DATE: June 14, 2016

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Proposed Rule: MaineCare Benefits Manual (MBM), Chapters II and III, Section 31, Federally Qualified Health Center Services

This letter gives notice of a proposed rule: MBM, Chapters II and III, Section 31, Federally Qualified Health Center Services (FQHCs). This rule proposes more specific guidance around the rate setting and adjustment processes for the Prospective Payment System (PPS) used in Federally Qualified Health Centers’ (FQHC) reimbursement.

The payment methodology for FQHCs conforms to Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. According to this methodology, FQHCs are reimbursed based on average reasonable costs of providing MaineCare scope of services during calendar years 1999 and 2000, adjusted annually by the Medicare Economic Index (MEI) for primary care services, and also adjusted to take into account any increase or decrease based on Department approved “change in scope of services.”

The Department proposes to outline the types of changes that may or may not be eligible for a rate adjustment based on a “change in scope of services” request, and includes examples as guidance. In addition, MaineCare proposes to change the data requirements for submitting a “change in scope of services” request. Adjustments to the PPS rate will be effective 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.

The Department also proposes to amend the current process for establishing rates for newly qualifying FQHCs. Currently, newly qualifying sites have PPS payments established by reference to payments to other FQHCs in the same or adjacent areas, or in the absence of such other centers, through cost reporting methods. This proposed change would require that reference sites must also have a “similar caseload” in order to provide a basis for the new FQHC’s rate.

Rules and related rulemaking documents may be reviewed at, or printed from, the MaineCare Services website at http://www.maine.gov/dhhs/oms/rules/index.shtml or for a fee, interested parties may request a paper copy of rules by calling (207) 624-4050. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 711.

A concise summary of the proposed rule is provided in the Notice of Agency Rule-making Proposal, which can be found at http://www.maine.gov/sos/cec/rules/notices.html. This notice also provides information regarding the rule-making process. Please address all comments to the agency contact person identified in the Notice of Agency Rule-making Proposal.
Notice of Agency Rule-making Proposal

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual, Chapters II and III, Section 31, Federally Qualified Health Center Services

PROPOSED RULE NUMBER:

CONCISE SUMMARY: This proposed rule amends the rate setting and rate-adjustment processes for the prospective payment system (PPS) used to reimburse Federally Qualified Health Centers (FQHCs).

This rulemaking clarifies and expands the current FQHC policy and procedures as follows:

- Provides additional guidance and consistency in the methodology for adjustments of PPS rates;
- Amends the process of rate establishment for newly qualifying FQHCs;
- Provides specific guidance in what constitutes “a change in scope of services”; and
- Expands the reporting requirements in conjunction with a request for rate adjustment due to a “change in scope of services”.

The Centers for Medicare and Medicaid Services (“CMS”) has approved a Maine State Plan Amendment related to initial rate-setting and “change in scope of services.” The payment methodology for FQHCs conforms to Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.


STATUTORY AUTHORITY: 22 M.R.S. §§ 42, 3173

PUBLIC HEARING:

Date: Tuesday, July 12, 2016
Time: 9:30 a.m.
Location: 19 Union St., Room 110
Augusta, ME

The Department requests that any interested party requiring special arrangements to attend the hearing contact the agency person listed below before Tuesday, July 5, 2016.

DEADLINE FOR COMMENTS: Comments must be received by 11:59 p.m., Friday, July 22, 2016

AGENCY CONTACT PERSON: Anne Labonte Perreault, Comprehensive Health Planner II
Anne.Labonte-Perreault@maine.gov

AGENCY NAME: MaineCare Services
ADDRESS: 242 State Street, 11 State House Station
Augusta, Maine 04333-0011

TELEPHONE: 207-624-4082 FAX: (207) 287-1864
TTY: 711 (Deaf or Hard of Hearing)

IMPACT ON MUNICIPALITIES OR COUNTIES (if any): The Department does not anticipate this rulemaking will have any impact on municipalities or counties.
TABLE OF CONTENTS

31.01 DEFINITIONS ....................................................................................................................... 1

31.01-1 Ambulatory Services ...................................................................................................... 1
31.01-2 Covered Services ............................................................................................................. 1
31.01-3 Federally Qualified Health Center (FQHC) .................................................................. 1
31.01-4 Federally Qualified Health Center Services .................................................................. 1
31.01-5 Homebound Member ...................................................................................................... 1
31.01-6 Plan of Treatment ........................................................................................................... 2
31.01-7 Primary Health Care ....................................................................................................... 2
31.01-8 FQHC Unit of Service .................................................................................................... 2
31.01-9 Incidental Services and Supplies .................................................................................... 2

