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MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of MaineCare Services

Request for Applications (RFA)

MaineCare Accountable Communities Initiative

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Deadline for Written Questions: October 23, 2013, 5:00 p.m. local time

Deadline for Notice of Interest/ Intent: November 15, 2013, 5:00 p.m. local time

Completed Applications Due: December 9, 2013, no later than 5:00 p.m. local time

I. Table of Contents

II. Definition of Terms

The following terms appearing throughout this Request for Applications (RFA) and Attachments have the following meanings, unless the context clearly indicates otherwise.

Accountable Community (AC): Provider(s) under a Lead Entity that contracts with the Department to share in a percentage of any savings achieved for an assigned member population, commensurate with performance on specified quality metrics. Providers also have the option to agree to share in any downside risk in years two and three of the initiative in exchange for sharing in a greater percentage of any shared savings.

Accountable Community (AC) Provider: an individual or group of providers under a sub contractual agreement with a Lead Entity contracting with the Department as an AC.

Actual Total Cost of Care (TCOC): The average MaineCare expenditures on Core and any selected Optional Services during the Performance Year.

Applicant: A Lead Entity that submits an application to participate in the Accountable Communities Initiative pursuant to this RFA.

Attribution: The operational process by which the Department determines whether a member has chosen to receive a sufficient level of the requisite primary care services from an AC provider so that the AC may be appropriately designated as exercising basic responsibility for that member's care.

Base Period: The most recent 12 months of claims data available from which the Benchmark TCOC is calculated.

Behavioral Health Services: Health care services related to mental illness, emotional disorders and substance use, and the application of behavioral principles to address lifestyle and health risk issues.

Benchmark TCOC: Projected average MaineCare expenditures on Core Services and any Optional Services the AC selects as further described in Section VIII.B.1.

Care Coordination: A set of services focused on tracking and assisting patients as they move across care settings and coordinating services with other service providers, including Primary Care, Behavioral Health Services, long-term care providers, specialty care, inpatient care, social services, and natural community supports.

Core Service Costs: The cost of all services listed in Section VIII.B.1(a) that are included in the Total Cost of Care for all Accountable Communities.

Department of Health and Human Services ("The Department"): The single state agency responsible for the administration of the Medicaid program, pursuant to Title XIX and XXI of the Social Security Act and other applicable laws and waivers.

Downside Risk: The financial risk taken on by an AC in Model II, for which the AC Lead Entity is required to pay the Department a portion of any Shared Losses.

Excluded Service Costs: The costs of any services listed in Section VIII.B.1(c) that are excluded from the Total Cost of Care.

Fee-for-Service: A payment mechanism in which all reimbursable health care activity is described and categorized into discrete and separate units of service and each health care provider is separately reimbursed for each discrete service rendered to a patient.

Lead Entity: The legal entity that enters into a contract with the Department on behalf of the AC and is responsible for receipt and distribution of any shared savings or loss payment, the provision of primary care case management (PCCM) services, and the fulfillment of requirements of MaineCare rule with respect to Accountable Communities.

Learning Collaborative: A shared learning, educational process which may include attending in-person learning sessions, sharing best practices, participating in conference calls and webinars, monitoring progress on achieving stated aims, and implementing quality improvement cycles designed to develop changed and improved delivery of care.

MaineCare: The medical assistance or benefit programs administered by DHHS to provide and pay for medical services to eligible Members pursuant to Title XIX of the Social Security Act, Title XXI of the Social Security Act, M.G.L. c. 118E, and other applicable laws and waivers.

Member: A person determined by DHHS to be eligible for MaineCare.

Optional Service Costs: The cost of any services listed in Section VIII.B.1(b) that the AC may choose to include in its Total Cost of Care.

Performance Year: the 12-month period beginning on the implementation date/ effective contract date of each year during the agreement period, unless otherwise noted in the AC's contract with the Department.

Practice Site: A physical location with an individual address from which an Applicant or AC provides Primary Care Services.

Primary Care Case Management (PCCM): A system of managed care used by state Medicaid agencies in which a primary care provider is responsible for approving and monitoring the care of enrolled Medicaid members in accordance with 1905(t)(1) of the Social Security Act.

Primary Care Provider: Physicians, nurse practitioners, certified nurse midwifes, 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.

Primary Care Services: Evaluation and Management, preventive, and wellness services identified through procedure codes, as well as services provided by Federally Qualified Health Centers and Rural Health Centers identified through Revenue Codes.

Quality Measures: A set of metrics defined by the Department to assess the quality and care furnished to attributed members.

Request for Applications (RFA): This Request for Applications for the Accountable Communities initiative and its Attachments.

Shared Losses: The portion of the difference between Benchmark TCOC and Actual TCOC that is to be paid by the Department to the AC Lead Entity under Model II.

Shared Savings: The portion of the difference between Benchmark TCOC and Actual TCOC that is to be paid by the Department to the AC Lead Entity.

Total Cost of Care (TCOC): The total per member per month cost of care for with Core Service Costs any Optional Service Costs elected by the AC.

