Wisconsin Medicaid Program

Outpatient Hospital State Plan, Attachment 4.19-B
Methods and Standards for Determining Payment Rates

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SECTION 1000 OVERVIEW

This section is an overview of how the Wisconsin Medicaid Program (WMP) establishes payment rates for hospital outpatient care provided to persons eligible for fee-for-service (FFS) coverage under the WMP. The payment is for outpatient medical services provided by a hospital in its inpatient hospital licensed facility, for which the patient does not need to be admitted for an overnight stay, and for which the WMP does not pay another certified WMP provider.

Effective April 1, 2013, all hospitals that qualify for payment under the WMP are reimbursed for outpatient services under the Enhanced Ambulatory Patient Grouping (EAPG) system. No final cost settlement is done for these hospitals, as EAPG payments are considered final and are not subject to cost settlement.

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SECTION 2000 STATUTORY BASIS

The Wisconsin outpatient hospital payment system is designed to promote the objectives of the Wisconsin state statutes regarding payment for hospital services (Chapter 49, Wis. Stats.) and to meet the criteria for Title XIX hospital payment systems contained in the federal Social Security Act and federal regulations (Title 42 CFR, Subpart C). The outpatient payment system shall comply with all current and future applicable federal and state laws and regulations and reflect all adjustments required under said laws and regulations. Federal regulations (42 CFR §447.321) require that the payment system not pay more for outpatient hospital services than hospital providers would receive for comparable services under comparable circumstances under Medicare.

SECTION 3000 DEFINITIONS

Access Payment. To promote WMP member access to acute care, children's, rehabilitation, and critical access hospitals throughout Wisconsin, the WMP provides a hospital access payment amount per eligible outpatient claim. See §4250 for further details.

Acute Care Hospital. A hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition).

Annual Rate Update. The process of annually adjusting hospital payment rates to be effective January 1 of each year based on more current Medicare cost reports.

Border Status Hospital. A hospital not located in Wisconsin, which has been certified by the WMP as a border status hospital to provide hospital services to WMP recipients. Exact criteria for eligibility for border status are provided in §4240 of the Inpatient Hospital State Plan.

Centers for Medicare and Medicaid Services (CMS). The federal agency which regulates the WMP.

CMS Market Basket. The inflation index published by CMS used to estimate hospital inflation during the rate setting process.

Children's Hospital. Acute care hospital that meets the federal definition of a children's hospital (42 CFR 412.23(d)) and whose primary activity is to serve children.

Clinical Diagnostic Laboratory Reimbursement. The lower of the laboratory fee schedule amounts of the WMP and the hospital's laboratory charges for services provided. This payment shall not exceed the Medicare rate on a per-test basis.

Critical Access Hospital (CAH). A hospital that meets both the requirements under 42 CFR Part 485, Subpart F and the following requirements: no more than 25 beds for inpatient acute care and/or swing-bed services; no more than 4 beds for observation services; an annual average inpatient stay of no more than 96 hours; provision of emergency services and availability of registered nurses on a 24-hour-per-day basis; and establishment of a written referral agreement with one or more network hospitals.

Department. The Wisconsin Department of Health Services (or its agent); the state agency responsible for the administration of the WMP.

EAPG Base Rate. The dollar value that is multiplied by the final EAPG weight for each EAPG on a claim to determine the total allowable WMP operating payment for a visit.

Enhanced Ambulatory Patient Grouping (EAPG). A group of outpatient procedures, encounters, or ancillary services, which reflect similar patient characteristics and resource utilization, and which incorporate the use of ICD-9-CM (before October 1, 2015) and ICD-10-CM (after October 1, 2015) diagnosis and Healthcare Common Procedure Coding System (HCPCS) procedure codes.

Fee-for-Service (FFS). A WMP payment methodology in which providers are reimbursed service-by-service for serving WMP members. Most WMP members are either enrolled with Health Maintenance Organizations (HMOs) or have their services reimbursed on a FFS basis.

Final EAPG Weight. The allowed EAPG weight for a given visit as calculated by the EAPG software using the logic in the EAPG definitions manual, including all adjustments applicable to bundling, packaging, and discounting.

