Updated June 17, 2020 with additional information on revisions to key dates and the ACO/MCO contracting process as well as a response to one additional question that was received.

#	Question	DMMA Response
1	Is additional infrastructure funding available from DMMA to Medicaid MCOs or the participating ACOs to build additional capabilities to support this initiative? • Through our national experience, we realized that it was very helpful in NY, MA and other states to get ACOs ready and enabled them to take downside risk	Additional infrastructure funding is not available from DMMA to Medicaid MCOs or ACOs at this time.
2	If we became an approved Medicaid ACO and entered into contractual agreements with any of the DE Medicaid MCOs, will funding from the state continue to be made to support existing primary care provider (PCP) programs (Perform PLUS for AmeriHealth Caritas and True Performance for Highmark Health Options); i.e. will those programs continue in addition to the TCOC program?	Provider organizations and MCOs will have the option of continuing existing PCP programs in addition to the Medicaid ACO program. Please note that for the Medicaid ACO program, 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.
3	Is it mandatory for approved Medicaid ACOs to enter into value-based agreements with Medicaid MCOs or would it be possible to enter into a value-based arrangement directly with DMMA? • Through our national experience, we found that this has led to lowering cost of care, more efficient for the state of DE and better experience for beneficiaries and would be our preference.	The Medicaid ACO program will operate through Medicaid MCOs only.

#	Question	DMMA Response
4	Does DMMA have programmatic goals for this model? For example, in some states they use this to add (or require) other services such as integrated BH.	DMMA's goals for the ACO program are to improve health outcomes for Medicaid/CHIP beneficiaries in the State of Delaware while reducing costs. To support these high-level goals, Medicaid ACOs must have capabilities in the areas of governance, finance, care delivery, quality improvement and health information technology and data exchange as defined in the ACO application. Please see the "Standard" descriptions in Sections 4.B–4.F of the Delaware Medicaid ACO Application for a summary of program requirements. To allow broad participation in the ACO program and encourage innovation, DMMA has intentionally allowed flexibility in how organizations may satisfy the Medicaid ACO program requirements. For example, while DMMA requires ACOs to support delivery of high quality primary care and coordinate services across the care continuum, the program does not require specific care delivery models. Please note that the ACO program does emphasize ACO development of capabilities to address social determinants of health (see questions D6 and D7), which may be a new area of focus for participating organizations. DMMA is seeking Medicaid ACOs that can demonstrate a commitment to transitioning away from traditional fee-for-service (FFS) payment models consistent with the State's guidelines and goals described in the Medicaid ACO application.

#	Question	DMMA Response
5	Can we explore the possibility of ramping it up to the 5000 required members to make it actuarially credible pool? For example, could an ACO stay in an upside--only track until the ACO grows to 5000 members? • In our experience, smaller pools are less credible and cannot absorb volatility which usually ends in making losses and make overall program unsustainable.	Only organizations that have or can demonstrate capabilities, capacity and size to cover at least 5,000 attributed members on the MCO contract effective data will be authorized as a Medicaid ACO. This requirement was implemented in recognition that TCOC is subject to random variation and small risk pools may not allow shared savings/loss to be measured accurately enough for an ACO program to be sustainable. DMMA will accept ACO authorization applications on an annual basis, and organizations that currently have less than 5,000 attributable beneficiaries through MCO contracts are encouraged to apply at a later date, once they can demonstrate ability to meet this threshold.
6	Does approval of Medicaid ACO by DMMA obligate that ACO to enter into an agreement with either of the two DE Medicaid MCOs?	Medicaid ACO authorization by DMMA does not require authorized Medicaid ACOs to enter into contracts with a Medicaid MCO. Authorization is also not a guarantee of a contract with a Medicaid MCO. 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.
7	Is the term of the Medicaid ACO agreement with Medicaid MCO required to be 3 years or can a shorter term with renewal/extension provision be negotiated?	Subject to an MCO continuing to have an MCO contract with DMMA, the Medicaid ACO contracts must be three years in length. Contracts between MCOs and authorized ACOs may need to be periodically amended to comply with program and contract updates. Contracts may include provisions that terminate ACO/MCO contracts under certain circumstances such as the MCOs ending their contract with DMMA, ACOs not maintaining at least 5,000 member per MCO contract, etc.
8	Please provide the specific assignment methodology of the two MCOs' assignment model, for when that is used.	Per Section 2.E, the MCO PCP assignment methodology must consider the member's utilization of primary care services over the past 12–24 months. 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.

