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STATE PLAN FOR MEDICAID PROVIDER REIMBURSEMENT

INPATIENT HOSPITAL

Inpatient hospital services provided by acute care, specialty, and psychiatric hospitals are paid for Medicaid recipients by means of rates determined in accordance with the following principles, methods and standards which comply with [42 CFR 447.250 THROUGH 477.299] 1902(a)(13)(A), 1902(a)(30), and 1923 of the Social Security Act and Federal regulations at 42 CFR 447.250 through .252, .256, .257, .272, .280, and .296 through .299.

I Introduction:

Rate setting principles and methods are contained in Alaska Statutes 47.07.070 - 47.07.900 and administrative regulations in Alaska Administrative Code 7 AAC 43.

For purposes of this section the following definitions apply:

1. Acute Care Hospital – means a facility that provides inpatient hospitalization for medical and surgical care of acute illness or injury and perinatal care.
2. Specialty Hospital – means a rehabilitation hospital that is operated primarily for the purpose of inpatient care assisting in the restoration of persons with physical handicaps.
3. Psychiatric Hospital – means a facility that primarily provides inpatient psychiatric services for the diagnosis and treatment of mental illness; “psychiatric hospital” does not include a residential treatment center.

Data sources used by the Department of Health and Social Services (the Department) are the following:

1. When rebasing occurs, the Medicare Cost Report for the facility’s fiscal year ending 12 months before the beginning of the year that is rebased (base year).

2. Budgeted capital costs, submitted by the facility and reviewed and adjusted by the Department as appropriate in accordance with Section II, for the rate year on capital projects or acquisitions which are placed in service after the base year and before the end of the rate year and for which an approved Certificate of Need has been obtained.
3. Year end reports which contain historical financial and statistical information submitted by facility's for past rate setting years.
4. Utilization and payment history report (commonly known as the MR-0-14) provided by the Division of Health Care Services.

## II Allowable Costs:

Allowable costs are documented costs that are ordinary and necessary in the delivery of a cost effective service. Allowable costs are those which directly relate to Title XIX program recipients. Costs would include those necessary to conform with the state and federal laws, regulations, and quality and safety standards.

Most of the elements of Medicaid allowable costs are defined in Medicare and reported, subject to audit, on the Medicare Cost Report. The following items are possible adjustments from financial statement classifications to Medicaid classifications, and may be reflected either within the Medicare Cost Report or elsewhere in the Medicaid cost finding process.

return on investment is not an allowable cost for any facility.

advertising cost is allowable only to the extent that the advertising is directly related to patient care. The reasonable cost of only the following types of advertising and marketing is allowable:

- o announcing the opening of or change of name of a facility.
- o recruiting for personnel.
- o advertising for the procurement or sale of items.
- o obtaining bids for construction or renovation.
- o advertising for a bond issue.
- o informational listing of the provider in a telephone directory.
- o listing a facility's hours of operation.
- o advertising specifically required as a part of a facility's accreditation process.

Advocacy and lobbying expenses, along with any costs related to these activities, are not allowable.

Costs for facility-initiated court or administrative proceedings are non-allowable except when the facility prevails on the issue and the judgment doesn't include an award of fees and costs. Any allowable costs are limited to expenses incurred in the base year.

- \* physician compensation costs and related charges associated with providing care to patients are not allowable for purposes of calculating a prospective payment rate.
- \* medical services which a facility or unit of a facility is not licensed to provide are not included as an allowable cost.
- \* costs not authorized by a certificate of need when a certificate of need is required are not included as an allowable cost.

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- \* Management fees or home office costs that are not reasonably attributable to the management of the facility. Home office costs may not exceed those reported in the most recently Medicare audited Home Office Cost Report.

Allowable patient-related costs include wages, salaries, and employee benefits, purchased services; supplies; utilities, depreciation, rentals, leases; taxes, excluding local, state, and federal income taxes; and interest expense. Facilities may claim a maximum of 75% of dues, meetings, conference fees, and memberships in trade organizations and associations. A facility must reduce operating costs by the cost of all activities not directly related to health care. Other specific non-allowed costs are bad debts, charity, contractual adjustments, and discounts taken by payers. Base year costs and rate calculations may be adjusted for regulatory changes in allowable costs that become effective after the last adjustment for inflation.

If a certificate of need is required on assets purchased after July 1, 1990, the amount of capital costs included in the rate calculation will be limited to the amounts described within the certificate of need application and other information the facility provided as a basis for approval of the certificate of need. In determining whether capital costs exceed those amounts approved under a certificate of need, the department will consider:

1. the terms of issuance describing the nature and extent of the activities authorized by the certificate; and
2. the facts and assertions presented by the facility within the application and certificate of need review record, including purchase or contract prices, the rate of interest identified or assumed for any borrowed capital, lease costs, donations, developmental costs, staffing and administration costs, and other information the facility provided as a basis for approval of the certificate of need.

## II. Inflation Adjustments

Allowable base year costs are adjusted for inflation. Inflation adjustments may be reduced if a facility fails to timely file their year-end reports with the Department. The department will utilize the most recent quarterly publication of Global Insight's "Health Care Cost Review" available 60 days before the beginning of a facility's fiscal year. For the inflation adjustment relating to allowable non-capital costs, the department will utilize the Global Insight Hospital Market Basket. Allowable capital and allowable home office capital will be adjusted using the Global Insight Health Care Costs, Building Cost Index, CMS New 1997-based PPS Hospital Capital IPI.

For state fiscal year 2020, inflationary adjustments to the non-capital and capital payment rate for facilities not being rebased with a new four-year rate cycle beginning in state fiscal year 2020, will not be applied. Facilities licensed as Critical Access Hospitals will be exempt from this provision.

IV. Determination of Prospective Payment Rates:

The prospective payment rate for inpatient hospital services rendered to Medicaid recipients is a per-day rate reflecting costs related to patient care and attributable to the Medicaid program. Prospective payment rates will be determined under one of three methodologies – Basic, Optional, and New Facilities.

a. Basic Prospective Payment Rate Methodology

The prospective payment rate consists of four components – costs excluding capital for routine cost centers, capital costs for routine cost centers, capital costs for ancillary cost centers, and costs excluding capital for ancillary cost centers. The prospective payment rates will be annual rates based on the facility's fiscal year. Except for facilities electing to be reimbursed under the optional payment rate methodology detailed in Subsection IV-b, re-basing will occur for all facilities no less than every four years.

For state fiscal year 2018, rebasing of prospective payment rates using more current cost data will not occur. For facilities that will be getting their first cost-based rate, the freeze on rebasing in state fiscal year 2018 will not occur. Facilities that currently are receiving exceptional relief and are scheduled to be rebased in state fiscal year 2018 will not be affected by the rebasing freeze in state fiscal year 2018.

The prospective per-day rates for inpatient acute care, specialty, and psychiatric hospitals are computed as follows:

1. Total allowable base year costs excluding capital costs for each routine cost center are divided by the total inpatient days in that cost center and the resulting per-day cost is multiplied by allowable paid Medicaid days in that cost center to arrive at Medicaid allowable base year routine costs for that cost center. The sum of the Medicaid allowable base year costs for all routine cost centers are divided by the sum of the allowable paid Medicaid inpatient days for all routine cost centers resulting in the facility's base year Medicaid specific non-capital routine cost per-day.
2. Total allowable base year capital costs for each routine cost center are divided by the total inpatient days in that cost center and the resulting per-day cost is multiplied by allowable paid Medicaid days in that cost center to arrive at Medicaid allowable base year routine capital costs for that cost center. The sum of the Medicaid

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allowable base year capital costs for all routine cost centers are divided by the sum of the allowable paid Medicaid inpatient days for all routine cost centers resulting in the facility's base year Medicaid specific capital routine cost per-day.

3. The percentage of base year capital costs in each ancillary cost center is applied to the Medicaid ancillary costs for the cost center calculated by first dividing allowable ancillary costs by total inpatient days and applying the resulting per-day costs to paid Medicaid inpatient days. The sum of the Medicaid allowable capital costs for all ancillary cost centers is divided by the sum of the allowable paid Medicaid inpatient days for all ancillary cost centers resulting in the facility's base year Medicaid-specific capital ancillary cost per day.
4. The sum of the Medicaid allowable capital costs for all ancillary cost centers determined in #3 (above) is removed from the total base year Medicaid specific ancillary costs determined by dividing total base year ancillary costs by total inpatient days and applying the resulting amount to the total paid Medicaid inpatient days. The resulting base year allowable ancillary cost is then divided by paid Medicaid inpatient days to arrive at the facility's base year Medicaid specific non-capital ancillary cost per-day.

Each base year component rate is then adjusted for inflation in accordance with Section III and summed to arrive at the facility's prospective payment rate.

The capital components of the prospective payment rate will be adjusted for Certificate of Need assets placed into service if their total value is at least \$5 million. This adjustment will reflect appropriate capital costs for the prospective year based on the certificate of need documentation, assets retired in conjunction with the certificate of need, and Medicare cost reporting requirements.

For purposes of determining prospective payment rates, nursery days constitute inpatient days and swing-bed days do not constitute inpatient days. Costs and charges associated with swing-bed services, determined by applying the swing-bed rate in the base year to the number of swing-bed days, are removed prior to calculating the prospective payment rate. For the routine cost centers, the Medicaid inpatient days are the covered days from payment history reports generated by the Division of Health Care Services (commonly known as the MR-0-14). For the ancillary cost centers, Medicaid inpatient days will be those days reported in either the facility reported Medicaid audited days or covered days from the payment history reports.

Prospective payment rates for facilities that are calculated and paid on a per-day basis as discussed in this section will be no greater than the per-day rates proposed in the certificate of need application and other information provided as a basis for approval of the certificate of need for the first year during which the following are available for use and for two years immediately following the first year:

1. opening of a new or modified health care facility;
2. alteration of bed capacity; or
3. the implementation date of a change in offered categories of health service or bed capacity.

If a facility is granted a certificate of need for additional beds, the additional capital payment add-on to the per-day rate will include the base year's inpatient days plus additional days associated with the additional beds. The additional days are calculated as the base year's occupancy percentage multiplied by 80 percent and then multiplied by the additional beds approved in the certificate of need. The resulting figure is further multiplied by 365.

Except for critical access hospitals, costs are the lower of costs or charges in the aggregate to the general public. For state fiscal year 2018, the payment rate will be 95% of the payment rate in state fiscal year 2017.

For state fiscal year 2020, the payment rate will be 95% of the facility's rate that would have been effective July 1, 2019. Facilities licensed as Critical Access Hospitals will be exempt from this provision and will be reimbursed at 100% of the rate calculated under the provisions of Subsection IVa.

**B. Optional Prospective Payment Rate Methodology and Criteria for Small Facilities**

A facility that had 4,000 or fewer total inpatient hospital days as an acute care, specialty or psychiatric hospital, or as a combined hospital-nursing facility during the facility's fiscal year that ended 12 months before the beginning of its prospective payment rate year during calendar year 2001 may elect to be reimbursed for inpatient hospital services under provisions of this Subsection. If a facility that meets this criterion does not elect to participate during its first fiscal year after December 31, 2000, the facility may not elect to participate under the provisions of this Subsection until after a re-basing occurs under the provisions of Subsection IVa.

If a facility that elected to be reimbursed under the prior Optional Payment Rate Methodology for Small Hospitals for its payment years beginning in calendar year 1998 until the last day of its fiscal year ending during the period of July 1, 2001 through June 30, 2002, does not elect to participate after its agreement expires or does not terminate the agreement for its first fiscal year beginning after December 31, 2000, the facility may not elect to participate under the provisions of this Subsection until after a re-basing occurs under the provisions of Subsection IVa. Its prospective payment rate will be determined pursuant to Subsection IVa until a rebasing has been executed.

A facility electing to be reimbursed under this subsection must have an agreement with the department that will not expire, lapse, or be revoked before four facility fiscal years have lapsed.

The agreement may be renewed after it expires if the facility still qualifies for reimbursement under this subsection. A re-basing of the prospective payment rate for the renewed agreement will occur in accordance with Subsection IV.

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For a facility that was not reimbursed under the Optional Payment Rate Methodology for Small Hospitals prior to its first fiscal year beginning after December 31, 2000, that elects to be reimbursed under this Subsection rather than Subsection IVa, its prospective payment rate will be based on its 1999 established rate or the rate calculated under Subsection IVa at the election of the facility. If the facility elects its 1999 payment rate, its initial year prospective payment rate during calendar year 2001 will be determined as follows:

The prospective payment rate will be expressed as a per-day rate, composed of separate capital and non-capital components.

1. The capital component is calculated by dividing the facility's Medicaid capital per adjusted admission reflected in its 1999 payment rate by the average Medicaid length of stay and adjusted for inflation by 1.1 percent per year for each fiscal year after the first year of election and ends at the expiration of its agreement.
2. The non-capital component is calculated by dividing the facility's allowable Medicaid costs per adjusted admission by the facility's average Medicaid length of stay, and subtracting the capital component from the quotient. The resulting amount is adjusted for inflation at three percent per year for each fiscal year after the first year of election and ends at the expiration of the agreement.

For state fiscal year 2016, 2017, and 2018, the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent.

For state fiscal year 2020, the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent. Facilities licensed as Critical Access Hospitals will be exempt from this provision and will be reimbursed at 100% of the rate calculated under the provisions of Subsection IVa.

For state fiscal year 2020, the payment rate will be 95% of the facility's rate that would have been effective July 1, 2019. Facilities licensed as Critical Access Hospitals will be exempt from this provision and will be reimbursed at 100% of the rate calculated under the provisions of Subsection IVa.

For a facility that was not reimbursed under the Optional Payment Rate Methodology for Small Hospitals prior to its first fiscal year beginning after December 31, 2000, that elects to be reimbursed under this Subsection under the provisions of Subsection IVa, its prospective payment rate for the first year beginning in calendar year 2001 and each year thereafter until the facility's agreement expires will be determined pursuant to Subsection IVa except that the non-capital and capital components of the payment rate will be adjusted annually for inflation, except when the state implements cost containment, after the first year by 3 percent and 1.1 percent respectively. For state fiscal year 2016, 2017, and 2018, the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent.

For state fiscal year 2020, the non-capital and capital components of the payment rate will not be adjusted for inflation by 3 percent or 1.1 percent. Facilities licensed as Critical Access Hospitals will be exempt from this provision and will be reimbursed at 100% of the rate calculated under the provisions of Subsection IVa.

For state fiscal year 2020, the payment rate will be 95% of the facility's rate that would have been effective July 1, 2019. Facilities licensed as Critical Access Hospitals will be exempt from this provision and will be reimbursed at 100% of the rate calculated under the provisions of Subsection IVa.

Increases in the capital component of the prospective payment rate for new assets placed in service during the period covered by the agreement will be allowed based on the provisions in subsection Iva if the following conditions are met:

- 1) The assets placed into service have a value of at least \$5,000,000;
- 2) The facility obtains one or more certificates of need for the assets placed into service; and
- 3) The facility provides a detailed budget before the increase in prospective payment rate that reflects the allowance for the new assets.

The administrative appeals process provided under subsection VIII is not available and the facility will use the "exceptional relief" process pursuant to subsection XII except in the case that the facility disputes an action or decision of the department that relates to the following:

- 1) The facility's eligibility to elect rate setting under the subsection;
- 2) The violation of a term of the rate agreement between the facility and the department;
- 3) The denial of an increase in the capital component of the prospective payment rate for new assets and a related approved certificate of need.

c. New Facility Prospective Payment Rate Methodology

Under this subsection –

A new facility is described as a facility that has not, within the previous 36 months, provided the same or similar level of Medicaid certified patient services within 25 miles of the facility either through present or previous ownership

A new provider means an actively enrolled Medicaid facility that is currently receiving reimbursement for Medicaid services outside of the state prospective payment system and elects to enter the state prospective payment system.

If a new facility, new provider, or a new psychiatric unit in an acute care hospital is licensed, the rates will be calculated as follows:

For acute care and specialty hospitals, or separately licensed or certified psychiatric units in acute care hospitals, the inpatient per-day rate will be established at the statewide weighted average of inpatient per-day rates and of acute and specialty hospitals in accordance with this section for the most recent 12 months of permanent rates. Patient rates are the statewide weighted average using the base year's patient days.

For inpatient psychiatric hospitals or new separately licensed or certified psychiatric units in acute care hospitals, the inpatient prospective payment rate will be established at the statewide weighted average of inpatient per-day rates of psychiatric hospitals for the most recent 12 months of permanent rates; rates are the statewide weighted average using the base year's patient days.

Prospective payment rates for new facilities and new providers will be established under the provisions of section IV after two full years of cost data is reported.

V. (Reserved)

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VI Sale of Facilities:

An appropriate allowance for depreciation, interest on capital indebtedness and (if applicable) return on equity capital for an asset of a facility which has undergone a change of ownership will be valued at the lesser of the allowance acquisition cost of the asset to the owner of record on or after July 18, 1984, or the acquisition cost of the asset to the new owner in accordance with Section 1861(v)(1)(O) of the Act. In addition, the recapture of depreciation expense on disposition of assets that accommodate gains under the Medicaid program will be limited by the provisions of Section 1861(v)(1)(O)(ii) of the Act. Payment for acquisition costs associated with buying and selling of the facility will be limited by the provisions of Section 1861(v)(1)(O)(iii) of the Act.Adjustment to Rates:

VII. Adjustment to Rates

All rates for facilities are set by the department. Facilities have the opportunity to provide additional information on significant changes that would impact the rates.

The department on its own motion or at the request of an applicant may reconsider its actions within 30 days. There is nothing to preclude a facility from petitioning the department at any time during its fiscal year for additional consideration.

Reconsiderations are warranted only in those cases where the proper application of the methods and standards described in Attachment 4.19-A is in question or is being challenged.

VIII Provider Appeals:

If a party feels aggrieved as a result of the department's rate setting decisions, the party may appeal and request reconsideration or an administrative hearing. Administrative hearings are conducted by Governor appointed Hearing Officers. An administrative appeal must be filed within 30 days of the mailing of the decision of the department.

The Hearing Officer would hear a case in accordance with administrative law in the State of Alaska. The Hearing Officer would prepare draft findings, conclusions and order for the commissioner of the department's review. The commissioner of the department would review the findings of the Hearing Officer and may accept, reject, or modify the

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Hearing Officer's recommendations. If a party still feels aggrieved at this point, judicial review is available to contest actions of the department and the rate set.

