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State/Territory Name: Maine

State Plan Amendment (SPA) #: 23-0013

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

December 15, 2023

Michelle Probert, Director
Office of MaineCare Services
Department of Health and Human Services
109 Capitol Street, 11 State House Station
Augusta, Maine 04333-0011

Re: Maine State Plan Amendment (SPA) 23-0013

Dear Director Probert:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 23-0013. This amendment proposes to amend Maine's Accountable Communities Program.

This letter is to inform you that Maine Medicaid SPA 23-0013 was approved on December 15, 2023, with an effective date of July 1, 2023.

If you have any questions, please contact Gilson DaSilva at (617) 565-1227 or via email at Gilson.DaSilva@cms.hhs.gov.

Sincerely,

[redacted]

Ruth A. Hughes, Acting Director
Division of Program Operations

Enclosures

cc: Kristin Merrill, Acting Policy Director, Office of MaineCare Services

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **23 __ 0013**

2. STATE: **Maine (ME)**

3. PROGRAM IDENTIFICATION: TITLE **XIX** OF THE SOCIALSECURITY ACT

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
7/1/23

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(t)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY **2023** $ 0
b. FFY **2024** $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A Page 12b and 12c, Attachment 4.19-B pages 7b-7e, 7g-h

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-A Page 12b and 12c, Attachment 4.19-B pages 7b-7e, 7g-7h

9. SUBJECT OF AMENDMENT
Amendment to Maines Accountable Communities program.

10. GOVERNOR'S REVIEW *(Check One)*

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
- ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ☑ OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Michelle Probert

13. TITLE
Director, MaineCare Services

14. DATE SUBMITTED
September 28, 2023

15. RETURN TO
Michelle Probert
Director, MaineCare Services
#11 State House Station
109 Capitol Street
Augusta, Maine 04333-0011

FOR CMS USE ONLY

16. DATE RECEIVED 09/28/2023

17. DATE APPROVED 12/15/2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL 07/01/2023

19. SIGNATUR[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Ruth A. Hughes

21. TITLE OF APPROVING OFFICIAL
Acting Director, Division of Program Operations

22. REMARKS

with at least one Public Health Entity, if such a provider serves members in the AC's service area.

1. If the AC Lead Entity is contracted or has a documented relationship with a PCPlus Practice as an AC provider, the AC Lead Entity must invite any Behavioral Health Home Organization or Community Care Team with which the PCPlus Practice partners to provide Community Care Team or Behavioral Health Home services to participate as a contracted AC Provider with the AC Lead Entity.

2. Develop and submit the AC's Joint Care Management and Population Health Strategy by July 31 of each year. The Joint Care Management and Population Health Strategy shall include a high-level description of the process used to ensure the AC Lead Entity, their primary care, and Community Care Team partners will efficiently coordinate care derived from patient goals and clinical needs.

A. **Service Description**

I. Accountable Community (AC) Program

Maine's Accountable Communities initiative's goal is to improve the quality and value of the care provided to MaineCare members. Accountable Communities will achieve the triple aim of better care for individuals, better population health, and lower cost through a program that provides the opportunity for shared savings payments based on quality performance through improved care coordination.

Accountable Communities will benefit from a value-based purchasing strategy that supports more integrated and coordinated systems of care. Accountable Community Lead Entities will ensure the location, coordination and monitoring of primary care health services and lab services, acute, and behavioral health care services. Accountable Community Lead Entities that elect to include long term service and support services as Optional Service Costs in the assessment of any shared savings as outlined in SPA pages 4.19 will also ensure the location, coordination, and monitoring of long-term services and supports.

Under the AC program, an AC "Lead Entity" MaineCare provider contracts with the Office of MaineCare Services (the Department) to share in a percentage of savings or losses for an assigned member population, commensurate with performance on specified quality metrics in fivecategories:

1. Chronic Conditions;
2. Behavioral Health;
3. Reproductive and Child Health;
4. Avoidable Use; and
5. Patient Experience

Performance on these quality metrics reflects the outcomes of locating, coordinating and monitoring of services by AC Lead Entities and AC Providers for members assigned to the AC for the performance year.

