diabetes (<8.0%)	NCQA	Admin/ Clinical		P4P	P4P
Immunizations for Adolescents (Combo 2)	NCQA	Admin/ Clinical		Reporting-only	Reporting-only
Kidney Health Evaluation for Patients with Diabetes	NCQA	Admin/ Clinical			Reporting-only
Lead Screening in Children	NCQA	Admin		P4P	P4P
<b>Non-HEDIS Measures (Externally Developed)</b>					
Developmental Screening in the First Three Years of Life	OHSU	Admin/ Clinical	QPY7-QPY8: CMS Core Set of Children’s Health Care	Reporting-only	Reporting-only

<sup>7</sup> “Admin/Clinical” indicates that the measure requires use of both administrative and clinical data.

<sup>8</sup> Please refer to the May 21, 2021 version of the Implementation Manual for more information on the QPY1 and QPY2 measures. Please refer to the April 20, 2022 version for more information on the QPY3 measures, to the September 12, 2022 version for information on the QPY4 measures, and to the February 2, 2024 version for information on the QPY5 and QPY6 measures.

<sup>9</sup> NCQA transitioned to exclusively using the Electronic Clinical Data Systems (ECDS) reporting standard for this measure beginning in MY23. RI EOHHS has adopted this practice to align with NCQA. For more information, see: <https://www.ncqa.org/blog/transition-to-ecds-reporting-breast-cancer-screening/>

<sup>10</sup> NCQA transitioned to exclusively using the ECDS reporting standard for this measure beginning in MY24. RI EOHHS had adopted this practice to align with NCQA. For more information, see: <https://www.ncqa.org/blog/improving-quality-measurement-for-colorectal-cancer-screening/>

Measures	Steward	Data Source <sup>7</sup>	Specifications	AE Common Measure Slate <sup>8</sup>	
				QPY7 Reporting and Incentive Use	QPY8 Reporting and Incentive Use
			Quality Measures for Medicaid and CHIP <sup>11</sup>		
<i>Screening for Depression and Follow-up Plan</i>	CMS	Admin/ Clinical	QPY7: CMS MIPS 2024, modified by EOHHS (January 25, 2024 version - included in Quality Measure Specifications Manual <sup>12</sup> ) QPY8: CMS MIPS 2025 (see Quality Measure Specifications Manual <sup>13</sup> for guidance on defining “follow-up”)	P4P	P4P
<b>Non-HEDIS Measures (EOHHS-developed)</b>					
<i>Patient Engagement with an AE Primary Care Provider</i>	RI EOHHS	Admin	QPY7-QPY8: EOHHS (February 2, 2023 version – included in Quality Measure Specifications Manual <sup>14</sup> )	Reporting-only	Reporting-only
<i>Social Determinants of Health Screening</i>	RI EOHHS	Admin/ Clinical	QPY7-QPY8: EOHHS (May 18, 2023 version – included in Quality Measure Specifications Manual <sup>15</sup> )	P4P	P4P
<i>Race, Ethnicity, and Language (REL) Data Completeness</i>	RI EOHHS	Clinical	QPY8: EOHHS (November 13, 2024 version – included in Quality Measure Specifications Manual <sup>16</sup> )		P4P
<i>Race, Ethnicity, Language and Disability Status (RELD) Stratification</i>	RI EOHHS	Clinical	QPY8: EOHHS (November 13, 2024 version – included in Quality Measure Specifications Manual <sup>17</sup> )		Reporting-only

\*Measures are subject to change based on the recommendations of OHIC’s Measure Alignment Review Committee

<sup>11</sup> <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set-reporting-resources/index.html>

<sup>12</sup> Refer to the Quality Measure Specifications Manual, which can be found here: <https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents>.

<sup>13</sup> Refer to the Quality Measure Specifications Manual, which can be found here: <https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents>.

<sup>14</sup> Refer to the Quality Measure Specifications Manual, which can be found here: <https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents>.

<sup>15</sup> Refer to the Quality Measure Specifications Manual, which can be found here: <https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents>.

<sup>16</sup> Refer to the Quality Measure Specifications Manual, which can be found here: <https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents>.

<sup>17</sup> Refer to the Quality Measure Specifications Manual, which can be found here: <https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents>.

