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An Office of the
Department of Health and Human Services
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DATE: April 24, 2012

TO: Interested Parties

FROM: Stefanie Nadeau, Director, Office of MaineCare Services

SUBJECT: EMERGENCY RULE: MaineCare Benefits Manual, Chapter III, Section 45, Hospital Services

This letter gives notice of an EMERGENCY RULE: MaineCare Benefits Manual, Chapter III, Section 45, Hospital Services. This rulemaking updates the supplemental pool amount and method for distributing that pool to Non-Critical Access and other hospitals to better align with Diagnosis Related Group reimbursement. Effective April 24, 2012, the Department is decreasing the supplemental pool for Non-Critical Access, Rehabilitation Hospitals and Hospitals Reclassified to a Wage Area Outside Maine from $51,847,218 to $51,642,035. The distribution methodology for that pool is also being amended from a system based solely on the relative share of MaineCare discharges to one that also uses the relative share of MaineCare days. The Department is also making caps on Prospective Interim Payments (PIP) consistent across the system so that the total payment to all hospitals receiving a PIP is not less than 70% of the calculated amount of the total PIP for the current year. The DHHS will be seeking CMS approval of the State Plan for this change.

Rules and related rulemaking documents may be reviewed and printed from the Office of MaineCare Services website at http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.html or for a fee, interested parties may request a paper copy of rules by calling 207-287-9368. 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. 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.

SECTION 45 **HOSPITAL SERVICES** **ESTABLISHED 1/1/85**

LAST UPDATED 4/24/12

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: Chapter 101, MaineCare Benefits Manual, Chapter III, Section 45, Hospital Services

ADOPTED RULE NUMBER:

CONCISE SUMMARY: This emergency rulemaking updates the supplemental pool amount and method for distributing that pool to Non-Critical Access and other hospitals to better align with Diagnosis Related Group reimbursement. Effective April 24, 2012, the Department is decreasing the supplemental pool for Non-Critical Access, Rehabilitation Hospitals and Hospitals Reclassified to a Wage Area Outside Maine from $51,847,218 to $51,642,035. The distribution methodology for that pool is also being amended from a system based solely on the relative share of MaineCare discharges to one that also uses the relative share of MaineCare days. The Department is also making caps on Prospective Interim Payments (PIP) consistent across the system so that the total payment to all hospitals receiving a PIP is not less than 70% of the calculated amount of the total PIP for the current year.

Visit HTTP://WWW.MAINE.GOV/DHHS/OMS/RULES/INDEX.SHTML for rules and related rulemaking documents.

EFFECTIVE DATE: April 24, 2012

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PLEASE APPROVE BOTTOM PORTION OF THIS FORM AND ASSIGN APPROPRIATE MFASIS NUMBER

APPROVED FOR PAYMENT _____ **DATE:** _____
Authorized Signature

FUND: 013 **AGENCY:** 10A **ORG:** 3026 **APP:** 012 **JOB:** **OBJT:** **AMOUNT:**
FUND: 010 **AGENCY:** 10A **ORG:** 3026 **APP:** 012 **JOB:** **OBJT:** **AMOUNT:**

SECTION 45 **HOSPITAL SERVICES** **ESTABLISHED 1/1/85**

LAST UPDATED 4/24/12

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INTRODUCTION

MaineCare recognizes five different types of hospitals for the purpose of reimbursement, all of which are detailed below. MaineCare uses a different payment methodology for each type of facility. MaineCare reimburses hospitals in the following ways:

1) **Acute Care Non-Critical Access Hospitals** if approved by the Centers For Medicare and Medicaid Services (CMS)**,** effective July 1, 2011, are reimbursed using a Diagnosis Related Group (DRG) based methodology for inpatient services and at a percentage of cost basis for outpatient services;

2) **Acute Care Critical Access Hospitals** are reimbursed at a percentage of cost basis for inpatient and outpatient services;

3) **State Owned Psychiatric Hospitals** are reimbursed on a cost basis for inpatient and outpatient services;

4) **Private Psychiatric Hospitals** are reimbursed at a percentage of charge basis for inpatient services and at a percentage of cost basis for outpatient services; and

5) **Hospitals Reclassified to a Wage Area Outside Maine by the Medicare Geographic Classification Review Board** are reimbursed at a percentage of cost basis for inpatient and outpatient services.

45.01 **DEFINITIONS**

45.01-1 **Acute Care Critical Access Hospital** is a hospital licensed by the Department of Health and Human Services (DHHS or "the Department") as a critical access hospital that is being reimbursed as a critical access hospital by Medicare.

45.01-2 **Acute Care Non-Critical Access Hospital** is a hospital licensed by the Department as an acute care hospital that is not being reimbursed as a critical access hospital by Medicare.

45.01-3 **Ambulatory Payment Classifications (APC)** means the classification of hospital-based outpatient services for use in determining facility reimbursement as defined in the Medicare APC system.

45.01-4 **As-Filed Medicare Cost Report** means the cost report that the hospital files with the Medicare fiscal intermediary and with MaineCare, utilizing the CMS Medicare Cost Report form. In order for an As-Filed Medicare Cost Report to be accepted by MaineCare, hospitals must complete all information in the sections relevant to Title XIX, whether or not required by CMS.

45.01-5 **Diagnosis-Related Group** (DRG) means the classification of medical diagnoses for use in determining reimbursement as defined in the Medicare DRG system or as otherwise specified by the Department.

45.01 **DEFINITIONS** (cont.)

45.01-6 **Discharge** is when a member is formally released from the hospital, transferred from one hospital to another, or dies in the hospital. For purposes of this Section, a member is not considered discharged if he or she is transferred to any different location or different unit, such as a rehab unit, in the same hospital, or is readmitted to the same hospital on the same day or is readmitted to the same hospital within seventy-two (72) hours of an inpatient admission for a diagnosis within the same DRG, excluding complications or co-morbidity. Effective July 1, 2011, for hospitals billing under DRG based methodology, transferring a member to a distinct rehabilitation unit within the same hospital for the same diagnosis will be considered a discharge.

45.01-7 **Distinct Rehabilitation Unit** is a unit within an acute care non-critical access hospital that specializes in the delivery of inpatient rehabilitation services. The unit must be reimbursed as a distinct rehabilitation unit as a sub provider on the Medicare cost report.

45.01-8 **Distinct Psychiatric Unit** is a unit within an acute care non-critical access hospital that specializes in the delivery of inpatient psychiatric services. The unit must be reimbursed as a distinct psychiatric unit as a sub provider on the Medicare cost report or must be comprised of beds reserved for use for involuntary commitments under the terms of a contract with the Department of Health and Human Services. The claim must also be distinguishable as representing a discharge from a distinct psychiatric unit in the MaineCare claims processing system.

45.01-9 **Final Cost Settlement Report** is the report issued by the DHHS Office of Audit that contains the final settlement calculation and settlement amount due to or due from the hospital. This Report utilizes the hospital cost data from the Medicare Final Cost Report.

45.01-10 **Hospital Reclassified to a Wage Area Outside Maine by the Medicare Geographic Classification Review Board (MGCRB)** is a hospital that has been reclassified by the MGCRB. The MGCRB decides on requests of hospitals that are reimbursed under the Prospective Payment System (PPS) for the purposes of Medicare for reclassification to another area (urban or in some cases rural) for the purposes of receiving a higher wage index. (See section 1886 of the Social Security Act, 42 U.S.C. § 1395ww). Further information can be found at http://www.cms.hhs.gov/MGCRB/.

45.01-11 **Institution for Mental Disease** (IMD) means an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. This includes medical attention, nursing care, and related services.

45.01-12 **Interim Cost Settlement Report** is the report issued by the DHHS Office of Audit that contains the settlement calculation and amount due to or due from the hospital. This report utilizes the hospital cost data from the As-Filed Medicare Cost Report.

45.01 **DEFINITIONS** (cont.)

45.01-13 **Low Income Utilization Rate** for a hospital means the sum of:

1) the fraction (expressed as a percentage)

a) the numerator of which is the sum (for a period) of (i) the total revenues paid the hospital for patient services under a State plan, and (ii) the amount of the cash subsidies for patient services received directly from State and local governments, and

b) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

2) the fraction (expressed as a percentage)

a) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause a) (ii) of subparagraph 1) in the period reasonably attributable to inpatient hospital services, this numerator shall not include contractual allowances and discounts (other than for indigent patients not eligible for MaineCare), and

b) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

45.01-14 **MaineCare Supplemental Data Form**, also known as the As-Filed MaineCare Report, is a form submitted by hospitals on a template provided by the department which contains information supplemental to the Medicare Cost Report necessary for computing the Prospective Interim Payment, including, but not limited to, data pertaining to hospital-based physicians, lab and radiology claims and third party payments.

