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INTRODUCTION

A. BACKGROUND AND PURPOSE

Five years ago, the Centers for Medicare & Medicaid Services (CMS) awarded Delaware a State Innovation Model grant to achieve five state-defined objectives, one of which was to engage payers to move health care payment to a pay-for-value model based on total cost of care (TCOC) budgeting. Since that time, and following considerable intensive stakeholder work, it has become apparent there are limits to the scope and pace of progress through voluntary adoption of payment and delivery reform by payers and providers. In states that have initiated or implemented reform, state government and stakeholders have collaborated to create mechanisms that bolster and accelerate system transformation.

In its 2017 Report to the Delaware General Assembly on Establishing a Health Care Benchmark, the Department of Health and Social Services (DHSS) identified five strategies to advance the adoption of value-based purchasing (VBP) models, one of which was the implementation of TCOC alternative payment models (APMs) within Medicaid managed care contracts and the State Employee Benefit Contracts. In 2018, DHSS increased its focus on promoting alternative payment strategies by adding VBP requirements to Medicaid managed care contracts for calendar year 2018. Furthermore, in 2019, DHSS released a request for information on the design and development of Medicaid accountable care organizations (ACOs) in Delaware.

To continue advancing this work toward TCOC APMs, the Division of Medicaid & Medical Assistance (DMMA), under the direction of DHSS, has created a Medicaid/Children's Health Insurance Program (CHIP) Accountable Care Organization Program (Medicaid ACO Program) for the purpose of improving health outcomes while reducing costs through VBP arrangements which include downside financial risk for participating ACOs. DMMA seeks a Medicaid ACO Program with a strong foundation in supporting a robust primary care system within the State.

ACOs are group arrangements in which health care practitioners (e.g., hospitals, physicians, other health care providers) agree to assume responsibility for the quality, outcomes and cost of health care for a designated group of patients. Through VBP arrangements based on a TCOC calculation, ACOs are financially incentivized to coordinate patient care across care settings, address behavioral health and social needs and improve patient experience.

The Medicaid ACO Program has been designed to allow qualified provider organizations to apply to become Medicaid ACOs and contract with Medicaid managed care organizations (MCOs) in a

TCOC arrangement. DMMA believes that by working together, Medicaid ACOs and MCOs can better coordinate care for Delaware's Medicaid and CHIP members, providing better health outcomes and lower costs.

B. STATUTORY AUTHORITY

The Medicaid ACO Program is implemented pursuant to section 80000 of Division of Social Services Manual (DSSM), Authorization and Regulation of Medicaid/CHIP Accountable Care Organizations. Under the statutory authority of 42 CFR 438.6(c)(i) and 29 Del.C. § 7931, this regulation sets forth standards for the authorization and regulation of ACOs for Medicaid/CHIP beneficiaries in the State of Delaware to improve health outcomes while reducing costs through VBP arrangements which include downside financial risk for participating ACOs.

C. DEFINITIONS

Accountable Care Organization (ACO): A group arrangement in which health care practitioners (e.g., hospitals, physicians, other health care providers) agree to assume responsibility for the quality, outcomes and cost of health care for a designated group of Medicaid and/or CHIP members.

ACO Contract: A contract formed between an ACO and a Medicaid MCO, which includes payment via a value-based arrangement as defined by DHSS. There will not be a direct contract between DMMA and the applicant ACO as part of this initiative.

ACO Requirements: Minimum standards and qualifications needed for an ACO to receive authorization from DMMA to participate in the program as an approved Medicaid ACO. Receiving DMMA authorization does not guarantee a subsequent ACO contract from a Medicaid MCO.

ACO Participant: A health care provider organization identified by a tax identification number (TIN) that has contractual arrangements with the applicant ACO entity for the purposes of participating in a Medicaid TCOC model and coordinating care for members (e.g., hospitals, clinics, specialists, etc.).

Applicant ACO: The health care provider, provider organization or other entity applying for ACO authorization through DMMA.

Behavioral Health: Health care services related to the diagnosis or treatment of mental illness, emotional disorders, or substance use disorders (SUDs) and the application of behavioral health principles to address lifestyle and health risk issues.

Governing Body: The board of directors or other entity responsible for formulating the policy and directing the affairs of the Medicaid ACO.

Medicaid ACO: An applicant ACO that receives DMMA authorization to participate in the Medicaid ACO program.

Medicaid MCO: The managed care entity that DMMA contracts with directly for the provision of Medicaid/CHIP services. Currently, there are two Medicaid MCOs: AmeriHealth Caritas Delaware and Highmark Health Options.

Participating Clinicians: A clinician (e.g., primary care provider (PCP), specialist, etc.) that contracts with or is part of the applicant ACO for the Delaware Medicaid ACO Program.

Participating Primary Care Provider (Participating PCP): A PCP that contracts with or is part of the applicant ACO for the Delaware Medicaid ACO Program and is eligible for member attribution. To enable attribution, the respective participating PCP must be exclusive to the Medicaid ACO.