## Attachment B: TCOC Financial Solvency Filing for Accountable Entities Bearing Financial Risk

### i. Background

During early 2020, EOHHS required Accountable Entities (AEs) that were anticipating downside risk in their *future PY3 contracts* with Medicaid MCOs to submit a pre-qualification application and supporting documentation to Office of the Health Insurance Commissioner (OHIC) by January 15, 2020. (PY3 was the period July 1, 2020 through June 30, 2021.) OHIC reviewed each submission to determine if an AE was “pre-qualified” as having the financial capacity to bear an estimated amount of downside risk across all of its Rhode Island Medicaid MCO contracts for PY3. Because AEs ultimately did not execute PY3 contracts with downside risk, in PY4 EOHHS again required AEs to submit a pre-qualification application in advance of PY4 downside risk contracts. **For PY8, all AEs who were fully qualified to take on downside risk pursuant to the PY7 TCOC Financial Solvency Filing process are considered pre-qualified for downside risk in PY8.**

To ensure that AEs assuming downside risk in their *executed contracts* with Medicaid MCOs are able to cover any financial losses, EOHHS will continue to require that AEs complete the annual TCOC Financial Solvency Filing process to certify AEs for downside risk assumption. This Attachment B lays out the Financial Solvency Filing process for PY8 (July 1, 2025 through June 30, 2026). EOHHS will review and assess the financial impact of downside risk associated across all of an AE’s Medicaid MCO risk contracts.

### ii. PY8 TCOC Financial Solvency Filing, Review, and Assessment

#### a. AEs that Must File for Financial Solvency Review and Assessment

EOHHS will maintain a single review process for all AEs that have entered into arrangements that include shared losses. This review will assess the amount of downside risk the AE assumed in PY8 and whether the AE has an adequate combination of assets and / or other financial mechanisms (e.g., reinsurance, letter of credit) to cover the maximum risk exposure. The PY8 review will also assess an AE’s performance in its PY7 risk contracts, as best understood at the time, to ensure adequate financial protections for a combined PY7 loss (if applicable) and PY8 maximum potential loss.

#### b. Requirements

EOHHS will allow for flexibility in AEs’ approaches to managing their risk exposure as long as the AE can document a thorough strategy for obtaining protection from estimated maximum potential losses. If an AE has a strong balance sheet, its strategy for covering maximum potential losses due to downside risk could include documenting that it has sufficient existing secured liquid assets and reinsurance to cover the maximum potential losses, with evidence that these funds are secured in a controlled or custodial account. Other organizations without available liquid assets to cover the maximum potential losses may need to develop a risk strategy portfolio consisting of several different approaches. Strategies could include, for example, aggregate and individual stop loss insurance, corporate investors, provider partner organization contributions, insurer withholds, delegation of risk to contracted provider organizations, insurer-provided capital, securities in trust, and letters of

credit.<sup>18</sup>

For AEs without the necessary secured liquid assets to cover their estimated maximum potential loss, EOHHS will require provision of copies of any agreements with organizations assuming some or all of the risk on behalf of the AE. Such agreements should, at a minimum, detail the financial arrangement, and the amount of risk being assumed by each organization. EOHHS will require that each AE submit documentation that it has taken adequate steps to cover the risk using a) secured assets in a custodial or controlled account(s), and/or b) a reinsurance policy which can be used to protect the interests of enrolled Medicaid members, and/or c) delegation of risk to one or more parties. Taken together, the value of these strategies should not be less than the potential maximum losses due to all downside risk contracts with Medicaid MCOs.

AEs must also submit a planned process for ongoing monitoring of performance against the downside financial risk arrangements for the AE and any subcontracted entities assuming delegated risk.

### **c. Process for Filing and Review**

For PY8, AEs must submit to EOHHS a completed filing application (see attached template) and documents requested in the application, including the following:

- a. Final executed AE/MCO contract for PY8 (July 1, 2025-June 30, 2026)
- b. AE descriptive information
- c. Final description of the financial risk arrangements (see Table 2 in the PY8 filing application)
- d. Final description of experience managing financial risk to date
- e. Current assessment of financial performance relative to PY7 risk arrangements, recognizing that claim runout and settlement processes will not yet be complete. AEs should report the extent of their financial exposure if a loss is projected<sup>19</sup>
- f. Final financial protection and risk mitigation processes / mechanisms
- g. Final monitoring processes

Following submission of the final terms of the PY8 contract, EOHHS will review the financial risk arrangements, the AE's financial protections, and financial performance monitoring processes. **The completed filing application, including contracts, is due to EOHHS by September 3, 2025.** EOHHS will notify AEs who meet this deadline of their financial solvency certification status or communicate any concerns or additional information requests by **December 1, 2025.**

The process that EOHHS will follow in its review is outlined below in i-vii.

---

<sup>18</sup> The AE should be the beneficiary of a surety bond or letter of credit.

<sup>19</sup> AEs will need demonstrate the capacity to fund PY7 losses and protect against future TCOC financial losses.