III. Overview

The goal of Maine's Accountable Communities initiative is to improve the quality and value of the care provided to MaineCare members and, through its contribution to payment and delivery system reform, the citizens of Maine as a whole. Through Accountable Communities, MaineCare will engage in shared savings arrangements with provider organizations that, as a group, coordinate and/or deliver care to a specified patient population. Accountable Communities that demonstrate cost savings share in savings generated under the model proportionate to their performance on quality of care metrics. This initiative will be offered statewide as a Medicaid State Plan option.

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: Accountable Communities will benefit from a Value-Based Purchasing strategy that supports more integrated and coordinated systems of care.

- Practice-level transformation: Accountable Communities will align with, and build on, the principles of Maine's multi-payer Patient-Centered Medical Home (PCMH) Pilot and MaineCare Health Homes Initiatives.

- Coordination across the continuum of care: Accountable Communities will ensure the coordination of primary, acute, and behavioral health care, as well as long-term services and supports. This includes leveraging the Department's existing investment in care coordination for members with chronic conditions, behavioral health needs, and long term services and supports needs.

- Community-led innovation: local health care needs, resources, and solutions will drive Maine's Accountable Communities. While each Accountable Community (AC) will meet baseline criteria, report on core quality measures and be responsible for the cost of a set of

core services, Accountable Communities will also be encouraged and afforded flexibility to structure services and solutions that fit locally-identified priorities and context.

A. Maine State Innovation Model (SIM)

The Accountable Communities Initiative is an important component of Maine's State Innovation Model (SIM) grant under the Center for Medicare and Medicaid Innovation (CMMI). Under SIM, Maine is building on the foundation of its multi-payer PCMH Pilot and MaineCare Health Homes Initiative to form multi-payer Accountable Care Organizations that commit to a set of core measures for public reporting and payment reform efforts. As a payer, MaineCare is committed to maximizing appropriate alignment of its quality framework and payment reform structure under Accountable Communities to other payer efforts in the state, including Medicare's Shared Savings Program (MSSP) and Pioneer ACOs, as well as other state efforts in the commercial sectors. Accountable Communities will benefit from SIM through participation in the multi-payer Accountable Care Implementation (ACI) learning collaborative workgroup; the receipt of regular attribution, utilization and quality reports; and the SIM goals of multi-payer alignment on core quality measures and value-based payment.

B. Stakeholder Engagement

The Maine Department of Health & Human Services (the Department) released a Request for Information (RFI) in November 2011 and held three initial regional forums in the spring of 2012. In addition, the Department engaged with a designated Member Standing Committee (MSC) regarding its Value-Based Purchasing Strategy from October 2011 through August 2012, and has accommodated all requests for presentations and conversations regarding its Value-Based Purchasing Strategy to the maximum extent possible. The Department received 28 responses to its RFI and incorporated this information together with feedback from the Spring 2012 forums, MSC and other meetings to inform the development of the Accountable Communities initiative. The Department's Design Management Committee (DMC), comprised of representatives from all Offices within the Department, has met monthly over the past year to refine the model based on guidance issued by CMS and received through Maine's participation in the Center for Health Care Strategies' Medicaid Accountable Care Organization Learning Collaborative. In September 2013, the Department held a second round of three regional forums in anticipation of the release of this RFA.

C. Additional Information

- The Department's Value-Based Purchasing Strategy website, including RFI response summary, Fall 2013 regional forum presentations, and pages on the Accountable Communities, Health Homes, and Behavioral Health Homes Initiatives: www.maine.gov/dhhs/oms/vbp

- Additional information on Maine Quality Counts multi-payer PCMH Pilot and MaineCare Health Homes Initiative: http://www.mainequalitycounts.org/page/896-659/patient-centered-medical-home

- Maine SIM model: www.maine.gov/sim
- Information on the Triple Aim from the Institute for Healthcare Improvement: http://www.ihi.org/explore/tripleaim/pages/default.aspx

IV. Purpose of Request

The Department is seeking applications from providers able to demonstrate their ability and intent to meet the qualifications laid forth in Section VI of this RFA to enter into contract agreements with the Department to form Accountable Communities, whereby a group of providers represented by a Lead Entity ensure the coordination of care for an assigned patient population and are eligible to share in achieved savings commensurate with their performance on defined quality outcomes.

V. Objective of this RFA

The objective of this RFA is to contract with all qualified providers to perform the tasks and services set forth in this RFA. The Department anticipates that any contract awarded under this RFA will have a start date of May 1, 2014. Applications must be submitted by 5:00 p.m. on December 9, 2013. This RFA does not obligate the Department or any provider to enter into a contract.

VI. Accountable Community Requirements

Provider participation requirements reflect Center for Medicare and Medicaid Services (CMS) Integrated Care Model (ICM) requirements, and align to the extent feasible and appropriate with the MSSP ACO. These requirements will be further refined in contract.

A. Common or Diverse Ownership

The AC may be comprised of one or multiple provider organizations, whether or not these organizations are part of one common system or ownership.

B. MaineCare Provider Status

All providers included in the AC must be enrolled MaineCare providers prior to contract finalization with the Department. For information and assistance with the enrollment process, providers may contact a Provider Representative at 1-866-690-5585 and/or access the enrollment guide at https://mainecare.maine.gov/ProviderHomePage.aspx.

