ATTACHMENT B

TRANSITION PERCENTAGES FOR CAPITAL PAYMENT AMOUNTS

MAJOR TEACHING HOSPITALS

	Major Teaching Peer Group Amounts	Own Case-mix Adjusted Capital Cost @ Case	
1996	25.0 %	75.0 %	(1994)
1997	50.0	50.0	(1995)
1998	75.0	25.0	(1996)
1999	100.0	0.0	(1997)

LARGE URBAN HOSPITALS

	Large Urban Peer Group Amount	Non-Major Teaching Peer Group Amount	Own Case-mix Adjusted Capital Cost @ Case
1996	25.0 %	0.0 %	75.0 %
1997	37.5	12.5	50.0
1998	37.5	37.5	25.0
1999	0.0	100.0	0.0

ALL-OTHER HOSPITALS

	All-Other Peer Group Amount	Non-Major Teaching Peer Group Amount	Own Case-mix Adjusted Capital Cost @ Case
1996	25.0 %	0.0 %	75.0 %
1997	37.5	12.5	50.0
1998	37.5	37.5	25.0
1999	0.0	100.0	0.0

NOTES: Major Teaching: FTE Interns and Residents/Average Daily Census) > 0.20
Large Urban: Kanawha, Putnam, and Cabell counties

CITATION

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

Payment Adjustment for Provider Preventable Conditions

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

Health Care-Acquired Conditions

With the implementation of HIPAA 5010 system conversion, inpatient hospital claims that are reimbursed under a Prospective Payment System will have payment adjusted for Hospital-Acquired Conditions (HACs) indicated by designation in the diagnosis field with a Present on Admission (POA) Indicator value of N or U. A value of N indicates that the condition was not present at the time of inpatient admission. A value of U indicates that the documentation was insufficient to determine if the condition was present at the time of inpatient admission. When either of these condition(s) exist, the claim will be paid as though the secondary diagnosis is not present. Only diagnosis codes with a POA indicator equal to Y or W will be considered for full DRG reimbursement. A value of Y indicates the condition was present upon admission while a value of W indicates that the provider is unable to clinically determine whether the condition was present at the time of admission or not.

Critical Access Hospitals (CAHs) will have payment adjusted for HACs at final cost settlement. CAHs will be required to prepare a supplemental schedule to Cost Report Form 2552-10 to aggregate all Medicaid HAC related charges and all HAC related costs. All costs and charges related to HACs will be excluded for Medicaid settlement purposes at the time of final Medicaid settlement.

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

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

Other Provider-Preventable Conditions

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

For claims submitted with certain condition code(s) and/or ICD-9 diagnosis codes indicating Other Provider-Preventable Conditions, claims will be denied for payment at the time of submission for:

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 (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: