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 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 Medicaid provider.

Effective April 1, 2013, all hospitals that qualify for payment under 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.

Under §5700, a prospective outpatient payment is provided for approved respiratory nursing care for part of a day on the site of an acute care general hospital. Payment for this service is separate from and not covered by the final cost settlements for services prior to April 1, 2013.

SECTION 2000 STATUTORY BASIS

The outpatient reimbursement shall comply with all current and future applicable Federal and State laws and regulations and shall reflect all adjustments allowed under said laws and regulations. Federal regulations (42 CFR §447.321) require the Medicaid agency not pay more for outpatient hospital services than hospital providers would receive for comparable services under comparable circumstances under Medicare.

SECTION 3000 GENERAL ITEMS

Inpatient Hospital Licensed Facility. An inpatient *hospital licensed facility* is that part of the physical entity, surveyed and licensed by the Wisconsin Department of Health and Social Services under Chapter 150, Wis. Stats., 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 for purposes of reimbursement under the Outpatient Hospital State Plan, 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, a hospital facility is 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.

Hospital Licensure of Provider Premise. Only medically necessary covered services provided within the inpatient *hospital licensed facility (even if the facility is considered to be part of the hospital under the hospital license or for purposes of Medicare reimbursement)* are eligible for reimbursement under outpatient hospital payment rates described in this document entitled "Methods and Standards for Determining Outpatient Hospital Payment Rates". This means a hospital cannot bill as outpatient hospital services those services provided off the physical premise of the licensed hospital facility or in an unlicensed portion of the hospital facility.

Outpatient Visit. Unless otherwise specified in 49.45(3)(e)10m and 49.45(3)(e)1Or of state statutes, an admission to an outpatient department of an inpatient hospital licensed facility on a given calendar day, regardless of the number of procedures or examinations performed or departments visited.

Cost Reporting. To establish cost for outpatient rate setting, DHS will utilize the most recently available audited cost report (as of the March 31 date that occurs before the rate year) in the Healthcare Cost Report Information System (HCRIS) maintained by the federal Center for Medicare and Medicaid Services (CMS). If the most recently audited cost report available in HCRIS is greater than five years old from the prior fiscal year, the Department may use an unaudited Medicare cost report. However, if an unaudited cost report is utilized, the Department will recalculate the outpatient rate once the unaudited cost report is audited to determine the final rate.

Clinical Diagnostic Laboratory Reimbursement. The lower of laboratory fee schedule amounts of the Wisconsin Medicaid program or the hospital's laboratory charges for services provided. This payment will not exceed the Medicare rate on a per test basis.

State Fiscal Year. The State Fiscal Year (SFY) is defined as July 1 – June 30.

Upcoming Rate Year. The upcoming rate year is the time period beginning April 1, 2013 for which prospective outpatient rates are calculated under §4200.

Critical Access Hospital. A critical access hospital (CAH) is a hospital that meets the requirements under 42 CFR Part 485, Subpart F and is designated as a critical access hospital by CMS (HCFA), and the requirements of Wisconsin Administrative Code HFS 124.40 and is designated as a critical access hospital by the Department.

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 diagnosis and Healthcare Common Procedure Coding System (HCPCS) procedure codes.

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

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.

SECTION 4000 REIMBURSEMENT OF OUTPATIENT SERVICES OF IN-STATE HOSPITAL PROVIDERS FOR OUTPATIENT VISITS ON AND AFTER APRIL 1, 2013

4100 Introduction

This section describes the methodology for reimbursing all acute, psychiatric, rehabilitation, 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 fee-for-service medical coverage by the Wisconsin Medicaid program (WMP). The Enhanced Ambulatory Patient Grouping (EAPG) System, described in §4200 through §4240, will be used to classify and calculate reimbursement for outpatient visits occurring on and after April 1, 2013. The Enhanced Ambulatory Patient Groups used in the EAPG System categorize the amount and type of resources used in various outpatient visits.

4200 EAPG Reimbursement Methodology

4210 Establishing Wisconsin-Specific EAPG Weights. The initial EAPG relative weight calculations were completed using line level charges from SFY2011 and SFY2012 Wisconsin Medicaid outpatient hospital adjudicated claims, paid through MMIS, converted to cost using the ratio of cost to charges methodology. The State calculated hospital-specific, cost-center specific cost to charge ratios using the most recently audited 2552 Medicare Cost Reports. The cost to charge ratios were crosswalked to the SFY 2011 and SFY 2012 claims data using line level revenue codes, and multiplied by the line level charges.

The line level costs were normalized across providers and time periods to determine the average cost of each EAPG by adjusting the cost to charge ratios as follows:

- Wage: Adjusted the wage portion of costs using the published wage index from CMS;
- Capital: Adjusted costs to account for only 95% of capital costs;
- Medical Education: Adjusted costs to remove medical education costs; and
- Global Insight: Inflated costs from the time period associated with the most recently audited cost report for each hospital to the midyear of SFY 2012.

The EAPG weight is calculated by dividing the cost of an individual EAPG over the average cost of all EAPGs. For EAPGs that lacked sufficient volume (less than 30 occurrences of an EAPG), the EAPG will default to the National Weight for the specific EAPG (as calculated by 3M). The current EAPG weights can found on the Wisconsin Forward Health portal (www.forwardhealth.wi.gov).

The EAPG relative weights shall be updated at least annually based on the three most recent complete state fiscal years of Wisconsin Medicaid hospital claims data.

4220 Calculating EAPG Base Rates. CAHs will each have a provider-specific base rate calculated by dividing the Outpatient Medicaid costs from the last audited Medicare cost report and dividing by the total hospital adjusted weights. All other hospitals will use a statewide base rate that is calculated by taking the DHS Outpatient Budget less CAH payments and dividing this amount by the total adjusted EAPG weights for all other hospitals. The current EAPG base rates can found on the Wisconsin Forward Health portal (www.forwardhealth.wi.gov).

4230 Calculating Final EAPG Payment. Each line of an outpatient hospital claim will be assigned to an EAPG and therefore assigned a distinct weight. The calculated hospital base rate will then be multiplied by the weight of each EAPG on a given outpatient hospital claim. The total reimbursement for an outpatient hospital claim is the sum of all claim lines, with the following exceptions:

- Clinical Diagnostic Laboratory Services will be paid on a Fee Schedule.

4240 Exclusions from the EAPG Reimbursement System. The following services are not included under 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, WMP will provide a hospital access payment amount per eligible outpatient 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 upper payment limits (UPL). This amount of funding is divided by the estimated number of paid outpatient claims for the state fiscal year to develop the per claim access payment rate.

For state fiscal year 2014, the access payment funding pool amount for outpatient acute care, children's, and rehabilitation hospitals is $116,965,165, resulting in an access payment amount of $311 per claim; the access payment funding pool amount for outpatient critical access hospitals is $2,554,351, resulting in an access payment amount of $30 per claim. These access payment per claim amounts are identified on the hospital reimbursement rate web page of the Wisconsin Forward Health website at www.forwardhealth.wi.gov. This payment per claim will be in addition to the EAPG base payment described in §4230. Access payments per claim are only provided until the fee-for-service hospital access payment budget has been expended for the state fiscal year.

Access payments are subject to the same federal upper payment limit standards as base rate payments. 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.

4300 Performance-Based Payments

The Department has a Hospital Withhold Pay-for-Performance (HWP4P) program that provides for payments for acute care, children's, critical access, and psychiatric hospital services. Long term care, rehabilitation, and out of state hospitals are exempt from the HWP4P program.

The HWP4P program is administered on a measurement year (MY) basis. The chart below shows the start and end dates for the first two MYs, which did not occupy a full 12 months.

