EOHHS Total Cost of Care (TCOC) Guidance

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A. TCOC Definition

The total cost of care (TCOC) calculation is a fundamental element in any shared savings and/or risk arrangement. Most fundamentally, it includes a historical baseline or benchmark cost of care specifically tied to an Accountable Entity's (AE) attributed population projected forward to the performance period. Actual costs during the performance period are then compared to those projections to identify a potential shared savings or risk pool, depending on the terms of the arrangement.

Effective TCOC methodologies provide an incentive for AEs to invest in care management and other appropriate services to address the needs of their attributed populations and reduce duplication of services. For populations with long-term care needs, effective TCOC methodologies also provide incentives for AEs to help beneficiaries live successfully in the community and reduce use of institutional services. In doing so, AEs will be able to improve outcomes, lower overall healthcare costs, and be able to earn savings. Shared savings distributions must be based on well-defined quality and outcomes metrics.

B. TCOC Methodology Goals

These TCOC guidelines have been designed to support **Meaningful Performance Measurement**, thereby creating financial incentives to reduce costs and improve quality. In order to accomplish meaningful performance measurement, this methodology must incorporate the following:

- **Provide opportunity for a sustainable business model**
  Create 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; (4) identifying clinical pathways for complex co-occurring chronic conditions that are prevalent among Medicaid high utilizers; (5) addressing social determinants (e.g., housing, food security, access to non-medical transportation) that impact health outcomes and costs; and (6) implementing effective interventions to help elders and adults with disabilities remain in the community.
- **Be fiscally responsible for all participating parties**
  Adequately protect the solvency of the AEs and managed care organizations (MCOs) and the financial interests of the RI Medicaid Program.
- **Specifically recognize and address the challenge of small populations**
  Implement mitigation strategies to minimize the impact of small numbers, given the state's small size and particularly related to LTSS.
- **Incorporate quality metrics related to increased access and improved member outcomes**
  Have reporting mechanisms for MCOs and AEs that allow for timely data exchange and performance improvement to ensure access and quality.
- **Define and establish a progression toward meaningful AE risk**

- **Establish consistent core components of the TCOC methodology while still allowing some innovation and flexibility**
  Balance these competing goals. Allow for some variation in TCOC methodology within uniform state guidelines/criteria, with recognition of the importance of alignment in the methodology for the managed care and fee-for-service populations attributed to Specialized LTSS AEs.

C. General Requirements for Program Participants

1. **Minimum Membership and Population Size**
   For comprehensive AEs, MCOs may utilize TCOC-based payment models only with AEs with which the MCO has at least 5,000 attributed Medicaid members. For specialized LTSS AEs, there must be at least 500 attributed lives in Medicaid managed care and/or Medicaid fee-for-service.

2. **State/MCO Capitation Arrangement**
   The MCO retains the base contract with the State, and the MCO medical capitation will be adjusted for savings/risk associated with the program. There will be no gain-share between the State and the MCO on the Shared Savings/(Loss) Pool (after required adjustments). 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. **Other Approved Alternative Payment Methodologies for LTSS Providers**
   The MCO and Medicaid fee-for-service may implement other approved alternative payment methodologies (APMs) (as described in Section G), in addition to TCOC arrangements, for providers in Specialized LTSS AEs. Participation in those APMs is voluntary for providers.

5. **Attribution**
   AE specific historical base must be based on the AE's attributed lives for a given period, in accordance with EOHHS defined attribution guidance, as defined separately.

D. TCOC Methodology: Required Elements for Comprehensive AEs

MCO TCOC arrangements with comprehensive AEs must meet the following requirements, listed here and described in more detail below:

1. Defining a Historical Base
2. Required Adjustments to the Historical Base
3. TCOC Expenditure Target for the Performance Period
4. Actual Expenditures for the Performance Period
5. Shared Savings/(Loss) Pool Calculations
6. AE Share of Shared Savings/(Loss) Pool
7. Required Progression to Risk Based Arrangements

1. Defining a Historical Base

a. AE-Specific Historical Cost Data

The TCOC historical base shall include three years of AE-specific historical cost data with more recent years weighted more heavily than more distant years. MCOs are strongly encouraged to use three years of historic data in creating the benchmark in order to stabilize the historic base; at a minimum, all existing AE experience must be utilized.

b. Covered Services

TCOC methodologies shall include all costs associated with covered services that are included in EOHHS's contract with MCOs for the performance year, with the following clarifications/exceptions. Any further adjustments to covered services outside of those listed below must be requested in writing and pre-approved by EOHHS prior to MCO-AE contract execution for the affected contractual performance year:

I. Exclude services currently covered under stop-loss provisions between EOHHS and the MCO, as outlined below:

- Long-term care in an intermediate or skilled facility in excess of 30 days.
- Costs associated with the transplant of a bodily organ. Includes costs incurred from the date of admission through the date of discharge associated with the specific hospital stay in which an organ is implanted. The AE TCOC calculation will include all costs up to the transplant of a bodily organ.
- Early Intervention Services in excess of $5,000 for an individual.
- Hepatitis C Pharmacy Costs: Costs in excess of the per member per month level as set forth in the *Provisions for Stop Loss Claiming for Pharmacy Expenditure in Treatment of Enrollees with Hepatitis C*.

II. Exclude HSTP performance incentive payments.

III. Include other infrastructure payments made by MCOs to AEs and AE-affiliated providers, including but not limited to any patient-centered medical home (PCMH), care management, and utilization management payments.

c. Mitigation of Impact of Outliers: Claims threshold for high cost claims

TCOC calculations shall be adjusted for outlier costs by defining a threshold ceiling. However, the historical base must include 10% of any annualized spending per member above the spending threshold shown below. This threshold is based on the 95.5th percentile of Rhode Island Medicaid per member annual claims cost for the AE-eligible population and for AE allowable TCOC Expenditures, as calculated by EOHHS and shown below. This threshold shall be established across all members (not by rate cell). Upon AE request, an alternative threshold of 99.7% may be applied, as shown below.

Percentile	Annualized per member spending threshold
95.5 percentile	$xx TBD
99.7 percentile	$xx TBD

d. Adjusting for a Changing Risk Profile

To account for possible changes in the risk profile of an AE's attributed patient population over the historical base years, the MCO shall employ one of the following two risk adjustment methodologies:

- **Risk Adjustment Software**
  MCOs may apply a clinical risk adjustment software. Under such an approach, risk calculations and any adjustments shall be applied at the total population and not the EOHHS rate cell level. The TCOC methodology must describe the MCO's risk-adjustment method including underlying software parameters set by the MCO. Such information shall also be disclosed to contracting AEs.
- **Rate Cell Calculations**
  MCOs may use the population mix by rate cell, for each period, to adjust for changes in this population mix over time.