**IX Audit Function:**

The Department has statutory authority to audit data relating to Medicaid prospective payment rates. Audit findings that would affect the prospective payment rates are adopted by the Department and incorporated into future prospective rate calculations. This means that even though an audit is not completed before a subsequent year has passed and retroactive recoupment from the facility will not take place, the results of the audit will be incorporated into the rate calculations relating to future prospective periods as applicable.

**X Inappropriate Level of Care:**

Payment for hospital patients receiving service at an inappropriate level of care under conditions similar to those described in Section 1861(v)(1)(G) of the Social Security Act will be made at lower rates, reflecting the level of care actually received, in a manner consistent with Section 1861(v)(1)(G). The payment rate will be the average statewide rate for swing bed days. The state uses the same methodology for SNF services and ICF services, and does not differentiate between the different types of services. The swing bed rate is a composite rate weighted by patient days and is a summation of each facility's payment rate for the preceding calendar year multiplied by patient days of each facility and then divided by the total patient days of all SNF/ICF facilities. The swing bed rate is determined and approved by the Department prior to the beginning of the calendar year and is based, where applicable, on estimated data.

The state continues the policy of paying the lower rates to inpatient hospitals when the patient receives care at either the skilled or intermediate level nursing services with no exceptions.

**XI Hospitals Serving A Disproportionate Share of Low Income Patients:**

As required by Section 1902(a)(13)(A) and Section 1923(a)(1) of the Social Security Act, the Medicaid reimbursement system takes into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs by making a payment adjustment for qualifying hospitals. Hospitals serving a disproportionate number of patients with special needs will receive a payment adjustment based on the following criteria and methods:

To be eligible for a disproportionate share payment a hospital must:

- (1) be an acute care hospital, a specialty hospital, or a psychiatric hospital;
- (2) meet the obstetrical staffing requirements of 42 U.S.C. 1396r-4(d), and must provide the names and Medicaid provider numbers of at least two obstetricians who meet the requirements of that section, unless it qualifies for the exception set out in 42 U.S.C. 1396r-4(d)(2); and
- (3) have a minimum Medicaid utilization rate of not less than one percent for the qualifying year.

Disproportionate Share Hospital (DSH) payments are subject to several requirements, including federal allocation of DSH funds, legislative appropriation of DSH funds, facility specific limit on receipt of DSH funds, and other requirements identified in the State Plan. The State intends to make DSH payments to facilities that satisfy such requirements in response to their respective service to low-income patients with special needs. To accomplish this goal, it is understood in this State Plan, that the State intends to adjust DSH payments to ensure that the costs incurred on behalf of Medicaid and uninsured patients are covered to the maximum extent permitted by the State's DSH allotment from the federal government.

- (1) DSH Payment Classifications. An eligible hospital may receive a DSH payment under one or more of the following classifications:

Medicaid Inpatient Utilization Disproportionate Share Hospital;  
Low Income Disproportionate Share Hospital;  
Single Point of Entry Psychiatric Disproportionate Share Hospital;  
Designated Evaluation and Treatment Disproportionate Share Hospital;  
Institution for Mental Disease Disproportionate Share Hospital;  
Children's Medical Care Disproportionate Share Hospital;  
Institutional Community Health Care Disproportionate Share Hospital;  
Rural Hospital Clinic Assistance Disproportionate Share Hospital;  
Mental Health Clinic Assistance Disproportionate Share Hospital;  
Substance Abuse Treatment Provider Disproportionate Share Hospital; and  
Remainder of Government Allocation Disproportionate Share Hospital.

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Mental Health Clinic Assistance and Substance Abuse Treatment Provider DSH are agreements to provide services through freestanding clinics and their costs are not included in the hospital facility specific limit for DSH payments.

(a) Medicaid Inpatient Utilization Disproportionate Share Hospital (MIU DSH)

A hospital eligible for a DSH payment may qualify for a MIU DSH payment adjustment if the hospital has a state Medicaid inpatient utilization rate at least one standard deviation above the mean of state Medicaid inpatient utilization rates for all hospitals in the state; the department will make a pediatric outlier payment adjustment, as necessary, in the manner described under section 2(b), MIU DSH and LI DSH Payments.

The state Medicaid inpatient rate is a fraction, expressed as a percentage, of which the numerator is the hospital's number of Medicaid-eligible inpatient days in this state for the hospital's qualifying year and the denominator is the total number of the hospital's inpatient days including Medicaid managed care days for its qualifying year; and the mean of Medicaid inpatient utilization rates for all hospitals in the state is the fraction, expressed as a percentage, of which the numerator is the total number of Medicaid-eligible inpatient days including Medicaid managed care days for all hospitals in this state for their qualifying year and the denominator is the total number of inpatient days for all hospitals in this state for their qualifying year.

(b) Low Income Disproportionate Share Hospital (LI DSH)

A hospital eligible for a DSH payment may qualify for a LI DSH payment adjustment if the hospital has a low-income utilization rate exceeding 25 percent; the department will make a pediatric outlier payment adjustment, as necessary, in the manner described under section 2(b), MIU DSH and LI DSH Payments.

The low-income utilization rate is calculated as the sum of: a) the fraction, expressed as a percentage, of which the numerator is the sum of the total Medicaid hospital revenue paid to the qualifying hospital for patient services provided to Medicaid-eligible patients including Medicaid managed care patients in this state in the hospital's qualifying year and the amount of cash subsidies received directly from the state or from local governments for patient services provided in this state in the hospital's qualifying year, and the denominator is the total amount of hospital revenue for services, including the amount of cash subsidies specified in this subparagraph for that hospital's qualifying year; and b) the fraction, expressed as a percentage, of which the numerator is the total amount of the qualifying hospital's charges for inpatient hospital services attributable to charity care for the hospital's qualifying year, less the portion of any cash subsidies received directly from the state or from local governments for inpatient hospital services, and the denominator is the total amount of the hospital's charges

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for inpatient services for the hospital's qualifying year; for a state-owned qualifying hospital that does not have a charge structure, the hospital's charges for charity care are equal to the cash subsidies received by the hospital from the state or from local governments.

out-of-state hospitals providing inpatient services to Alaska Medicaid recipients and who have a disproportionate share of Medicaid patients may request to receive a payment adjustment relative to the methods and standards in (1)(a) and (1)(b) above. If an out-of-state hospital does request a DSH adjustment, they must supply all necessary data in order for the State to complete the calculations.

