Potentially Preventable Readmissions

Effective date: 2/23/11

Pursuant to the authority vested in the Commissioner of Health by section 2807-c(35) of the Public Health Law, Subpart 86-1 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York, is amended by adding a new Section 86-1.37, to be effective upon publication of the Notice of Adoption in the New York State Register, to read as follows:

Part 86-1.37 Readmissions

(a) For discharges occurring on and after July 1, 2010, Medicaid rates of payment to hospitals that have an excess number of readmissions as defined in accordance with the criteria set forth in subdivision (c), as determined by a risk adjusted comparison of the actual and expected number of readmissions in a hospital as described by subdivision (d), shall be reduced in accordance with subdivision (e).

(b) Definitions. For purposes applicable to this section the following terms shall be defined as follows:

(1) Potentially Preventable Readmission (PPR) shall mean a readmission to a hospital that follows a prior discharge from a hospital within 14 days, and that is clinically-related to the prior hospital admission.

(2) Hospital shall mean a general hospital as defined pursuant to section 2801 of the Public Health Law.

(3) 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.

(4) 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.

(5) Excess Rate of Readmission shall mean the difference between the observed rates of potentially preventable readmissions and the expected rate of potentially preventable readmissions for each hospital.

(6) Behavioral Health shall mean an admission that includes a primary or secondary diagnosis of a major mental health related condition, including, but not limited to, chemical dependency and substance abuse.

(7) Managed Care Encounter Data shall mean claims-like data that describes services provided by managed care plans to their enrollees.

(c) Readmission Criteria.

(1) A readmission is a return hospitalization following a prior discharge that meets all of the following criteria:

(i) 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.

(ii) 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:

(a) The same or closely related condition or procedure as the prior discharge.

(b) An infection or other complication of care.

(c) A condition or procedure indicative of a failed surgical intervention.

(d) An acute decompensation of a coexisting chronic disease.

(iii) The readmission is back to the same or to any other hospital.

(2) Readmissions, for the purposes of determining PPRs, excludes the following circumstances:

(i) 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.

(ii) The original discharge was for the purpose of securing treatment of a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions.

(iii) The readmission was a planned readmission or one that occurred on or after 15 days following an initial admission.

(iv) For readmissions occurring during the period up through March 31, 2012, the readmission involves an original discharge determined to be behavioral health related.

(d) Methodology.

(1) Rate adjustments for each hospital shall be based on such hospital's 2007 Medicaid paid claims data and managed care encounter data for discharges that occurred between January 1, 2007 and December 31, 2007.

(2) The expected rate of readmissions shall be reduced by 24% for each hospital for periods prior to September 30, 2010; 38.5% for the period October 1, 2010 through December 31, 2010; and 33.3% on and after January 1, 2011.

(3) Excess readmission rates are calculated based on the difference between the observed rate of PPRs and the expected rate of PPRs for each hospital.

(4) In the event the observed rate of PPRs for a hospital is lower than the expected rate of PPRs, the excess number of readmissions shall be set at zero.

(e) Payment Calculation.

(1) For the excess readmissions identified in paragraph (3) of subdivision (d) of this section, each hospital's projected payment rate for the 2010 rate period, as otherwise computed in accordance with this subpart, will be used to compute the relative aggregate payments, excluding behavioral health, associated with the risk adjusted excess readmissions in each hospital.

(2) For each hospital, a hospital specific readmission adjustment factor shall be computed as one minus the ratio of the hospital's relative aggregate payments associated with the excess readmissions from paragraph (3) of subdivision (d) of this section and the

hospital's relative aggregate payments for all non-behavioral health Medicaid discharges as determined pursuant to this subdivision.

(3) Non-behavioral health related payments to hospitals shall be reduced by applying the hospital readmission adjustment factor from paragraph (2) of this subdivision to the applicable case payment or per-diem payment amount for all non-behavioral health related Medicaid discharges to the hospital.

REGULATORY IMPACT STATEMENT

Statutory Authority:

The requirement to implement a rate adjustment to hospitals to address potentially preventable readmissions (PPRs) using a methodology that is based on a comparison of the actual and the expected number of PPRs in a given hospital pursuant to regulations is set forth in section 2807-c(35)(b)(v) of the Public Health Law.