45.01-15 **MaineCare Paid Claims History** is a summary of all claims billed by the hospital to MaineCare for MaineCare eligible members that have been processed and accepted for payment by MaineCare.

45.01-16 **MaineCare Utilization Rate (MUR)** means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital’s number of inpatient days attributable to patients who (for such days) were eligible for MaineCare and the denominator of which is the total number of the hospital’s inpatient days in that period.

45.01 **DEFINITIONS** (cont.)

In this paragraph, the term "inpatient days" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere. The period used to determine the MUR is the Payment Year, as defined below.

45.01-17 **Medicare Final Cost Report** means the Report issued by the Medicare fiscal intermediary and issued to the hospital and to MaineCare.

45.01-18 **Payment Year,** for purposes of Disproportionate Share (DSH) eligibility calculations, means a year commencing on or after October 1st. However, if a hospital has a fiscal year that commences between September 20 and September 30, then its fiscal year shall be deemed to be a fiscal year commencing October 1st of the same calendar year. For example, if a hospital's fiscal year ends September 25, its fiscal year shall be deemed to be a fiscal year commencing October 1 of that calendar year.

45.01-19 **Private Psychiatric Hospital** is a hospital that is primarily engaged in providing psychiatric services for the diagnosis, treatment, and care of persons with mental illness and is privately owned. The facility must be licensed as a psychiatric hospital by the Department of Health and Human Services. A psychiatric hospital may also be known as an institution for mental disease.

45.01-20 **Prospective Interim Payment (PIP)** is the prospective periodic payment made to hospitals. State owned hospitals receive quarterly prospective interim payments. All other hospitals that receive PIP payments will receive them on a weekly basis. These payments may represent only a portion of the amount due the hospital; other lump sum payments made to hospitals throughout the year are not Prospective Interim Payment unless designated.

45.01-21 **Provider's Fiscal Year** is the twelve (12) month period used by a hospital as an accounting period.

45.01-22 *Rehabilitation Hospital* ***is a hospital that provides an intensive rehabilitation program and is recognized as an Inpatient Rehabilitation Facility by Medicare.***

45.01-23 **State Fiscal Year** is the twelve (12) month period used by the State of Maine as an accounting period which begins July 1 and ends June 30 (e. g., SFY 2001 begins July 1, 2000, and ends June 30, 2001).

45.01-24 **State Owned Psychiatric Hospital** is a hospital that is primarily engaged in providing psychiatric services for the diagnosis, treatment, and care of persons with mental illness and is owned and operated by the State of Maine. The facility must be licensed as a psychiatric hospital by the Department of Health and Human Services. A psychiatric hospital may also be known as an institution for mental disease.

45.01 **DEFINITIONS** (cont.)

45.01-25 **Transfer** means a member is moved from one hospital to the care of another hospital. MaineCare will not reimburse for more than two discharges for each episode of care for a member transferring between multiple hospitals.

45.02 **GENERAL PROVISIONS**

45.02-1 **Inflation**

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

45.02-2 **Third Party Liability (TPL)**

When a member is admitted to a hospital, it is the hospital's responsibility to identify all coverage available and perform all procedural requirements of that identified coverage to assure proper reimbursement. The Department will remove claims data from the MaineCare paid claims history when the TPL reimbursement for that claim is equal to or exceeds MaineCare reimbursement. Please see Chapter I Section 1.07 of the MaineCare Benefits Manual for detailed definitions applicable to Third Party Liability. Providers must adhere to the procedures outlined in that Section. Any MaineCare claims data submitted by a hospital may only be withdrawn within one hundred twenty (120) days of the date of the remittance statement.

45.02-3 **Interim and Final Cost Settlements**

At interim and final settlements, the hospital will reimburse the Department for any overpayments within thirty (30) days of receipt of the settlement report, or the Department will reimburse the amount of any underpayment to the hospital. Each Interim and Final Cost Settlement Report must be treated separately for purposes of remitting checks for overpayment and underpayment. If no payment is received within thirty (30) days, the Department may offset prospective interim payments, if permitted by federal and state law. Any caps imposed on Prospective Interim Payments (PIPs) are not applicable to the determination of settlement amounts.