(c) Single Point of Entry Psychiatric Disproportionate Share Hospital (SPEP DSH)

A hospital other than an IMD that is eligible for a DSH payment may qualify for a SPEP DSH payment adjustment if the hospital enters into a SPEP DSH agreement with the department under which it agrees to report the number of SPEP encounters for use in determining the appropriate distribution of SPEP DSH funds among all hospitals that qualify for an SPEP DSH payment.

(d) Designated Evaluation and Treatment Disproportionate Share Hospital (DET DSH)

A hospital other than an IMD that is eligible for a DSH payment may qualify for a DET DSH payment adjustment if is designated as an evaluation and treatment facility as required by department regulations (7 AAC 72) and it enters into an agreement with the department under which it agrees to report the number of DET encounters for use in determining the appropriate distribution of DET DSH funds among all hospitals that qualify for an DET DSH payment.

(e) Institution for Mental Disease Disproportionate Share Hospital (IMD DSH)

A psychiatric hospital eligible for a DSH payment may qualify for a IMD DSH payment adjustment if the hospital is designated to receive involuntary commitments under state law. The total amount of funds available for IMD DSH payments is limited by the appropriation of the legislature and the federal percentage of federal DSH funding allowed for IMD payments.

(f) Children's Medical Care Disproportionate Share Hospital (CMC DSH)

A hospital other than an IMD that is eligible for a DSH payment may qualify for a CMC DSH payment adjustment if it enters into an agreement with the department under which it agrees to report the number of CMC encounters for use in determining the appropriate distribution of CMC DSH funds among all hospitals that qualify for an CMC DSH payment.

(g) Institutional Community Health Care Disproportionate Share Hospital (ICHC DSH)

A hospital other than an IMD that is eligible for a DSH payment may qualify for a ICHC DSH payment adjustment if it enters into an agreement with the department under which it agrees to report the number of ICHC encounters for use in determining the appropriate distribution of ICHC DSH funds among all hospitals that qualify for an ICHC DSH payment.

(h) Rural Hospital Clinic Assistance Disproportionate Share Hospital (RHCA DSH)

A hospital other than an IMD that is eligible for a DSH payment may qualify for a RHCA DSH payment adjustment if it enters into an agreement with the department under which it agrees to report the number of RHCA encounters for use in determining the appropriate distribution of RHCA DSH funds among all hospitals that qualify for an RHCA DSH payment.

(i) Mental Health Clinic Assistance Disproportionate Share Hospital (MHCA DSH)

A hospital other than an IMD that is eligible for a DSH payment may qualify for a MHCA DSH payment adjustment if it enters into an agreement with the department under which it agrees to report the number of MHCA encounters for use in determining the appropriate distribution of MHCA DSH funds among all hospitals that qualify for an MHCA DSH payment.

(J) Substance Abuse Treatment Provider Disproportionate Share Hospital (SATP)

A hospital other than an IMD that is eligible for a DSH payment may qualify for a SATP DSH payment adjustment if it enters into an agreement with the department under which it agrees to report the number of SATP encounters for use in determining the appropriate distribution of SATP DSH funds among all hospitals that qualify for an SATP DSH payment.

(k) Remainder of Government Allocation Disproportionate Share Hospital (ROGA DSH)

A hospital other than an IMD that is eligible for a DSH payment may qualify for a ROGA DSH payment adjustment if it enters into an agreement with the department for a ROGA DSH payment and has sufficient FSL to receive a ROGA DSH payment after all other DSH payments to the hospital for the qualifying year are determined.

(2) Distribution of DSH Payments. DSH payments will be distributed to qualified hospitals according to the following methods.

(a) IMD DSH. Each disproportionate share payment for the IMD DSH classification will be calculated based on the qualifying hospital's Medicaid inpatient days, divided by the sum of the Medicaid inpatient days of all qualifying

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IMD DSHs in the qualifying year; the resulting percentage will be multiplied by the amount of the allocation of DSH funds applicable to the IMD DSH classification. Payments will be subject to the hospital's FSL, the federal IMD disproportionate share cap in effect for the federal fiscal year in which payments are made, and the amount of appropriations from the legislature as allocated by the department.

(b) MIU DSH and LI DSH Payments. Each qualifying hospital within the MIU DSH classification and each qualifying hospital within the LI DSH classification will receive a minimum payment of \$10,000 per payment year and per classification, subject to the hospital's FSL, the federal IMD disproportionate share cap in effect for the federal fiscal year in which payments are made, and the amount of appropriations from the legislature as allocated by the department.

Each disproportionate share payment for the MIU DSH classification will be calculated based on the qualifying hospital's SDM, divided by the sum of the SDMs of all qualifying MIU DSHs in the qualifying year; the resulting percentage will be multiplied by the amount of the allocation of DSH funds applicable to the MIU DSH classification. "SDM" means the amount over a Medicaid inpatient utilization rate at least one standard deviation above the mean of state Medicaid inpatient utilization rates for all hospitals in the state.

Each disproportionate share payment for the LI DSH classification will be calculated based on the qualifying hospital's LUR, divided by the sum of the LURs of all qualifying LI DSHs in the qualifying year; the resulting percentage will be multiplied by the amount of the allocation of DSH funds applicable to the LI DSH classification. "LUR" means the amount over a low-income utilization rate exceeding 25 percent.

Hospitals that qualify for an MIU DSH or for an LI DSH payment will receive a pediatric outlier payment adjustment in the disproportionate share payment if the hospital provides inpatient services not excluded under state Medicaid regulations to a Medicaid patient who is under age six at the time of admission and that involve exceptionally long stays per admission that are 150 percent or more of the length of stay of an average admission for the hospital. The pediatric outlier payment is subject to legislative appropriation and will be divided proportionately among the MIU DSH or LI DSH qualified based upon the number of inpatient days for children under age six who qualify within the respective DSH classification.