The Department's AC contract is only with the Lead Entity; it is not with any additional AC Providers that may make up the AC.

II. Covered Population

MaineCare members who receive full MaineCare benefits, including Categorically Needy, Medically Needy, SSI-related Coverage Groups, Home and Community-Based Waiver members, and Children's Health Insurance Plan (CHIP) are eligible for assignment to Lead Entities for the assessment of savings and determination of quality metrics. Medicaid members will be assigned to an AC based on an algorithm defined in pages 4-19. Medicaid members' freedom to choose to receive any Medicaid service from any qualified Medicaid provider is in no way limited by the members' assignment to a Lead Entity.

B. **Core Services**

The following MaineCare services are included: Physician Services; Nurse Midwife Services; Federally Qualified Health Centers; Rural Health Clinic; Indian Health Centers; Targeted Case Management Services (excluding services provided by Department employees); Mental Health Services; Substance Use Disorder Treatment Services; Rehabilitative and Community Support Services; Home Health Services; Pharmacy Services; Hospice Care Services; Other Laboratory and X-ray Services; Ambulance Services; Medical Supplies Equipment, and Appliances (DME); Family Planning Services; Occupational Therapy Services; Physical Therapy Services; Speech Therapy Services; Chiropractic Services; Optometrist's Services; Hearing Aids; Audiology Services; Podiatrist's Services; Clinic Services; Early and Periodic Screening, Diagnostic and Treatment Services; Inpatient Hospital Services; Outpatient Hospital Services; Inpatient Psychiatric Facilities Services including Psychiatric Residential Treatment Facilities; Behavioral Health Home Services; Opioid Health Home Services; Health Home Services – Community Care Team Service; MaineMOM Services; Private Non-Medical Institution Services (specifically Substance Use Disorder residential treatment services and children's residential treatment services).

C. **Optional Services**

The AC may also elect to include any of the additional MaineCare services: HCBS waiver services (excluding the Other Related Conditions waiver); Nursing Facility Services; Intermediate Care Facilities for Individuals with Intellectual Disability (ICF-IID); Private Duty Nursing and Personal Care Services; and Dental Services.

D. **Limitations**

I. The following populations are excluded from assignment to an AC:

- Members without full MaineCare benefits
- MaineCare members who have less than six (6) months of continuous MaineCare eligibility or less than nine (9) months of non-continuous eligibility within the twelve (12) month period of analysis.

II. The following services/program costs are excluded:

- Other Private Non-Medical Institutions (PNMI) services not included as Core services above

2. Calculation of Savings or Losses

The shared savings payment or loss recoupment for each Performance Year is based on the difference between the Benchmark TCOC and the actual, realized TCOC for each Performance Year, for specified services provided to the population assigned to the AC by any qualified Medicaid providers, regardless of whether the providers are part of the AC. Savings must meet or exceed 2.5% for ACs with 1,000 to 4,999 attributed members or 2.0% for ACs with greater than 5,000 attributed members in order to allow payment. Payment is adjusted based on the AC's performance on defined quality benchmarks for the performance year. AC Lead Entities may share savings or losses with its AC Providers.

The Department will determine shared savings or losses by comparing:

a) Benchmark Total Cost of Care: The total baseline per member per month cost of care for Core Service Costs and any Optional Service Costs elected by the AC for the assigned population, adjusted for trend, policy changes, and risk (described below); and

b) Actual Performance Year Total Cost of Care: The total actual per member per month expenditures on Core Service Costs and any Optional Service Costs elected by the AC for the assigned population during the Performance Year.

In order to avoid duplication of payment for locating, coordinating and monitoring services, the Department will subtract from the savings calculation above, for each Performance Year, MaineCare population-based, per member per month payments that were made to any of Primary Care Plus (PCPlus) providers who make up the AC Lead Entity, for PCPlus services delivered to assigned members.

Providers may choose one of two payment models. One model includes gain-sharing only, the other model includes both gain-sharing and loss-sharing after the first year, though the percentage of shared savings decreases for any AC Lead Entity not participating in a Department-Aligned Initiative. Final payments will be made within 17 months of the end of the Performance Year.

