


Janet T. Mills
Governor



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Jeanne M. Lambrew, Ph.D.
Commissioner

DATE: July 19, 2023
TO: Interested Parties
FROM: Michelle Probert, Director, MaineCare Services 
SUBJECT: Proposed Rule: 10-144 C.M.R. ch. 101, MaineCare Benefits Manual, Chapter III, Section 45. Hospital Services

PUBLIC HEARING: 9:00am; Wednesday, August 9, 2023

Location: 109 Capital St, Augusta, ME; Conference Room A

The public hearing will be held both in-person and via zoom.

Zoom Meeting link:

<https://mainestate.zoom.us/j/84802366882?pwd=L1VVYmpRWnYyRkJFL0l2SWQyMzRQUT09>

Meeting ID: 848 0236 6882

Some devices may require downloading a free app from Zoom prior to joining the public hearing event. The Department requests that any individual requiring special arrangements to participate in the hearing contact the person listed for this filing 5 days in advance of the hearing

COMMENT DEADLINE: Comments must be received by 11:59 PM on Saturday, August 19, 2023

This letter gives notice of proposed rule: 10-144 C.M.R. Chapter 101, MaineCare Benefits Manual, Chapter III, Section 45, Hospital Services.

The principal reason the Department is proposing this rule is to eliminate the current provider-specific rates for reimbursing distinct psychiatric units and distinct substance use disorder (SUD) units in hospitals, and to establish a new reimbursement methodology. In compliance with 22 M.R.S. Sec. 3173-J(2), the Department conducted a rate determination process: a Rate Determination Initiation Notice was issued on October 7, 2022; MaineCare presented the draft rate methodology and definitions to providers and interested stakeholders in January 2023; accepted public comments until February 3, 2023; and will respond in writing to comments with an explanation of whether and how feedback was incorporated into the final rate determination. The Department's resulting reimbursement methodology, as proposed here, generally aligns with Medicare's payment method for distinct psychiatric units. In compliance with P.L. 2023, ch. 3, Sec. S-1, the initial per diem base rates were set so the methodology will provide, in aggregate, one hundred percent (100%) cost reimbursement across all hospitals with these distinct units based upon 2022 data.

This proposed rulemaking seeks to make the following specific changes:

- Section 45.01- Definitions:

Change the definition of “Discharge” to add that a discharge occurs if a patient is transferred to a distinct psychiatric Unit or a distinct SUD unit. The Department proposes a retroactive application of July 1, 2023, for this change, as authorized by 22 M.R.S. Sec. 42(8), as this change benefits, and does not harm MaineCare members or providers.

Added definitions for “From Date” and Medicare Severity Diagnosis-Related Group (MS-DRG), terms utilized in Section 45.03-1(B), the new reimbursement methodology for distinct psychiatric Units and SUD units.

- Section 45.02-1- Inflation:

Change the name of the entity producing the economic trend factor used by the Department for determining inflation, from Global Insight to IHS Markit due to a change in the name of the organization that publishes the “Healthcare Cost Review”.

- Section 45.03-1(B) New Reimbursement Methodology for Distinct Psychiatric Units and Distinct Substance Use Disorder (SUD) Units:

The Department proposes to eliminate the current methodology for reimbursing distinct psychiatric units and distinct SUD units and to establish a new reimbursement methodology that the Department has determined in accordance with 22 M.R.S. Sec. 3173-J(2). Under the proposed new methodology, the Department will calculate reimbursement for covered in-person stays in these units using the following formula: multiplying the per diem base rate (determined by whether the MS-DRG is a psychiatric or SUD MS-DRG) by the applicable MS-DRG relative weight and multiplying that figure by the applicable Length of Stay factor.

The Department calculated per diem base rates to result in total reimbursement equal to one hundred percent (100%) of the costs of such discharges in the aggregate across all hospitals with distinct psychiatric units and distinct SUD units, utilizing 2022 data when adjusted for MS-DRG relative weights and Length of Stay factor.

The Department proposes to adopt the Medicare MS-DRG and Length of Stay factors for the new reimbursement methodology. The Medicare Length of Stay factor is a cumulative factor that takes into account how many days the patient stays in the distinct unit.

The Department proposes to update the per diem base rate annually based on the inflation provision in this rule (Section 45.02-1): the economic trend factor from the most recent addition of the “Healthcare Cost Review” from IHS Markit. In accordance with 22 M.R.S. Sec. 3173-J(3), the per diem base rates are posted on the MaineCare Provider Fee Schedule, and the Department is not required to do rulemaking to make the annual inflation adjustments to the per diem base rate.

The Department proposes that the new reimbursement methodology have a retroactive application date of July 1, 2023, as authorized by 22 M.R.S. 42(8), as the changes benefit, and do not harm MaineCare members or providers. In order to prevent any adverse financial impact to any hospital with a distinct psychiatric unit, the Department has proposed a time limited supplemental payment for hospitals with distinct psychiatric units that are located in zip codes that CMS designates as “super rural” and that also have a High Geographic Need Health Professional Shortage Area for mental health designation by the Health Resources and Services Administration.

- Appendix A(VIII):

The Department includes distinct psychiatric units and SUD units in this provision, so that hospitals can claim for two episodes of care if patients are transferred to distinct rehabilitation, psychiatric or SUD units. The Department proposes a retroactive application of July 1, 2023, for this change, as authorized by 22 M.R.S. Sec. 42(8), as this change benefits, and does not harm MaineCare members or providers.

- Remove website addresses and embed links to those websites in their place.
- Make minor technical edits and format corrections.

Rules and related rulemaking documents may be reviewed at, or printed from, the MaineCare website at <http://www.maine.gov/dhhs/oms/rules/index.shtml> or for a fee, interested parties may request a paper copy of rules by calling (207) 624-4050 or Maine Relay number 711.

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

Notice of Agency Rule-making Proposal

AGENCY: Department of Health and Human Services, MaineCare Services, Division of Policy

CHAPTER NUMBER AND TITLE: 10-144 C.M.R., Chapter 101, MaineCare Benefits Manual, Chapter III, Section 45, Hospital Services

PROPOSED RULE NUMBER:

CONCISE SUMMARY:

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This proposed rulemaking seeks to make the following specific changes:

- Section 45.01- Definitions:

Change the definition of "Discharge" to add that a discharge occurs if a patient is transferred to a distinct psychiatric Unit or a distinct SUD unit. The Department proposes a retroactive application of July 1, 2023, for this change, as authorized by 22 M.R.S. Sec. 42(8), as this change benefits, and does not harm MaineCare members or providers.

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The Department calculated per diem base rates to result in total reimbursement equal to one hundred percent (100%) of the costs of such discharges in the aggregate across all hospitals with distinct psychiatric units and distinct SUD units, utilizing 2022 data when adjusted for MS-DRG relative weights and Length of Stay factor.

The Department proposes to adopt the Medicare MS-DRG and Length of Stay factors for the new reimbursement methodology. The Medicare Length of Stay factor is a cumulative factor that takes into account how many days the patient stays in the distinct unit.

The Department proposes to update the per diem base rate annually based on the inflation provision in this rule (Section 45.02-1): the economic trend factor from the most recent addition of the “Healthcare Cost Review” from IHS Markit. In accordance with 22 M.R.S. Sec. 3173-J(3), the per diem base rates are posted on the MaineCare Provider Fee Schedule, and the Department is not required to do rulemaking to make the annual inflation adjustments to the per diem base rate.