(c) Encounter Based Classification Payments. Each disproportionate share payment for the SPEP DSH, DET DSH, CMC DSH, ICHC DSH, RHCA DSH, MHCA DSH and SATP DSH classifications will be calculated within each classification based on the number of encounters to be performed by the

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qualifying hospital for that classification, as specified in the agreement required for that classification, divided by the total number of encounters to be performed by all qualifying hospitals within that classification, as specified in the agreements required for that classification; the resulting percentage will be multiplied by the amount of the allocation of DSH funds applicable to that classification.

(d) ROGA Classification Payments. The amount of disproportionate share payments to qualifying hospitals under the ROGA DSH classification will be determined and calculated 1) to not exceed the facility-specific limits established for each hospital; and 2) proportionately to reflect remaining available disproportionate share money after calculation of the payments for other DSH payments classifications.

In determining the amount of a DSH payment the department will allocate the lesser of 1) the amount of those ROGA DSH payments that the qualifying hospital has requested; or 2) a proportionate amount calculated, as a percentage, in which the numerator is the amount of those ROGA DSH payments that the qualifying hospital has requested and the denominator is the sum of all disproportionate share payments to all qualifying hospitals within the ROGA DSH classification.

- (3) Payment Limits. The total annual disproportionate share payment for each qualifying hospital is subject to a facility-specific limit (FSL) calculated for the hospital's qualifying year. The FSL is calculated as the cost of services provided to Medicaid patients, less the amount paid to the hospital under the non-DSH provisions of the State Plan, plus the cost of services provided to patients without health insurance or another source of third party payments that applied to services rendered during the qualifying year, less any payments made by those patients without insurance or another source of third party payment for those services; the hospital's cost of services for this calculation is the total hospital allowable costs as defined in the State Plan divided by the hospital's total adjusted inpatient days; this result is multiplied by the total of the hospital's adjusted inpatient days not covered by insurance or third party payment and Medicaid adjusted inpatient days; the cost of services includes the cost of excluded services under an insurance policy; the cost of services does not include amounts that were not reimbursed to the hospital by the patient's health insurance or other source of third party payments because of per diem maximums, coverage limitations, or unpaid patient co-payments or deductibles; for purposes of this paragraph, third party payments do not include state payments to hospitals paid by the department's programs for General Relief Medical Assistance (7 AAC 47) or Chronic and Acute Medical Assistance (7 AAC 48.500 - 7 AAC 48.900).

Inpatient days not covered by insurance is determined from a log submitted by the hospital and reviewed and accepted by the department before a DSH payment is

made. The submitted log must include in sufficient detail for the department to verify uninsured care: charges, admissions, patient days, any payments made by the patient for the services offered, payments made on behalf of the patient by a third party for the services offered, and dates of service. A hospital must bill insurance and other third party sources whenever possible. A log entry for a person who has insurance that records zero payment made by the insurance will be accepted as demonstrating no insurance for the services offered, however, such a log entry will be reduced by \$1,000 to ensure that non-payment as a result of an insurance policy deductible is excluded from the log. If the hospital attaches an explanation of benefits or other documentation from the insurance company that demonstrates the services offered are excluded from coverage under the patient's insurance policy, the entire amount of that log entry will be accepted, subject to the other requirements in this paragraph, when determining the amount of uninsured care.

A disproportionate share payment is not subject to the limitations of 100% of charges.

- (4) Hospital Notification and Reconsideration. The department will notify eligible hospitals each year of its allocation of available DSH funds to DSH classifications and will provide an opportunity for eligible hospitals to participate in each DSH classification. Eligible hospitals that choose to participate will give notice to the department in writing. The department's determination of the participation by an eligible hospital will be contingent upon its submission of a certified log of uninsured care for the qualifying year and the department's determination of the sufficiency of the hospital's FSL to receive DSH payments.

On or before the qualification date, the department will send to each hospital a list of the qualifying hospitals and the amount of the payments for the upcoming payment year, except that for payment year 2002, the department will send that list on or before December 3, 2001. The department's determination will be the department's final administrative action, unless a request for reconsideration is filed as required within department regulations.

- (5) Monitoring and Recouping. The department will monitor DSH payments quarterly, in quarters in which a DSH payment is made. Each quarter DMA will receive a report showing the amounts paid for each DSH payment. Expenditures under that report will be reviewed to assure that FSLs have not been exceeded for the qualifying year of hospitals that receive a DSH payment. If a hospital reaches its FSL, payments will be stopped. If a hospital exceeds its FSL the department will recoup the excess part of DSH payments in the following order of payments: ROGA DSH, SATP DSH, MHCA DSH, RHCA DSH, ICHC DSH, CMC DSH, DET DSH, SPEP DSH, LI DSH, MUI DSH, IMD DSH. For example, if a hospital were receiving payments from all DSH programs, the over payment

adjustment would be made in ROGA DSH to the extent possible before adjusting RHCA DSH payments. Similarly, if the DSH state-wide allotment is exceeded appropriate adjustments will be made in the payment order shown above.

The State will recalculate and reallocate the disproportionate share eligibility and payments for all hospitals and will recoup payments from all hospitals if the disproportionate share eligibility and payment for any hospital must be recalculated as a result of a final commissioner's decision in an administrative appeal or of a court decision that would cause the total disproportionate share payments to exceed the federal allotment and/or the IMD cap for the federal fiscal year in which the payment rate was in effect.

The total disproportionate share payments to all hospitals in the aggregate will be limited to the Federal disproportionate share cap established for the State of Alaska. A comparison of the Federal cap to the State's estimated total disproportionate share payments for the federal fiscal year will occur before any payments are distributed to qualifying hospitals.

**(6) Definitions.**

(a) "encounter" means a unit of service, visit, or face-to-face contact that is a covered service under an agreement with the department as required under (d)(3), (d)(4), (d)(6), (d)(7), (d)(8), or (d)(9) of this section.

(b) "institution for mental disease" or "IMD" means a facility of more than 16 beds that is

primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases, including medical attention, nursing care, and related services; whether an institution is an institution for mental disease is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not the facility is licensed as such.