MY 2013	**Start:** July 1, 2012	**End:** March 31, 2013
MY 2014	**Start:** May 15, 2013	**End:** March 31, 2014

Subsequent MYs will be on a 12 month cycle, from April 1 through March 31 of the next calendar year.

For each MY, the Department will pay claims for services at the rate of 98.5% of the fee schedule in effect at the beginning of the MY. The HWP4P pool will be calculated as an amount equal to 1.5% of the fee schedule amounts in effect at the beginning of the MY for those same claims.

The calculation of the pool amount does not apply to hospital supplemental payment amounts made to eligible providers, including access payments.

Payments for each MY will be made annually by the December 31 following the conclusion of the MY.

The remainder of this section describes the program's design and requirements for MY 2014. In order to be eligible for HWP4P program payments, hospitals are required to report performance measure data and meet performance-based targets as specified in the Hospital Pay-for-Performance (P4P) Guide (effective May 15, 2013 for MY 2014) available at:
https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Provider/medicaid/hospital/P4P_MY2014_051513.pdf.spage

Hospitals that meet both reporting requirements and performance-based targets, for the measures described below, are eligible to receive payments from the HWP4P pool as follows:

a. The total amount available in the HWP4P pool for hospital services will be calculated as an amount equal to 1.5% of the total claim-based fee-for-service payments, excluding supplemental payments, made during the MY for Medicaid inpatient services to eligible hospitals.

b. HWP4P pool amounts will be individually calculated for each eligible hospital as an amount equal to 1.5% of the total claim-based fee-for-service payments, excluding supplemental payments, made during the MY for Medicaid inpatient services to the eligible hospital. At the end of the MY, the total HWP4P pool amount available for each hospital will be divided by the number of measures applicable to that hospital to determine the value of each measure. (E.g., if the hospital's individual pool equals $100,000 and the hospital qualifies to participate in four measures, each measure would be worth a maximum supplemental payment of $25,000.)

c. If a hospital meets all of its performance targets for all applicable measures, it will receive a supplemental payment equal to the hospital's total HWP4P pool amount for all measures.

d. If a hospital does not meet all of its performance targets, it will earn dollars for those measures where the targets were met in a graduated manner, as specified in the P4P Guide.

e. If all participating hospitals meet all of their individually applicable targets, no HWP4P additional pool funds would be available and no supplemental payments above those described in *5600.a* would be made to any hospital.

f. If any participating hospital does not meet any of its performance targets, the hospital will not receive any additional payment and the pool amount attributable to that hospital for that measure will be aggregated and distributed as an additional bonus payment to other hospitals that meet all of their performance targets.

The Department has designed the additional bonus pool to ensure that all HWP4P pool dollars are paid back to hospitals. Bonus dollars will be shared proportionally among hospitals based on the relative amounts calculated for the HWP4P pool for all hospitals that qualified for the additional bonus. Therefore, hospitals with a larger HWP4P pool calculated amount will receive a larger portion of the additional bonus dollars available. The

University of Wisconsin Medical Center and Critical Access Hospitals are only eligible for payment up to cost for base hospital payments, including the performance-based payments.

The state will notify each eligible hospital, prior to the MY, of the minimum performance requirements to receive the 1.5% HWP4P pool payment. Complete details including technical information regarding specific quality and reporting metrics, performance requirements and HWP4P adjustments are available in the Hospital Pay-for-Performance (P4P) Guide referenced above. The performance measures that are in effect in this SPA on the first day of each MY will be the measures that are used for that MY. Except in cases of emergency rule, providers will receive at least 30-days written notice of any and all changes to the Hospital Pay-for-Performance (P4P) Guide.