The final settlement will not be performed until the Department receives the Medicare Final Cost Report. If the Medicare Final Cost Report has been received by the Department prior to the issuance of the Interim Cost Settlement Report, the Department will issue only a Final Cost Settlement Report.

Pursuant to PL 2007, P & S Law, Chapter 19, and subject to CMS approval, when carrying out final and interim settlements of payments, the Department shall pay all final

45.02 **GENERAL PROVISIONS** (cont)

settlements for hospital fiscal years 2003 and earlier prior to paying interim settlements for services for hospital fiscal years 2005 and later. This does not limit the Department's authority to:

1. Make ongoing MaineCare payments for services being rendered during the current fiscal year; or

2. Provide partial settlements for hospital fiscal years 2004 and later to certain hospitals in need of such relief in order to relieve financial hardship. Financial hardship is determined by the Department and includes consideration of such factors as a high settlement amount due as a percent of total patient revenue, significant negative operating margins and/or negative cash flow as reflected on audited financial statements.

   The provider must submit a written request for a hardship waiver to the DHHS Commissioner 60 days from the due date for the hospital's MaineCare cost report. All supporting documentation must be submitted with the request.

   The Department will not make a determination of financial hardship until resources are available to issue interim or final hospital audit settlements. The Department may request additional information to support the provider's claim of financial hardship before making a determination.

45.02-4 Crossover Payments

MaineCare does not reimburse for Medicare crossover payments, except to the extent required by CMS (See 42 U.S.C. 1396a(a)(10)(E)(i) and 42 U.S.C. 1396d(p)(3)).

45.02-5 **Reporting and Payment Requirements**

All Maine hospitals are required to submit an As-Filed Medicare Cost Report, MaineCare Supplemental Data Form and additional documents as described below, within five (5) months of the end of the provider's fiscal year, as defined above, to the State of Maine Department of Health and Human Services, Office of Audit, 11 State House Station, Augusta, ME, 04333. Non-Maine (out-of-state) hospitals are not required to submit any cost reports.

A. As-Filed Medicare Cost Report and MaineCare Supplemental Data Forms

Maine hospitals are required to utilize the Medicare Cost Report forms including both Title XVIII and Title XIX work sheets for their As-Filed Medicare Cost Reports. Title XIX worksheets must include all MaineCare charge data available at the time of filing. The MaineCare Supplemental Data Form must also be

45.02 **GENERAL PROVISIONS** (cont)

provided on a template provided by the Department. All sections relevant to Title XIX must be completed, whether or not required by CMS.

B. Required Certifications and Signatures

All documents must bear original signatures. The administrator of the hospital must certify the As-Filed Medicare Cost Report by signing it. If someone other than facility staff prepares the return, the preparer must also sign the report.

The hospital shall also submit a copy of the MaineCare Supplemental Data Form electronically.

C. As-Filed Medicare Cost Report and MaineCare Supplemental Data Form Time Period

The As-Filed Medicare Cost Report and the MaineCare Supplemental Data Form shall cover the twelve (12) month period of each provider's fiscal year unless:

1. a change in licensing category has become effective during a provider's fiscal year, (e.g., a hospital becomes designated as a critical access hospital) in which case the hospital must file two (2) versions of As-Filed Medicare Cost Report and the MaineCare Supplemental Data Form, one (1) for the part of the fiscal year under one licensing category and another for the part of the fiscal year under the second licensing category; or

2. advance authorization to submit an As-Filed Medicare Cost Report and a MaineCare Supplemental Data Form for a lesser period has been granted in writing by the Director of the Office of Audit.

D. Documentation Required to Be Filed With the As-Filed Medicare Cost Report

The Department requires that the following supporting documentation be submitted with the As-Filed Medicare Cost Report:

Note: [Cents are omitted in the preparation of all schedules except when inclusion is required to properly reflect per diem costs or rates.]

1. Audited financial statements,
2. Worksheet reconciling financial statement revenue to the Worksheet C charges on the As-Filed Medicare Cost Report.
3. MaineCare Supplemental Data Form

45.02 **GENERAL PROVISIONS** (cont.)

E. Payment Requirements in the Event of an Overpayment to the Hospital
If a hospital determines from the As-Filed Medicare Cost Report that the hospital owes monies to the Department of Health and Human Services, a check equal to fifty percent (50%) of the amount owed to the Department must accompany the As-Filed Medicare Cost Report.