(c) "inpatient days" means patient days at licensed hospitals that are calculated

(1) to include patient days related to a hospitalization for acute treatment of the following:

(A) injured, disabled, or sick patients;

(B) substance abuse patients who are hospitalized for substance abuse detoxification;

(C) patients hospitalized for rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(D) patients in a hospital receiving psychiatric services for the diagnosis and treatment of mental illness;

(E) newborn infants in hospital nurseries; and

(2) not to include patient days related to the treatment of patients

- 
- (A) at licensed nursing facilities;
  - (B) in a residential treatment bed;
  - (C) on a leave of absence from a hospital beginning with the day the patient begins a leave of absence;
  - (D) who are in a hospital for observation to determine the need for inpatient admission; or
  - (E) who receive services at a hospital during the day but are not housed there at midnight.
- (d) “Medicaid-eligible inpatient days” means patient days at licensed hospitals that are calculated
- (1) to include Medicaid covered and Medicaid non-covered days related to a hospitalization for acute treatment of the following:
    - (A) injured, disabled, or sick patients;
    - (B) substance abuse patients who are hospitalized for substance abuse detoxification;
    - (C) patients hospitalized for rehabilitation services for the rehabilitation of injured, disabled, or sick persons;
    - (D) patients in a hospital receiving psychiatric services for the diagnosis and treatment of mental illness;
    - (E) newborn infants in hospital nurseries; and
  - (2) not to include Medicaid covered and Medicaid non-covered patient days related to the treatment of patients
    - (A) at licensed nursing facilities;
    - (B) in a residential treatment bed;
    - (C) on a leave of absence from a hospital beginning with the day the patient begins a leave of absence;
    - (D) who are in a hospital for observation to determine the need for inpatient admission; or
    - (E) who receive services at a hospital during the day but are not housed there at midnight.
- (e) “payment year” means the state fiscal year.
- (f) “qualifying hospital” means a hospital that qualifies for one or more DSH payments under this section.
- (g) “qualifying year” means the hospital's most recent fiscal year ending at least 11 months but not more than 37 months before the state fiscal year in which the disproportionate share payment is made and within the most recent 12 month reporting cycle in which all facilities have filed a complete year-end report with the department.

XII. Exceptional Relief to Rate Setting:

If the rate setting methodology results in a permanent rate which does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the facility may apply to the deputy commissioner of the department for exceptional relief from the rate setting methodology. This provision applies to situations where a facility is forced to close or dramatically reduce quality of care to its residents due to the inadequacy of its payment rate. To apply for exceptional relief, the facility's application should include:

1. the amount by which the facility estimates that the rate should be increased to allow reasonable access to quality patient care provided by an efficiently managed facility;
2. the reasons why and the need for exceptional relief requested, including any resolution by the facility's governing body to support the reasons offered, and why such a rate increase cannot be obtained through the existing rate setting process;
3. the description of management actions taken by the facility to respond to the situation on which the exceptional relief request is based;
4. the audited financial statement for the facility for the most recently completed facility fiscal year and financial data, including a statement of income and expenses and a statement of assets, liabilities, and equities and a monthly facility cash flow analysis for the fiscal year for which the exception is requested;
5. a detailed description of recent efforts by the facility to offset the deficiency by securing revenue sharing, charity or foundation contributions, or local community support;
6. an analysis of community needs for the service on which the exception request is based;
7. a detailed analysis of the options of the facility if the exception is denied;
8. an analysis of how Medicaid patients will lose access to Medicaid services available to the general public in the same geographic area if exceptional relief is not granted.
9. a plan for future action to respond to the problem; and
10. any other information requested by the deputy commissioner to evaluate the request.

The deputy commissioner may increase the rate, by all or part of the facility's request if the deputy commissioner finds by clear and convincing evidence that the rate established under section IV of Attachment 4.19-A does not allow for reasonable access to quality patient care provided by an efficiently and economically managed facility and that the granting of an

exception is in the public interest. In determining whether the exception is in the public interest, the deputy commissioner may consider at least:

1. the necessity of the rate increase to allow reasonable access to quality patient care provided by an efficiently and economically managed facility, including any findings of the governing body of the facility to support the need;
2. the assessment of continued need for this facility's services in the community;
3. whether the facility has taken effective steps to respond to the crisis and has adopted effective management strategies to alleviate or avoid the future need for exceptional relief;
4. the availability of other resources available to the facility to respond to the crisis;
5. whether the relief should have been obtained under the existing rate methodology;
6. other factors relevant to assess reasonable access to quality patient care provided by an efficiently and economically managed facility.

The deputy commissioner will impose conditions on the receipt of exceptional relief including, but not limited to the following:

1. the facility sharing the cost of the rate exception granted;
2. the facility taking effective steps in the future to alleviate the need for future requests for exceptional relief;
3. the facility providing documentation as specified of the continued need for the exception; or
4. a maximum amount of exceptional relief to be granted to the facility under this section.

Amounts granted as exceptional relief shall not be included as part of the base on which future prospective rates are determined. Exceptional relief shall be effective prospectively from the date of the exceptional relief decision and for a period of time not to extend beyond the facility's rate setting year. A facility may apply for and be granted exceptional relief in the following year. A party aggrieved by a decision of the deputy

commissioner concerning exceptional relief may request an administrative hearing to the commissioner of the department.

**XIII Public Process**

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

**XIV Proportionate Share Incentive Payments for Public Hospitals.**

The department recognizes that many public hospitals provide basic support for community and regional health care to clients who would otherwise be unable to readily access needed inpatient hospital service. To ensure continued access, proportionate share incentive payments (Hospital Pro-Share payments) are provided to in-State public hospitals. At least annually, the department will advise all such hospitals to formally request participation in the Hospital Pro-Share payment program.

2. A public hospital is a non-state government owned or operated facility.
3. The state determines a reasonable estimate of what Medicare would have paid to public hospitals by calculating the Medicare upper payment limit (UPL). The Medicare UPL is the result of inflating the TEFRA inpatient rate forward from the 1982 base year, using allowable adjustments as set out in public law, the Federal register, notices from the Centers for Medicare and Medicaid Services, hearing decisions, or similar authoritative notices. For hospitals built after 1982, the first full year of operation is the hospital's base year.

The TEFRA inpatient rate is expressed as a discharge rate and Medicaid estimated payments are based on per diem rates. Medicaid inpatient days are divided by the average length of stay to obtain the Medicaid discharge rate. Medicaid discharges are then multiplied by the inflated TEFRA inpatient rate, resulting in the Medicare UPL. Inpatient rates and discharges are based on the most recent Medicare cost reports.

