MaineCare

Accountable Communities Initiative

October 15, 2013

https://www.maine.gov/dhhs/oms/vbp
Accountable Communities Agenda

• Timeline: Looking Back and Forward
• Request for Application Key Dates
• High Level Overview of Accountable Communities Structure
• Accountable Communities Proposed Model Overview & Discussion
  • Leadership & Management
  • Coordination of the Full Continuum of Care
  • Payment Models
• Total Cost of Care Savings Assessment Methodology
• Quality Framework
• Data Feedback to Providers
• Request for Applications Process
Accountable Communities & Value-Based Purchasing Timeline to Date

- **Aug 2011**: VBP Strategy announced
- **Nov 2011**: Request for Information (RFI)
- **Spring 2012**: Value-Based Purchasing Forums reviewing proposed models for Health Homes and Accountable Communities
- **July 2012**: CMS releases guidance regarding policy considerations for Integrated Care Models (ICM), which include shared savings ACO models
- **September 2012**: State Innovation Model (SIM) application submitted
- **January 2013**: Health Homes implemented for members with chronic conditions (Stage A)

Throughout this time, MaineCare has refined its model through active engagement with:

- The Center for Health Care Strategies’ national Medicaid ACO Learning Collaborative
- Its contracted actuarial team
- The DHHS Design Management Committee
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep 2013</td>
<td>• Public Forums</td>
</tr>
<tr>
<td>Oct 2013</td>
<td>• Release of Request for Applications (RFA)</td>
</tr>
<tr>
<td>Dec 2013</td>
<td>• Eligible Accountable Communities Notified</td>
</tr>
<tr>
<td>Winter 2014</td>
<td>• Contract Negotiations</td>
</tr>
<tr>
<td>Spring 2014</td>
<td>• Implementation</td>
</tr>
</tbody>
</table>
## Request for Applications (RFA) Key Dates

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>RFA posted</td>
<td>October 9, 2013</td>
</tr>
<tr>
<td>Written Questions Due</td>
<td>October 23, 2013</td>
</tr>
<tr>
<td>Summary of Questions and Answers</td>
<td>November 6, 2013</td>
</tr>
<tr>
<td>Optional individual Q&amp;A sessions with potential applicants</td>
<td>October 28 – November 8, 2013</td>
</tr>
<tr>
<td>Optional Notice of Intent/ Interest</td>
<td>November 15, 2013</td>
</tr>
<tr>
<td>Applications Due</td>
<td>December 9, 2013</td>
</tr>
<tr>
<td>Notice of Intent to Contract issued by State</td>
<td>December 20, 2013</td>
</tr>
<tr>
<td>Begin contract plenary sessions and negotiations</td>
<td>January 6, 2013</td>
</tr>
<tr>
<td>Performance Year begins</td>
<td>May 1, 2014</td>
</tr>
</tbody>
</table>
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Accountable Communities: What is an Accountable Care Organization (ACO)?

The definition of an ACO depends on who you ask...

The Department is adopting the simple definition that an ACO is:

An entity or group of entities responsible for a population’s health and health costs that:

• Is provider-owned and driven
• Has a structure with a strong consumer component and community collaboration to address the entire continuum of care
• Includes shared accountability for both cost and quality
Strategy to Achieve the Triple Aim

Accountable Communities will achieve the triple aim of better care for individuals, better population health, and lower cost through four overarching strategies:

- Shared savings based on quality performance
- Practice-level transformation
- Coordination across the continuum of care
- Community-led innovation
MaineCare Accountable Communities

• Open to any willing and qualified providers statewide
  – Qualified providers will be determined through a Request for Application (RFA) process
  – Accountable Communities will not be limited by geographical area
• Members retain choice of providers
• Alignment with aspects of other emerging ACOs in the state wherever feasible and appropriate
Accountable Communities: Shared Savings Model

- Total Cost of Care (TCOC)
- Benchmark TCOC
- Actual TCOC

- Calculated per Member per Month

Based on risk-adjusted actuarial analysis of projected costs.