Should the MCO wish to further adjust for a changing risk profile using clinical and social risk factor data exogenous to the risk adjustment methodologies described above, it may do so after review and approval by EOHHS.

e. Historical Base with Required Cost Trend Assumptions

When projecting (or trending) historical costs forward into the performance year, TCOC methodologies shall appropriately account for trends in the medical component of capitation rates being paid to MCOs by EOHHS. Unless otherwise approved by EOHHS, trends assigned to TCOC baselines shall not exceed the final cumulative trends to the medical portion of rates contained in the EOHHS data books by cap cell. The trends may be applied by the MCO to the AE in aggregate based on either the AE's or the MCO's member mix.

2. Required Adjustments to the Historical Base

In order to prospectively establish an AE's TCOC Expenditure Target, the MCO must apply the following adjustments to the historical base. Note that no additional adjustments are allowed without prior approval from EOHHS.

a. Adjustment for Prior Year Savings

The TCOC Expenditure Target must include an upward adjustment equal to an AE's share of prior year savings, after adjustment for quality performance, so that AEs have an opportunity to retain a portion of generated savings year over year. This adjustment must not exceed 2% of the unadjusted TCOC Expenditure Target.

b. Adjustment for Historically Low-Cost AEs

Should any AE have three years of historical cost data demonstrating that risk-adjusted per capita spending for the AE's historically attributed patient population for TCOC covered services was significantly below the MCO average (statistically significant at $p <= .05$), the MCO may adjust that AE's TCOC Expenditure Target upward by up to the percentage by which the TCOC fell below MCO average spending for the assessed historical time period. This adjustment must not exceed 2% of the unadjusted TCOC Expenditure Target. This adjustment shall not be applied to entities with a historically attributed patient population for TCOC covered services that was significantly above the MCO average.

Note that reconciliation payments made to FQHCs must be accounted for in the risk-adjusted per capita spending for FQHCs over the assessed historical time period. Reconciliation payments are also to be subsequently included in the TCOC calculations for the performance period.

3. TCOC Expenditure Target for the Performance Period

Once an AE-specific adjusted historical base is established, this base must be trended forward into the performance period to create an AE-specific TCOC Expenditure Target.

TCOC methodologies shall be based on a performance time period of 12 months aligned with the state fiscal year. Initial contractual performance time periods may extend longer than 12 months if necessary.

a. Required Cost Trend Assumptions

The adjusted historical base must be cost trended to the performance year according to the cost trend assumptions described in Section D.1.e of this document.

b. Final Target Adjusted for Changes in the Attributed Population's Risk Profile

The MCO must apply a risk adjustment methodology to assess any changes in an attributed population's risk profile from the risk-adjusted historical base to the contractual performance period. This methodology must be consistent with the risk adjustment methodology used in developing the adjusted historical base as described

in Section D.1.d of this document.

4. Actual Expenditures for the Performance Period

a. Calculate Actual Expenditures Consistent with the Historical Base Methodology

Actual Expenditures for the Performance Period must be calculated consistent with the historical base methodology as described in Sections D.1.b and D.1.c of this document.

5. Shared Savings/(Loss) Pool Calculations

The Shared Savings/(Loss) Pool shall be calculated as the difference between Actual Expenditures (Section D.4) and TCOC Expenditure Target (Section D.3), after the following adjustments:

a. Small Sample Size Adjustment for Random Variation

TCOC methodologies shall account for statistical uncertainty in performance measurement due to the effect of random variation in utilization and spending in small populations. MCOs shall address the impact of random variation of cost savings results through the application of a shared savings adjustment factor, defined by performance year AE attributed population size (calculated as attributed member months divided by 12).

The shared savings adjustment factor adjusts the AE's shared savings/(loss) pool proportionately by the probability of true savings (1 minus the probability of achieving shared savings as a result of chance). The proportion of savings for which an AE is eligible shall be adjusted along a sliding scale by AE size, based on the parameters below.

Shared Savings/Loss Adjustment Factor Parameters

Shared Savings/Loss Adjustment Factor Parameters by AE Size and Savings Rate				Probability of Achieving Shared Savings/Loss as a Result of Chance*			
Savings %	**Small AE** *(5-9,999)*	**Medium AE** *(10-19,999)*	**Large AE** *(20,000+)*	**Savings %**	**5,000 members**	**10,000 members**	**20,000 members**
1%	73%	79%	89%	**1%**	27%	21%	11%
2%	82%	92%	97%	**2%**	18%	8%	3%
3%	91%	97%	99%	**3%**	9%	3%	1%
4%	95%	99%	100%	**4%**	5%	1%	0%
5%	98%	100%	100%	**5%**	2%	0%	0%
6%	99%	100%	100%	**6%**	1%	0%	0%

Source: Weissman J, Bailit MH, D'Andrea G, Rosenthal MB. "The Design And Application Of Shared Savings Programs: Lessons From Early Adopters," *Health Affairs*, September 2012

b. Impact of Quality and Outcomes

The Shared Savings/(Loss) Pool shall be adjusted based on an assessment of

performance relative to a set of quality measures for the attributed population. A detailed quality scoring methodology is under development.

c. Maximum Allowable Shared Savings/(Loss) Pool

In any given performance year, the Shared Savings Pool must not exceed 10% of the TCOC Expenditure Target, as calculated in Section D.3 of this document. In instances where the AE is responsible for downside risk, the Shared Loss Pool must not exceed 5% of the TCOC Expenditure Target.

6. AE Share of Savings/(Loss) Pool

In Year 1, AEs may be eligible to retain up to 40% of the Shared Savings Pool, as defined in Section D.5 above. AEs assuming downside risk may be eligible for up to 60% of the Shared Savings Pool, and may be responsible for up to 60% of the Shared Loss Pool.

AE Shared Savings Model	AE Share of Savings	Maximum Allowable Shared Savings Pool	Maximum Allowable Shared Loss Pool	AE Share of Losses
Option 1: Shared savings only	Up to 40% of Savings Pool	10% of the TCOC Expenditure Target	NA	NA
Option 2: Shared savings + risk	Up to 60% of Savings Pool	10% of the TCOC Expenditure Target	5% of the TCOC Expenditure Target	Up to 60% of Loss Pool

Any MCO/AE downside risk arrangement must be implemented with a minimum withhold, capturing at least 75 percent of the maximum shared loss pool.

7. Required Progression to Risk Based Arrangements

Qualified TCOC-based contractual arrangements (or "Certified AEs") must demonstrate a progression of risk to include meaningful downside shared risk within three years of AE program participation. After five years, development and implementation funding will end, and AEs will be sustained going forward based on their successful performance and associated financial rewards in accordance with their MCO contract(s).