- i. EOHHS determines the AE's actual maximum risk exposure for MCO contracts for the Performance Year.
- ii. EOHHS determines whether the AE has sufficient financial resources to protect itself from the estimated maximum potential losses from all Medicaid MCO contracts with downside risk using one or more financial mechanisms (e.g., liquid assets, stop-loss insurance, working capital and reserves, withhold arrangements or other financial mechanisms). This assessment will factor in the AE's financial performance in PY4 downside risk arrangements to ensure adequate financial protections to cover the combined projected PY7 losses (as applicable) **and** maximum potential losses in PY8.
- iii. EOHHS also determines whether those AE subcontracted entities with which the AE is sharing TCOC downside risk have sufficient financial resources to protect themselves from the estimated maximum potential losses from the AE's subcontract using one or more financial mechanisms.
- iv. EOHHS ensures that if the AE has liquid assets as part of its current or planned process to protect itself from the maximum potential losses, that the liquid assets are in a custodial or controlled account, which can be used exclusively to protect the interests of attributed Rhode Island Medicaid patients.
- v. EOHHS reviews the AE's current and/or planned process for ongoing monitoring of performance against downside financial risk arrangements and assurance of financial solvency and ensures that the process is acceptable.
- vi. EOHHS reviews the AE's current and/or planned process for ongoing monitoring of any subcontracted provider entities assuming AE-delegated downside risk and ensures that process is acceptable.
- vii. Communication of status of review: By December 1, 2025, EOHHS notifies the AE of successful certification or communicates any concerns and/or an additional information request related to the AE's final risk terms. AEs can appeal the final decision, in writing to EOHHS, within 30 days of its notification. AEs that choose not to appeal the decision but would like to reapply for financial solvency certification can do so by re-submitting the application and supporting documents addressing the concerns highlighted by EOHHS in the original application.

If at any time during its review EOHHS determines that it requires additional documentation, it will notify the AE in writing specifying the additional documentation needed.

**d. TCOC Financial Solvency Filing Application Materials**

**Medicaid Accountable Entity TCOC Financial Solvency Certification for PY8**

Purpose: AEs should use this application to report the terms of their PY8 TCOC downside risk arrangements as executed in their contracts with Medicaid MCOs.

1. AE Descriptive Information

Rhode Island Medicaid Accountable Entity Organization Information

Name of Applicant: \_\_\_\_\_

The following information is required of the individual (within the Accountable Entity) who is designated to be the AE’s primary contact for the Financial Solvency Filing process:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Position: \_\_\_\_\_

Street or PO Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

2. Provide a list of the names of the Medicaid MCOs with which the applicant executed a contract to assume financial accountability for the full range, or nearly the full range, of an attributed MCO member population’s health care needs. Please include contracts for which the AE has accepted downside risk for any or all of PY8.

For each MCO contract, provide the nature of the reimbursement arrangement and the estimated number of attributed patient lives in PY8.

**AE/MCO Contract Risk Arrangement Terms for PY8<sup>20</sup>**

Name of MCO	Risk Arrangement Terms of Executed Contracts	Aggregate Number of Attributed Patients and Associated Date
	PMPM budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	
	PMPM Budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	
	PMPM budget: Provider Revenue: Risk Exposure Cap: Risk Sharing Rate:	

---

<sup>20</sup> See Glossary of Terms at the back of Attachment B for definitions of the terms used in this table.

3. Provide a statement that describes the applicant’s experience to date in managing population-based contracts that hold the applicant organization financially responsible for a negotiated portion of costs that exceed a predetermined population-based total cost of care (TCOC) budget.
- 
- 
- 

- viii. Report financial performance relative to PY7 risk arrangements across all Medicaid MCO contracts identified in the August 2024 certification application, as best known at the time of this filing.

Indicate if the applicant projects any losses under its PY6 risk arrangements.

Name of Medicaid MCO	Projected Risk Arrangement Loss for PY7 (Y/N)

- ix. Please attach a plan that provides details of the applicant’s processes and mechanism(s) for ensuring sufficient financial resources to protect a) the applicant and b) those provider entities with which it has subcontracted and intends to share downside risk, from the estimated potential maximum losses from downside risk associated with MCO contract(s) and AE subcontracts, respectively. AEs should also provide supporting documentation to demonstrate adequate protection against financial loss.

