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State/Territory Name: Texas

State Plan Amendment (SPA) #: 14-17 NIRT

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

NOV 13 2014

Ms. Kay Ghahremani
State Medicaid/CHIP Director
Health and Human Services Commission
Post Office Box 13247
Mail Code: H100
Austin, Texas 78711

RE: TN 14-17

Dear Ms. Ghahremani:

We have reviewed the proposed amendment to Attachments 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-17. This amendment clarifies the definitions, timing, and methodology related to calculating potentially preventable events reimbursement adjustments for Medicaid.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

Based upon your assurances, Medicaid State plan amendment 14-17 is approved effective September 1, 2014. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,

[redacted]

Timothy Hill
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **14-017**

2. STATE: **TEXAS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **September 1, 2014**

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 USC sections 1396a(a)(19), (30).

7. FEDERAL BUDGET IMPACT: **SEE ATTACHMENT**
a. **FFY 2014** **$0**
b. **FFY 2015** **$0**
c. **FFY 2016** **$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SEE ATTACHMENT TO BLOCKS 8 & 9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHMENT TO BLOCKS 8 & 9

10. SUBJECT OF AMENDMENT:
The proposed amendment revises the Texas Health and Human Services Commission's (HHSC's) potentially preventable events program by revising the timing of the reporting process relative to reimbursement reductions, including financial disincentives for hospitals that do not properly code "present on admission" conditions, and refining the methodology previously used in potentially preventable readmission and potentially preventable complication reports.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Kay Ghahremani

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
September 16, 2014

16. RETURN TO:
Kay Ghahremani
State Medicaid Director
Post Office Box 13247, MC: H-100
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 16, 2014

18. DATE APPROVED: NOV 13 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: September 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Deputy Director, FMG

23. REMARKS:

FORM CMS – 179 (07-92)

Attachment to Blocks 8 & 9 of CMS Form 179

Transmittal Number 14-017

Number of the Plan Section or Attachment	**Number of the Superseded Plan Section or Attachment**
Appendix 2 to Attachment 4.19-A	Appendix 2 to Attachment 4.19-A
Page 1	Page 1 (TN 13-016)
Page 2	Page 2 (TN 13-016)
Page 3	Page 3 (TN 13-016)
Page 4	Page 4 (TN 13-016)
Page 5	N/A - New Page
Appendix 3 to Attachment 4.19-A	Appendix 3 to Attachment 4.19-A
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State: Texas
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Payment Adjustment for Potentially Preventable Readmissions

(a) Introduction. The Health and Human Services Commission (HHSC) may penalize a hospital under this section based on the hospital's performance with respect to failing to meet outcome and process measures relative to all Texas Medicaid and CHIP hospitals regarding the rates of potentially preventable events.

(b) Definitions.

(1) Actual-to-Expected Ratio—A ratio that measures the impact of potentially preventable readmissions (PPRs) by deriving an actual hospital rate compared to an expected hospital rate based on a methodology defined by HHSC. HHSC may use cost of PPR as a factor in weighting PPRs and in calculating the PPR Actual-to-Expected Ratio.

(2) Adjustment time period—The state fiscal year (September through August) that a hospital's claims are adjusted in accordance with subsection (f) of this section. Adjustments will be done on an annual basis.

(3) All Patient Refined Diagnosis-Related Group (APR-DRG)—A diagnosis and procedure code classification system for inpatient services.

(4) Candidate admission—An admission that is at risk of a PPR.

(5) Case-mix—A measure of the clinical characteristics of patients treated during the reporting time period and measured using all patient refined-diagnosis related group (APR-DRG) or its replacement classification system, severity of illness, patient age, and the presence of a major mental health or substance abuse comorbidity.

(6) Claims during the reporting time period—Includes Medicaid traditional fee-for-service (FFS), Children's Health Insurance Program (CHIP), and managed care inpatient hospital claims filed for reimbursement by a hospital that:

(A) had a date of admission occurring within the reporting period;

(B) were adjudicated and approved for payment during the reporting period and the six-month grace period that immediately followed, except for claims that had zero inpatient days;

Payment Adjustment for Potentially Preventable Readmissions (continued)

(C) were not claims for patients who are covered by Medicare;

(D) were not claims for individuals classified as undocumented immigrants; and

(E) were not subject to other exclusions as determined by HHSC.

(7) Children's Health Insurance Program or CHIP—The Texas State Children's Health Insurance Program established under Title XXI of the federal Social Security Act (42 U.S.C. Chapter 7, Title XXI).

(8) Clinically related—A requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following the initial admission. A clinically related admission occurs within a specified readmission time interval resulting from the process of care and treatment during the initial admission or from a lack of post admission follow-up, but not from unrelated events occurring after the initial admission.

(9) HHSC—The Health and Human Services Commission or its designee.

(10) Hospital—A public or private institution licensed or run by the state to provide medical, surgical, or psychiatric treatment.

(11) Initial admission—A candidate admission followed by one or more readmissions that are clinically related.

(12) Medicaid program—A jointly funded state-federal health care program established under Title XIX of the federal Social Security Act (42 U.S.C. Chapter 7, Title XIX).

(13) Potentially preventable event (PPE)—A potentially preventable admission, a potentially preventable ancillary service, a potentially preventable complication, a potentially preventable emergency room visit, a potentially preventable readmission, or a combination of these events.

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Payment Adjustment for Potentially Preventable Readmissions (continued)

(14) Potentially preventable readmission (PPR)—A return hospitalization of a person within a time period specified by HHSC that may have resulted from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up. The term does not include a hospital readmission necessitated by the occurrence of unrelated events after the discharge. The term includes the readmission of a person to a hospital for:

(A) the same condition or procedure for which the person was previously admitted;

(B) an infection or other complication resulting from care previously provided;

(C) a condition or procedure that indicates that a surgical intervention performed during a previous admission was unsuccessful in achieving the anticipated outcome; or

(D) another condition or procedure of a similar nature, as determined by HHSC.

(15) Readmission chain—A sequence of PPRs that are all clinically related to the Initial Admission. A readmission chain may contain an Initial Admission and only one PPR, or may contain multiple PPRs following the Initial Admission.

(16) Reporting time period—The period of time that includes hospital claims that are assessed for PPRs. This may be a state fiscal year (September through August) or other specified time frame as determined by HHSC. PPR Reports will consist of statewide and hospital-specific reports and will be done at least on an annual basis, using the most complete data period available to HHSC.

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Payment Adjustment for Potentially Preventable Readmissions (continued)

(c) Calculating a PPR rate. Using claims during the reporting period and HHSC-designated software and methodology, HHSC calculates an actual PPR rate and an expected PPR rate for each hospital in the analysis. The methodology for inclusion of hospitals in the analysis will be described in the statewide and hospital-specific reports. HHSC may use cost of PPR as a factor in weighting PPRs, and in calculating the PPR Actual-to-Expected Ratio.

(1) The actual PPR rate is the number of readmission chains divided by the number of candidate admissions.

(2) The expected PPR rate is the expected number of readmission chains divided by the number of candidate admissions. The expected number of readmission chains is based on the hospital's case-mix relative to the case-mix of all hospitals included in the analysis during the reporting period.

(d) Comparing the PPR performance of all hospitals included in the analysis. Using the rates determined in subsection (c) of this section, HHSC calculates a ratio of actual-to-expected PPR rates.

(e) Reporting results of PPR rate calculations. HHSC provides a confidential report to each hospital included in the analysis regarding the hospital's performance with respect to potentially preventable readmissions, including the PPR rates calculated as described in subsection (c) of this section and the hospital's actual-to-expected ratio calculated as described in subsection (d) of this section.

(f) Hospitals subject to reimbursement adjustment and amount of adjustment.

(1) A hospital with an actual-to-expected PPR ratio equal to or greater than 1.10 and equal to or less than 1.25 is subject to a reimbursement adjustment of -1 percent;

(2) A hospital with an actual-to-expected PPR ratio greater than 1.25 is subject to a reimbursement adjustment of -2 percent.

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Payment Adjustment for Potentially Preventable Readmissions (continued)

(g) Claims subject to reimbursement adjustment.

(1) The reimbursement adjustments described in subsection (f) of this section will apply to all Medicaid fee-for-service claims based on patient discharge date for the adjustment time period after the confidential report on which the reimbursement adjustments are based is made available to hospitals.

(2) The reimbursement adjustments for a hospital will cease in the adjustment time period that is after the hospital receives a confidential report indicating an actual-to-expected ratio of less than 1.10.

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Payment Adjustment for Potentially Preventable Complications

(a) Introduction. The Health and Human Services Commission (HHSC) may penalize a hospital under this section based on the hospital's performance with respect to failing to achieve outcome and process measures relative to all Texas Medicaid and CHIP hospitals regarding the rates of potentially preventable events.

(b) Definitions.

(1) Actual-to-Expected Ratio—The ratio of actual potentially preventable complications (PPCs) within an inpatient stay compared with expected PPCs within an inpatient stay. The expected number depends on the all patient refined-diagnosis related group at the time of admission (APR-DRG or its replacement classification system). HHSC calculates the expected number based on the statewide norms, and it is derived from Medicaid traditional fee-for-service (FFS), Children's Health Insurance Program (CHIP), and managed care data.

HHSC adjusts the ratio to account for the patient's severity of illness. HHSC, at its discretion, determines the relative weights of PPCs when calculating the actual-to-expected ratio.

(2) Adjustment time period—The state fiscal year (September through August) that a hospital's claims are adjusted in accordance with subsection (f) or (g)(4) of this section. Adjustments will be done on an annual basis.

(3) All Patient Refined Diagnosis-Related Group (APR-DRG)—A diagnosis and procedure code classification system for inpatient services.

(4) Case-mix—A measure of the clinical characteristics of patients treated during the reporting time period based on diagnosis and severity of illness. "Higher" case-mix refers to sicker patients who require more hospital resources.

(5) Children's Health Insurance Program or CHIP—The Texas State Children's Health Insurance Program established under Title XXI of the federal Social Security Act (42 U.S.C. Chapter 7, Title XXI).

Payment Adjustment for Potentially Preventable Complications (continued)

(6) Inpatient claims during the reporting time period—Includes Medicaid traditional FFS, CHIP, and, if available, managed care data for inpatient hospital claims filed for reimbursement by a hospital that:

(A) had a date of admission occurring within the reporting time period;

(B) were adjudicated and approved for payment during the reporting time period and the six-month grace period that immediately followed, except for such claims that had zero inpatient days;

(C) were not inpatient stays for patients who are covered by Medicare;

(D) were not claims for patients diagnosed with major metastatic cancer, organ transplants, human immunodeficiency virus (HIV), or major trauma; and

(E) were not subject to other exclusions as determined by HHSC.

(7) HHSC—The Health and Human Services Commission or its designee.

(8) Hospital—A public or private institution licensed or run by the state to provide medical, surgical, or psychiatric treatment.

(9) Medicaid program—A jointly funded state-federal health care program established under Title XIX of the federal Social Security Act (42 U.S.C. Chapter 7, Title XIX).

(10) Norm—The Texas statewide average or the standard by which hospital PPC performance is compared.

(11) Potentially preventable complication (PPC)—A harmful event or negative outcome with respect to a person, including an infection or surgical complication, that:

(A) occurs after the person's admission to an inpatient acute care hospital; and

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Payment Adjustment for Potentially Preventable Complications (continued)

(B) may have resulted from the care, lack of care, or treatment provided during the hospital stay rather than from a natural progression of an underlying disease.

(12) Potentially preventable event (PPE)—A potentially preventable admission, a potentially preventable ancillary service, a potentially preventable complication, a potentially preventable emergency room visit, a potentially preventable readmission, or a combination of those events.

(13) Present on Admission (POA) Indicators—A coding system that requires hospitals to accurately submit principal and secondary diagnoses that are present at the time of admission. POA codes are essential for the accurate calculation of PPC rates and consist of the current coding set approved by CMS.

(14) Reporting time period—The period of time that includes hospital claims that are assessed for PPCs. This may be a state fiscal year (September through August) or other specified time frame as determined by HHSC. PPC Reports will consist of statewide and hospital-specific reports and will be done at least on an annual basis, using the most complete data period available to HHSC.

(c) Calculating a PPC rate. Using inpatient claims during the reporting time period and HHSC-designated software and methodology, HHSC calculates an actual PPC rate and an expected PPC rate for each hospital included in the analysis. The methodology for inclusion of hospitals in the analysis will be described in the statewide and hospital-specific reports. HHSC will determine at its discretion the relative weights of PPCs when calculating the actual-to-expected ratio.

(d) Comparing the PPC performance of all hospitals included in the analysis. Using the rates determined in subsection (c) of this section, HHSC calculates a ratio of actual-to-expected PPC rates.

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Payment Adjustment for Potentially Preventable Complications (continued)

(e) Reporting results of PPC rate calculations. HHSC provides a confidential report to each hospital included in the analysis regarding the hospital's performance with respect to potentially preventable complications, including the PPC rates calculated as described in subsection (c) of this section and the hospital's actual-to-expected ratio calculated as described in subsection (d) of this section.

(f) Hospitals subject to reimbursement adjustment and amount of adjustment.

(1) A hospital with an actual-to-expected PPC ratio equal to or greater than 1.10 and equal to or less than 1.25 is subject to a reimbursement adjustment of -2 percent;

(2) A hospital with an actual-to-expected PPC ratio greater than 1.25 is subject to a reimbursement adjustment of -2.5 percent.

(g) Claims subject to reimbursement adjustment.

(1) The reimbursement adjustments described in subsection (f) of this section apply to all Medicaid fee-for-service claims beginning November 1, 2013 and after.

(2) The reimbursement adjustments will occur after the confidential report on which the reimbursement adjustments are based is made available to hospitals.

(3) The reimbursement adjustments for a hospital will cease in the adjustment time period that is after the hospital receives a confidential report indicating an actual-to-expected ratio of less than 1.10.

(4) Based on HHSC-approved POA data screening criteria, HHSC may implement automatic payment reductions to hospitals who fail POA screening. The POA screening criteria and methodology will be described in the statewide and hospital-specific reports. The POA screening process will begin during the 2015 state fiscal year reporting time period and will apply to the corresponding adjustment time period as follows:

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(A) Failure to meet POA screening criteria, first reporting period violation: 2 percent reduction applied to all Medicaid fee-for-service claims in the corresponding adjustment period.

(B) Failure to meet POA screening criteria, two or more violations in a row: 2.5 percent applied to all Medicaid fee-for-service claims in the corresponding adjustment period.

(C) If a hospital passes POA screening criteria during a reporting time period, any future violations of the POA screening criteria will be considered a first violation.

(5) The reimbursement adjustments based on POA screening criteria will cease when the hospital passes HHSC-approved POA screening criteria for an entire reporting time period, at which point the hospital will be subject to reimbursement adjustments, if applicable, based on criteria outlined in subsection (f) of this section.

(6) Hospitals that receive a reimbursement adjustment based on POA screening criteria outlined in paragraph (4) of this section will not concurrently receive reductions outlined in subsection (f) of this section.

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