Table of Contents

State/Territory Name: Maine

State Plan Amendment (SPA) #: 24-0019

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 13, 2024

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) 24-0019

Dear Director Probert:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 24-0019. This amendment proposes several clarifications to the MaineCare Accountable Communities (AC) Program.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act in Section 1902(t). This letter informs you that Maine's Medicaid SPA TN 24-0019 was approved on December 13, 2024, effective July 1, 2024.

Enclosed are copies of Form CMS-179 and the approved SPA pages to be incorporated into the Maine State Plan.

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

Sincerely,

[redacted]
J
Division of Program Operations

Enclosures

cc: Kristin Merrill, State Plan and Policy Development Manager, Office of MaineCare Services

DEPARTMENT OF HEALTH AND HUMAN 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: **24 0019**

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

3. PROGRAM IDENTIFICATION: TITLE **XIX** OF THE SOCIAL SECURITY ACT

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

4. PROPOSED EFFECTIVE DATE
7/1/24

5. FEDERAL STATUTE/REGULATION CITATION
1905(t)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY **2024** $ **0**
b. FFY **2025** $ **0**

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A page 12c
~~**Attachment 4.19-B pages 7a, 7c, 7g, and 7h**~~
Attachment 4.19-B pages 7a, 7b, 7c, 7d, 7g and 7h

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

9. SUBJECT OF AMENDMENT
Clarifications to the MaineCare Accountable Communities (AC) 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 30, 2024

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 09/30/2024

17. DATE APPROVED 12/13/2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
07/01/2024

19. SIG [redacted]

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

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

22. REMARKS

12/09/2024 - ME agreed to P&I revisions to add Attachment 4.19-B, pages 7b and 7d in boxes 7 and 8.

Instructions on Back

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).

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

areas follows: 2021-2022 is PY8, 2022-2023 is PY9, and 2023-2034 is PY10, and so forth. During the year July 1, 2024 - June 30, 2025 the AC Performance Year does not include a shared savings or loss opportunity as described herein

1. Total Cost of Care Calculation for Base Year and Performance Years

The per member per month TCOC for the base year and for Performance Years will be calculated by the Department retrospectively, using fee-for-service claims and non claims-based service payment data. The cost in the Base and Performance Years will include the Core Service Costs and any Optional Service Costs selected by the Lead Entity, for the population assigned to the AC. All of the assigned members' Core Service Costs and Optional Service Costs elected by the AC will be calculated as part of the Benchmark TCOC amounts for the AC, regardless of whether the AC delivered the services associated with those costs. The TCOC will not include a member's total annual claims costs in excess of 50,000 for ACs with 1,000-1,999 attributed members; $155,000 for ACs with 2,000-4,999 attributed members; or $210,000 for ACs with 5,000 attributed members or greater

The Benchmark TCOC amount for each Performance Year will be developed using the base year TCOC adjusted for policy changes through the end of the Performance Year, changes in the aggregate risk of the attributed population from the base year to the Performance Year, completion factor adjustments to account for claims incurred but not paid, the claims cap adjustments referenced above, and trend calculated from the Performance Year based on sub population trends within a non-AC comparison group.

The non-AC comparison group consists of members who would meet the criteria to be attributed to an AC except that the providers through which they would otherwise be attributed are not participating in the initiative.

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 exceed2.5% for ACs with 1,000 to 4,999 attributed members or 2.0% for ACs with greater than 5,000attributed 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, or may occur later due to emergencies or unforeseen circumstances.

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.

State Plan Title XIX of the Social Security Act

Integrated Care Model

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 identifiedthrough 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.

(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 11months 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

https://www.maine.gov/dhhs/oms/providers/value-based-purchasing

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. 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.

E. 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).

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 (effective July 1, 2024)

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

1. Maine will remove COVID-19 costs related to testing, treatment, and vaccinations from TCOC accountability and will make corresponding risk score and member months adjustments to account for the removal of these costs in the PY8 TCOC reconciliation analysis.

2. Maine will also adjust quality measure scoring and benchmarks to align with COVID-related guidance from national measure stewards' guidance regarding impacts of COVID-19 on cross year comparisons. When indicated, these alignments result in allowing or disallowing quality improvement points and switching transitions to same year benchmarks instead of multi-year benchmarks.