- Savings accrued to state
- Savings accrued to AC

Historical | Base Year | Performance Year

$ Calculated per Member per Month Total Cost of Care (TCOC)
Who Can be an Accountable Community?

• One or multiple provider organizations represented by a Lead Entity
• Providers must be MaineCare providers
• Include providers that directly deliver primary care services
• Have partnerships to leverage DHHS care coordination resources that support members with:
  – Chronic conditions, including developmental disabilities
  – Long Term Services and Support needs
  – Behavioral Health needs
• Demonstrate collaboration with the larger community to address:
  – Transitions of care
  – Population health
  – Psycho-social barriers
What does an Accountable Community look like?
### What could an Accountable Community look like?

<table>
<thead>
<tr>
<th>Federally Qualified Health Center</th>
<th>Pediatrics Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Access Hospital</td>
<td>School Health Center</td>
</tr>
<tr>
<td>Home &amp; Community Based Waiver Services Provider</td>
<td>Dentist Practice</td>
</tr>
<tr>
<td>2 Health Home practices</td>
<td>Single Health System</td>
</tr>
<tr>
<td>Behavioral Health Home</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>4 Primary Care Practices</td>
</tr>
<tr>
<td>3 Hospital-owned Primary Care Practices</td>
<td>3 Behavioral Health Organizations</td>
</tr>
<tr>
<td>2 Nursing Facilities</td>
<td></td>
</tr>
</tbody>
</table>
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Lead Entity Requirements

Legal Entity will contract with the Department

• Receive and distribute any payments
• Hold contractual agreements with other providers sharing in savings/ loss under the AC
• Ensure the delivery of Primary Care Case Management (PCCM) services (1905(t)(1) of the Social Security Act
  – Primary Care Providers that “Locate, coordinate and monitor” health care services
  – 24 hour availability of information, referral and treatment in emergencies
Governance

- Structure, roles, processes
- Transparent (access and communications)
- Includes MaineCare members
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Ensure coordination of primary, acute, and behavioral health care, as well as long-term services and supports

**Direct Delivery of Primary Care**

- Physicians, nurse practitioners, certified nurse midwives, or physician assistants who:
  - Have a primary specialty designation of internal medicine, general practice, family practice, pediatrics, geriatric medicine, obstetrics or gynecology; and/or
  - Practice in a rural health center, federally qualified health center, an Indian Health Services center, or School Health Center.
Coordination of the Full Continuum of Care

Leverage DHHS Care Coordination Resources: Contractual agreement or other partnership with at least one provider under each category:

• Chronic Conditions, including Developmental Disabilities
  – Health Homes (Stage A), Targeted Case Management (TCM)

• Long Term Services & Supports
  – Home and Community Based Waiver (HCBS) case management

• Behavioral Health
  – Behavioral Health Homes (Stage B), TCM, Community Integration
Coordination of the Full Continuum of Care

Leverage DHHS Care Coordination Resources:

• **Health Homes (Stage A):** Accountable Communities that include a Health Home primary care site must extend an invitation to the partnering Community Care Team

• **Behavioral Health Homes (Stage B):** Accountable Communities that include a Behavioral Health Home (Stage B) primary care site must extend an invitation to the partnering Behavioral Health Home Organization
Community Partnerships: Accountable Communities must develop contractual or informal partnerships with

- All hospitals in the proposed service area
- Public Health Entities

And are encouraged to engage with other community-based organizations.
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## Shared Savings/ Loss Models

