§3174-V. Federally qualified health center reimbursements

The reimbursement requirements set forth in this section apply to payments for certain federally qualified health centers as defined in 42 United States Code, Section 1395x, subsection(aa)(1993). [PL 2021, c. 747, §1 (AMD).]

1. Services furnished by center. The department shall reimburse a federally qualified health center no less than 100% of reasonable costs, reduced by the total copayments for which members are responsible, for services furnished by the center within the scope of service approved by the federal Health Resources and Services Administration or the commissioner if that center:

A. Is receiving a grant under Section 330 of the federal Public Health Services Act; or [PL 1999, c. 401, Pt. T, §1 (NEW).]

B. Is receiving funding under contract with the recipient of a grant under Section 330 of the federal Public Health Services Act, is identified as a subrecipient in the Section 330 grantee's approved scope of work and meets the requirements to receive a grant under Section 330 of that Act. [PL 1999, c. 401, Pt. T, §1 (NEW).]

[PL 2003, c. 20, Pt. K, §11 (AMD).]

2. Contracted services. When a federally qualified health center otherwise meeting the requirements of subsection 1 contracts with a managed care plan or the Dirigo Health Program for the provision of MaineCare services, the department shall reimburse that center the difference between the payment received by the center from the managed care plan or the Dirigo Health Program and 100% of the reasonable cost, reduced by the total copayments for which members are responsible, incurred in providing services within the scope of service approved by the federal Health Resources and Services Administration or the commissioner. Any such managed care contract must provide payments for the services of a center that are not less than the level and amount of payment that the managed care plan or the Dirigo Health Program would make for services provided by an entity not defined as a federally qualified health center.

[PL 2005, c. 400, Pt. C, §1 (AMD).]

3. Updated base year option. No later than March 1, 2023, the department shall provide an alternative, updated prospective payment method for each federally qualified health center that is the same as the prospective payment system set forth in 42 United States Code, Section 1396a(bb)(3), except that the base year for determining the costs of providing services must be the average of the reasonable costs incurred in the center's fiscal years ending in 2018 and 2019, adjusted for any change in scope adjustments approved since the base year and for inflation measured by the federally qualified health center market basket percentage published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. Each federally qualified health center must be given the option to be reimbursed under the method provided by this subsection or under the method provided by federal law. After December 31, 2023, the department may update the base year described in this subsection to a more recent base year.

[RR 2023, c. 1, Pt. A, §14 (COR).]

4. Change in scope adjustments. The department's method for adjusting for changes in the scope of services provided by a federally qualified health center under the payment model provided under subsection 3 or 42 United States Code, Section 1396a(bb)(3) must adjust the center's reimbursement rate to reflect changes in its costs of providing services whenever the center establishes that it has experienced a material change in either:

A. The type, intensity, duration or quantity of services provided; or [PL 2021, c. 747, §3 (NEW).]

B. The characteristics of the population receiving a service that affect the cost of the service. [PL 2021, c. 747, §3 (NEW).]

An adjustment under this subsection must reflect costs incurred retroactive to the date that the department received the federally qualified health center request for the adjustment, unless the department determines that the change in scope was due to conditions or events that were beyond the control of the federally qualified health center, in which case the adjustment must be retroactive to the more recent of the date that the federally qualified health center incurred the cost increases requiring an adjustment and the date that is one year prior to the date the department received the federally qualified health center change in scope request.
[PL 2021, c. 747, §3 (NEW).]

5. Alternative payment model. The following requirements apply to any alternative payment model developed by the department for payments to federally qualified health centers.

A. The alternative payment model must be consistent with the requirements of 42 United States Code, Section 1396a(bb). [PL 2021, c. 747, §4 (NEW).]

B. As long as federal law continues to require that the department allow a federally qualified health center to elect to use the prospective payment system set forth in 42 United States Code, Section 1396a(bb)(3), the alternative payment model developed under this subsection must be an additional option and not a replacement of the updated base year option provided in subsection 3. [PL 2021, c. 747, §4 (NEW).]

C. In developing the alternative payment model, the department shall consult with federally qualified health centers and provide a reasonable opportunity for dialogue and exchange of data before any rule implementing such a model is proposed. [PL 2021, c. 747, §4 (NEW).]
[PL 2021, c. 747, §4 (NEW).]

6. Rulemaking. The department may adopt rules to implement subsections 3 to 5. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2021, c. 747, §5 (NEW).]

SECTION HISTORY

PL 1999, c. 401, §T1 (NEW). PL 2003, c. 20, §K11 (AMD). PL 2003, c. 469, §A7 (AMD). PL 2005, c. 400, §C1 (AMD). PL 2021, c. 747, §§1-5 (AMD). RR 2023, c. 1, Pt. A, §14 (COR).