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State/Territory Name: ME

State Plan Amendment (SPA) #: 17-0017A

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

Bethany Hamm, Acting Commissioner
Department of Health and Human Services
State of Maine
221 State Street
11 State House Station
Augusta, ME 04333-0011

August 21, 2018

RE: Maine 17-0017-A

Dear Commissioner Hamm:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 17-0017-A. This amendment revises reimbursement for inpatient hospital services. Specifically it: 1) adds reimbursement for Long Active Reversible Contraceptives (LARC) during postpartum inpatient hospital stay to provide adequate reimbursement to provider for the device; 2) changes data used to calculate Prospective Interim Payment (PIP) to provide more accuracy; and 3) further revises the state's fourteen day readmission protocol which was approved under TN 14-0003 and further amended under TN 15-0010.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447. We are pleased to inform you that Medicaid State plan amendment 17-0017-A is approved effective November 14, 2017. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Novena James-Hailey at (617) 565-1291.

Sincerely,

[redacted]

Kristin Fan
Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 17-0017A	2. STATE Maine
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR Centers for Medicare and Medicaid Services Department of Health and Human Services	4. PROPOSED EFFECTIVE DATE November 14, 2017	

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: 42 CFR 447	7. FEDERAL BUDGET IMPACT: a. FFY 2018 increase: $0 b. FFY 2019 increase: $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A pages 1, 1A, 2-5, 5(A), 6-7, ~~XXX~~	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-A pages 1-7, ~~XXX~~

10. SUBJECT OF AMENDMENT:
Hospital inpatient reimbursement: including fourteen (14) day readmission protocol, Long Acting Reversible Contraceptive (LARC), Prospective Interim Payment (PIP) and ~~Disproportionate Share Hospitals (DSH) reimbursement~~ language.

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: Stefanie Nadeau, Director, MaineCare Services

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: Stefanie Nadeau Director, MaineCare Services #11 State House Station 242 State Street Augusta, Maine 04333-0011
[redacted]D NAME: Stefanie Nadeau	
14. TITLE: Director, MaineCare Services	
15. DATE SUBMITTED: December 29, 2017 (REVISED 5/24/2018)	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: AUG 21 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: NOV 14 2017	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Kristin Fan	22. TITLE: Director FMG

23. REMARKS: State provided authorization for pen and ink change to remove withdrawn pages 10-11 in boxes 8, 9 and reference to Disproportionate Share payments (DSH) in box 10.

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A DEFINITIONS

A-1 Acute Care Critical Access Hospitals

A hospital licensed by the Department as a critical access hospital that is being reimbursed as a critical access hospital by Medicare.

A-2 Acute Care Non-Critical Access Hospitals

A hospital licensed by the Department as an acute care hospital that is not being reimbursed as a critical access hospital by Medicare.

A-3 Diagnosis Related Group (DRG)

The classification of medical diagnoses for use in determining reimbursement as defined in the Medicare DRG system or as otherwise specified by the Department.

A-4 Discharge

A member is considered discharged when the member is formally released from the hospital, transferred from one hospital to another, or dies in the hospital. For purposes of this Section, excluding Critical Access Hospitals, a member is not considered discharged if moved from one location within a hospital to another, or readmitted to the same hospital on the same day, or stays less than 24 hours; or is readmitted to the same hospital within fourteen (14) days of an inpatient discharge within the same DRG, excluding complications or co-morbidity.

There are exceptions to the fourteen (14) day readmission protocol. The exceptions are as follows:

a) Readmissions for individuals who are diagnosed with a mental health diagnosis described in the most current version of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM);

b) Readmissions for individual whose symptoms meet the American Society of Addiction Medicine (ASAM) Level 4 Criteria, as defined in the most recent edition of the ASAM Criteria: Treatment Criteria for Addictive, Substance-related, and Co-Occurring Conditions; and

c) Readmissions for individual receiving inpatient maintenance chemotherapy treatment.

Effective July 1, 2011, for hospitals billing under DRG based methodology, transferring a member to a distinct rehabilitation unit within the same hospital for the same diagnosis will be considered a discharge.

A-5 Distinct Psychiatric Unit

A unit within an acute care non-critical access hospital that specializes in the delivery of inpatient psychiatric services. The unit must be reimbursed as a distinct psychiatric unit as a sub-provider on the Medicare cost report or must be comprised of beds reserved for use for involuntary commitments under the terms of a contract with the Department of Health and Human Services. The claim must also be distinguishable as representing a discharge from a distinct psychiatric unit on the MaineCare claims processing system.