#	Question	DMMA Response
9	Will the FFS population not currently assigned to a Medicaid MCO today be obligated to sign up with a Medicaid MCO? If so, how will assignment occur? Opt in, opt out?	No, the FFS population not currently assigned to a Medicaid MCO will not be obligated to sign up with a Medicaid MCO.
10	Is attribution to PCPs only, and what source of data will the state use for determining PCP status? And for NPs, how will the methodology determine that the NP is a PCP and not working in as a specialty care provider?	Attribution to Medicaid ACOs will be made through PCPs only, as defined in the Medicaid ACO application. 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. MCOs and ACOs will have the flexibility to negotiate the specific attribution methodology. The State anticipates that patients will not be attributed to NPs acting in specialty provider roles.
11	How will the Medicaid MCO or DMMA identify participating providers at the highest or lowest level? Will participant be defined at the taxpayer identification numbers (TINs) or NPIs level, assuming risk or total cost of care is assigned at the highest level?	At the highest level, the Medicaid ACO held accountable for TCOC will be identified by the TIN provided in question A1 of the Delaware Medicaid ACO Application. Additional participating provider organizations will be identified by the TIN(s) provided in question A5. DMMA will identify participating PCPs through the data submitted by Applicant ACOs through the Delaware Medicaid ACO Application Appendix Participating PCP Template; though MCOs may use alternative sources of data to determine PCP status.
12	What downstream agreement is required with those participating Medicaid ACO providers TINs/NPIs	DMMA is allowing flexibility in the nature of agreement developed between Medicaid ACOs and participating organizations/clinicians. While DMMA does not have specific requirements or provisions related to these agreements, DMMA expects ACO participant organizations to be bound contractually to the ACO in cases when ACO participants are not owned by the principal ACO entity.

#	Question	DMMA Response
13	To what extent would DMMA act as arbitrator in value-based arrangement term negotiations between Medicaid ACO and Medicaid MCO, if we have a disagreement over terms or settlement for example, or simply need further guidance?	DMMA will not act as an arbitrator in Medicaid ACO contract negotiations. All ACO contracts must be negotiated and agreed to by the Medicaid ACOs and Medicaid MCOs. While DMMA reserves the right to review ACO contracts upon request, DMMA does not plan to provide additional guidance beyond Section 2 of the Delaware Medicaid ACO Application at this time. MCOs will negotiate ACO contracts with the highest level of the ACO (the TIN identified in A1).
14	How would DMMA support providers in situations where the state moves services for the Medicaid population under the Medicaid MCOs or creates new payments for services that impact the total spend through new policy (and no ability to impact on the provider side)?	From time to time, DMMA may provide additional guidance to Medicaid ACOs and MCOs on how anticipated Medicaid policy changes may impact the Medicaid ACO model. For example, as the need arises, DMMA may consider providing guidance on whether new populations and/or services are included in the MCO/ACO model, the timeline for including new populations/services into the MCO/ACO model and/or how to adjust TCOC calculations to reflect new populations or services. If additional guidance were provided, DMMA will make every effort to allow a reasonable amount of time for Medicaid ACOs and MCOs to transition to these changes.
15	We share the state's goal to establish a fair and transparent benchmark. What is the baseline period which is used to create the baseline which is trended forward to establish the target, and how/how often is that updated?	DMMA is allowing flexibility in how MCOs/ACOs calculate the TCOC target and not requiring a standardized methodology. MCOs/ACOs may negotiate how the TCOC target is calculated, within the guidelines of Section 2.D-2.F of the Delaware Medicaid ACO Application. DMMA is not requiring a particular baseline period and/or trend methodology be used.
16	How will the growth trend be developed?	See response to question #15.
17	Will the MSR fluctuate with the # of attributed lives? Will the Medicaid ACO be able to choose it's MSR within an established band?	MCOs/ACOs may negotiate the details of the Medicaid ACO payment model, including a Minimum Savings Rate, within the guidelines of Section 2.D-2.F of the Delaware Medicaid ACO Application. Per Section 2.F.iii, DMMA recommends ACO contracts contain a 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.