If the Department does not receive a check with the As-Filed Medicare Cost Report, the Department may elect to suspend prospective payments, pursuant to State regulations and statutes, until the provider pays fifty percent (50%) of the money owed the Department.

F. Consequences of Failing to File Complete and Adequate As-Filed Medicare Cost Report and MaineCare Supplemental Data Form

The Department has determined that failing to file an adequate, complete As-Filed Medicare Cost Report and MaineCare Supplemental Data Form, as determined by the Department, in a timely manner as required above is grounds for the Department to impose sanctions pursuant to the MaineCare Benefits Manual Chapter I, Section I.

The Office of Audit may reject any reports that do not comply with these regulations. In such cases, the Department shall deem the report incomplete until re-filed and in compliance.

G. Extensions

Hospitals must file all requests for extension of time to file an As-Filed Medicare Cost Report and/or MaineCare Supplemental Data Form in writing, and the Office of Audit must receive the request no less than fifteen (15) days prior to the due date. The hospital must clearly explain the reason for the request and specify the date by which the Office of Audit will receive the report.

The Office of Audit will not grant automatic extensions. The Director of the Office of Audit has the sole discretion to determine whether the request is for good cause based on the merits of each request. A "good cause" is one that supplies a substantial basis for the delay or an intervening action beyond the provider’s control. Ignorance of the rule, inconvenience, or a Cost Report preparer engaged in other work will not be considered “good cause.”

45.02-6 **Data for PIP Calculation**

To calculate the PIP for a given state fiscal year the Department will use the most recent As-Filed Medicare Cost Report, and the MaineCare Supplemental data form filed by the hospital, to the extent these reports contain complete information, including but not

45.02 **GENERAL PROVISIONS** (cont.)

limited to, the Title XIX section of the Medicare Cost Report and the MaineCare paid claims history to the extent that it is available. If they are not complete, the Department will use the most recent Cost Settlement Report. The Department will also review any additional data submitted by the deadline regarding significant differences in costs that occurred after the year of the cost report. The Department's estimates of PIP will also reflect operational and/or policy revisions expected to result in substantive changes to services provided by hospitals.

The deadline for receipt of data related to the calculation of prospective interim payments, including estimated discharges, will be May 31 of the calendar year in which the state calculates the PIP.

Effective 4/24/12

45.02-7 **Cap on PIP Payments**

The Department caps PIP payments so that the total payment to all hospitals receiving a PIP is not less than 70% of the calculated amount of the total PIP for the current year.

45.03 **ACUTE CARE NON-CRITICAL ACCESS HOSPITALS**
(Including Rehabilitation Hospitals Until October 1, 2011 if Approved by CMS)

45.03-1 **Department's Total Obligation to the Hospital**

If approved by CMS, 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 and graduate medical education costs + Disproportionate Share Payments (for eligible hospitals) and supplemental pool reimbursements.

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

If CMS approves, 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 July 1, 2009, MaineCare will pay a distinct psychiatric unit discharge rate equal to $6,438.72, except for Northern Maine Medical, for which the distinct psychiatric discharge unit rate will be $15,679.94. Effective July 1,

45.03 **ACUTE CARE NON-CRITICAL ACCESS HOSPITALS** (cont.)

2011, MaineCare will pay a distinct psychiatric unit discharge rate equal to $6,007, except for Northern Maine Medical, for which the distinct psychiatric discharge unit rate will be $14,629. Effective October 1, 2011, MaineCare will pay a distinct psychiatric unit discharge rate equal to $6,438.72, except for Northern Maine Medical, for which the distinct psychiatric discharge unit rate
will be $15,679.94. 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. **Outpatient Services, Including Laboratory and Radiology**

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.hhs.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.

D. **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.

45.03 **ACUTE CARE NON-CRITICAL ACCESS HOSPITALS** (cont.)

E. **Hospital based Physician**

If CMS approves, 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 costs, and
- 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.

F. **Third Party Liability Costs**

MaineCare will reimburse its share of inpatient and outpatient third party liability.

45.03-2 **Prospective Interim Payment (PIP) for Outpatient Services**

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 Department caps this PIP payment so that the total payment to all hospitals is not less than 70% of the calculated amount of the total PIP for the current year. 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 45.03-1 (D) and (F).