Primary Care Provider (PCP): PCPs may include Medical Doctors or Doctors of Osteopathy in the following specialties: internal medicine, family medicine, general practice, pediatrics, and geriatric medicine. In addition to physicians noted, a PCP may also be a Certified Registered Nurse Practitioner or a Federally Qualified Health Center.

Related ACO Party: Entities other than the applicant ACO that either have a legal or financial responsibility for the actions of the applicant ACO (e.g., parent organization, related parties).

Social Determinants of Health (SDOH): Non-medical drivers of health outcomes, status and costs, such as housing and adequate nutrition.

Value-Based Purchasing (VBP): a model for provider reimbursement that promotes value over volume, such as a shared savings or risk-based arrangement.

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MEDICAID ACO MODEL DESIGN ELEMENTS

A. ELIGIBILITY

Medicaid ACOs must be an approved legal entity in the State of Delaware. Applicant ACOs may or may not be a credentialed Medicaid provider organization, but the ACO's governance structure must have sufficient authority to ensure the delivery of high quality, cost-effective care to Medicaid and CHIP members. The applicant ACO must be able to enter into an ACO contract in accordance with the payment model as described in Section F, including taking on downside risk within a TCOC arrangement. The applicant ACO must successfully demonstrate the ability to coordinate the full scope of health care services included under the Medicaid ACO program, as well as fulfill all other capabilities outlined in the application. DMMA may modify Medicaid ACO program guidance and/or requirements from time to time. Medicaid MCOs and Medicaid ACOs are expected to comply with program updates and all relevant federal and state regulations.

Each contract between a Medicaid ACO and Medicaid MCO must involve a minimum of 5,000 Medicaid and/or CHIP attributed members. The applicant ACO must demonstrate how it will achieve and sustain this minimum member attribution level. Failure to sustain at least 5,000 attributed members in each contract with a Medicaid MCO may result in DMMA rescinding authorization to the ACO to participate in this program.

Medicaid ACOs are expected to have a Compliance Plan in place that outlines the organization's compliance with all applicable federal and state laws and Delaware Medicaid ACO program requirements. The Compliance Plan should outline ways of preventing, detecting and correcting noncompliance and must be made available to DMMA upon request.

B. MCO INVOLVEMENT AND NETWORK USAGE

Medicaid ACOs will enter into three-year TCOC agreements with Medicaid MCOs, provided that the MCOs maintain their MCO contracts with DMMA for the term of the agreement, according to parameters in Section F. MCOs will be responsible for attributing members to ACOs through selection of or assignment to a participating PCP (see Section E for details). Participating PCPs may only participate with one ACO; specialists may participate in multiple ACOs. Members attributed to ACOs will be able to use any provider in the Medicaid MCO's network as well as other providers as permitted under applicable federal or state law (e.g., family planning services). All ACO participants and participating clinicians in an ACO must be a credentialed provider with the Delaware Medicaid program, as applicable.

C. POPULATIONS INCLUDED AND ELIGIBLE FOR ATTRIBUTION

All Medicaid and CHIP managed care enrollees in the State of Delaware will be eligible for attribution to Medicaid ACOs with the exception of the following populations:

- Medicare-Medicaid dual eligibles.
- Long-term care facility residents (e.g., nursing facility residents).
- Individuals receiving long-term services and supports (LTSS) through eligibility for enhanced Diamond State Health Plan (DSHP) Plus benefits, enrollment in the PROMISE program or Lifespan program.

Please note that individuals receiving traditional Medicaid covered support services such as home health care or private duty nursing are not excluded from ACO attribution simply by virtue of receiving any “LTSS-like” benefit.

D. SCOPE OF SERVICES INCLUDED IN TOTAL COST OF CARE

The Medicaid ACO TCOC calculations will include all medical, physical health, behavioral health and pharmacy services included under the Medicaid MCO contracts for attributed members. The current Medicaid MCO contract is comprehensive in that the Medicaid MCOs cover most Medicaid/CHIP services for enrolled members. Unless the individual is excluded from this ACO program, all services that are part of the Medicaid MCO contract will be included in the TCOC payment model including services such as home health care or private duty nursing, which may be considered LTSS for other purposes. Any service that is the responsibility of the State and excluded from the Medicaid MCO contract (e.g., fee-for-service (FFS) carve-outs) will not be included in the Medicaid ACO TCOC payment model. A current example is dental benefits for children.

Any supplemental or additional care management, care coordination or similar payments made from the Medicaid MCO to the Medicaid ACO or ACO participant will be included in the TCOC calculation. Separate performance, quality or outcome-based incentive payments made by the Medicaid MCO to the Medicaid ACO or ACO participant will not be included in the TCOC calculations.

All of the attributed members’ care as provided in the TCOC calculation will be attributed to the Medicaid ACO, regardless of whether the Medicaid ACO delivered the services.

E. MEMBER ATTRIBUTION

Members will be attributed to a Medicaid ACO prospectively based on:

1. Member PCP selection.
2. If the member does not select a PCP, MCO assignment to a PCP.

If MCO assignment is used, the assignment methodology should consider the member’s utilization of primary care services over the past 12–24 months.