EOHHS has defined "meaningful risk" based on learnings from other states, OHIC requirements and federal MACRA rules. The required progression of increasing risk for all comprehensive AEs is as follows:

	Marginal Risk *AE Share of Losses*	Loss Cap *Maximum Shared Loss Pool*	Total Potential Risk
Definition	*The percentage of any Shared Loss Pool for which the AE is financially at risk.*	*The maximum percentage loss over the TCOC Expenditure Target for which the AE is financially at risk.*	*The maximum potential loss for which the AE is financially at risk.*

Year 1	0	NA	0
Year 2	0	NA	0
Year 3	At least 15% of any Shared Loss Pool	At least 2% No more than 5%	15% x 2% x Adjustment Factor (82% to 97%) = .2% to .3%
Year 4	At least 30% of any Shared Loss Pool	At least 2% No more than 10%	30% x 2% x Adjustment Factor (82% to 97%) = .5% to .6%
Year 5	At least 50% of any Shared Loss Pool	At least 2% No more than 10%	50% x 2% x Adjustment Factor (82% to 97%) = .8% to 1.0%

Should an MCO and AE wish to share risk on a more accelerated schedule than that outlined above, the MCO and AE shall submit written documentation to EOHHS, including:

- the draft contractual financial terms between the parties;
- a statement of why the AE is qualified to assume greater risk than that outlined above, including its infrastructure to manage clinical risk, an established record of meeting quality metrics, and the likelihood that the AE will meet the quality thresholds established by EOHHS and the MCO; and
- documentation of secured funds necessary to meet the maximum financial obligation that the AE could potentially incur under the terms of the proposed agreement.

Following review of the aforementioned information, EOHHS will decide whether the arrangement may proceed.

Additionally, if an AE enters into an arrangement that provides for shared losses with a total potential risk that equals or exceeds 10% of expected expenditures, the AE must meet all of the financial reserve and risk-based capital requirements required of an MCO, with oversight by the Department of Business Regulation.[1] EOHHS anticipates that any AEs taking on such risk must, at a minimum, demonstrate adequate capitalization to cover three months of claims.[2]

In order to monitor AE financial performance, AEs and MCOs will be required to furnish financial reports regarding risk performance on a semi-annual basis to EOHHS.

[1] As specified in the standards for minimum risk-based capital (RBC) requirements for health organizations in Chapter 27-4.7 of the RI general statute. http://webserver.rilin.state.ri.us/Statutes/Title27/27-4.7/INDEX.HTM

[2] Note that CMS has issued guidance for shared savings programs for both Medicaid and for Medicare Shared Savings Programs. For ease of reference links to relevant State Medicaid Director Letters are provided: www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf; www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-002.pdf. Links for the Medicare Shared Savings Program final rule and a CMS Factsheet are also provided: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Methodology_Factsheet_ICN907405.pdf. The Shared Savings Program final rule can be downloaded at www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf on the Government Printing Office (GPO) website

E. TCOC Methodology: Required Elements for Specialized LTSS AEs

TCOC arrangements with specialized LTSS AEs must meet the following requirements, listed here and described in more detail below:

1. Defining a Historical Base
2. Required Adjustments to the Historical Base
3. TCOC Expenditure Target for the Performance Period
4. Actual Expenditures for the Performance Period
5. Shared Savings/(Loss) Pool Calculations
6. AE Share of Shared Savings/(Loss) Pool
7. Required Progression to Risk Based Arrangements

1. Defining a Historical Base

a. AE Specific Historical Cost Data

The TCOC historical base shall include three years of AE-specific historical cost data with more recent years weighted more heavily than more distant years. MCOs are strongly encouraged to use three years of historic data in creating the benchmark in order to stabilize the historic base; at a minimum, all existing AE experience must be utilized. For newly established AEs, the TCOC historical base can be created on a simulated attributed population identified using historical utilization data, as historical authorization data may not be available.

b. Covered Services

TCOC methodologies shall include all Medicaid costs associated with covered services listed in Attachment B that are included in EOHHS's contract with MCOs, as well as equivalent Medicaid fee-for-service covered services for people not enrolled in managed care, for the performance year, with the following clarifications/exceptions. Any further adjustments to covered services outside of those listed below must be requested in writing and pre-approved by EOHHS prior to MCO-AE contract execution for the affected contractual performance year:

I. Exclude services currently covered under stop-loss provisions between EOHHS and the MCO;
II. Exclude services managed by BHDDH for people with intellectual and development disabilities;
III. Exclude long-stay/custodial nursing facility costs in excess of six consecutive months (disregarding any short-term acute hospital or skilled nursing facility stays that interrupt an otherwise continuous long-stay/custodial nursing facility stay);
IV. Exclude HSTP performance incentive payments; and
V. Include other infrastructure payments made by MCOs or EOHHS to AEs and AE-affiliated providers, including but not limited to care management and utilization management payments.

c. Mitigation of Impact of Outliers: Claims threshold for high cost claims

TCOC calculations are adjusted for outlier costs by defining a threshold ceiling. However, the historical base must include 10% of any annualized spending per member above the spending threshold shown below. This threshold is based on the 95.5th percentile of Rhode Island Medicaid per member annual claims cost for the AE-eligible population and for AE allowable TCOC Expenditures, as calculated by EOHHS and shown below. This threshold shall be established across all members. Upon AE request, an alternative threshold of 99.7% may be applied, as shown below.

Percentile	Annualized per member spending threshold
95.5 percentile	$xx TBD
99.7 percentile	$xx TBD

d. Adjusting for a Changing Risk Profile

To account for possible changes in the risk profile of an AE's attributed patient population over the historical base years, a risk adjustment methodology, using a clinical risk adjustment software, shall be applied. Under such an approach, risk calculations and any adjustments shall be applied at the total attributed population and not the EOHHS rate cell level. The TCOC methodology must describe the risk-adjustment method including underlying software parameters set by the MCO/payer. With EOHHS approval, adjustments using clinical and social risk factor data exogenous to the risk adjustment methodologies described above may be used. The MCO/payer may also propose an alternative approach to risk adjustment. The risk adjustment method must be equivalently provided to the MCO-enrolled and Medicaid fee-for-service populations within the AE. Information on risk adjustment methodologies shall be disclosed to contracting AEs.

e. Historical Base with Required Cost Trend Assumptions

When projecting (or trending) historical costs forward into the performance year, TCOC methodologies shall appropriately account for trends in nursing facility and home and community-based LTSS spending. Unless otherwise approved by EOHHS, trends assigned to TCOC baselines shall not exceed the final cumulative trends to the medical portion of Rhody Health Options rates for the nursing facility and the community LTSS capitation cells for Medicaid-only and Medicare-Medicaid populations contained in the EOHHS data books. The trends shall be applied to the AE in aggregate based on the AE's member mix.