The HWP4P pool amount will be distributed prior to the December 31 following the MY to participating hospitals for the following seven measures, as applicable to the hospitals:

1) Thirty-day hospital readmission – Hospitals will be scored on the percent of patients that had a qualifying readmission within 30 days of a qualifying discharge. This measure will be applicable to a hospital that has at least 30 observations during the MY. To qualify for its earn back on this measure, a hospital must improve upon its past performance (since the Department is not using a risk adjustment methodology for this measure, a hospital's score will not be compared to the statewide average). Past performance was calculated using 12 months of data (4/1/11 – 3/31/12).
2) Mental health follow-up visit within 30 days of discharge for mental health inpatient care – Hospitals will be scored on the percent of patients who had a mental health follow-up appointment within 30 days of qualifying mental health discharge. This measure will be applicable to a hospital that has at least 30 observations during the MY. To qualify for its earn back on this measure, a hospital must improve upon its past performance (since the Department is not using a risk adjustment methodology for this measure, a hospital's score will not be compared to the statewide average). Past performance was calculated using 12 months of data (4/1/11 – 3/31/12).
3) Asthma care for children – Hospitals will be scored on the percent of children admitted to a hospital with a qualifying asthma diagnosis that were discharged with a Home Management Plan of Care (HMPC). This measure will be applicable to children's hospitals that have at least 30 observations during the MY. To qualify for its earn back on this measure, a hospital must submit its data to the Joint Commission by the September 30 following the MY and must exceed either the national average or their past performance on this measure.
4) Surgical infection prevention index (SCIP Index) - Hospitals will be scored on the percent of surgical patients that were given all the care they needed to prevent an infection based on selected measures. This measure will be applicable to a hospital that has at least 25 observations during the MY. To qualify for its earn back on this measure, a hospital must submit its data to the Wisconsin CheckPoint (www.checkpoint.org) prior to the September 15 following the MY and must exceed either the state average or its past performance on this measure.
5) Initial antibiotic for community-acquired pneumonia (PN-6) – Hospitals will be scored on the percent of immunoincompetent patients with community-acquired pneumonia that receive an initial antibiotic within 24 hours of admission into the hospital. This measure will be applicable to a hospital that has at least 25 observations during the MY. To qualify for its earn back on this measure, a hospital must submit its data to CheckPoint prior to the September 15 following the MY and must exceed either the state average or its past performance on this measure.
6) Healthcare personnel influenza vaccination – Hospitals will be evaluated based on their performance on the Health Care Personnel Influenza Vaccination measure submitted via the CDC's National Healthcare Safety Network (NHSN) module. To qualify for its earn back on this measure, a hospital must exceed either the national average (as published by NHSN) for the previous flu season (for MY2014 the target for hospitals is 66.9%) or its baseline (calculated using the hospital's performance on the measure during the previous MY). Hospitals must report their healthcare personnel influenza vaccination results to the NHSN module prior to the deadline set by NHSN.
7) Early elective induced deliveries - PC-01 (pay-for-reporting) – Hospitals will be evaluated based on their submission of the early elective induced delivery data to CheckPoint. This measure will be applicable to a hospital that has at least 25 observations during the MY. To qualify for its earn back on this measure, a hospital must submit its data to CheckPoint prior to the September 15 following the MY.

HWP4P payments, including the additional bonus payments, are limited by the federal upper payment limit (UPL) regulations at 42 CFR §447.321. All HWP4P payments, including the additional bonus payments, are included in the UPL calculation for the MY regardless of when payments are actually made.

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

Outpatient hospital services provided at all out-of-state hospitals, including border status hospitals, shall be paid using the EAPG methodology. The EAPG weights applied to out-of-state outpatient hospital claims are the same weights calculated for in-state hospitals. The EAPG base rate for out-of-state hospitals will be the statewide base rate for non-CAH hospitals, as outlined in Section §4200. Payment for outpatient services provided by out-of-state hospitals which are not certified as border status will be limited to emergency services or services prior authorized by the Wisconsin Medical Assistance Program.

SECTION 5700 HOSPITAL OUTPATIENT EXTENDED NURSING SERVICES

Hospital outpatient extended nursing services are nursing services and respiratory care provided by nurses, for part of a day, in a group setting, on the site of an acute care general hospital approved under Wis. Admin. Code ch. HS 124 or in a building physically connected to an acute care general hospital approved under Wis. Adm. Code ch. HS 124. The nursing services must be administered by or under the direct on-site supervision of a registered nurse. All medical care services must be prescribed by a physician.

Prior Authorization. Hospital outpatient extended nursing services must be prior authorized by the WMAP and, if not prior authorized, will not be reimbursed. Only persons who require eight or more hours per day of nursing services as determined by the WMAP may qualify for outpatient extended nursing services. The WMAP will use its criteria for private duty nursing services to determine a person's need for nursing services. The request for prior authorization must describe the expected means by which the participant will regularly be transported between the participant's residence and the hospital.

Reimbursement. Reimbursement for outpatient extended nursing services shall cover all nursing services and shall recognize the additional costs associated with individuals who must remain for observation for extended periods of time. The services will be reimbursed at an hourly rate. The hourly outpatient extended nursing services rate may be billed only for the time during which an outpatient extended nursing services patient is physically present at the hospital and attended by a nurse or a hospital staff person under the direct supervision of a nurse. Any portion of a quarter of an hour of presence at the hospital for outpatient extended nursing services can be charged as a full quarter of an hour.

The payment rate is the lesser of the provider's usual and customary charge per hour or the maximum hourly fee established by the Wisconsin Medicaid program for private duty nursing services provided by a registered nurse (RN) certified for respiratory care. The methods and standards for establishing the maximum fee is described in Item F, Methods and Standards for Establishing Payment Rates for Non-Institutional Care, of Attachment 4.19B of this state plan as amended by Wisconsin State Plan Amendment 96-013, effective April 1, 1996.

No Final Settlement. The reimbursement for outpatient extended nursing services will not be included in the outpatient final settlement.

Cost Reporting. A hospital must separately identify and report in its cost report those direct and indirect costs attributable to the outpatient extended nursing services in order to qualify.

SECTION 6000 ADMINISTRATIVE ADJUSTMENT ACTIONS

For Hospitals in Wisconsin Only

6100 Introduction

The Department provides an administrative adjustment procedure through which an in-state hospital may receive prompt administrative review of its outpatient reimbursement under the circumstances described in §6200. Department staff review a request for an adjustment and determine if it should be denied or approved and, if approved, the amount of adjustment.

6200 Criteria for Administrative Adjustment: Correction of a Rate Calculation Error

The Department provides a mechanism through which a hospital may receive review of its outpatient reimbursement in case of a calculation error. This mechanism is described below:

Qualifying Determination: The interim payment rate or a final settlement must have been inappropriately calculated under the rate setting plan.

(a) The application of the rate setting methodology or standards to incomplete or incorrect data contained in the hospital's cost report or to other incomplete or incorrect data used to determine the hospital's payment rate, or
(b) A clerical error in calculating the hospital's payment rate, or
(c) 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 payment rate schedule or in determining any administrative adjustment of a hospital's payment.

Hospitals may appeal the accuracy of their rate calculation under this section within 60 days of the date of their rate notification letter. If the appeal results in a new rate determination, the rate will apply to all claims with dates of service in the rate year. The Department at its own discretion may recalculate a hospital rate at any time during the rate year if the Department identifies a rate calculation error.

SECTION 7000 FUNDING OF OUTPATIENT MEDICAID DEFICIT

7100 General Introduction

A hospital in Wisconsin can receive additional reimbursement from the Wisconsin Medicaid program for costs it incurred for providing outpatient hospital services to Wisconsin Medicaid recipients if provisions of this section are met. This is referred to as 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 deficit reduction funding if:

(a) it is an acute care general 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 Medicaid outpatient services (described in §7120 below); and

(c) the operator of the hospital certifies that it has expended public funds to cover the deficit.