F. MEDICAID ACO PAYMENT MODEL OVERVIEW

The Medicaid ACO program will include two payment tracks, which are based on TCOC and outlined in Table 1 below. Both payment tracks are intended to promote value-based payment and the deployment of more innovative APMs to providers. Each track specifies the split of shared savings/risk between the Medicaid ACO, Medicaid MCO and the maximum savings/loss rate. Under Track 1, Medicaid ACOs will have upside-only risk the first year and take on downside risk in program years two and three. Track 2 will allow Medicaid ACOs to take on downside risk beginning in program year one and shift from shared risk to a full-risk model by year three. For each ACO contract, DMMA expects the Medicaid ACO and Medicaid MCO to negotiate a contract in good faith incorporating Track 1 or Track 2. DMMA reserves the right to review ACO contracts, including updates and amendments, upon request.

TABLE 1

	TRACK 1	TRACK 2
Year 1	Upside-only shared savings. 50/50 shared savings split between the ACO and the MCO. * Maximum savings rate of 10% of target.	Shared savings and risk. 60/40 shared savings and risk split.* Maximum savings rate of 10% of target, downside risk capped at 5% of target.
Year 2	Shared savings and risk. 60/40 shared savings split, 25/75 shared risk split.* Maximum savings rate of 10% of target, downside risk capped at 5% of target.	Shared savings and risk. 75/25 shared savings and risk split. * Maximum savings rate of 10% of target, downside risk capped at 10% of target.
Year 3	Shared savings and risk. 60/40 shared savings split, 50/50 shared risk split.* Maximum savings rate of 10% of target, downside risk capped at 5% of target.	Full risk. Maximum savings rate of 10% of capitation rate, downside risk capped at 10% of capitation rate.

*Shared savings and shared risk splits are listed as ACO/MCO. Shared savings percentage represents the maximum amount that can be given to ACOs if the ACO gets a perfect quality score. The shared risk percentage is the minimum level of risk ACOs must be responsible for, given a minimum quality score. ACOs and MCOs have the option to negotiate adjustable shared savings/risk percentages based on quality performance within these boundaries. Specifically, the shared savings rate for ACOs may be lessened if ACOs do not meet negotiated quality targets. The shared risk percentage for ACOs may be lessened if ACOs meet negotiated quality targets.

Payments to ACOs will be adjusted for quality/outcomes as described in Section G. DMMA intends to give flexibility to the Medicaid ACOs and Medicaid MCOs to negotiate specific payment design details within the broad framework of this application. DMMA expects the details listed below will be articulated in any ACO/MCO contract; guidance for these aspects are listed below:

i. Defining a TCOC Target

The TCOC target must include the TCOC scope of services outlined above for all providers. The ACO/MCO will determine the TCOC target and comparison group (e.g., historical performance of the ACO, minimum attainment, statewide average or other reasonable and appropriate means). The ACO contract must include an expected growth trend to which the target value is expected to grow over time, which is reasonable, transparent and straightforward. The TCOC target and growth trend must be risk adjusted using a reputable risk adjustment process. ACOs and MCOs are encouraged to factor SDOH into these adjustments.

DMMA is encouraging, although not currently mandating, providers be paid using APMs that move away from traditional FFS. DMMA may, at a future point, specify a provider payment model for a given service or provider type

ii. Truncation of Expenditures for TCOC Calculations

Medicaid ACO programs typically truncate costs for extremely high cost patients at a predetermined level. Truncating costs at a specific level is not required, but DMMA advises Medicaid ACOs and MCOs to consider truncating applicable member expenditures subject to TCOC calculations on a per member per year basis above either the: (1) top 1% of member costs or (2) \$250,000 in total covered expenditures.

iii. Minimum Savings Rate

DMMA recommends ACO contracts contain a minimum savings rate (MSR) appropriate for the number of members served under the contract to ensure savings earned by the ACO, or losses incurred by the ACO, are the result of actual care coordination efforts and not random variation. Such rates must be based on an actuarially sound computation. The MSR should only be intended to mitigate the effect of random variation and not be used by either the Medicaid ACO or Medicaid MCO as a detriment to negotiating an ACO contract in good faith. For example, a MSR of 2% may be reasonable, but a MSR of 10% is not.

iv. Tying Payment to Quality

Contracts between Medicaid ACOs and MCOs must tie payment to quality using a methodology mutually agreeable. More information on quality measures is given in Section G below.

v. Financial Viability to Accept Downside Risk

The ACO must be able to demonstrate financial viability to accept downside financial risk in its contract with its Medicaid MCO partner(s). For Track 2 ACO arrangements, the arrangement must be made as part of the initial ACO/MCO contract, while Track 1 ACOs will need to demonstrate financial viability by year two of an ACO contract. These arrangements will be subject to agreement by the contracting ACO and MCO. Financial viability may be ensured through a number of different means, including, but not limited to, a performance bond, financial risk certificate, stop loss insurance, cash reserves or another risk mitigation strategy.