Legislative Objectives:

After discussions between the Executive, Legislature, and hospital associations, the Legislature chose to address the issue of a high rate of readmissions in hospitals that could have been avoided. Pursuant to statute, the PPR methodology was chosen as the vehicle to address this through a rate adjustment that would reduce reimbursement to hospitals that had a historically (based on 2007 data) high rate of clinically related readmissions.

Needs and Benefits:

The proposed regulations implement the provisions of Public Health Law section 2807-c(35)(b)(v) which requires a rate adjustment related to PPRs. Hospital readmissions are increasingly viewed as indicative of quality of care issues, ranging from complications during the hospital stay or immediately afterward, incomplete treatment of the underlying medical problem during the hospitalization, or poor or no outpatient care. Readmissions are also costly; thereby fueling the interest in linking payment to quality of care, especially when these readmissions might have been avoided.

This regulation, in concert with enacted statute, implements an adjustment to hospital rates to incentivize these providers to become more accountable to the individuals that they are discharging. Better quality of care, upfront, will likely reduce the rate of readmissions thereby saving funds that would have otherwise been expensed simultaneously resulting in better patient outcomes. It is anticipated that this payment adjustment is the first step into addressing the policy issue of readmission rates in hospitals and will likely be refined in future regulation amendments to address a broader Medicaid population and more recent data sources.

COSTS:

Costs to State Government:

Section 2807-c(35)(b)(v) of the Public Health Law requires that the rates of payment for hospital inpatient services be reduced to result in a net statewide decrease in aggregate Medicaid payments of no less than $35 million for the period July 1, 2010 through March 31, 2011 and no less than $47 million for the period April 1, 2011 through March 31, 2012.

Costs of Local Government:

There will be no additional cost to local governments as a result of these amendments because local districts' share of Medicaid costs is statutorily capped.

Costs to the Department of Health:

There will be no additional costs to the Department of Health as a result of these amendments.

Local Government Mandates:

The proposed regulations do not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

Paperwork:

There is no additional paperwork required of providers as a result of these amendments.

Duplication:

These regulations do not duplicate existing State and Federal regulations.

Alternatives:

No significant alternatives are available. The Department is required by the Public Health Law sections 2807-c(35)(b)(v) to promulgate implementing regulations. However, alternatives may be available at a later date as a result of the requirement that the Department enters into consultations with representatives of the health care facilities regarding potential prospective revisions to the methodologies and benchmarks set forth in this amendment by no later than April 1, 2011.

Federal Standards:

This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:

The proposed amendment establishes a new rate adjustment to address potentially preventable readmissions (PPRs) in hospitals for discharges on or after July 1, 2010; there is no period of time necessary for regulated parties to achieve compliance.

Contact Person: Katherine Ceroalo
New York State Department of Health
Bureau of House Counsel, Regulatory Affairs Unit
Corning Tower Building, Room 2438
Empire State Plaza
Albany, New York 12237
(518) 473-7488
(518) 473-2019 (FAX)
REGSQNA@health.state.ny.us

REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESS AND LOCAL GOVERNMENTS

Effect on Small Business and Local Governments:

For the purpose of this regulatory flexibility analysis, small businesses were considered to be general hospitals with 100 or fewer full time equivalents. Based on recent financial and statistical data extracted from the Institutional Cost Report, seven hospitals were identified as employing fewer than 100 employees.

In aggregate, health care providers subject to this regulation will see a decrease in average per discharge Medicaid funding, but this is not anticipated for all affected providers.

This rule will have no direct effect on Local Governments.

Compliance Requirements:

No new reporting, record keeping or other compliance requirements are being imposed as a result of these rules. Affected health care providers will bill Medicaid using procedure codes and ICD-9 codes approved by the American Medical Association, as is currently required.

The rule should have no direct effect on Local Governments.

Professional Services:

No new or additional professional services are required in order to comply with the proposed amendments.

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor will there be an annual cost of compliance. As a result of the amendment to 86-1.37 there will be an anticipated decrease in statewide aggregate hospital Medicaid revenues for hospital inpatient services.

Economic and Technical Feasibility:

Small businesses will be able to comply with the economic and technological aspects of this rule. The proposed amendments are technologically feasible because it requires the use of existing technology. The overall economic impact to comply with the requirements of this regulation is expected to be minimal.

