DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

JUL 18 2013

Mary C. Mayhew, Commissioner
Department of Health and Human Services
State of Maine
221 State Street
11 State House Station
Augusta, ME 04333-0011

RE: Maine 12-009

Dear Ms. Mayhew:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 12-009. This amendment makes changes to the reimbursement method for inpatient hospital services. Specifically, it revises the readmission policy for critical access hospitals (CAHs); reduces the supplemental payment for CAHs; and changes the distribution method for the supplemental pool. This amendment was also submitted in compliance with Section 2702 of the Affordable Care Act. Specifically, it proposes non-payment for identified Health Care-Acquired Conditions (HCACs) and Other Provider-Preventable Conditions (OPPCs) in hospitals and other health care settings.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 12-009 is approved effective April 24, 2012. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Novena James-Hailey at (617) 565-1291.

Sincerely,
/s/

Cindy Mann
Director

| **TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL**<br>FOR: HEALTH CARE FINANCING ADMINISTRATION | 1. TRANSMITTAL NUMBER: 12-009 | 2. STATE: MAINE |
|---|---|---|
| | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR<br>CENTERS FOR MEDICARE AND MEDICAID SERVICES<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE(S)<br>~~April 28, 2012; July 1, 2012;~~ April 24, 2012 | |

5. TYPE OF PLAN MATERIAL *(CHECK ONE)*: HOSPITAL INPATIENT REIMBURSEMENT

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

| 6. FEDERAL STATUTE/REGULATION CITATION:<br>42 CFR 440.80, 447, 434, 438 | 7. FEDERAL BUDGET IMPACT:<br>FFY 12 N/A<br>FFY 13 N/A |
|---|---|
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br>4.19A; ~~ENTIRE SECTION~~ 8, 9, with 18 & 19 new<br>4.19B: 2 (new) | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:<br>4.19B: 2 (new) 4.19A; ~~ENTIRE SECTION~~ 8; 9 |

SUBJECT OF AMENDMENT: INPATIENT HOSPITAL REIMBURSEMENT: CHANGE IN AMOUNT AND DISTRIBUTION METHODOLOGY FOR SUPPLEMENTAL PAYMENT POOL FOR NON-CAH HOSPITALS; CHANGE IN REIMBURSEMENT FOR PROVIDER PREVENTABLE CONDITIONS

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
COMMISSIONER, DEPT. OF HEALTH AND HUMAN SERVICES

| 12. SIGNATURE OF STATE AGENCY OFFICIAL:<br>/s/ | 16. RETURN TO: |
|---|---|
| 13. TYPED NAME:<br>MARY C. MAYHEW | STEFANIE NADEAU |
| 14. TITLE:<br>Commissioner, Maine Department of Health and Human Services | Director, MaineCare Services<br>#11 State House Station |
| 15. DATE SUBMITTED: JUNE 29, 2012 | 442 CIVIC CENTER DRIVE<br>Augusta, ME 04333-0011 |

**FOR REGIONAL OFFICE USE ONLY**

| 17. DATE RECEIVED: | 18. DATE APPROVED: JUL 18 2013 |
|---|---|

PLAN APPROVED – ONE COPY ATTACHED

| 19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 24 2012 | 20. SIGNATURE OF REGIONAL OFFICIAL:<br>/s/ |
|---|---|
| 21. TYPED NAME: [redacted] | 22. TITLE: Deputy Director, Policy + Financial Mgt., CMCS |
| 23. REMARKS: | |

FORM HCFA-179 (07-92)

Inpatient Hospital Services Detailed Description of Reimbursement

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## A DEFINITIONS

A-1 Acute Care Critical Access Hospitals

A hospital licensed by the Department as a critical access hospital that is being reimbursed as a critical access hospital by Medicare.

A-2 Acute Care Non-Critical Access Hospitals

A hospital licensed by the Department as an acute care hospital that is not being reimbursed as a critical access hospital by Medicare.

A-3 Diagnosis Related Group (DRG)

The classification of medical diagnoses for use in determining reimbursement as defined in the Medicare DRG system or as otherwise specified by the Department.

A-4 Discharge

A member is considered discharged when the member is formally released from the hospital, transferred from one hospital to another, or dies in the hospital. For purposes of this Section, excluding Critical Access Hospitals, a member is not considered discharged if moved from one location within a hospital to another, or readmitted to the same hospital on the same day, or stays less than 24 hours; 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.

A-5 Distinct Psychiatric Unit

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 on the MaineCare claims processing system.

A-6 Distinct Rehabilitation Unit

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. The claim must also be distinguishable as representing a discharge from a distinct rehabilitation unit on the MaineCare claims processing system.

A-7 MaineCare Paid Claims History

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. A record of these claims is kept in the Department's claim processing system.

A-8 Private Psychiatric Hospital

A hospital that is primarily engaged in providing psychiatric services for the diagnosis, treatment and care of persons with mental illness and is not 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 (DHHS). A psychiatric hospital may also be known as an institution for mental disease.

A-9 Prospective Interim Payment (PIP)

The weekly (or quarterly in the case of state owned psychiatric hospitals) payment made to a private hospital based on the estimated total annual Department obligation as calculated below. This payment may represent only a portion of the amount due the hospital; other lump sum payments may be made throughout the year. Such circumstances would include, but not be limited to, error correction and interim volume adjustments. For purposes of the PIP calculation, a MaineCare discharge for the most recently completed state fiscal year is one with a discharge date occurring within the state fiscal year and submitted prior to the time of calculation.

A-10 Rehabilitation Hospital

A hospital that provides an intensive rehabilitation program and is recognized as an Inpatient Rehabilitation Facility by Medicare.

A-11 State Owned Psychiatric Hospital

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.

A-12 Transfer

A member is considered transferred if 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.

## B GENERAL PROVISIONS

B-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 shall be used.

B-2 Third Party Liability (TPL)
Any MaineCare claim submitted by a hospital may only be withdrawn within 120 days.

B-3 Interim and Final Settlement

At interim and final settlements, the hospital will reimburse the Department for any overpayments; or the Department will reimburse the amount of any underpayment to the hospital. In either case, the lump sum payment must be made within 30 days of the date of the letter notifying the provider of the results of the interim or final settlement. If more than one year's reconciliation or settlement is completed in the same proceeding, the net amount must be paid. If no payment is received within thirty (30) days, the Department may offset prospective interim payments. Any caps imposed on PIP payments are not applicable to the determination of settlement amounts.

For hospital fiscal years beginning July 1, 2011, interim settlement will be performed within twelve (12) months of receipt of the Medicare Interim Cost Settlement Report with the Department, and final settlement will be performed within twelve (12) months of receipt of the Medicare Final Cost Settlement Report by the Department. If the Medicare Final Cost Settlement 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.

Hospitals are required to file with the DHHS, Division of Audit a year-end cost report within five months from their fiscal year end. The cost report filing consists of: CMS Form 2552 or its equivalent, audited financial statements, and any other related documentation as requested by the DHHS-Division of Audit. The cost report must include applicable MaineCare utilization and a calculated balance due to/from MaineCare.

## C ACUTE CARE NON-CRITICAL ACCESS HOSPITALS

C-1 Department's Inpatient 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 + inpatient capital costs + inpatient hospital based physician costs + graduate medical education costs + Disproportionate Share Payments (for eligible hospitals) and supplemental pool reimbursements + until July 1 2011, days awaiting placement.

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

The Department pays using DRG-based discharge rates, which include estimated capital and medical education costs (see Appendix for full description). As explained in the Appendix , the payment is comprised of three components: the capital expense and graduate medical education components both of which will be subject to interim and final cost settlement, and the DRG direct rate component which will not be cost settled.

B. **Distinct Psychiatric Unit**

MaineCare pays 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 episode of care.

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

The Department will reimburse hospitals based on UB-04 and/or CMS 1500 billing forms. This payment is not subject to cost settlement.

C. **Inpatient Hospital Based Physician**

MaineCare will reimburse 93.3% of its share of inpatient hospital based physicians.

C-2 Interim Settlement

All calculations are based on the relevant payment methodology that was in effect when services were rendered, using the hospital's As-Filed Medicare Cost Report and MaineCare paid claims history for the year for which interim settlement is being performed.

1. Settlements for years up to and including SFY11

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 September 1, 2010.

No cap previously imposed on a prospective interim payment will limit or otherwise affect the determination of settlement amounts.

2. DRG Based System

MaineCare's interim cost settlement for state fiscal years under the DRG-based system will include settlement of:

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

C-3 Final Settlement

All settlement processes are based on the relevant payment methodology using charges included in MaineCare paid claims history for the applicable year and the hospital's Medicare Final Cost Report.

1. Settlements for years up to and including SFY11

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

- Prospective interim payments;
- Payments made for hospital based physician services provided on or after September 1, 2010.

No cap previously imposed on a prospective interim payment 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.

## D. REHABILITATION HOSPITALS

### D-1 Department's Inpatient Obligation to the Hospital

The Department of Health and Human Services' inpatient obligation to a hospital will be the sum of MaineCare's obligation for the following: inpatient services + inpatient capital costs + Disproportionate Share Payments (for eligible hospitals) and supplemental pool reimbursements.

a. **Inpatient Services**

The Department will reimburse $12,440.44 per discharge paid based on claims submitted. Payment for these services is not subject to cost settlement.

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

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

**c. Hospital based Physicians**

MaineCare will reimburse 93.3% of its share of inpatient hospital based physician costs. Hospitals will initially be reimbursed based on claim forms filed with the Department. These payments are subsequently subject to cost settlement.

**d. Third Party Liability Costs**

MaineCare will reimburse its share of third party liability.

D-2 **Interim Cost Settlement**

The Department calculates the Interim Cost Settlement using 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. Cost settlement is performed for hospital based physician costs and for capital costs.

D-3 **Final Cost Settlement**

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

**E ACUTE CARE CRITICAL ACCESS HOSPITALS AND HOSPITALS RECLASSIFIED TO A WAGE AREA OUTSIDE MAINE BY THE MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD (MGCRB) PRIOR TO OCTOBER 1, 2008**

All calculations made in relation to these hospitals must be made in accordance with the requirements for completion of the Medicare Cost Report and Generally Accepted Accounting Principles, unless otherwise noted, plus a DSH adjustment payment for eligible hospitals.

E-1 Department's Inpatient Obligation to the Hospital

The Department of Health and Human Services' total annual inpatient obligation to the hospitals will be the sum of MaineCare's obligation of the following: inpatient services + days awaiting placement + hospital based physician + direct graduate medical education costs. Third party liability payments are subtracted from the obligation.

These computed amounts are calculated as described below:

A. Inpatient Services

109% of the total MaineCare inpatient operating costs from the most recent interim cost-settled report issued by the Department, inflated to the current state fiscal year. Additionally, a supplemental pool will be allocated on the basis of the hospital's relative share of Medicaid payments for private critical access hospitals only, not those hospitals reclassified to a wage area outside Maine by the Medicare Geographic Classification Review Board or public hospitals. In SFY 11 that amount will be $3,500,000. In SFY 12 and subsequent years that amount will be $4,000,000.

The relative share is defined as:

$$\frac{\text{total Medicaid payments to CAH hospital} \times \text{pool amount}}{\text{total Medicaid payments to all CAH hospitals}}$$

B. MaineCare Member Days Awaiting Placement (DAP) at a Nursing Facility (NF)

Reimbursement will be made 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 4.19D Principles of Reimbursement for Nursing Facilities. The average statewide rate per member day shall be computed 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.

C. 93.3% of MaineCare's share of inpatient hospital based physician costs + MaineCare's share of graduate medical education costs.

E-2 Prospective Interim Payment (PIP)

The estimated departmental annual inpatient obligation, described above, will be calculated using the most recent as-filed hospital fiscal year end MaineCare cost report and supplemental data sheet, inflated to the current state fiscal year. Third party liability payments are subtracted from the PIP obligation. The PIP payment does not include DSH payments or the hospital's share of the supplemental pool as described below.

E-3 Interim Adjustment

The State would expect to initiate an interim 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); if and when a new population group was made eligible for MaineCare (e.g., the State is contemplating an eligibility expansion to include higher income parents); or a hospital closes or opens and there is a redistribution of patients among facilities.

E-4 Interim Settlement

The Department of Health and Human Services' interim settlement with a hospital is calculated using the same methodology as is used when calculating the PIP, except that the data sources used will be the hospital's as filed cost report and MaineCare paid claims history for the year for which reconciliation is being performed.

E-5 Final Settlement

The Department of Health and Human Services' final settlement with a hospital is calculated using the same methodology as is used when calculating the PIP, except that the data sources used will be the hospital's final cost report from the Medicare fiscal intermediary and MaineCare paid claims history for the year for which settlement is being performed.

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

The Department will allocate the supplemental pool annually among the private acute care non-critical access hospitals, rehabilitation hospitals, and hospitals reclassified to a wage area outside Maine by the Medicare Geographic Classification Review Board prior to October 1, 2008. The pool shall equal $51,642,035 and be used to support hospital payments even under DRG methodology.

This pool will be proportionately decreased if a hospital that was in the pool when the total pool amount was set subsequently becomes a critical access hospital. This amount will not be adjusted at the time of audit.

Effective April 24, 2012, 50% of the pool shall be distributed based on each hospital's relative share of inpatient MaineCare non-psychiatric discharges. Relative share shall equal the hospital's acute care non-CAH MaineCare discharges divided by total acute care non-CAH MaineCare discharges for all hospitals times ½ the pool amount. The other 50% of the pool shall be distributed based on each hospital's relative share of total inpatient MaineCare days. Relative share shall equal the hospital's acute care non-CAH MaineCare days divided by the total acute care non-CAH MaineCare days for all hospitals times ½ the pool amount. MaineCare will use the most recent as filed Medicare cost report available to determine the MaineCare days and discharges used in the distribution of the pool.

Pool payments will be paid 50% in November and 50% in May of each state fiscal year.

## G PRIVATE PSYCHIATRIC HOSPITALS

G-1 Department's Inpatient Obligation to the Hospitals

Private owned psychiatric hospitals will be paid weekly prospective interim payments based on the Department's estimate of the total annual obligation to the hospital. The Department's total annual obligation shall be computed based on the hospital's negotiated percentage rate. The negotiated percentage rate shall be between 85% and 100% of the hospital's estimated inpatient charges, less third party liability. The negotiation involves hospital representatives and State representatives, including individuals from the Office of MaineCare Services, Attorney General's office, Division of Audit and the former Department of Behavioral Developmental Services, now part of the Department. The negotiation process is designed to ensure adequate access to psychiatric hospital services, which are a critical part of the State's psychiatric hospital network; these two private IMDs represent the only significant providers of psychiatric hospitalization services for children.

G-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.

G-3 Interim Adjustment

The Department may initiate a comparison of MaineCare charges on claims to the projected charges used in calculating the PIP payment and may renegotiate the payment rate.

G-4 Interim Settlement

The Department of Health and Human Services' interim settlement with a hospital is calculated using the same methodology as is used when calculating the PIP, except that the data sources used will be the hospital's interim cost-settled report as issued by the Department and MaineCare paid claims history for the year for which reconciliation is being performed.

G-5 Final Settlement

The Department's total annual obligation with a hospital will be computed based on the hospital's negotiated percentage rate. The obligation amount shall be greater than or equal to 85 percent but not more than 100 percent of the hospital's actual MaineCare charges from paid claims history, less third party liability.

## H. STATE OWNED PSYCHIATRIC HOSPITALS

All calculations made in relation to these hospitals must be made in accordance with the Tax Equity and Fiscal Responsibility Act (TEFRA), except as stated below, plus a DSH adjustment payment for eligible hospitals.

H-1 Prospective Interim Payment (PIP)

The Department of Health and Human Services' total annual PIP obligation to the hospitals will be the sum of MaineCare's obligation of the following: inpatient services + days awaiting placement + hospital based physician + graduate medical education costs + estimated DSH. Third party liability payments are subtracted from the PIP obligation.

These computed amounts are calculated as described below:

A. Inpatient Services
The total MaineCare inpatient operating costs from the most recent as-filed cost report.

B. MaineCare's share of hospital based physician + graduate medical education costs are taken from the most recent hospital fiscal year end MaineCare interim cost-settled report issued by DHHS Division of Audit, inflated to the current state fiscal year.

H-2 Interim Adjustment

The State would expect to initiate an interim 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); if and when a new population group was made eligible for MaineCare; or a hospital closes or opens and there is a redistribution of patients among facilities.

H-3 Interim Settlement

The Department of Health and Human Services' interim settlement with a hospital is calculated using the same methodology as is used when calculating the PIP, except that the data sources used will be the hospital's interim cost-settled report as issued by the Department and MaineCare paid claims history for the year for which reconciliation is being performed.

H-4 Final Settlement

The Department of Health and Human Services' final settlement with a hospital is calculated using the same methodology as is used when calculating the PIP, except that the data sources used will be the hospital's final cost report from the Medicare fiscal intermediary and MaineCare paid claims history for the year for which settlement is being performed.

**I OUT OF STATE HOSPITALS**

The Department will reimburse out of state hospitals for inpatient services based on:

1. The MaineCare rate if applicable;
2. The lowest negotiated rate with a payor whose rate the provider currently accepts;
3. The provider's in State Medicaid rate;

4. A percentage of charges; or
5. A rate specified in MaineCare's contract with the provider.

Out of State 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.

## J DISPROPORTIONATE SHARE HOSPITALS

### J-1 Eligibility for DSH Payments

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 interim cost settlement report for the same period to apply the standard deviation test. After interim cost settlement is complete for all hospitals in a category (i.e., acute care or psychiatric) hospitals within the category are assessed for eligibility for disproportionate share payments.

A. Institutions for Mental Disease

The IMD (psychiatric hospital) must have a MaineCare utilization rate (MUR) of at least one percent.

B. Acute Care Hospitals

The hospital must a) have a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state (as defined in section 1923 b1A of the SSA or b have a low income inpatient utilization rate as defined in section 1923 b1b of the Social Security Act exceeding 25%.

D. Calculation of MaineCare Utilization Rate (MUR)

The MaineCare utilization rate calculation is:
**MUR** % = 100 X M/T
**M** = Hospital's number of inpatient days attributable to MaineCare covered patients **T** = Hospital's total inpatient days

In calculating the inpatient MUR, the State will include newborn nursery days, whether billed under the mother's MaineCare identification number or the infants, days in specialized wards, including intensive and critical care units, administratively necessary days including days awaiting placement, and days attributable to individuals eligible for Medicaid in another State. The State will not include days attributable to MaineCare members between 21 and 65 years of age in institutions for mental disease, unless such days are reimbursable under MaineCare.

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 as-filed cost report for the same period to apply the applicable MUR test. If at the time of final audit the as-filed cost reports prove to be inaccurate to the degree that a hospital's disproportionate share status changes, adjustments will be made at that time.

E. For All Hospitals

i) the hospital must have at least two 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 MSA 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.

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

J-2 DSH Adjustments for Institutions for Mental Diseases

Subject to the Cap Adjustment described below, unless otherwise provided, the DSH adjustment will be 100% of the actual cost, as calculated using TEFRA and GAAP principles, of:

a) services furnished to MaineCare members, plus
b) uncompensated care provided to individuals with no source of third party coverage for the hospital services they received as reported on the hospital's most recent audited financial statement.
c) minus payments made by the State for services furnished to MaineCare members.

IMD Cap Adjustment

The Centers for Medicare and Medicaid Services (CMS) establishes an aggregate cap on the DSH payment for which the State may claim federal financial participation (overall cap). Within that overall aggregate cap, there is a limit on the amount of DSH payment that may be made to IMDs (IMD cap).

If the Department determines that aggregate payments, as calculated above, would exceed the IMD cap established by CMS, payments will be made to State-run facilities first. Remaining IMD DSH payments will be proportionately reduced for all remaining IMDs.

The CMS places a limit on the amount of DSH payment that may be made to a single hospital. If the Department or CMS determines 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 Department will calculate the proportionate reduction by applying the original DSH payment percentage determined for each hospital to the applicable DSH payment amount (cap) available.

J-3 Final DSH Adjustment for IMDs

The Department of Health and Human Services' total year end DSH obligation to a psychiatric hospital is calculated using the methodology described above based on the hospital's final cost report data, audited financial statement, and actual MaineCare claims from paid claims history for the year for which settlement is being performed. All DSH calculations are reconciled to actual costs.

J-4 DSH Adjustment 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.

   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.

## APPENDIX

## DRG-BASED PAYMENT METHODOLOGY

The Department has adopted the Medicare Severity Diagnosis Related Groups (which precludes payment for certain hospital acquired conditions) as described at www.cms.gov/AcuteInpatientPPS/.

I. **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)

II. **Hospital Specific Base Rate Calculation**

Each hospital specific rate is the total of 3 components:

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

III. **Direct Care Rate Calculations**

The statewide DRG direct care rate is calculated as follows. The Department:

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

The hospital-specific DRG direct care rate for hospital fiscal year 2012 is calculated as follows. The Department:

- 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 2011 as described in B-1 above

## IV. 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 as filed 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, the average between 2007 and 2008. These rates will be hospital specific for all years. 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.

## V. 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 cost reports, estimated costs are derived by trending medical education costs to state fiscal year 2011 using a 2.5% annual trend rate, the average between 2007 and 2008. 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. 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

b. DRGs with fewer than 10 admissions

If there are fewer than 10 cases for a DRG, the Department adjusts the 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 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 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 threshold 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.

## Provider Preventable Conditions

**Citation**

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

**Payment Adjustment for Provider Preventable Conditions**

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19(A)

__X Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19-A.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

______ Additional Other Provider-Preventable Conditions identified below:

In compliance with 42 CFR 447.26(c), the DHHS assures that:

1. No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
2. Reductions in provider payment may be limited to the extent that the following apply:
   a. The identified PPC would otherwise result in an increase in payment.
   b. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the PPC.
3. Non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

In order to determine the non-payment amount, for services paid under Section 4.19(A) of this State Plan, the DHHS will utilize the diagnoses and present on admission indicator submitted by providers on claims.

This provision applies to all providers providing services under Section 4.19(A).

Effective June 28, 2012, 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 when the condition was not present on admission. Providers bill using modifiers and claims holding PPC modifiers will be denied. 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. Inpatient days days associated with a PPC will not be reimbursed at cost reconciliation.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE**

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**Citation**
42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions
The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions (PPCs).

Other Provider-Preventable Conditions
The State identifies the following Other Provider-Preventable Conditions for non-payments under Section 4.19(b) of this State Plan.

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below:

In compliance with 42 CFR 447.26(c), the DHHS assures that:

1. No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
2. Reductions in provider payment may be limited to the extent that the following apply:
   a. The identified PPC would otherwise result in an increase in payment.
   b. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the PPC.
3. Non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

This provision applies to all providers providing services under Section 4.19(B).

Effective June 28, 2012, 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. Specific diagnosis codes associated with PPCs will be denied reimbursement. All CMS 1500 claims with a claim line submitted containing modifiers PA, PB, or PC must have that line denied using CARC CO 50 to report to providers. All CMS 1500 claims with a diagnosis pointer that refers to any of the following codes E876.5, E876.6, or E876.7 must have that line denied using CARC CO 50 to report to providers.