- Include in this plan evidence of any insurance coverage or other agreements that protect the applicant from maximum potential losses from current downside risk, and a description and evidence of the applicant’s other risk mitigation mechanisms including any aggregate stop-loss insurance, security deposits, working capital and reserves, withhold arrangements, etc.
- Distinguish current liquid assets from other mechanisms, including insurance coverage or other agreements that protect the applicant from potential maximum losses from future downside risk. If the AE is employing liquid assets as part of its plan to protect itself from maximum potential losses, those liquid assets must be in a controlled or custodial account to be used exclusively to protect the interests of attributed Medicaid patients. Applicant should provide evidence that the funds are in a controlled or custodial account. If the applicant intends to utilize a surety bond to protect the applicant from potential maximum losses from future downside risk, the bonding company must be certified by the U.S. Treasury.<sup>21</sup>

---

<sup>21</sup> <https://fiscal.treasury.gov/surety-bonds/list-certified-companies.html>.

- If the applicant is planning a financial arrangement with any partner organization(s) that is assuming any of the applicant's downside risk, the partner(s) must execute a Parental Guarantee<sup>22</sup> document prior to applying for pre-qualification. The partner organization with which the AE is executing a Parental Guarantee should have a custodial or controlled account to cover losses. The AE should furnish documentation of the Parental Guarantee's custodial or controlled account.
  - If the Risk Exposure Cap is greater than or equal to 10%, the AE must present an actuarial analysis that estimates maximum potential loss. The actuarial analysis must be performed by an independent actuary and the results of the analysis be provided in a letter signed by the responsible actuary. This analysis will be used to substantiate the risk mitigation plan proposed by the AE.
- x. Include a description of the applicant's current or planned process for ongoing monitoring of the applicant's financial risk arrangements and financial solvency. This process should include a timely review of the quarterly data reports received from the MCOs.
- xi. Include a description of mechanisms that are or will be put in place by the applicant to monitor the financial solvency of any provider entity(ies) with which it has a contracting affiliation and intends to share downside risk associated with MCO contract(s).

---

<sup>22</sup> A Parental Guarantee is an agreement between an entity that controls a health care provider and the health care provider. It guarantees the performance of the provider's obligations under the financial risk transfer agreement including the payment of any amounts owed by the health care provider to participating providers for services rendered pursuant to a risk transfer agreement.

## Glossary of Terms

**Parental Guarantee** - An agreement between an entity that controls a health care provider and the health care provider. It guarantees the performance of the provider's obligations under the financial risk transfer agreement including the payment of any amounts owed by the health care provider to participating providers for services rendered pursuant to a risk transfer agreement.

**Partner Organization** - An entity that will be assuming some of the AE's downside risk. It may be, but is not limited to, a corporate parent or otherwise related corporate entity, an investor, a business partner, or a delegated provider entity that delivers health care services to the AE's attributed patients. A delegated physician or other professional provider is not a partner organization if the totality of its assumption of AE risk is borne through a payment withhold.

**PMPM (Per Member Per Month) Budget** – A prospectively defined spending target associated with an Accountable Entity's (AE) attributed population, wherein spending is defined on an average monthly per capita basis, or "per member per month." For pre-qualification, PMPM budget can be estimated using the latest available TCOC targets.

**Provider Revenue** – Revenue of AE providers from the insurer under the contract refers to revenue paid by the insurer (MCO) to any Tax Identification Number that the AE identifies as participating in the AE. This is not limited to primary care practices or providers through whom Medicaid members are attributed to the AE, but rather refers to all providers that have signed AE participation agreements for the Program Year in question. The revenue for these providers is all revenue for services rendered to any Medicaid patient covered by the insurer and is not limited to members attributed to the AE. This does not include revenue for services rendered to patients covered by the Medicare-Medicaid Plan or any non-Medicaid product offered by the same insurer.

**Risk Exposure Cap** - This is a cap on the losses the organization may incur under the contract, expressed as a percentage of a) the total cost of care or b) the annual service revenue from the insurer under the contract. It is the maximum percentage of the organization's contract revenue for which the organization is financially at risk.

**Risk Sharing Rate** - Also called the Marginal Risk. This is the percentage of total losses shared by the organization with the insurer under the contract after the application of any Risk Exposure Cap and/or minimum loss rate. It is the percentage of any Shared Loss Pool for which the organization is financially at risk.

**Stop Loss Insurance (aggregate/specific)** - Aggregate stop-loss insurance is a policy designed to limit claim coverage (losses) to a specific amount. This coverage ensures that a catastrophic claim (specific stop-loss) or numerous claims (aggregate stop-loss) do not drain the financial reserves of the organization.

**Total Cost of Care** - A historical baseline or benchmark cost of care specifically tied to an Accountable Entity's (AE) attributed population projected forward to the performance period.

**Withhold Arrangement** - A withhold arrangement is characterized by the insurer withholding the amount of money at risk until the contracting organization furnishes services to the members and meets certain quality and/or cost standards.