MaineCare Accountable Communities Notice of Interest or Intent

Respondents must read the MaineCare Accountable Communities Request for Applications (RFA) posted online at http://www.maine.gov/dhhs/oms/vbp/accountable.html prior to filling out htis Notice of Interest and/or Intent.

The Department encourages entities interested in or intending to apply to form an Accountable Community to submit a non-binding Notice of Interest and/or Intent at https://www.surveymonkey.com/s/MaineCareACInterest.

Notices of Interest/ Intent will be accepted until November 15. Providers should indicate their interest and/or intent to apply by filling out the following survey.

With permission, the Department will post information for providers in order to facilitate provider identification of other regional providers with an interest and/or intent to form or join an Accountable Community.

Respondents may also submit a Notice of Intent or Interest for the Department's informational purposes only and choose not to share the information publicly.

Contact Information & Intent to Apply

1. Indicate your Organization's contact information for this Notice of Intent or Interest

Name:

Organization:

Address:

Address 2:

City/Town:

ZIP:

Email Address:

Phone Number:

2. In what region(s) of Maine are you located?

- [ ] Northern
- [ ] Downeast
- [ ] Central
- [ ] Western
- [ ] Southern

Other (please specify)

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***3. Do you intend to apply to form an Accountable Community?**

- ◯ Yes
- ◯ We are interested, but not yet sure if we will apply
- ◯ No

Intent to Participate

***4. Would you like to participate in an Accountable Community?**

- ◯ Yes
- ◯ We are interested, but not yet sure if we will participate
- ◯ No

Factors Impacting Your Decision Whether to Apply

5. What will impact your decision whether or not to apply or participate?

- ☐ Ability to identify other provider organizations with which to partner and/or collaborate
- ☐ Ability to reach minimum number of attributed members
- ☐ Concerns regarding infrastructure for care coordination, quality improvement
- ☐ Need for a better understanding of the shared savings and/or risk model
- ☐ Unsure of ability to impact costs
- ☐ Other (Specify)

Other (please specify)

Seeking Other Provider Organizations

***6. Are you looking for other provider organizations with which to contract and/ or collaborate?**

- ◯ Yes, we have some provider organizations but require some more
- ◯ Yes, we do not yet have any other provider organizations with which to partner
- ◯ Not yet decided
- ◯ No, we do not need any other provider organizations

Provider Organizations Sought

7. With what kind of provider organizations are you looking to partner under your Accountable Community?

- [ ] Health Home Practices
- [ ] Other Primary Care Practice(s)
- [ ] Community Care Team(s)
- [ ] Targeted Case Management Provider(s)
- [ ] Community Integration Provider(s)
- [ ] Home and Community Based Waiver case management provider(s)
- [ ] Behavioral Health Homes
- [ ] Other Behavioral Health Organization
- [ ] Hospital(s)
- [ ] Public Health entity/ies
- [ ] Health System
- [ ] Long Term Services & Support provider
- [ ] Medical Specialist Provider
- [ ] Unsure
- [ ] Other (specify)

Other (please specify)

8. In what region(s) are you looking for provider organization(s)?

- [ ] Northern
- [ ] Downeast
- [ ] Central
- [ ] Western
- [ ] Southern

Other (please specify)

Description of Respondent's Provider Type and/ or Services Delivered

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***9. Select the best description of your organization**

- ◯ Behavioral Health Organization
- ◯ Community Care Team (under Health Homes)
- ◯ Health System
- ◯ Hospital
- ◯ Long Term Services & Support Provider
- ◯ Medical Specialist Provider
- ◯ Primary Care Practice Site(s)
- ◯ Public Health Entity
- ◯ Targeted Case Management Provider (non Behavioral Health)
- ◯ Other (specify below)

Other (please specify)

Primary Care Practice Site Information

10. Primary Care Practice Site Information: Select a response for each of your Primary Care Practice sites regarding practice type, specialty, MaineCare PCCM and Health Homes status, and interest in Behavioral Health Homes.

	Practice Type	PC Specialty Type	PCCM Status	Health Homes Status	Interested in Behavioral Health Homes
PC Practice Site 1					
PC Practice Site 2					
PC Practice Site 3					
PC Practice Site 4					
PC Practice Site 5					
PC Practice Site 6					
PC Practice Site 7					
PC Practice Site 8					
PC Practice Site 9					
PC Practice Site 10					

Behavioral Health Organization Provider Information

11. As a Behavioral Health Organization, indicate any of the following services you deliver that would help an Accountable Community to meet its requirement to leverage care coordination resources:

- ☐ N/A We are not a Behavioral Health Organization
- ☐ Community Integration
- ☐ Targeted Case Management for children with Behavioral Health
- ☐ Targeted Case Management for adults with Substance Abuse Disorders
- ☐ Interested in becoming a Behavioral Health Home
- ☐ We do not provide any of these services

Comment:

Targeted Case Management (TCM) (Non Behavioral Health) Provider Information

12. Indicate the kinds of (non behavioral health) Targeted Case Management (TCM) you provide:

- ☐ N/A We do not provide TCM
- ☐ TCM for children with developmental disabilities
- ☐ TCM for children with chronic health conditions
- ☐ TCM for adults with developmental disabilities
- ☐ TCM for adults with HIV
- ☐ TCM for homeless adults

Long Term Services and Supports (LTSS) Provider Information

13. As a Long Term Services and Supports (LTSS) provider, indicate whether you provide Home and Community Based case management under one of the following Home and Community Based waivers:

- ☐ N/A We are not an LTSS provider
- ☐ We do not provide waiver case management
- ☐ Elderly and Adults with Disabilities
- ☐ Members with Intellectual Disabilities or Autistic Disorder
- ☐ Physically Disabled
- ☐ Adults with Other Related Conditions

Permission to Share Information

***14. Indicate which types of information you will allow the Department to publicly share:**

- ☐ Contact information
- ☐ Region(s) of location for Accountable Community
- ☐ Intent to apply/ Potential interest in applying
- ☐ Any kinds of provider organizations being sought
- ☐ Region(s) where seeking provider organizations
- ☐ Your provider type and/ or services delivered
- ☐ Other (Specify Below)
- ☐ None: Please do not publicly share ANY of my information; it is for the Department's use only

Other (please specify)