

ACUTE CARE NON-CRITICAL ACCESS HOSPITALS**Department's Total 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 + outpatient services + inpatient capital costs + hospital based physician costs + graduate medical education costs + Disproportionate Share Payments (for eligible hospitals) + supplemental pool reimbursements – third party liability payments.

- A. **Inpatient Services** (not including distinct psychiatric or, if CMS approves, substance abuse unit discharges)

Effective for reimbursement for admissions on or after July 1, 2011, the Department will pay using DRG-based discharge rates, which include estimated capital and medical education costs (see Appendix for full description). The Department will reimburse hospitals based on required billing forms, as described in the Department's billing instructions. As explained in Appendix, the payment is comprised of three components: the capital expense and graduate medical education components will be subject to interim and final cost settlement, and the DRG direct rate component will not be cost settled.

- B. **Distinct Psychiatric Unit**

Effective October 1, 2011, MaineCare will pay a distinct psychiatric unit discharge rate equal to \$6,438.72, except for: (1) Northern Maine Medical Center, for which the distinct psychiatric discharge unit rate will be \$15,679.94, and (2) effective July 1, 2013 \$9,128.31 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 (1) episode of care.

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

- 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. For each patient's separate hospital admission, even if the patient was admitted to the distinct substance abuse unit and any other unit in the hospital, MaineCare will only reimburse for one (1) discharge.

ACUTE CARE NON-CRITICAL ACCESS HOSPITALS (cont.)**D. Outpatient Services, Including Laboratory and Radiology****1. Private Hospitals****a. APC Payment**

Effective July 1, 2013, the Department will reimburse hospitals 83.7% of the adjusted Medicare APC rate for all outpatient services where that rate is available unless otherwise specified in this rule.

The APC payment does not include hospital-based physician services. The APC payment does include ancillary services such as x-rays and laboratory test costs. Effective July 1, 2013, if multiple procedures are performed, the Department pays the hospital 83.7% of Medicare's single bundled APC rate.

APC payments are made when the member receives services in an emergency room, clinic or other outpatient setting, or if the outpatient is transferred to another hospital or facility that is not affiliated with the initial hospital where the patient received the outpatient services. If the outpatient is admitted from a hospital's clinic or emergency department, to the same hospital as an inpatient, the hospital shall be paid only a DRG-based discharge rate and will not receive an APC payment.

An outlier payment adjustment is made to the rate when an unusually high level of resources has been used for a case. Effective July 1, 2013, calculations for outlier payments will follow Medicare rules and be paid at 83.7% of the Medicare payment.

b. Fee Schedule Payments

A limited number of Current Procedural Terminology (CPT) codes do not have associated Medicare APC rates, as listed in Addendum B (see: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>). MaineCare covers certain services listed in

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Addendum B and pays for these services based on a fee schedule (see: <https://mainecare.maine.gov/Provider%20Fee%20Schedules/Forms/Publication.aspx>).

2. Public Hospitals

Effective July 1, 2009, the Department's total annual obligation to a hospital for outpatient services equals the lower of 83.8% of MaineCare outpatient costs or charges.

MaineCare's share of clinical laboratory and radiology costs are added to this amount. The procedure codes and terminology of the Healthcare Common Procedure Coding System (HCPCS) (available at www.cms.gov) are used to establish MaineCare allowances for clinical laboratory and radiology services.

Hospitals must use APC billing for all outpatient services.

The APC billing does not include hospital-based physician services. The APC billing does include ancillary services such as x-rays and laboratory test costs.

APC billing is required when the member receives services in an emergency room, clinic or other outpatient setting, or if the outpatient is transferred to another hospital or facility that is not affiliated with the initial hospital where the patient received the outpatient services. If the outpatient is admitted from a hospital's clinic or emergency department, to the same hospital as an inpatient, the hospital shall not report this under APC billing requirements.

E. Capital and Graduate Medical Education Costs

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

Estimates of these costs will be included in the DRG-based discharge rate as described in the Appendix. This reimbursement is subject to cost settlement.

F. Hospital based Physician

MaineCare will reimburse

- 93.3% of its share of inpatient hospital based physician,
- 93.4% of its share of outpatient emergency room hospital based physician costs, and

ACUTE CARE NON-CRITICAL ACCESS HOSPITALS (cont.)

- 83.8% of non-emergency room outpatient hospital based physician costs.