Graduate Medical Education (GME). The phase of training that occurs after the completion of medical school in which physicians serve as residents, typically at a teaching hospital, and receive several years of supervised, hands-on training in a particular area of expertise. Hospitals that train residents incur real and significant costs beyond those customarily associated with providing patient care; in recognition of this, the WMP provides various payment adjustments to help defray the direct costs of GME programs.

Healthcare Cost Report Information System (HCRIS). The centralized electronic clearinghouse for Medicare cost reports maintained by CMS.

Inpatient Hospital Licensed Facility. For hospitals located in Wisconsin, that part of the physical entity, as surveyed and licensed by the Department, in which inpatient care is provided. Any emergency department, clinic, or other part of the licensed hospital that is not located on the same premises as the inpatient hospital licensed facility is not part of the inpatient hospital licensed facility, irrespective of whether that off-premises emergency department, clinic, or other part is considered to be part of the hospital under the hospital license or for purposes of Medicare reimbursement. For hospitals not located in Wisconsin, the physical entity that is covered by surveying, licensure, certification, accreditation, or such comparable regulatory activities of the state in which the hospital is located.

Long-Term Care Hospital. A separately licensed hospital that meets the requirements of 42 CFR 412.23(e) and is reimbursed by Medicare under the Medicare prospective payment system for long-term care hospitals.

Measurement Year (MY). The claims experience period used to develop a benchmark for evaluation, as in the Hospital Withhold Pay-for-Performance (HWP4P) program.

Medicaid Deficit. The amount by which the cost of providing outpatient services to WMP recipients exceeds the WMP payment for those services. See §7000 for further details.

Medicaid Management Information System (MMIS). The system used by the WMP to process and document provider claims for payment.

Medicare Cost Report. The CMS 2552 form.

Outpatient Visit. The provision of services by an outpatient department located within an inpatient hospital licensed facility on a given calendar day, regardless of the number of procedures or examinations performed or departments visited, which does not include or lead to an inpatient admission to the facility. Services provided at a facility operated by the University of Wisconsin Hospitals and Clinics Authority need not occur within an inpatient hospital licensed facility to qualify for outpatient status under this definition. Services provided at a facility operated by a free-standing pediatric teaching hospital need not occur within an inpatient hospital licensed facility to qualify for outpatient status under this definition if the facility was added to the hospital's certificate of approval on or after July 1, 2009.

Psychiatric Hospital. A general psychiatric hospital which is not a satellite of an acute care hospital and for which the department has issued a certificate of approval that applies only to the psychiatric hospital. A subcategory of psychiatric hospital is Institution for Mental Disease (IMD), which is defined in 42 CFR 435.1009, though IMDs are only eligible for Medicaid reimbursement under specific circumstances.

Rate Notification Letter. The notification provided to hospitals at the conclusion of the annual rate update informing each hospital of its updated reimbursement rates and how to appeal them if necessary.

Rate Year (RY). The time period from January 1 through December 31 for which prospective outpatient rates are calculated under §4200.

Rehabilitation Hospital. A separately licensed hospital that meets the requirements of 42 CFR 412.23(b) and is reimbursed by Medicare under the Medicare prospective payment system for rehabilitation hospitals. The hospital provides intensive rehabilitative services for conditions such as stroke, brain injury, spinal cord injury, amputation, hip fractures, and multiple traumas to at least 75% of its patient population. IMD hospitals cannot be considered rehabilitation hospitals under the provisions of this plan.

State Fiscal Year (SFY). July 1 – June 30. For example, SFY 2014 is defined as July 1, 2013 – June 30, 2014.

Upper Payment Limit (UPL). The maximum amount the WMP may reimburse a hospital for services provided to WMP members. This is formally specified in 42 CFR 447.321.

Wisconsin CheckPoint. A centralized electronic clearinghouse for quality data for Wisconsin hospitals, maintained by the Wisconsin Hospital Association, available at www.wicheckpoint.org.

Wisconsin ForwardHealth Portal. A website administered by the WMP listed at www.forwardhealth.wi.gov.

Wisconsin Medicaid Program (WMP). The State of Wisconsin's implementation of Medical Assistance as per Title XIX of the federal Social Security Act.

