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**3.01 INTRODUCTION**

Primary Care Plus (PCPlus) is a model that gives Primary Care Providers (PCPs) greater flexibility and incentives to effectively meet MaineCare members’ health care needs by transitioning away from a volume-based (fee-for-service) payment system with little connection to value, toward an approach that provides Population-Based Payments (PBPs) tied to cost- and quality-related outcomes. Participation in PCPlus is voluntary for PCPs. For PCPs that elect to participate, the Maine Department of Health and Human Services (Department) shall share quality and utilization data, offer a value-based payment model, and provide technical assistance to help practices transform care delivery and achieve performance outcomes.

Member participation in this model is voluntary, is based on members’ selection of a PCP, and has no bearing on MaineCare members’ freedom of choice to access services from any qualified MaineCare provider. Section 1905(t)(1) of the Social Security Act (42 U.S.C. §1396d(t)(1)) provides the federal statutory authority for PCPlus.

**3.02 DEFINITIONS**

**3.02-1** **Accountable Community (AC)** is an entity participating in a MaineCare program established through a contract between the Department and an AC Lead Entity that establishes a financial relationship between the Department and the AC Lead Entity to both provide a financial incentive and hold the AC accountable for the provision of efficient, coordinated, and high-quality care. AC Lead Entities that achieve savings relative to a benchmark Total Cost of Care (TCOC) amount are eligible to receive a portion of these savings dependent on and proportional to their performance on a number of quality measures.

**3.02-2** **Attribution** **Assessment Period** is the twenty-four- (24) month “lookback” period used for member attribution.

**3.02-3** **Behavioral and Physical Health Integration** is the care a member experiences as a result of a team of primary care and behavioral health providers, working together with members and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population (based on the definition of “Integrated Behavioral Health Care” from the Agency for Healthcare Research and Quality).

**3.02-4** **Care Plans** are developed and updated by the PCP in collaboration with the Member and their families and contain a problem list, expected outcome/prognosis, treatment goals, and medication management.

**3.02 DEFINITIONS** (cont.)

**3.02-5 Certified Electronic Health Record Technology (CEHRT)** is Electronic Health Record (EHR) technology (which could include multiple technologies) certified under the Office of National Coordinator for Health IT Certification Program that meets the criteria listed in 42 CFR §414.1305.

**3.02-6 Community Health Worker (CHW)** is a trained health worker who applies their unique understanding of the community’s experience, socio-economic needs, language and/or culture to advocate for individual and community needs and acts as a bridge between providers and individuals to promote health, reduce disparities, and improve service delivery. CHWs are distinguished from other health professionals in that they are hired primarily for their understanding of the populations and communities they serve, conduct outreach a significant portion of the time, and have experience providing services in community settings (adapted from the Maine State Innovation Model).

CHW training shall include CHW core competencies defined by The Community Health Worker Core Consensus Project (see <https://www.c3project.org/roles-competencies>) or be evidenced by a Maine CHW certification or registration (effective the date such a designation becomes active in the State of Maine).

**3.02-7** **Joint Care Management and Population Health Strategy** is a written three-year plan, updated annually, which describes operational and financial coordination across the PCPlus practice, the AC, and any Community Care Team (as described in Section 91 of the MaineCare Benefits Manual) that is contracted with the AC and/or the PCPlus practice.

**3.02-8** **MaineCare Peer Group** is a group of PCPs, determined by the Department, based on Risk Scores and influenced by Tier level, practice size, practice type, and rurality, as needed. MaineCare Peer Group assignment will be determined upon acceptance into PCPlus and reassessed at least annually or when a PCP undergoes a significant change, which may include a relocation or inclusion of new populations.

**3.02-9** **Medication for Addiction Treatment (MAT)** is the use of medications for the treatment of substance use disorders.

**3.02-10** **Members** are MaineCare members attributed to a PCP for the purposes of reimbursement.

**3.02-11** **Performance-Based Adjustments (PBA)** are quarterly adjustments made to participating PCPs’ PBPs based on PCP performance on PCPlus performance measures.

**3.02 DEFINITIONS** (cont.)

**3.02-12 Performance-Based Adjustment Assessment Period** is the twelve (12)-month “lookback” period used for assessing PBAs.

**3.02-13** **Population-Based Payments (PBP)** are monthly payments that the Department calculates quarterly by adding the Tier per member per month (PMPM) rate and the population group and risk category PMPM rate and multiplying the sum by the PCP’s total number of Members. These payments are for a flexible array of care delivery approaches, including those that are not dependent on office-based, face-to-face care, such as care management, access to additional care team members, and targeted patient supports that best meet the needs of the Members.

**3.02-14** **Primary Care Services** are evaluation and management, preventive, and wellness services.

**3.02-15** **Risk Score** is a metric from a patient classification model that evaluates and forecasts individual healthcare utilization and costs for each individual Member using demographic and heath care data from a rolling twelve-(12) month period with a two-month claims run out period.

**3.03 PROVIDER REQUIREMENTS**

Each PCP shall:

1. Be approved by the Department through the PCPlus application process. The application process will open, at a minimum, annually, and providers must receive initial approval and subsequently recertify annually;
2. Be a provider or provider group (i.e. solo or group practice) that delivers primary care services, limited to the following:
   1. A physician (including residents), nurse practitioner, certified nurse midwife, or physician assistant with a primary specialty designation of pediatrics, general practice, family practice/medicine, geriatrics, internal medicine, obstetrics, gynecology, or other specialties approved by the Department, where Primary Care Services account for fifty percent (50%) of the service location’s collective billing;
   2. A rural health clinic (as defined in MBM, Section 103);
   3. A federally qualified health center (as defined in MBM, Section 31); or
   4. A tribal health clinic (as defined in MBM, Section 9); and
3. Meet Tier One requirements (3.03-1). PCPs who meet Tier Two (3.03-2) or Tier Three (3.03-3) requirements are eligible for enhanced reimbursement.

**3.03 PROVIDER REQUIREMENTS** (cont.)

**3.03-1** **Tier One PCP Requirements**

1. The PCP shall ensure twenty-four (24) hour availability of information for triage and referral to treatment for medical emergencies. This requirement may be fulfilled through an after-hours telephone number that connects the patient to:
   * + - 1. The PCP or an authorized licensed medical practitioner providing coverage for the PCP;
         2. A live voice call center system or answering service which directs the patient to the appropriate care site or connects the patient to the PCP/authorized covering medical practitioner; or
         3. A hospital if the PCP has standing orders with the hospital to direct patients to the appropriate care site within the hospital.

The following are examples of what does not constitute adequate coverage:

* + - * + A twenty-four (24) hour telephone number answered only by an answering machine without provision for arranging for interaction with the PCP or their covering provider;
        + Referring to hospital Emergency Departments (EDs) that do not offer phone triage or assistance in reaching the PCP or their covering provider; or
        + Emergency medical technicians who do not offer phone triage or assistance in reaching the PCP.

The PCP shall inform members of their normal office hours and explain to members the procedures that should be followed when seeking care outside of office hours. The PCP shall update its twenty-four (24)-hour availability information with the Department. The PCP shall ensure that their covering provider(s) is/are authorized to provide all necessary referrals for services for Members while providing coverage. The covering provider shall be a participating MaineCare provider and shall have real-time access to current, up-to-date medical records in the electronic health record during hours they are covering.

1. Annually, at least one representative from each PCP shall participate in designated Department-sponsored quality improvement initiatives and technical assistance activities. The Department will not require more than eight hours of PCP participation annually. The PCP’s representative shall be involved in clinical care, population health, and/or quality improvement.
2. The PCP shall adopt and maintain, at a minimum, a CEHRT.

**3.03 PROVIDER REQUIREMENTS** (cont.)

1. The PCP shall, annually with the PCPlus application/recertification, submit a completed assessment of the PCP’s Behavioral and Physical Health Integration progress and identify an area of focus for the following twelve (12) month period to improve Behavioral and Physical Health Integration. The Department will provide the assessment tool.
2. The PCP shall, as appropriate and at a minimum of once biennially, educate Members about the appropriate use of office visits, urgent care clinics, and the ED. PCPs may provide this education through methods including, but not limited to, pamphlets, signage, direct discussion, or Member letters.

**3.03-2 Tier Two PCP Requirements**

Tier Two PCPs shall meet all Tier One (3.03-1) requirements and shall:

1. Hold active Patient-Centered Medical Home recognition from the National Committee for Quality Assurance, the Joint Commission, the Accreditation Association for Ambulatory Health Care, or another accreditation body as approved by the Department, OR be approved by the Centers for Medicare and Medicaid Innovation as a Primary Care First practice and participate in the Primary Care First alternative payment model;
2. Maintain a Participant Agreement for data sharing with Maine’s statewide state-designated Health Information Exchange (HIE). The minimum clinical data set the practice shares must include: all patient demographic, encounter, and visit information (including diagnosis and procedure coding) and must be shared via a Health Level Seven (HL7) Admission, Discharge & Transfer (ADT) interface. Tribal health clinics may connect to the HIE as view-only participants;
3. Conduct a standard, routine assessment or screening to identify health-related social needs of Members and use the results to make necessary referrals. Assessment for health-related social needs involves using screening tools or questions that identify community and social service needs among Members;
4. Have a current documented relationship (e.g. Memorandum of Understanding or practice agreement) with at least one Behavioral Health Home Organization (as defined in MBM, Ch. II, Section 92) in the PCP’s service area that describes procedures and protocols for regular communication and collaboration between the PCP and the Behavioral Health Home Organization to effectively serve shared members.

**3.03 PROVIDER REQUIREMENTS** (cont.)

This must include the designation of the role(s) responsible for this coordination and the method for contacting the specific role(s). This may also include, but is not limited to, acceptable mode(s) of electronic communication to ensure effective and privacy-protected exchange of health information, frequency of communication, procedures to access shared members’ plans of care and other health information, referral protocols for new members, and expectations for collaboration on treatment planning;

1. Maintain processes and procedures to initiate and coordinate care with a Community Care Team (CCT) as defined in MBM, Ch. II, Section 91, in the PCP service area, for Members who are high-risk and/or high-cost whose needs cannot be managed solely by the PCP and are eligible for Section 91 covered services;
2. Offer MAT services in alignment with American Society for Addiction Medicine guidelines for appropriate level of care, have a cooperative referral process with specialty behavioral health providers including a mechanism for co-management for the provision of MAT as needed, or be co-located with a MAT provider;
3. Offer telehealth as an alternative to traditional office visits in accordance with MBM, Ch. I, Sec. 4, Telehealth Services, and/or for non-office visit supports and outreach to increase access to the care team and clinicians in a way that best meets the needs of Members;
4. Include MaineCare members and/or their families in advisory activities to identify needs and solutions for practice improvement. Advisory activities may include, but are not limited to, having MaineCare members on an advisory board and/or holding focus groups with members. Solely collecting survey data, e.g., patient experience data, without inclusion of members/families in synchronous engagement activities to identify needs and solutions is insufficient;
5. Submit to the Department an environmental scan of which populations served by the PCP could benefit from CHW engagement. This scan shall include basic demographic information of the practice to identify population groups that may benefit from CHW services and the identification and description of any CHW services currently offered through the provider’s practice or through partnerships with community-based organizations; and
6. Beginning April 1, 2024, ensure the provision of community-based CHW services that are aligned with best practices for the identified population(s) of Members at the practice through contracting with a community-based organization (preferred) or employing a CHW through the health system (e.g. the PCP, contracting CCT, and/or associated AC).

**3.03 PROVIDER REQUIREMENTS** (cont.)

**3.03-3 Tier Three PCP Requirements**

Tier Three PCPs shall meet all Tier One (3.03-1) and Tier Two (3.03-2) requirements, unless otherwise noted, and shall:

1. Be included in the list of AC primary care sites for attribution purposes in the AC program;
2. Submit an aligned Joint Care Management and Population Health Strategy (Strategy) to the Department on or before July 31st of every year. The Strategy shall include a high-level description of the process used to ensure that care is coordinated, efficient, and based on patient goals and needs. The Strategy includes:
   1. An overview of how information is obtained from various data sources to risk stratify, identify, and target specific populations that may benefit from specified interventions. The summary shall include how health disparities and health related social needs will be assessed and addressed and how the participant providers ensure consistent collection and use of demographic information such as, but not limited to, race, ethnicity, and language data;
   2. A discussion of the processes the practice uses to communicate internally and amongst external partners about changes in a member's medical, emotional and social status, risks, or needs, as they evolve;
   3. An overview of current population health, wellness, or disease management initiatives deployed by the PCP, CCT (if applicable), AC, and their community-based partners (e.g. community-based organizations); and
   4. An outline of the strategies (including PCPlus and CCT payments and AC shared savings payments, when applicable) the entities believe are necessary to support the Strategy, including how these resources support collaborations with community-based partners and the use of health information technology, including HIE and electronic health records; and
3. Maintain a Participant Agreement for data sharing with Maine’s statewide, state-designated HIE for the purpose of submitting the required data elements to allow the HIE to produce specified clinical quality measures within PCPlus. This may include, but is not limited to, sharing data related to all patient demographic, encounter, and visit information (including diagnosis and procedure coding), vital signs, and laboratory test results and coding via HL7 ADT and/or Observation Result (ORU) interfaces. This requirement satisfies the requirements of 3.03-2(B).

**3.04** **COVERED SERVICES**

The Department reimburses PCPlus PCPs for locating, coordinating, and monitoring health care services to provide Members with high-quality and cost-effective care.

This includes locating MaineCare providers who can provide timely access to patient centered, culturally and linguistically appropriate, medically necessary MaineCare covered services. This also includes supporting whole-person coordination and transitions of care; completing timely prior authorizations; providing referrals and clinician orders; tracking and following up on referrals; and closing care gaps.

PCPs shall document all covered services provided to Members in their EHR. PCPs shall:

1. **Care Plans**. Partner with Members and other care team members to create care plans that support members’ needs. Use shared-decision aids and consider Members’ health literacy levels in assessment and care planning. Include both clinician and patient action plans in the care plan as clinically appropriate;
2. **Care Coordination**. Engage in coordination with any external care coordinator, case manager, discharge planners, or care team of the Member, as determined appropriate by the needs of the Member, in accordance with all applicable state and federal privacy laws and best practices to support the Member’s care goals. This may include but is not limited to coordinating covered services with providers of: Section 13, Targeted Case Management; Section 17, Community Support Services; Section 91, Health Home Services – Community Care Teams; Section 92, Behavioral Health Homes; and Section 93, Opioid Health Homes. When coordinating and partnering with other providers, PCPs shall not duplicate efforts;
3. **Assessments.** Connect Members to clinically appropriate assessments including, but not limited to, Medical Eligibility Determination (MED) assessments for long-term care needs;
4. **Care Transition Services**. Provide care transition services between healthcare providers and settings to ensure continuity of care and reduce emergency department (ED) use, morbidity, mortality, inpatient admissions, readmissions, and lengths of stay.

Pediatric-to-adult health care transition services shall include but are not limited to the following:

* + 1. Preparing a current medical summary and plan of care;
    2. Identifying an adult primary care provider;
    3. Scheduling and ensuring that initial and follow-up appointments with the adult primary care provider are kept; and
    4. Facilitating linkages to other adult care providers (e.g., reproductive, behavioral, medical specialties);

**3.04** **COVERED SERVICES** (cont.)

1. **Screenings**. Ensure the provision of the following screenings, deliver screening-related services, and develop follow-up plans based on results:
2. **Developmental Screenings**. Provide the American Academy of Pediatrics/Bright Futures recommended screenings. This includes, but is not limited to:
   * + 1. For all children by ages one (1), two (2), and three (3): Ages and Stages Questionnaire (ASQ), Parents’ Evaluation of Development Status (PEDS), or the Survey of Well Being of Young Children (SWYC) developmental screening; and
       2. The M-CHAT-R (Modified Checklist for Autism in Toddlers, Revised) screening tool to assess the risk for autism at eighteen (18) and twenty-four (24) months and the M-CHAT-F (Follow-up) screening if a child does not pass the initial M-CHAT-R screening test;
3. **Lead Testing**. Provide required blood lead level testing for all children at one year of age and two years of age per Maine Public Law, Chapter 479, An Act to Strengthen the Lead Poisoning Control Act and develop follow-up plans based on results;
4. **Other Screenings**. Provide the following screenings:
   1. Measurement of Body Mass Index (BMI) in all adult patients at baseline and at least every two years, and BMI percent-for-age at least annually in all children;
   2. Depression, anxiety, and substance use screenings as clinically appropriate (e.g. Patient Health Questionnaire (PHQ-9), Alcohol Use Disorder Identification Test (AUDIT), Drug Abuse Screening Test (DAST), CRAFFT for adolescents);
   3. Postpartum screening for depression (e.g. Edinburgh Postpartum Depression Scale (EPDS)) at least once in the first six (6) weeks postpartum; and
   4. Beginning one (1) year after the PCPlus effective date, implement a documented process to routinely perform Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Members;
5. **EPSDT**. Afford children enrolled in MaineCare and CHIP Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits through written member acknowledgement of *MBM, Chapter II, Section 94.* States must provide all medically necessary section 1905(a) services coverable under the Medicaid program to eligible children and youth under age twenty-one (21) in order to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Maine Medicaid State Plan. PCPlus providers shall apply this understanding of EPSDT rights and demonstrate an ability to appropriately request prior authorizations for EPSDT services;

**3.04** **COVERED SERVICES** (cont.)

1. **Oral Health**

1. **Oral Health Risk Assessment**. Offer oral health risk assessments for Members in accordance with Section 90.04-31;

2. **Fluoride**. Offer topical fluoride varnish for Members under age 21 in accordance with Section 90.04-30.

1. **Immunizations.** Offer all appropriate immunizations to each Member in accordance with the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices immunization schedule;
2. **United States Preventive Services Task Force (USPSTF) Recommendations**. Provide or provide referrals for all USPSTF recommendations with a Grade of A or B, as outlined on <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations>; and
3. **Advanced Care Planning and Palliative Care**. Offer or refer Members who may benefit to advanced care planning and palliative care consultation.

**3.05 MEMBER ATTRIBUTION**

1. Attribution is the process of assigning members to a PCP panel. MaineCare members will be attributed to a PCP if all the following criteria are met:

1. The member is eligible for all MaineCare state plan services; and

2. The member has received at least one eligible Primary Care Service from a PCP during the Attribution Assessment Period or has contacted MaineCare Member Services to request assignment to a PCP.

B. The Department will attribute members to a PCP on a quarterly basis. Attribution will be based on where the member received a plurality of eligible Primary Care Services during the Attribution Assessment Period. In the case of a tie, the most recent visit determines attribution. Regardless of primary care service utilization, Members may contact MaineCare Member Services to select assignment to a PCP. If the Member does not receive at least one Primary Care Service from the PCP they selected for one (1) year from the selection date or does not receive a plurality of Primary Care Services from the selected PCP, the Department will verify that the selected PCP is still the Member’s choice. If the Member does not respond, the Department will attribute the Member in accordance with the Primary Care Services-based methodology in the next quarterly attribution.

**3.05 MEMBER ATTRIBUTION** (cont.)

C. The Department will notify Members of which PCP they have been attributed to, how personal information will be used in PCPlus, and what financial incentives are included for their PCP. Members may seek care from any willing, qualified, and enrolled MaineCare provider. Member participation in PCPlus is voluntary and shall not restrict a Member’s free choice of providers. In addition, enrolled providers shall not interfere with a Member’s freedom of choice in seeking medical care from any willing and qualified MaineCare provider. Providers shall not limit Members’ access to other MBM services, including primary care services, based on the Member’s election to decline or accept PCPlus services. PCPlus services (3.04) are voluntary for Members. Members may opt out of the PCPlus program at any time by contacting MaineCare Member Services, and the Department shall remove the Member from attribution and no PCP shall receive PCPlus reimbursement for the Member.

**3.06 REPORTING REQUIREMENTS**

In addition to the documentation and reporting requirements of MBM, Chapter I, Section 1, and other reports that may be required by the Department, PCPs shall report as follows.

**3.06-1 Application and Annual Certification**

Each PCP shall submit documentation required by the Department and comply with other information-sharing requirements from the Department, initially and then annually, through a recertification process to determine their appropriate Tier (3.03).

PCPs shall maintain documentation of all requirements described in Section 3.03 and make the documents available upon request for review by the Department. If a PCP fails to fulfill requirements for the approved Tier level for more than thirty (30) continuous days, the PCP shall notify the Department in writing. The Department may (a) require an action plan from the PCP to address satisfaction of the requirement(s) and/or (b) adjust a PCP’s Tier to ensure Tier assignment is consistent with maintenance of stated requirements. The Department may adjust the PCP’s Tier if the PCP fails to comply with this rule. The Department shall provide notice to the PCP thirty (30) business days in advance of any Tier change.

**3.06-2 Attribution**

PCPs shall provide any required practice and/or rendering provider information requested by the Department in order for the Department to accurately perform PCPlus attribution.

**3.06 REPORTING REQUIREMENTS** (cont.)

**3.06-3 Performance Assessment**

PCPs are eligible for payment based on outcomes of specified quality measures as set forth in Section 3.08-2. Data sources for measures may include, but are not limited to, claims, clinical data, and information submitted by the PCP. PCPs shall submit all data necessary to compile and report on PCPlus performance measures.

Providers who fail to submit performance, application and/or annual recertification-related data and/or reports may be terminated from the PCPlus program.

**3.07 POLICIES AND PROCEDURES**

**3.07-1 Beneficiary Protections**

Providers may not engage in any marketing and/or other activities intended to result or resulting in the selective recruitment and enrollment of individuals with more favorable health status. Section 1905(t)(3)(D) of the Social Security Act prohibits discrimination based on health status, marketing activities included.

**3.07-2** **Termination**

The Department may terminate a provider from the PCPlus program based on failure to meet program requirements or any other basis provided in Ch. I, Sec. 1.20-1 of the MBM. Termination from the PCPlus program will be in accordance with the provisions of Ch. I, Sec. 1.19-1. PCPs may terminate their participation from PCPlus without cause with thirty (30) days’ notice by sending written notification to [PCP-Network-Services.DHHS@maine.gov](mailto:PCP-Network-Services.DHHS@maine.gov).

**3.08 REIMBURSEMENT**

**3.08-1 Population-Based Payment**

Population-Based Payments (PBPs) are monthly payments that the Department shall calculate quarterly for each participating PCP. The Department calculates the PBP by adding the Tier PMPM Rate and the Population Group and Risk Category PMPM Rate and multiplying the sum by the PCP’s total number of attributed Members. Both PMPM rates are determined annually.

**3.08 REIMBURSEMENT** (cont.)

1. Tier PMPM Rate

This PMPM rate is determined by the provider’s Tier, and the Department adjusts this PMPM rate by the Performance-Based Adjustment (PBA) when calculating the PBP, per Section 3.08-2. Each Tier described in Section 3.03 has a PMPM rate:

Tier One: $2.10

Tier Two: $6.30

Tier Three: $6.90

1. Population Group and Risk Category PMPM Rate

Annually, the Department will assign Members to a population group based on their eligibility category in the most recent month of the PBA Assessment Period and a risk category based on the most recent Risk Score. The population groups are children, adults, aged/blind/disabled, and dual-eligible. The risk categories are “generally well” and “complex.” Each combination of population group and risk category has a PMPM rate (see Figure 1). The Department calculates the overall PMPM rate by multiplying the number of Members the PCP has in each combination of population group and risk category by the assigned PMPM rate. The Department then adds the totals from each combination and divides by the PCP’s number of Members.

Providers may request a reassessment of their Population Group and Risk Category PMPM if there is a significant change within the practice, such as a relocation or inclusion of a new population.

|  |  |  |
| --- | --- | --- |
| **Figure 1. Population group and risk category PMPM rates** | | |
| **Population Group** | **Risk Category** | |
| **Generally Well PMPM** | **Complex PMPM** |
| Children | $1.65 | $4.95 |
| Adults | $1.15 | $3.00 |
| Aged, Blind, Disabled | $2.25 | $6.60 |
| Duals | $2.50 | $8.75 |

* + 1. **Performance-Based Adjustment**

The PBA is based on a PCP’s performance on no more than ten (10) quality measures. Current quality measures will be listed on: <https://www.maine.gov/dhhs/oms/providers/value-based-purchasing>. The PBA may range from negative ten percent (-10%) to twenty five percent (25%) and is applied quarterly to the Tier PMPM rate.

**3.08 REIMBURSEMENT** (cont.)

For the first year of the PCPlus program, the Department will apply a PBA of 25% to Tier One PCPs, 8.3% to Tier Two PCPs, and 7.6% to Tier Three PCPs. Performance data will be shared for information only during this time.

Beginning one (1) year after the effective date of the PCPlus rule, the Department will calculate and apply the PBA, as described herein.

1. **Calculation of PBA**. The PBA equals the sum of the quality measures’ Improvement and Achievement Adjustments (see subparts 3 and 4), which are based on a PCP’s Percentile Score (see subpart 1) for each quality measure and each quality measure’s domain (see subpart 2).
2. **Percentile Score**.To calculate the Percentile Score, the Department first calculates the PCP’s performance on each quality measure. Calculating performance varies for each measure. For example, performance on the Lead Testing in Children quality measure equals the percentage of Members two (2) years of age who had at least one capillary or venous lead blood test for lead poisoning by their second birthday.

The Department then compares the PCP’s performance on each quality measure with the performance of the PCPs in its MaineCare Peer Group to determine its Percentile Score for each quality measure. A PCP’s Percentile Score represents the percentage of PCPs that performed below the PCP, e.g. a PCP with a Percentile Score of 65% performed better than 65% of the PCPs in its MaineCare Peer Group.

1. **Domain**. Each quality measure falls under either the Utilization or Comprehensive Care domain. For example, Acute Hospital Utilization falls under the Utilization domain, and Developmental Screening in the First Three Years of Life and Total Cost of Care fall under the Comprehensive Care domain. Each domain has a unique set of Improvement and Achievement Adjustment percentages that apply to the quality measures that fall under each domain (see Figure 2). The total minimum and maximum adjustment amounts from the quality measure(s) under the Utilization and Comprehensive Care domains are 30% and 70%, respectively, of the minimum and maximum PBA.

3. **Improvement Adjustment**. The Department will determine Improvement Adjustments by comparing the PCP’s Percentile Score for each quality measure in the most recent PBA Assessment Period to the PCP’s Percentile Score in the calendar year that falls two (2) years prior to the end date of the current PBA Assessment Period, e.g. a PBA Assessment Period ending July 2023 would be compared to calendar year 2021.

**3.08 REIMBURSEMENT** (cont.)

A PCP’s Percentile Score must improve by at least three percentage points, regardless of whether the PCP’s MaineCare Peer Group is different than its MaineCare Peer Group in the comparison year, to be eligible for the Improvement Adjustment, e.g. a PCP with a Percentile Score of 65% in the comparison year would have to achieve a Percentile Score of at least 68% in the Assessment Period to obtain the Improvement Adjustment for a quality measure (see Figure 2).

4. **Achievement Adjustment**. The Department will determine Achievement Adjustments for each quality measure based on Percentile Score (see Figure 2).

1. Through 2023, the Department will calculate Percentile Scores for the Achievement Adjustments by comparing the PCP’s performance to its MaineCare Peer Group’s performance from the most recent PBA Assessment Period.
2. Beginning in 2024, the Department will calculate Percentile Scores for the Achievement Adjustments by comparing the PCP’s performance from the most recent PBA Assessment Period to the performance of its MaineCare Peer Group in the calendar year that falls two (2) years prior to the end date of the current Assessment Period.

5. **Methodology Illustration**. To illustrate the methodology using Figure 2, a PCP with a Percentile Score between 60% and 69% for the Acute Hospital Utilization quality measure would receive an Achievement Adjustment of 1.5%. If the PCP’s Percentile Score improved by at least 3% from the comparison year, it would also earn the 1.3% Improvement Adjustment. If the PCP earned a Percentile Score between 50% and 59% for the Total Cost of Care quality measure, it would receive a 0.3% Achievement Adjustment. If the PCP’s Percentile Score did not improve by at least 3% from the comparison year, it would not earn the 0.1% Improvement Adjustment. This assessment is done for each quality measure, and the PBA equals the sum of the Achievement and Improvement Adjustments.

**3.08 REIMBURSEMENT** (cont.)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Figure 2. Achievement and Improvement Adjustments\* under the Utilization and Comprehensive Care domains, adapted from the Centers for Medicare and Medicaid Innovation, Primary Care First methodology.** | | | | |
| **Percentile Scores Relative to Peer Group** | **Utilization** | | **Comprehensive Care** | |
|  | *Achievement adjustment (%)* | *Improvement adjustment*  *(if earned) (%)* | *Achievement adjustment (%)* | *Improvement adjustment*  *(if earned) (%)* |
| <25 | -3.0 | 2.5 | -0.9 | 0.8 |
| 25-49 | 0 | 0.5 | 0 | 0.2 |
| 50-59 | .8 | 0.7 | 0.3 | 0.1 |
| 60-69 | 1.5 | 1.3 | 0.4 | 0.4 |
| 70-79 | 3.5 | 1.0 | 1.0 | 0.3 |
| 80-89 | 5.0 | 0.9 | 1.5 | 0.2 |
| >90 | 7.0 | 0.5 | 2.1 | 0.1 |

\*The adjustment percentages in Figure 2 are based on using nine (9) quality measures, one (1) under the Utilization domain and eight (8) under the Comprehensive Care domain. If more or fewer quality measures are used, the Department will change the adjustment percentages proportionally so the PBA range remains between negative ten (-10) and 25% and so the total minimum and maximum adjustment amounts from the quality measure(s) under the Utilization and Comprehensive Care domains remains 30% and 70%, respectively, of the minimum and maximum PBA.

1. The Department shall use the rolling twelve- (12) month PBA Assessment Period to collect claims data for the PBA and apply the PBA six (6) months after the Assessment Period ends to allow for three (3) months of claims run out and three (3) months to calculate the PBA.
2. A quality measure will only be used to assess performance if there is a sufficient quality measure-eligible population to allow for appropriate assessment. The sufficient quality measure-eligible population for each quality measure will be listed on: <https://www.maine.gov/dhhs/oms/providers/value-based-purchasing>. If a quality measure cannot be included in the performance assessment because of an insufficient quality measure-eligible population, the respective portion of the PBA for that quality measure will be redistributed equally among all other qualifying quality measures within the same domain.

**3.08 REIMBURSEMENT** (cont.)

1. PCPs must have sufficient Members on at least one (1) quality measure in the Utilization domain and at least three (3) quality measures in the Comprehensive Care domain to be eligible for each quality measure’s adjustments within their domain. If a PCP does not meet the minimum quality measure requirement for a domain, they shall receive a neutral PBA (zero percent (0%)) for that domain.
2. The Department will notify PCPs at least one hundred twenty (120) days prior to any changes to the quality measures. The Department will provide PCPs quarterly reports on performance on quality measures, beginning no later than the second quarter of PCPlus program implementation.