2. Required Adjustments to the Historical Base

In order to prospectively establish an AE's TCOC Expenditure Target, the following adjustments to the historical base must be applied. Note that no additional adjustments are allowed without prior approval from EOHHS.

a. **Adjustment for Prior Year Savings**
   The TCOC Expenditure Target must include an upward adjustment equal to an AE's share of prior year savings, after adjustment for quality performance, so that AEs have an opportunity to retain a portion of generated savings year over year. This adjustment must not exceed 2% of the unadjusted TCOC Expenditure Target.
b. **Adjustment for Historically Low-Cost AEs**
   Should any AE have three years of historical cost data demonstrating that risk-adjusted per capita spending for the AE's historically attributed patient population for TCOC covered services (see Attachment B) was significantly below the MCO average (statistically significant at p <= .05), the MCO may adjust that AE's TCOC Expenditure Target upward by up to the percentage by which the TCOC fell below MCO average spending for the assessed historical time period. This adjustment must not exceed 2% of the unadjusted TCOC Expenditure Target. This adjustment shall not be applied to entities with a historically attributed patient population for TCOC covered services that was significantly above the MCO average.

3. **TCOC Expenditure Target for the Performance Period**
   Once an AE-specific, adjusted historical base is established, this base must be trended forward into the performance period to create an AE-specific TCOC Expenditure Target. TCOC methodologies shall be based on a performance time period of 12 months aligned with the state fiscal year. Initial contractual performance time periods may extend longer than 12 months if necessary.
   a. **Required Cost Trend Assumptions**
      The adjusted historical base must be cost trended to the performance year according to the LTSS cost trend assumptions described in Section E.1.e of this document.
   b. **Final Target Adjusted for Changes in the Attributed Population's Risk Profile**
      A risk adjustment methodology must be applied to assess any changes in an attributed population's risk profile from the risk-adjusted historical base to the contractual performance period, provided it can be equally applied to the MCO-enrolled and Medicaid fee-for-service populations within the AE. This methodology must be consistent with the LTSS risk adjustment methodology used in developing the adjusted historical base as described in Section E.1.d of this document.

4. **Actual Expenditures for the Performance Period**
   a. **Calculate Actual Expenditures Consistent with the Historical Base Methodology**
      Actual Expenditures for the Performance Period must be calculated consistent with the LTSS historical base methodology as described in Sections E.1.b and E.1.c of this document.

5. **Shared Savings/(Loss) Pool Calculations**
   The Shared Savings/(Loss) Pool shall be calculated as the difference between Actual Expenditures (Section E.4) and the TCOC Expenditure Target (Section E.3), after the following adjustments:

a. Small Sample Size Adjustment for Random Variation: Minimum Savings (Loss) Rate

Shared savings calculations are intended to provide an incentive for outcomes based on performance. There is a methodological challenge posed in differentiating results based on performance versus random variation. In the calculations for comprehensive AE TCOC projections, an accommodation is made to adjust for the impact of random variation in small populations. Given the smaller sizes in the attributed populations of the specialized LTSS AEs, there is a higher likelihood of volatility in shared savings pool calculations. EOHHS is continuing to review potential approaches to stabilizing the shared savings pool calculations. The method outlined here is preliminary pending further examination and input.

Given the smaller attributed populations expected to be attributed to specialized LTSS AEs, it is necessary to account for statistical uncertainty in performance measurement due to the effect of random variation in utilization and spending. Specialized LTSS AEs will be subject to a 4% Minimum Savings (Loss) Rate. A specialized LTSS AE must achieve shared savings of greater than or equal to 4% of the TCOC Expenditure Target in order to be eligible for shared savings. Where the AE is responsible for downside risk, the AE will share in losses if the shared loss rate is greater than or equal to 4% of TCOC Expenditure Target. During the pilot, EOHHS will assess the effectiveness of the Minimum Savings (Loss) Rate for the specialized LTSS AE program and may make changes to the adjustment or develop an alternative approach to better account for random variation. These approaches may include, but are not limited to, exclusion of low frequency high-cost services and separate calculations for higher cost conditions.

b. Impact of Quality and Outcomes

The Shared Savings/(Loss) Pool shall be adjusted based on an assessment of performance relative to a set of quality measures for the attributed population. A detailed quality scoring methodology is under development.

c. Adjustment for MCO Enrollment[3]

The Shared Savings/(Loss) Pool will be adjusted based on the percentage of member months that the AE's attributed population is enrolled in managed care. With EOHHS approval, an MCO may apply a risk adjustment methodology to account for differences in the risk of the MCO-enrolled and Medicaid fee-for-service populations.

[3] The TCOC methodology includes MCO-enrolled and Medicaid fee-for-service populations to increase the reliability and validity of the TCOC calculations for the specialized LTSS AEs. However, EOHHS does not have federal authority to distribute shared savings payments to AEs for Medicaid beneficiaries who are not enrolled in managed care. As a result, the TCOC methodology adjusts for the proportion of a specialized LTSS AE's attributed population that is enrolled in managed care. In contrast, specialized LTSS AEs will be eligible to earn Infrastructure Incentive Payments based on the AE's performance relative to the AE's TCOC Expenditure Target for its total attributed population, which includes MCO-enrolled and Medicaid fee-for-service beneficiaries. As articulated in the Incentive Program Guidance, 20% of the specialized LTSS AE Specific Incentive Pool shall be set aside to support potential shared savings achieved by an AE relative to the AE's TCOC Expenditure Target, without adjustment for MCO Enrollment.

d. Maximum Allowable Shared Savings/(Loss) Pool

To establish the Shared Savings Pool for specialized LTSS AEs, the TCOC Expenditure Target, as calculated in Section E.3 of this document, will be adjusted based on the percentage of member months that the AE's attributed population is enrolled in managed care. In any given performance year, the Shared Savings Pool must not exceed 10% of the adjusted TCOC Expenditure Target. In instances where the AE is responsible for downside risk, the Shared Loss Pool must not exceed 5% of the adjusted TCOC Expenditure Target.

6. AE Share of Savings (Loss) Pool

In Year 1, AEs may be eligible to retain up to 40% of the Shared Savings Pool, as defined in Section E.5 above. AEs assuming downside risk may be eligible for up to 60% of the Shared Savings Pool, and may be responsible for up to 60% of the Shared Loss Pool. However, no Specialized LTSS AEs will be eligible to assume downside risk in the first year of the AE program. EOHHS will issue additional guidance in the future on downside risk arrangements for specialized LTSS AEs.

Specialized LTSS AE Shared Savings Model	AE Share of Savings	Maximum Allowable Shared Savings Pool	Maximum Allowable Shared Loss Pool	AE Share of Losses
Shared savings only	Up to 40% of Savings Pool	10% of the TCOC Expenditure Target adjusted for MCO enrollment	NA	NA

7. Required Progression to Risk Based Arrangements

It is anticipated that, over time, shared savings and incentive opportunities will be in relation to shared risk. AEs will be expected to move into downside risk arrangements within four to five years of the launch of the specialized LTSS AE program. After five years, development and implementation funding will end, and AEs will be sustained going forward based on their successful performance and associated financial rewards in accordance with their MCO contract(s).

EOHHS has defined "meaningful risk" based on learnings from other states, OHIC requirements, and federal MACRA rules. The required progression of increasing risk for all specialized LTSS AEs is as follows:

	Marginal Risk *AE Share of Losses*	Loss Cap *Maximum Shared Loss Pool*	Total Potential Risk
Definition	*The percentage of any Shared Loss Pool for which the AE is financially at risk.*	*The maximum percentage loss over the TCOC Expenditure Target for which the AE is financially at risk.*	*The maximum potential loss for which the AE is financially at risk.*
Year 1	0	NA	0
Year 2	0	NA	0
Year 3	0	NA	0

Year 4	At least 15% of any Shared Loss Pool	At least 2% No more than 5%	15% x 2% = .3%
Year 5	At least 30% of any Shared Loss Pool	At least 2% No more than 10%	30% x 2% = .6%

Should an MCO and AE wish to share risk on a more accelerated schedule than that outlined above, the MCO and AE shall submit written documentation to EOHHS, including:

- the draft contractual financial terms between the parties;
- a statement of why the AE is qualified to assume greater risk than that outlined above, including its infrastructure to manage clinical risk, an established record of meeting quality metrics, and the likelihood that the AE will meet the quality thresholds established by EOHHS and the MCO;
- documentation of secured funds necessary to meet the maximum financial obligation that the AE could potentially incur under the terms of the proposed agreement.

Following review of the aforementioned information, EOHHS will decide whether the arrangement may proceed.

Additionally, if an AE enters into an arrangement that provides for shared losses with a total potential risk that equals or exceeds 10% of expected expenditures, the AE must meet all of the financial reserve and risk-based capital requirements required of an MCO, with oversight by the Department of Business Regulation.[4] EOHHS anticipates that any AEs taking on such risk must, at a minimum, demonstrate adequate capitalization to cover three months of claims.[5]

In order to monitor AE financial performance, AEs and MCOs will be required to furnish financial reports regarding risk performance on a semi-annual basis to EOHHS.

F. TCOC Development and Approval Process

Medicaid MCOs and AEs will establish TCOC calculation methodologies that serve as the basis for their shared savings and/or risk arrangements. These methodologies must be approved by EOHHS. EOHHS will review the MCO's TCOC methodologies and reserves the right to ask

[4] As specified in the standards for minimum risk-based capital (RBC) requirements for health organizations in Chapter 27-4.7 of the RI general statute. http://webserver.rilin.state.ri.us/Statutes/Title27/27-4.7/INDEX.HTM

[5] Note that CMS has issued guidance for shared savings programs for both Medicaid and for Medicare Shared Savings Programs. For ease of reference links to relevant State Medicaid Director Letters are provided: www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf; www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-002.pdf. Links for the Medicare Shared Savings Program final rule and a CMS Factsheet are also provided: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Methodology_Factsheet_ICN907405.pdf. The Shared Savings Program final rule can be downloaded at www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf on the Government Printing Office (GPO) website

for modifications before granting approval.[6] EOHHS also reserves the right to review these methodologies on an annual basis. EOHHS' approval, denial, or requests for amendment will also be transmitted in writing, without unreasonable delay. Further, for specialized LTSS AEs, the TCOC calculation methodologies will be equivalently applied to the MCO-enrolled and Medicaid fee-for-service populations within the AE.

MCOs must submit details of their TCOC methodologies to EOHHS for approval in writing, in advance of contracting with AEs. Applications must document and demonstrate specific compliance with the requirements outlined in Sections C, D, and E of this guidance. Simple numerical examples may be helpful. Applications must also include comprehensive answers to the questions below:

1. **Benchmark Time Period**
   What is the time period for the historical data used to establish an AE's cost benchmark? How does the methodology account for attributed patients for whom no historical data is available?
2. **Benchmark Data Source**
   What data sources are used to establish an AE's cost benchmark?
3. **Mid-Year Changes**
   How does the TCOC calculation account for month-to-month changes in MCO enrollment and/or PCP assignment/specialized LTSS AE attribution, whether during benchmark years or the performance year? How does the TCOC calculation account for month-to-month changes in the PCP/LTSS provider roster of an AE, whether during benchmark years or the performance year?
4. **Shared Savings/Loss Distribution Rate and Calculation**
   What portion of the eligible shared savings pool (after accounting for scaling based on quality and outcomes metrics) will be distributed to the AE?
5. **Shared Savings/Loss Distribution Timing**
   At what time are shared savings distributions made to qualifying AEs? If distributions are made more frequently than annually, please also describe any true-up processes.
6. **Alignment between MCO and FFS populations**
   Can the TCOC methodology be applied equally to MCO and Medicaid fee-for-service populations within a single specialized LTSS AE?

Where appropriate, MCOs should respond separately to the questions for comprehensive and specialized LTSS AEs. MCOs must also submit to EOHHS a completed attached template (Attachment A) for each AE within 15 days, at the latest, of concluding any AE contract. If any entity is certified and contracted as both a comprehensive AE and a specialized LTSS AE,

[6] In addition to this EOHHS requirement, note that depending on circumstances transparency in such arrangements is specifically required in CFR42 §438.6 Contract requirements 438.6(g): Inspection and audit of financial records – Risk contracts must provide that the state agency and the Department may inspect and audit any financial records of the entity or its subcontractors. 438.6(h) Physician Incentive plans – MCO contracts must provide for compliance with the requirements set forth in 422.208 and 422.210 of this chapter. 436.6(k) All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

separate comprehensive AE and specialized LTSS AE templates must be completed for the entity.

Material amendments to TCOC methodology must be approved by EOHHS in advance. If an MCO utilizes a TCOC methodology that differs in any respect from the approved methodology, EOHHS reserves the right to calculate risk- and gain-share with the MCO as if the approved methodology had been utilized, and the MCO shall provide EOHHS with all information necessary to make that calculation.