31.02 ELIGIBILITY FOR CARE .................................................................................................... 2

31.03 DURATION OF CARE ......................................................................................................... 2

31.04 COVERED SERVICES ....................................................................................................... 2

31.04-1 Core Services .................................................................................................................. 3
31.04-2 Ambulatory Services ...................................................................................................... 3
31.04-3 Off-site Delivery of Services .......................................................................................... 5
31.04-4 Visiting Nurse Services .................................................................................................. 5
31.04-5 Interpreter Services ....................................................................................................... 6

31.05 NONCOVERED SERVICES ............................................................................................... 6

31.06 POLICIES AND PROCEDURES ..................................................................................... 6

31.06-1 Professional and other Qualified Staff ........................................................................... 6
31.06-2 Supervision by a Physician or Other Licensed Practitioner ........................................... 7
31.06-3 Member Records .......................................................................................................... 7
31.06-4 Program Integrity ......................................................................................................... 9

31.07 REIMBURSEMENT ............................................................................................................ 9

31.07-1 General Reimbursement ............................................................................................... 9
31.07-2 PPS Reimbursement Methodology .............................................................................. 10
31.07-3 Reimbursement for Members Eligible for both Medicare and MaineCare .............. 13

31.08 COPAYMENT ................................................................................................................... 14

31.09 BILLING INSTRUCTIONS ............................................................................................... 15
31.01 DEFINITIONS

31.01-1 **Ambulatory services** are services provided by a federally qualified health center other than those core services described in Section 31.04-1 that are also included in the State's Medicaid Plan and that are provided in accordance with all applicable sections of the MaineCare Benefits Manual. This includes dental services provided by dentists, independent practice dental hygienists (effective October 1, 2013, subject to approval by CMS), dental hygienists, and licensed dental entities.

31.01-2 **Covered services** are those services described in Section 31.04 for which payment can be made under Title XIX and XXI by the Department of Health and Human Services.

31.01-3 **Federally Qualified Health Center (FQHC)** refers to a facility or program that is federally qualified and may also be known as a community health center, migrant health center, or health-care program for the homeless. A center is "federally qualified" if it:

A. is receiving a grant under Section 330 of the Federal Public Health Service (PHS) Act;

B. is receiving funding from such a grant under a contract with the recipient of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act;

C. is determined by the Secretary of the Department of Health and Human Services, to meet the requirements for receiving such a grant (look-alike), based on the recommendation of the Health Resources and Services Administration (HRSA) within the Public Health Service;

D. was treated by the Secretary (of Health and Human Services), for purposes of Medicare Part B, as a comprehensive federally funded health center as of January 1, 1990; or

E. is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

31.01-4 **Federally Qualified Health Center Services** are those primary health-care (core services) and other ambulatory services furnished by the facility's professional and other qualified staff during a visit.

31.01-5 **Homebound member** is defined as an individual who is confined permanently or temporarily to his or her place of residence because of a medical or health condition. The individual may be considered homebound if he or she leaves the place of residence infrequently. For this purpose, "place of residence" does not include a hospital or long-term care facility.
31.01 DEFINITIONS (cont.)

31.01-6 **Plan of treatment** is a written plan of medical services for part-time or intermittent visiting nurse care that is established and reviewed at least every sixty (60) days by a supervising physician of the health center. When delegated by the supervising physician, and when in compliance with all other State licensure requirements, it may also be established by a physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner and reviewed and approved at least every sixty (60) days by a supervising physician of the health center.

31.01-7 **Primary health care** refers to preventative, diagnostic and therapeutic services furnished by the health center's professional staff and, where appropriate, the supplies commonly used to support those services, basic laboratory services essential for diagnosis and treatment, and emergency medical care for the treatment of life-threatening injuries and acute illness.

31.01-8 **FQHC unit of service** is a visit that includes a face-to-face contact with one or more of the center's core or ambulatory professional and other qualified staff and, where appropriate, receipt of supplies, treatments, and laboratory services.

31.01-9 **Incidental Services and Supplies** refer to certain services and supplies authorized by licensed medical, dental and mental health practitioners.

31.02 ELIGIBILITY FOR CARE

Individuals must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

It is the responsibility of the provider to verify a member's eligibility for MaineCare as described in Chapter I.

31.03 DURATION OF CARE

Each Title XIX and Title XXI member may receive as many covered services as are medically necessary. The Department reserves the right to request additional information to evaluate medical necessity.