<table>
<thead>
<tr>
<th></th>
<th>Model I</th>
<th>Model II</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimum Attributed Members</strong></td>
<td>1000</td>
<td>2000</td>
</tr>
<tr>
<td><strong>Minimum Savings/Loss Rate</strong></td>
<td>+/- 2% (savings back to first $1)</td>
<td>+/- 2% (savings back to first $1)</td>
</tr>
<tr>
<td><strong>Shared Savings Rate</strong></td>
<td>50% max depending on quality</td>
<td>60% max depending on quality</td>
</tr>
<tr>
<td><strong>Performance Payment</strong></td>
<td>Performance payments capped at 10% of TCOC</td>
<td>Performance payments capped at 15% of TCOC</td>
</tr>
<tr>
<td><strong>Shared Loss Rate</strong></td>
<td>No downside risk</td>
<td>Shared loss payment percentage will vary based on quality performance, ranging from 40-60%</td>
</tr>
</tbody>
</table>
| **Loss Recoupment Limit** |                               | • Yr 1: No downside risk  
• Yr 2: Risk capped at 5% TCOC  
• Yr 3: Risk capped at 10% TCOC |
**Model I & II Shared Savings Example For Accountable Community ABC**

Benchmark TCOC for Yr 1: $500  
Actual TCOC for Yr 1: $390  
Risk Corridor: $500 * 0.98 = $490  

Savings: Savings exceed the 2% risk corridor, so there will be shared savings.  
Eligible savings to share: $500 - $390 = $110  

*Assuming a 100% score on its quality metrics*, the shared savings are:

<table>
<thead>
<tr>
<th></th>
<th>Model I</th>
<th>Model II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared Savings Rate</td>
<td>$110 * 50% = $55 PMPM</td>
<td>$110 * 60% = $66 PMPM</td>
</tr>
<tr>
<td>Performance Payment Cap</td>
<td>$500 * 10% = $50 PMPM</td>
<td>$500 * 15% = $75 PMPM</td>
</tr>
<tr>
<td>Savings Received</td>
<td>$50 PMPM</td>
<td>$66 PMPM</td>
</tr>
</tbody>
</table>
Model II Shared Loss Example For Accountable Community XYZ, Years 2 & 3

Benchmark TCOC: $500
Actual TCOC: $570
Risk Corridor: $500 * 1.02 = $510

Loss: Loss exceeded the 2% risk corridor, so there will be shared losses.
Eligible loss for which liable: $570 - $500 = $70

Assuming a 100% score on its quality metrics, the shared loss is:

<table>
<thead>
<tr>
<th></th>
<th>Model II (Year 2)</th>
<th>Model II (Year 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared Loss Rate (1-shared savings rate)</td>
<td>$70 * (1-60%) = $28 PMPM</td>
<td>$70 * (1-60%) = $28 PMPM</td>
</tr>
<tr>
<td>Loss Recoupment Limit</td>
<td>$500 * 5% = $25 PMPM</td>
<td>$500 * 10% = $50 PMPM</td>
</tr>
<tr>
<td>Loss for which liable</td>
<td>$25 PMPM</td>
<td>$28 PMPM</td>
</tr>
</tbody>
</table>
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**“Core” Services for Inclusion in TCOC**

Accountable Communities must be accountable for the cost of all “core” services. AC’s need not directly provide all services.

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Audiology</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Podiatry</td>
</tr>
<tr>
<td>Physician/ PA/ NP/ CNM</td>
<td>Optometry</td>
</tr>
<tr>
<td>FQHC, RHC, Indian Health Services, School Health Centers</td>
<td>Occupational, Physical and Speech Therapy Chiropractic Services</td>
</tr>
<tr>
<td>Primary Care Case Management (PCCM), Health Homes</td>
<td>Behavioral Health Services</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Rehabilitative &amp; Community Support Svcs</td>
</tr>
<tr>
<td>Hospice</td>
<td>Inpatient Psychiatric</td>
</tr>
<tr>
<td>Home Health</td>
<td>Outpatient Psychiatric</td>
</tr>
<tr>
<td>Lab &amp; Imaging</td>
<td>Behavioral Health Homes</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Targeted Case Management</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Early Intervention</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Family Planning</td>
</tr>
</tbody>
</table>
## Services Optional for Inclusion in TCOC

### Optional Service Costs

In addition to the core services, AC’s may choose to include the cost of the following services in their TCOC:

