

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850



Financial Management Group

JUN 26 2015

Jason A. Helgeson
State Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs
NYS Department of Health
Corning Tower, (OCP – 1211)
Albany, NY 12237

RE: State Plan Amendment (SPA) 14-0026

Dear Commissioner Helgeson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-26. Effective April 1, 2014, this amendment continues hospital reimbursement adjustments related to potentially preventable readmissions (PPR) and potentially preventable complications (PPC) through March 31, 2015.

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 regulations at 42 CFR 447 Subpart C. This is to inform you that New York 13-0041 is approved effective April 1, 2014. We are enclosing CMS-179 and the approved plan pages.

If you have any questions, please contact Betsy Pinho at 518-396-3810.

Sincerely,

A handwritten signature in black ink, appearing to read "Timothy Hill". The signature is written in a cursive, flowing style.

Timothy Hill
Director

A small handwritten mark or signature, possibly initials, located to the right of the typed name "Timothy Hill".

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 14-0026	2. STATE New York
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 1, 2014	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a) of the Social Security Act, and 42 CFR 447		7. FEDERAL BUDGET IMPACT: (in thousands) a. FFY 04/01/14-09/30/14 \$ (8,550.00) b. FFY 10/01/14-03/31/15 \$ (8,550.00)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A: Pages 120(a)(ii), 120(a)(iv), 120(b), 120(b)(i), 120(b)(ii)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-A: Pages 120(a)(ii), 120(a)(iv), 120(b), 120(b)(i), 120(b)(ii)	
10. SUBJECT OF AMENDMENT: PPNOs/PPRs Extension (FMAP = 50%)			
11. GOVERNOR'S REVIEW (Check One): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO: New York State Department of Health Division of Finance & Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1460 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgerson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: JUN 23 2014			

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17. DATE RECEIVED:	18. DATE APPROVED: JUN 26 2015
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 01 2014	20. SIGNATURE OF REGIONAL OFFICIAL: <i>Kristen Fan</i>
21. TYPED NAME: <i>Kristen Fan</i>	22. TITLE: Deputy Director, P&MG
23. REMARKS:	

New York
120(a)(ii)**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 for this period will result in an aggregate reduction in Medicaid payments of \$31,257,000. For discharges occurring on and after April 1, 2013 through March 31, 2014, such rate adjustments will result in an aggregate reduction in Medicaid payments of \$41,000,000. For discharges beginning April 1, 2014 through March 31, 2015, such rate adjustments will result in an aggregate reduction in Medicaid payments of \$20,500,000.

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

1. **Potentially Preventable Complications** will 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] 30 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] effective for periods on and after July 1, 2011, are available on the following Department of Health website link:

www.health.ny.gov/health_care/medicaid/quality/ppo/complications
2. **Hospital** will 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** will mean all non-Medicare acute care cases.
4. **PPC Coefficient** will 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** will be defined as the assigned hospital admission APR-DRG SOI for each observed case using version [28] 30 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.

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**New York
120(a)(iv)**

PPC Adjustment Factor.

1. Effective for the period July 1, 2011 through March 31, 2012, and for periods April 1, 2013 through March 31, [2014] 2015, 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 (IME) 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. POA data was evaluated using 2009 Statewide Planning and Research Cooperative System (SPARCS) 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

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120(b)**

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, will be reduced in accordance with the Payment Calculation Section. Such rate adjustments will result in an aggregate reduction in Medicaid payments of \$27.8 million for the period July 1, 2010 through March 31, 2011 and \$12 million for the period April 1, 2011 through March 31, 2012. For discharges occurring on and after April 1, 2013 through March 31, 2014, rate adjustments will result in an aggregate reduction in Medicaid payments of \$27.4 million and \$13.7 million for the period April 1, 2014 through March 31, 2015.

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

1. **Potentially Preventable Readmissions (PPR)** will 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 March 31, 2011; version 28 for the period April 1, 2011 through March 31, 2012; [and] version 29 for the period April 1, 2013 through March 31, 2014; version 30 for the period April 1, 2014 through June 30, 2014; version 31 for the period July 1, 2014 through December 31, 2014; and version 32 for the period January 1, 2015 through March 31, 2015.
2. **Hospital** will 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; and April 1, 2013 through March 31, [2014] 2015, the Expected Potentially Preventable Readmissions will 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** will mean the number of admissions in each hospital that were actually followed by at least one PPR divided by the total number of admissions.

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120(b)(i)

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, and for periods April 1, 2013 through March 31, [2014] 2015, 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:

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120(b)(ii)

- 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, 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, and for periods April 1, 2013 through March 31, [2014] 2015, 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, and for periods April 1, 2013 through March 31, [2014] 2015, the readmissions involve a discharge determined to be behavioral health related.

Methodology.

1. For the period July 1, 2010 through June 30, 2011, 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, and for periods April 1, 2013 through March 31, [2014] 2015, 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 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.

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