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State/Territory Name: Texas

State Plan Amendment (SPA) #: 16-0004 NIRT

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved Page(s)

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



Financial Management Group

MAY 24 2016

Mr. Gary Jessee
State Medicaid/CHIP Director
Health and Human Services Commission
Post Office Box 13247
Mail Code: H100
Austin, Texas 78711

RE: TN 16-0004

Dear Mr. Jessee:

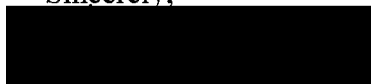
We have reviewed the proposed amendment to Attachments 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 16-0004. The purpose of this amendment is to revise the Texas Health and Human Services Commission's (HHSC's) potentially preventable events program. Specifically, it identifies a methodology for the payment of incentives to hospitals that have a relatively low rate of potentially preventable readmissions and potentially preventable complications.

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 16-0004 is approved effective May 15, 2016. We are enclosing the CMS-179 and the amended plan pages.

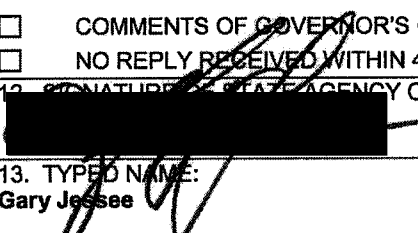

If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,



Kristin Fan
Director

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 16-0004	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: May 15, 2016	
5. TYPE OF PLAN MATERIAL (Circle 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: 42 U.S.C. §1396a(a)(19), (30)		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2016 \$6,435,078 b. FFY 2017 \$8,349,421 c. FFY 2018 \$8,335,446	
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: <p>The purpose of this amendment is to revise the Texas Health and Human Services Commission's (HHSC's) potentially preventable events program. Specifically, it would identify a methodology for incentives for HHSC-defined safety-net hospitals that have a relatively low rate of potentially preventable readmissions and potentially preventable complications. The Texas Legislature directed HHSC to implement such an incentive program. See the 2016-2017 General Appropriations Act, House Bill 1, 84th Legislature, Regular Session, 2015 (Article II, Special Provisions Section 59(b)). In addition, the amendments will clarify a hospital's ability to request its underlying data and the additional information it will contain. The amendments will also further refine the methodology, such as clarifying definitions, the present on admission screening adjustment, the rounding of the actual-to-expected ratio that is used to determine the penalties and incentives, and adds flexibility required for the changing needs of the program.</p>			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt. <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: Gary Jessee State Medicaid Director Post Office Box 13247, MC: H-100 Austin, Texas 78711	
13. TYPED NAME: Gary Jessee			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: March 16, 2016			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 3-16-2016		18. DATE APPROVED: MAY 24 2016	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 5-15-2016		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Kristin Fan		22. TITLE: Director, FMG	
23. REMARKS:			

Attachment to Blocks 8 & 9 of CMS Form 179

Transmittal Number 16-0004

**Number of the
Plan Section or Attachment**

**Number of the Superseded
Plan Section or Attachment**

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State of Texas
Appendix 2 to Attachment 4.19-A
Page 1

Payment Adjustment for Potentially Preventable Readmissions

- (a) Introduction. The Health and Human Services Commission (HHSC) may reward or penalize a hospital under this section based on the hospital's performance with respect to exceeding or 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.
 - (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 (APRDRG)—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 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;
 - (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.

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Payment Adjustment for Potentially Preventable Readmissions (continued)

- (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) Managed care organization (MCO)--A provider or organization under contract with HHSC to provide services to Medicaid or CHIP recipients using a health care delivery system or dental services delivery system in which provider or organization coordinates the patient's overall care.
- (13) 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).
- (14) 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)

- (15) 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.
- (16) 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.
- (17) Reporting time period—The period of time that includes hospital claims that are assessed for PPRs. This is a state fiscal year (September through August). 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.
- (18) Safety-net hospital—An urban or children's that meets the eligibility and qualification requirements (relating to Disproportionate Share Hospital Reimbursement Methodology) for the most recent federal fiscal year for which such eligibility and qualification determinations have been made.

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Payment Adjustment for Potentially Preventable Readmissions (continued)

- (c) Calculating a PPR rate. Using claims during the reporting time 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. The Actual-to-Expected Ratio is rounded to two decimal places and used to determine reimbursement adjustments described in subsection (f).
- (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.
 - (3) HHSC weights PPRs based on expected resource use.
- (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.
- (1) A hospital may request the underlying data used in the analysis to generate the report via an email request to the HHSC email address found on the report.
 - (2) The underlying data contains patient-level identifiers, information on all hospitals where the readmissions occurred, and other information deemed relevant by HHSC.
- (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 negative 1 percent;
 - (2) A hospital with an actual-to-expected PPR ratio greater than 1.25 is subject to a reimbursement adjustment of negative 2 percent.

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.
- (3) On an annual basis and based on review of the data quality and accuracy, HHSC may determine if reimbursement adjustments are appropriate.

(h) Targeted incentive payments for safety-net hospitals.

- (1) HHSC determines annually whether a safety-net hospital will receive an incentive payment for performance on PPR incidence.
- (2) The appropriated funds for the targeted incentive payments are split in half, 50 percent for PPRs and 50 percent for potentially preventable complications. HHSC can change the allocated percentages based on review of data and the changing needs of the program.
- (3) The dataset used in the incentive analysis is the same as the dataset used in the PPR reimbursement adjustments.
- (4) Hospitals that are eligible for a targeted incentive payment must meet the following requirements:
 - (A) be a safety-net hospital;
 - (B) have an actual-to-expected ratio of at least 10 percent lower than the statewide average (actual-to-expected ratio is less than or equal to 0.90);
 - (C) have not received a penalty for either PPRs or potentially preventable complications;
 - (D) are not low-volume, as defined by HHSC.

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Payment Adjustment for Potentially Preventable Readmissions (continued)

- (5) Calculation of targeted incentive payments.
 - (A) Calculate base allocation: Each eligible hospital is awarded a base allocation not to exceed \$100,000.
 - (B) Calculate variable allocation: Each eligible hospital is awarded a variable allocation, which are calculated from remaining funds after distribution of base allocations to all eligible hospitals. The variable allocation has the following components:
 - (i) Hospital size score: Each eligible hospital's size divided by the average size of the whole group of hospitals within each incentive pool. Size is calculated based on total inpatient facility claims paid to each eligible hospital. Each eligible hospital's size calculation is capped at 2.00.
 - (ii) Hospital Performance score: Each eligible hospital's performance divided by the average performance of the whole group of hospitals within each incentive pool. Performance is calculated by actual to expected ratio.
 - (iii) Composite score: Each eligible hospital receives a composite score, which is the hospital's size score multiplied by the hospital's performance score.
 - (iv) Each hospital's composite score divided by the sum of all eligible hospitals' composite scores is multiplied by the remaining incentive funds, after distribution of base allocations.
 - (C) Calculate final allocation: The final allocation to each eligible hospital is equal to the eligible hospital's base allocation plus the eligible hospital's variable allocation.
- (6) Each eligible hospital's PPR incentive payment will be divided between FFS and MCO reimbursements based on the percentage of its total paid FFS and MCO Medicaid inpatient hospital reimbursements for the reporting time period accruing from FFS.
- (7) PPR incentive payments will be made as lump sum payments or tied to particular claims or recipients, at HHSC's discretion.
- (8) HHSC will post the methodology for calculating and distributing incentives on its public website at http://www.hhsc.state.tx.us/hhsc_projects/ECI/Potentially-Preventable-Events.shtml.
- (9) Targeted incentive payments for safety-net hospitals are not included in the calculation of a hospital's hospital-specific limit or low income utilization rate.

Payment Adjustment for Potentially Preventable Complications

(a) Introduction. The Health and Human Services Commission (HHSC) may reward or penalize a hospital under this section based on the hospital's performance with respect to exceeding or 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 (APRDRG 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 (APRDRG)**—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).

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Payment Adjustment for Potentially Preventable Complications (continued)

- (6) HHSC—The Health and Human Services Commission or its designee.
- (7) 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.
- (8) Hospital—A public or private institution licensed or run by the state to provide medical, surgical, or psychiatric treatment.
- (9) Managed care organization (MCO)— Managed care is a health care delivery system or dental services delivery system in which the overall care of a patient is coordinated by or through a single provider or organization. MCO refers to such a provider or organization under contract with HHSC to provide services to Medicaid recipients.
- (10) 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).
- (11) Norm—The Texas statewide average or the standard by which hospital PPC performance is compared.
- (12) 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
 - (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.