G. QUALITY MEASURES

ACO payment will be tied to a limited set of meaningful, quality measures. DMMA intends to provide flexibility in the quality measures that can be used and how performance is evaluated. In the future, DMMA may choose to more specifically define which quality measures must be used and how the measures are used to impact payment. To reduce the reporting burden on ACO participants, the quality measure must closely align with quality measures sets used in Delaware, such as the quality performance measures (QPMs) in DMMA's Medicaid MCO agreements, statewide quality benchmark measures, Delaware Common Scorecard measures and Healthcare Effectiveness Data and Information Set (HEDIS) measures. DMMA expects the quality measures used in the Medicaid ACO payment model to be appropriate for the applicable ACO member population and, where practical, to leverage the same quality measures currently used for other Medicaid programs.

The ACO/MCO contract's payment model must be tied to performance on the quality measure set in a meaningful way. In a track that involves shared savings/losses, the amount of savings/losses should reflect quality performance; in the case of a capitation rate, a quality withhold should be implemented. DMMA expects the relationship between payment and quality be designed so the Medicaid ACO earns a greater share of savings if it performs well on quality measures, and less or nothing at all if the Medicaid ACO performs poorly. In an arrangement with shared losses, losses may be reduced if quality performance is high.

H. CARE DELIVERY CAPABILITIES

Medicaid ACOs must be able to effectively deliver coordinated, cross-continuum care and have a plan in place to do so. This includes building on a strong primary care foundation to deploy care coordination capabilities across primary care services, specialty care services and the ability to provide access, either directly or through affiliations/contractual relationships, to behavioral health care, acute care, maternal and perinatal care, community and social support, long-term care and oral-health care. The Medicaid ACO should also have a plan in place to measure, monitor, report and improve member health outcomes and quality. This plan must include consumer engagement strategies and approaches to addressing population health, including member behavioral health and SDOH. At this time, DMMA will not require specific care delivery models to be implemented as part of the Medicaid ACO program, but the ACOs must have a plan in place to effectively and efficiently deliver and coordinate necessary services with their partner Medicaid MCO. The ability of the Medicaid ACO to effectively and efficiently collaborate and coordinate with the Medicaid MCO(s) regarding member care will impact how successful the ACO will be in subsequently obtaining and maintaining an ACO contract.

Medicaid ACOs will be required to coordinate care management responsibilities with the Medicaid MCOs, but the ACOs will not be required to submit this strategy to the State for approval. However, since there is the potential for duplication of care coordination activities and limited integration, it is expected that Medicaid ACOs and MCOs should clearly delineate their roles. DMMA intends to monitor this going forward to ensure program efficiency and modify the design of the Medicaid ACO program as needed.

I. INFORMATION TECHNOLOGY AND DATA SHARING CAPABILITIES

The Medicaid ACOs' ability to effectively and efficiently accept, analyze, exchange, meaningfully use and report on data to the Medicaid MCOs, ACO participants and participating PCPs will be a key factor in subsequently obtaining and maintaining an ACO contract. Through this Medicaid ACO initiative, DMMA is seeking to leverage advances in information management and use them to improve health care quality and outcomes and positively impact the level of health care expenditures. To that end, Medicaid ACOs must demonstrate their information technology and data sharing capabilities, including the following parameters:

- Widespread adoption of a common electronic health record (EHR) or interoperable EHRs across the Medicaid ACO.
- The ability to report accurate quality and other data to Medicaid MCOs on a timely basis.
- The capability to effectively manage risk-based contracts, including being able to receive and analyze quality and cost data on a timely basis.
- Effectively use and securely exchange actionable data with ACO participants and participating clinicians to improve outcomes and reduce unnecessary costs.
- Comply with applicable federal or state laws and regulations regarding handling, storage and exchange of health information (e.g., The Health Insurance and Portability Act (HIPAA) compliance).

Additionally, Medicaid ACOs are encouraged, but not required, to exchange admissions, discharge and transfers (ADT) data with the DHIN.

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APPLICATION PROCESS

Organizations interested in becoming Medicaid ACOs are invited to submit the application in Section 4 below for consideration by DMMA. While this is not a competitive application process, DMMA may not approve all ACO applicants and may request additional information as part of the application review process. Applications will be accepted during an annual application period, and approved Medicaid ACOs would enter into contracts with MCOs effective January 1 of the following year.

A. KEY ACO APPLICATION DATES

The Medicaid ACO application period for participation in the Medicaid MCO contract period starting on January 1, 2021 will run from March 1, 2020 to April 24, 2020. Key dates in this application process are shown in the table below:

TABLE 2: KEY DATES BEGINNING JANUARY 1, 2021

KEY EVENTS	KEY DATES
ACO application released	March 2, 2020
Questions on application due	March 11, 2020 by 1:00pm ET
Responses to questions	Approximately March 25, 2020
ACO applications due	April 24, 2020 by 1:00pm ET
Approved ACOs announced/ACO authorization period commences	By June 15, 2020
ACO/MCO contract start date	January 1, 2021
ACO/MCO contract end date ¹	December 31, 2023
ACO authorization end date (if not renewed)	December 31, 2023

¹ Subject to MCO continuing to have an MCO agreement with DMMA.