Minimizing Adverse Impact:

The proposed amendment reflects statutory intent and requirements. This amendment is the result of ongoing discussions with industry associations regarding the appropriate implementation of a risk adjusted PPR methodology. The Department is required by Public Health Law sections 2807-c(35)(b)(v) to enter into consultations with representatives of health care facilities regarding potential prospective revisions to the applicable methodologies and benchmarks set forth in this amendment by no later than April 1, 2011.

Small Business and Local Government Participation:

Draft regulations, prior to filing with the Secretary of State, were shared with industry associations representing hospitals and comments were solicited from all affected parties. Informational briefings were held with such associations.

RURAL AREA FLEXIBILITY ANALYSIS

Effect on Rural Areas:

Rural areas are defined as counties with a population less than 200,000 and, for counties with a population greater than 200,000, includes towns with population densities of 150 persons or less per square mile. The following 44 counties have a population less than 200,000:

Allegany	Hamilton	Schenectady
Cattaraugus	Herkimer	Schoharie
Cayuga	Jefferson	Schuyler
Chautauqua	Lewis	Seneca
Chemung	Livingston	Steuben
Chenango	Madison	Sullivan
Clinton	Montgomery	Tioga
Columbia	Ontario	Tompkins
Cortland	Orleans	Ulster
Delaware	Oswego	Warren
Essex	Otsego	Washington
Franklin	Putnam	Wayne
Fulton	Rensselaer	Wyoming
Genesee	St. Lawrence	Yates
Greene	Saratoga	

The following 9 counties have certain townships with population densities of 150 persons or less per square mile:

Albany	Erie	Oneida
Broome	Monroe	Onondaga
Dutchess	Niagara	Orange

Compliance Requirements:

No new reporting, record keeping, or other compliance requirements are being imposed as a result of this proposal.

Professional Services:

No new additional professional services are required in order for providers in rural areas to comply with the proposed amendments.

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor is there an annual cost of compliance.

Minimizing Adverse Impact:

The proposed amendments reflect statutory intent and requirements. The Legislature considered various alternatives for addressing hospital readmissions that are determined to be clinically related to an initial discharge; however, the enacted budget adopted the risk adjusted PPR methodology.

Rural Area Participation:

Draft regulations, prior to filing with the Secretary of State, were shared with the industry associations representing hospitals and comments were solicited from all affected parties. Such associations include members from rural areas.

JOB IMPACT STATEMENT

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent, from the nature and purpose of the proposed rules, that they will not have a substantial adverse impact on jobs or employment opportunities. The proposed regulations revise the reimbursement system for inpatient hospital services. The proposed regulations have no implications for job opportunities.

Assessment of Public Comment

The Department received a letter with comments and concerns relating to the establishment of Part 86-1.37, regulations implementing the Potentially Preventable Readmissions payment policy. The comments in the letter coordinated by the Healthcare Association of New York State (HANYS) and our response to them are as follows:

1. Comment: HANYS argues that the methodology of adjusting expected experiences to meet targeted rate reductions, which effects over 90% of hospitals, is counterintuitive to promoting appropriate quality related measures.

   Response: The Department has established a risk adjusted method that predicts the expected number of PPRs within a 14 day window at each hospital based on historic (2007) claims data. For all hospital admissions that were "at risk" of being followed by a PPR, a statistical model was developed that predicted the likelihood of a subsequent PPR based on the recipient's condition (APR-DRG) and severity of illness, as well as the recipient's age at the time of that initial hospital admission. In this way, the recipient's clinical condition prior to any subsequent readmissions served as the basis for our estimate of whether or not a subsequent readmission was likely to occur.
   The expected number of PPRs are derived from the statistical model for all at risk events at each hospital was then compared to the observed number of PPRs at that hospital within 14 days of the at risk event to examine performance standards. As a result of

budget negotiations, the statute incorporated a required gross Medicaid savings target. In order to comply with the enabling statute, the expected number of PPRs derived from the statistical model had to be reduced.

Although under the proposed regulations 92% of hospitals would suffer financial penalties, only 3.8% of hospitals will sustain a PPR penalty exceeding 2% of their Medicaid revenue (full annual hospital-specific PPR percentage reduction factors).