Hospitals will be reimbursed based on claim forms filed with the Department. The billing procedure is described in Chapter II, Section 45. These payments are subject to cost settlement.

Prospective Interim Payment (PIP) for Outpatient Services (Public Hospitals Only)

The estimated Departmental outpatient annual obligation will be calculated to determine the PIP payment using data as described in 45.02-6. This sum will be reduced by the anticipated amount of reimbursement for Medicare approved provider based primary care physician services required to be billed on the CMS 1500 under Chapter II, Section 45 and those outpatient services the hospital has elected to bill on the CMS 1500. The PIP payment does not include DSH payments or the hospital's share of the supplemental pool as described below. The computed amounts are calculated as described in 45.03-1 (C)(2).

Interim Cost Settlement

All calculations are based on 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. No cap imposed on a PIP will limit or otherwise affect the determination of settlement amounts.

1. Interim Settlement for years up to and including SFY '11

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 the date MIHMS went live.

2. DRG Based System/Outpatient Prospective Payment – SFY 2012 Only for Private Hospitals, SFY 2012 and Forward for Public Hospitals

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

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

ACUTE CARE NON-CRITICAL ACCESS HOSPITALS (cont.)**3. DRG and APC Based System – SFY 2013 and Forward for Private Hospitals**

MaineCare's interim cost settlement with a hospital operating under the DRG and APC based system will include settlement of:

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

APC payments will not be cost settled.

Final Cost Settlement

All settlement processes use charges included in MaineCare paid claims history for the relevant year, MaineCare supplemental data form and the hospital's Medicare Final Cost Report. No cap imposed on a PIP will limit or otherwise affect the determination of settlement amounts.

1. Final Settlement for years up to and including SFY '11

MaineCare's final cost settlement with a hospital will include settlement of:

- Prospective interim payments, and
- Payments made for hospital based physician services provided on or after the date MIHMS went live.

2. DRG Based System/Outpatient Prospective Payment – SFY 2012 Only for Private Hospitals, SFY 2012 and Subsequent for Public Hospitals

- 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;
- Payments made for hospital based physician services; and
- Outpatient prospective interim payments

3. DRG and APC Based System – SFY 2013 and Forward – Private Hospitals

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

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

APC payments will not be cost settled.

ACUTE CARE CRITICAL ACCESS HOSPITALS

All calculations made in relation to acute care critical access hospitals (CAH) must be made in accordance with the requirements for completion of the Medicare Cost Report and Generally Accepted Accounting Principles, except as stated below.

Department's Total Obligation to the Hospital

The Department of Health and Human Services' total annual obligation to the hospitals will be the sum of MaineCare's obligation of the following: inpatient services + outpatient services + days awaiting placement and in swing beds + hospital based physician + Disproportionate Share Hospital (for eligible hospitals) + supplemental pool reimbursements (for eligible hospitals) – third party liability payments.

A. Inpatient Services

MaineCare will reimburse one hundred and nine percent (109%) of allowable costs.

B. Outpatient Services

MaineCare will reimburse one hundred and nine percent (109%) of allowable costs.

C. Supplemental Pool

Effective November 1, 2011, the Department will allocate the supplemental amount of four million dollars (\$4,000,000) each state fiscal year among the privately owned and operated acute care critical access hospitals based on their relative share of total MaineCare payment as compared to other critical access hospitals. Each privately owned and operated hospital will receive its relative share of this supplemental payment.

The relative share is defined as the critical access hospital's MaineCare payment in the applicable state fiscal year divided by MaineCare payments made to all CAH hospitals in that year; multiplied by the total supplemental pool. This amount will not be adjusted at the time of audit.

Data used to determine the relative share will relate to the latest state fiscal year for which there exists an As-Filed Medicare Cost Report or a Final Cost

Settlement Report for all critical access hospitals at the time the pool allocation is done.

ACUTE CARE CRITICAL ACCESS HOSPITALS (CAH) (cont.)**D. MaineCare Member Days Awaiting Placement at a Nursing Facility**

The Department will reimburse prospectively at the estimated statewide average rate per member day for NF services. The Department will reimburse at the prospective statewide average rates per member day for NF services that are specified in the Principles of Reimbursement for Nursing Facilities, *MaineCare Benefits Manual* Chapter III, Section 67. The Department shall compute the average statewide rate per member day 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.

E. Other Components

MaineCare will reimburse its share of inpatient hospital based physician, outpatient emergency room hospital based physicians and all graduate medical education costs.