#	Question	DMMA Response
18	We share the state's goal to expand access to Behavioral Health, but have found that challenging. Will there be additional payments to encourage BH providers to open/expand access to Medicaid beneficiaries? Will other providers – e.g. Health Coaches, Community Health Workers -- be able to access payments for BH services?	DMMA does not plan to include additional payments for BH services in MCO capitation rates or change payment policies related to Health Coaches and Community Health Workers as part of the Medicaid ACO initiative at this time. MCOs have the flexibility to negotiate new, VBP arrangements with ACOs.
19	Is the applicant ACO TIN a Delaware Medicaid enrolled provider? • Is No an acceptable answer to this question? Our ACO is a network of individual practices and does not directly provide health care services.	"No" is an acceptable answer to A7.
20	Please describe how the governing body will incorporate meaningful input from members and families into decision making, • Is representation on the governing body by a Medicaid member required and/or desired?	DMMA encourages, but does not require, representation on the governing body by a Medicaid member. ACOs may use other strategies to incorporate meaningful input from members and families into ACO decision making, such as a patient and family advisory committee that reports to the governing body.
21	How does the ACO plan to demonstrate its financial viability to accept downside financial risk… • Most of our ACO contracts specific the amount of guarantee required. It will be difficult to provide valid information on method without some sense of the expected amount	DMMA recognizes specific requirements and methods used to demonstrate financial viability depend on contract specifications, the size and nature of the population involved in the contract, the risk level and other considerations. To answer the question, ACO Applicants may describe, at high level, expected methods for demonstrating financial viability, which could be those including those included as examples in the question. Please also see Section 2.F.v. of the ACO Application for more information. It is acceptable for ACOs to describe how the method may differ based on specifics of contracts negotiations.

#	Question	DMMA Response
22	Please describe how the applicant ACO will assess and address the health need. • Our answer to this question will vary dramatically depending on if claims information is available from the MCO. It is impossible to accurately answer this question without knowing the status of claims data availability. Claims data is necessary to close quality gaps.	The goal of this question is to assess ACO capabilities and experience in assessing and addressing the health needs of its member population. In answering this question, ACOs should describe, at a high level, their capabilities, prior experience and strategies for assessing and addressing health needs. Applicants should assume that data sharing will occur between the ACO and MCO(s).
23	Electronically submit data to the Medicaid MCOs for quality measure calculation. This question is impossible to answer without knowing what standard the Medicaid ACO will accept. Certified EHR Technologies are only required to support C-CDA and QRDA output.	This answer assumes the question was intended to ask"…what standards the Medicaid MCO will accept". DMMA recognizes MCO processes and standards for collecting quality data may vary. ACO Applicants may answer this question by describing, at a high level, their existing reporting capabilities and/or providing examples of how they currently electronically submit data for other value-based payment (VBP) programs.
24	How much notice will be provided for any ACO requirement changes?	The timing of DMMA notice of Medicaid ACO requirement changes may depend on a variety of factors including the nature and impact of program changes. If requirements are changed, DMMA will make every effort to allow a reasonable amount of time for Medicaid ACOs and MCOs to transition to these changes.
25	Will there be a time-window for patients to be able to switch out of their ACO at the start of the contract? • For example: 90 days	Managed care members will be attributed to ACOs through member PCP selection or MCO assignment to a PCP. DMMA is not defining a limited time window for PCP selection/changes nor a "lock out" period in which members may not be attributed to a new ACO. ACOs and MCOs may negotiate the frequency of which attribution changes are made based on PCP changes.
26	Will there be a patient "lock-in" period and/or "elective" period? • For example, in the Massachusetts ACO model patients can drop out at any time but they can't join the ACO after a certain date or period of up to a year. Patients also have a 3-month elective period.	See response to question #25.