C. Leadership & Management

1. Leadership

The AC must identify a senior leader to represent the AC, whose position may be but is not limited to a clinician, executive, officer, manager, general partner, or similar party from one of

the AC's contracted provider organizations. This individual must visibly champion achievement of the triple aim: better care for individuals, better health for populations, and lower growth in expenditures. The leader takes an active role in working with other providers and staff within the AC to influence or direct clinical practice to improve efficiency processes and outcomes.

2. Lead Entity Requirements

The AC must designate a legal Lead Entity to contract with the state to assume the following responsibilities on behalf of the AC:

a) Receipt and Distribution of Shared Savings Payments or Payment of Shared Loss

Either the Lead Entity or a designated fiscal agent under contract with the Lead Entity must receive and distribute any shared saving payments from the State. A Lead Entity under Model II (See Section VIII.A.2 below) must also be responsible for payment to the Department of any shared loss in Years two or three.

b) Financial Stability

The Lead Entity must agree to share with the Department sufficient financial documentation to establish their financial stability.

The Lead Entity must provide documents upon request that may include, but are not limited to:

- Submission of Certified Financial Audit, IRS Form 990, or Most Recent Board-Reviewed Financial Statements
- Demonstration of cash reserves to carry the Responder through shortages or delays in receipt of revenue, and/or
- Information about any pending major accusations that could affect its financial stability.

ACs participating in Model II, described under Section VII.A.2 below, must demonstrate the capacity to bear risk and may be subject to additional review.

c) Provider Agreements

The Lead Entity shall contract with any other provider organizations that together comprise the AC. The contract shall include:

1) An explicit requirement that the AC provider agrees to participate in and comply with the applicable requirements of the MaineCare Accountable Communities initiative.

2) A description of the AC provider's rights and obligations in, and representation by, the Lead Entity, including language giving the Lead Entity the authority to terminate a provider for its non-compliance with the participation agreement or any of the requirements of MaineCare rule.

3) Language that AC providers must allow MaineCare members freedom of choice of provider and may not require that members be referred to providers within the AC.

ACs that elect to include Optional Service Costs within their TCOC (see Section VIII.B.1(b) must contract with providers of those Optional Services.

d) Primary Care Case Management (PCCM)

The Lead Entity, per CMS guidance regarding the implementation of Integrated Care models under Medicaid, must ensure the delivery of services that meet the definition of Primary Care Case Management (PCCM) services as outlined under 1905(t)(1) of the Social Security Act.

As such, the Lead Entity must be, employ, or contract with:

[1] A designated MaineCare PCCM Provider under Chapter VI, Section 1 of the MaineCare Benefits Manual

OR

[2] An entity or individual that:

[a] Meets the definition of a primary care case manager as outlined under 1905(t)(1) of the Social Security Act:

[i] An individual practitioner, physician, nurse practitioner, certified nurse-midwife, or physician assistant; or

[ii] A physician group practice, or entity employing or having arrangements with physicians to provide such services.

[b] Provides services that meet the definition of PCCM services as outlined under 1905(t)(1) of the Social Security Act:

[i] Locating, coordinating, and monitoring of health care services

[ii] Twenty-four hour availability of information, referral and treatment in emergencies and the capability to arrange for, or refer to, a sufficient number of providers for the population served.

e) Coordination of Services

The Lead Entity ensures the coordination of a full range of services under the AC, to include integration of primary, acute, and behavioral health care, as well as long-term services and supports. See Section VI.D for additional details regarding requirements for coordination across the full continuum of care.

f) Other Duties

The Lead Entity shall fulfill any other duties CMS may require through contract.

3. Governance

The AC must establish a governance structure that has responsibility for oversight and strategic direction of the AC. The AC does not need to be an incorporated entity.

a) Transparency

The governing body must have a transparent governing process. This includes ensuring access to and communications regarding the AC's organizational governance structure, roles, processes, decisions and action items to interested parties.

b) Inclusion of MaineCare Members

The governance structure must include at least two MaineCare members (or their caregivers) served by the AC.

4. Provider Commitment

Each provider within the AC must demonstrate a meaningful commitment to the mission of the AC to ensure its likely success. A meaningful commitment may be demonstrated by:

- Sufficient financial or human investment (for example, time and effort) in the ongoing operations of the AC such that the potential loss or recoupment of the investment is likely to motivate the provider to achieve the AC's mission, and

- AC provider's agreement with the Lead Entity to comply with and implement the Accountable Communities initiative requirements as will be detailed under MaineCare rule, including the requirement to meet specified Accountable Communities performance standards.

D. Coordination with the Full Continuum of Care

The AC must ensure the coordination of a full range of services, to include integration of primary, acute, and behavioral health care, as well as long-term services and supports, regardless of whether or not these services are directly delivered by providers within the AC.

1. Delivery of Primary Care

Provider organizations within the AC must include providers that directly deliver the full scope of primary care services, defined as overall and ongoing medical responsibility for comprehensive care for preventive care and a full range of acute and chronic conditions. Providers eligible to deliver the full scope of primary care services for the purposes of the Accountable Communities Initiative include physicians, nurse practitioners, certified nurse midwifes, 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.