Total estimated Medicaid payments for the current year are obtained by multiplying the current facility Medicaid inpatient rate by the number of Medicaid inpatient days reported on the most recent Medicare cost report. This total is then subtracted from the UPL to determine the difference, if any, between the UPL and the estimated Medicaid payments. The most recent complete Medicare cost report data are adjusted to take into consideration any facility fiscal year offset with the state fiscal year, amended information submitted by the facility, and capital costs.

The public hospital facility-specific differences between UPL and estimated Medicaid payments are added together to calculate the statewide total for additional payments to all publicly owned hospitals for inpatient services. This aggregate difference represents the total available in the Hospital Pro-Share Program. An adjustment is made to the statewide total UPL to account for the effect of Medicare disproportionate share payments and Medicare graduate medical education payments.

4. Hospital Pro-Share payments will be paid annually on or before September 30<sup>th</sup> during each federal fiscal year. The state may make one additional payment per year, if needed to reconcile the federal fiscal year with state fiscal year expenditures. State fiscal year payments require money from two Federal fiscal years. The second payment may be held until the next Federal fiscal year monies are available. Payments are based on projections of completed years, therefore no further adjustments are made for over-or under-payments.

The State recognizes that occupancy is the key measure in determining the payment for each participating hospital. Specifically, a hospital with a low occupancy level tends to be more fiscally vulnerable compared to a hospital with a high occupancy level. Each participating hospital will be assigned an occupancy weight as follows:

<u>Occupancy Level</u>	<u>Occupancy Weight</u>
40 percent or more	1.00
30 – 39 percent	1.05
20 – 29 percent	1.10
10 – 19 percent	1.15
less than 10 percent	1.20

The occupancy level used to determine a hospital's occupancy weight will be the percent that results from dividing the total number of patient days by the total number of available bed days disclosed in the Medicare cost report for the hospital's fiscal year ending 24 months before the payment. These payments, when combined with other non-DSH medical assistance payments, will not, in aggregate, exceed a reasonable estimate of what Medicare would have paid for similar services.

5. Hospital Pro-Share payments will not be subject to settlement (payment at the lower of costs or rate), or to state law governing payment rates AS 47.07.070 or regulations in 7 AAC 43.670 – 7 AAC 43.676 and 7 AAC 43.678 – 7AAC 43.709.

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XVI. State Hospital Proportionate Share Incentive Payments

1. The department recognizes that state owned hospitals provide basic support for community and regional health care to clients who would otherwise be unable to readily access needed inpatient hospital service. To ensure continued access, the department will make a State Hospital Proportionate Share (SHPS) incentive payment each year to state owned hospitals in accordance with federal law in 42 CFR 447.272.

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TN No. 03-03

Effective Date July 1, 2005

Approval Date JUN - 4 2009

Supersedes TN No. 02-005

- 2 A qualified state owned hospital is one that:
  - a) is enrolled as a Medicaid provider of inpatient hospital services;
  - b) is located within the State of Alaska; and
  - c) is a state owned or operated facility.
  
3. SHPS payments shall be paid annually on or before September 30<sup>th</sup> during each federal fiscal year. The state may make one additional payment per year if needed to reconcile the federal fiscal year with state fiscal year expenditures. State fiscal year payments require money from two Federal fiscal years. The second payment may be held until the next Federal fiscal year monies are available.

The state determines a reasonable estimate of what Medicare would have paid to state-owned hospitals, by calculating the Medicare upper limit in the following way:

- a) Starting with the 1982 base year, each hospital's total Medicare allowable costs, less capital costs, is inflated forward to the current year using allowable adjustments as set out in public law, the Federal register, notices from the Centers for Medicare and Medicaid Services, hearing decisions, or similar authoritative notices.
  - b) The current year inflated amount under a) is divided by the number of inpatient days reported on the most recent Medicaid cost report to estimate the TEFRA limit per patient day for each state owned hospital.
  - c) Each hospital's TEFRA limit per patient day is multiplied by the estimated number of Medicaid inpatient days for the current year based on data reported in the facility's most recent Medicaid cost reports to arrive at a TEFRA limit for the facility's current year.
  - d) The percentage of capital attributable to Medicaid inpatient days is added to the TEFRA limit calculated in c) to arrive at the total TEFRA limit for the current year.
  - e) The total of estimated Medicaid payments for the current year is obtained by multiplying the current facility Medicaid inpatient rate by the number of Medicaid inpatient days reported on the most recent Medicaid cost report.
  - f) The estimated Medicaid payments calculated in e) are compared to the UPL calculated under a), b), c), and d) to determine the difference, if any, between the UPL and the estimated Medicaid payments.
  - g) The amount available for SHPS distribution is determined by calculating the Medicare TEFRA upper payment limit for all the hospitals in the SHPS group in the base year, less payments that were made to the hospitals. The aggregate difference represents the total available in the SHPS program.
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4. Apportionment of available SHPS funds among qualifying hospitals will be made according each hospital's number of Medicaid inpatient days as a percentage of the total Medicaid inpatient days at all state owned hospitals.

Inpatient Psychiatric Services for Individuals Under 21

Payment to an accredited residential psychiatric facility for the treatment of individuals under 21 years of age is at daily rates established by the department. The department will pay for therapeutically appropriate, medically necessary diagnostic and treatment services, including the following services: individual psychotherapy; group psychotherapy; family psychotherapy; group skill-development; individual skill-development; family skill-development; pharmacologic management and medication administration; crisis intervention; and intake assessment. In SFY20, the payment rates will be 95% of the SFY19 rates.

The daily reimbursement rates are published and available at:

[http://manuals.medicaidalaska.com/inpatient\\_psych\\_rptc/inpatient\\_psych\\_rptc.htm](http://manuals.medicaidalaska.com/inpatient_psych_rptc/inpatient_psych_rptc.htm).

The rates were last updated to be effective for services on or after 7/1/19.

**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.

The Medicaid agency will adjust payments for provider health care-acquired conditions and other provider preventable conditions as follows: after post payment review of the medical record by a QIO, the Medicaid agency will reduce payment by recouping funds that were paid for dates of service that were a direct result of a provider preventable condition.

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

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

**Health Care-Acquired Conditions**

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

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

**Other Provider-Preventable Conditions**

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

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 (*please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services*) of the plan: