



## **Overview: Model Legislation to Reduce Potentially Preventable Readmissions and Complications**

### **A Crisis in Quality**

When patients are admitted to a hospital, they expect to get the care they need to improve their health. Unfortunately, too many patients become sicker during their stay or leave the hospital without the instructions or follow-up care needed to avoid bouncing back within days or weeks after their discharge. These problems – referred to as potentially preventable complications or readmissions – have serious and negative consequences for patients' health.

**Potentially preventable complications (PPCs)** include problems such as infections in surgical sites, urinary tract infections from catheters, instruments or other foreign bodies left in patients after surgery, or a heart attack after being admitted into the hospital. These types of complications often lower the quality of life for patients and add significant costs to a patient's hospital stay. For instance, about 1 in 20 patients gets an infection each year while receiving medical care. That translates to an estimated 1.7 million health care associated infections annually, leading to longer hospital stays and, tragically, about 100,000 deaths. And yet, PPCs can often be avoided by following evidence-based guidelines for care.

**Potentially preventable readmissions (PPRs)** are hospital readmissions – occurring in a short window of time after a patient leaves the hospital the first time – that could have been prevented had the hospital engaged in effective discharge care planning and coordinated outpatient follow-up. Approximately 20 percent of patients admitted to U.S. hospitals each year are readmitted within 30 days of discharge.

### **A Crisis in Cost**

The human toll of PPRs and PPCs is clear. But, these events also exact an enormous cost on our public programs, including Medicaid and Medicare. PPRs cost an estimated \$25 billion annually. The Medicare Payment Advisory Commission (MedPAC) estimated that in 2005, readmissions cost the Medicare program \$15 billion – \$12 billion of which could have been prevented.

The cost to state Medicaid programs is also huge. In Maryland, for example, during fiscal year 2008, PPCs occurred in over six percent of inpatient cases costing the state \$522 million. A study of PPCs in Maryland and California found that they added more than nine percent to the cost of hospital care, and even more hospital costs are attributable to PPRs.

### **What's To Be Done?**

States, whose budgets are still in dire condition, are actively searching for ways to reduce their Medicaid costs. To date, many states have proposed Medicaid provider rate cuts, benefit cuts, cost-sharing increases, and eligibility cuts. These cuts jeopardize access to needed services for

some of America's most vulnerable populations: low-income seniors, people with disabilities, and children with special needs. Moreover, they do nothing to move the health care system in a better direction. Instead they increase the cost of uncompensated care and the burden of medical debt, reduce provider participation in the Medicaid program, and often push patients to use more inpatient and institutional care rather than lower cost alternatives.

## A Better Way

Instead of cutting eligibility, benefits or rates, states can put Medicaid on a more sustainable path by changing the way Medicaid pays hospitals to create incentives for reducing PPCs and PPRs. Two states – New York and Maryland – have already begun taking this approach, and are seeing impressive savings. For example, in its second year of adjusting payment rates for PPCs, Maryland experienced an 11.9 percent drop in the frequency of PPCs, resulting in savings of approximately \$62.5 million. And New York estimates that they will see \$47 million in total savings in the first year of their payment reform through rate changes alone (not counting savings associated with a potential drop in PPRs). Texas recently enacted a law that would take a similar approach.

## The Rate-Based Approach

It is this background that provides the impetus for this [Model Legislation](#). In creating model requirements, we seek to provide states with a sensible alternative to harmful Medicaid cuts; one that promotes better care for beneficiaries while also lowering overall Medicaid costs. Through the Model Legislation, we encourage states to go further than the minimum federal requirements around PPCs and PPRs.

This Model Legislation provides a statutory framework for a rate-based approach to reducing potentially preventable readmissions and complications. This approach would reduce inpatient payment rates to hospitals with higher-than-expected rates of PPRs or PPCs.

The Model Legislation takes a balanced view of these adverse hospital outcomes: not every complication or readmission is always preventable, and no hospital could be expected to lower its rate of these events to zero. Thus, we do not believe it is appropriate to *eliminate* payment altogether for these events. Instead, the Model Legislation is premised on an approach that allows states to *adjust a portion of hospital payments* based on their rates of PPRs and PPCs. We believe that with this approach, states can produce immediate savings in public programs while creating meaningful incentives for hospitals to improve quality of care.

## Key considerations

### PPCs: How Many to Include?

States must first decide which PPCs to consider when determining payment adjustments for hospitals. States can look at a narrow list of complications that hospitals have more control over – for example, those that Medicare currently uses to deny payments to providers. However, this is a limited list of so-called “never events” – such as surgery on the wrong body part – that are virtually always preventable if providers follow evidence-

based guidelines for care. Fortunately, this type of event occurs very infrequently. But, as a result, reducing payment for these events is unlikely to achieve major savings or improve quality of care significantly. Indeed, Medicare's nonpayment policy is estimated to reduce payments by only .001 percent.

By contrast, adjusting rates for a wider array of PPCs – those that are still usually preventable but over which hospitals have slightly less control – will produce greater savings and quality improvements. For example, Maryland's Medicaid payment policy, implemented in 2009, applies to a much more comprehensive list of potentially preventable events than the list from the Centers for Medicare and Medicaid Services – 49 in total. After risk-adjustments to account for patient characteristics, Maryland hospitals with higher than average PPCs got an overall decrease in their payment rates, and hospitals with lower than average PPCs got an overall increase in their payment rates.

While the Model Legislation does not recommend a particular number or type of PPCs, it defines PPCs broadly enough to encompass complications far beyond “never events” and charges a state with the responsibility of developing a comprehensive list through the regulatory process.

### **PPRs: Time Interval and Location of Readmission**

In defining a PPR, states should carefully consider the time interval between a patient's discharge and a readmission. Shorter intervals, such as 7 days, will increase the certainty that the readmission is related to the prior discharge, whereas longer intervals, such as 30 days, will decrease the certainty but increase the savings to a state. The Model Legislation charges the state with using the regulatory process to define the time interval.

Another issue for states to consider is whether to adjust payments for readmissions that happen at hospitals beyond the original admitting hospital. We recommend that states define PPRs as admissions to *any hospital* within a specified time period, rather than admissions only to the discharging hospital. When a state defines PPRs as readmissions to any hospital within a specified time period, it must ensure that only the discharging hospital is held responsible for a PPR, which is more likely to relate to shortcomings in the discharge, not the admission.

### **Collecting the right data**

In order to separate conditions with which patients enter the hospital from conditions that are acquired at the hospital and could have been prevented, states will need to collect data on conditions present at the time of admission. While some states already collect this data, many do not. To find out whether your state collects this data, contact your state hospital licensing agency, your state health care data collection agency, or your state public health agency.

### **Risk adjustment**

To design a successful strategy for reducing PPCs and PPRs, states must “risk-adjust” hospitals' rates of preventable complications or readmissions. This will take into account

the unique health status and social risk factors of the patients of each hospital. Risk adjustment is essential to prevent penalizing hospitals that treat patients who are sicker and harder to care for, since these patients are more prone to PPCs and PPRs. Risk adjusting hospitals' rates of complications or readmissions allows the state to see how their rates would compare if they all saw the same variety of patients.

Risk adjustment should differ for PPCs and PPRs. States should account for a patient's socioeconomic status and other psychosocial factors when risk adjusting a hospital's rate of PPRs, since those factors correlate with higher rates of readmissions. Unlike PPRs, states should *not* risk-adjust PPC rates to reflect socioeconomic status, since PPCs arise from failures in the hospital's care processes and are likely not correlated with a patient's socioeconomic status.

It is important to note that creating a fair risk adjustment system, while fundamental, is likely to be among the greatest technical challenges for states. Although some states already use a risk adjustment method for payment rates, many states use simplistic or outdated methodologies that don't account for varied risk.

### **An appropriate benchmark**

Another critical issue for states is setting the standard against which hospitals' performance on PPCs and PPRs will be measured. For example, do we compare hospitals' PPC and PPR rates with the average rate, the median rate, or with a higher standard achieved by the best-performing hospitals? The Model Legislation measures hospitals' performance against a benchmark set by the state after reviewing the rates achieved by all hospitals within the state and the rates achieved by its best-performing hospitals. Payment adjustments would be based on the excess number of PPRs or PPCs in a hospital, determined by comparing a hospital's risk-adjusted rate to the benchmark rate, after risk-adjustment. A state might also consider whether a hospital should get "credit" for having a PPC or PPR rate that is *below* the benchmark level.

A final consideration for states is whether to define the rate of PPCs as the percentage of admissions with at least one PPC or as the total number of PPCs divided by the total number of admissions. If a state defines the rate of PPCs as the percentage of admissions with at least one PPC, then the definition would not capture admissions with multiple PPCs during the hospital stay.

## **The Bottom Line**

State laws that adjust hospital payments rates for potentially preventable readmissions and complications can both improve hospital care for patients while also reducing the wasteful costs associated with that care. This approach provides a better alternative to the kinds of dangerous tactics – Medicaid provider rate cuts, benefit cuts, cost-sharing increases, and eligibility cuts – that would only result in diminishing the quality of health care for our most vulnerable populations.