MaineCare's share of emergency room hospital based physician costs is reimbursed at 100% of cost.

Effective July 1, 2009, MaineCare will reimburse 93.3% of its share of inpatient hospital based physician, 93.4% of its share of outpatient emergency room hospital based physician, and 83.8% of outpatient non-emergency room hospital based physician costs.

Prospective Interim Payment

The estimated departmental annual inpatient obligation, described above, will be calculated using the most recent MaineCare Supplemental Data Form, inflated to the current state fiscal year. Third party liability payments are subtracted from the PIP obligation.

PIPs will be reduced by the anticipated amount of reimbursement for Medicare approved provider based primary care physician services as required to be billed on the CMS 1500 under Chapter II, Section 45, all inpatient hospital based physician payments and those outpatient services the hospital has elected to bill on the CMS 1500. The PIP payment does not include DSH payments or the hospital's share of the supplemental pool payments.

Interim PIP Adjustment

The Department initiates an interim PIP adjustment under very limited circumstances, including but not limited to, restructuring payment methodology as reflected in a state plan

ACUTE CARE CRITICAL ACCESS HOSPITALS (CAH) (cont.)

amendment; when a hospital “changes” categories (e.g., becomes designated critical access); or a hospital opens or closes resulting in a redistribution of patients among facilities.

Interim Cost Settlement

The Department calculates the Interim Cost Settlement with a hospital using the same methodology as is used when calculating the PIP, except that the data sources used are 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.

Final Cost Settlement

The Department of Health and Human Services’ calculates the final settlement with a hospital using the same methodology as is used when calculating the PIP, 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.

HOSPITALS RECLASSIFIED TO A WAGE AREA OUTSIDE MAINE BY THE MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD (MGCRB) PRIOR TO OCTOBER 1, 2008.

The reimbursement methodology for these hospitals is identical to that used for critical access hospitals, except that these hospitals are not eligible for payments from the supplemental pool described in Section 45.04.

REHABILITATION HOSPITALS**Department’s Total 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 + outpatient services + inpatient capital costs + days awaiting placement in swing beds+ Disproportionate Share Payments (for eligible hospitals) + supplemental pool reimbursements – third party liability payments.

A. Inpatient Services

The Department will reimburse \$12,440.44 per discharge.

B. Outpatient Services, including lab and radiology**1. APC Payments**

REHABILITATION HOSPITALS (cont.)

Effective July 1, 2013, the Department will reimburse rehabilitation hospitals 83.7% of the adjusted Medicare APC rate for almost all outpatient services.

The APC payment does not include hospital-based physician services. The APC payment does include ancillary services such as x-rays and laboratory test costs. Effective July 1, 2013, if multiple procedures are performed, the Department will pay the hospital 83.7% of Medicare's single bundled APC rate.

APC payments will be made for services received in an emergency room, clinic or other outpatient setting, or, if the outpatient is transferred to another hospital or facility that is not affiliated with the initial hospital, where the member received the outpatient services. If the outpatient is admitted from a hospital's clinic or emergency department to the same hospital as an inpatient, the hospital will be paid only a DRG-based discharge rate and will not receive an APC payment.

An outlier payment adjustment will be made to the rate when an unusually high level of resources has been used for a case. Effective July 1, 2013 calculations for outlier payments will follow Medicare rules and be paid at 83.7% of the Medicare payment.

2. Fee Schedule Payments

A limited number of Current Procedural Terminology (CPT) codes do not have associated Medicare APC rates, as listed in Addendum B (see: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>). MaineCare covers certain services listed in Addendum B and pays for these services based on a fee schedule (see: <https://mainecare.maine.gov/Provider%20Fee%20Schedules/Forms/Publication.aspx>).

C. Capital and Graduate Medical Education Costs

MaineCare will reimburse its share of inpatient capital costs and all graduate medical education costs during the interim and final settlement processes.

REHABILITATION HOSPITALS (cont.)**D. Hospital based Physicians**

MaineCare will reimburse

- 93.3% of its share of inpatient hospital based physician,
- 83.8% of outpatient hospital based physician costs.

Hospitals will be reimbursed based on claim forms filed with the Department. The billing procedure is described in Chapter II, Section 45. These payments are subject to cost settlement.

Interim Cost Settlement

All calculations will be based on 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. No cap imposed on a PIP will limit or otherwise affect the determination of settlement amounts.

1. Interim Settlement for years up to and including SFY 2011

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 the date MIHMS went live.

2. Discharge Rate/Outpatient Prospective Payment – SFY 2012 Only

MaineCare's interim cost settlement with a hospital operating under the discharge rate based system will include settlement of:

- Capital and medical education costs based on Medicare and GAAP principles
- Payments made for hospital based physician services
- Outpatient prospective interim payments

3. Discharge Rate and APC Based System – SFY '13 and Forward

MaineCare's interim cost settlement with a rehabilitation hospital operating under the discharge rate and APC based system will include settlement of:

- Capital and medical education costs based on Medicare and GAAP principles
- Payments made for hospital based physician services

REHABILITATION HOSPITALS (cont.)

APC payments will not be cost settled

Final Cost Settlement

All calculations are based on the hospital's Final Medicare Cost Report, MaineCare Supplemental Data Form and MaineCare paid claims history for the year for which interim settlement is being performed. No cap imposed on a PIP will limit or otherwise affect the determination of settlement amounts.

1. Final Settlement for years up to and including SFY 2011

To the extent applicable, MaineCare's final cost settlement with a hospital will include settlement of:

- Prospective interim payments; and
- Payments made for hospital based physician services provided on or after the date MIHMS went live.

2. Discharge Rate/Outpatient Prospective Payment – SFY 2012 Only

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

- Capital and medical education costs based on Medicare and GAAP principles
- Payments made for hospital based physician services

3. Discharge Rate and APC Based System – SFY 2013 and Forward

MaineCare's final cost settlement with a rehabilitation hospital operating under the discharge rate and APC based system will include settlement of:

- Capital and medical education costs based on Medicare and GAAP principles
- Payments made for hospital based physician services

APC payments will not be cost settled

SUPPLEMENTAL POOL FOR NON CRITICAL ACCESS HOSPITALS, HOSPITALS RECLASSIFIED TO A WAGE AREA OUTSIDE MAINE AND REHABILITATION HOSPITALS

The Department will allocate a supplemental pool for each state fiscal year among the privately owned and operated Acute Care Non-Critical Access hospitals, hospitals reclassified to a wage area outside Maine by the Medicare Geographic Classification Review Board

SUPPLEMENTAL POOL FOR NON CRITICAL ACCESS HOSPITALS, HOSPITALS RECLASSIFIED TO A WAGE AREA OUTSIDE MAINE AND REHABILITATION HOSPITALS (cont.)

and rehabilitation hospitals. If approved by CMS, effective July 7, 2015, the pool shall equal sixty-four million seven hundred sixty-nine thousand four hundred seventeen dollars (\$64,769,417). Effective May 1, 2012, fifty percent (50%) of the pool shall be distributed based on each hospital's relative share of inpatient MaineCare non-psychiatric discharges. The other fifty percent (50%) of the pool shall be distributed based on each hospital's relative share of total inpatient MaineCare days. Funds will be distributed semiannually, in even distributions in November and May.

This pool will be decreased by the amount a hospital would have received if that hospital was in the pool when the total pool amount was set and subsequently becomes an approved critical access hospital.

Each hospital in the pool will receive its relative share of this supplemental payment. The relative share is defined as the number of the MaineCare non-psychiatric discharges or total MaineCare days (as applicable), from that hospital in the latest calendar year for which all hospitals have interim or final cost settlement reports, divided by MaineCare non-psychiatric discharges or days (as applicable) for all hospitals eligible to receive funds from the pool in that year; multiplied by the supplemental pool.

Data used to determine the relative share will relate to the latest state fiscal year for which there exists an As-Filed Medicare Cost Report or a Final Cost Settlement Report for all hospitals eligible to receive funds from the pool at the time the PIPs are set.

This supplemental pool payment is not subject to cost settlement.

PRIVATE PSYCHIATRIC HOSPITALS**Department's Total Annual Obligation to the Hospital**

The Department of Health and Human Services' total annual obligation to the hospitals is the sum of MaineCare's obligation of the following: inpatient services + outpatient services + Disproportionate Share Hospital (for eligible hospitals) – third party liability payments.

A. Inpatient Services

The rate will be negotiated and becomes effective at the beginning of a hospital's fiscal year. The Department's total annual obligation shall be computed based on the hospital's negotiated rate.

PRIVATE PSYCHIATRIC HOSPITALS (cont.)