#	Question	DMMA Response
27	What happens to existing -LTSS patients that we are currently at risk for, if we move to an ACO model which excludes LTSS patients?	The Medicaid ACO program excludes long-term care facility residents (e.g., nursing facility residents) and individuals receiving LTSS through eligibility for enhanced Diamond State Health Plan (DSHP) Plus benefits, enrollment in the PROMISE program or Lifespan program. Providers, including those part of the Medicaid ACOs, can continue to serve these members under existing models.
28	What is the expectation for provision of adult dental services included within the ACO/MCO contracts, particularly with respect to the State's new adult Medicaid dental benefits anticipated to begin on October 1, 2020?	DMMA is currently evaluating how adult dental benefits may impact the Medicaid ACO model; further guidance will be issued later.
29	Will Medicaid ACOs have input into assignment/attribution models? How much contractual flexibility does DMMA anticipate for attribution methodology? • For example, for individuals who have not selected a PCP, is the State willing to assign such individuals to the MCO/ACO (for the ACO to determine how to engage with the member) versus assign members to a specific PCP within the ACO?	The ACO program will not impact DMMA's MCO selection/auto-assignment process at this time. The MCOs and ACOs will have flexibility to determine the specific details of the member attribution process within the guidelines described in the ACO Application. See also responses to questions #8 and #10.
30	How much contractual flexibility will exist with respect to capturing and tracking quality measures not presently mandated by the State, captured in MCO claims data repositories or otherwise available in the DHIN?	DMMA intends to provide flexibility in the quality measures that can be used and how performance is evaluated. To reduce the reporting burden on ACO participants, the quality measures must closely align with quality measures sets already used in Delaware. See Section 2.G. for further details. 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.
31	Once the ACO is authorized, will it thereafter be required to pursue a particular payment track?	Following ACO Authorization, Medicaid ACOs may determine, as part of negotiations with MCOs, which of the two tracks described in Section 2.F is most appropriate. It is possible for a Medicaid ACO to have different payment tracks with different MCOs (e.g., Track 1 with MCO #1, Track 2 with MCO #2, etc.).

#	Question	DMMA Response
32	What future payment models is DMMA considering for potential future mandatory models, as indicated in the application?	Information is not available at this time, but will be provided to the Medicaid MCOs and ACOs when/if applicable.
33	Please clarify the state's expectations with respect to the Total Cost of Care (TCOC) Target and risk--adjustment mechanisms. We would appreciate more clarity as to how "TCOC" is derived (MLR target, other benchmark data, etc.) and more information about the ability to include contractual provisions to "truncate costs for extremely high-cost patients."	DMMA is allowing flexibility in how MCOs/ACOs calculate the TCOC target and not requiring a standardized methodology. MCOs/ACOs may negotiate how the TCOC target is calculated, within the guidelines of the Delaware Medicaid ACO Application.
34	How much notice will be provided before adding one or more new quality measures?	See response to question #24.
35	Will the ACO be able to submit EMR based supplemental data feeds for hybrid HEDIS measures?	The Medicaid ACOs and MCOs have the flexibility to negotiate processes for quality measure data submission.
36	Will there be specific provisions for limited specialty services (Pedi specialty, cancer, rheum; BH-MAT/SUDs providers)? • For example, addressing patients with Behavioral Health and Cancer providers outside of the partnering MCO network and their allowance to continue these relationships.	There are no specific provisions for specialty services in the Medicaid ACO program.
37	How will maternity patients with out-of-ACO network obstetricians but in-network PCPs be managed in the ACO? Will there be a grace period for delivering moms?	There are no specific provisions for maternity patients in the Medicaid ACO program.
38	Will there be MCO data sharing expectations as well? • The focus in the guidance stresses ACO capacity to produce data but does not identify this for MCOs.	The application requires Applicant ACOs to report on their data sharing capabilities. While the Medicaid ACO Application does not pertain to MCOs, MCO contracts with DMMA include provisions related to VBP data sharing requirements.
39	Will we have full access to claims data? Will there be any redacted claims?	The Medicaid MCOs and ACOs will be able to negotiate the format and level of detail of claims data available.

#	Question	DMMA Response
40	Is the three-year contemplated contractual period sufficient to determine whether the ACO program is successful? • We are aware of recent changes to the Medicare Shared Savings Program (MSSP) based on a determination by the Centers for Medicare & Medicaid Services (CMS) that three years may not be sufficient, and five-year cycles may be more appropriate.	Medicaid ACOs are expected to have three-year contract periods with MCOs, if Medicaid ACOs and MCOs would like to extend such agreements for additional years following the three-year period, which would be possible assuming the MCO continues to have a contract with DMMA. The ACO is an approved Medicaid ACO at that point in time, and the contract meets DMMA requirements at that time.
41	To what extent is DMMA willing to be flexible as to integration of existing Medicaid risk contracts with the anticipated contract start date of January 1, 2021 for the new Medicaid ACO contracts?	Medicaid ACO 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. Organizations not ready to implement a contract by January 1, 2021 are invited to apply to the Medicaid ACO program in a future year. ACOs and MCOs have the flexibility to negotiate the details of the ACO contract, within the guidelines of Section 2 of the Delaware Medicaid ACO Application. ACOs/MCOs may build off existing VBP arrangements to meet Medicaid ACO program requirements. DMMA may consider additional flexibilities early in the program in consideration of the COVID-19 pandemic as long as the general objectives of the respective Track are achieved/maintained.
42	How will DMMA insert itself into negotiations between providers and payers?	See response to question #13.
43	What incentives will MCOs be receiving?	DMMA will not offer further comment on MCO contract terms at this time.
44	Please clarify the definition of “recognized legal entity” in the statement that “the applicant ACO must be a recognized legal entity in the State of Delaware.”	A Medicaid ACO must be a legal entity (e.g., corporation, Limited Liability Corporation (LLC)) with a Federal TIN formed under applicable Delaware and Federal laws and authorized to conduct business in the State of Delaware.