B. ACO AUTHORIZATION PERIOD

ACOs will be authorized for a period of three complete calendar years beginning on the date the application is authorized by DMMA through the end of the subsequent third full calendar year. For example, if an ACO's application is approved by DMMA on June 15, 2020, approval will commence on that day through December 31, 2023. If ACO application criteria change, previously authorized ACOs may be required to submit additional information to comply with these new requirements.

Authorization is not a guarantee of a contract with a Medicaid MCO nor a guarantee of ACO cost or quality performance. While Medicaid MCOs may be incentivized by DMMA to enter into contracts with Medicaid ACOs, all ACO contracts must be negotiated and agreed to by the Medicaid ACOs

and Medicaid MCOs. DMMA reserves the right to review ACO contracts, including updates and amendments, upon request. Subject to an MCO continuing to have an MCO contract with DMMA, the ACO contracts must be three years in length beginning on January 1 contracts between MCOs and authorized ACOs may need to be periodically amended to comply with program and contract updates.

C. ACO APPLICATION QUESTIONS

DMMA will accept questions regarding this application process. DMMA's preference is that questions are limited to the Medicaid ACO application in Chapter 4 below. Questions must be submitted by email using a question submission format of the applicant's choosing that is clear, directly related to the ACO application and contains the following information:

- Applicant's name.
- Medicaid ACO application section, part, item (e.g., Section A, Part A1, Item C).
- Applicant's question.

DMMA intends to compile all questions and provide responses on or around March 25, 2020.

All Medicaid ACO application questions must be submitted by email with the subject line "Medicaid ACO Application Questions — [Responder Name]". Questions must be emailed to and received by Delaware's Medicaid Director's Office by 1:00pm ET on March 11, 2020: Email to:

- ACO@delaware.gov

D. ACO Application Submission

Application responses should include narratives and documentation in order of the questions listed below. Responses to each question should be clearly labeled with the question number. Large data files or marketing materials are not preferred. Applicants should provide complete and succinct responses. Any supporting information should be concise and specific to enabling DMMA to evaluate the ACO's response efficiently and clearly cross-referenced to the specific application question.

Completed applications must be emailed to and received by Delaware's Medicaid Director's Office by 1:00pm ET on Friday, April 24, 2020. Email to:

- ACO@delaware.gov

4

MEDICAID ACO APPLICATION

A. BACKGROUND INFORMATION

A1. Please provide the applicant ACO's organization information:

- A. Legal name of the organization and any doing business as (DBAs).
- B. TIN.
- C. Address.
- D. Website, if applicable.
- E. Does the entity identified by this TIN serve other functions besides administering a Medicaid ACO program? If so, please list and explain the additional functions of this entity.

A2. Primary Contact: Please identify a primary contact for the ACO authorization application. The primary contact will be DMMA's point of contact for application inquiries and status updates:

- A. Name.
- B. Title.
- C. Address.
- D. Phone number.
- E. Email.

A3. Secondary Contact (optional):

- A. Name.
- B. Title.
- C. Address.
- D. Phone number.
- E. Email.

A4. Type of applicant ACO (please choose one):

- A. Medical group practice.
- B. Network of individual practices (e.g., Independent Physicians Association (IPA)).
- C. Hospital system.
- D. Integrated delivery system.
- E. Partnership of hospital system(s) and medical practices.
- F. Other, please describe.

A5. Please list all ACO participants, including the legal name and TIN of each organization and a high-level overview of each organization including: services provided (e.g. inpatient services, cardiology), expected activities related to the applicant ACO and number/type of participating clinicians. Organizations may be considered ACO participants if they have contractual arrangements with the applicant ACO entity for the purposes of participating in a Medicaid TCOC model and coordinating care for members.

*Note: ACO applicants do **not** need to submit a complete list of individual participating clinicians and their specialties.*

A6. Please submit a list of participating PCPs including the provider name, organization name, legal and DBA address, individual PCP/organization National Provider Identifier (NPI), TIN, specialty, Provider Medicaid ID (if applicable) by completing the Excel template in **Appendix 1**.

Note: PCPs may include Medical Doctors or Doctors of Osteopathy in the following specialties: internal medicine, family medicine, general practice, pediatrics, and geriatric medicine. In addition to physicians noted, a PCP may also be a Certified Registered Nurse Practitioner or a Federally Qualified Health Center.

A7. Is the applicant ACO TIN a Delaware Medicaid enrolled provider (choose one)?

- A. Yes.
- B. No.

A8. Please provide a summary (*Two pages or less total*) of key characteristics of the applicant ACO, including:

- A. A description of applicant ACO's geographic service area.