As discussed in Section VIII.B.2 below, MaineCare members will be attributed to an AC on the basis of their receipt of primary care services. See Attachment A for a detailed list of eligible primary care providers by Maine Integrated Health Management Solution (MIHMS) provider and specialty type. Eligible providers are indicated with a "PCP" in the "Primary Care" column.

2. Leveraging Department Care Coordination Resources

The Department currently invests in care coordination of its MaineCare members through services which focus on members with chronic conditions, behavioral health disorders, and long term service and support needs. The AC must demonstrate how it will leverage these existing care coordination resources, through contractual or informal partnerships, to most effectively and efficiently address the full range of services. The AC must have relationships with at least one provider of services listed under each of the following three categories, as long as those services exist in the AC's service area. For listings of current MaineCare CI, Health Homes, HCBS case management and TCM providers, see Attachments B-D, respectively.

a) Chronic Conditions, including Developmental Disabilities

Care Coordination Services for members with chronic conditions include:

- Health Homes (Stage A) initiative for members with chronic conditions (Chapter II, Section 91 of the MaineCare Benefits Manual)
- Targeted Case Management (TCM) services for children with developmental disabilities or chronic health conditions; and adults with developmental disabilities or HIV (Chapter II, Section 13 of the MaineCare Benefits Manual)

Under MaineCare's current (Stage A) Health Homes Initiative, operational since January 2013, Community Care Teams partner with Health Home primary care practice sites to provide wraparound support and community linkages to the highest need members enrolled in the Health Home . Accountable Communities that include a Health Home primary care site must extend an invitation to the Community Care Team partnered with the primary care site to participate in the AC.

Successful engagement of a Stage A Health Home practice fulfills the requirement for an AC to leverage care coordination for members with chronic conditions, whether or not the Community Care Team agrees to participate.

b) Long Term Services and Supports

Care coordination services for members with long term services and supports needs include Home and Community Based Waiver (HCBS) case management services for the elderly and adults with disabilities, adults with other related conditions, the physically disabled, and members with intellectual disabilities or autism spectrum disorder (under Chapter II, Sections 19, 20, 21 and 22, respectively).

c) Behavioral Health

Care coordination services for members with behavioral health needs include:

- TCM services for children with Serious Emotional Disturbance (SED) and adults with substance abuse disorders (Chapter II, Section 13 of the MaineCare Benefits Manual)
- CI Services for adults with SMI (under Chapter II, Section 17 of the MaineCare Benefits Manual).
- The Department will be implementing Behavioral Health Homes (Stage B) early in 2014 which will provide intensive care management for adults with Serious Mental Illness (SMI) and children with SED (see http://www.maine.gov/dhhs/oms/vbp/health-homes/stageb.html). Members with SMI or SED currently receiving services through TCM or CI will have the option of receiving Behavioral Health Home services, which will have a greater emphasis on integration with physical health through partnership with Health Home primary care practices.

ACs that include primary care sites that plan to partner with a behavioral health organization to form a Behavioral Health Home must extend an invitation to the Behavioral Health Home Organization (BHHO)to participate in the AC as well.

Successful engagement of a BHHO fulfills the requirement for an AC to leverage care coordination for members with behavioral health issues. Engagement of a Health Home practice alone under Behavioral Health Homes is not sufficient to meet the requirement without the engagement of the partnering Behavioral Health Home Organization, as well.

3. Community Partnerships

Providers within the AC must engage the larger community to collaborate on improving transitions of care, addressing the psycho-social needs of at-risk and high cost members, and addressing population health. In addition to the relationships outlined above, ACs must also develop contractual or informal partnerships with:

- All hospitals in the proposed service area in order to improve transitions of care, and

- One or more Public Health entities (may include, but is not limited to, local Healthy Maine Partnerships; District Public Health Coordinating Councils; City of Portland Public Health Division, Bangor Health and Community Services; Maine State Public Health Nurses; local Women, Infants and Children (WIC) Nutrition Program clinics)

Examples of other community partnerships the Department encourages include those with faith-based organizations, peer and family support organizations, schools and educational systems, Local Career Centers and Regional Divisions of Vocational Rehabilitation, Maine's Non-Emergency Transportation brokers, Full Service Regional Transportation Providers, Area Agencies on Aging, Community Action Programs, food assistance programs and others.

E. Member Choice

Per CMS regulations, ACs must ensure member assignment to an AC does not inhibit free choice within any Medicaid service. For instance, a primary care physician within an AC cannot restrict an attributed member's ability to make an appointment with any other physician who is qualified and willing to provide care outside the AC.

F. Quality Improvement and Learning Collaborative Activities

The AC must commit to participating in quality measurement and improvement activities as required by the Department, including participation in the multi-payer ACI workgroup facilitated by the Maine Health Management Coalition (MHMC) as part of Maine's SIM Model.

G. Changes/ Additional Requirements

The State may change requirements or impose additional requirements for participation as an AC as required through the federal approval process with CMS.

VII. Covered Populations

All MaineCare members who receive full MaineCare benefits, including Categorically Needy, Medically Needy, SSI-related Coverage Groups, Home and Community-Based Waiver and HIV Waiver members, and others are eligible for attribution to the Accountable Communities. The attribution process is described below in Section VIII.B.2.

VIII. Payment Models and Risk

Organizations that meet and/or commit to the requirements described above are eligible to participate in one of two shared savings models. The payment models outlined are based on AC performance against a risk-adjusted total cost of care (TCOC) target for all qualifying MaineCare members attributed to the AC for the Performance Year. The total cost of care target will be calculated using risk-adjusted MaineCare fee-for-service claims data. Shared savings related to reducing total costs will be contingent on performance on quality and patient experience outcomes. All risk/gain payments under the models described below will be calculated and disbursed annually via a reconciliation payment. Providers will continue to receive the current MaineCare fee-for-service payments during the Performance Year. Responders are encouraged to involve community organizations, defined in Section VI.D.2 and VI.D.3, in the distribution of shared savings and loss payments.

To assure the credibility of the process during the three years of the initial scope of the Accountable Communities initiative, the payment models and process as described below may be subject to mutually agreed-upon modifications based on additional CMS feedback, Department research, emerging findings or feedback from the participating Accountable Communities.

A. Payment Models

1. Model I: Shared Savings

Model I will distribute the difference between annual expected and actual realized TCOC if savings are achieved, contingent on quality and patient experience outcomes.

a) Sharing Rate

Accountable Communities under Model I may share in a maximum of 50 percent of savings, based on quality performance.

b) Performance Payment

The amount of shared savings an eligible AC receives under Model I may not exceed 10 percent of the benchmark TCOC.

c) Shared Loss

ACs participating under Model I are not accountable for any downside risk in any of the three performance years.

d) Minimum Attributed Members

ACs electing to participate under Model I must meet a minimum assigned MaineCare population of 1,000 members.

2. Model 2: Shared Savings & Risk

Model II incorporates shared risk over time and builds toward a two-way risk-sharing model that distributes the difference between the annual expected and actual realized TCOC whether savings are achieved or not, contingent on quality and patient experience measures.

a) Sharing Rate

ACs participating under Model II share in a maximum of 60 percent of savings, based on quality performance.

b) Performance Payment

The amount of shared savings an eligible AC receives under Model II may not exceed 15 percent of the benchmark TCOC.

c) Shared Loss Rate

ACs participating under Model I are not accountable for any downside risk in the first performance year.

In the second and third performance year, the amount of shared loss is determined based on the inverse of its final sharing rate as determined by quality performance (that is, 1 minus the final shared savings rate); and may not exceed 60 percent.

d) Loss Recoupment Limit

ACs participating under Model I are not accountable for any downside risk in the first performance year.

The amount of shared losses for which an eligible AC is liable may not exceed the following percentages of its TCOC benchmark:

- 5 percent in the second performance year
- 10 percent in the third performance year

e) Minimum Attributed Members

ACs electing to participate under Model II must meet a minimum assigned MaineCare population of 2,000 members.

B. TCOC Savings Assessment Methodology

AC savings assessment is based on a comparison of the observed TCOC for each Performance Period to a TCOC benchmark. The Benchmark TCOC is calculated based on a base period TCOC after adjusting for expected trend and changes in attributed population size and relative risk from the base period to the Performance Year.

Benchmark TCOC for the MaineCare AC program will be developed for a one year period which is anticipated to be from May 1, 2014 through April 30, 2015. The Benchmark TCOC will be developed on the basis of past claim experience and membership data with a base period of the most recent 12 months of data available. The Department will review the base data as well as market trends to determine the appropriate adjustments such as trend, outliers, completion, policy changes, etc. to project the base experience data into the Performance Year. The Benchmark TCOC will be developed for the defined Medicaid population as well as the services categories covered in the program and specific to each AC.

2. Services within the Defined TCOC

a) Core Service Costs

The TCOC will be calculated based on a defined set of core service costs for all Accountable Communities:

- Physician, Physician Assistant, Nurse Practitioner, Certified Nurse Midwife
- Federally Qualified Health Centers, Rural Health Centers, Indian Health Services, School Health Centers
- Primary Care Case Management
- Health Homes
- Targeted Case Management (excluding services provided by Department employees)
- Behavioral Health Homes
- Behavioral Health Services
- Rehabilitative and Community Support Services
- Inpatient Psychiatric
- Outpatient Psychiatric
- Inpatient
- Outpatient
- Pharmacy
- Hospice
- Home Health
- Lab & Imaging services
- Ambulance
- Dialysis
- Durable Medical Equipment
- Early Intervention
- Family Planning
- Occupational, Physical and Speech Therapy (including services provided in schools and at Nursing Facilities)
- Chiropractic Services
- Optometry
- Audiology
- Podiatry

ACs do not need to deliver all core services; rather, they will be accountable for the cost of these services. ACs may impact the TCOC of these services through enhanced care coordination, community partnerships, and other strategies within allowable MaineCare rule, state and federal law at the discretion of each AC.

c) Optional Service Costs

In addition to the core services, Accountable Communities may choose to include the cost of the following services in their TCOC:

- Dental
- Children's Private Non-Medical Institution (PNMI) services
- Long Term Care Services and Supports (excluding Home Health, Hospice, and PT, OT and Speech provided at Nursing Facilities, which are all core)
    - HCBS waiver services (excluding the Other Related Conditions waiver)
    - Nursing Facilities
    - Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/ MR)
    - Assisted Living Services
    - Adult Family Care
    - Adult Private Duty Nursing
    - Children's Private Duty Nursing
    - Personal Care Assistance (PCA)
    - Day Health Services

For example, a primary care practice and dental practice, which together have an innovative approach to encouraging preventive care that should reduce overall dental costs and other medical costs, may have an incentive to include the cost of dental services in their AC TCOC.

