Table of Contents

State/Territory Name: ME

State Plan Amendment (SPA): ME-23-0003

This file contains the following documents in the order

listed:1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

June 22, 2023

Michelle Probert, Director
Maine Department of Health and Human Services
MaineCare Services
Policy Division
11 State House Station
Augusta, Maine 04333-0011

RE: TN 23-0003

Dear Director Probert:

We have reviewed the proposed Maine State Plan Amendment (SPA) to Attachment 4.19-B ME-23-0003 which was submitted to the Centers for Medicare & Medicaid Services (CMS) on March 31, 2023. This SPA authorizes an Alternative Payment Methodology (APM) for Medicaid Federally Qualified Health Centers (FQHCs).

Based upon the information provided by the State, we have approved the amendment with an effective date of March 1, 2023. We are enclosing the approved CMS-179 and a copy of the new state plan page.

If you have any additional questions or need further assistance, please contact Blake Holt at 303-844-6218 or blake.holt@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

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: 23 00 03

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
03/01/2023

5. FEDERAL STATUTE/REGULATION CITATION
1905(a)(2)(c) , 1902(bb)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY **2023** $ 9,621,438
b. FFY **2024** $ 15,788,175

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement 1 to Attachment 4.19-B Pages 1.5 and 1.6
1.3 and 1.4

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supplement 1 to Attachment 4.19-B Pages 1.5 and 1.6 and 1.3 and 1.4

9. SUBJECT OF AMENDMENT
Updates reimbursement for federally qualified health centers (FQHCs)

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
March 31, 2023

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
March 31, 2023

17. DATE APPROVED
June 22, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
March 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS
6/14/23: State provides pen and ink authorization for Boxes 7 and 8.
6/20/23: State provides pen and ink authorization for Boxes 1 and 5.

Instructions on Back

iv. Provider Reimbursement by Payment Methodology:
All services must be provided by individuals appropriately licensed or certified, practicing within their scope of licensure or certification, and in accordance with State rules.

a) Prospective Payment System or Encounter-Based APM Rate Billing
To be eligible to receive the PPS or APM rate for RHC services, there must be a face-to-face service with one of the following PPS-eligible staff members of the RHC: physician, podiatrist, physician assistant, advanced practice registered nurse, psychologist, licensed clinical social worker, licensed clinical professional counselor, and/or dentist and dental hygienist. Visiting nurse services provided by a registered nurse or licensed practical nurse to a homebound member may also receive the PPS or APM rate.

If an encounter does not involve a covered service by one of the above practitioners, the PPS or APM rate should not be billed.

b) FFS Rate Billing
PPS-eligible providers may also bill FFS for out of scope services, in addition to billing the PPS rate, when the out of scope services are delivered on the same day as the eligible in scope PPS services.

When any other provider (i.e. a non-PPS eligible provider) delivers a FFS APM service, only the FFS reimbursement will be made. This payment will be made regardless of whether a PPS eligible visit was made on that day.

c. Federally Qualified Rural Health Centers (FQHC)··

i. Change in Scope of Services Adjustments

A "change in the scope of services" refers to a change in the overall picture of a FQHC's services through a change in the type, intensity, duration and/or amount of services

The following examples are offered as guidance to FQHCs to facilitate understanding of the types of changes that may be recognized as a "change in scope of services." These examples should not be interpreted as a definitive nor comprehensive delineation of the definition of "change of scope of services."

i. The addition of a new covered service or deletion of an existing covered service that is present in the existing PPS rate. Covered services are those which meet the definition of FQHC services as provided in section l 905(a)(2)(C) of the Social Security Act;
ii. The addition of a new professional staff (i.e. employed or contracted) who is licensed to perform a covered service that no current professional staff is licensed to perform;
iii. A change in the intensity of a service that fundamentally alters the service delivery model and increases or decreases the quantity of labor and materials consumed by an individual during an average encounter. This change may be attributed to changes in the types of patients served;

An increase or decrease in scope of service does not necessarily result from any of the following (although some of these changes may occur in conjunction with a change is scope of service):

i. A change in the cost of providing an existing service:
ii. A change of ownership;
iii. A change in status between free-standing and provider-based;
iv. The expansion of an existing service to a new population;
v. The expansion of the FQHC to a new site which provides the same services;
vi. The addition or reduction of staff members to or from an existing service;
vii. A change in office hours; or
viii. An increase or decrease in the number of encounters.

It is the FQHC's responsibility to notify the Department of any "change in the scope of services'· and provide proper documentation to support the rate change request. The FQHC must submit either at least six (6) months or actual cost data for changes that have already taken place. or twelve (12) months of projected costs for anticipated changes.

When a site submits projected costs for an anticipated change that amounts to a PPS rate change that is greater than or equal to 5%. the Department may request data for a subsequent rate adjustment when at least six (6) months of actual data becomes available. The site must also submit a narrative describing the change. Requests for a rate adjustment based on a prior change must be received no later than one hundred and fifty (150) days after the FQHC's fiscal year end in which the ··change in scope of services·· occurred. The Department will respond to a rate adjustment request within sixty (60) days of receiving a completed application.

Adjustments to the PPS rate for the increase or decrease in scope of services will be reflected in the PPS rate beginning with services provided the first day of the month immediately following either the date the Department approves the "change in scope of services" adjustment or the date an anticipated change will begin, whichever is later.

ii. Provider Reimbursement by Payment Methodology:

All services must be provided face-to-face by individuals appropriately licensed or certified, practicing within their scope of licensure or certification, and in accordance with State rules.

a) Prospective Payment System

FQHCs that existed prior to BIPA 2000

i. The payment methodology for FQHCs will conform to all of the requirements of section 702 of the BIPA 2000 legislation, including the BIPA 2000 requirements for Prospective Payment System (PPS), FQHCs will be reimbursed on the basis of 100% of the average of their reasonable costs of providing Medicaid-covered services during FY 1999 and FY 2000, adjusted to take into account any increase or decrease in the scope of services furnished during FY 2001 (calculating the amount of payment on per visit basis).

ii. Beginning in FY 2002; and for each fiscal year thereafter, each FQHC is entitled to the payment amount (on a per visit basis) to which the center was entitled under the Act in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase or decrease in the scope of services furnished during that fiscal year.

b) Alternate Payment Methodology (APM)

Effective March 1, 2023, an FQHC is eligible to receive an APM for the provision of FQHC services under an alternative payment methodology that is agreed to by the State and the center or clinic and results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under the PPS, compared annually. The APM was developed using one hundred percent (100%) of the average of their reasonable costs of providing in-scope MaineCare-covered FQHC services within fiscal years 2018 and 2019. The Department then accounted for any Change in Scope requests that had been approved by the Department between fiscals years 2020 and 2022 and inflated by the federally qualified health center market basket percentage published by the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services. This index will also be used for annual inflation adjustments beginning July 2024 and each July thereafter.

c) FFS Rates

PPS-eligible providers may also bill FFS for out of scope services, in addition to billing the PPS rate, when the out of scope services are delivered on the same day as the eligible in scope PPS services.

iii. Establishment of payment amount for new FQHCs

This section applies to each new FQHC site or location with a separate Medicaid number that is opening for the first time, either with or without an affiliation to an existing organization, regardless of previous service delivery.

The State shall provide payment of covered services furnished by the FQHC in the first fiscal year in which the clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during the fiscal year based on the rates established under 2(c)(ii)(a) or, if applicable instead, 2(c)(ii)(b) for other such FQHC located in the same or adjacent area with a similar caseload. In the absence of such a FQHC, the initial rate will be established through cost reporting methods.

For each fiscal year following the initial fiscal year in which the entity first qualifies as a FQHC, the State shall provide the payment amount in accordance with 2(c)(ii)(a) or, if applicable instead, 2(c)(ii)(b).