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Payment Adjustment for Potentially Preventable Complications (continued)

- (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 those events.
- (14) 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.
- (15) 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.
- (16) Safety-net hospital—An urban or children's hospital that meets the eligibility and qualification requirements (relating to Disproportionate Share Hospital Reimbursement Methodology) for the most recent federal fiscal year for which such eligibility and qualification determinations have been made.

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Payment Adjustment for Potentially Preventable Complications (continued)

- (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. The Actual-to-Expected Ratio is rounded to two decimal places and used to determine reimbursement adjustments described in subsection (f).
- (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.
- (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.
 - (1) A hospital can request the underlying data used in the analysis to generate the report via an email request to the HHSC email address found on the report.
 - (2) The underlying data contains patient-level identifiers and other information deemed relevant by HHSC.
- (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 negative 2 percent;
 - (2) A hospital with an actual-to-expected PPC ratio greater than 1.25 is subject to a reimbursement adjustment of negative 2.5 percent.

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Payment Adjustment for Potentially Preventable Complications (continued)

(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) On an annual basis and based on review of the data quality and accuracy, HHSC may determine if reimbursement adjustments are appropriate.
- (5) 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. At its discretion, HHSC applies the following adjustments based on POA screening criteria:
 - (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.
- (6) 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.
- (7) 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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Payment Adjustment for Potentially Preventable Complications (continued)

(h) Targeted incentive payments for safety-net hospitals.

- (1) HHSC determines annually whether a safety-net hospital will receive an incentive payment for performance on PPC incidence.
- (2) The appropriated funds for the targeted incentive payments are split in half, 50 percent for PPCs and 50 percent for potentially preventable readmissions. HHSC can change the allocated percentages based on review of data and the changing needs of the program.
- (3) The dataset used in the incentive analysis is the same as the dataset used in the PPC reimbursement adjustments.
- (4) Hospitals that are eligible for a targeted incentive payment must meet the following requirements:
 - (A) be a safety-net hospital;
 - (B) have an actual-to-expected ratio of at least 10 percent lower than the statewide average (actual-to-expected ratio is less than or equal to 0.90);
 - (C) have not received a penalty for either PPCs or potentially preventable readmissions;
 - (D) are not low-volume, as defined by HHSC.

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Payment Adjustment for Potentially Preventable Complications (continued)

- (5) Calculation of targeted incentive payments.
 - (A) Calculate base allocation: Each eligible hospital is awarded a base allocation not to exceed \$100,000.
 - (B) Calculate variable allocation: Each eligible hospital is awarded a variable allocation, which are calculated from remaining funds after distribution of base allocations to all eligible hospitals. The variable allocation has the following components:
 - (i) Hospital size score: Each eligible hospital's size divided by the average size of the whole group of hospitals within each incentive pool. Size is calculated based on total inpatient facility claims paid to each eligible hospital. Each eligible hospital's size calculation is capped at 2.00.
 - (ii) Hospital Performance score: Each eligible hospital's performance divided by the average performance of the whole group of hospitals within each incentive pool. Performance is calculated by actual to expected ratio.
 - (iii) Composite score: Each eligible hospital receives a composite score, which is the hospital's size score multiplied by the hospital's performance score.
 - (iv) Each hospital's composite score divided by the sum of all eligible hospitals' composite scores is multiplied by the remaining incentive funds, after distribution of base allocations.
 - (C) Calculate final allocation: The final allocation to each eligible hospital is equal to the eligible hospital's base allocation plus the eligible hospital's variable allocation.
- (6) Each eligible hospital's PPC incentive payment will be divided between FFS and MCO reimbursements based on the percentage of its total paid FFS and MCO Medicaid inpatient hospital reimbursements for the reporting time period accruing from FFS.
- (7) PPC incentive payments will be made as lump sum payments or tied to particular claims or recipients, at HHSC's discretion.
- (8) HHSC will post the methodology for calculating and distributing incentives on its public website at http://www.hhsc.state.tx.us/hhsc_projects/ECI/Potentially-Preventable-Events.shtml.
- (9) Targeted incentive payments for safety-net hospitals are not included in the calculation of a hospital's hospital-specific limit or low income utilization rate.