The negotiated rate shall be between eighty-five percent (85%) and one hundred percent (100%) of the hospital's estimated inpatient charges, less third party liability. The hospital must notify the Department sixty (60) days prior to any increase in its charges.

If the hospital increases charges subsequent to the annual adjustment, the hospital and the Department will meet to consider the extent that the increase in charges will affect the amount paid by MaineCare and to negotiate the amount by which the previously negotiated percentage of charges must be adjusted to account for the impact. If the hospital commences any new MaineCare inpatient covered service, whether or not subject to Certificate of Need review, the parties will separately negotiate the percentage of charges to be paid by MaineCare for that service.

Special circumstances may arise during the course of a year that may warrant reconsideration and adjustment of the negotiated rate. These circumstances could include changes in psychiatric bed capacity or patient populations within the State that materially impact MaineCare or uncompensated care volume, extraordinary increases in charges, legislative deappropriation, MaineCare deficits that may result in decreased State funding, as well as other special circumstances that the parties cannot now foresee.

B. Outpatient Services

The Department's total annual obligation to the hospital will be one hundred and seventeen percent (117%) of allowable outpatient costs, determined from the most recent Interim Cost Settlement Report, inflated forward to the current State fiscal year.

Prospective Interim Payment

Private psychiatric hospitals will be paid weekly prospective interim payments based on the Department's estimate of the total annual obligation to the hospital.

Interim Cost Settlement

The Interim Cost Settlement with a hospital is calculated using the same methodology and negotiated percentage rate as is used when calculating the PIP, except that the data source used is the hospital's MaineCare paid claims history for the year for which Interim

PRIVATE PSYCHIATRIC HOSPITALS (cont.)

Cost Settlement is being performed. The hospital is required to submit its Medicare As-Filed Cost Report to the Department.

Final Cost Settlement

The Department's total annual obligation to a hospital will be computed using the same methodology as is used when calculating the PIP, except that the data sources used are the hospital's Medicare Final Cost Report submitted to DHHS, MaineCare Supplemental Data Form and MaineCare paid claims history for the year for which settlement is being performed.

Note: The Department retains the right to reopen and modify cost settlement(s) affecting the timeframe from October 1, 2001 forward to assure consistency with the State Plan in effect for the time period covered by the settlement.

STATE OWNED PSYCHIATRIC HOSPITALS

State owned psychiatric hospitals will be reimbursed as follows:

Total Obligation to the Hospital

The MaineCare total annual obligation to the hospitals will be the sum of: MaineCare's obligation of the following: inpatient services + outpatient services + days awaiting placement + hospital based physician + direct graduate medical education costs + estimated DSH obligation – third party liability payments. Amounts are calculated as described below:

A. Inpatient Services

The total MaineCare inpatient operating costs from the most recent Interim Cost Settlement Report inflated forward as described in Section 45.02-1 to the current State fiscal year.

B. Outpatient Services

MaineCare outpatient costs inflated to the current State fiscal year using the most recent Interim Cost Settlement Report.

C. MaineCare Member Days Awaiting Placement at a Nursing Facility

The Department will reimburse 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 Principles of Reimbursement for Nursing Facilities, *MaineCare*

STATE OWNED PSYCHIATRIC HOSPITALS (cont.)

Benefits Manual, Chapter III, Section 67. The Department will compute the average statewide rate per member day 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.

D. Other Components

MaineCare's share of hospital based physician + graduate medical education costs are taken from the most recent hospital Interim Cost Settlement Report inflated to the current year.

Estimated Claims Payments

The Department will reimburse claims submitted for inpatient and outpatient services, subject to final cost settlement.

Final Cost Settlement

The Department will calculate MaineCare's Final Cost Settlement with a hospital using the Medicare Final Cost Report and MaineCare paid claims history for the year for which settlement is being performed. A final DSH adjustment will be made for eligible hospitals.

OUT-OF-STATE HOSPITALS

The Department will reimburse out-of-state hospitals for inpatient and outpatient services based on

1. The MaineCare rate if applicable;
2. The lowest negotiated rate with a payor whose rate the hospital provider currently accepts;
3. The hospital provider's in-State Medicaid rate;
4. A percentage of charges; or
5. A rate specified in MaineCare's contract with the hospital provider.

Except as otherwise specifically provided in the agreement between MaineCare and the out-of-state hospital providers, out-of-state hospital providers must accept MaineCare reimbursement for inpatient services as payment in full for all services necessary to address the illness, injury or condition that led to the admission.

Out-of-State hospital providers must meet all requirements outlined in Chapter I of the *MaineCare Benefits Manual* (MBM) including signing a provider/supplier agreement and obtaining prior authorization.

CLINICAL LABORATORY AND RADIOLOGY SERVICES

Hospital laboratory services provided to a member not currently a patient of the hospital are considered outpatient hospital services and are reimbursable in accordance with MBM Chapter II, Section 55, Laboratory Services, or Chapter III, Section 90, Physician Services.

In the case of tissues, blood samples or specimens taken by personnel that are not employed by the hospital but are sent to a hospital for performance of tests, the tests are not considered outpatient hospital services since the member does not receive services directly from the hospital.

Certain clinical diagnostic laboratory tests must be performed by a physician and are, therefore, exempt from the fee schedule. Medicare periodically sends updated lists of exempted tests to hospitals.

Laboratory services must comply with the rules implementing the Clinical Laboratory Improvement Amendments (CLIA 88) and any applicable amendments. Hospital imaging services provided to a member not currently a patient of the hospital are considered outpatient hospital services and are reimbursable in accordance with MBM Chapter II, Section 101, Medical Imaging Services, or Chapter III, Section 90, Physician Services. Rates for those services are posted on the Department's designated website.

PROVIDER PREVENTABLE CONDITIONS

If approved by CMS, in accordance with the Affordable Care Act, MaineCare will not reimburse providers for Provider Preventable Conditions (PPCs) as defined in the federal Medicaid regulation, 42 CFR 447.26.

All hospitals must identify and report to the Department all PPCs, but Hospital providers are prohibited from submitting claims for payment of these conditions except as permitted in 42 CFR 447.26, when the PPC for a particular patient existed prior to the initiation of treatment for that patient by that hospital provider.

The DRG payment calculations automatically ensure that providers will not be compensated for these conditions. Hospital providers who are not reimbursed using DRGs must report all PPCs on claims and bill zero charges for these PPCs, except as provided above.

DISPROPORTIONATE SHARE (DSH) PAYMENTS**General Eligibility Requirements for DSH Payments**

To be eligible for DSH payments a hospital must have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals

DISPROPORTIONATE SHARE (DSH) PAYMENTS (cont.)

entitled to such services under the State Plan. In the case of a hospital located in a rural area that is an area outside of a Metropolitan Statistical Area as defined by the Executive Office of Management and Budget, the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

However, the obstetric criteria above do not apply to hospitals in which the inpatients are predominantly individuals under eighteen (18) years of age or to hospitals that did not offer non-emergency obstetric services as of December 21, 1987.

The hospital must also have a MaineCare utilization rate of at least one percent (1%). Acute care hospitals must also meet additional requirements as described below.

Additional Eligibility Requirements for Acute Care Hospitals

The hospital must also either a) have a MaineCare inpatient utilization rate at least one (1) standard deviation above the mean MaineCare inpatient utilization rate for hospitals receiving MaineCare payments in the state), or b) have a low income inpatient utilization rate exceeding twenty-five percent (25%).

For purposes of determining whether a hospital is a disproportionate share hospital in a Payment Year the Department will use data from the hospital's Medicare interim Cost Report for the same period to apply the standard deviation test. Interim Cost Settlement Reports for the specified payment year must be issued by the Department for all acute care hospitals in order for DSH to be calculated by the Department.

Disproportionate Share Payments**A. DSH Adjustment for Institutions for Mental Disease (IMD)**

Subject to the CMS IMD Cap described below and to the extent allowed by the Centers for Medicare and Medicaid Services (CMS), the DSH adjustment will be one hundred percent (100%) of the actual uncompensated cost, as calculated using Medicare Cost Report and GAAP principles, of:

1. services furnished to MaineCare members plus,
2. charity care as reported on the hospital's audited financial statement for the relevant payment year, MINUS
3. payments made by the State for services furnished to MaineCare members.

DISPROPORTIONATE SHARE (DSH) PAYMENTS (cont.)

CMS places a limit on the amount of DSH payment that may be made to IMDs (IMD cap). If the Department determines that aggregate payments to IMDs, as calculated above, would exceed the CMS IMD cap, payments will be made to State-owned facilities first. Remaining IMD DSH payments will be allocated

among the DSH eligible hospitals based on their relative share of applicable DSH payments absent the federal or state cap.