The Department proposes that the new reimbursement methodology have a retroactive application date of July 1, 2023, as authorized by 22 M.R.S. 42(8), as the changes benefit, and do not harm MaineCare members or providers. In order to prevent any adverse financial impact to any hospital with a distinct psychiatric unit, the Department has proposed a time limited supplemental payment for hospitals with distinct psychiatric units that are located in zip codes that CMS designates as “super rural” and that also have a High Geographic Need Health Professional Shortage Area for mental health designation by the Health Resources and Services Administration.

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- Make minor technical edits and format corrections.

See <http://www.maine.gov/dhhs/oms/rules/index.shtml> for rules and related rulemaking documents.

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

PUBLIC HEARING:

Date and Time: Wednesday, August 9, 2023; 9:00am

Location: 109 Capital St, Augusta, ME; Conference Room A

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AGENCY CONTACT PERSON: Catherine Coolidge, Comprehensive Health Planner II
catherine.coolidge@maine.gov

AGENCY NAME: MaineCare Services

ADDRESS: 109 Capitol Street, 11 State House Station
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TTY: 711 (Deaf or Hard of Hearing)

IMPACT ON MUNICIPALITIES OR COUNTIES (if any): The Department anticipates that this rulemaking will not have any impact on municipalities or counties.

CONTACT PERSON FOR SMALL BUSINESS INFORMATION (if different): N/A

STATUTORY AUTHORITY FOR THIS RULE: 22 M.R.S. §§ 42, 3173; 22 M.R.S. 3173-J

10-144 Chapter 101
 MAINECARE BENEFITS MANUAL
 CHAPTER III, PRINCIPLES OF REIMBURSEMENT

SECTION 45

HOSPITAL SERVICES

~~ESTABLISHED~~Established: 1/1/85

LEGAL EFFECTIVE DATE: 10/24/2022

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HOSPITAL SERVICES

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INTRODUCTION

MaineCare recognizes seven 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) **Private Acute Care Non-Critical Access Hospitals** will be reimbursed using a Diagnosis Related Group (DRG) based methodology for inpatient services effective July 1, 2012, using Ambulatory Patient Classification system payments for outpatient services. There are two subsets of Private Acute Care Non-Critical Access Hospitals: rural hospitals and non-rural hospitals;
- 2) **Public Acute Care Non-Critical Access Hospitals** will be reimbursed using a Diagnosis Related Group (DRG) based methodology for inpatient services and at a percentage of cost basis for outpatient services;
- 3) **Acute Care Critical Access Hospitals** will be reimbursed at a percentage of cost basis for inpatient and outpatient services;
- 4) **State Owned Psychiatric Hospitals** will be reimbursed on a cost basis for inpatient and outpatient services;
- 5) **Private Psychiatric Hospitals** will be reimbursed at a percentage of charge basis for inpatient services and at a percentage of cost basis for outpatient services; ~~and~~
- 6) **Hospitals Reclassified to a Wage Area Outside Maine by the Medicare Geographic Classification Review Board** will be reimbursed at a percentage of cost basis for inpatient and outpatient services; ~~and~~
- 7) **Rehabilitation Hospitals** will be reimbursed using a discharge rate effective July 1, 2012, Ambulatory Patient Classification system payments for outpatient services.

45.01 DEFINITIONS

- 45.01-1 **Accountable Communities (AC)** is a MaineCare initiative established through a contract between the Department and an Accountable Community Lead Entity that establishes a financial relationship between the Department and the AC Lead Entity to both provide a financial incentive and hold the AC accountable for the provision of efficient, coordinated, and high-quality care. AC Lead Entities that achieve savings relative to a benchmark Total Cost of Care (TCOC) amount are eligible to receive a portion of these savings dependent on and proportional to their performance on a number of quality measures.
- 45.01-2 **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.

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45.01 DEFINITIONS (cont.)

- 45.01-3 **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. There are two subsets of Private Acute Care Non-Critical Access Hospitals: rural hospitals and non-rural hospitals.
- 45.01-4 **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.
- 45.01-5 **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.
- 45.01-6 **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.
- 45.01-7 **Discharge** ~~is~~occurs when a member is formally released from the hospital, transferred from one hospital to another, transferred to a distinct unit in the same hospital (distinct units include distinct rehabilitation psychiatric, and substance use disorder units), or dies in the hospital. For purposes of this Section for all hospitals except critical access hospitals, a member is not considered discharged if he or she is transferred to any different location or ~~different non-distinct unit, such as a rehab unit,~~ in the same hospital, or ~~effective July 7, 2015,~~ is readmitted to the same hospital on the same day, or is readmitted to the same hospital within fourteen (14) days of an inpatient discharge for a diagnosis within the same DRG, regardless of complications or co-morbidity.

There are exceptions to the fourteen (14) day readmission protocol. The exceptions are as follows:

- a) Readmissions for individuals who are diagnosed with a mental health diagnosis described in the most current version of the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM)*;
- b) Readmissions for individual whose symptoms meet the American Society of Addiction Medicine (ASAM) Level 4 Criteria, as defined in the most recent edition of the ASAM Criteria: Treatment Criteria for Addictive, Substance-related, and Co-Occurring Conditions; and
- b)c) Readmissions for individual receiving inpatient maintenance chemotherapy treatment.

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45.01 DEFINITIONS (cont.)

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.

* Effective July 1, 2023, for hospitals billing under DRG based methodology, transferring a member to a distinct psychiatric or substance use disorder unit from a non-distinct unit within the same hospital will be considered a discharge.

45.01-8 **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.

45.01-9 **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.

45.01-10 **Distinct Substance Use Disorder Unit** is a unit that combines the medical management of withdrawal with a structured inpatient rehabilitation program. Services include coordinated group education and psychotherapy, and individual psychotherapy and family counseling as needed. Licensed Alcohol and Drug Abuse Counselors (LADCs) assist medical staff in developing an interdisciplinary plan of care.

Evidence-based best practices such as motivational interviewing are used by staff who are trained in substance use disorder treatment. The claim must also be distinguishable as representing a discharge from a distinct substance use disorder unit in the MaineCare claims processing system. This label is not a Medicare designation.

45.01-11 **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.

45.01-12 **From Date** is the earliest date the hospital provides care to the member during an inpatient stay including up to one (1) day preceding, a member's admission to a distinct unit, or three (3) days preceding, a member's admission to a medical unit. This date is indicated on the UB-04 Claim Form in Field Locator 6 under statement covers period.

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45.01 **DEFINITIONS** (cont.)

45.01-~~12~~13 **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/http://www.cms.hhs.gov/MGCRB/>.

45.01-~~13~~14 **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-~~14~~15 **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-~~15~~16 **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 ~~p~~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) above 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.

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45.01 **DEFINITIONS** (cont.)

45.01-~~16-17~~ **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-~~17-18~~ **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-~~18-19~~ **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.

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-~~19-20~~ **Medicare Final Cost Report** means the Report issued by the Medicare fiscal intermediary and issued to the hospital and to MaineCare.