- B. Projected number of Medicaid/CHIP members served by the applicant ACO in its first year through all potential ACO contracts.
 - i. Demographics of the potential member population to be served through the applicant ACO.
 - ii. History of the applicant ACO organization, ACO participants and its related ACO party(s) (e.g., business relationships, collaboration on quality improvement or value-based payment initiatives, etc.).
 - iii. Any additional information that may help DMMA understand the organization of the applicant ACO and its motivation for participating in the Medicaid ACO program.

A9. Please indicate if the ACO is interested in participating in Track 1 arrangements, Track 2 arrangements or both.

B. GOVERNANCE

Standard:

The applicant ACO must be a recognized legal entity in the state of Delaware. The applicant ACO has a governing body with the authority to execute the functions of the ACO and governance structures, which incorporate meaningful input from participating PCPs and Medicaid members and families. The applicant ACO has a clearly defined leadership team to manage ACO operations and is accountable to the governing body or executive committees. The applicant ACO must have a plan for complying with federal and state regulations governing ACOs.

Application Questions and Documentation Requirements:

B1. Please submit a copy of the ACO applicant’s certificate of incorporation that indicates the applicant ACO is recognized as a legal entity by Delaware.

B2. Please submit organizational chart(s) describing the ACO applicant’s governance structures, including the governing body, any committees or subcommittees and executive leadership. As a part of the chart or as a separate narrative, identify and describe all controlling persons, principal stockholders, health-related subsidiaries and parent corporations of the applicant ACO. This information may be presented through an organizational chart, narrative or both.

B3. Please list the membership of the applicant ACO’s governing body including the following fields:

NAME	TITLE AND CLINICAL DEGREES/SPECIALTIES, IF APPLICABLE	CONSUMER ADVOCATE OR PATIENT REPRESENTATIVE (Y/N)
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B4. If ACO participants are not owned by the principal ACO entity, please describe the contractual and/or other relationship between the applicant ACO and those ACO participants.

*Note: While ACO applicants do **not** need to submit the individual contracts between applicant ACOs and ACO participants to DMMA, DMMA reserves the right to request these contracts for review.*

B5. Please submit a copy of the bylaws of the governing body. If not included in the bylaws, submit additional authoritative documentation demonstrating the governing body's authority to execute the functions of the ACO.

B6. Please describe the applicant ACO's leadership structure and responsibilities, including:

- A. A list of members of the Medicaid ACO leadership team including team member names, titles, and approximate amount of time that will be dedicated to the Delaware Medicaid ACO program.
- B. A description of how the leadership team interacts with the governance structure and how responsibilities are divided across the leadership team.

B7. Please describe how the governing body will incorporate meaningful input from members and families into decision making, including:

- A. Structures/policies to facilitate member and family input (e.g., patient and family advisory committee, patient/consumer representation on governing body, etc.).
- B. Membership and scope of work of relevant committees/workgroups.
- C. Processes to facilitate member and family input (e.g., mode and frequency of input).

B8. Please describe how the governing body and leadership have meaningful representation and input from participating PCPs to support and promote innovation in the delivery of primary care.

B9. Please submit the applicant ACO's Compliance Plan, which must include a conflict of interest policy and a method for dealing with member complaints. If a Compliance Plan has not been developed yet, a detailed description of how the applicant ACO will comply with federal and state regulations governing ACOs must be submitted.

C. FINANCIAL PLAN AND EXPERIENCE WITH RISK SHARING

Standard:

The applicant ACO must have a credible plan for demonstrating financial viability to accept downside risk and distributing shared savings and losses. The applicant ACO must demonstrate a commitment to transitioning away from FFS payment and utilizing the Medicaid ACO program to advance the goals of improving health outcomes and lowering health care costs.

*Note: Please refer to the [Health Care Payment Learning & Action Network Alternative Payment Model Framework](#) for more information on VBP arrangements. Paying participating PCPs through VBP arrangements are **not** currently required for ACO authorization, but DMMA strongly encourages and expects this new delivery model to incorporate the use of alternative VBP models and strategies that shift away from traditional FFS. The State may elect to define a VBP provider payment model(s) in the future.*

DMMA acknowledges operational details related to distributing shared savings/losses may be contingent on the final ACO contract terms and conditions. The purpose of question C3 is to enable DMMA to assess how prepared the applicant ACO is to participate in this program and to what degree the ACO has experience or strategies pertinent to supporting the State's goals.

Application Questions:

C1. Does the ACO or its participants have experience operating contracts with downside financial risk? If so, please explain the nature of the agreements and the ACO's/participants' performance on quality and cost as part of these contracts.

C2. How does the ACO plan to demonstrate its financial viability to accept downside financial risk in the subsequent ACO contracts with the Medicaid MCOs (financial viability may be ensured through a number of different means including, a performance bond, financial risk certificate, stop loss insurance, cash reserves or another risk mitigation strategy.)?