ACs that elect to include Optional Service Costs within their TCOC must contract with providers of those optional services. For example, an AC that chooses to include the costs of HCBS waiver services must have contractual agreements between the Lead Entity and providers of HCBS.

d) Excluded Service Costs

The following services are excluded from the TCOC calculation:

- PNMI, except for children's PNMI: these services are in the process of being restructured and any future impact on cost is unclear.
- Non-Emergency Transportation: these services are under a separate, capitated brokerage system
- TCM provided by Department employees
- Other Related Conditions HCBS Waiver

Benchmark cost TCOC will be developed by including "core" services in the Benchmark TCOC, to be consistent for each AC, and then an add-on or adjustment factor would be applied to the core service benchmark cost for the AC specific "optional" services.

3. Attribution Methodology

The Department will attribute members to an AC prior to the beginning of the program performance year based on historical claims analysis for the purposes of determining the Benchmark TCOC and Actual TCOC. Members will be attributed to one AC at a time. All of the

attributed members' care as provided in the TCOC definition will be attributed to the AC, regardless of whether the AC delivered the services.

The final attributed population for the Performance Year will be re-calculated following three months of claims run-out for purposes of accountability under the payment models. The AC will receive an updated roster of members attributed to the AC at set intervals throughout the performance year. Attribution will be conducted using a stepwise process that incents active outreach and retention of patients by the AC under the following general methodology:

1. Members who have six months of continuous eligibility or nine months of non-continuous eligibility during the most recent 12 months of base data will be eligible for assignment.

2. Members enrolled in a Health Home practice that is part of an AC will be attributed first.

3. Members not assigned in #2 will be attributed to the AC where they had a plurality of primary care services with a primary care provider. Primary Care Services are defined as Evaluation and Management, preventive, and wellness services identified through procedure codes, as well as services provided by Federally Qualified Health Centers and Rural Health Centers identified through Revenue Codes.

   A primary care provider is defined for the purposes of this RFA as a physician, nurse practitioner, certified nurse midwife, or physician assistant who:

   - has a primary specialty designation of internal medicine, general practice, family practice, pediatrics, geriatric medicine, obstetrics or gynecology
   - practices in a rural health center, federally qualified health center, an Indian Health Services center, or school health center

   A full list of provider and specialty type codes used to identify primary care services for the purposes of attribution under Accountable Communities is available in Attachment A.

4. Members not assigned under #2 or #3 will then be attributed to the AC in which they had 3 or more ER visits.

5. If the member does not meet the above outlined criteria, the member will not be assigned to an AC.

Depending on how many members are allocated to each AC and the credibility for each community, Benchmark cost TCOC will be set for each AC based on historical claims experience of the assigned members. If the amount of members assigned to an AC is not fully credible, the Benchmark TCOC for those members will be evaluated in conjunction with regional or state wide benchmark costs. For this, either a regional benchmark cost will be set or a statewide

benchmark cost will be set and adjusted for regional differences based on the location of each AC.

4. Data Adjustments

a) Policy Adjustments

The Department will apply adjustments to account for the following types of programmatic or policy changes that may occur between the base period and effective period:

- Fee for Service payment rate adjustments
- Policy change adjustments to account for projected changes in expenditures due to benefit, eligibility, or reimbursement structure changes occurring after the base period

b) Trend

The Department will develop separate utilization and unit cost trend estimates based on historical data as well as future budget allocations. Trends will be analyzed at the high level service category level by population group and compared with Medicaid benchmarks, national indices, published studies for reasonableness if available.

c) Risk Adjustment

The Department will utilize risk adjustment in the development of TCOC in order to account for population differences between ACs as well as changes in population risk from the base period to the Performance Year. The Department will utilize a regression risk model software based on age, gender, and diagnosis codes, and will apply the risk adjustment to service claims. On the medical side, the risk adjustment software will utilize diagnosis-based codes, as well as age and gender, to assess the risk. On the pharmacy side, National Drug Codes as well as age and gender will be used to assess risk.

The Department will apply risk adjustment across all populations, geographic regions and ACs. Risk adjustment will be cost-neutral and will not add any additional costs to the Accountable Communities initiative.

To reduce the potential variability of the risk assessment process and the financial results, MaineCare will develop risk scores and total cost of care PMPM by removing the claim costs for individual members that fall above specific thresholds.

(2) High Cost Member Adjustments

In order to smooth any potential volatility resulting from an abnormal distribution of catastrophic claims, the Department will truncate an attributed member's costs (only including services covered for the attributed AC) at a per member annual cap amount according to the number of members assigned to the AC entity:

- Small Population = 1,000-2,000 attributed members
    - Annual Enrollee TCOC Cap = $50,000
- Medium = 2,000–5,000 attributed members
    - Annual Enrollee TCOC Cap = $200,000
- Large = 5,000+ attributed members
    - Annual Enrollee TCOC Cap = $500,000

Only the dollars above the threshold for any given member will be removed. The dollars below the threshold will be included in the Actual TCOC. By incorporating these thresholds, the Department reduces variation in costs, thereby lowering the risk of paying ACs savings or requiring ACs to pay losses that result from catastrophic random variation. The Department believes that truncating claims at a per member annual cap achieves an appropriate balance between limiting catastrophic costs and continuing to hold ACs responsible to increase efficiency for high-cost patients.

5. Determination of Final Benchmark TCOC

The Department will summarize costs for each AC for each core service and for any optional services selected. All data for the members attributed to an AC will be adjusted as described above to develop the Benchmark TCOC.

All Benchmark TCOC amounts will include all core services, with the exception of per member per month (PMPM) payments for PCCM, Health Homes, and Behavioral Health Homes. Since these PMPM payments are outside the claims system and there is not a historical record of PMPM payments for each enrolled MaineCare member, the cost of these PMPM payments will be separately tabulated over the course of the performance year and netted out from any shared savings.

Additive adjustments will be made to the Benchmark TCOC amounts for optional services a given AC opts to include.

6. Assessment of Shared Savings/ Loss

At the end of each Performance Year, the Department will determine the Performance Period Attributed Population using retrospective claims data and the attribution process as described in Section VIII.B.2.

At the conclusion of the first performance year, the Department will compare the Actual TCOC for the attributed member population with the Benchmark TCOC. The Department will adjust these Actual TCOC amounts for risk through applying the risk adjustment and high cost member annual claims caps as described in Section VIII.B.3(c) above.

The risk score for the measurement period's attributed population will be used to calculate the change in relative risk from the base period to the Performance Year. Using the change in relative risk, the Benchmark TCOC will be adjusted based on the increase or decrease in the risk of the attributed populations.

The cost of PMPM care management fees paid under the Department's PCCM, Health Homes, and Behavioral Health Homes Initiatives will be netted out from any shared savings.

a) Minimum Savings or Loss Rate

To qualify for shared savings under either model, an AC's average Actual TCOC for the performance year must be below its Benchmark TCOC for the year by at least two percent. The AC will receive up to a specified percentage of demonstrated savings as long as they achieve savings beyond a two percent risk corridor, back to the first dollar saved.

To be responsible for sharing losses under Model II, an AC's average Actual TCOC for performance years two and three must be at least two percent above its Benchmark TCOC for the year. The AC will be liable for up to a specified percentage of demonstrated losses as long if the losses exceed a two percent risk corridor, back to the first dollar lost.

C. Quality Framework

Shared savings and loss rates under the Accountable Communities Models will be contingent on performance in the areas of clinical quality and patient experience.

As a key objective under its SIM grant, the Department will work with its SIM partners and other stakeholders to align quality measures with existing measures and data collection under other State and CMS efforts MSSP, Pathways to Excellence (PTE), MaineCare Health Homes, MaineCare Improving Health Outcomes for Children (IHOC), etc.) to the extent feasible and appropriate.

The Department will define and finalize a core set of quality measures for all ACs no later than December 1, 2013 on its Value-Based Purchasing website.

To date, the Department has developed the following criteria on which to base its selection of appropriate quality metrics:

1. Metrics measure success of the Triple Aim
   - Better Health
   - Improved Patient Experience of Care
   - Lower Cost
2. Metrics address populations and performance areas meaningful for MaineCare's population, providers, healthcare processes and structure

3. Maximize alignment of metrics with currently reported metrics in the State and nationally (Medicare ACO, Health Homes, Pathways to Excellence (PTE), Improving Health Outcomes for Children (IHOC), etc.) to the extent feasible and appropriate
4. Metrics Reflect a mix of process and outcomes measurement, and short and long term impacts
5. Minimize reporting burden to providers, to extent feasible
    - Keep number of metrics to a reasonable number
6. Measure performance (vs. reporting only) beginning in first performance year
7. Metrics Highlight differences between providers

IX. Data Feedback to Providers

The Department will provide utilization, cost and quality information available to ACs for their attributed populations. Data will be as timely as possible given standard claims lag, and will be available via standardized reports. Key variables available to AC providers will include population-level and patient-level data.

Reports to AC providers will include the following:

- Utilization report for high risk members (monthly) at primary care provider site levels
- Attributed member roster (quarterly or more frequently) at primary care provider site levels
- Actual TCOC compared to Benchmark (quarterly), with drill down to primary care provider site, population and service category
- Claims-based quality performance measures for attributed population (quarterly), with drill down to primary care provider site and population category.

X. Contract Term and Termination

The initial term of the contract shall be for one year, and shall automatically renew at the end of the initial term for a successive one-year term, not to exceed a total of three years, unless the Department or AC gives written notice of its intention not to renew at least sixty (60) days before expiration of the then-current term. Term and termination requirements will be spelled out in further detail in the contract to be finalized between AC Lead Entities and the Department.

XI. Application Requirements

Applicants must complete the application at https://www.surveymonkey.com/s/MaineCareACapplication. Applicants must demonstrate through their responses that they currently meet, or commit to meet, all requirements under Section VI of this RFA.

