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State/Territory Name: Maine

State Plan Amendment (SPA) #: 22-0002

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

April 21, 2022

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) 22-0002

Dear Ms. Probert:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 22-0002. This amendment proposes to implement the Primary Care Plus (PCPlus) Program to replace Maine's three existing primary care programs with a single simplified and integrated program.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations that generally require states to assure necessary transportation for beneficiaries to and from covered services. This letter is to inform you that Maine Medicaid SPA 22-0002 was approved on April 21, 2022, with an effective date of July 1, 2022.

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 ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22 0002

2. STATE: Maine (ME)

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIALSECURITY ACT

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

4. PROPOSED EFFECTIVE DATE
~~04/01/2022~~ 07/01/2022

5. FEDERAL STATUTE/REGULATION CITATION
1905(t) if the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2021 $ N/A
b. FFY 2022 $ N/A

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A Pages 17-23 and Attachment 4.19-B pages 10-15

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
NEW

9. SUBJECT OF AMENDMENT
Implementing Maine's Primary Care Plus (PCPlus) model.

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
January 21, 2022

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 01/21/2022

17. DATE APPROVED 04/21/2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL 04/01/2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

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

22. REMARKS

04/20/2022 - State provided pen-and-ink authority to revise the effective date to July 1, 2022.

Instructions on Back

31. PRIMARY CARE PLUS

DEFINITIONS: see Attachment 3.1-A, page 18

MEMBER ATTRIBUTION

Attribution is the process of assigning members to a primary care provider (PCP) panel. MaineCare members will be attributed to a PCP if all the following criteria are met:

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

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

If the above criteria are not met, a member will not be attributed.

The Department shall attribute members to a provider on a quarterly basis. Attribution will be based on where the member received a plurality of eligible Primary Care Services during the Assessment Period. In the case of a tie, the most recent visit determines attribution. Regardless of primary care service utilization, members may also contact MaineCare Member Services to select assignment to a PCP which will be incorporated with the subsequent quarter's attribution, since billing units are quarterly (paid out monthly). If the Member does not receive at least one Primary Care Service from the PCP they selected for one year from the selection date, the Department will notify the Member and reassign them in accordance with the Primary Care Services claims-based methodology. Members may not be attributed to more than one PCP at any point in time. The Department shall provide Member panel and payment reports to participating PCPs via a secure online portal on a monthly basis. Providers can notify the Department of any discrepancy regarding their panel or reports. Providers can appeal Departmental actions, including payment.

There is no minimum number of attributed members required for provider participation, nor does the Department set a maximum number of allowable attributed members.

Methods and Standards for Establishing Payments rates

PAYMENT METHODOLOGY

Population-Based Payment

Population-Based Payments (PBPs) are monthly payments that the Department shall calculate quarterly for each participating PCP. Only one payment will be made to a single PCP per Member in order to prevent duplication. The Department will check eligibility status monthly, prior to each monthly payment, to ensure providers are only being paid for currently eligible and enrolled members.

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.

A. Tier PMPM Rate

This PMPM rate is determined by the provider's Tier, , as defined in Attachment 3.1-A, and the Department adjusts this PMPM rate by the Performance-Based Adjustment (PBA) when calculating the PBP. Each Tier has a PMPM rate:

Tier One: $2.10
Tier Two: $6.30
Tier Three: $6.90

B. 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 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 attributed 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 to result in an average PMPM rate.

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. Reassessments will result in a change to the PMPM for the following quarter.

More information on the risk score model and the risk categories of "generally well" and "complex" is found at https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/primary-care

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

Performance-Based Adjustments

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/primary-care. The PBA may range from negative ten percent (-10%) to a positive twenty five percent (25%) and is applied quarterly to the Tier PMPM rate.

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 informational purposes only during this time period.

One year after the effective date of the PCPlus program, the Department will calculate and apply the PBA, as described herein.

A. **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).

1. **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's performance level, e.g. a PCP with a Percentile Score of 65% performed better than 65% of the PCPs in its MaineCare Peer Group.

2. **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 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 Assessment Period, e.g. an Assessment Period ending July 30, 2023 would be compared to calendar year 2021.

   A PCP's Percentile Score must improve by at least three percent (3%), 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).

   a. Through December 31, 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 Assessment Period.

   b. Beginning January 1, 2024, the Department will calculate Percentile Scores for the Achievement Adjustments by comparing the PCP's performance from the most recent 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. These benchmarks will be posted on the following website by July 1, 2023: https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/primary-care (effective July 1, 2023).

5. **Methodology Illustration**. To illustrate the methodology, Figure 2 shows that 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.

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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. Tables corresponding to different measure amounts are listed on: https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/primary-care (effective 7/1/2022).

B. The Department shall use a rolling twelve (12)-month 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.

C. A quality measure will only be used to assess performance if there is a sufficient quality measure-eligible population size to allow for appropriate assessment. The sufficient quality measure-eligible population size for each quality measure will be listed on: https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/primary-care. If a quality measure cannot be included in the performance assessment because of an insufficient quality measure-eligible population size, the respective portion of the PBA for that quality measure will be redistributed equally among all other qualifying quality measures within the same domain.

D. PCPs must have a sufficient quality measure-eligible population size 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.

E. 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.

31. PRIMARY CARE PLUS

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. PCPlus services include locating, coordinating and monitoring health care services, in accordance with Section 1905(t) of the Social Security Act.