45.01-21 **Medicare Severity Diagnosis-Related Group (MS-DRG)** means the classification of medical diagnoses which adds patient's severity of illness and risk of mortality for use in determining reimbursement as defined in the Medicare DRG system or as otherwise specified by the Department.

45.01-~~20-22~~ **Non-rural Hospital** is a private acute care non-critical access hospital that does not meet the definition of a "Rural Hospital" as defined in this regulation.

45.01-~~21-23~~ **Payment Year**, for purposes of Disproportionate Share (DSH) eligibility calculations, means a year commencing on or after October ~~1st~~1. 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~~1 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-~~22-24~~ **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

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45.01 **DEFINITIONS** (cont.)

by the Department of Health and Human Services. A psychiatric hospital may also be known as an institution for mental disease.

45.01-~~2325~~ **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-~~2426~~ **Provider's Fiscal Year** is the twelve (12) month period used by a hospital as an accounting period.

45.01-~~2527~~ **Rehabilitation Hospital** is a hospital that provides an intensive rehabilitation program and is recognized as an Inpatient Rehabilitation Facility by Medicare.

45.01-~~2628~~ **Rural Hospital** is a private acute care non-critical access hospital that meets one of the following criteria:

1. Is a "Sole Community Hospital" as designated by Medicare, and as reported on the hospital's Medicare cost report; ~~OR~~or
2. Is a "Medicare-Dependent Hospital" as designated by Medicare, and as reported on the hospital's Medicare cost report; ~~OR~~or
3. Is a participating hospital on the Medicare "Rural Community Hospital Demonstration", as reported in the hospital's Medicare cost report.

45.01-~~2729~~ **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-~~2830~~ **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-~~2931~~ **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.

***The Department shall submit to CMS and anticipates approval for a State Plan Amendment related to these provisions.**

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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~~ IHS Markit 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, when carrying out final and interim settlements of payments, the Department shall pay all final 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

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45.02 **GENERAL PROVISIONS** (cont.)

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 sixty (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.

5.02-4 **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 provided on a template provided by the Department. All sections relevant to Title XIX must be completed, whether or not required by CMS.

45.02 GENERAL PROVISIONS (cont.)

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)~~1. Audited financial statements;
- ~~(2)~~2. Worksheet reconciling financial statement revenue to the Worksheet C charges on the As-Filed Medicare Cost Report;

45.02 GENERAL PROVISIONS (cont.)

- ~~(3)~~3. MaineCare Supplemental Data Form;
- ~~(4)~~4. UB Mapping – mapping revenue codes to appropriate cost center; and
- ~~(5)~~5. 1500 Mapping – mapping of 1500 claims to clinic/cost centers by service area, specialty, or physician.

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 one hundred percent (100%) 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.

***The Department shall submit to CMS and anticipates approval for a State Plan Amendment related to these provisions.**

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

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45.02 GENERAL PROVISIONS (cont.)

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 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.

45.02-7 Cap on PIP Payments

If CMS approves, the Department caps PIP payments so that the total payment to all hospitals receiving a PIP is not less than ~~70%~~ **seventy percent (70%)** of the calculated amount of the total PIP for the state fiscal year.

45.02-8 Days Awaiting Nursing Facility (NF) Placement Effective January 1, 2019 through December 31, 2023

Effective January 1, 2019 through the period ending December 31, 2023, the Department will reimburse hospitals other than critical access hospitals for each day after the tenth (10th) day that a MaineCare eligible member is in the care of the hospital while awaiting placement in a NF. The Department will reimburse at the statewide average rate per MaineCare member day for NF services. The statewide average rate will be computed based on the simple average NF rate per MaineCare member day for the applicable state fiscal year or years prorated for the hospital's fiscal year. Reimbursement for days awaiting placement pursuant to this section is limited to a maximum of \$500,000 of combined state General Fund funds and federal funds for each year. The Department will reimburse quarterly by order of claim date. In the event the cap is expected to be exceeded in any quarter, reimbursement for claims in that quarter will be paid out proportionately, and a notification of total funds expended for that year will be sent out to providers. This section is repealed December 31, 2023.

45.03 ACUTE CARE NON-CRITICAL ACCESS HOSPITALS

45.03-1 Department's Total Obligation to the Hospital

The Department of Health and Human Services' total annual obligation to a hospital will be the sum of MaineCare's obligation for the following: inpatient services + outpatient services + inpatient capital costs + hospital-based physician costs + graduate medical education costs + Disproportionate Share Payments (for eligible hospitals) + supplemental pool reimbursements – third party liability payments.

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

Effective for reimbursement for admissions on or after July 1, 2011, the Department will pay using DRG-based discharge rates, which include estimated capital and medical education costs (see Appendix for full description). The Department will reimburse hospitals based on required billing forms, as described in the Department's billing instructions. As explained in [the](#) 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.

Distinct Psychiatric Unit

- ~~B.—~~

~~Effective October 1, 2011, MaineCare will pay a distinct psychiatric unit discharge rate equal to \$6,438.72, except for: (1) Northern Maine Medical Center, for which the distinct psychiatric discharge unit rate will be \$15,679.94, (2) effective July 1, 2013, \$9,128.31 per psychiatric discharge for members under 18 years of age from hospitals in the Lewiston-Auburn area, and (3) effective October 1, 2021, the distinct psychiatric discharge unit rate for Southern Maine Health Care's psychiatric inpatient unit will be \$10,166.00. MaineCare will only reimburse at the distinct unit psychiatric rate when the member has spent the majority of his or her stay in the distinct unit.~~

~~MaineCare will only reimburse for one (1) discharge for a single hospital for one (1) episode of care.~~

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

- ~~C.—~~ **Distinct Substance Use Disorder Unit**

~~Effective April 1, 2013, MaineCare will pay a distinct substance use disorder unit discharge rate equal to \$4,898. MaineCare will only reimburse at the distinct unit substance use disorder rate when the member has spent the majority of his or her stay in the distinct unit. For each patient's separate hospital admission, even if the patient was admitted to the distinct substance use disorder unit and any other unit in the hospital, MaineCare will only reimburse for one (1) discharge.~~

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

B. *Distinct Psychiatric Units and Distinct Substance Use Disorder Units

Effective July 1, 2023, the Department will pay distinct psychiatric unit and distinct substance use disorder (SUD) units as outlined below. This reimbursement methodology shall apply for members whose From Date is on or after July 1, 2023. The methodology shall be as follows:

1. Payment Rate for Distinct Psychiatric Units and Distinct Substance Use Disorder Units

- a. The Department has adopted the Medicare MS-DRG and Length of Stay factors as specified in the distinct psychiatric unit and distinct SUD unit reimbursement schedule which is posted on the Department's website. Per diem base rates were calculated to result in total reimbursement equal to one hundred percent (100%) of the costs of such discharges in the aggregate across all hospitals with distinct psychiatric units and distinct SUD units, utilizing 2022 data, when adjusted for MS-DRG relative weights and Length of Stay factor. The Medicare Length of Stay factor is a cumulative factor that takes into account how many days the patient stays in the distinct unit.
- b. The Department will calculate reimbursement for covered inpatient stays in these distinct units using the following formula:

Per diem base rate (determined by whether the MS-DRG is a psychiatric or SUD MS-DRG) multiplied by the applicable MS-DRG relative weight multiplied by the applicable Length of Stay factor
- c. Per diem base rates for psychiatric MS-DRGs differ for adults aged nineteen (19) and older and youth aged eighteen (18) and younger, reflecting the significant difference in average costs observed in hospitals' 2021 and 2022 cost report data for these populations. The per diem base rate for SUD MS-DRGs will remain consistent regardless of member's age.
- d. Per diem base rates will be updated annually based on the inflation provision in this rule and are posted on the MaineCare Provider Fee Schedule, in accordance with 22 MRSA Section 3173-J.
- e. DRG and outlier methodology as described in the Appendix does not apply to claims from these distinct units.