A-6 Distinct Rehabilitation Unit

A unit within an acute care non-critical access hospital that specializes in the delivery of inpatient rehabilitation services. The unit must be reimbursed as a distinct rehabilitation unit as a sub-provider on the Medicare cost report. The claim must also be distinguishable as representing a discharge from a distinct rehabilitation unit on the MaineCare claims processing system.

A-7 **Distinct Substance Abuse Unit**

A unit that combines the medical management of withdrawal with a structured inpatient rehabilitation program. Services include coordinated group education and psychotherapy, individual psychotherapy and family counseling as needed. Licensed Alcohol and Drug Abuse Counselors (LADCs) assist medical staff in developing an interdisciplinary plan of care. Evidence-based best practices, such as motivational interviewing are used by staff who are trained in substance abuse treatment. The claim must also be distinguishable as representing a discharge from a distinct substance abuse unit in the MaineCare claims processing system. This label is not a Medicare designation.

A-8 MaineCare Paid Claims History

A summary of all claims billed by the hospital to MaineCare for MaineCare eligible members that have been processed and accepted for payment by MaineCare. A record of these claims is kept in the Department's claim processing system.

A-9 Private Psychiatric Hospital

A hospital that is primarily engaged in providing psychiatric services for the diagnosis, treatment and care of persons with mental illness and is not owned and operated by the State of Maine. The facility must be licensed as a psychiatric hospital by the Department of Health and Human Services (DHHS). A psychiatric hospital may also be known as an institution for mental disease.

A-10 Prospective Interim Payment (PIP)

The weekly (or quarterly in the case of state owned psychiatric hospitals) payment made to a private hospital based on the estimated total annual Department obligation as calculated below. This payment may represent only a portion of the amount due the hospital; other lump sum payments may be made throughout the year. Such circumstances would include, but not be limited to, error correction and interim volume adjustments. For purposes of the PIP calculation, a MaineCare discharge for the most recently completed state fiscal year is one with a discharge date occurring within the state fiscal year and submitted prior to the time of calculation.

A-11 Rehabilitation Hospital

A hospital that provides an intensive rehabilitation program and is recognized as an Inpatient Rehabilitation Facility by Medicare.

A-12 State Owned Psychiatric Hospital

A hospital that is primarily engaged in providing psychiatric services for the diagnosis, treatment and care of persons with mental illness and is owned and operated by the State of Maine. The facility must be licensed as a psychiatric hospital by the Department of Health and Human Services. A psychiatric hospital may also be known as an institution for mental disease.

A-13 Transfer

A member is considered transferred if moved from one hospital to the care of another hospital. MaineCare will not reimburse for more than two discharges for each episode of care for a member transferring between multiple hospitals.

B GENERAL PROVISIONS

B-1 Inflation

For purposes of determining inflation, unless otherwise specified, the economic trend factor from the most recent edition of the "Health Care Cost Review" from Global Insight shall be used.

B-2 Third Party Liability (TPL)
Any MaineCare claim submitted by a hospital may only be withdrawn within 120 days.

B-3 Interim and Final Settlement

At interim and final settlements, the hospital will reimburse the Department for any overpayments; or the Department will reimburse the amount of any underpayment to the hospital. In either case, the lump sum payment must be made within 30 days of the date of the letter notifying the provider of the results of the interim or final settlement. If more than one year's reconciliation or settlement is completed in the same proceeding, the net amount must be paid. If no payment is received within thirty (30) days, the Department may offset prospective interim payments. Any caps imposed on PIP payments are not applicable to the determination of settlement amounts.

For hospital fiscal years beginning July 1, 2011, interim settlement will be performed within twelve (12) months of receipt of the Medicare Interim Cost Settlement Report with the Department, and final settlement will be performed within twelve (12) months of receipt of the Medicare Final Cost Settlement Report by the Department. If the Medicare Final Cost Settlement Report has been received by the Department prior to the issuance of the Interim Cost Settlement Report, the Department will issue only a Final Cost Settlement Report.

Hospitals are required to file with the DHHS, Division of Audit a year-end cost report within five months from their fiscal year end. The cost report filing consists of: CMS Form 2552 or its equivalent, audited financial statements, and any other related documentation as requested by the DHHS-Division of Audit. The cost report must include applicable MaineCare utilization and a calculated balance due to/from MaineCare.