#	Question	DMMA Response
45	What contractual flexibility or other measures does DMMA anticipate with respect to the ability to cap total losses to the ACO for attributed members (particularly for an ACO serving larger totals of members than the anticipated 5,000 member minimum)?	DMMA is allowing Medicaid MCOs and ACOs flexibility in negotiating the Medicaid ACO payment model within the guidelines of Section 2 of the Delaware Medicaid ACO Application. Table 1 outlines risk caps in each payment track. DMMA may consider additional flexibilities early in the program in consideration of the COVID-19 pandemic as long as the general objectives of the respective Track are achieved/maintained.
46	How will the State reconcile the expectation of care coordination and integration of primary care with behavioral health services for patients with serious and persistent mental illness currently served by DSAMH/PROMISE?	Per Section 2.C in the Delaware Medicaid ACO Application, individuals enrolled in the PROMISE program are excluded from attribution to Medicaid ACOs. Therefore, these patients are expected to receive the same care as they would independent of the Medicaid ACO program.
47	What information or data is the State planning to share with a Medicaid ACO (and contractual MCO partner) about the total cost of care projections and risk/SDOH profile of the ACO's attributed members?	DMMA will not be sharing data with Medicaid ACOs at this time. MCOs and ACOs have the flexibility to negotiate data and information sharing.
48	There are several references indicating that a PCP must be exclusive to the Medicaid ACO or that PCPs may only participate with one ACO. Is exclusivity to one ACO for purposes of the Medicaid ACO Contract only? Many ACOs are not exclusive participation, so the exclusivity needs to be worded in a way that makes PCPs comfortable that they have the option to participate in multiple ACOs (should their participation agreement with the ACO allow such) and the exclusivity is only limited to the Medicaid ACO contract.	For purposes of member attribution in the Medicaid ACO model, PCP providers must elect to participate with only one Medicaid ACO as a participating provider. This provision does not affect non-Medicaid ACO relationships that a PCP may consider (ACO application, Section 1, C. Definitions).
49	Section 2 Medicaid ACO Model Design Elements, A. Eligibility: the application states, "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 scope of capabilities outlined in the application." Similar to our comments to the regulation, we request clarification that this provision be specific to "for attributed members."	Applicant ACOs must describe their care coordination capabilities to demonstrate their ability to coordinate of the full scope of services for which an attributed member could need access to during the contract period.