G. Other APMs for Specialized LTSS AEs

Currently, most Medicaid nursing facility and home and community-based LTSS in Rhode Island are reimbursed using encounter-based and other fee-for-service payment models that do not reward quality, efficiency, or value. EOHHS seeks to move away from fee-for-service payment models toward alternative payment models (APMs) that incentivize providers to be more accountable for Medicaid patients' care and outcomes. EOHHS intends to pilot test APMs, including bundled payments, per member per month (PMPM) payments, episodic payments, and other value-based payment (VBP) models, on a voluntary basis with Partner and Affiliate Providers in specialized LTSS AEs. EOHHS anticipates requesting expenditure authority under Section 1115(a)(2) of the Social Security Act to implement APMs for nursing facility and home and community-based LTSS. Additional guidance on the APMs and on the APM pilot opportunities will be provided separately.

H. Comprehensive AE TCOC Methodology Example

OHHS Comprehensive AE Total Cost of Care (TCOC) Guidance		AE Specific Variables
Comprehensive AE TCOC Calculation Tool		Calculation Variables

*Note: all data is illustrative only

		SFY 2014	SFY 2015	SFY 2016			SFY 2018	
	AE Specific Historical Data Input: Membership and Cost	Year 1	Year 2	Year 3	Historical Base		Performance Year	
INPUT ->	Attributed Lives (Members)	5,000	5,000	5,250	5,150		5,250	
INPUT ->	PMPM	$345.00	$347.00	$320.00	$330.29		$350.00	1

		1 Calculating the Historical Base and Initial TCOC Target	Year 1	Year 2	Year 3	Historical Base $	Historical Base pmpm	Performance Year Target $	Performance Year Target pmpm	
	A	Total Cost of Care (Unadjusted)	$20,700,000	$20,820,000	$20,160,000	**$20,412,000**	**$330.29**			
	B	Base Year Weight	10%	30%	60%					2
	C	Trend Factor		2%	2%					3
	D	Trend Adjustment	$836,280	$416,400	$0	$208,548	$3.37			
Details below	E	Risk Adjustment	$871,579	$429,278	$0	$215,941	$3.49			
	F	Total Cost of Care (Adjusted)	$22,407,859	$21,665,678	$20,160,000	**$20,836,489**	**$337.16**			
Details below	G	Prior Year Savings Adjustment			$176,400	$176,400	$2.85			
Details below	H	Historical Performance Adjustment			$408,240	$408,240	$6.61	Projected Trend	Time Period (Yrs)	
	I	Total Cost of Care (Adjusted, with Sustainability Adjustments)				**$21,421,129**	**$346.62**	2%	2	
	J	**Total Cost of Care (Initial Target)**						**$22,286,543**	**$360.62**	4
								TCOC Initial PY Target		

		2 Calculating the Final TCOC Target		
Details below	A	Risk Adjustment	$458,976	$7.29
	B	*Final Target based on risk-adjusted PMPM with performance year membership — *Impact of change in membership*	$432,748	$0.00
		Total Cost of Care (Final Target)	**$23,178,267**	**$367.91**
			TCOC Final PY Target	

		3 Calculating and Distributing the Shared Savings (Loss) Pool	Performance Year $	Performance Year pmpm
	A	**Total Cost of Care (Actual Expenditures)**	**$22,050,000**	**$350.00**
			TCOC Actual	
	B	**Shared Savings (Loss) Pool**	**$1,128,267**	**$17.91**
Details below	C	Random Variation Adjustment	-$22,565	-$0.36
Details below	D	Quality and Outcomes Adjustment	$0	$0.00
	E	**Shared Savings (Loss) Pool (Adjusted)**	**$1,105,702**	**$17.55**
	F	Eligible Shared Savings Pool	$1,105,702	$17.55
	G	Eligible Shared Loss Pool	NO	NO
Cap: 10% Target	H	Maximum Allowable Shared Savings Pool	$2,317,827	$36.79
Cap: 5% Target	I	Maximum Allowable Shared Loss Pool	-$1,158,913	-$18.40
	J	**Final Shared Savings Pool**	**$1,105,702**	**$17.55**
	K	**Final Shared Loss Pool**	**NO**	**NO**

	L	**AE Share of Shared Savings (Loss) Pool**								
	M	**Option 1 AEs: Shared Savings Only**	***AE Share***	**20%**		**30%**		**40%**		
				$	pmpm	**$**	pmpm	**$**	pmpm	
		Shared Savings		**$221,140**	**$3.51**	**$331,711**	**$5.27**	**$442,281**	**$7.02**	

	N	**Option 2 AEs: Shared Savings and Risk**	***AE Share***	**40%**		**50%**		**60%**		
				$	pmpm	**$**	pmpm	**$**	pmpm	
		Shared Savings		**$442,281**	**$7.02**	**$552,851**	**$8.78**	**$663,421**	**$10.53**	
		Shared Loss		**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	

Adjustment Details

1 Historical Base and Initial TCOC Target Adjustments

		Year 1	Year 2	Year 3	Historical Base	
Risk Adj	E Average Risk Score	0.95	0.97	0.99	0.98	<- INPUT
	TCOC (Dollars): Years 1 and 2 Risk-Adjusted to Year 3 Risk Mix	$359.53	$354.15	$320.00	$334.20	
	Risk Adjustment	$14.53	$7.15	$0.00	$3.60	

Adjustment for Prior Year Savings	G Prior Year Savings: Target - Actual TCOC (pmpm)		$7.00	<- INPUT	
	Eligible Adjustment: AE Share		$2.80	40%	AE Share
	Eligible Adjustment: Total Dollars		$176,400		
	Maxium Adjustment for Prior Year Savings (2%)		$408,240		*2%* ***Max Allowable***
	Eligible Adjustment or Max Allowable		$176,400		

Historical Performance Adjustment	H MCO Average Cost (pmpm)	$334.00	<- INPUT	
	MCO Average Risk Score	1.00		
	AE Average Risk Score	0.99		
	AE Cost (pmpm)	$320.00		
	AE Cost with FQHC PPS Adjustment (pmpm)	$320.00	$0.00	FQHC PPS Adjustment (pmpm), if applicable
	AE Average Risk Normalized Cost (pmpm)	$323.23		
	Cost Score (% above/below MCO Average)	-4%		
	Eligible Adjustment	$13.84		
	Eligible Adjustment: Total Dollars	$855,593		
	Max Allowable Adjustment	$408,240		*2%* ***Max Allowable***
	Eligible Adjustment or Max Allowable	$408,240		

2 Final TCOC Target Adjustments

		PY	
Risk Adj	A Average Risk Score	1.01	<- INPUT
	Risk Adjustment	$7.29	

3 Shared Savings (Loss) Pool Adjustments

Small Sample Size Random Variation Adjustment

C **Shared Savings (Loss) Adjustment Factor Parameters by AE Size and Savings Rat**