PCPlus seeks to improve health care access and outcomes for MaineCare members, demonstrating cost-effective use of resources, and creating an environment where providers are incentivized to deliver high-value care. Programmatically, Maine will evaluate provider participation in this service and whether providers advance through payment tiers, as their provider characteristics advance.

Maine will also regularly assess provider performance on no more than ten (10) quality measures to evaluate quality of comprehensive person-centered primary care (e.g. provision of preventive services) and control of health care costs (e.g. acute hospitalization). Maine will track overall program performance and improvements over time as an indicator of program success. Lastly, Maine will share performance data regularly with providers and offer technical assistance on relevant topics.

DEFINITIONS:

Attribution Assessment Period is twenty-four- (24) month "lookback" period for member attribution

Attributed Members are MaineCare members assigned to a participating PCPlus provider for the purposes of population-based payments and performance assessment.

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.

Members are MaineCare members attributed to a PCP for the purposes of service delivery and reimbursement.

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

Performance-Based Adjustment Assessment Period: is the twelve (12)-month "lookback" period used for assessing PBAs.

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 Attributed Members.

Primary Care Services are evaluation and management, preventive, and wellness services. See the full list of procedure and diagnosis codes used here: https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/primary-care (Effective date: 7/1/2022)

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 twelve-(12) month period with a two-month claims run out period.

PROVIDER ELIGIBILITY:

Eligible providers participating in PCPlus receive PBPs as detailed in Attachment 4.19-B pages 10-10(e). All eligible providers must:

A. Be approved by the Maine Department of Health and Human Services (the Department) through the PCPlus application process. The application process will open annually, at a minimum, and providers must receive initial approval and subsequently recertify annually;
B. 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 at least fifty percent (50%) of the service location's collective billing;
    2. A rural health clinic;
    3. A federally qualified health center; or
    4. A tribal health clinic; and
C. Meet Tier One PCP requirements. PCPs who meet Tier Two or Tier Three requirements are eligible for enhanced reimbursement.

Tier One PCP Requirements:

A. 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 that 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;

B. Annually, at least one representative from each PCP shall participate in designated Department-sponsored quality improvement initiatives and technical assistance activities. The PCP's representative shall be involved in clinical care, population health, and/or quality improvement.

C. The PCP shall adopt and maintain, at a minimum, a Certified Electronic Health Record Technology (CEHRT); and

D. 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.

E. 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.

Tier Two PCP Requirements:

Tier two Providers shall meet all Tier One criteria and shall:

A. Hold active patient-centered medical home recognition through a Department-approved organization 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;
B. Maintain a Participant Agreement for data sharing with Maine's statewide state-designated Health Information Exchange (HIE). Tribal health clinics may connect to the HIE as view-only participants;
C. Conduct a standard, routine assessment or screening to identify health-related social needs of Members and use the results to make necessary referrals;
D. Have a current documented relationship with at least one Behavioral Health Home Organization 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;
E. Maintain processes and procedures to initiate and coordinate care with a Community Care Team (CCT), 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 CCT covered services;
F. Offer Medication for Addiction Treatment (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. Note: MAT services are not billed or reimbursed under this program;
G. Offer telehealth as an alternative to traditional office visits 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;
H. Include MaineCare Members and/or their families in advisory activities to identify needs and solutions for practice improvement;
I. Submit to the Department an environmental scan of which populations served by the PCP could benefit from Community Health Worker (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;

Tier Three PCP Requirements:

Tier Three Providers shall meet all Tier One and Tier Two criteria, unless otherwise noted, and shall:

A. Be included in the list of Accountable Communities (AC) primary care sites for attribution purposes in the AC program;
B. Submit an aligned AC and PCPlus Joint Care Management and Population Health Strategy (Strategy) to the Department on or before July 31st of every year, beginning 7/31/2022. 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;
C. 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.

MEMBER INCLUSION:

A. Member participation in PCPlus is voluntary. Members may opt out of the PCPlus program at any time by contacting MaineCare Member Services, in which case the Department shall remove the Member from attribution and no PCP shall receive PCPlus reimbursement for the Member.
B. MaineCare members will be attributed to a PCP based on where the member received a plurality of eligible Primary Care Services. Regardless of primary care service utilization, members may also 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.

ASSURANCES:

- The Department will comply with all applicable provisions of section 1932 of the Social Security Act.
- All service under PCPlus are provided in accordance with the provision of 1905(t) of the Social Security Act.
- PCPlus does not restrict a members' freedom of choice of providers. In addition, enrolled providers must not interfere with a member's freedom of choice in seeking medical care from any willing and qualified MaineCare provider.
- All provider participants in PCPlus 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. Section 1905(t)(3)(D) of the Act prohibits discrimination based on health status, marketing activities included. Any marketing and/or other activities must not result in selecting recruitment and assignment of individuals with more favorable health status.
- The Department shall notify PCPlus attributed members of their attribution, describe how personal information will be used under PCPlus, and disclose any correlative payment arrangements (e.g. incentives), including the payment arrangements described herein.
- Sections 1905(t)(3)(E) and 1905(t)(3)(F) refer to section 1932 of the Act, which allows the Centers for Medicare and Medicaid Services to enforce this provision without applying the general 42 CFR Part 438 regulations.