#	Question	DMMA Response
50	Section 2 Medicaid ACO Model Design Elements, A. Eligibility: the application states, "Each contract between a Medicaid ACO and Medicaid MCO must involve a minimum of 5,000 Medicaid and/or CHIP attributed members." Is there an exception process, should a Medicaid ACO be willing and able to take risk for a lesser threshold? [Since each Medicaid MCO has a different enrollment mix, it may be difficult to reach the minimum 5,000 attributed lives with each MCO]. In addition, as a Medicaid ACO, [we] will want to work on initiatives to help all Medicaid beneficiaries. If we are unable to move to APMs based upon a threshold, it will be limiting for Medicaid beneficiaries. We would like clarity regarding whether there is an option to request an exception at a future time.	Only organizations that have, or can clearly demonstrate the ability to achieve at least 5,000 attributed members at contract effective date through an MCO contract, will be authorized as a Medicaid ACO. Medicaid ACOs are not required to contract with every Medicaid MCO, but the 5,000-member level applies to each MCO contract an ACO chooses to enter into. This requirement was implemented in recognition that TCOC is subject to random variation and that small-risk pools may not allow shared savings/loss to be measured accurately enough for an ACO program to be sustainable. DMMA will accept ACO Authorization applications on an annual basis, and organizations that cannot obtain the 5,000 attributable member level are encouraged to apply later, once they can meet this threshold.
51	Section 2 Medicaid ACO Model Design Elements, E. Member Attribution: Is there any forthcoming guidance on retro-eligibility and retro PCP assignments? We request it be made clear that member attribution to the primary care will be future-based. Also, will DMMA provide guidance on valid reasons for Medicaid ACO initiated transfers and the required timing for Medicaid MCO processing? Members should not be attributed to a Medicaid ACO incorrectly.	MCOs and ACOs will have the flexibility to negotiate the specific attribution methodology. Managed care members will be attributed to a Medicaid ACO prospectively based on member PCP selection or MCO assignment to a PCP. MCO assignment methodology must consider the member's utilization of primary care services over the past 12–24 months. 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.
52	Section 2 Medicaid ACO Model Design Elements, F. Medicaid ACO Payment Model Overview: Will the ACO contract be public by virtue of DMMA's ability to review? We need to clarify that although the ACO Contract is not with DMMA, the ACO Contract is not made public.	DMMA retains the right to review the contract upon request. To the extent DMMA has a copy of the MCO/ACO contract, it could be subject to a public records request. However, any such request would go through the State's standard process of giving parties an opportunity to redact confidential, proprietary information consistent with State laws and regulations

#	Question	DMMA Response
53	Section 2 Medicaid ACO Model Design Elements, F. Medicaid ACO Payment Model Overview, Table 1: Can DMMA clarify if the use of "target" in both tracks should be "TCOC target?"	The term "target" in the payment model table refers to the TCOC target budget amount/level.
54	Section 2 Medicaid ACO Model Design Elements, F. Medicaid ACO Payment Model Overview, Table 1: Are these the minimum components of the track? May the Medicaid ACO and Medicaid MCO agree to a more expedited timeline and different terms? For example, if a Medicaid ACO wants to move to Year 3, Track 1 at Year 1, would that be acceptable?	DMMA is allowing Medicaid MCOs and ACOs flexibility in negotiating the Medicaid ACO payment model within the guidelines of Section 2.F of the Delaware Medicaid ACO Application. DMMA may consider additional flexibilities early in the program in consideration of the COVID-19 pandemic as long as the general objectives of the respective Track are achieved/maintained.
55	Section 2 Medicaid ACO Model Design Elements, F. Medicaid ACO Payment Model Overview, Table 1, Track 2, Year 3, states "Full Risk." It appears this can include (but is not limited to) subcapitation from the Medicaid MCO to the Medicaid ACO. If the Medicaid ACO is willing to accept "full risk" can DMMA provide insight on why there would be a maximum savings or loss of 10% of capitation rate instead of having the parties negotiate corridors?	See response to question #54.
56	Section 2 Medicaid ACO Model Design Elements, Fi. Defining a TCOC Target states: "ACOs and MCOs are encouraged to factor SDOH into these adjustments." Can DMMA clarify if these SDOH factors will also be captured in the Medicaid MCO encounter data submission since "The State uses Encounter Data to set capitation rates…" (Source: 2018 MCO Contract)?	Depending on the nature of how SDOH are addressed, MCOs may include information in their encounter data or other data submissions to the State.
57	Section 2 Medicaid ACO Model Design Elements, Fi. Defining a TCOC Target states, "ACOs and MCOs are encouraged to factor SDOH into these adjustments." Can DMMA clarify if these SDOH factors will be captured in the numerator for the TCOC calculation and further, will these factors be captured in the Medicaid MCO's MLR calculation with DMMA?	See responses to questions #2, #15, and #33. The MCO MLR calculation formula is defined by CMS in Federal regulations at 42 CFR 438.8.