3. Risk Score

For both the base year and the Performance Year, the Department will calculate a risk score utilizing a proprietary scoring system embedded in its MSIS system that is based on diagnoses, condition interactions, age, and sex of the population assigned to the AC. The Benchmark TCOC will be adjusted based on the increase or decrease in the risk of the assigned populations between the Base Year and Performance Year.

A. Member Assignment Methodology and Minimum Number of Members Required

(1) The Department will assign members to an AC Lead Entity using the following stepwise process:

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

b. Members enrolled in a PCPlus practice that is part of or contracted by an AC Lead Entity will be assigned to that AC Lead Entity.

c. Members not assigned in (b) will be assigned to the AC Lead Entity where they had a plurality of primary care services with a primary care provider. Primary Care Services are defined as Evaluation and Management, preventive, and wellness services identified through procedure codes, as listed in the provider contract.

d. Members not assigned under b or c who have had three (3) or more Emergency Department (ED) visits will be assigned to the AC that includes a hospital(s) at which the member has had a plurality of his or her ED visits.

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

Members under the age of 21 who receive children's residential treatment services (known as children's Private Non-Medical Institution (PNMI) Services) (excluding treatment foster care) will be reassigned to ensure that accountability for care aligns with the AC Lead Entity responsible for care coordination prior to the member's PNMI stay. Attribution of these members are cross-referenced against an algorithm designed to identify the most recent period in which the member has less than 183 days of PNMI services—over the current and preceding 2-year time period—with the AC Lead Entity responsible for care coordination at that point in time. Using these three-year time periods, members are attributed to the AC Lead Entity responsible for care coordination during the time-period associated with the fewest number of days in PNMI.

(2) Minimum Assigned Members:

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

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

(3) Members may not be assigned to more than one AC Lead Entity at any point in time.

(4) On a biannual basis, the Department will assign members to an AC for rolling twelve-month periods. The final assigned population for each performance year will be determined at the end of the performance year for purposes of accountability under the payment model.

(5) In order to shift (by one month) the performance year spanning 2021-2022, the shared savings payment for this specific performance year, will only utilize member months generated for 11 months to avoid duplication of payment with the previous performance year.

B. Quality Measures

Savings payments will vary proportionately to the AC Lead Entity's performance on quality measures. There will be a minimum acceptable attainment level for each measure. The measures will be posted on http://www.maine.gov/dhhs/oms/vbp/accountable.html and may be updated three months prior to the start of each performance year.

1. An AC may earn both achievement points for meeting the minimum attainment level or better on each measure, and improvement points for improving on their performance from the previous year..
2. If the AC achieves at least a 35% overall quality score, the AC will be eligible to earn points and to share in a portion of the savings for its assigned population (i.e., a portion of the difference between the benchmark TCOC and actual TCOC, subject to the limits described below in Section E). ACs that fail to achieve the 35% overall quality score will not be eligible to share savings for its assigned population.

C. 3.If the AC fails to achieve the minimum attainment level on the above specified percentage , the Department may give the AC a warning, ask the AC to develop a corrective action plan, or put the AC in a special monitoring plan. Failure to meet the quality standard may result in termination. An AC that has been terminated from the program is disqualified from sharing in savings. Savings and Loss-Sharing Calculation Methodology

Providers may choose one of two payment models. Under both models, to qualify for a shared savings payment: (1) the difference between the actual TCOC for the Performance Year and the Benchmark TCOC for the population assigned to the AC must meet or exceed at least 2.5 % for ACs with 1,000 to 4,999 attributed members or 2.0% for ACs with greater than 5,000 attributed members, and (2) the AC Lead Entity must achieve a minimum aggregate quality score.

