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State/Territory Name: Maine

State Plan Amendment (SPA) #: 25-0008

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

June 8, 2026

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) - 25-0008

Dear Director Probert:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 25-0008. This amendment was submitted to modify the methodology for accountable communities (AC) to qualify for a shared savings payment or be required to pay a shared loss payment.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act in Section 1905(t). This letter informs you that Maine's Medicaid SPA TN 25-0008 was approved on June 8, 2026, with an effective date of July 1, 2025.

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]

Nicole McKnight
Acting Director, Division of Program Operations

Enclosures

cc: Kristin Merrill, Associate Director of Program Implementation, 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: 25 0008

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
7/1/2025

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

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 0

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

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

9. SUBJECT OF AMENDMENT
The Department is moving to a shared risk model for the Performance Year (PY) aligning with State Fiscal Year 2026 (SFY 26, July 1, 2025 – June 30, 2026). This change impacts the methodology under which an AC may qualify for a shared savings payment or be required to repay a shared loss payment. The Department is offering two shared risk models

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
9/30/25

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
09/30/2025

17. DATE APPROVED
06/08/2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
07/01/2025

19. [redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Nicole McKnight

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

22. REMARKS

06/04/26 - ME provided pen-and-ink authority to revise boxes 7 and 8, replacing Page 12(a) with parentheses with Page 12a.

Instructions on Back

28. Integrated Care Model Accountable Community (AC) Program

A. **Provider**

Under the Accountable Communities Program, the State will contract with a Lead Entity. The term "Accountable Community" refers to the Lead Entity plus any other providers with which the Lead Entity enters into agreement. These other providers are referred to as "AC Providers."

I. Lead Entity Integrated Care Model – 1905(t)(1) Requirements

A Lead Entity must be, employ, or contract with:

1. An approved MaineCare Primary Care Plus (PCPlus) Provider, or

2. An entity or individual that otherwise meets the following requirements that the entity or individual:

   a. Be a physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services; a nurse practitioner; a certified nurse-midwife; or a physician assistant;

   b. Have a primary specialty designation of internal medicine, general practice, family practice, pediatrics, geriatric medicine, obstetrics or gynecology; and/or practice in a Rural Health Center, Federally Qualified Health Center, a tribal health clinic, or School Health Centers;

   c. Provides for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;

   d. Provides for arrangements with, or referrals to, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

   e. Prohibits discrimination on the basis of health status or requirements for health care services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance under this title; and

   f. Complies with the other applicable provisions of section 1932.

II. Other Lead Entity Requirements.

Lead Entities must also:

1. Have submitted successful responses to a Department's AC request for applications.

2. Enter into a contract with the State to participate in the initiative. Fulfill required reporting and notification requirements for program operations. Meet State requirements around governance, contracting, coordination, and population health. 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 requirements.
3. Allow MaineCare members freedom of choice of providers and may not engage in any activities that limit the members' freedom to choose to receive services from providers who are not part of the AC.

4. Have an established an adequate repayment mechanism for potential shared loss payment.

5. Include applicable Emergency Department (ED)/hospitals for the purposes of member attribution (see 4.19) to ensure accountability for members who frequently visit the ED instead of primary care locations.

6. Participate in quality measurement and learning activities as required by the State.

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 or risk of shared loss 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 Core services and any optional services selected by the AC Lead Entity.

Under the AC program, an AC Lead Entity MaineCare provider contracts with the State to share in a percentage of savings or losses for an assigned member population, commensurate with performance on specified quality metrics in five categories:

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.

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; Advanced Practice Registered Nurse Services; Federally Qualified Health Centers; Rural Health Clinic; Tribal Health Clinics; 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; Preventive 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; other Long-Term Services and Supports (e.g. day health, adult family care homes), 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. Services not included above as Core or Optional Services are excluded services.

E. **Assurances**

The Department makes the following assurances:

1. The AC program does not restrict members' free choice of provider as described in 42 CFR 431.51.

2. All services under the AC program are provided in accordance to the provision of 1905(t) of the Social Security Act. Specifically the Department assures:

   a. All provider participants in the AC program are prohibited from discriminating on the basis of health status or requirements for health care services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance. Any marketing and/or other activities must not result in selecting recruitment and assignment of individuals with more favorable health status

   b. The Department will notify members who are assigned to an AC of the program. The Department will notify the State's Medicaid beneficiaries of the program through an annual mailing beginning with the first trimester in which the member is assigned, including a description of provider payment incentives, and the use of personal information.

   c. The Department will comply with all applicable provisions of section 1932 of the Social Security Act.

28. Integrated Care Models (Primary Care Case Management)

A. Overview

Under the Accountable Community (AC) program, an AC "Lead Entity" MaineCare provider contracts with the Department to share in a percentage of savings or losses for an assigned member population, commensurate with performance on specified quality metrics. The Department does not contract with the individual providers that make up the Lead Entity. The Lead Entity may distribute payment to or share responsibility for losses with any of its other AC providers.

As part of program operations, Maine will evaluate the program to demonstrate improvement against past performance using cost and quality data to determine whether the payment methodology has achieved or needs revisions to achieve the goals of improving health, increasing quality and lowering the growth of health care costs.
When requested by CMS or as determined necessary by the State, Maine will:

- Provide CMS, with data and reports supporting achievements in the goals of improving health, increasing quality and lowering the growth of health care costs.
- Provide CMS with updates, as conducted, to the state's metrics.
- Review and renew the payment methodology as part of the evaluation.
- Make all necessary modifications to the methodology, including those determined based on the evaluation and program success, through State Plan Amendment submissions.

Shared savings payments will be made under the statutory authority of 1905(a)(25) and 1905(t)(1) of the Social Security Act, which includes location, coordination and monitoring of health care services. Fee-for-service payments will continue to be made to any qualified Medicaid provider – including AC providers – that provides any Medicaid service to a member who has been attributed to a Lead Entity.

B. Payment Methodology

"Performance Year" is the twelve-month period of participation in the Accountable Community program by the AC Lead Entity, beginning on July 1 of each year. "Base Year" is a historical twelve-month period , on which analysis is based to establish the per member per month total cost of care (TCOC) benchmark. For State Fiscal Year 2026 and 2027/Performance Years, the Base Year is July 1, 2023-June 30, 2024.

. 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 $200,000 for ACs with 2,000-4,999 attributed members; or $300,000 for ACs with 5,000 attributed members or greater. The claims cap for the Comparison Group is $400,000.

The Benchmark TCOC amount for each Performance Year will be developed using the base year TCOC adjusted for policy or other related 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 AC Comparison Group.

The AC Comparison Group consists of two groups of members. First, 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. Second, the AC Comparison group also includes members that were attributed to an AC.

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 2,000 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. Final payments will be made within 27 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 MMIS 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 and/or diagnostic 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 that meet the above criteria for a practice or hospital that is not part of an AC Lead Entity will be assigned to the Comparison Group. The Comparison Group includes both AC and Comparison Group members.

(2) Minimum Assigned Members:

Lead Entities electing to participate 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 effective for services on or after 7/1/25 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.

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.

C. Shared Risk Model

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 2,000 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.

Model I:

a. **Shared Savings Rate.** Lead Entities under Model I may share in a maximum of 40 percent of savings, based on quality performance. If the AC Lead Entity does not complete at least one Department-Aligned Initiative, that Entity may share in a maximum of 35 percent of savings, based on quality performance.

b. **Quality Measure Adjusted Rate.** The product of the quality score times the applicable shared savings percentage or 1 minus the quality score for the quality-adjusted shared loss percentage.

c. **Shared Savings Payment Limit.** The AC Lead Entity's initial shared savings rate will be capped at 5% (i.e. the initial difference between benchmark and PY TCOC, as a percentage). The shared savings payment is capped at 1 percent of the AC's core costs before claims cap of the PY.

d. **Shared Loss.** Lead Entities under Model I are liable for up to 15 percent of shared losses, based on quality performance. If the AC Lead Entity does not complete at least one Department-Aligned Initiative, that Entity will be liable for up to 20 percent of the shared loss, based on quality performance.

e. **Shared Loss Payment Limit:** The AC Lead Entity's shared loss payment is capped by the lower of:

i. The total aggregate difference between Tier 2 and Tier 3 PCPlus PMPM payments to PCPlus practices that are part of the AC, or

ii. 0.25 percent of the AC's core costs before claims cap of the PY.

Model II:

a. **Shared Savings Rate.** Lead Entities participating under Model II share in a maximum of 60 percent of savings, based on quality measure performance. If the AC Lead Entity does not complete at least one Department-Aligned Initiative, that Entity will be eligible for up to 55 percent of the shared loss, based on quality performance.

b. **Quality Measure Adjusted Rate.** The product of the quality score times the applicable shared savings percentage or 1 minus the quality score for the quality-adjusted shared loss percentage. The AC Lead Entity's quality score is capped at 80 percent for the quality-adjusted shared loss percentage.

c. **Shared Savings Payment Limit.** The AC Lead Entity's initial shared savings rate will be capped at 7 percent (i.e. the initial difference between benchmark and PY TCOC, as a percentage). The shared savings payment is capped at 2 percent of the AC's core costs before Claims Cap of the PY.

d. **Shared Loss Rate.** Lead Entities under Model II are liable for up to 25 percent of shared losses, based on quality performance. If the AC Lead Entity does not complete at least one Department-Aligned Initiative, that Entity will be liable for up to 30 percent of the shared loss, based on quality performance.

e. **Shared Loss Payment Limit.** The AC Lead Entity's Shared Loss Payment is capped by the lower of:

i. The total aggregate difference above Tier 1 (excluding performance-based payment components) PCPlus PMPM payments to PCPlus Practices that are part of the AC, or

ii. 1 percent of the AC's core costs before claims cap of the PY.

Initiative requirements for successful participation in Department-Aligned Initiatives are established here https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/accountable-communities, effective for services on and after July 1, 2025. Department-Aligned Initiatives relate to the following three areas:

1. Improving Care for Substance Use Disorder and Enhancing Access to Medications for Opioid Use Disorder in Hospital Settings
2. National Diabetes Prevention Program (NDPP).
3. Improved Primary Care for Members Residing in Assisted Living Housing

D. Ensuring Continued Provision of Medically Necessary Care

The AC program's use of quality measures – including multiple measures that are specific to appropriate use of care – in determining the shared savings and loss payments ensures that the AC Lead Entity has an incentive to promote the use of appropriate care.

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 ClinicTribal Health Clinic; 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;Preventive Services).

F. 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; other Long-Term Services and Supports, and Dental Services.

G. Excluded Service Costs

Services not included above as Core or Optional Services are excluded services.

H. COVID-19 Adjustments to the Total Cost of Care Reconciliation for Performance Year 9 covering July 1, 2022 – June 30, 2023 (effective June 1, 2025)

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 PY9 TCOC reconciliation analysis.