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

2. Supplemental Payment for Certain Distinct Psychiatric Units

Hospitals that have distinct psychiatric units, are located in zip codes that CMS designates as “super rural,” meaning they are in the bottom quartile of nonmetropolitan zip codes by population density, and also have a designation by the Health Resources and Services Administration (HRSA) as a High Needs Geographic Health Professional Shortage Area (HPSA) for mental health are eligible to receive a yearly supplemental payment in the amount of eight hundred and seventy-five thousand dollars \$875,000. This supplemental payment will be distributed in equal payments in May and November. This supplemental payment is not subject to cost settlement. The supplemental payment will expire on June 30, 2025.

3. Cost Settlement

Claims paid under this methodology do not include graduate medical education costs, and will not be subject to cost settlement, with the exception of capital costs incurred prior to July 1, 2025.

4. Billing Practices

Providers billing for distinct psychiatric units or distinct SUD units should ensure billing practices align with requirements outlined in the MaineCare UB-04 Billing Instructions Guide located on the HealthPAS website.

***The Department shall submit to CMS and anticipates approval for a State Plan Amendment related to these provisions.**

C. Outpatient Services, Including Laboratory and Imaging

1. Private Hospitals

a. APC Payment

Effective July 1, 2013, the Department will reimburse hospitals ~~83.7%~~eighty- three and seven tenths percent (83.7%) of the adjusted Medicare APC rates, where the APC is applicable, unless otherwise specified in this rule.

The APC payment does not include hospital-based physician services. The APC payment may include ancillary services such as imaging and laboratory test costs.

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

APC payments are made when the member receives services in an emergency room, clinic, or other outpatient setting, or if the outpatient is transferred to another hospital or facility that is not affiliated with the initial hospital where the patient received the outpatient services.

If the outpatient is admitted from a hospital's clinic or emergency department, to the same hospital as an inpatient, the hospital shall be paid only a DRG-based discharge rate and will not receive an APC payment.

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

b. Payment Window Rule

This rule institutes billing and payment procedures for outpatient services provided on either the date of a member's inpatient hospital admission or during the three ~~(3)~~(3) calendar days immediately preceding the date of a member's inpatient hospital admission. Hospitals (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a member's inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient non-diagnostic services that are furnished to the member during the ~~three (3)~~three (3) days immediately preceding the date of inpatient hospital admission. Distinct rehabilitation, psychiatric, and substance use disorder units of a hospital are subject to only a ~~one (1-)~~one (1) day payment window (the ~~one (1)~~one (1) calendar day immediately preceding the date of inpatient hospital admission.) An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity.

The technical component of all outpatient diagnostic and clinically related non-diagnostic services that are provided by the hospital, or by an entity wholly owned or wholly operated by the hospital, are to be billed with the claim for inpatient services when the outpatient services are provided in the three (3) calendar days (or ~~one (1)~~one (1) calendar day if applicable) preceding an inpatient admission.

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

All non-clinically related, non-diagnostic services provided before admission are not to be included on the inpatient claim. These outpatient services should be identified with the appropriate condition code. All non-diagnostic services, clinically related or not, provided on the date of inpatient admission are always deemed to be related to the admission and are to be included on the inpatient claim.

MaineCare will reimburse the technical portion of the outpatient services on the inpatient claim.

For physician services provided during the payment window and billed on the CMS 1500, the entity must append the appropriate modifier to all claim lines identified as connected to the inpatient stay. MaineCare will reimburse the professional component with payment rates that include a professional and technical split and at the facility rate for services that do not have a professional and technical split.

It is the responsibility of the admitting hospital to notify wholly-owned or wholly-operated entities of an inpatient admission which may impact the entities eligibility for payment.

The payment window rule does not apply to outpatient services included in the rural health clinic or federally qualified health center all-inclusive rate, nor does it apply to ambulance and maintenance renal dialysis services.

c. **Fee Schedule Payments**

A limited number of Current Procedural Terminology (CPT) codes do not have associated Medicare APC rates, as listed in ~~Addendum B~~ (~~see: Addendum B. MaineCare covers certain services listed in Addendum B and pays for these services based on rates listed on the MaineCare Provider Fee Schedule.~~

~~<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>). MaineCare covers certain services listed in Addendum B and pays for these services based on a fee schedule (see: <https://mainecare.maine.gov/Provider%20Fee%20Schedules/Forms/Publication.aspx>).~~

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

d. **Payment for Non-emergency use of the Emergency Department**

Effective October 1, 2015, hospital payment for an emergency department visit (CPT codes 99281-99285 billed with revenue codes 0450-0459), with a primary diagnosis code included in Appendix B will be paid the outpatient physician's professional evaluation and management service fee schedule rate. This will be determined by using the current physician's payment rate listed in the ~~MaineCare Fee Schedule~~ MaineCare Provider Fee Schedule associated with the emergency department CPT code reported on the UB04 claim. ~~The MaineCare Fee schedule can be found at: <https://mainecare.maine.gov>.~~

2. **Public Hospitals**

a. **APC Payment**

Effective July 1, 2009, the Department's total annual obligation to a hospital for outpatient services equals the lower of ~~83.8%~~ eighty-three and eight tenths percent (83.8%) of MaineCare outpatient costs or charges.

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

Hospitals must use APC billing for all outpatient services. The APC billing does not include hospital-based physician services. The APC billing may include ancillary services such as imaging 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.

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

b. Payment for Non-emergency use of the Emergency Department

Effective October 1, 2015, hospital payment for an emergency department visit (CPT codes 99281-99285 billed with revenue codes 0450-0459), with a primary diagnosis code included in Appendix B will be the outpatient physician's professional evaluation and management service fee schedule rate. This will be determined by using the current physician's payment rate listed in the ~~MaineCare Fee Schedule~~ MaineCare Provider Fee Schedule associated with the emergency department CPT code reported on the UB04 claim. ~~The MaineCare Fee schedule can be found at: <https://mainecare.maine.gov>.~~

3. Hospital Outpatient Provider-Based Departments (PBDs)

Effective November 14, 2017, items and/or services that are furnished by an off-campus hospital outpatient provider-based department (PBDs) will be reimbursed as follows:

*MaineCare requires hospitals to use a PN modifier to identify non-excepted items and services provided by PBDs. These services are paid at a reduced MaineCare rate, proportionate to the reimbursement described in the annual CMS OPPI/ASC final rule. PBDs are required to bill non-excepted items and services on an institution claim (UB04) and report the PN modifier on each claim line for non-excepted items and services. Physicians will be paid the professional claim and will be paid at the facility rate consistent with current policies for physicians practicing in an institutional setting for the technical component of all non-excepted items and services.