C3. In general terms, please describe how the applicant ACO intends to distribute shared savings/losses to participating providers (e.g., participating PCPs, ACO participants, related ACO party, etc.), such as:

- A. Which provider types and/or specialties will be eligible to share in savings/losses?
- B. Whether shared savings/losses will be distributed to individual clinicians, practices or another type of organization (e.g., physician organization, independent practice association, physician hospital organization, etc.).
- C. What factors determine whether providers will be eligible to receive shared savings or required to share in saved losses? (e.g., quality performance, cost, structural or process factors, etc.).
- D. What amount of shared savings does the applicant ACO plan to reinvest/use to build infrastructure? If applicable, describe the applicant ACO's specific plans for how to use such funds (e.g., investment in primary care infrastructure, care coordination, analytic capabilities, etc.)?
- E. Whether the applicant ACO plans to use shared savings for any other purposes besides distributions to providers or reinvestment. If yes, how will the funds be used?

C4. Through the ACO initiative, Delaware seeks to transition away from FFS payment for providers. Please describe how the applicant ACO would support and effectuate this transition away from FFS payment, such as:

- A. What percentage of the applicant ACO's participating PCPs are currently being paid through VBP or APMs? Please delineate by the primary characteristic of the VBP/APM (e.g., care coordination payments, shared savings, risk/capitation, bundled payments, global budgets, etc.).
- B. What percentage of the applicant ACO's participating PCPs are currently taking downside risk or capitated risk for medical services (please indicate both types)?
- C. What percentage of your participating PCPs earn a salary from an employer that is an ACO participant?
- D. To what extent are the applicant ACO's other major ACO participants (e.g., hospitals, clinics, specialists, etc.) willing and able to transition to VBP/APM during the first three years of this Medicaid ACO Program. Delineate by major provider entity. If the applicant ACO's composition is limited to only PCPs, this question is not applicable.
- E. How will the applicant ACO support, promote and expand the use of VBP/APMs that promote value over volume in each of the first three years of participation in the Medicaid ACO Program.

C5. If the applicant ACO is intending to be paid on a full risk basis (e.g., subcapitation, fixed payments), from the Medicaid MCO (through a Track 2 arrangement), please provide information on the following:

- A. The methodology the ACO intends to use to pay each major provider for the provision of medical services (e.g., hospitals, physicians, pharmacists, clinics, behavioral health providers, etc.).
- B. The applicant ACO's provider claims processing capabilities including how the ACO will ensure program payment timeliness, integrity and accuracy.
- C. The applicant ACO's capabilities to transmit complete and accurate encounter claims data in a timely manner to the Medicaid MCO(s).
- D. What percentage of the attributed member TCOC is estimated to be incurred by ACO participants versus other providers?

D. CARE DELIVERY MODEL

Standard:

The applicant ACO must support delivery of efficient, robust and high quality primary care. The applicant ACO must have the ability to coordinate services across the care continuum, either through direct provision of services or coordinating with providers outside the ACO, as necessary. Further, the applicant ACO must demonstrate a commitment to delivering linguistically and culturally competent care.

Additionally, the applicant ACO, in coordination with Medicaid MCOs, must have the ability to risk stratify their member populations. The applicant ACO must also have a plan for using population-level data to develop care programs and interventions tailored to the needs of its member population. As a part of these efforts, the applicant ACO must have a specific plan for identifying and addressing SDOH relevant to its member population, including through developing partnerships with community-based organizations.

i. Primary Care Foundation

Application Questions:

D1. Please describe whether and to what extent participating PCPs are recognized as a patient-centered medical home (PCMH) by an accreditation organization (e.g., National Committee for Quality Assurance (NCQA), Joint Commission, URAC, Accreditation Association for Ambulatory Health Care (AAAHC)) or participating in a national Primary Care Initiative (e.g., participating in Comprehensive Primary Care Plus (CPC+), planning to participate in Primary Care First).

*Note: PCMH recognition or participation in a national recognition program is **not** required for ACO authorization.*

D2. Please describe, at a high-level, the extent to which the applicant ACO currently delivers patient-centered care and how the ACO will support a robust primary care delivery structure during the first three years of participating in this initiative (e.g., through technical assistance, investment in primary care, etc.). In answering this questions, consider the following capabilities:

- A. Access to care.
- B. Care planning, including transitions of care.
- C. Team-based care delivery.
- D. Integration of primary health care with behavioral health services (including mental health and SUD services).
- E. Any other means.

D3. Please describe how the applicant ACO will assess and address the health needs of its member population, including through use of health information technology. Please describe:

- A. How the applicant ACO will identify gaps in care.
- B. How the applicant ACO will assess health disparities and encourage health equity among its member population.
- C. How the applicant ACO will risk stratify and segment its member population for care interventions.
- D. ACO strategies for meeting the needs of members with different levels of need, from low-risk, relatively healthy populations to high-risk, high-need populations.
- E. How the applicant ACO currently coordinates or plans to coordinate with MCOs to develop and implement population health interventions.
- F. How the applicant ACO will engage attributed patients to ensure that their preferences and priorities are understood and incorporated into care delivery.

ii. Care Coordination and Cross-Continuum Care

Application Questions:

D4. Please provide an overview of the applicant ACO's capabilities and strategies for coordinating care across care settings, including care transitions, both within and outside the ACO. In answering this question, include an overview of any affiliations (such as existing or potential contractual relationships or referral relationships) and approaches for coordinating the following types of care:

- A. Behavioral health care, including substance use disorder.
- B. Acute care.
- C. Maternal and perinatal care.
- D. Community and social support.
- E. Long-term care.
- F. Oral health care.