2. Comment: HANYS contends that the Department's use of 2007 data does not incentivize hospitals to improve outcomes now and in the future

   Response: 2007 claims were the most recent and reliable records that the Department had available during the development of the PPR methodology. During budget discussions and in the educational webinars the State has indicated that a process to engage stakeholders was underway to begin advancing the base year data for 2011 and forward.

3. Comment: HANYS does not agree with the State's policy to include PPRs where the initial admission was medical/surgical but the readmission has a primary or secondary diagnosis of behavioral health.

   Response: The PPR proposal excludes all initial events followed by PPRs and all subsequent readmissions (regardless of whether they were behavioral health related or not) if the initial admission had a primary or secondary diagnosis that was behavioral

health related, mental health or substance abuse related (as defined by ICD-9-CM diagnosis codes). However, if the initial admission was not behavioral health related, this admission and all subsequent readmissions (behavioral health or not) were included in all subsequent calculations. The State believes that it is entirely appropriate to include these events since it was the initial medical/surgical admission that was clinically related to subsequent readmissions.

4. Comment: HANYS proposes utilizing other variables in assessing the risk adjusted rates for readmissions, which will recognize the disproportionate impact on safety net providers and other hospitals serving low income communities.

   Response: Although we believe clinical risk for readmissions was appropriately assessed using the methodology described, the State is open to further discussions with the Industry on any opportunity to improve the risk adjusted methodology. Regardless of any revisions, unless statutorily changed, $47 million in gross Medicaid savings will have to be achieved.

5. Comment: HANYS contends that non-case payment hospitals should be excluded from the PPR reduction calculation.

   Response: A statutory change would be required to exclude non-case payment hospitals and/or low volume Medicaid providers from the PPR reduction calculation.

6. Comment: HANYS is advocating for a reconciliation of savings by hospital to the statewide target reduction due to fluctuations in volume.

   Response: A statutory change would be required to reconcile the actual savings achieved to the total penalty calculated for each hospital based on historic data. Although there will most likely be inequities caused by fluctuations in hospital volume and any increase in hospital admissions subsequent to 2007, some of that is captured under DOH's current methodology because the percentage reduction is calculated using projected 2010 revenue (using 2008 Medicaid claims). In addition, the Department plans to use more recent Medicaid claims data (2009) to calculate PPR rates and adjustments in subsequent fiscal years, which should mitigate this issue.

7. Comment: HANYS indicates that the 3M proprietary software is cost prohibitive, thus limiting the ability of hospitals to access the software to monitor and replicate the calculations used by DOH or to inform their ongoing quality improvement efforts.

   Response: 3M's APR-DRG grouping software is currently being used by all hospitals and most vendors for Medicaid claiming purposes. In addition, at the request of the State, 3M has worked with the Associations and individual hospitals to negotiate significantly discounted rates for the grouping and PPR software applications.

8. Comment: HANYS believes that Medicaid savings should come from reduced readmission rates, not financial penalties adjusted to meet a budget target. HANYS is

concerned that the message this proposal regulation communicates to the provider community is that cost savings, not standards of care, will drive quality of care and patient safety.

Response: The current design of the Medicaid fee-for-service inpatient payment system does not provide incentives to contain avoidable readmissions or promote high quality of care. It presents incentives for providers to increase volume of care rather than to reduce it; reducing readmissions would result in fewer billable discharges. A hospital that has performed poorly, observed higher readmission rates than what was expected, will be penalized.

9. Comment: HANYS encourages an approach targeted toward the dual goals of cost savings and improved care management. HANYS believes a positive first step toward creation of a quality-directed readmissions policy is for DOH to reward hospitals that take action to reduce preventable readmissions.

Response: DOH's original intent was to promote quality improvement through incentive payments to improved/high quality of care performers. The Governor's Executive Budget (2010-11) proposal for PPRs did include financial incentives for those hospitals demonstrating improved rates of readmissions. However, this initiative was not included as part of the final negotiated budget. Incentive payments cannot be made without statutory authority. DOH agrees that there will be associated savings accrued from a

decrease in the number of readmissions going forward, and that these savings need to be recognized in some manner (i.e. incentive payment funding).