#	Question	DMMA Response
58	Section 2 Medicaid ACO Model Design Elements, H. Care Delivery Capabilities: Can DMMA add language to require that the Medicaid ACO and Medicaid MCO enter into good faith negotiations on the care delivery capabilities that should be delegated to the Medicaid ACO? If Medicaid ACOs are moving to accept risk, there should be sincere effort to evaluate the services that should be transitioned, with the appropriate administrative dollars. For example, both the Medicaid MCO and Medicaid ACOs are currently providing care coordination. There is overlap and confusion. We have also submitted our application for NCQA complex case management accreditation, but the Medicaid MCO is also performing case management. The same goes for specific utilization functions like inpatient. Although this may seem like an obvious question, we have already encountered lack of desire with justification statements suggesting DMMA is not encouraging this. It would help to have DMMA make a statement around expectations.	DMMA is providing flexibility for MCOs/ACOs to determine the contractual relationship within the framework described in Section 2 of the ACO application. This flexibility allows MCOs/ACOs and participating providers to determine the level of coordination and collaboration to best deliver care coordination and quality services. As described in section 2, H., Medicaid ACOs will be required to coordinate care management responsibilities with the Medicaid MCOs, since there is the potential for duplication of care coordination activities. DMMA will not mandate contractual relationships between MCOs and ACOs but intends to monitor this going forward to ensure program efficiency.
59	Section 2 Medicaid ACO Model Design Elements, H. Care Delivery Capabilities: Will DMMA modify the application to state, “Medicaid ACOs must be able to effectively deliver coordinated, cross-continuum care and have a plan in place to do so for the members attributed?” As a pediatric-focused clinically integrated network, it should be clear that we are responding to care delivery capabilities specific to the needs of pediatrics.	DMMA expects Medicaid ACOs are able to coordinate and collaborate with the Medicaid MCO(s) for the full range of services included in the Medicaid ACO model for attributed members.

#	Question	DMMA Response
60	Section 2 Medicaid ACO Model Design Elements, I. Information Technology and Data Sharing Capabilities: Will DMMA add language around the requirements for the Medicaid MCOs to share data, including capitation rates for attributed members and at least two years of historical claims data for Medicaid ACOs to appropriately evaluate the ability to ingest the claims data and negotiate contract terms? More specifically, will DMMA add that Medicaid MCOs must release this information within 30 days of DMMA's approved ACO announcement for approved Medicaid ACOs and then on an ongoing basis at least twice a month?	MCOs and ACOs will be able to negotiate the format, frequency and level of detail of data available. The purpose of this application is to ascertain a Medicaid ACO's capabilities, experience and abilities. DMMA will not add this language at this time.
61	Will the Medicaid ACOs be able to access the funding that DMMA is intending to pass to the Medicaid MCOs for strategies that address individual health-related social needs (HRSN) and impact community-level SDOH? We understand DMMA intends to pass these through the Medicaid MCOs. If Medicaid ACOs are moving to increasing risk, having access to such funds will be important to align efforts to those taking risk.	DMMA is not mandating a specific payment model beyond the terms described in section 2, F of the application. MCOs and ACOs are encouraged to incorporate SDOH and value-based strategies within their delivery and payment models.
62	Although this is intended to be a three-year agreement, we'd like to confirm that the contract terms (including the term of the contract) will be negotiated between the Medicaid ACO and the Medicaid MCO. We'd also like confirmation that applying for the Medicaid ACO does not preclude the Medicaid ACO from working on alternate future options such as filing as a health maintenance organization in the future.	See response to question #7. Participating in the Medicaid ACO program does not prohibit the ACO from exploring other delivery options in the future.
63	There are a few places in the application that state "at a future point" or "at this time." It's unclear the implication to these potential future unknown changes. Medicaid ACOs will need to contemplate that within the ACO Contract, requiring advance notice of changes that materially impact the terms of the ACO Contract.	See responses to questions #14 and #24.

#	Question	DMMA Response
64	Will DMMA provide actuarial support to the Medicaid ACOs?	DMMA will not provide actuarial support to the Medicaid ACOs.
65	We appreciate the extension in the question submissions. Is the extension going to bump the other dates in the timeline contained within the application?	Updates to the Medicaid ACO application process will be posted to DMMA's website.
66	Can specialists participate or just PCPs?	Yes, a Medicaid ACO can include a variety of providers, including hospitals and specialists. The definition of ACO for purposes of the Medicaid ACO program is "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". It is important to note that MCO enrollees can only be attributed to the ACO through its participating PCPs. PCPs are defined in the application as 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. Additionally, the ACO cannot limit attributed members to utilizing providers only in the ACO network.
67	Will there be a large claims threshold in the TCOC calculation?	MCOs and ACOs will have the flexibility to negotiate whether a large claims threshold is used. 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. See Section 2.F.ii of the application.