SECTION 4000 REIMBURSEMENT OF OUTPATIENT SERVICES OF IN-STATE HOSPITAL PROVIDERS

4100 Introduction

This section describes the methodology for reimbursing all acute care, psychiatric, rehabilitation, long-term care, and critical access hospitals located in the State of Wisconsin for outpatient hospital services provided in outpatient departments of inpatient hospital licensed facilities to persons eligible for FFS medical coverage by the WMP. The EAPG system, described in §4200 through §4240, is used to classify and calculate reimbursement for outpatient visits. EAPGs categorize the amount and type of resources used in various outpatient visits. The WMP base rates and EAPG weights have been updated as of January 1 of the current rate year, effective for services provided on or after that date.

4200 EAPG Reimbursement Methodology

4210 EAPG Weights. EAPG relative weights effective January 1 of the current rate year are based on 3M's EAPG national weights, scaled to result in the same modeled aggregate case mix as the EAPG weights in the prior rate year. EAPG national weights are published by 3M for each EAPG grouper version, and are calculated based on the average cost per visit using national Medicare Provider and Analysis Review (MEDPAR) data. DHS adjusts the national weight for each EAPG by a single statewide factor such that the aggregate modeled EAPG case mix for the rate year is equal to the aggregate modeled case mix under the EAPG weights used in the prior rate year. The EAPG grouper version and associated weights are updated annually, and are effective January 1 of the current rate year. EAPG relative weights can be found on the Wisconsin ForwardHealth Portal here: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/SW/StaticContent/Provider/medicaid/hospital/drg/drg.htm.spage#

4211 Calculating EAPG Base Rates for Critical Access Hospitals (CAHs). CAHs each have a provider-specific EAPG base rate calculated by estimating the outpatient WMP claim costs using Medicare cost report data, inflating costs to the new rate year, and dividing by the total hospital final EAPG weights. The calculation results in a prospective, provider-specific EAPG base rate at 100 percent of Medicaid cost for EAPG qualifying services. The CAH EAPG base rates are effective January 1 of the current rate year and can be found on the Wisconsin ForwardHealth Portal here: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/SW/StaticContent/Provider/medicaid/hospital/drg/drg.htm.spage#.

4212 Calculating EAPG Base Rates for Psychiatric Hospitals. Psychiatric hospitals each have a provider-specific EAPG base rate calculated by estimating the outpatient WMP claim costs using Medicare cost report data, inflating costs to the new rate year, and dividing by the total hospital final EAPG weights. Final hospital-specific base rates are subject to a budget reduction factor of 85.08 percent to ensure compliance with the Department's annual budget. The psychiatric hospital EAPG base rates are effective January 1 of the current rate year and can be found on the Wisconsin ForwardHealth Portal here: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/SW/StaticContent/Provider/medicaid/hospital/drg/drg.htm.spage#.

4213 Calculating EAPG Base Rates for Hospitals that are not CAHs nor Psychiatric Hospitals. Hospitals that do not qualify as Critical Access Hospitals or as Psychiatric Hospitals use a statewide EAPG base rate that is calculated by inflating the statewide EAPG base rate from the prior rate year to the new rate year. Qualifying hospital EAPG base rates also include a Direct Graduate Medical Education (GME) add on, as described in section 4221.The EAPG base rates are effective January 1 of the current rate year and can be found on the Wisconsin ForwardHealth Portal here: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/SW/StaticContent/Provider/medicaid/hospital/drg/drg.htm.spage#.

4214 Use of Cost Reports in Rate Setting. The WMP uses the Medicare cost report to establish certain components of an in-state hospital's specific payment for direct graduate medical education. Cost reports are

also used to establish critical access hospitals' estimated costs. The Department obtains Medicare cost reports through the Healthcare Cost Report Information System (HCRIS) maintained by the Centers for Medicare and Medicaid Services (CMS).

4215 Selection of Cost Reporting Period. The Department uses the most recently submitted 12-month Medicare cost report available in HCRIS as of the March 31 prior to the start of the RY. For example, rates effective January 1, 2015 (i.e. RY '15) would use the most recently submitted 12-month Medicare cost report available in HCRIS as of March 31, 2014. If the most recently submitted 12-month Medicare cost report available is a "no utilization" cost report, the Department may request an alternate 12-month cost report from the hospital.

4216 Cost Reports for Recent Hospital Combinings. A "hospital combining" is the result of two or more hospitals combining into one operation, under one WMP provider certification, either through merger or consolidation, or a hospital absorbing a major portion of the operation of another hospital through purchase, lease, or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. For combining hospitals, the Department will perform calculations based upon the most recently submitted 12-month Medicare cost reports of the combining hospitals prior to the combining.

