**Potentially Preventable Negative Outcomes (PPNOs)**

**Potentially Preventable Complications (PPC)**

For discharges occurring on and after July 1, 2011 through March 31, 2012, Medicaid rates of payment to hospitals that have higher than expected Medicaid payments related to potentially preventable complications, based on the criteria set forth in the Complication Criteria section, as determined by a risk adjusted comparison of the actual and expected Medicaid payments per case for each hospital as described by the Methodology section, will be reduced in accordance with the PPC Adjustment Factor section. Such rate adjustments will result in an aggregate reduction in Medicaid payments of $31,257,000.

**Definitions.** As used in this Section, the following definitions shall apply:

1. **Potentially Preventable Complications** shall mean harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than from natural progression of the underlying illness, as defined under version 28 of the Potentially Preventable Complication grouping logic software developed and published by 3M Health Information Systems, Inc. (3M). The software identifies 1,450 ICD-9-CM diagnosis codes as a PPC diagnoses. Each ICD-9-CM code designated as a PPC diagnosis was assigned to one of 64 mutually exclusive complication groups called PPCs. A list of such PPCs are available on the following Department of Health website link:

   www.health.ny.gov/health_care/medicaid/quality/ppo/complications

2. **Hospital** shall mean a general hospital as defined pursuant to the Hospital Inpatient Reimbursement – Effective December 1, 2009 section, excluding, effective July 1, 2011, those hospitals exempt from the APR-DRG reimbursement methodology and critical access hospitals.
3. **Observed case** shall mean all non-Medicare acute care cases.
4. **PPC Coefficient** shall mean a dollar amount, the result of an indirect standardization, equal to the statewide average incremental Medicaid payment attributable to each of the 64 PPCs.
5. **Adjusted Admission APR-DRG** shall be defined as the assigned hospital admission APR-DRG SOI for each observed case using version 28 of the APR-DRG grouper and results from 3M's PPC grouping logic software. The software results identify each PPC per admission, which has been adjusted to reassign all secondary diagnosis, not identified as a PPC or the direct cause of a PPC, as present on admission.

**Complication Criteria.**

A complication is a condition that develops after admission to the hospital. Complications may or may not be preventable. For a complication to qualify as a PPC, the secondary diagnosis must meet the following criteria:

a. Shall not be redundant with the diagnosis that was the reason for hospital admission;

b. Shall not be an inevitable, natural, or expected consequence or manifestation of the reason for hospital admission;

c. Shall be expected to have a significant impact on short or long-term debility, mortality, patient suffering, or resource use; and

d. Shall have a relatively narrow spectrum of manifestations, meaning that the impact of the diagnosis on the clinical course or on the resource use must not be significant for some patients but trivial for others.

**Methodology.**

1. The actual Medicaid payment will be computed as the aggregate Medicaid payment for each hospital observed case assigned using version 28 of the APR-DRG grouper. The discharge APR-DRG severity of illness (SOI) service intensity weight (SIW) is multiplied by the Medicaid statewide base price for the applicable rate period.
2. The expected Medicaid payment will be computed as the aggregate Medicaid payment for each adjusted admission APR-DRG. The expected Medicaid payment will equal the adjusted admission APR-DRG SIW multiplied by the Medicaid statewide base price for the applicable rate period. The expected Medicaid payment will then be reduced by the sum of the PPC coefficient for the particular observed case.
3. For each hospital, a hospital-specific coefficient will be computed and equal to the aggregate actual Medicaid payment minus the aggregate expected Medicaid payment of all observed cases, divided by the total number of observed cases. In the event the hospital-specific coefficient is less than zero, the hospital coefficient shall be set to zero.

**PPC Adjustment Factor.**

1. Effective for the period July 1, 2011 through March 31, 2012, rate adjustments for each hospital will be calculated using 2009 Medicaid claims data for discharges that occurred between January 1, 2009 and December 31, 2009.
2. The hospital-specific coefficient is multiplied by the total number of non-behavioral health Medicaid discharges to compute the PPC penalty. The PPC penalty is then multiplied by the hospital's wage equalization factor (WEF) and, for teaching hospitals, the indirect graduate medical education (GME) factor.
3. The Medicaid case payment rate for the applicable rate period shall be used to compute the total Medicaid operating payments for all non-behavioral health Medicaid discharges in each hospital.
4. For each hospital, a PPC adjustment factor will be computed as the ratio of the hospital's PPC penalty and the hospital's total Medicaid operating payments for all non-behavioral health Medicaid discharges in each hospital as determined pursuant to this section.