1. **Model I: Shared Savings Payment Methodology.** The Model 1 Shared Savings Payment will be calculated as follows:

   a. **Shared Savings Rate.** Lead Entities under Model I may share in a maximum of 50 percent of savings, based on quality performance. If the AC Lead Entity is not participating in at least one Department-Aligned Initiative, (as established here https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/accountable-communities, effective for services on and after July 1, 2023) that Entity may share in a maximum of 40 percent of savings, based on quality performance.

   b. **Quality Measure Adjusted Rate.** The AC's Lead Entity's aggregate percentage score on the quality measures multiplied by the Shared Savings Rate.

   c. **Shared Savings Payment Limit.** The amount of the shared savings payment an eligible Lead Entity receives under Model I may not exceed 6 percent of the Benchmark TCOC for each Performance Year.

   d. **Shared Loss.** Lead Entities participating under Model I are not accountable for any losses in any of the three performance years.

   e. **Shared Savings Payment Calculation.** Take the calculated per member per month savings amount, multiply that number by the Quality Measure Adjusted rate. The resulting per member per month savings amount is subject to the 10 percent Payment Limit above, once payments to the AC for PCPlus have been subtracted. This amount is then multiplied times the total number of member months for the year to equal the total annual Shared Savings Payment.

2. **Model II: Shared Savings & Shared Losses Payment methodology.** The Model II Shared Savings or Shared Loss Payments are calculated as follows:

   a. **Shared Savings Rate.** Lead Entities participating under Model II share in a maximum of 60 percent of savings, based on quality measure performance.
   b. **Quality Measure Adjusted Rate.** The AC Lead Entity's aggregate percentage score on the quality measures multiplied by the Shared Savings Rate.

   c. **Shared Savings Payment Limit.** The per member per month amount of shared savings an eligible Lead Entity receives under Model II may not exceed 15 percent of the Benchmark TCOC for that Performance Year.

D. Core Service Costs

Costs for the following MaineCare services are included in the TCOC calculations: Physician Services; Advanced Practice Registered Nurse Services; Federally Qualified Health Centers; Rural Health Clinic; Indian Health Centers; Targeted Case Management Services (excluding services provided by Department employees); Mental Health Services; Substance Use Disorder Treatment Services; Rehabilitative and Community Support Services; Home Health Services; Pharmacy Services; Hospice Care Services; Other Laboratory and X-ray Services; Ambulance Services; Medical Supplies Equipment, and Appliances(DME); Family Planning Services; Occupational Therapy Services; Physical Therapy Services; Speech Therapy Services; Chiropractic Services; Optometrist's Services; Hearing Aids; Audiology Services; Podiatrist's Services; Clinic Services; Early and Periodic Screening, Diagnostic and Treatment Services; Inpatient Hospital Services; Outpatient Hospital Services; Inpatient Psychiatric Facilities Services, including Psychiatric Residential Treatment Facilities; Opioid Health Home Services; Behavioral Health Home Services; Health Home Services -Community Care Team Services; MaineMOM Services; Private Non-Medical Institution Services (specifically Substance Use Disorder residential treatment services and children's residential treatment services).

H. Optional Service Costs

The AC may also elect to include costs for the following MaineCare services in its TCOC calculations: HCBS waiver services (excluding the Other Related Conditions waiver); Nursing Facility Services; Intermediate Care Facilities for Individuals with Intellectual Disability (ICF- IID); Private Duty Nursing and Personal Care Services; and Dental Services.

I. Excluded Service Costs

The following service costs are excluded from the TCOC calculation: other PNMI, services not listed under "Core Service Costs" (above); Non-Emergency Transportation; TCM provided by Department employees, and Other Related Conditions HCBS Waiver.

J. Participation in Department-Aligned Initiatives

An AC has the option to select one of three Department-Aligned Initiatives to be eligible for the Maximum Shared Savings Rate of 50%.:

1. Improving Care for Substance Use Disorder and Enhancing Access to Medications for Opioid Use Disorder in Hospital Settings
2. Funding for Health-Related Social Needs.
3. Improved Readiness for Payment Reform within Nursing Facilities.

Initiative requirements for successful participation are established here https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/accountable-communities, effective for services on and after July 1, 2023.

G. COVID-19 Adjustments to the Total Cost of Care Reconciliation for Performance Year 8 covering August 1, 2021 – July 31, 2022

To ensure the Accountable Communities program captures the savings related to locating, coordinating, and monitoring of attributed members while minimizing either beneficial or negative impact on savings due to the effects of the COVID-19 pandemic, the following adjustments will be made to the Total Cost of Care.

1. Maine will remove COVID-19 costs related to testing, treatment, and vaccinations from the PY 8 TCOC reconciliation analysis.