4217 Changes of Ownership. Payment rates will not change solely as a result of a change of ownership. At the time of ownership change, the new owner will be assigned the hospital-specific EAPG base rate of the prior owner. Subsequent changes to the hospital-specific EAPG base rate for the new owner will be determined as if no change in ownership had occurred; that is, the prior owner's Medicare cost reports will be used until the new owner's Medicare cost reports come due for use in the annual rate update.

4218 Rates for New Hospitals. The start-up period for new acute care and children's hospitals begins the date the hospital admits its first WMP recipient and ends when a 12-month Medicare cost report is available in the HCRIS to the Department at time of rate calculation. New acute care and children's hospitals are paid prospectively the statewide EAPG base rate effective for the rate year, without retrospective settlement. The start-up period for new psychiatric, rehabilitation, or long-term care hospitals begins the date the hospital admits its first WMP recipient and ends when a Medicare cost report with at least a six-month reporting period is available in the HCRIS to the Department at time of rate calculation. New psychiatric hospitals during a start-up period will be paid the highest rate paid to other psychiatric hospitals within the last 12 months, not including rates paid to new psychiatric hospitals. The start-up rate being paid to a new psychiatric hospital will be paid on an interim basis. The Department will also conduct a reimbursement settlement for new psychiatric hospitals for the start- up period following the interim reconciliation methodology described in steps 1-5 of §7125 below (unless the hospital already qualifies for an outpatient Medicaid deficit funding settlement), with the exception that a budget reduction factor of 85.08 percent is applied to the cost settlement target, no inflation is applied, and the costs are not considered a certified public expenditure. If the startup period for a new psychiatric hospital includes a period not covered by the Medicare cost report submitted to CMS, the hospital will submit cost report data covering that period directly to the Department with sufficient detail to calculate the reimbursement settlement. For psychiatric, rehabilitation, and long-term care hospitals not in the startup period and without sufficient claims to establish a provider rate, hospitals will be paid the statewide median rate for the provider type.

4221 Direct Graduate Medical Education Add-On. For in-state, non-CAH providers that have a GME program, the Department adds an amount to a hospital's specific EAPG base rate for costs directly associated to the program. The Department determines the direct GME add-on to the EAPG base rate from a hospital's Medicare cost report. The Department performs the calculation as follows:

1. The Department determines the direct GME costs attributable to WMP outpatient services by multiplying the projected outpatient costs attributable to WMP recipients by the ratio of total allowed direct GME costs to total allowed hospital costs. The total allowed direct GME costs are taken from Worksheet B Part I, Line 118, Columns 21 and 22 for the CMS 2552-10. The total allowed hospital costs are taken from Worksheet B Part I, Line 118, Column 26 for the CMS 2552-10.
2. The Department divides the resulting amount by the total hospital-specific final EAPG weights for the current RY to form the direct GME add-on for that hospital.

4230 Calculating Final EAPG Payment. Each line of an outpatient hospital claim is assigned to an EAPG and therefore has a distinct weight. These weights are multiplied by the hospital's specific EAPG base rate. The total reimbursement for an outpatient hospital claim is the sum of these multiplications, with the following exceptions:

- Clinical Diagnostic Laboratory Services are paid on a fee schedule basis.

4240 Exclusions from the EAPG Reimbursement System. The following services are not included within the EAPG reimbursement system:

- Therapy Services
- Clinical Diagnostic Laboratory Services
- Durable Medical Equipment (DME)
- Provider-Based End Stage Renal Disease (ESRD) Services

4250 Outpatient Access Payment. To promote WMP member access to acute care, children's, rehabilitation, and critical access hospitals throughout Wisconsin, the WMP provides a hospital access payment amount per eligible outpatient FFS claim. Access payments are intended to reimburse hospital providers based on WMP volume. Therefore, the payment amounts per claim are not differentiated by hospital based on acuity or individual hospital cost. However, critical access hospitals receive a different access payment per claim than do acute care, children's, and rehabilitation hospitals.

The amount of the hospital access payment per claim is based on an available funding pool appropriated in the state budget and aggregate hospital UPLs. This amount of funding is divided by the estimated number of paid outpatient FFS claims for the SFY to develop the per claim access payment rate.

The access payment per claim amounts are effective for dates of service on or after July 1, 2018 and are identified on the hospital reimbursement rate web page of the Wisconsin ForwardHealth Portal here: https://www.forwardhealth.wi.gov/wiportal/content/provider/medicaid/hospital/resources_01.htm.spage. This payment per claim is in addition to the EAPG base payment described in §4230. Access payments per claim are only provided until the FFS access payment funding pool amount has been expended for the SFY.

Access payments are subject to the same federal UPL standards as base rate payments, described in 42 CFR §447.321. Access payment amounts are not interim payments and are not subject to settlement. Psychiatric hospitals are not eligible for access payments because of the unique rate setting methods used to establish rates for those hospitals.

4260 Outpatient Dental Add-on Payment. The Department provides an outpatient per visit add-on of $700 (in addition to the EAPG payment) for outpatient dental services where deep sedation is provided. Claims qualifying for the add-on payment will be acute hospital claims billing procedure code 41899 with modifier U2 to indicate sedation.

SECTION 5000 REIMBURSEMENT FOR OUTPATIENT SERVICES PROVIDED OUT-OF-STATE

Outpatient hospital services provided at all out-of-state hospitals, including border status hospitals, are paid using EAPGs. The EAPG weights applied to out-of-state outpatient hospital claims are the same weights used for in-state hospitals. The EAPG base rate for out-of-state hospitals is the statewide EAPG base rate for non-CAH hospitals, as outlined in §4200. Payment for outpatient services provided by out-of-state hospitals without border status is limited to emergency services and services prior authorized by the WMP.

SECTION 6000 ADMINISTRATIVE ADJUSTMENT ACTIONS FOR IN-STATE HOSPITALS

6100 Introduction

The Department provides an administrative adjustment procedure through which an in-state hospital may receive prompt administrative review of its outpatient reimbursement. Department staff will review a request for an adjustment and determine if it should be denied or approved; if a request is approved, Department staff will determine the amount of adjustment.

An in-state hospital may appeal its outpatient reimbursement for one of the reasons listed in §6200 within 60 days of the date of its rate notification. If the appeal results in a new rate determination, the rate will apply to all claims with dates of service in the RY.

If, at any time during the RY, the Department identifies a rate calculation error (that is, qualifications (a) through (c) below), it may, at its own discretion, recalculate a hospital rate and apply the new rate to all claims with dates of service in the RY.

6200 Criteria for Administrative Adjustment

Allowable reasons for an outpatient payment rate appeal include:

(a) a clerical error in calculating the hospital's outpatient payment rate; or
(b) incorrect or incomplete application by the Department of provisions of the reimbursement methodology or standards in determining one or more components of the hospital's outpatient payment rate or in determining any administrative adjustment of a hospital's outpatient payment rate; or
(c) the most recently submitted 12-month Medicare cost report used as outlined in §4214 is incorrect per the HCRIS report record number.

SECTION 7000 FUNDING OF OUTPATIENT MEDICAID DEFICIT

7100 General Introduction

A hospital in Wisconsin can receive additional reimbursement from the WMP for costs it incurred for providing outpatient hospital services to WMP recipients if provisions of this section are met. This is referred to as Medicaid deficit reduction funding and is an adjustment to prior year costs as defined in 45 CFR §95.4. The reimbursement as described below is available beginning September 1, 2013 and is determined based on a hospital's Medicare cost report for its completed fiscal year.

7110 Qualifying Criteria.
A hospital can qualify for Medicaid deficit reduction funding if:
(a) it is an acute care hospital operated by the State or a local government in Wisconsin or is a non-state public psychiatric hospital located in Wisconsin; and
(b) it incurred a deficit from providing WMP outpatient services (described in §7120 below).

7120 Deficit from Providing WMP Outpatient Services.
The deficit from providing outpatient services to WMP recipients (that is, the Medicaid deficit) is the amount by which the cost, reduced for excess laboratory cost, of providing the services exceeds the WMP payment for those services. The cost of providing the WMP outpatient services is identified from the hospital's audited Medicare cost report for the hospital's fiscal year under consideration for the Medicaid deficit reduction.

Payment refers to the total of the reimbursement provided for outpatient services under the provisions of §4000 and §8000 of this Attachment 4.19B of the State Plan for the respective hospital fiscal year. Excess laboratory cost is the amount by which the costs of laboratory procedures exceed the clinical diagnostic laboratory reimbursement for those procedures.

7125 Interim Payment, Interim Reconciliation, and the Final Reconciliation

The Department identifies the total amount of uncompensated WMP FFS outpatient hospital costs as described in §7120 to determine interim payments under this section until finalized hospital Medicare cost reports are available. For the hospital fiscal year, the Department determines cost-to-charge ratios for routine (hospital-based clinic services) and ancillary cost centers using the hospital's most recently filed Medicare cost report as available on HCRIS. The process for the interim payment calculation is as follows:

Step 1
The Department identifies total hospital costs from Worksheet C, Column 1, Lines 50-76 and Lines 90-92 for the CMS 2552-10 (Worksheet C, Column 1, Lines 37 through 62 for the CMS 2552-96). The Department uses these costs to determine the outpatient cost-to-charge ratios.

Step 2
The Department identifies the hospital's total charges by cost center from Worksheet C Part I, Columns 6 and 7 for both the CMS 2552-10 and CMS 2552-96.

Step 3
For each outpatient routine and ancillary cost center, the Department calculates the cost-to-charge ratio by dividing the total hospital costs identified in Step 1 by the total hospital charges identified in Step 2.

The Department uses the cost-to-charge ratios determined through the above process (steps 1-3) to determine the hospital's outpatient costs for the hospital fiscal year. These costs for WMP FFS are determined as follows:

Step 4
To determine outpatient WMP costs for the hospital fiscal year, the Department aggregates the hospital's WMP FFS outpatient charges by cost center. These charges are obtained from MMIS. To project WMP cost, the Department inflates the WMP charges from MMIS by the CMS Market Basket for hospitals. The Department then multiplies the projected charges by the cost-to-charge ratios from Step 3 for each respective routine and ancillary cost center to determine the WMP FFS outpatient costs for each cost center.

Step 5
The WMP FFS cost eligible to be reimbursed via certified public expenditure (the Medicaid deficit) is the difference between the WMP FFS outpatient payments as recorded in MMIS and the WMP FFS outpatient costs from Step 4.

Final Reconciliation
Once the Medicare cost report for the hospital fiscal year has been finalized and audited, the Department conducts a reconciliation of the finalized amounts. This settlement is completed no more than one year after the Medicare cost report has been audited. The Department uses the same method as described above for the interim reconciliation for the final reconciliation, except that the finalized amounts are substituted as appropriate.

7130 Limitations on the Amount of Deficit Reduction Funding.

The combined total of (a) the Medicaid deficit reduction funding and (b) all other payments to the hospital for outpatient WMP services shall not exceed the hospital's total charges for the services for the hospital fiscal year. If necessary, the Medicaid deficit reduction funding shall be adjusted so the combined total payments do not exceed charges.

The aggregate Medicaid deficit reduction funding provided to hospitals under this section shall not exceed the amount for which federal matching dollars are available under federal UPLs at 42 CFR §447.321.

SECTION 8000 SUPPLEMENTAL FUNDING FOR ADULT LEVEL ONE TRAUMA CENTERS

For services provided on or after July 1, 2012, the WMP provides annual statewide funding of $4,000,000 per SFY to hospitals with an Adult Level One Trauma Center, as designated by the American College of Surgeons. The WMP makes this payment to hospitals with an Adult Level One Trauma Center to assist with the high costs associated with operating a center with this designation. The WMP distributes the funds proportionately among qualifying hospitals based on the number of eligible hospitals as described below.

The WMP pays the trauma outpatient supplement monthly. A qualifying hospital's outpatient supplement is determined as follows:

$$\text{Hospital's annual trauma supplement} = \frac{\text{Qualifying Trauma Hospital}}{\text{Total Number of Hospitals Qualifying as Trauma Hospital}} \times \text{\$4,000,000 Statewide Annual Funding}$$

SECTION 9000 PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

Payment Adjustment for Provider Preventable Conditions

The Department meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The Department identifies the following Health Care-Acquired Conditions for non-payment under Attachment 4.19-A:

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

Other Provider-Preventable Conditions

The Department identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-B.

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

_____ Additional Other Provider-Preventable Conditions identified below.

In compliance with 42 CFR 447.26 (c), the Department provides:

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