Savings %	Small AE	Medium AE	Large AE
	(5-9,999)	*(10-19,999)*	*(20,000+)*
1%	73%	79%	89%
2%	82%	92%	97%
3%	91%	97%	99%
4%	95%	99%	100%
5%	98%	100%	100%
6%	99%	100%	100%

Parameter Lookup

Savings %	4.87%	5.00%	**5.00%**	**Savings Rate Bracket Lookup**
Small AE	98%			
Medium AE	100%			
Large AE	100%			
Random Variation Adjustment	**98%**		**Small AE**	**AE Size Classification**

Quality Adj	D Quality Score Multiplier	1.00	<- INPUT
	Detailed Quality Measure Scoring Methodology to come		

1 TCOC inputs must account for covered service exclusions and claims cap truncation
2 Base Year Weights are flexible, example uses MSSP methodology
3 Placeholder trend, to populate OHHS data book trends, Year 2 trend = Year 2/Year 1
4 Change compounding formula based on time period between Base Year 3 and Performance Year (assumes 2 year period)

I. Specialized LTSS AE TCOC Methodology Example

OHHS Specialized AE Total Cost of Care (TCOC) Guidance — AE Specific Variables
Specialized AE TCOC Calculation Tool — Calculation Variables

***Note: All data is illustrative only**

	AE Specific Historical Data Input: Membership and Cost	SFY 2014 Year 1	SFY 2015 Year 2	SFY 2016 Year 3	Historical Base	SFY 2018 Performance Year	
INPUT ->	Attributed Lives (Members)	1,000	1,000	1,000	1,000	1,000	
INPUT ->	PMPM	$1,125.00	$1,200.00	$1,275.00	$1,237.50	$1,225.00	1

1 Calculating the Historical Base and Initial TCOC Target

		Year 1	Year 2	Year 3	Historical Base $	Historical Base pmpm	Performance Year Target $	Performance Year Target pmpm	
A	Total Cost of Care (Unadjusted)	$13,500,000	$14,400,000	$15,300,000	**$14,850,000**	**$1,237.50**			
B	Base Year Weight	10%	30%	60%					2
C	Trend Factor		2%	2%					3
D	Trend Adjustment	$545,400	$288,000	$0	$140,940	$11.75			
Details below	E Risk Adjustment	$0	$0	$0	$0	$0.00			
	F Total Cost of Care (Adjusted)	$14,045,400	$14,688,000	$15,300,000	**$14,990,940**	**$1,249.25**			
Details below	G Prior Year Savings Adjustment			$0	$0	$0.00			
Details below	H Historical Performance Adjustment			$0	$0	$0.00	Projected Trend	me Period (Yrs)	
	I Total Cost of Care (Adjusted, with Sustainability Adjustments)				**$14,990,940**	**$1,249.25**	2%	2	
	J **Total Cost of Care (Initial Target)**						**$15,596,574**	**$1,299.71**	4
							TCOC Initial PY Target		

2 Calculating the Final TCOC Target

Details below	A Risk Adjustment	$0	$0.00
	B *Final Target based on risk-adjusted PMPM with performance year membership — *Impact of change in membership*	$0	$0.00
	Total Cost of Care (Final Target)	**$15,596,574**	**$1,299.71**
		TCOC Final PY Target	

3 Calculating and Distributing the Shared Savings (Loss) Pool

		Performance Year $	Performance Year pmpm	
A	**Total Cost of Care (Actual Expenditures)**	**$14,700,000**	**$1,225.00**	
		TCOC Actual		
B	**Shared Savings (Loss) Pool**	**$896,574**	**$74.71**	
C	**Shared Savings Pool**	**$896,574**	**$74.71**	
D	**Shared Loss Pool**	**NO**	**NO**	
Details below	E **Shared Savings Pool After MSR**	**$896,574**	**$74.71**	
	F **Shared Loss Pool After MLR**	**NO**	**NO**	
	G Quality and Outcomes Adjustment: Quality Score Multiplier	1.00		<- INPUT
	H **Shared Savings Pool (Adjusted)**	**$896,574**	**$74.71**	
	I **Shared Loss Pool (Adjusted)**	**NO**	**NO**	
	J Adjustment for MCO Enrollment (% MCO Member Months)	50%		<- INPUT
	K **Eligible MCO-Adjusted Shared Savings Pool**	**$448,287**	**$37.36**	
	L **Eligible MCO-Adjusted Shared Loss Pool**	**NO**	**NO**	
Cap: 10% MCO- Adj. Target	M Maximum Allowable MCO Shared Savings Pool	$779,829	$64.99	
Cap: 5% MCO-Adj. Target	N Maximum Allowable MCO Shared Loss Pool	-$389,914	-$32.49	
	O **Final MCO Shared Savings Pool**	**$448,287**	**$37.36**	
	P **Final MCO Shared Loss Pool**	**NO**	**NO**	

Q	**AE Share of Final Shared Savings (Loss) Pool**								
R	**Option 1 AEs: Shared Savings Only**	***AE Share***	**20%**		**30%**		**40%**		
			$	pmpm	**$**	pmpm	**$**	pmpm	
	Shared Savings		**$89,657**	**$7.47**	**$134,486**	**$11.21**	**$179,315**	**$14.94**	

Adjustment Details

1 Historical Base and Initial TCOC Target Adjustments

			Year 1	Year 2	Year 3	Historical Base	
Risk Adj	E	Average Risk Score	1.0	1.0	1.0	1.00	<- INPUT
		TCOC (Dollars): Years 1 and 2 Risk-Adjusted to Year 3 Risk Mix	$1,125.00	$1,200.00	$1,275.00	$1,237.50	
		Risk Adjustment	$0.00	$0.00	$0.00	$0.00	
Adjustment for Prior Year Savings	G	Prior Year Savings: Target - Actual TCOC (pmpm)			$0.00	<- INPUT	
		Eligible Adjustment: AE Share			$0	40%	AE Share
		Eligible Adjustment: Total Dollars			$0		
		Maxium Adjustment for Prior Year Savings (2%)			$297,000	*2%*	***Max Allowable***
		Eligible Adjustment or Max Allowable			$0		
Historical Performance Adjustment	H	MCO Average Cost (pmpm)			$1,100.00	<- INPUT	
		MCO Average Risk Score			1.0		
		AE Average Risk Score			1.0		
		AE Cost (pmpm)			$1,275.00		
		AE Average Risk Normalized Cost (pmpm)			$1,275.00		
		Cost Score (% above/below MCO Average)			16%		
		Eligible Adjustment			-$196.88		
		Eligible Adjustment: Total Dollars			-$2,362,500		
		Max Allowable Adjustment			$297,000	*2%*	***Max Allowable***
		Eligible Adjustment or Max Allowable			$0		

2 Final TCOC Target Adjustments

			PY	
Risk Adj	A	Average Risk Score	1.00	<- INPUT
		Risk Adjustment	$0.00	

3 Shared Savings (Loss) Pool Adjustments

MSR/ MLR	E/F	**Application of Minimum Shared Savings (Loss) Rate**		
		Minimum Savings (Loss) Rate	4.0%	Targeted Expenditures
		Minimum Savings	$623,863	$51.99
		Minimum Loss	-$623,863	-$51.99

1 TCOC inputs must account for covered service exclusions and claims cap truncation
2 Base Year Weights are flexible, example uses MSSP methodology
3 Placeholder trend, to populate OHHS data book trends, Year 2 trend = Year 2/Year 1
4 Change compounding formula based on time period between Base Year 3 and Performance Year (assumes 2 year period)

Adjustment Details

1 Historical Base and Initial TCOC Target Adjustments

			Year 1	Year 2	Year 3	Historical Base	
Risk Adj	E	Average Risk Score	1.0	1.0	1.0	1.00	<- INPUT
		TCOC (Dollars): Years 1 and 2 Risk-Adjusted to Year 3 Risk Mix	$1,125.00	$1,200.00	$1,275.00	$1,237.50	
		Risk Adjustment	$0.00	$0.00	$0.00	$0.00	
Adjustment for Prior Year Savings	G	Prior Year Savings: Target - Actual TCOC (pmpm)			$0.00	<- INPUT	
		Eligible Adjustment: AE Share			$0	40%	AE Share
		Eligible Adjustment: Total Dollars			$0		
		Maxium Adjustment for Prior Year Savings (2%)			$297,000	*2%*	***Max Allowable***
		Eligible Adjustment or Max Allowable			$0		
Historical Performance Adjustment	H	MCO Average Cost (pmpm)			$1,100.00	<- INPUT	
		MCO Average Risk Score			1.0		
		AE Average Risk Score			1.0		
		AE Cost (pmpm)			$1,275.00		
		AE Average Risk Normalized Cost (pmpm)			$1,275.00		
		Cost Score (% above/below MCO Average)			16%		
		Eligible Adjustment			-$196.88		
		Eligible Adjustment: Total Dollars			-$2,362,500		
		Max Allowable Adjustment			$297,000	*2%*	***Max Allowable***
		Eligible Adjustment or Max Allowable			$0		

2 Final TCOC Target Adjustments

			PY	
Risk Adj	A	Average Risk Score	1.00	<- INPUT
		Risk Adjustment	$0.00	

3 Shared Savings (Loss) Pool Adjustments

MSR/ MLR	E/F	**Application of Minimum Shared Savings (Loss) Rate**		
		Minimum Savings (Loss) Rate	4.0%	Targeted Expenditures
		Minimum Savings	$623,863	$51.99
		Minimum Loss	-$623,863	-$51.99

1 TCOC inputs must account for covered service exclusions and claims cap truncation
2 Base Year Weights are flexible, example uses MSSP methodology
3 Placeholder trend, to populate OHHS data book trends, Year 2 trend = Year 2/Year 1
4 Change compounding formula based on time period between Base Year 3 and Performance Year (assumes 2 year period)

Attachment A: AE Specific TCOC Expenditure Target Calculation: Reporting Template

OHHS Total Cost of Care (TCOC) Guidance

Attachment A: AE Specific TCOC Target Calculation: Reporting Template

AE Name:

Note: All cells highlighted in yellow must be populated with actual data; the remaining cells will calculate automatically off of data inputs

Time Period (e.g. SFY 16)					
AE Specific Historical Data Input: Membership and Cost	**Year 1**	**Year 2**	**Year 3**	**Historical Base**	**Performance Year**
Attributed Lives (Members)				0	
PMPM				#DIV/0!	

1 Calculating the Historical Base and Initial TCOC Target

		Year 1	Year 2	Year 3	Historical Base $	Historical Base pmpm	Performance Year Target $	Performance Year Target pmpm
A	Total Cost of Care (Unadjusted)	$0	$0	$0	**$0**	**#DIV/0!**		
B	Base Year Weight							
C	Trend Factor							
D	Trend Adjustment	$0	$0	$0	$0	#DIV/0!		
E	Risk Adjustment	#DIV/0!	#DIV/0!	$0	#DIV/0!	#DIV/0!		
F	Total Cost of Care (Adjusted)	#DIV/0!	#DIV/0!	$0	**#DIV/0!**	**#DIV/0!**		
G	Prior Year Savings Adjustment			$0	$0	#DIV/0!		
H	Historical Performance Adjustment			$0	$0	#DIV/0!		
I	**Total Cost of Care (Initial Target)**				**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
							TCOC Initial PY Target	

Time period between Historic Base Year 3 and Performance Year

years

1 Historical Base and Initial TCOC Target Adjustments

			Year 1	Year 2	Year 3		
E	Risk Adj	Average Risk Score					
		Risk Adjustment	#DIV/0!	#DIV/0!			
G	Adjustment for Prior Year Savings	Prior Year Savings (Target - Actual TCOC)					
		Eligible Adjustment: AE Share			$0		AE Share
		Maxium Adjustment for Prior Year Savings (2%)			$0	2%	**Max Allowable**
		Eligible Adjustment or Max Allowable			$0		
H	Historical Performance Adjustment	MCO Average Cost (pmpm)					
		MCO Average Risk Score					
		AE Average Risk Score					
		AE Cost (pmpm)			$0.00		
		AE Cost with FQHC PPS Adjustment (pmpm)			$0.00		FQHC PPS Adjustment (pmpm), if applicable
		AE Average Risk Normalized Cost (pmpm)			#DIV/0!		
		Cost Score (% above/below MCO Average)			#DIV/0!		
		Eligible Adjustment			#DIV/0!		
		Eligible Adjustment: Total Dollars			#DIV/0!		
		Max Allowable Adjustment			$0	2%	**Max Allowable**
		Eligible Adjustment or Max Allowable			#DIV/0!		

Attachment B: Services Included in Specialized LTSS AE TCOC Analyses

Homemaker
Environmental Modifications
Special Medical Equipment
Minor Environmental Modifications
Meals on Wheels
Personal Emergency Response (PERS)
LPN Services (Skilled Nursing)
Home Health Services (skilled)
Skilled Therapies (PT, OT, Speech)
Community Transition Services
Residential Supports
Day Supports
Supported Employment
Supported Living Arrangements/Shared Living
Private Duty Nursing
Adult Companion
Assisted Living
Personal Care Assistance/Certified Nursing Assistant (CNA)/Attendant Care Services
Respite
Habilitative Services
Adult Day Services
Long Stay Nursing Facility
Hospice
Skilled Nursing Facility (SNF)