The non-excepted items and services PN modifier requirement does not apply to items and services furnished by:

1. A dedicated emergency department;
- ~~2.~~ 2. Remote locations of a hospital (where inpatient services are furnished) and locations that are within two hundred fifty (250) yards of a remote location of a hospital; and
- ~~2.3.~~ 2.3. A location that was billing as an outpatient department of a hospital prior to November 2, 2015 (known as "excepted" locations).

*MaineCare does not require providers to bill using the Centers for Medicare & Medicaid Services (CMS) created HCPCS "PO" modifier for hospital claims for outpatient hospital excepted items and services furnished in an excepted off-campus provider-based (PBD) department of a hospital. Providers must follow guidelines set by the primary insurance carriers.

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

*Relocation of an off campus PBD from the hospital's recorded address of November 1, 2015, will be considered "new" and ineligible for continued excepted status. Any expansion of an excepted PBD (to include new or additional services) will be considered "new" and ineligible for excepted status for those new or additional services.

*** The Department shall submit to CMS and anticipates approval for a State Plan Amendment related to these provisions.**

ED. Capital and Graduate Medical Education Costs

MaineCare will reimburse its share of inpatient capital costs. Effective January 1, 2020, Maine will reimburse one hundred percent (100%) of all graduate medical education costs for both rural and non-rural hospitals.

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.

FE. Hospital-based Physician, Effective January 1, 2020:

MaineCare will reimburse non-rural hospitals

- Ninety-three and three tenths percent (93.3%%) of its share of inpatient hospital-based physician costs,
- Ninety-three and four tenths percent (93.4%%) of its share of outpatient emergency room hospital-based physician costs, and
- ~~83.8%~~ Eighty-three and eight tenths percent (83.8%) of non-emergency room outpatient hospital-based physician costs.

MaineCare will reimburse rural hospitals

- One hundred percent (100%%) of its share of inpatient hospital-based physician costs,
- One hundred percent (100%) of its share of outpatient emergency room hospital-based physician costs, and
- One hundred percent (100%%) 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.

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

45.03-2 Prospective Interim Payment (PIP) for Outpatient Services (Public Hospitals Only)

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

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

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

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

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

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

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

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

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

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

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

 APC payments will not be cost settled.

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

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.

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

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

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

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

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

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

APC payments will not be cost settled.

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.

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

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) + supplemental pool reimbursements (for eligible hospitals) – third party liability payments.

A. **Inpatient Services**

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

B. **Outpatient Services**

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

C. **Supplemental Pool**

The Department will allocate the supplemental pool amount for 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.

Total annual supplemental pool amounts are available on the ~~MaineCare Services website:~~

<https://mainecare.maine.gov/Provider%20Fee%20Schedules/Forms/Publication.aspx> ~~MaineCare Services website~~; or, interested parties may request a paper copy by calling (207) 624-4050 or Maine Relay number 711.

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.

For state fiscal year beginning on or after July 1, 2019, but before July 1, 2021, the hospital's applicable year is the hospital's fiscal year that ended during calendar year 2016.

Each hospital in the pool will receive its relative share of this supplemental payment. Supplemental payments will be distributed semiannually in November and May.

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

D. MaineCare Member Days Awaiting Placement at a Nursing Facility

The Department will reimburse prospectively at the estimated statewide average rate per member day for NF services. The Department will reimburse at the prospective statewide average rates per member day for NF services that are specified in the “Principles of Reimbursement for Nursing Facilities”, *MaineCare Benefits Manual* Chapter III, Section 67. The Department shall compute the average statewide rate per member day based on the simple average of the NF rate per member day for the applicable State fiscal year(s) and prorated for a hospital’s fiscal year.

E. Other Components

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

Effective January 1, 2020, MaineCare’s share of hospital-based physician costs is reimbursed at one hundred percent (100%) of costs.

July 1, 2009, through December 31, 2019, MaineCare will reimburse ninety-three and three tenths percent (93.3%) of its share of inpatient hospital-based physician, ninety-three and four tenths percent (93.4%) of its share of outpatient emergency room hospital-based physician, and eighty-three and eight tenths percent (83.8%) of outpatient non-emergency room hospital-based physician costs.

45.04-2 ***Prospective Interim Payment**

The estimated departmental annual inpatient/outpatient obligation, described above, will be calculated using the most recent MaineCare Supplemental Data Form increased by the rate of inflation to the beginning of 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.

***The Department shall submit to CMS and anticipates approval for a State Plan Amendment. Pending approval, the change will be effective.**

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45.04 ACUTE CARE CRITICAL ACCESS HOSPITALS (cont.)

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.

45.04-4 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

45.06-1 Department's Total Obligation to the Hospital

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

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45.06 **REHABILITATION HOSPITALS** (cont.)

A. **Inpatient Services**

Effective July 10, 2018, the Department will reimburse \$15,161.43 per discharge.

B. **Outpatient Services, including Laboratory and Imaging**

1. **APC Payments**

Effective July 1, 2013, the Department will reimburse rehabilitation hospitals ~~83.7%~~eighty-three and seven tenths percent (83.7%) of the adjusted Medicare APC rate where the APC applies.

The APC payment does not include hospital-based physician services. The APC payment may include ancillary services such as imaging and laboratory test costs. If multiple procedures are performed, the Department will pay the hospital eighty-three and seven tenths percent (83.7%) of Medicare's single bundled APC rate.

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

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

2. **Payment Window Rule**

This rule institutes billing and payment procedures for outpatient services provided on either the date of a member's inpatient hospital admission or during the one (1) calendar day immediately preceding the date of a member's inpatient hospital admission. Hospitals (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a member's inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient non-diagnostic services that are furnished to the member during the one (1) day immediately preceding the date of inpatient hospital admission.

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45.06 **REHABILITATION HOSPITALS** (cont.)

An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the ~~entity's routine~~ operations, regardless of whether the hospital also has policymaking authority over the entity.

The technical component of all outpatient diagnostic and clinically related non-diagnostic services that are provided by the hospital, or by an entity wholly owned or wholly operated by the hospital, are to be billed with the claim for inpatient services when the outpatient services are provided in the one (1) calendar day preceding an inpatient admission.

All non-clinically related, non-diagnostic services provided before admission are not to be included on the inpatient claim. These outpatient services should be identified with the appropriate condition code. All non-diagnostic services, clinically related or not, provided on the date of inpatient admission are always deemed to be related to the admission and are to be included on the inpatient claim.

MaineCare will reimburse the technical portion of the outpatient services on the inpatient claim.

For physician services provided during the payment window and billed on the CMS 1500, the entity must append the appropriate modifier to all claim lines identified as connected to the inpatient stay. MaineCare will reimburse the professional component with payment rates that include a professional and technical split and at the facility rate for services that do not have a professional and technical split.

It is the responsibility of the admitting hospital to notify wholly-owned or wholly-operated entities of an inpatient admission which may impact the entities eligibility for payment.

The payment window rule does not apply to outpatient services included in the rural health clinic or federally qualified health center all-inclusive rate, nor does it apply to ambulance and maintenance renal dialysis services.

3. **Fee Schedule Payments**

A limited number of Current Procedural Terminology (CPT) codes do not have associated Medicare APC rates, as listed in ~~Addendum B~~ (see: Addendum B)

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45.06 **REHABILITATION HOSPITALS** (cont.)

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates>). MaineCare covers certain services listed in Addendum B and pays for these services based on a ~~fee schedule~~ (see: <https://mainecare.maine.gov/Provider%20Fee%20Schedules/Forms/Publication.aspx>) ~~fee schedule~~.

C. Capital and Graduate Medical Education Costs

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

D. Hospital based Physicians

MaineCare will reimburse

- Ninety-three and three tenths percent (93.3%) of its share of inpatient hospital-based physician,
- 83.8% Eighty-three and eight tenths percent (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.

45.06-2 **Interim Cost Settlement**

All calculations will be based on the hospital's As-Filed Medicare Cost Report, MaineCare Supplemental Data Form and MaineCare paid claims history for the year for

which interim settlement is being performed. No cap imposed on a PIP will limit or otherwise affect the determination of settlement amounts.

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

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

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

45.06 REHABILITATION HOSPITALS (cont.)

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

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

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

C. Discharge Rate and APC Based System – SFY ’13 and Forward

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

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

APC payments will not be cost settled

45.06-3 **Final Cost Settlement**

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

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

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

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

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

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

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

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45.06 **REHABILITATION HOSPITALS (cont.)**

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

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

- Capital and medical education costs based on Medicare and GAAP principles
- Payments made for hospital-based physician services APC payments will not be cost settled.

45.07 **Value-Based Purchasing (VBP) Supplemental Sub-pool**

The Value-Based Purchasing (VBP) Supplemental Sub-Pool awards and distributes \$600,000 each year to hospitals that meet the eligibility criteria below. Each awarded hospital will receive ~~its~~ relative share of this supplemental payment, distributed annually in May.

Allocations will not exceed the total VBP Supplemental Sub-Pool amount and will not exceed allowable aggregate upper payment limits.

Hospitals must meet the following criteria to be eligible for the VBP Supplemental Sub-Pool:

- A. The hospital must be an Acute Care Non-Critical Access Hospital, Acute Care Critical Access Hospital, or a Hospital Reclassified to a Wage Area Outside of Maine, and
- B. The hospital must participate in the MaineCare Accountable Communities (AC) Initiative. Participation in the MaineCare AC Initiative is demonstrated by one of the following:

The hospital’s Emergency Department is in an AC contract as a location that contributes to member attribution to the AC;

- The hospital is an official contracted partner of the AC; or
- The hospital is part of the same ownership Employer Identification Number/Taxpayer Identification Number (EIN/TIN) as the AC.

Funds will be distributed based on performance on one or more quality measures. The Department’s ~~website~~ at <https://www.maine.gov/dhhs/oms/providers/value-based-purchasing> lists the current measure(s). Interested parties may request a paper copy of the measures by calling (207) 624-4050 or Maine Relay number 711. The Department will notify hospitals at least one hundred twenty (120) days prior to any changes to the VBP Supplemental Sub-Pool measure(s).

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45.06 **REHABILITATION HOSPITALS** (cont.)

Hospital Service Area (HSA). The Department will utilize Hospital Service Areas (HSAs) in its calculation of the VBP Supplemental Sub-Pool. The HSA methodology is developed by the Dartmouth Institute for Health Policy and Clinical Practice and made publicly available on their website. Maine Health Data Organization (MHDO) makes available HSA assignments for Maine hospitals based on the most recent available crosswalk posted by the Dartmouth Institute. Annually with the VBP Supplemental Sub-Pool assessment, the Department will post the mapping of HSAs by zip code and hospital on <https://www.maine.gov/dhhs/oms/providers/value-based-purchasing-their-website>. Interested parties may request a paper copy by calling (207) 624-4050 or Maine Relay number 711. Each HSA consists of a group of cities and towns that include one or more hospitals where local residents receive most of their hospitalizations.

<i>Performance Rank</i>	<i>Share of Sub-Pool</i>
<i>Top ranked HSA</i>	<i>\$75,000</i>
<i>2nd and 3rd ranked HSA</i>	<i>\$50,000 each (\$100,000 total)</i>
<i>4th through 8th ranked HSA</i>	<i>\$25,000 each (\$125,000 total)</i>
<i>Total:</i>	<i>\$300,000</i>

Measure Example: Primary care utilization among full benefit MaineCare members in each HSA, assessed for a twelve (12-)-month period.

- Numerator: Number of MaineCare Members in the HSA who had one or more primary care visits in a twelve (12-)-month period.
- Denominator: Number of MaineCare Members in the HSA.

The Department first determines which HSAs are eligible to have the hospitals located in the HSA awarded payment from the VBP Supplemental Sub-Pool. The Department will allocate the \$600,000 according to performance rank (\$300,000 divided) and to performance weighted by HSA size (\$300,000 divided). HSA size means the number of MaineCare members in each HSA.

Performance weighted by HSA size:

$$\text{Performance Weighted Portion of Payment} = \text{Member Count} * \text{Per Member Average} * \frac{\text{HSA measure result}}{\text{Top 8 average measure result}}$$

If an awarded HSA contains more than one (1) hospital from different ACs, the amount of funds will be distributed proportionate to the number of AC attributed lives within the HSA associated with each hospitals' corresponding AC.

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45.07 Value-Based Purchasing (VBP) Supplemental Sub-pool (cont.)

If an awarded HSA contains more than one (1) hospital from the same AC, the funds are distributed according to a secondary AC-specific measure. The secondary AC specific measure can be located on: <https://www.maine.gov/dhhs/oms/providers/value-based-purchasing-the-department-s-website>. Interested parties may request a paper copy by calling (207) 624-4050 or Maine Relay number 711.

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

The Department will allocate a supplemental pool for each state fiscal year among the privately owned and operated Acute Care Non-Critical Access hospitals, hospitals reclassified to a wage area outside Maine by the Medicare Geographic Classification Review Board and rehabilitation hospitals. Allocations will not exceed the total supplemental pool amount and not exceed allowable aggregate upper payment limits. Total annual supplemental pool amounts are available on the MaineCare Services website: <https://mainecare.maine.gov/Provider%20Fee%20Schedules/Forms/Publication.aspx>; or, interested parties may request a paper copy by calling (207) 624-4050 or Maine Relay number 711..

45.08-1 Inpatient Pool. Effective November 14, 2019, the allocated inpatient pool amount will be distributed based on each hospital's relative share of inpatient MaineCare payments, defined as the hospital's inpatient MaineCare payment in the applicable hospital fiscal year divided by inpatient MaineCare payments made to all 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 for the same period; multiplied by the supplemental pool. For state fiscal years beginning on or after July 1, 2019, but before July 1, 2021, the hospital's year is the hospital's fiscal year that ended during calendar year 2016.

45.08-2 Outpatient Pool. Effective November 14, 2019, the allocated outpatient pool amount will be distributed based on each hospital's relative share of outpatient MaineCare payments, defined as the hospital's outpatient MaineCare payment in the applicable hospital fiscal year divided by outpatient MaineCare payments made to all 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 for the same period; multiplied by the supplemental pool. For state fiscal year beginning on or after July 1, 2019, but before July 1, 2021, the hospital's applicable year is the hospital's fiscal year that ended during calendar year 2016.

Each hospital in the pool will receive its relative share of this supplemental payment. Supplemental payments will be distributed semiannually 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.

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

This supplemental pool payment is not subject to cost settlement.

45.09 PRIVATE PSYCHIATRIC HOSPITALS

45.09-1 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) – third party liability payments.

A. Inpatient Services

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

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.

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45.09 PRIVATE PSYCHIATRIC HOSPITALS (cont.)

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.

45.09-2 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.

45.09-3 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.

45.09-4 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.

45.10 STATE OWNED PSYCHIATRIC HOSPITALS

State owned psychiatric hospitals will be reimbursed as follows:

45.10-1 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 – third party liability payments. Amounts are calculated as described below:

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45.10 **STATE OWNED PSYCHIATRIC HOSPITALS** (cont.)

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.

45.10-2 **Estimated Claims Payments**

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

45.10-3 **Final Cost Settlement**

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

45.11 OUT-OF-STATE HOSPITALS

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

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

Except as otherwise specifically provided in the agreement between MaineCare and the out-of-state hospital providers, out-of-state hospital providers must accept MaineCare reimbursement for inpatient services as payment in full for all services necessary to address the illness, injury or condition that led to the admission. Reimbursement for out-of-state hospital outpatient laboratory and imaging services shall not exceed the one-hundred percent (100%) of the Medicare reimbursement rate for the Maine area ("99 locality"). Out-of-state hospitals are required to report and are subject to all applicable pricing modifiers.

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.

45.12 CLINICAL LABORATORY AND IMAGING SERVICES

Hospital laboratory, imaging, and physician services provided to a member not currently a patient of the hospital are considered outpatient hospital services. These services are covered in accordance with requirements, and utilization limitations (including prior authorizations) described in the following sections of the *MaineCare Benefits Manual* and are reimbursable in accordance with MBM Chapter II, Section 55, Laboratory Services, Chapter II, Section 90, Physician Services, or Chapter II, Section 101, Medical Imaging Services. Rates for those services are posted on <https://mainecare.maine.gov/>-the Department's website.

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.

45.13 PROVIDER PREVENTABLE CONDITIONS

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

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

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

45.14 DISPROPORTIONATE SHARE (DSH) PAYMENTS

45.14-1 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.

45.14-2 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.

45.14 DISPROPORTIONATE SHARE (DSH) PAYMENTS (cont.)

45.14-3 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 member.

CMS places a limit on the amount of DSH payment that may be made to IMDs (IMD cap). If the Department determines that aggregate payments to IMDs, as calculated above, would exceed the CMS IMD cap, payments will be made to State-owned facilities first. Remaining IMD DSH payments will be allocated among the DSH eligible hospitals based on their relative share of applicable DSH payments absent the federal or state cap.

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

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

The “relative share” is calculated as follows: calculate the fraction, the numerator of which is one hundred percent (100%~~%~~) of actual uncompensated cost of a non-state owned IMD, the denominator of which is the total of one hundred percent (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.

45.14 DISPROPORTIONATE SHARE (DSH) PAYMENTS (cont.)

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.

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
4. 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.

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

For example:

Assume the same three hospitals, X, Y and Z, are all eligible for DSH. Respectively, their utilization rates are six (6-), seven (7) and eight (8) percentage points above the mean MUR plus one (1) standard deviation. The resulting total percentage points above the mean for all hospitals would be twenty-one (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 (1) 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.

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APPENDIX A

DRG-BASED PAYMENT METHODOLOGY

Effective July 1, 2011 (SFY 2012):

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

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

III. **Hospital Specific Base Rate Calculation**

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

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

IV. **DRG Direct Care Rate Calculations**

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

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

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

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

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

APPENDIX A (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 five and five tenths percent (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 two and five tenths percent (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

APPENDIX A (cont.)

- 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 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**

Effective July 1, 2023, 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~~between an acute care unit ~~to~~and a distinct rehabilitation, psychiatric, or substance use disorder unit in the same hospital. For a patient transferred to a distinct rehabilitation unit, 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. For a patient transferred to a distinct psychiatric or substance use disorder unit, the Department will reimburse the hospital one DRG-based discharge rate for the episode of acute care and one Payment Rate for Distinct Psychiatric Units and Distinct Substance Use Disorder Units for the distinct unit episode of care.

* The Department shall submit to CMS and anticipates approval for a State Plan Amendment related to these provisions.

APPENDIX A (cont.)

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%~~eighty percent (80%) of the resulting value.

The outlier threshold is equal to the value that ensures that five percent (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.

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**The following shall apply to non-emergent use of the emergency department
 (see Sec. 45.03-1(D)(1)(c) and 45.03-1(D)(2)(b))**

ICD-10 codes will be used to identify non-emergent use of the emergency department for services delivered beginning October 1, 2015.

ICD-10 Code	ICD-10 Code Description
J02.0	Streptococcal pharyngitis
J03.00	Acute streptococcal tonsillitis, unspecified
J03.01	Acute recurrent streptococcal tonsillitis
B97.10	Unspecified enterovirus as the cause of diseases classified elsewhere
B97.89	Other viral agents as the cause of diseases classified elsewhere
F41.9	Anxiety disorder, unspecified
F41.1	Generalized anxiety disorder
H10.30	Unspecified acute conjunctivitis, unspecified eye
H10.31	Unspecified acute conjunctivitis, right eye
H10.32	Unspecified acute conjunctivitis, left eye
H10.33	Unspecified acute conjunctivitis, bilateral
H10.9	Unspecified conjunctivitis
H60.00	Abscess of external ear, unspecified ear
H60.01	Abscess of right external ear
H60.02	Abscess of left external ear
H60.03	Abscess of external ear, bilateral
H60.10	Cellulitis of external ear, unspecified ear
H60.11	Cellulitis of right external ear
H60.12	Cellulitis of left external ear
H60.13	Cellulitis of external ear, bilateral
H60.311	Diffuse otitis externa, right ear
H60.312	Diffuse otitis externa, left ear
H60.313	Diffuse otitis externa, bilateral
H60.319	Diffuse otitis externa, unspecified ear
H60.321	Hemorrhagic otitis externa, right ear
H60.322	Hemorrhagic otitis externa, left ear
H60.323	Hemorrhagic otitis externa, bilateral
H60.329	Hemorrhagic otitis externa, unspecified ear
H60.391	Other infective otitis externa, right ear
H60.392	Other infective otitis externa, left ear
H60.393	Other infective otitis externa, bilateral

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H60.399	Other infective otitis externa, unspecified ear
H65.00	Acute serous otitis media, unspecified ear
H65.01	Acute serous otitis media, right ear
H65.02	Acute serous otitis media, left ear
H65.03	Acute serous otitis media, bilateral
H65.04	Acute serous otitis media recurrent, right ear
H65.05	Acute serous otitis media recurrent, left ear
H65.06	Acute serous otitis media, recurrent, bilateral
H65.07	Acute serous otitis media, recurrent, unspecified ear
H65.90	Unspecified nonsuppurative otitis media, unspecified ear
H65.91	Unspecified nonsuppurative otitis media, right ear
H65.92	Unspecified nonsuppurative otitis media, left ear
H65.93	Unspecified nonsuppurative otitis media, bilateral
H66.001	Acute suppurative otitis media without spontaneous rupture of the ear drum, right ear
H66.002	Acute suppurative otitis media without spontaneous rupture of the ear drum, left ear
H66.003	Acute suppurative otitis media without spontaneous rupture of the ear drum, bilateral
H66.004	Acute suppurative otitis media without spontaneous rupture of the ear drum, recurrent, right ear
H66.005	Acute suppurative otitis media without spontaneous rupture of the ear drum, recurrent, left ear
H66.006	Acute suppurative otitis media without spontaneous rupture of the ear drum, recurrent, bilateral
H66.007	Acute suppurative otitis media without spontaneous rupture of the ear drum, recurrent, unspecified ear
H66.009	Acute suppurative otitis media without spontaneous rupture of the ear drum, unspecified ear
H66.90	Otitis media, unspecified, unspecified ear
H66.91	Otitis media, unspecified, right ear
H66.92	Otitis media, unspecified, left ear
H66.93	Otitis media, unspecified, bilateral
J01.90	Acute sinusitis, unspecified
J01.91	Acute recurrent sinusitis, unspecified
J02.8	Acute pharyngitis due to other specified organisms
J02.9	Acute pharyngitis, unspecified
J06.9	Acute upper respiratory infection, unspecified
J20.0	Acute bronchitis due to Mycoplasma pneumoniae
J20.1	Acute bronchitis due to Hemophilus influenzae
J20.2	Acute bronchitis due to streptococcus
J20.3	Acute bronchitis due to coxsackievirus
J20.4	Acute bronchitis due to parainfluenza virus
J20.5	Acute bronchitis due to respiratory syncytial virus
J20.6	Acute bronchitis due to rhinovirus
J20.7	Acute bronchitis due to echovirus

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J20.8	Acute bronchitis due to other specified organisms
J20.9	Acute bronchitis, unspecified
J32.9	Chronic sinusitis, unspecified
J40	Bronchitis, not specified as acute or chronic
J45.20	Mild intermittent asthma, uncomplicated
J45.30	Mild persistent asthma, uncomplicated
J45.40	Moderate persistent asthma, uncomplicated
J45.50	Severe persistent asthma, uncomplicated
J45.21	Mild intermittent asthma w/ (acute) exacerbation
J45.31	Mild persistent asthma w/ (acute) exacerbation
J45.41	Moderate persist asthma w/ (acute) exacerbation
J45.51	Severe persist asthma w/ (acute) exacerbation
J45.20	Mild intermittent asthma, uncomplicated
J45.30	Mild persistent asthma, uncomplicated
J45.40	Moderate persistent asthma, uncomplicated
J45.50	Severe persistent asthma, uncomplicated
J45.21	Mild intermittent asthma w/ (acute) exacerbation
J45.31	Mild persistent asthma w/ (acute) exacerbations
J45.41	Moderate persist asthma w/ (acute) exacerbation
J45.51	Severe persist asthma w/ (acute) exacerbation
J44.9	Chronic obstructive pulmonary disease, unspecified
J44.1	Chronic obstructive pulmonary disease w/ (acute) exacerbation
J45.990	Exercise induced bronchospasm
J45.991	Cough variant asthma
J45.909	Unspecified asthma, uncomplicated
J45.998	Other asthma
J45.901	Unspecified asthma with (acute) exacerbation
L22	Diaper dermatitis
L20.0	Besnier's prurigo
L20.81	Atopic neurodermatitis
L20.82	Flexural eczema
L20.84	Intrinsic (allergic) eczema
L20.89	Other atopic dermatitis
L20.9	Atopic dermatitis, unspecified
L23.7	Allergic contact dermatitis due to plants, except food
L24.7	Irritant contact dermatitis due to plants, except food
L25.5	Unspecified contact dermatitis due to plants, except food
L23.9	Allergic contact dermatitis, unspecified cause
L24.9	Irritant contact dermatitis, unspecified cause
L25.9	Unspecified contact dermatitis, unspecified cause

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L30.0	Nummular dermatitis
L30.2	Cutaneous autosensitization
L30.8	Other specified dermatitis
L30.9	Dermatitis, unspecified
M25.512	Pain in left shoulder
M25.519	Pain in unspecified shoulder
M25.521	Pain in right elbow
M25.522	Pain in left elbow
M25.529	Pain in unspecified elbow
M25.531	Pain in right wrist
M25.532	Pain in left wrist
M25.539	Pain in unspecified wrist
M79.643	Pain in unspecified hand
M79.646	Pain in unspecified finger(s)
M25.551	Pain in right hip
M25.552	Pain in left hip
M25.559	Pain in unspecified hip
M25.561	Pain in right knee
M25.562	Pain in left knee
M25.569	Pain in unspecified knee
M25.571	Pain in right ankle and joints of right foot
M25.572	Pain in left ankle and joints of left foot
M25.579	Pain in unspecified ankle and joints of unspecified foot
M54.5	Low back pain
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
M60.80	Other myositis, unspecified site
M60.811	Other myositis, right shoulder
M60.812	Other myositis, left shoulder
M60.819	Other myositis, unspecified shoulder
M60.821	Other myositis, right upper arm
M60.822	Other myositis, left upper arm
M60.829	Other myositis, unspecified upper arm
M60.831	Other myositis, right forearm
M60.832	Other myositis, left forearm

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M60.839	Other myositis, unspecified forearm
M60.841	Other myositis, right hand
M60.842	Other myositis, left hand
M60.849	Other myositis, unspecified hand
M60.851	Other myositis, right thigh
M60.852	Other myositis, left thigh
M60.859	Other myositis, unspecified thigh
M60.861	Other myositis, right lower leg
M60.862	Other myositis, left lower leg
M60.869	Other myositis, unspecified lower leg
M60.871	Other myositis, right ankle and foot
M60.872	Other myositis, left ankle and foot
M60.879	Other myositis, unspecified ankle and foot
M60.88	Other myositis, other site
M60.89	Other myositis, multiple sites
M60.9	Myositis, unspecified
M79.1	Myalgia
M79.7	Fibromyalgia
M79.601	Pain in right arm
M79.602	Pain in left arm
M79.603	Pain in arm, unspecified
M79.604	Pain in right leg
M79.605	Pain in left leg
M79.606	Pain in leg, unspecified
M79.609	Pain in unspecified limb
M79.621	Pain in right upper arm
M79.622	Pain in left upper arm
M79.629	Pain in unspecified upper arm
M79.631	Pain in right forearm
M79.632	Pain in left forearm
M79.639	Pain in unspecified forearm
M79.641	Pain in right hand
M79.642	Pain in left hand
M79.643	Pain in unspecified hand

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M79.644	Pain in right finger(s)
M79.645	Pain in left finger(s)
M79.646	Pain in unspecified finger(s)
M79.651	Pain in right thigh
M79.652	Pain in left thigh
M79.659	Pain in unspecified thigh
M79.661	Pain in right lower leg
M79.662	Pain in left lower leg
M79.669	Pain in unspecified lower leg
M79.671	Pain in right foot
M79.672	Pain in left foot
M79.673	Pain in unspecified foot
M79.674	Pain in right toe(s)
M79.675	Pain in left toe(s)
M79.676	Pain in unspecified toe(s)
G93.3	Postviral fatigue syndrome
R53.0	Neoplastic (malignant) related fatigue
R53.1	Weakness
R53.81	Other malaise
R58.83	Other fatigue
R21	Rash and other nonspecific skin eruption
G44.1	Vascular headache, not elsewhere classified
R51	Headache
R05	Cough