CMS places a limit on the amount of DSH payment that may be made to a single hospital. If approved by CMS, if the Department or CMS determine that payments to a hospital would exceed that cap, the overage shall be redistributed as follows:

- If any state owned hospital has not reached its DSH cap it will receive DSH payments to the extent funds are available up to the limit of its hospital-specific cap
- Remaining IMD DSH funds will be allocated among the DSH eligible hospitals based on their relative share of applicable DSH payments absent the federal or state cap.

The “relative share” is calculated as follows: calculate the fraction, the numerator of which is 100% of actual uncompensated cost of a non-state owned IMD, the denominator of which is the total of 100% of actual uncompensated cost for all non-state owned IMDs. That fraction is then multiplied by the remaining available for IMD DSH payments, as described above, to give the relative share for each non-state-owned IMD.

B. For Acute Care Hospitals

1. The pool of available funds for DSH adjustments for all acute care hospitals equals two hundred thousand dollars (\$200,000) for each State fiscal year.
2. Fifty percent (50%) of this pool will be distributed among eligible hospitals in proportion to their relative share of MaineCare days of all eligible acute care hospitals. Relative share will be calculated as follows: the MaineCare days for each DSH eligible hospital will be divided by the sum of the MaineCare days for all DSH eligible hospitals to determine the DSH allocation percentage. This DSH allocation percentage for each eligible hospital will be multiplied by one hundred thousand dollars (\$100,000) to determine each eligible hospital’s share.

DISPROPORTIONATE SHARE (DSH) PAYMENTS (cont.)

For example:

Hospitals X, Y and Z are all eligible for DSH. MaineCare days for X equals five thousand (5,000); Y equals ten thousand (10,000) and Z equals fifteen thousand (15,000). The resulting total MaineCare days for DSH eligible hospitals would be thirty thousand (30,000)

(5,000+10,000+15,000). Hospital X's DSH allocation percentage would be sixteen and seven tenths percent (16.7%) (5,000/30,000).

Hospital X would get sixteen thousand seven hundred dollars (\$16,700) (\$100,000 times 16.7%) in DSH payments related to utilization.

3. Fifty percent (50%) of this pool will be distributed among eligible hospitals in proportion to the percentage by which the hospital's MaineCare utilization rate as defined above, exceeds one standard deviation above the mean. The percentage points above the first standard deviation for each DSH eligible hospital will be divided by the sum of the percentage points above the standard deviation for all acute care eligible hospitals to determine the DSH allocation percentage.

This standard deviation related DSH allocation percentage for each eligible acute care hospital will be multiplied by one hundred thousand dollars (\$100,000) to determine each hospital's share of the DSH payments.

For example:

Assume the same three hospitals, X, Y and Z, are all eligible for DSH. Respectively, their utilization rates are 6, 7 and 8 percentage points above the mean MUR plus one standard deviation. The resulting total percentage points above the mean for all hospitals would be 21 (6+7+8). Hospital X's DSH allocation percentage would be twenty-eight and fifty-seven hundredths (28.57%) (6/21). If fifty percent (50%) of the available DSH pool is one hundred thousand dollars (\$100,000), then Hospital X would get twenty eight thousand five hundred and seventy dollars (\$28,570) (\$100,000 times 28.57%) in DSH payments related to distance above one standard deviation above the mean.

After final settlement is complete for all hospitals in a category (i.e., acute care or psychiatric) hospitals within the category are assessed for eligibility for DSH payments. However, state psychiatric hospitals only may be paid estimated DSH prospectively if they are expected to be found eligible.

APPENDIX**DRG-BASED PAYMENT METHODOLOGY**

Effective July 1, 2011 (SFY 2012):

- I. The Department has adopted the Medicare Severity Diagnosis Related Groups as described at www.cms.gov/AcuteInpatientPPS/.
- II. The Department will calculate reimbursement for a covered inpatient service using the following formula:

(The hospital specific base rate multiplied by the DRG relative weight)
plus an outlier payment (if applicable)

- III. **Hospital Specific Base Rate Calculation**

Each hospital specific base rate is the total of 3 components:

- statewide DRG direct care rate
- hospital-specific capital rate
- hospital-specific medical education rate

- IV. **DRG Direct Care Rate Calculations**

The statewide DRG direct care rate for all hospitals being paid under the DRG system is as follows:

- Multiplies each hospital-specific base DRG rate by the number of discharges of each hospital, resulting in a total direct care payment for each hospital
- Sums the total direct care payment for each hospital
- Divides this sum by the total number of discharges

The hospital-specific DRG direct care rate used in the calculation of the statewide DRG direct care rate for July 1, 2011 is calculated as follows:

- divides the hospital's SFY 10 discharge rate by the hospital's case mix index (the average relative weight of a hospital's base year claims, which equals the sum of the relative weights for all applicable discharges divided by the total number of discharges calculated using calendar year 2007 discharges)
- inflates this figure to SFY 11

The DRG direct care rate component of the DRG-based rate payment is not settled during the cost settlement process.