7120 Deficit from Providing Medicaid Outpatient Services.
The deficit from providing outpatient services to Wisconsin Medicaid recipients (that is, the Medicaid deficit) is the amount by which the cost, reduced for excess laboratory cost, exceeds the payment for the Medicaid outpatient hospital services.

Payment above refers to the total of the reimbursement provided under the provisions of §4000 of this Attachment 4.19B of the State Plan for the respective fiscal year.

Excess laboratory cost is the amount by which the costs of laboratory procedures exceed the clinical diagnostic laboratory reimbursement for those procedures. Clinical diagnostic laboratory reimbursement is the lower of laboratory fee schedule amounts of the Medicaid program or the hospital's charges for the procedures (as defined in §3000).

This section describes the cost of providing outpatient hospital services. For the payment year, the cost to charge ratios for the routine and ancillary cost centers are determined using the hospital's most recently filed Medicare cost report (CMS 2552) as filed with the Medicare fiscal intermediary. Routine outpatient costs refer to hospital based clinic services. The cost to charge ratios are calculated as follows:

Step 1
Total hospital costs will be identified from Worksheet C, Column 1, lines 37 through 62.
These costs represent the total hospital costs for purposes of determining the outpatient cost to charge ratios.

Step 2
The hospital's total charges by cost center are identified from Worksheet C Part I Columns 6 and 7.

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

The cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's outpatient costs for the payment year. The hospital costs for Medicaid FFS for the payment year are determined as follows:

Step 4
To determine outpatient Medicaid costs for the payment year, the hospital's Medicaid FFS outpatient charges are aggregated by cost center. These charges are obtained from the Medicaid Management Information System (MMIS). To project Medicaid cost, the Medicaid charges from MMIS are inflated by the "Health Care Cost Review" index that is published quarterly by the IHS Global Insight Company. The projected charges are multiplied by the cost to charge ratios from Step 3 for each respective routine and ancillary cost center to determine the Medicaid FFS outpatient costs for each cost center.

Step 5
The Medicaid FFS costs eligible as certified public expenditures are determined by adding the Medicaid FFS outpatient costs from Step 4 and subtracting Medicaid FFS outpatient payments received as determined from the Medicaid Management Information System (MMIS). The Medicaid deficit is the difference of Medicaid cost compared to Medicaid payments.

Final Reconciliation
Once the CMS 2552 cost report for the payment year has been finalized and audited by the Medicare fiscal intermediary, a reconciliation of the finalized amounts will be carried out. This settlement will be completed within one year after the Medicare cost report has been audited by the Medicare fiscal intermediary. The same method as described for the interim reconciliation will be used except that the finalized amounts will be substituted as appropriate.

7130 Limitation on the Amount of Deficit Reduction Funding.
The combined total of: (a) the deficit reduction funding, and (b) all other payments to the hospital for outpatient Medicaid services, will not exceed the hospital's total charges for the services for the settlement year. If necessary, the deficit reduction funding will be adjusted so the combined total payments do not exceed charges.

The aggregate deficit reduction funding provided hospitals under this section will not exceed the amount for which FFP that is available under federal upper-payment limits at 42 CFR §447.321.

SECTION 8000 SUPPLEMENTAL FUNDING FOR ADULT LEVEL ONE TRAUMA CENTERS

For services provided on or after July 1st, 2012, the WMP will provide annual statewide funding of $4,000,000 per state fiscal year to hospitals with an Adult Level One Trauma Center, as designated by the American College of Surgeons.

The trauma outpatient supplement is paid as a monthly amount established according to the following method. A total of $4,000,000 is distributed each state fiscal year among hospitals qualifying for this supplement. This is distributed proportionately among qualifying hospitals based on their number of eligible hospitals as described below.

A qualifying hospital's outpatient supplement will be determined as follows:

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

SECTION 9000 PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

Payment Adjustment for Provider Preventable Conditions

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

Health Care-Acquired Conditions

The State 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 State 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 State 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 State 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 Medicaid beneficiaries.