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**State/Territory Name:** Maine

**State Plan Amendment (SPA) #:**15-020

This file contains the following documents in the order listed:

1) Approval Letter

2) CMS 179 Form

3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

**Division of Medicaid and Children's Health Operations / Boston Regional Office**

February 3, 2016

Mary Mayhew, Commissioner
Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011

RE: Maine ME 15-020

Dear Commissioner Mayhew:

We are now ready to approve State Plan Amendment (SPA) No. ME 15-020; attached you will find an approved copy of the SPA. As requested, this SPA is effective May 1, 2016.

The purpose of this SPA is to amend the State's approved Title XIX State Plan to amend reimbursement and add criteria for consideration of a change in scope of services provided by Federally Qualified Health Centers and Rural Health Centers. This SPA is estimated to be cost neutral.

If you have any questions regarding this SPA, please contact Aimee Campbell-O'Connor, Maine State Lead, at 617/565-1642, or at Aimee.Campbell-O'Connor@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

cc: Stefanie Nadeau, Director, Office of Maine Care Services
Sam Senft, Director, Policy, Children's and Waiver Services

| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL<br><br>FOR: HEALTH CARE FINANCING ADMINISTRATION | 1. TRANSMITTAL NUMBER: 15-020 | 2. STATE Maine |
|---|---|---|
| | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR<br>Centers for Medicare and Medicaid Services<br>Department of Health and Human Services | 4. PROPOSED EFFECTIVE DATE<br>XXXXXXXX 5/1/2016 | |

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:<br>Section 1902 (bb)(3),and Section 1902(a)(15) of the Social Security Act; Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106-554 (2000); . 42 CFR 491; 42 CFR 447.371 | 7. FEDERAL BUDGET IMPACT:<br>a. XXXXXXXXXXXXXXXXXX see remarks below.<br>b. XXXXXXXXXXXXXXXXXX |
|---|---|
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br><br>Attachment 4.19-B pages , XXXXXXXXX 1, 1.1, 1.2; 1.3; 1.4; 1.5; 1.6 and 1.7 | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:<br><br>Attachment 4.19-B page 1; 1.1; 1.2 |

10. SUBJECT OF AMENDMENT:
Change in reimbursement methodology for Rural Health Centers and Federally Qualified Health Clinics

11. 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: Commissioner, Dept. of Health and Human Services

| 12. SIGNATURE OF STATE AGENCY OFFICIAL:<br>/s/ | 16. RETURN TO:<br><br>Stefanie Nadeau<br>Director, Office of MaineCare Services<br>#11 State House Station<br>242 State Street<br>Augusta, Maine 04333-0011 |
|---|---|
| 13. TYPED NAME:<br>Mary C. Mayhew | |
| 14. TITLE:<br>Commissioner, Department of Health and Human Services | |
| 15. DATE SUBMITTED:<br>September 11, 2015 | |

**FOR REGIONAL OFFICE USE ONLY**

| 17. DATE RECEIVED:<br>9/24/15 | 18. DATE APPROVED:<br>2/3/16 |
|---|---|

PLAN APPROVED – ONE COPY ATTACHED

| 19. EFFECTIVE DATE OF APPROVED MATERIAL:<br>5/1/16 | 20. SIGNATURE OF REGIONAL OFFICIAL:<br>/s/ |
|---|---|
| 21. TYPED NAME:<br>Richard McGreal | 22. TITLE:<br>Associate Regional Administrator |

23. REMARKS:
1/25/16- State requested updated effective date with RAI responses and requested pen and ink change to 179.
1/26/16- State provided pen and ink authorization to update Box 7 to indicate estimated Federal Fiscal impact is cost neutral for FFYs 2016 and 2017.
2/3/16- State provided pen and ink authorization to update Box 8 to include correct pagination for the state's submission of updated and new pages.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

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1. Inpatient hospital services see Attachment 4.19·A

2. a. Outpatient hospital services ·Same as Attachment 4.19-A.

   b. Certified Rural Health Clinics.

**i. Prospective Payment System:**
The payment methodology for Certified Rural Health Clinics (RHCs) 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).

**a) RHCs that existed prior to BIPA 2000**

i. RHCs 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 a per visit basis).

ii. Beginning in FY 2002, and for each fiscal year thereafter, each RHC is entitled to the payment amount (on a per visit basis) to which the clinic 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) Establishment of payment amount for new RHCs**
This section applies to each new RHC 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 RHC 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(b)(i) for other such RHCs located in the same or adjacent area with a similar caseload. In the absence of such a RHC, the initial rate will be established through cost reporting methods.

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For each fiscal year following the initial fiscal year in which the entity first qualifies as a RHC, the State shall provide the payment amount in accordance with (2)(b)(i)(a)(ii).

**a) Change in Scope of Services Adjustments**

A “change in the scope of services” refers to a change in the overall picture of a RHC’s services through a change in the type, intensity, duration and/or amount of services.

The following examples are offered as guidance to RHCs 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 RHC services as provided in section 1905(a)(2)(B) 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 in 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 RHC to a new site which provides the same services;

vi. The addition or reduction of staff members to or from an existing service;

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vii. A change in office hours; or,

viii. An increase or decrease in the number of encounters.

It is the RHC'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 RHC must submit either at least six (6) months of 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 RHC'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. Alternate Payment Methodology (APM):**
The State reimburses for asthma education provided by non-physician providers, diabetes outpatient self-management, tobacco cessation classes, contraception (injectable), and the administration of influenza and pneumococcal vaccines through an alternate payment methodology as reflected on a fee schedule. State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of 11/5/2014 and is effective for services provided on or after that date. All rates are published at: http://www.maine.gov/dhhs/audit/rate-setting/documents/S103RHC_000.pdf.

The services located on this fee schedule may be billed in conjunction with the PPS or as a stand-alone visit based on the provider type that delivers these services

**iii. 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.

**c)** <u>Prospective Payment System Rate Billing</u>
To be eligible to receive the PPS 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

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nurse services provided by a registered nurse or licensed practical nurse to a homebound member may also receive the PPS rate.

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

**d)** Alternate Payment Methodology FFS Rate Billing
PPS-eligible providers may also bill FFS for APM services in addition to the PPS rate when APM services are delivered on the same day.

When any other provider (i.e. a non-PPS eligible provider) delivers an 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. Prospective Payment System:**

**a) 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.

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**b) 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(b)(i) 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)(b)(i)(a)(ii).

**c) 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 RHC services as provided in section 1905(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):

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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 of 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. Alternate Payment Methodology (APM):**
The State reimburses for asthma education provided by non-physician providers, diabetes outpatient self-management, tobacco cessation classes, contraception (injectable, implantable capsules, intrauterine devices), and the administration of influenza and pneumococcal vaccines through an alternate payment methodology as reflected on a fee schedule. State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of 11/05/14 and is effective for services provided on or after that date. All rates are published at http://www.maine.gov/dhhs/audit/rate-setting/documents/S31FQHC.pdf.

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The services located on this fee schedule may be billed in conjunction with the PPS or as a stand-alone visit based on the provider type that delivers these services.

**iii. 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.

**d)** Prospective Payment System Rate
To be eligible to receive the PPS rate for FQHC services, there must be a face-to-face service with one of the following PPS-eligible staff members of the FQHC: physician, podiatrist, physician assistant, advanced practice registered nurse, psychologist, licensed clinical social worker, licensed clinical professional counselor, dentist, dental hygienist, dental extern, dental resident, and/or physical therapist or any other provider that has been incorporated into the FQHCs PPS through a Department-approved change of scope of services request. Visiting nurse services provided by a registered nurse or licensed practical nurse to a homebound member may also receive the PPS rate.

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

**e)** Alternate Payment Methodology FFS Rates
PPS-eligible providers may also bill FFS for APM services in addition to the PPS when the APM services are delivered on the same day.

When any other provider (i.e. a non-PPS eligible provider) delivers an 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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

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3. Other laboratory and X-ray services 'the same as under Physicians' services, Item 5.

4. a. Skilled Nursing Facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older. See Attachment 4.19 D.

b. Early and Periodic Screening, Diagnosis and Treatment Services -- The State-agency will apply the rates currently in effect for the item of service provided, except the rates of payment for agencies participating in the EPSDT program under special agreements Is made on the basis of a negotiated fee schedule.

c. Family Planning Services and Supplies -- The State agency will apply the payment rate as described in Attachment 4.19 A when provided by a hospital, and as described in Item 5 below when provided as physician's services. Family Planning Agencies are reimbursed on the basis of a fixed fee schedule. For calendar year 2017, the fee schedule can be accessed at this website: https://mainecare.maine.gov/Provider%20Fee%20Schedules/Rate%20Setting/Section%20030%20-%20Family%20Planning%20Agency%20Services/Section%2030%20-%20Family%20Planning%202017.pdf

Beginning in calendar year 2018, the fee schedule can be accessed at this website: https://mainecare.maine.gov/Provider%20Fee%20Schedules/Rate%20Setting/Section%20030%20-%20Family%20Planning%20Agency%20Services/Archive/Section%2030%20-%20Family%20Planning%202017.pdf