A. Finalization of proposed AC constituent provider organizations

The Department recognizes the complexity involved, especially for independent provider organizations, to formalize agreements to join together as an AC. As such, the Department is allowing a stepwise approach to the finalization of AC constituent provider organizations and community partnerships.

1. Constituency Requirements for Application Due Date

Applicants must identify the following constituents of their proposed AC as part of their application by the application due date:

- The individual responsible for the AC leadership (See Section VI.C.1)
- The Lead Entity provider organization (See Section VI.C.2)
- All provider organizations within the AC that deliver primary care services (See Section VI.D.1). The Department requires National Provider Identifiers (NPIs) at both the site and individual provider level. Primary Care services delivered by these providers are the basis of patient attribution to the AC, as outlined in Section VIII.B.2.

2. Constituency and Community Partnership Requirements Due prior to Contract Finalization

In the application, applicants that have not yet identified care coordination providers (see Section VI.D.2), area hospitals, one or more public health entities (See Section VI.D.3), and any other community-based organizations which they plan to engage in contractual or informal partnerships under the AC must commit to engaging in such partnerships as part of the application and must identify and show evidence of these partnerships prior to finalization of the contract.

Applicants must finalize the participation of any additional provider organizations that will constitute the AC prior to finalization of the contract.

XII. Application

Applicants must complete the Accountable Communities application at the following link: https://www.surveymonkey.com/s/MaineCareACapplication.

A PDF version of the application is included as Attachment E to allow for review of the application prior to online completion. However, this version of the application should not be used as a substitute for the application itself, as it does not reflect or incorporate question skip logic (skipping questions that are not applicable based on the answer to a previous question), and does not show the contents of drop-down menus.

XIII. RFA Process

A. Timeline

Activity	Date
RFA posted	October 9, 2013
Written Questions Due	October 23, 2013
Summary of Questions and Answers	November 6, 2013
Optional individual Q&A sessions with potential applicants	October 28 – November 8, 2013
Optional Notice of Intent/ Interest	November 15, 2013
Applications Due	December 9, 2013
Notice of Intent to Contract issued by State	December 20, 2013
Begin contract plenary sessions and negotiations	January 6, 2013
Performance Year begins	May 1, 2014

B. Written Questions

Written questions must be received by the RFA Coordinator no later than 5:00 p.m. local time on October 23, 2013. No questions will be accepted after the Written Question due date.

Send written questions to:

RFA Coordinator: Michelle Probert, michelle.probert@maine.gov

Responses to all substantive questions will be compiled in writing and posted to the Accountable Communities website. The Department will make every effort to provide answers to the questions on or before November 6, 2013.

C. Individual Question & Answer Sessions

Department staff is making available to all potential provider applicants optional 30-minute Question and Answer (Q&A) sessions October 28 through November 8, 2013 in person or via conference call. The optional Q&A sessions will serve as an opportunity for applicants to ask specific questions of Department staff concerning the project. A Q&A session is not mandatory. Department staff will record all questions and answers provided in the individual sessions and post any questions and answers that have not already been posted to the Accountable Communities website, http://www.maine.gov/dhhs/oms/vbp/accountable.html.

To schedule a Question and Answer session for your provider organization, please contact:

Michelle Probert, michelle.probert@maine.gov

by October 18, 2013. Responders may attend via conference call. Oral answers given at the conference will be non-binding. Written responses to questions asked at the conference that have not already received a posted response will be posted on the Accountable Communities website, http://www.maine.gov/dhhs/oms/vbp/accountable.html.

D. Notice of Interest or Intent

The Department encourages entities interested in or intending to apply to form an AC to submit a non-binding Notice of Interest and/or Intent. Notices of Interest/ Intent will be accepted until November 15. Providers should indicate their interest and/or intent to apply by filling out the form at https://www.surveymonkey.com/s/MaineCareACInterest.

A PDF version of the Notice of Interest or Intent survey is included as Attachment F to allow for review of the Notice prior to online completion. However, this version of the Notice should not be used as a substitute of the Notice itself, as it does not reflect or incorporate question skip logic (skipping questions that are not applicable based on the answer to a previous question), and does not show the contents of drop-down menus.

1. Facilitation of Provider Identification to form Accountable Communities

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 AC. The Department will post the following categories of information, where consent is given, on a rolling basis on its Accountable Communities website:

- Respondent contact information
- Respondent's region(s) of location
- Respondent's intent to apply/ 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

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.

E. Application Review & Eligibility Notification

The Department will review all applications received by the deadline. The Department will notify all applicants that commit to and/or demonstrate they meet the AC requirements under Section VI in writing of their eligibility and the Department's desire to enter into contract negotiations.

1. Application Determination Reconsideration Review Process

The Department will contact any ineligible applicants prior to issuance of a denial letter to either confirm ineligibility or clarify or correct responses that would enable the applicant to become eligible.

If MaineCare makes the final determination that the applicant does not meet AC requirements and denies this application, the applicant has the right to request a reconsideration review of the initial determination. Details on how to request a reconsideration review will be included in the application denial letter.

2. Non-Binding Application

Selected applicants are not bound to enter into contract with the Department.