D5. Please describe how the applicant ACO delivers or plans to delivery culturally and linguistically competent care.

D6. Please provide a summary of the applicant ACO's current or planned approach to identifying and addressing the SDOH needs of its member population, including housing and/or food/nutrition needs, if applicable.

Note: Having initiatives or planning to address housing and/or food/nutrition needs are not required for ACO authorization, but strongly encouraged. ACOs may also consider identifying and addressing topics such as utility needs, interpersonal violence, transportation, family and social supports, education, employment, income and healthy behaviors.

Please describe:

- A. The social factors the applicant ACO currently or plans to focus on identifying and addressing.
- B. The applicant ACO's current or planned process for identifying SDOH needs of individual attributed members.
- C. The applicant's current or planned process for making referrals or warm handoffs to social/human service providers or in-house programs, including closing the loop on referrals/hand-offs, to address identified SDOH needs.
- D. How the applicant ACO will collaborate with MCOs to address SDOH.

D7. Please provide an overview of how the applicant ACO is currently or plans to address member SDOH through development of partnerships with non-profit community-based organization(s) that provide non-clinical social and human services. Specify community-based organizations the applicant ACO has or will establish relationships with. Please also describe which SDOH the applicant ACO is prioritizing addressing through community partnerships.

E. QUALITY IMPROVEMENT

Standard:

The applicant ACO must have a plan for monitoring and ensuring high quality of care as well as a strategy for engaging in quality improvement activities in collaboration with the Medicaid MCO(s), participating PCPs and other ACO participants.

Application Questions:

E1. Please describe which individuals, teams, or committees are responsible for monitoring and managing quality performance (e.g., quality committee, quality officer, etc.) for the applicant ACO. For individuals named, please provide the number of years of relevant and applicable experience.

E2. Please describe the applicant's current or planned processes for monitoring quality, outcomes, setting organizational quality goals and carrying out quality improvement initiatives. Please include a

description of how the applicant ACO plans to measure success in quality and outcome improvement.

F. HEALTH INFORMATION TECHNOLOGY AND DATA EXCHANGE:

Standard:

The majority of providers participating in the applicant ACO must utilize EHRs. The applicant ACO must be able to electronically submit quality and other data to Medicaid MCOs as well as effectively utilize data files from MCOs in a meaningful way to improve outcomes and reduce unnecessary spending. The applicant ACO must also have the ability to exchange data, within and outside the ACO, to support care coordination in a secure manner.

*Note: The applicant ACO and ACO participants can satisfy the EHR requirement through use of multiple interoperable EHR systems; use of a single EHR system is **not** required*

Application Questions:

F1. What percentage of participating clinicians in the ACO utilize EHRs?

F2. Describe the applicant ACO's ability to exchange performance and care management data in a secure and timely manner. Included in the answer, please describe the applicant ACO's ability to:

- A. Electronically submit data to the Medicaid MCOs for quality measure calculation.
- B. Receive performance and care management data files from the Medicaid MCOs.
- C. Analyze and utilize Medicaid MCO data to manage ACO performance and member care.
- D. Provide timely and actionable data to participating PCPs and other ACO participants, respectively. Provide examples of report templates/outputs in an attachment.
- E. Exchange member data and care plans with health care settings outside the ACO for purposes of effective and efficient care management, outcome improvement and care coordination.

F3. Does the applicant ACO currently have the capability to receive and transmit ADT data through the DHIN? If not, does the applicant ACO have plans to implement data exchange with the DHIN?

Note: Medicaid ACOs are encouraged, but not required, to exchange ADT data with the DHIN.

G. ASSURANCES AND ATTESTATIONS

An authorized representative of the applicant ACO is required to sign and confirm the following statements upon submission of an application for ACO authorization.

The undersigned hereby assures and certifies on behalf of the applicant ACO, _____, that:

- The information included in this application and all attachments are correct to the best of the undersigned's knowledge and belief.
- The undersigned understands and acknowledges DHHS requires authorized ACOs to notify DMMA of any significant changes to the information in the application during the authorization term that make it no longer able to meet authorization standards.
- The applicant ACO hereby affirms and acknowledges members' right to choice of provider.
- The applicant ACO will not seek to limit or restrict attributed members to providers within the ACO network.
- Furthermore, the applicant ACO will not limit Medicaid members' access to providers based on their attribution.
- The applicant ACO affirms that it will comply with applicable federal or state laws and regulations regarding handling, storage and exchange of health information (e.g., HIPAA compliance).

I attest that I am an executive of the applicant ACO, with the authority to make decisions about this proposed application. I attest to all the statements above on behalf of the applicant ACO.

Signature: _____

Name: _____

Title of Executive: _____

Date: _____