45.03- 3 **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.

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.

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

2. DRG Based System

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; and
- Payments made for hospital based physician services.

45.03-4 **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.

No cap imposed on a PIP will limit or otherwise affect the determination of settlement amounts

2. DRG Based System

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

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

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.

45.04 ACUTE CARE CRITICAL ACCESS HOSPITALS (CAH)

45.04-1 **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) and supplemental pool reimbursements (for eligible hospitals).

A. **Inpatient Services**

Effective July 1, 2009, MaineCare will reimburse one hundred and nine percent (109%) of allowable costs.

B. **Outpatient Services**

Effective July 1, 2009, MaineCare will reimburse one hundred and nine percent (109%) of allowable costs.

C. *Supplemental Pool*

Effective November 1, 2011, if approved by CMS 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 PIPs are set.

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.

45.04-2 **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.

45.04-3 **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 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.

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

45.04-4 **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.

45.04-5 **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.

45.05 **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.

45.06 **REHABILITATION HOSPITALS (Effective October 1, 2011 if Approved by CMS)**

45.06-1 **Department's Total Obligation to the Hospital**

If approved by CMS, 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) and supplemental pool reimbursements.

B. **Inpatient Services**

The Department will reimburse $12,440.44 per discharge.

C. **Outpatient Services, including lab and radiology**

The Department's total annual obligation to a hospital for outpatient services equals the lower of 83.8% of MaineCare outpatient costs or charges.

45.06 **REHABILITATION HOSPITALS** (cont.)

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.hhs.gov**) are used to establish MaineCare allowances for clinical laboratory and radiology services.

D. **Capital and Graduate Medical Education Costs**

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

E. **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.

F. **Third Party Liability Costs**

MaineCare will reimburse its share of inpatient and outpatient third party liability.

45.06-2 **Prospective Interim Payment (PIP) for Outpatient Services and Capital and Medical Education costs**

The estimated Departmental outpatient annual obligation will be calculated to determine the PIP payment using data as described in 45.02-6. The Department caps this PIP payment so that the total payment to all hospitals is not less than 80% of the calculated amount of the total PIP for the current year. 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 45.03-1 (D) and (F).

45.06-3 **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.

45.07 **REHABILITATION HOSPITALS** (cont.)

45.06-4 **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.

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

If approved by CMS, 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 and rehabilitation hospitals. If approved by CMS, effective May 1, 2012 the pool shall equal fifty-one million six hundred-forty-two thousand thirty five dollars ($51,642,035). If approved by CMS, 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.

Effective 4/24/12

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 acute discharges or total MaineCare days (as applicable), from that hospital in the latest calendar year for which all hospitals eligible to receive funds from the pool, divided by MaineCare acute 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 pool allocation is done.

This supplemental pool payment is not subject to cost settlement.

45.08 PRIVATE PSYCHIATRIC HOSPITALS

45.08-1 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).

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.

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.

45.08-2 **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.

45.08 **PRIVATE PSYCHIATRIC HOSPITALS** (cont.)

45.08-3 **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 Cost Settlement is being performed. The hospital is required to submit its Medicare As-Filed Cost Report to the Department.

45.08-4 **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.

45.09 STATE OWNED PSYCHIATRIC HOSPITALS

If CMS approves, state owned psychiatric hospitals are reimbursed as follows:

45.09-1 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. 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 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.

45.09-2 Estimated Claims Payments

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

45.09-3 **Final Cost Settlement**

The Department calculates 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.

45.10 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

45.10 OUT-OF-STATE HOSPITALS (cont.)

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. Hospitals are also subject to requirements outlined in MBM Chapter II, Section 45, Hospital Services and Section 46, Psychiatric Facility Services, as applicable.

45.11 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.

45.12 DISPROPORTIONATE SHARE (DSH) PAYMENTS

45.12-1 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 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.

45.12-2 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.

45.12-3 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.

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:

45.12 **DISPROPORTIONATE SHARE (DSH) PAYMENTS** (cont.)

- 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.

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.

45.12 **DISPROPORTIONATE SHARE (DSH) PAYMENTS** (cont.)

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

If CMS approves, Appendix will be adopted as follows, 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 calculates 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:

(charges multiplied by the hospital-specific cost to charge ratio)

minus the outlier threshhold minus DRG-based discharge rate

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.