APPENDIX (cont.)**V. Hospital Specific Capital Rate Calculation**

The hospital specific capital rate is calculated by allocating estimated capital costs over estimated discharges. Using data from hospital fiscal year 2008 cost reports, estimated capital costs are derived by applying capital cost to charge ratios to total charges, and trending that amount to state fiscal year 2011 using a 5.5% annual trend rate. These rates will be hospital specific for all years.

The capital rate component of the DRG-based rate payment is settled during the cost settlement process.

VI. Hospital Specific Medical Education Rate Calculation

The hospital specific medical education rate (including direct and indirect medical education) is calculated by allocating estimated education costs over estimated discharges. Using data from hospital fiscal year 2008 as filed Medicare cost reports, estimated costs are derived by trending medical education costs to state fiscal year 2011 using a 2.5% annual trend rate. These rates will be hospital specific for all years.

The medical education rate component of the DRG-based rate payment is settled during the cost settlement process.

VII. DRG Relative Weight Calculation

The relative weighting factor is assigned by the Department to represent the time and resources associated with providing services for that diagnosis related group. As described below, the Department calculated preliminary weights for each DRG, and then normalizes each weight to ensure that the statewide case mix index for applicable claims equals 1.0. The Department calculates relative weights using claims from critical access hospitals, non-critical access acute care hospitals and hospitals reclassified to a different Medicare geographic access area. The calculation does not include data from rehabilitation hospitals. Days awaiting placement in swing beds were taken into account when calculating relative weights.

a. DRGs with at least 10 admissions

The Department calculates preliminary weights for DRGs with at least 10 admissions by:

- Grouping base year claims for all hospitals described above by DRG
- For each DRG, the Department
 - Sums base year charges per claim
 - Divides this sum by the number of claims in the DRG to obtain an average charge per claim for this DRG
 - Divides this DRG-specific average by the average base year charge per claim for all applicable claims

APPENDIX (cont.)**b. DRGs with fewer than 10 admissions**

If there are fewer than 10 cases for a DRG, the Department adjusts the MS-DRG relative weight by multiplying the relative MS-DRG weight by an “adjustment factor.” This adjustment factor is developed by:

- Calculating the case mix index for all DRGs with at least 10 admissions using MaineCare charges as described above (for example 1.5)
- Calculating the case mix index for all DRGs with at least 10 admissions using MS-DRG (for example 1.2)
- Calculating the ratio of the MS-DRG derived weight to the charged-based rate (in this example this factor would equal 1.5/1.2 or 1.25)

c. Normalization

The resulting weights for all DRGs are then normalized to result in a weighted average case mix of 1.0. This is done by calculating the preliminary case mix index (CMI) for all applicable claims (for example 1.25) and then multiplying each individual case weight by the inverse of this global CMI (in this example equal to 0.8).

VIII. Transfer to a Distinct Rehabilitation Unit in the Same Hospital

Notwithstanding the definition of a discharge in 45.01 above, a hospital may bill for two distinct episodes of care for a patient who is transferred from an acute care unit to a distinct rehabilitation unit in the same hospital. The Department will reimburse the hospital one DRG-based discharge rate for the episode of acute care and one DRG based discharge rate for the rehabilitation episode of care.

IX. Outlier Adjustment Calculation

An outlier payment adjustment is made to the rate when an unusually high level of resources has been used for a case. An outlier payment is triggered when the result of the following equation is greater than zero:

$$\begin{aligned} & \text{(charges multiplied by the hospital-specific cost to charge ratio)} \\ & \text{minus the outlier threshold minus DRG-based discharge rate)} \end{aligned}$$

The payment is equal to 80% of the resulting value.

The outlier threshold is equal to the value that ensures that 5% of payments related to DRG-based discharge rates are outlier adjustment payments.

In no instance is a reduction made to the rates for cases with unusually low costs or charges.