31.04 COVERED SERVICES

All services must be provided within the HRSA-approved scope of service area, or to HRSA-Designated Medically Underserved Populations (MUP) at federally approved center locations such as school-based health centers, and be otherwise provided in conformance with Federal requirements.
31.04 COVERED SERVICES (cont.)

Covered services include core services, and other ambulatory services contained in the State’s Medicaid plan, and in the FQHC’s scope of project for base year 1999 as approved by HRSA, and any approved change in scope of service either as amended, or as specifically approved by the Commissioner of the Maine Department of Health and Human Services (DHHS). FQHCs must submit their HRSA-approved scope of project for base year 1999, or if established after 1999, for their first year of operation, and all subsequent HRSA-approved amendments to scope of project.

31.04-1 Core services include:

A. services provided by physicians, physician assistants, advanced practice registered nurses, clinical psychologists, licensed clinical social workers, and licensed clinical professional counselors;

B. services and supplies furnished as incident to services of approved and appropriate licensed practitioners. In order for incidental services to be covered, FQHC employees must perform the incidental service, unless it is an FQHC service routinely performed by contracted personnel or providers. Services provided by auxiliary personnel not in the employ of the FQHC, even if provided on the physician's order or included in the FQHC's bill, are not covered as incident to a physician's service. Thus, non-physician diagnostic and therapeutic services that an FQHC obtains, for example, from an independent laboratory, an independent licensed or otherwise qualified provider, or a hospital outpatient department are not covered FQHC services;

C. visiting nurse services (as described in Section 31.04-4).

31.04-2 Ambulatory services include the following:

A. Any other ambulatory service, including any incidental supplies associated with the performance of a service that is provided by the FQHC, and that is also included in the State's Medicaid Plan, are reimbursable. (These services must be provided in accordance with all applicable sections of the MaineCare Benefits Manual in order to be reimbursable.)

B. Asthma self-management services are reimbursable if they are based on the Open Airways or Breathe Easier curricula. Any other asthma management service that is approved by the National Heart, Lung and Blood Institute/American Lung Association or the Asthma and Allergy Foundation of America, are also reimbursable.

Each program must have:

1. a physician advisor;
31.04 **COVERED SERVICES** (cont.)

2. a primary instructor (a licensed health professional or a health educator with baccalaureate degree);

3. a pre and post assessment for each participant which shall be kept as part of the member's record;

4. an advisory committee which may be part of an overall patient education advisory committee; and

5. a physician referral for all participants.

C. Reimbursement for Ambulatory Diabetes Education and Follow-Up (ADEF) Services, or for similar services approved by a Centers for Medicare and Medicaid Services (CMS) approved national accreditation organization, will be reimbursed when a provider enrolled with the Maine Diabetes Prevention and Control Programs furnishes this service to a MaineCare member whose physician has prescribed this program for the management of the member's diabetes. The service is:

1. a pre-assessment interview to determine the member's knowledge, skills and attitudes about diabetes management and to develop an individualized education plan and behavior change goals;

2. a group class instruction covering the comprehensive curriculum outlined by the Maine Diabetes Control Project and based on the individualized education plan;

3. a meal planning interview to determine the member's knowledge, skills and attitudes about meal planning and to develop an individualized meal plan and behavior change goals;

4. a post-service interview to assess and document what the member has learned during the service, and to develop a plan for follow-up sessions to address the component areas not learned in the class series, and finalize behavioral goals; and

5. follow-up contacts to reassess and reinforce self-care skills, evaluate learning retention and progress toward achieving the member's behavior change goals. At a minimum, three-month, six-month, and one-year follow-up visits from the date of the last class are required to complete the member's participation in the service.
31.04 COVERED SERVICES (cont.)

When the MaineCare member is under age 21, this service will also be reimbursed when provided to the person/people who provide the member's daily care.

D. Effective August 1, 2014, smoking tobacco cessation counseling will be reimbursed, for eligible Members, provided by physicians or other providers who can provide smoking tobacco cessation counseling under their licenses or permits. There are no annual or lifetime limits on smoking tobacco cessation counseling services. These services may be provided in the form of individual or group counseling. Both forms of counseling may be provided by licensed practitioners within the scope of licensure as defined under State law and who are eligible to provide other coverable services in Section 31. Smoking cessation counseling may be billed alone, or in combination with other FQHC services. Documentation of the smoking tobacco cessation counseling must be contained in the medical record. Documentation must include:

1. a nicotine or tobacco dependence code from the version of the International Classification of Diseases (ICD) Manual required, pursuant to 45 CFR 162.000 et seq. by CMS on the date the service is delivered. Providers can check the Department’s website at https://mainecare.maine.gov/ProviderHomePage.aspx to determine which version of the ICD Manual is being utilized;

2. an assessment of the member’s willingness to quit smoking, or of his or her progress in quitting;

3. documentation of any ongoing barriers to quitting or staying tobacco-free; and

4. a brief outline of whatever motivational or educational information was provided.

5. the name and license level of person providing the smoking cessation services.

31.04-3 Off-site delivery of services furnished by health center staff are reimbursable when they are provided away from the center and when it is documented in the member's chart that it is the most clinically appropriate setting for the provision of services. Examples of off-site service locations include: a nursing facility, an emergency room, an inpatient hospital, or a member’s home.

31.04-4 Visiting nurse services will be reimbursed when:

A. a registered nurse or licensed practical nurse provides the services to a member who is homebound;

B. the services are provided in accordance with a written plan of treatment;
31.04 COVERED SERVICES (cont.)

C. the member's record documents that the member would not otherwise receive these services;

D. the services are provided in an area for which the Secretary of the US Department of Health and Human Services has determined there is a shortage of home health agencies; and

E. the health center that provides in-home services by a registered or licensed practical nurse is licensed by the State of Maine as a home health service provider.

31.04-5 Interpreter Services - Refer to Chapter I of the MaineCare Benefits Manual for information about the reimbursement for interpreter services.

31.05 NONCOVERED SERVICES

Unless the Department Commissioner of DHHS specifically approves an additional service, covered services are limited to those services HRSA approved in the FQHC’s scope of project. See Chapter I of the MaineCare Benefits manual for additional details on non-covered services.

31.06 POLICIES AND PROCEDURES

31.06-1 Professional and Other Qualified Staff

In order for a Federally Qualified Health Center to receive reimbursement, its professional staff must be conditionally, temporarily or fully licensed, in the state or province where services are provided, as documented by written evidence from the appropriate governing body, including: physicians, podiatrists, physician assistants, advanced practice registered nurses, clinical psychologists, clinical social workers, clinical professional counselors, registered nurses, licensed practical nurses, respiratory therapists, dentists, independent practice dental hygienists (effective October 1, 2013, subject to approval by CMS), and dental hygienists. Other qualified staff include: dental externs (added effective July 1, 2013) and dental residents (added effective July 1, 2013) as defined in the MaineCare Benefits Manual, Chapter II - Section 25: Dental Services, who must have a current permit from the Maine Board of Dental Examiners. MaineCare will also reimburse for advanced practice or registered nurses who hold a current, unencumbered compact license from another compact state that they claim as their legal residence. Qualifications of any other staff must be provided and billed in accordance with all other applicable sections of the MaineCare Benefits Manual.
31.06 POLICIES AND PROCEDURES (cont.)

31.06-2 Supervision by a Physician or Other Licensed Practitioner

Medical services rendered under this policy must be provided under the supervision of a physician, or other suitably licensed practitioner, to the extent required by applicable state or provincial laws or regulations. Clinical psychologists, LCSWs, LCPCs, dentists, and other non-medical staff are not subject to the supervision of the physician.

Physician supervision must be performed in accordance with the Maine Board of Licensure in Medicine or the Maine Board of Licensure in Osteopathy requirements. Dental services rendered under this policy must be performed in accordance with the Maine Board of Dental Examiners requirements.

31.06-3 Member Records

There shall be a specific record for each member, which shall include, but not necessarily be limited to:

A. the member's name, address and birth date;
B. the member's social and medical history, as appropriate;
C. a description of the findings from the physical examination;
D. long- and short-range goals, as appropriate, except for clinical psychologist, licensed clinical social worker and licensed clinical professional counselor services, where a mental health treatment plan containing long- and short-term goals and signed by both the provider and the member, must be developed by the third session, and updated with signatures at least quarterly thereafter;
E. a description of any tests ordered and performed and their results;
F. a description of treatment or follow-up care and dates scheduled for revisits;
G. any medications and/or supplies dispensed or prescribed;
H. any recommendations for and referral to other sources of care;
I. the dates on which all services were provided; and
J. written progress notes, which shall identify the services provided and progress toward achievement of goals.
31.06 POLICIES AND PROCEDURES (cont.)

K. for members with a history of chronic mental illness, who receive ongoing outpatient therapy by LCSWs, LCPCs, psychologists or advanced practice psychiatric nurses, or who receive medication management from advanced practice psychiatric nurses, the following additional record-keeping requirements apply:

1. Initial Assessment/Clinical Evaluation. An initial assessment, which must include a direct encounter with the member, and his/her family if appropriate, shall be performed and included in the member's FQHC record. The assessment must include the member's medical and social history and must include the member's diagnosis and the professional who made the diagnosis and that person's credentials.

2. Individual Treatment/Service Plan. An individual treatment/service plan must be developed by the third mental health visit. This individual treatment/service plan shall be in writing and shall identify mental health treatment needs, and shall delineate all specific services to be provided, the frequency and duration of each service, the mental health personnel who will provide the service, and the goals and/or expected outcomes of each service. Treatment plans must be reviewed and approved by a psychiatrist, physician, psychologist, or licensed clinical social worker, licensed clinical professional counselor or advanced psychiatric and mental health nurse, or a registered nurse certified in the specialized field of mental health within thirty (30) days of entry of the member into mental health treatment.

3. Written treatment or progress notes shall be maintained in chronological order, and shall be made for each mental health visit. These notes shall identify who provided the service, the provider's credentials, on what date the service was provided, its duration, and the progress the member is making toward attaining the goals or outcomes identified in the treatment plan.

4. The clinical record shall also specifically include written information or reports on all medication reviews, medical consultations, psychometric testing, and collateral contacts made on behalf of the member (name, relationship to member, etc.).

5. In cases where FQHC mental health services are needed in excess of two hours per week to prevent hospitalization, documentation must be included in the file and signed by a psychiatrist, physician, psychologist, licensed clinical social worker, licensed clinical professional counselor or psychiatric nurse.

6. Discharge/Closing Summary. A closing summary shall be signed and dated and included in the clinical record of discharge treatment and outcome in relation to the individual treatment/service plan.
31.06 **POLICIES AND PROCEDURES** (cont.)

7. In the event a member receives group services, there shall be no names of other group participants in the member's record. Entries are required for each service billed and must include the name, credentials, and signature of the service provider. See Chapter I of the MaineCare Benefits Manual for additional record keeping requirements.

31.06-4 **Program Integrity**

Please see Chapter I of the MaineCare Benefits Manual.

31.07 **REIMBURSEMENT**

31.07-1 **General Reimbursement**

FQHCs are reimbursed in accordance with the requirements of section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000, including requirements for a Prospective Payment System.

Reimbursement for Federally Qualified Health Center services is made on the basis of "reasonable cost" as determined by the Medicare Principles of Reimbursement. Reimbursement will be made for services provided in accordance with these rules.

Reimbursement is generally limited to one core service visit, and/or one ambulatory service visit per day. Reimbursement for a second core visit is also covered if the member has both an encounter with a physician, physician assistant, advanced nurse practitioner or visiting nurse, and in addition to that encounter, is seen by a licensed clinical psychologist, clinical social worker, clinical professional counselor or a clinical nurse specialist licensed as a psychiatric registered nurse on the same day.

An additional visit of any other kind will only be reimbursed for unforeseen circumstances as documented in the member's record. The goal remains to treat the whole individual during one visit.

Federally Qualified Health Centers may be reimbursed in excess of their core and additional (same day) visit rates when providing services delineated in the respective sections of the MaineCare Benefits Manual: Primary Care Case Management Services per Chapter VI, Section 1; and Chapter I.

Any additional center visits that are required in the patient's treatment plan that do not qualify as center visits for reimbursement purposes are non-billable.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from other third party payers prior to billing MaineCare for a rendered service. If a member has capitated third party coverage other than MaineCare, and if that third party carrier requires a member co-pay but makes no fee-for-service payment to cover FQHC services, MaineCare reimbursement will be limited to the amount of the co-pay alone.
31.07 **REIMBURSEMENT** (cont.)

FQHCs have the option of obtaining a separate MaineCare provider billing number for the limited purpose of FFS billing and reimbursement for such services as x-ray, EKG, inpatient hospital visits and other Medicare defined non-FQHC services that are billable under Medicare Part B. If a center chooses to bill fee for service for Medicare defined non-FQHC services, it may not report costs related to these services on its MaineCare cost report.

31.07-2 **PPS Reimbursement Methodology**

**A. Initial PPS Rates and Annual Adjustments**

Effective January 1, 2001, FQHCs (federally qualified health centers) will be reimbursed on the basis of 100% of the average of their reasonable costs of providing MaineCare-covered services during calendar years 1999 and 2000, adjusted to take into account any increase or decrease in the approved scope of services furnished during the provider’s fiscal year 2001 (calculating the amount of payment on a per visit basis).

At the start of each subsequent year, beginning in CY 2002, 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, inflated 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 any rate adjustment for the approved “change in scope of services.”

Until the initial new payment rate is calculated according to this methodology, federally qualified health centers will be paid at their current plan rate, which will be retroactively adjusted once the new payment rate is calculated.

Newly qualified FQHCs after state fiscal year 201790 will have initial payments (calculated on a per visit basis) established either by reference to payments to other centers in the same or adjacent areas with a similar caseload, or in the absence of such other centers, through cost reporting methods. Cost reports must accurately reflect the costs of the individual FQHC (i.e. may not be a consolidated report of multiple sites or organizations that is not able to distinguish FQHC costs). After the initial year, payment shall be adjusted for MEI and approved “change in scope of services.” This applies to each new FQHC site or location with a separate National Provider Identifier that is opening, regardless of affiliation to an existing organization, and regardless of previous service delivery methods used for other centers.

Federally qualified health centers are required to file a Medicare annual cost report with appropriate addenda to the Department of Health and Human Services Division of Audit within one hundred and fifty (150) days of their fiscal year end, unless an extension has been granted before the one hundred and fifty (150) days has expired by the Division of Audit. In addition, FQHCs must notify the Division of Audit on a timely basis if the year end for the agency changes. Cost reports must be submitted to the Division of Audit, Department of Health and Human Services, 11 State House Station, Augusta, 04333-9011.
REIMBURSEMENT (cont.)

Maine 04333 0011. Furthermore, for the purpose of establishing baseline information on FQHCs, FQHCs must submit their HRSA Scope Plan of Project for the Fiscal Year 1999, or for their first year of operation for FQHCs approved after Fiscal Year 1999, plus any subsequent approved Plan of Project amendments.

B. “Change in Scope of Services” Requests and 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.”

(1) 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 1905(a)(2)(C) of the Social Security Act;

(2) 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;

(3) 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 services” does not result from any of the following (although some of these changes may occur in conjunction with a “change in scope of services”):

(1) A change in the cost of providing an existing service;

(2) A change of ownership;

(3) A change in status between free-standing and provider-based;

(4) The expansion of an existing service to a new population;

(5) The expansion of the FQHC to a new site which provides the same services;

(6) The addition or reduction of staff members to or from an existing service;
31.07 REIMBURSEMENT (cont.)

(7) A change in office hours; or,

(8) 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 an FQHC submits projected costs for an anticipated change in the scope of services that amounts to a PPS rate change that is greater than or equal to five percent (5%), the Department may request data from the FQHC when at least six (6) months of actual data becomes available for a rate review and adjustment as determined by the Department. The FQHC 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 with a decision to a rate adjustment request within sixty (60) days of receiving a completed application. An application is considered complete when the Department confirms that it has received all the information needed to process the 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.

An FQHC request for a rate adjustment due to a substantial change in the type of service provided (equivalent to a change in scope of project) 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 occurred. The FQHC will be required to submit documentation showing that the Health Resources and Services Administration (HRSA) had approved its change in scope of project, and a cost report reflecting at least six (6) months of financial data and narrative documenting the change. The Department will respond to the Health Center’s request for a rate adjustment within sixty (60) days. If the Department determines that a related rate adjustment is warranted, the incremental cost per encounter from this change may be added to the calculations that set the existing rate, and a new rate may be established. This new rate will be based on the reasonable costs associated with the CMS-approved changes as determined by the Department, and will become effective on the date the change of scope was implemented by the FQHC.

An FQHC change in scope of service may also be based on a change specifically approved by the Commissioner of the Department of Health and Human Services.
In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to ascertain from each member whether there are any other resources (private or group insurance benefits, workers’ compensation, etc.) that is available for payment of the rendered service, and to seek payment from such resources prior to billing MaineCare.

Reimbursement is generally limited to one core service visit, and/or one ambulatory service visit per day. Reimbursement for a second core visit is also covered if the member has both an encounter with a physician, physician assistant, advanced nurse practitioner or visiting nurse, and in addition to that encounter, is seen by a licensed clinical psychologist, clinical social worker, clinical professional counselor or a clinical nurse specialist licensed as a psychiatric registered nurse on the same day. An additional visit of any other kind will only be reimbursed for unforeseen circumstances as documented in the member’s record. The goal remains to treat the whole individual during one visit.

Federally qualified health centers may be reimbursed in excess of their core and additional (same day) visit rates when providing the following services delineated in the respective sections of the MaineCare Benefits Manual: Primary Care Case Management Services per Chapter VI, Section 1; and Chapter 1.

Any additional center visits that are required in the patient’s treatment plan that do not qualify as center visits for reimbursement purposes are non-billable.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from other third party payers prior to billing MaineCare for a rendered service. If a member has capitated third party coverage other than MaineCare, and if that third party carrier requires a member co-pay but makes no fee-for-service payment to cover FQHC services, MaineCare reimbursement will be limited to the amount of the co-pay alone.

Centers have the option of obtaining a separate MaineCare provider billing number for the limited purpose of fee-for-service billing and reimbursement for such services as x-ray, EKG, inpatient hospital visits and other Medicare defined non-FQHC services that are billable under Medicare Part B. If a center chooses to bill fee for service for these Medicare defined non-FQHC services, they may not report costs related to these services on their MaineCare cost report.

31.07-32 Reimbursement for Members Eligible for both Medicare and MaineCare

For members who are eligible for both Medicare and MaineCare services, MaineCare will provide reimbursement to providers as follows:

(a) Qualified Medicare Beneficiaries without other Medicaid (QMB only)
31.07 **REIMBURSEMENT** (cont.)

After Medicare has completed its payment, the provider may bill MaineCare and MaineCare will pay the remaining amount up to the Medicare rate (including co-insurance), for Medicare only services.

**(b) B.** Qualified Medicare Beneficiaries with Medicaid (QMB Plus)

For services covered by Medicare, after Medicare has completed its payment, the provider may bill MaineCare and MaineCare will pay the remaining amount (including co-insurance) up to the MaineCare rate. For services only covered by MaineCare, MaineCare will pay all MaineCare expenses.

**(c) C.** Non-Qualified Medicare Beneficiaries (non-QMBs)

After Medicare has completed its payment, the provider may bill MaineCare and MaineCare will pay for covered MaineCare services provided by MaineCare providers but only to the extent that the MaineCare rate exceeds any Medicare payment for any service covered by both Medicare and MaineCare.

31.08 **COPAYMENT**

**A.** Providers will charge a copayment to each MaineCare member receiving services, unless the member is exempt under the provisions of Chapter I of the MaineCare Benefits Manual. Effective 8/1/14, no copayment shall be charged for smoking cessation counseling. The amount of the copayment shall not exceed $3.00 per day for services provided, according to the following schedule:

<table>
<thead>
<tr>
<th>MaineCare Payment for Service</th>
<th>Member Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10.00 or less</td>
<td>$.50</td>
</tr>
<tr>
<td>$10.01 - 25.00</td>
<td>$1.00</td>
</tr>
<tr>
<td>$25.01 - 50.00</td>
<td>$2.00</td>
</tr>
<tr>
<td>$50.01 or more</td>
<td>$3.00</td>
</tr>
</tbody>
</table>

**B.** The member shall be responsible for copayments up to $30.00 per month whether the copayment has been paid or not. After the $30.00 cap has been reached, the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services. Providers are subject to the Department’s copayment requirements. Refer to Chapter I, General Administrative Policies and Procedures for rules governing copayment requirements, exemptions and dispute resolution.
31.09 BILLING INSTRUCTIONS

Upon the implementation of MIHMS, providers billing for FQHC services must bill using standard CPT and HCPC procedure codes as detailed in Chapter III, Section 31, Table 1. For Core and Ambulatory Services, as described under Covered Services—Section 31.04, providers must bill T1015 and include the appropriate revenue codes. When billing, providers must use a UB 04 claim form. Effective October 1, 2010, in addition to billing the code T1015 for Core and Ambulatory Services, providers must also report all services provided including all procedures with the standard CPT and HCPC5 codes on the UB 04 claims form for reporting purposes.
<table>
<thead>
<tr>
<th>Procedure &amp; Revenue Codes</th>
<th>Description</th>
<th>Unit of Service</th>
<th>Maximum Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1015</td>
<td>Clinic visit/encounter, all inclusive</td>
<td>Per visit</td>
<td>By report</td>
</tr>
<tr>
<td>0521</td>
<td>FQHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1015 HE</td>
<td>Clinic visit/encounter, all inclusive</td>
<td>Per visit</td>
<td>By report</td>
</tr>
<tr>
<td>0521</td>
<td>FQHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1015</td>
<td>Home visit/encounter, all inclusive</td>
<td>Per visit</td>
<td>By report</td>
</tr>
<tr>
<td>0522</td>
<td>FQHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1015</td>
<td>Visit to SNF (Part A*)</td>
<td>Per visit</td>
<td>By report</td>
</tr>
<tr>
<td>0524</td>
<td>FQHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*A covered Part A stay means that Medicare A will pay the services as the primary carrier</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1015</td>
<td>Visit to SNF (Non-covered*)</td>
<td>Per visit</td>
<td>By report</td>
</tr>
<tr>
<td>0525</td>
<td>FQHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*A non-covered stay means that Medicare A is not paying for the inpatient stay/services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1015</td>
<td>Visit to Other Site</td>
<td>Per visit</td>
<td>By report</td>
</tr>
<tr>
<td>0528</td>
<td>FQHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1015</td>
<td>Ambulatory Clinic Visit</td>
<td>Per visit</td>
<td>By report</td>
</tr>
<tr>
<td>0529</td>
<td>FQHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S9441</td>
<td>Asthma education, nonphysician provider, per session</td>
<td>Per visit</td>
<td>By report</td>
</tr>
<tr>
<td>0521</td>
<td>FQHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0108</td>
<td>Diabetes outpatient self-management training services, individual, per 30 minutes</td>
<td>Per 30 minutes</td>
<td>By report</td>
</tr>
<tr>
<td>0521</td>
<td>FQHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0109</td>
<td>Diabetes outpatient self-management training services, group session (2 or more) per 30 minutes</td>
<td>Per 30 minutes</td>
<td>By report</td>
</tr>
<tr>
<td>0521</td>
<td>FQHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure &amp; Revenue Codes</td>
<td>Description</td>
<td>Unit of Service</td>
<td>Maximum Allowance</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------</td>
<td>----------------</td>
<td>------------------</td>
</tr>
<tr>
<td>99406 0521</td>
<td>Smoking and Tobacco Cessation Counseling; individual, intermediate</td>
<td>3-10 minutes</td>
<td>$8.67</td>
</tr>
<tr>
<td>99407 0521</td>
<td>Smoking and Tobacco Cessation Counseling; individual, intensive</td>
<td>Greater than 10 minutes</td>
<td>$16.81</td>
</tr>
<tr>
<td>99411 0521</td>
<td>Smoking Cessation Preventive Medicine Counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure), approximately 30 minutes</td>
<td>Per session</td>
<td>$20.00 $11.54</td>
</tr>
<tr>
<td>99412 0521</td>
<td>[Tobacco Cessation] Preventive Medicine Counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure), approximately 60 minutes</td>
<td>Per session</td>
<td>$15.04</td>
</tr>
<tr>
<td>G0009 0521</td>
<td>Administration of Pneumococcal Vaccine</td>
<td>1 unit</td>
<td>$5.00</td>
</tr>
<tr>
<td>G0008 0521</td>
<td>Administration of Influenza virus Vaccine</td>
<td>1 unit</td>
<td>$5.00</td>
</tr>
<tr>
<td>J1055 0636</td>
<td>Depo-Provera 150-MG</td>
<td>1 unit</td>
<td>By-report</td>
</tr>
<tr>
<td>11975 0250</td>
<td>Insertion, implantable contraceptive capsules</td>
<td>1 unit</td>
<td>By-report</td>
</tr>
<tr>
<td>11976 0250</td>
<td>Removal, implantable contraceptive capsules</td>
<td>1 unit</td>
<td>By-report</td>
</tr>
<tr>
<td>11977 0250</td>
<td>Removal with reinsertion, implantable contraceptive capsules</td>
<td>1 unit</td>
<td>By-report</td>
</tr>
</tbody>
</table>

*FQHCs are reimbursed for all Food and Drug Administration (FDA) approved Intrauterine Devices at the rate listed on the MaineCare UCR: https://mainecare.maine.gov/*
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7300</td>
<td>Intrauterine Device (IUD)</td>
<td>Unit</td>
<td>By-report</td>
</tr>
<tr>
<td>0636</td>
<td>Pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0009</td>
<td>Administration of Pneumococcal Vaccine</td>
<td>Unit</td>
<td>$5.00</td>
</tr>
<tr>
<td>0521</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0008</td>
<td>Administration of Influenza virus Vaccine</td>
<td>Unit</td>
<td>$5.00</td>
</tr>
<tr>
<td>0521</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0009</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Modifiers**

- **GT**: Via interactive audio and video telecommunication systems
- **HE**: Behavioral health
- **SL**: State supplied vaccine
- **UF**: Services provided in the morning (6 a.m. to 11:59 a.m.)
- **UG**: Services provided in the afternoon (12 p.m. to 5:59 p.m.)
- **UH**: Services provided in the evening (6 p.m. to 11:59 p.m.)
- **UJ**: Services provided at night (12 a.m. to 5:59 a.m.)