B -4 Long Acting Reversible Contraceptives

MaineCare will separately reimburse for Long Acting Reversible Contraceptives (LARCs), in addition to the hospital DRG reimbursement, if the device is placed immediately postpartum in the inpatient setting.

The State agency will apply the payment rate as described in Supplement 1 to Attachment 4.19-B, page 1-a (5) of the Maine Medicaid State Plan.

C ACUTE CARE NON-CRITICAL ACCESS HOSPITALS

C-1 Department's Inpatient Obligation to the Hospital

The Department of Health and Human Services' total annual obligation to a hospital will be the sum of MaineCare's obligation for the following: inpatient services + inpatient capital costs + inpatient hospital based physician costs + graduate medical education costs + Disproportionate Share Payments (for eligible hospitals) and supplemental pool reimbursements + until July 1 2011, days awaiting placement.

A. **Inpatient Services** (not including distinct psychiatric or substances abuse unit discharges)

The Department pays using DRG-based discharge rates, which include estimated capital and medical education costs (see Appendix for full description). As explained in the Appendix , the payment is comprised of three components: the capital expense and graduate medical education components both of which will be subject to interim and final cost settlement, and the DRG direct rate component which will not be cost settled.

B. **Distinct Psychiatric Unit**

MaineCare pays a distinct psychiatric unit discharge rate equal to $6,438.72, except for Northern Maine Medical, for (1) which the distinct psychiatric discharge unit rate will be $15,679.94, and (2) effective July 1, 2013, $9128.31 per psychiatric discharge for members under 18 years of age from hospitals in the Lewiston-Auburn area. MaineCare will only reimburse at the distinct unit psychiatric rate when the member has spent the majority of his or her stay in the distinct unit. MaineCare will only reimburse for one (1) discharge for a single hospital for one episode of care.

Distinct psychiatric unit discharge rates will not be adjusted annually for inflation.

The Department will reimburse hospitals based on UB-04 and/or CMS 1500 billing forms. This payment is not subject to cost settlement.

C. **Distinct Substance Abuse Unit**

Effective April 1, 2013 MaineCare will pay a distinct substance abuse unit discharge rate equal to $4,898. MaineCare will only reimburse at the distinct unit substance abuse rate when the member has spent the majority of his or her stay in the distinct unit. MaineCare will only reimburse for one (1) discharge for a single hospital for one (1) episode of care.

D. **Inpatient Hospital Based Physician**

MaineCare will reimburse 93.3% of its share of inpatient hospital based physicians.

C-2 Interim Settlement

All calculations are based on the relevant payment methodology that was in effect when services were rendered, using the hospital's As-Filed Medicare Cost Report and MaineCare paid claims history for the year for which interim settlement is being performed.

1. Settlements for years up to and including SFY11
   To the extent applicable, MaineCare's interim cost settlement with a hospital will include settlement of :

   - Prospective interim payments; and
   - Payments made for hospital based physician services provided on or after September 1, 2010.

   No cap previously imposed on a prospective interim payment will limit or otherwise affect the determination of settlement amounts.

2. DRG Based System

   MaineCare's interim cost settlement for state fiscal years under the DRG-based system will include settlement of:

   - The DRG-based discharge rate as further described in Appendix B; and
   - Payments made for hospital based physician services.

C-3 Final Settlement

All settlement processes are based on the relevant payment methodology using charges included in MaineCare paid claims history for the applicable year and the hospital's Medicare Final Cost Report.

1. Settlements for years up to and including SFY11

   MaineCare's final cost settlement with a hospital will include settlement of:
   - Prospective interim payments;
   - Payments made for hospital based physician services provided on or after September 1, 2010.

   No cap previously imposed on a prospective interim payment will limit or otherwise affect the determination of settlement amounts.

2. DRG Based System

   MaineCare's final cost settlement with a hospital operating under the DRG-based system will include settlement of:

   - The DRG-based discharge rate as described in the Appendix; and
   - Payments made for hospital based physician services.