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
</tr>
<tr>
<td>Children’s Private Non-Medical Institution (PNMI)</td>
</tr>
<tr>
<td>Long Term Services &amp; Supports</td>
</tr>
<tr>
<td>Home and Community Based waiver services</td>
</tr>
<tr>
<td>Nursing Facilities</td>
</tr>
<tr>
<td>Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/ MR)</td>
</tr>
<tr>
<td>Assisted Living Services</td>
</tr>
<tr>
<td>Adult Family Care</td>
</tr>
<tr>
<td>Adult Private Duty Nursing</td>
</tr>
<tr>
<td>Children's Private Duty Nursing</td>
</tr>
<tr>
<td>Personal Care Assistance (PCA)</td>
</tr>
<tr>
<td>Day Health Services</td>
</tr>
</tbody>
</table>

Services, not Members, may be excluded
## Excluded Services

The following services are excluded from the TCOC calculation:

<table>
<thead>
<tr>
<th>Service</th>
<th>Reason for Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Non-Medical Institutions (non-children’s only)</td>
<td>Restructuring service</td>
</tr>
<tr>
<td>Non-Emergency Transportation</td>
<td>Separate, capitated system</td>
</tr>
<tr>
<td>Other Related Conditions Home and Community Based Waiver</td>
<td>New service (no cost basis)</td>
</tr>
</tbody>
</table>

Services, not Members, may be excluded
Attribution Methodology

1. Members with 6 mo continuous eligibility or 9 mo non-continuous eligibility

2. Members enrolled in a Health Home practice that is part of an Accountable Community

3. Members not captured in 2 who have a plurality of primary care visits with a primary care provider that is part of an AC
   - Evaluation and Management, preventive, and wellness services, Federally Qualified Health Centers, Rural Health Centers

4. Members not captured in 2 or 3 who have 3 or more ED visits with a hospital that is part of an AC.
In order to calculate the projected benchmark TCOC, the baseline TCOC amount is adjusted for:

- Policy changes
- Trend
- Risk

Dollars will be removed above threshold claim caps for members based on AC size.

<table>
<thead>
<tr>
<th>Accountable Community Size (Attributed Members)</th>
<th>Annual Enrollee TCOC Claims Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small = 1,000-2,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Medium = 2,000–5,000</td>
<td>$200,000</td>
</tr>
<tr>
<td>Large = 5,000+</td>
<td>$500,000</td>
</tr>
</tbody>
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Quality Framework in Progress

Criteria for Selection of Metrics:

- Metrics measure success of the Triple Aim
- Maximize alignment of metrics with currently reported metrics in the State and nationally (MSSP, Health Homes, PTE, IHOC, etc) to the extent feasible and appropriate
- Address populations and needs prevalent in Medicaid
  - Children
  - Behavioral health
  - Long Term Services & Supports
  - Chronic conditions
- Address performance area meaningful for Maine’s population, healthcare processes and structure
- Measure set reflects a mix of process and outcomes measurement, and short and long term impacts
- Minimize reporting burden to providers, to extent feasible
  - Keep number of metrics to a reasonable number
  - Preference for claims-based measures
- Measure performance (vs reporting only) beginning in first performance year
- Incorporate measures that safeguard against “creaming, skimping and dumping” of patients (ie, focusing on lower cost patients at the expense of higher need patients)
- Metrics are clinically meaningful
- Measures highlight differences between providers
Quality Domains