**Adjustment for Hospitals With Unreliable Present On Admission (POA) Data.**

Each hospital will be evaluated on five criteria for the reliability of the POA indicator in Medicaid discharge data. Two levels of POA quality will be established for each of the criteria, "red" and "grey" zones. The criteria and levels will be as follows:

1. The percent of pre-existing diagnoses that are coded as not present on admission: "red" will be greater than or equal to 7.5%, "grey" will be greater than or equal to 5%, but less than 7.5%.
2. Excluding pre-existing and exempt diagnoses, the percent of remaining diagnoses coded as uncertain: "red" will be greater than or equal to 10%, "grey" will be greater than or equal to 5%, but less than 10%.
3. Excluding pre-existing, exempt, and perinatal diagnoses, a high percentage of remaining diagnoses coded as present on admission: "red" will be greater than or equal to 96%, "grey" will be greater than or equal to 93%, but less than 96%.
4. Excluding pre-existing, exempt, and perinatal diagnoses, a low percentage of remaining diagnoses coded as present on admission: "red" will be less than or equal to 70%, "grey" will be greater than or equal to 70%, but less than 77%; and

5. For surgical cases only, the percent of secondary diagnoses coded as present on admission: "red" will be greater than or equal to 40%, "grey" will be greater than or equal to 30%, but less than 40%.

6. Hospitals are determined to have unreliable POA data if any of the five criteria are in the "red" zone, or if two or more of the five criteria are in the "grey" zone. An upstate and downstate PPC adjustment factor will be applied to each hospital deemed to have unreliable POA data. The upstate and downstate PPC adjustment factor will be calculated using a weighted average of all hospitals with reliable POA data located in each designated region. For purposes of this section, the downstate region of New York State will consist of the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam and Dutchess. The upstate region of New York State will consist of all other New York counties.

**Potentially Preventable Hospital Readmissions (PPR)**

For discharges occurring on and after July 1, 2010 through March 31, 2012, Medicaid rates of payment to hospitals that have an excess number of readmissions based on the criteria set forth in the Readmission Criteria Section, as determined by a risk adjusted comparison of the actual and expected number of readmissions in a hospital as described by the Methodology Section, shall be reduced in accordance with the Payment Calculation Section. Such rate adjustments shall result in an aggregate reduction in Medicaid payments of $27.8 million for the period July 1, 2010 through March 31, 2011 and $[37]12 million for the period April 1, 2011 through March 31, 2012.

**Definitions.** As used in this Section, the following definitions shall apply:

1. **Potentially Preventable Readmissions (PPR)** shall mean a readmission to a hospital that follows a prior admission from a hospital within 14 days, and that is clinically-related to the prior hospital admission, as defined under the PPR grouping logic software developed and published by 3M Health Information Systems, Inc. (3M), version 26.1 for the period July 1, 2010 through June 30, 2011 and version 28 for the period July 1, 2011 through March 31, 2012.
2. **Hospital** shall mean a general hospital as defined pursuant to the Hospital Inpatient Reimbursement – Effective December 1, 2009 Section, excluding, effective July 1, 2011, those hospitals exempt from the APR-DRG reimbursement methodology and critical access hospitals.
3. **Expected Potentially Preventable Readmissions**, for the period July 1, 2010 through June 30, 2011, are derived using a logistic regression analysis that produces a predicted probability (a number ranging from zero to one) that a hospital admission would be followed by at least one PPR. The total number of expected PPRs shall equal the sum of the expected probabilities of a PPR for all admissions at each hospital. Effective for the period July 1, 2011, through March 31, 2012, the Expected Potentially Preventable Readmissions shall be derived using 2009 SPARCS Medicaid data through an indirect standardization. A statewide PPR rate, the number of at-risk admissions followed by at least one PPR divided by the total number of at-risk admissions, for every APR-DRG severity of illness (SOI) combination will be multiplied by the number of at-risk admissions in that APR-DRG SOI at each hospital. The sum of all APR-DRG SOI combinations will be the Expected PPRs.
4. **Observed Rate of Readmission** shall mean the number of admissions in each hospital that were actually followed by at least one PPR divided by the total number of admissions.