D. REHABILITATION HOSPITALS

D-1 **Department's Inpatient Obligation to the Hospital**

The Department of Health and Human Services' inpatient obligation to a hospital will be the sum of MaineCare's obligation for the following: inpatient services + inpatient capital

costs + Disproportionate Share Payments (for eligible hospitals) and supplemental pool reimbursements.

a. **Inpatient Services**

The Department will reimburse $12,440.44 per discharge paid based on claims submitted. Payment for these services is not subject to cost settlement.

b. Capital and Graduate Medical Education Costs

MaineCare will reimburse its share of inpatient capital costs and all graduate medical education costs.

c. Hospital based Physicians

MaineCare will reimburse 93.3% of its share of inpatient hospital based physician costs. Hospitals will initially be reimbursed based on claim forms filed with the Department. These payments are subsequently subject to cost settlement.

d. Third Party Liability Costs

MaineCare will reimburse its share of third party liability.

D-2 **Interim Cost Settlement**

The Department calculates the Interim Cost Settlement using the hospital's As-Filed Medicare Cost Report, MaineCare Supplemental Data Form and MaineCare paid claims history for the year for which interim settlement is being performed. Cost settlement is performed for hospital based physician costs and for capital costs.

D-3 **Final Cost Settlement**

The Department of Health and Human Services calculates the final settlement with a hospital using the same methodology as used when calculating the interim settlement, except that the data sources used are the Medicare Final Cost Report, MaineCare Supplemental Data Form and MaineCare paid claims history for the year for which settlement is being performed.

E ACUTE CARE CRITICAL ACCESS HOSPITALS AND HOSPITALS RECLASSIFIED TO A WAGE AREA OUTSIDE MAINE BY THE MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD (MGCRB) PRIOR TO OCTOBER 1, 2008

All calculations made in relation to these hospitals must be made in accordance with the requirements for completion of the Medicare Cost Report and Generally Accepted Accounting Principles, unless otherwise noted, plus a DSH adjustment payment for eligible hospitals.

E-1 Department's Inpatient Obligation to the Hospital

The Department of Health and Human Services' total annual inpatient obligation to the hospitals will be the sum of MaineCare's obligation of the following: inpatient services + days awaiting placement + hospital based physician + direct graduate medical education costs. Third party liability payments are subtracted from the obligation.

These computed amounts are calculated as described below:

A. Inpatient Services

109% of the total MaineCare inpatient operating costs from the most recent interim cost-settled report issued by the Department, inflated to the current state fiscal year. Additionally, a supplemental pool will be allocated on the basis of the hospital's relative share of Medicaid payments for private critical access hospitals only, not those hospitals reclassified to a wage area outside Maine by the Medicare Geographic Classification Review Board or public hospitals. In SFY 11 that amount will be $3,500,000. In SFY 12 and subsequent years that amount will be $4,000,000.

The relative share is defined as:

$$\frac{\text{total Medicaid payments to CAH hospital} \times \text{pool amount}}{\text{total Medicaid payments to all CAH hospitals}}$$

B. MaineCare Member Days Awaiting Placement (DAP) at a Nursing Facility (NF)

Reimbursement will be made prospectively at the estimated statewide average rate per member day for NF services. The Department shall adopt the prospective statewide average rates per member day for NF services that are specified in the 4.19D Principles of Reimbursement for Nursing Facilities. The average statewide rate per member day shall be computed based on the simple average of the NF rate per member day for the applicable State fiscal year(s) and prorated for a hospital's fiscal year.

C. 93.3% of MaineCare's share of inpatient hospital based physician costs + MaineCare's share of graduate medical education costs.

E-2 Prospective Interim Payment (PIP)

The estimated departmental annual inpatient obligation, described above, will be calculated using the most recent MaineCare Supplemental Data Form increased by the rate of inflation to the beginning of the current state fiscal year. Third party liability payments are subtracted from the PIP obligation. The PIP payment does not include DSH payments or the hospital's share of the supplemental pool as described below.

E-3 Interim Adjustment

The State would expect to initiate an interim adjustment under very limited circumstances, including but not limited to, restructuring payment methodology as reflected in a state plan amendment; when a hospital "changes" categories (e.g. becomes designated critical access);

OFFICIAL

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

5. Physicians' Services -The State agency will apply a fee schedule, The Fee Schedule reimburses at the lowest of the following for covered services: 1) The lowest amount allowed by Medicare Part B for Maine area "99" fee including the appropriate Medicare fee adjustments for place of service and modifiers, 2) for newly covered services/codes, the rate will be based on 70% of the 2009 CMS rate or 70% of the rate in the year CMS assigned a rate for that code, or 3)Where no other options are applicable, the Department researches other State Medicaid agencies that cover the relevant service/code. The Department then bases its rates on the average cost of the relevant services/codes from those other agencies. If the provider's usual and customary charge for a service is lower than the fee schedule rate, the provider's usual and customary charge will be reimbursed. MaineCare considers a claim paid in full if the third party payment exceeds the MaineCare rate of reimbursement.