• Patient Experience
• Care Coordination/ Patient Safety
• Preventive Health
• At Risk Populations
# Draft Quality Measures to Date (In Progress)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Alignment</th>
<th>Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Experience of Care</strong></td>
<td>Maine Quality Forum Initiative</td>
<td>Provider Reporting only in first year, all-payer</td>
</tr>
<tr>
<td>• Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Care Coordination/ Patient Safety</strong></td>
<td>• Health Homes</td>
<td>• Claims</td>
</tr>
<tr>
<td>• Ambulatory Care Sensitive Conditions Admissions</td>
<td>• Comparable to Medicare Shared Savings Program</td>
<td>• State collection and reporting (EHR measure)</td>
</tr>
<tr>
<td>• All Condition Readmissions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Non-Emergent ED Use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Imaging for low back pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Follow-up After Hospitalization for Mental Illness</td>
<td></td>
<td></td>
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<tr>
<td>• Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
<td></td>
<td></td>
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<tr>
<td>• LDL testing in patients with atypical antipsychotics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Use of High-Risk Medications in the Elderly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Percent of PCPs qualify for EHR Program Incentive Payment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure</td>
<td>Alignment</td>
<td>Reporting</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>Preventive Health (Adults Only)</td>
<td>• HealthInfoNet</td>
<td>• Reporting only yr 1</td>
</tr>
<tr>
<td>• Influenza immunizations (adults)</td>
<td>• Comparable to Medicare Shared Savings Program</td>
<td>• Claims</td>
</tr>
<tr>
<td>• Mammography Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Health (Children Only)</td>
<td>• Maine Improving Health Outcomes for Children (IHOC)</td>
<td>Claims</td>
</tr>
<tr>
<td>• Developmental Screening 0-3</td>
<td>• Maine Health Homes Measures</td>
<td></td>
</tr>
<tr>
<td>• Well Child Visits ages 3-6, 7-11, 12-20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At-Risk Populations</td>
<td>• Health Homes</td>
<td>Claims</td>
</tr>
<tr>
<td>• Diabetes HEDIS measures (HbA1c, Eye Care, LDL, Nephropathy)</td>
<td>• Comparable to Medicare Shared Savings Program</td>
<td></td>
</tr>
<tr>
<td>• Asthma Medication Management</td>
<td></td>
<td></td>
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<tr>
<td>• Spirometry Testing for COPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Children’s out of home placement rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To Be Determined</td>
<td></td>
<td>Claims</td>
</tr>
<tr>
<td>• Maternal Health</td>
<td></td>
<td></td>
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<tr>
<td>• Long Term Services &amp; Supports</td>
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</table>
The Department is discussing whether/how to align with the Medicare Shared Savings Program method of scoring performance and determining total allowable shared savings:

- The proportion of measures scored for performance, vs reporting, increases each year.
- Equal weighting across domains.
- Setting a minimum attainment level (Medicare = 30th percentile) below which Accountable Communities would not receive shared savings/may be placed on a corrective action plan.
- Selecting a benchmark for Maine Accountable Communities (state, national, relative performance or performance against fixed benchmarks).
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Data Feedback to Providers

Reports to Accountable Community providers will include the following:

- Utilization report for high risk members (monthly)
- Attributed member roster (quarterly)
- Actual TCOC compared to benchmark (quarterly)
- Claims-based quality performance measures for attributed population (quarterly)

Under the State Innovations Model (SIM) grant, the State will also be providing real-time notifications of Members’ Emergency Department visits, Inpatient Admissions, and missed labs to Accountable Community Care Managers.
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Application Process

• RFA is posted on DHHS VBP Accountable Communities webpage:  
  http://www.maine.gov/dhhs/oms/vbp/accountable.html
• Application will be completed on SurveyMonkey
• Application will be open for 2 months
• Applications must identify by due date:
  – Lead entity
  – Primary Care providers (used for attribution)
• Applicants have until contract finalization to identify partnerships to meet Continuum of Care requirements
• Eligible applicants will be notified within two weeks of application due date of the Department’s desire to enter into contract negotiations
Facilitation of Provider Identification to form Accountable Communities

With consent, the Department will post:

- Respondent contact information
- Respondent’s Region(s) of location
- Respondent’s Intent to apply/ Potential interest in applying
- Any kinds of provider organization(s) being sought by respondent
- Region(s) where respondent is seeking provider organization(s)
- Respondent’s provider type and/ or services delivered

Notice of Interest/ Intent Survey Link:
https://www.surveymonkey.com/s/MaineCareACInterest
Thank you!

michelle.probert@maine.gov

https://www.maine.gov\dhhs\oms\vbp