5. **Expected Rate of Readmission** shall mean a risk adjusted rate for each hospital that accounts for the severity of illness, APR-DRG, and age of patients at the time of discharge preceding the readmission. It shall equal the number of expected PPRs divided by the total number of at risk hospital admissions at that hospital.
6. **Excess Rate of Readmission** shall mean the difference between the observed rate of readmission and the expected rate of readmission for each hospital.
7. **Behavioral Health**, for the period July 1, 2010 through June 30, 2011, shall mean an admission that includes a primary or secondary diagnosis of a major mental health related condition. Effective for the period July 1, 2011 through March 31, 2012, Behavioral Health shall mean an admission that is assigned to a Major Diagnostic Category of 19-Mental Diseases and Disorders or 20-Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders.
8. **Average Hospital Specific Payment** shall equal the Medicaid operating payment, using the applicable Medicaid rates for such period, of the total number of PPRs identified for each hospital divided by the total number of PPRs identified for each hospital.

**Readmission Criteria.**

1. A readmission is a return hospitalization following a prior discharge that meets all of the following criteria:
    a. The readmission could reasonably have been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period.
    b. The readmission is for a condition or procedure related to the care during the prior discharge or the care during the period immediately following the prior discharge and including, but not limited to:
        i. the same or closely related condition or procedure as the prior discharge;
        ii. an infection or other complication of care;
        iii. a condition or procedure indicative of a failed surgical intervention; or
        iv. an acute decompensation of a coexisting chronic disease.
    c. The readmission is back to the same or to any other hospital.
2. Readmissions, for the purposes of determining PPRs, excludes the following circumstances:

a. The original discharge was a patient initiated discharge and was Against Medical Advice (AMA) and the circumstances of such discharge and readmission are documented in the patient's medical record.

b. For the period July 1, 2010 through June 30, 2011, [T]the original discharge was for the purpose of securing treatment of a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions. Effective for the period July 1, 2011 through March 31, 2012, the original discharge was for the purpose of securing treatments of the admissions listed on the following Department of Health website link:

www.health.ny.gov/health_care/medicaid/quality/ppo/outcomes

c. The readmission was a planned readmission that occurred on or after 15 days following an initial admission.

d. For readmissions occurring during the period up through March 31, 2012, the readmissions involve a discharge determined to be behavioral health related.

**Methodology.**

1. For the period July 1, 2010 through June 30, 2011, [R]rate adjustments for each hospital shall be calculated using 2007 Medicaid paid claims data for discharges that occurred between January 1, 2007 and December 31, 2007. Effective for the period July 1, 2011 through March 31, 2012, rate adjustments for each hospital will be calculated using 2009 Medicaid claims data for discharges that occurred between January 1, 2009 and December 31, 2009.

2. The expected rate of readmission shall be reduced by:

   (a) 24% for periods prior to September 30, 2010;

   (b) 38.5% for the period October 1, 2010 through December 31, 2010;

   (c) 33.3% for the period[s on and after] January 1, 2011 through June 30, 2011.

   (d) 11.4% for periods on and after July 1, 2011.

3. The excess rate of readmission is multiplied by the total number of at risk hospital admissions at each hospital to determine the total number of risk adjusted excess readmissions.

4. In the event the observed rate of readmission for a hospital is lower than the expected rate of readmission, after the expected rate of readmission has been reduced by the applicable percentage in accordance with this section, the risk adjusted excess readmissions shall be set at zero.

**Payment Calculation.**

1. An average hospital specific payment will be used to compute the total Medicaid operating payments, excluding behavioral health, associated with the risk adjusted excess readmissions in each hospital.

2. The Medicaid case payment rate for the applicable rate period shall be used to compute the total Medicaid operating payments for all non-behavioral health Medicaid discharges in each hospital.

3. For each hospital, a hospital specific readmission adjustment factor shall be computed as the ratio of the hospital's total Medicaid operating payments for the applicable rate period associated with the risk adjusted excess readmissions identified in the Methodology Section and the hospital's total Medicaid operating payments for the same rate period for all non-behavioral health Medicaid discharges in each hospital as determined pursuant to this Section.

New York
148(a)

Attachment 4.19-A
(07/11)

**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

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

__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 4.19(A) of this State plan.

__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.

__X__ Additional Other Provider-Preventable Conditions identified below: [Not applicable.]

Effective July 1, 2011, reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

PPCs are defined as two distinct categories: Health Care-Acquired Conditions (HCAC) and Other Provider-Preventable Conditions (OPPC).

For APR-DRG cases, the APR-DRG payable shall exclude the diagnoses not present on admission for any HCAC. For per diem payments, the number of covered days shall be reduced by the number of days associated with diagnoses not present on admission for any HCAC.