PHYSICIAN FEEDBACK REPORT AND INCENTIVE AWARDS

ELEMENTS OF PHYSICIAN FEEDBACK REPORT

Payment Calculation for provider incentive payment

A) Eligible Providers

- Office Based Primary Care Case Management (PCCM) Sites (Excludes RHC, FQHC, IHS, Hospital Employed)
- Currently enrolled in the PCCM Program
- Have a paid claim in the last quarter of the reporting period
- Have 20 or more members in their panel
- Servicing Providers practicing in more than one site are prorated across sites

B) Eligible Members

- Members must be enrolled In PCCM for at least 6 months

C) Calculation of Payment

- Total PCCM PIP Payment Per Year: $2.6 million ($1.3 Per Each Reporting Period)
- Each of these disbursements is further split between Child sites and Adult sites. based on the number of members served In each of the two site types
    - Adult/Child distribution split - prorate pool based on proportion of adults (age 21+) and children (age <21): age calculated at the beginning of the referent period. Calculations are run separately for adult and children.
- Within each site type, payment to individual sites is determined by performance measurements in three areas: **Access, ER Utilization**, and **Quality**

40% for performance in the Access Measure
30% for performance In the ER Utilization Measure
30% for performance in the quality Measure

• Definitions of performance areas are:

Access (40 percent): The performance calculation for the Access measure is based on the number of MaineCare members per servicing provider at the site.

UTILIZATION (30 percent): The performance calculation for the ER Utilization measure is based on the average number of ER visits for MaineCare members at the site.

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

August 21, 2018

Bethany Hamm, Acting Commissioner
Department of Health and Human Services
State of Maine
221 State Street
11 State House Station
Augusta, ME 04333-0011

RE: Maine Companion letter to 17-0017-A

Dear Commissioner Hamm:

This letter is being sent as a companion to our approval of transmittal number (TN) 17-0017-A which, in part, proposed to revise the reimbursement methodology for inpatient hospital services related to the state's Disproportionate Share Hospital program (DSH). Specifically, this particular proposal required final cost reports to calculate DSH payments. This state plan amendment (SPA) was received in the Boston Regional Office under the Centers for Medicare & Medicaid Services (CMS) on December 29, 2017, with an effective date of November 14, 2017. We are noting one area within the SPA that requires additional follow-up from the state.

Section l902(a)(13)(A)(iv) of the Social Security Act (the Act), in a manner consistent with section 1923, requires that state Medicaid programs make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. Federal law also requires states to submit an independent certified audit and an annual report to the Secretary describing DSH payments made to each DSH hospital. The Maine Medicaid state plan has provisions to make DSH payments to qualified providers. However, of all the qualified providers, DSH payments to only 2 providers are evident in all the required independent certified audit and annual reports submitted to CMS each year. Under TN 17-0017A, the state was asked to explain the discrepancy since changes were proposed to the approved DSH reimbursement methodology in the state plan and the state elected to withdraw the SPA page submitted rather than provide the requested information. With no evidence of claiming DSH payments for all qualified providers and the absence of an audit of DSH payments to said providers, CMS has concerns that the state is not reimbursing providers in accordance with the approved payment authority for DSH payments in the state plan.

We are issuing a companion letter to formally address the inconsistency between Maine's DSH payment authority, as described in the state plan, and the state's admission during recent conversations that the payments are not being made. In addition, the CMS 64 financial reports do not indicate that these payments have been made to all qualified hospitals. Consequently, not reimbursing providers in accordance with the approved payment authority in the state plan places the state out of compliance with Federal DSH and state plan requirements.

The State will need to revise Attachment 4.19-A of their state plan to include a comprehensive reimbursement methodology for how the state actually makes DSH payments in order to come into compliance.

The State has 90 days from the date of this letter to address the issues described above. Failure to respond may result in the initiation of a formal compliance process and put the state at financial risk. During the 90 days, CMS will provide any required technical assistance.

If you have any questions, please contact Novena James-Hailey of my staff. She can be reached at 617-565-1291 or by email at novena.jameshailey@cms.hhs.gov.

Sincerely,

Richard R. McGreal
Associate Regional Administrator