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State/Territory Name: Maine

State Plan Amendment (SPA) #: 21-0017

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 9, 2021

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

Dear Ms. Probert:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 21-0017. This amendment proposes changes to Maine's Accountable Community Program, including updates to performance years, lead entity requirements, TCOC (Total Cost of Care) core service inclusions as well as member assignments clarifications. This letter is to inform you that Maine's Medicaid SPA Transmittal Number 21-0017 was approved on December 7, 2021 with an effective date of August 1, 2021.

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

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

cc: Kristin Merrill, State Plan 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: **21 - 0017**

2. STATE: **Maine**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
August 1, 2021

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
1905 (t)

7. FEDERAL BUDGET IMPACT
a. FFY **2021** $ 0
b. FFY **2022** $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A Pages 12-12d
Attachment 4.19-B Pages ~~7-7g~~ 7a - 7d and 7f - 7g

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-A Pages 12-12d
Attachment 4.19-B Pages ~~7-7g~~ 7a - 7d and 7f - 7g

10. SUBJECT OF AMENDMENT
Changes to Accountable Community (AC) program

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

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

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Michelle Probert

14. TITLE
Director, MaineCare Services

15. DATE SUBMITTED
9/30/2021

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED 09/30/2021

18. DATE APPROVED **12/07/2021**

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL 08/01/2021

20. SIGNATURE OF REGIONAL OFFICIAL [redacted]

21. TYPED NAME James G. Scott

22. TITLE Director, Division of Program Operations

23. REMARKS

10/18/2021 - State provided pen-and-ink authority to revise texts in boxes 8 and 9 by erasing references to pages 7 - 7g and adding "7a-7d and 7f-7g".

FORM CMS-179 (07/92)

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 Primary Care Case Management (PCCM) Requirements

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

1. An approved MaineCare PCCM 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, an Indian Health Services center, 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.

3. Have a governing body that:

   a. has responsibility for oversight and strategic direction of the AC program;

   b. provides interested parties with access to and communications regarding the AC's governance structure, roles, processes, decisions and action items;

   c. Engages at least two MaineCare members served by the AC program or their caregivers or guardians in advisory activities for the purposes of advising or educating the Lead Entity on issues of importance.

4. 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.

5. Participate in quality measurement activities as required by the State.

6. Have contractual or other documented partnerships with at least one service provider in each of the following three categories, if such a provider serves members in the AC's service area. For purposes of this subsection, the AC's services area is defined as the totality of all Hospital Service Areas that include any of the AC's Providers that are Primary Care Providers.

   a. Chronic Conditions,
      i. Health Home Practices or Community Care Teams
      ii. Providers of Targeted Case Management (TCM) services for children with chronic health conditions; or
      iii. Providers of TCM services for adults with HIV

   b. Developmental Disabilities
      i. Providers of TCM for children with developmental disabilities, or
      ii. Providers of TCM for adults with developmental disabilities

   c. Behavioral Health
      i. Behavioral Health Home Organizations
      ii. Opioid Health Homes
      iii. Providers of Community Integration
      iv. Providers of TCM for children with Behavioral Health Disorders or Providers of TCM for adults with Substance Use Disorders

7. Have contractual or other documented partnerships or policies to ensure coordination with all hospitals in the AC's service area.

8. Have contractual or other documented partnerships or policies to ensure coordination

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

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

10. Develop and submit the AC's Joint Care Management and Population Health Strategy by the end of each Performance 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 Accountable Community (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 five domains:

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.

are as follows: Performance Year 1 is 2021 to 2022, Performance Year 2 is 2022-2023, and Performance Year 3 is 2023 to 2024, and so forth.

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 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, any MaineCare per member per month payments that were made to the AC Lead Entity, or to any of the individual providers who make up the AC Lead Entity, for Primary Care Case Management (PCCM) and Health Home 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. Final payments/recoupments will be made no more than 15 months after all necessary data is received in final form.

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.

C. 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 Health Home 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 least number of PNMI stays—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:

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

b. 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 trimesterly 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 models.

D. 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. The quality measures fall into specified domains. An AC may earn achievement points for meeting the minimum attainment level or better on each measure, improvement points for improving on their performance from the previous year, or a combination of the two. If the AC achieves the minimum attainment level on at least one measure in each quality domain that contains multiple measures, the AC will earn points and be eligible 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 minimum attainment level on at least one measure in each quality domain that contains multiple measures will not be eligible to share savings for its assigned population.

   The AC must meet the minimum attainment level on at least one measure in each domain that contains multiple measures. If the AC fails to achieve the minimum attainment level on the specified majority percentage of the measures in a domain, 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. If the AC fails to achieve improvement points in a given domain, the AC may submit a Performance Improvement Plan to receive partial improvement points—not to exceed 10% of the domain's total points. This plan must be submitted within three months of receiving the final AC Shared Savings/Loss Report.

E. 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.

d. **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 15% Payment Limit above, once payments to the AC for PCCM and health homes 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.

e. **Shared Loss Rate.** In Performance Years 2 and 3, the percentage of shared loss subject to recoupment is determined based on the inverse of the AC's Quality Measure Adjusted Rate, and may not exceed 60 percent.

f. **Shared Loss Payment Limit.** Lead Entities under Model II are not accountable for any downside risk in the first performance year. The amount of shared losses for which an eligible Lead Entity is liable in the second and third performance years may not exceed the following percentages of the benchmark monthly TCOC:
   - 5 percent in Performance Year 2
   - 10 percent in Performance Year 3

g. **Shared Loss Payment Calculation.** Take the calculated per member per month loss amount, multiply that number by the Shared Loss Rate. The resulting per member per month loss amount is subject to the Shared Loss Payment Limits above. This amount is then multiplied times the total number of member months for the year to equal the total annual Shared Loss Payment.

F. 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.

G. 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; 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.

III. 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; 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
- Non-Emergency Transportation
- Targeted Case Management when provided by Department employees
- Other Related Conditions HCBS Waiver

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.