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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

December 23, 2011

Mary C. Mayhew, Commissioner
Department of Health and Human Services
Commissioner's Office
11 State House Station
August, Maine 04333-0011

Dear Commissioner Mayhew:

We are sending this letter as a companion to our approval of Maine's State Plan amendment (SPA) No. 10-012. During our review of this SPA, we also performed a corresponding page review of the reimbursement language associated with the services described in this SPA.

The reimbursement methodology listed under Paragraph 12 of Section 4.19-B of your State plan (Other diagnostic, screening, preventive and rehabilitative services) does not currently meet our requirements. Based on our review of the coverage and reimbursement, it appears as if the reimbursement for these services is bundled.

A bundled payment exists when a State makes a single payment for one or more of a group of different services furnished to an individual during a fixed period of time. The payment is the same regardless of the number of units of service, types of service or level of practitioners providing the service or the specific costs, or otherwise available rates, of those services. CMS has identified that bundled payments may violate two provisions of the Social Security Act: 1902(a)(30)(A) and 1902(a)(32).

1. 1902(a)(30)(A) requires that payments for services are economic and efficient. Generally, bundled payments are not economic and efficient because they can be made for services that may or may not actually be rendered to the beneficiary or for services that may not be covered by Medicaid.

2. 1902(a)(32) requires direct payment to the provider of the service. Many providers receiving bundled payments for rehabilitative services are not individual practitioners (e.g. residential treatment centers). However, with the exception of outpatient hospital and clinic services, the only providers recognized in statute to provide non-institutional statutory services [i.e. those listed in 1905(a)] and be eligible for payment are individual practitioners.

CMS expects that States will develop bundled rates based upon actual service data maintained by providers. Therefore, Maine must ensure that PNMIs maintain data that supports a conclusion that the rate developed by MaineCare is economic and efficient. That data normally consists of information showing the provision by practitioner of the individual **covered** Medicaid services included in the bundled payment and the cost by practitioner and type of service actually delivered under the bundled rate. Maine must describe the development of the rate in the State plan. Costs related to room and board and other unallowable costs must clearly be excluded.

Additionally, 42 CFR 431.107 requires that each provider or organization furnishing services agree to keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Medicaid agency any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. The State Medicaid Manual in Section 2500.2(A) requires that a State Medicaid agency report "only expenditures for which all supporting documentation is available, in readily reviewable form, which has been compiled and which is immediately available when the claim is filed" on the CMS-64. This section continues by stating that "... supporting documentation includes as a minimum the following: date of service; name of recipient; Medicaid identification number; name of provider agency and person providing the service; nature, extent or units of service; and the place of service." In accordance with these requirements, Maine must include language in the State plan identifying the data to be maintained by providers and must assure that the State will review that data in order to develop and revise as necessary, an economic and efficient rate.

Include in the State plan a description of the State's proposal for monitoring the provision of services paid under a bundled rate to ensure that beneficiaries receive the types, quantity and intensity of services required to meet their medical needs.

The State will have 90 days to address the issues identified. Within that period the State may submit SPAs to address the inconsistencies or submit a corrective action plan describing in detail how the State will resolve the issues identified above in a timely manner. Failure to respond will result in the initiation of a formal compliance process. During the 90-day period, CMS will provide any required technical assistance to assist you in resolving these issues.

If there are questions, please contact Robert Cruz at 617-565-1257 or robert.cruz@cms.hhs.gov. We look forward to working with you on these issues.

Sincerely,

Richard R. McGreal for
Associate Regional Administrator

cc: Stefanie Nadeau, Director, Office of Maine Care Services