#	Question	DMMA Response
68	If an ACO chooses track one but determines during that first year that they are not able to assume risk in year two, can the upside only arrangement be extended?	DMMA has considered the payment tracks described in the application carefully and described a pathway forward toward risk that allows the MCOs and ACOs to meet providers where they are today. DMMA believes the timing described in reasonable and attainable. DMMA may consider additional flexibilities early in the program in consideration of the COVID-19 pandemic as long as the general objectives of the respective Track are achieved/maintained.
69	What date will DMMA be placing a bid out for the MCO renewals?	The Medicaid MCO contracts were last reprocured in 2017 with new contracts beginning January 1, 2018 and currently run through December, 31, 2020. The current procurement can be extended for two additional one-year periods through December 31, 2022 No date has been set for the next Medicaid MCO reprocurement.
70	Will the care coordination payments or pmpms be determined by the MCO themselves?	ACOs will negotiate the arrangement with the MCO including the parameters of the TCOC arrangement including the target spending benchmark and shared savings arrangements within the payment tracks defined in Section 2 of the DE Medicaid ACO Application, “Medicaid ACO Payment Model Overview”. DMMA encourages the ACOs to explore value-based purchasing strategies with the MCOs and the ACOs participating providers. It is important to note that MCOs are not required to offer new care coordination payments to providers as part of this program.
71	Will the participants in the Medicaid ACO/PCPs keep their underlying FFS contract with the MCO and the Medicaid ACO contract will be in addition to that?	DMMA is seeking Medicaid ACOs that can demonstrate a commitment to transitioning away from traditional FFS payment models consistent with the State’s guidelines and goals described in the Medicaid ACO application. DMMA is not mandating/defining a specific VBP provider payment model at this time, but may do so in the future with reasonable notice provided to the Medicaid MCOs/ACOs.

June 17, 2020 Updates:

#	Question	DMMA Response
72	While this is not the case today, is it permissible to have members of the governing body who are NOT residents of the state of DE?	There are no Delaware residency requirements for the Medicaid ACO's governing body. DMMA would prefer that the Medicaid ACO's governing body have a connection with, knowledge of and/or relational experience with the local Delaware market, but Delaware residency of the governing body is not required. Moreover, it is DMMA's expectation that the members and families that are to provide "meaningful input" (see question B.7) are residents of Delaware and are impacted by the Medicaid ACO initiative in a material way. In addition, since question B.8 references "participating PCPs" having "meaningful representation and input", DMMA expects these PCPs to be Delaware Medicaid providers whether or not the PCP resides in Delaware.

Due to the ongoing COVID-19 response and related activities, DMMA is modifying the timeline and contracting requirements of the Medicaid ACO program for 2021 and subsequent years. In order to accommodate the extended Medicaid ACO application date of June 30, 2020 and provide sufficient time for ACO/MCO contract negotiations, DMMA is revising the Key Dates table in Section 3 of application and updating the contracting terms as follows:

Table 2: Key Dates

Key Dates for Medicaid ACOs Submitting Applications in 2020	
ACO applications due	**Tuesday, June 30, 2020 by 1:00pm ET**
Approved ACOs announced/ACO authorization period commences	**By September 30, 2020**
ACO/MCO contract start date	**July 1, 2021**
ACO/MCO contract end date[1]	**December 31, 2024**

Key Dates for Medicaid ACOs Submitting Applications in 2020	
ACO authorization end date (if not renewed)	December 31, 2024

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

- **ACOs authorized in 2020 will be authorized for a period of four full calendar years (e.g., Medicaid ACOs authorized in 2020 will have authorization for calendar years 2021-2024).**
- **Medicaid ACOs will be expected to enter into three and a half year total cost of care agreements beginning July 1, 2021 with Medicaid MCOs, provided that the MCO(s) maintain their MCO contracts with DMMA for the term of the agreement.**
- **The two payment tracks described in Section 2.F are still applicable as described in the application; however, "Year 1" will now be the 18-month period of July 1, 2021 through December 31, 2022 to accommodate the later start of the Medicaid ACO program. Each ACO/MCO contract will have the option to use Track 1 or Track 2 for the entire 18-month period or divide the initial contracting period into a 6-month and 12-month period using an applicable Track for each period as mutually agreed to (e.g., Track 1 then Track 2, Track 1 for each period but with different total cost of care targets, Track 1 for entire period, etc.). DMMA is endeavoring to offer as much as flexibility as practical during the initial period.**
- **Year 2, as noted in the payment tracks Section 2.F, will commence January 1, 2023 and each ACO/MCO agreement will be required to meet the requirements described in the application for Year 2 of the Medicaid ACO program.**