**Section 152.300 Adjustment for Potentially Preventable Readmissions**

a) Notwithstanding any provision set forth in 89 Ill. Adm. Code 148 or 149 and unless otherwise stated in this Section, the changes described in this Section will be effective January 1, 2013.

b) For clean claims received on or after January 1, 2013, rates of payment to hospitals that have an excess number of readmissions, as defined in accordance with the criteria set forth in subsection (d), as determined by a risk adjusted comparison of the actual and targeted number of readmissions in a hospital as described by subsection (e), shall be reduced in accordance with subsection (f).

c) Definitions. For purposes of this Section, the following terms are defined in this subsection (c). For State fiscal year 2013, the Potentially Preventable Readmission (PPR) methodology, version 27 of the definitions manual applicable to the 3M Potentially Preventable Readmissions Grouping Software created and maintained by the 3M Corporation will be used by HFS to process admissions data and determine whether an admission is a Potentially Preventable Readmission. This version is available by registering at the following link: https://support.3mhis.com/app/answers/detail/a\_id/4133/kw/PPR. For the State fiscal year 2014 PPR methodology, version 29 of the definitions manual applicable to the PPR software created and maintained by the 3M Corporation will be used by HFS to process admissions data and determine whether an admission is a Potentially Preventable Admission. This version is available by registering at the link referenced above. Beyond State fiscal year 2014, the version that the Department will utilize will be updated in rule as soon as the information becomes available to the Department. Except when other definitions and criteria applicable to PPR are specified in this Section, the methodology applied by the 3M PPR Grouping Software and contained in the Potentially Preventable Readmissions Classification System Methodology Overview (GRP-139, May 2008, no later amendments or editions included) published by 3M Health Information Systems, 575 West Murray Blvd., Salt Lake City UT 84123, and accessible athttp://www2.illinois.gov/hfs/SiteCollectionDocuments/

3MPotentiallyPreventableReadmissions.pdf, is incorporated by reference.

1) "Potentially Preventable Readmission" or "PPR" shall mean a readmission meeting the readmission criteria in subsection (d) that follows a prior discharge from a hospital within 30 days and that is clinically-related to the prior hospital admission.

2) "Hospital" shall mean a hospital as defined in 89 Ill. Adm. Code 148.25(b).

3) "Base Year" shall mean State fiscal year 2010 and it is the initial data year the Department used to calculate the statewide average PPR rate. Each hospital Current Year is compared to the Base Year to measure the hospital's PPR performance over time.

4) "Current Year" shall mean the State fiscal year in which Targeted Rate of Readmission is set for hospitals to achieve their Targeted Rates of Readmission.

5) "Data Year" shall mean the most recent fully adjudicated claims data in a State fiscal year available to the Department, which is used to calculate the Actual Rate of Readmission and the Targeted Rate of Readmission for each hospital.

6) "Clean Claim" shall mean a claim as defined in 42 CFR 447.45(b).

7) "Clinically Related" shall mean that the underlying reason for readmission is plausibly related to the care rendered during a prior hospital admission. A clinically-related readmission results from the process of care and treatment provided during the prior admission (e.g., readmission for a surgical wound infection) or from a lack of post-admission follow up (e.g., lack of follow-up care arrangements with a primary physician) rather than from unrelated events that occurred after the prior admission (such as a broken leg due to trauma) within a specified readmission time interval.

8) "Initial Admission" shall mean an admission to a hospital that is followed by a subsequent readmission or readmissions within 30 days that are determined by the 3M Corporation's PPR methodology to be clinically related.

9) "Only Admission" shall mean an admission without an associated readmission.

10) "Potentially Preventable Readmission Chain" or "PPR Chain" shall mean an initial admission occurring at a hospital that is followed by one or more clinically-related PPRs. The PPRs may occur at the same hospital or a different hospital.

11) "Qualifying Admission" shall mean the number of PPR Chains plus the number of "Only Admissions", but specifically excludes the admissions detailed in subsection (d)(2).

12) "Actual Rate" shall mean the number of PPR Chains for a hospital divided by the total number of qualifying admissions for the hospital.

13) "Targeted Rate of Readmissions" shall mean a risk adjusted readmission rate for each hospital that accounts for the severity of illness, APR-DRG, presence of behavioral health issues, and age of patient at the time of discharge preceding the readmission.

14) "Excess Rate of Readmission" shall mean the difference between the actual rate of readmission and the targeted rate of readmission for each hospital.

15) "Behavioral Health", for the purposes of risk adjustments, shall mean an admission that includes a secondary diagnosis of a major behavioral health related condition, including, but not limited to, mental disorders, chemical dependency and substance abuse.

16) As of August 1, 2013, "Pediatric/Behavioral Health Factor" shall mean a factor that is a calculation of PPR for both children and adults with and without a secondary diagnosis of Behavioral Health. This is a risk adjustment factor. This factor is multiplied by a hospital's Actual Rate of PPR at the service level before it is compared to the statewide average rate of PPR in order to calculate the hospital's Actual Rate of readmission. There are three categories of factors that are calculated and within each category there are three factors that are calculated for a total of nine factors. The categories include pediatric at a non-Tier I PICU Facility, a pediatric at a Tier I PICU Facility and an adult. Within each category, the three factor calculations include a primary diagnosis of non-behavioral health with no presence of behavioral health, a primary diagnosis of non behavioral health with a secondary diagnosis of behavioral health and a primary diagnosis of behavioral health. For example, Tier I PICU Facilities treat higher acuity children and therefore have a higher expected rate of readmission than those children with the same diagnosis treated at the non-Tier I PICU Facilities. By applying this factor, it risk-adjusts the hospital's PPR rate to account for the variance in readmission rates for the different categories.

17) As of August 1, 2013, "Tier I Pediatric Intensive Care Unit" or "PICU" shall mean, a hospital that is either freestanding or has a Distinct Part Unit having pediatric trauma units and provides two or three of the following sets of procedures: pediatric transplants, Extracorporeal Membrane Oxygenation (ECMO), and complex pediatric cardiac surgeries.

d) Readmission Criteria

1) A readmission is defined as an inpatient readmission within 30 days after discharge that is clinically related to the initial admission, as defined by the PPR software created and maintained by the 3M Corporation, and meets all of the following criteria:

A) The readmission is potentially preventable by the provision of appropriate care consistent with accepted standards, based on the 3M software, 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.

C) The PPR Chain may have one or more readmissions that are clinically related to the Initial Admission. The first readmission is within 30 days after the Initial Admission, but the 30 day timeframe begins again at the discharge of either the Initial Admission or the most recent readmission clinically related to the Initial Admission. For example, a patient is discharged after being admitted for back surgery and readmitted two weeks after the discharge for a post-operation infection that is clinically related to the back surgery. The 30 day period begins again at the discharge for the post-operation infection. However, if the patient is readmitted for a broken leg within 30 days after the post-operation infection, there is no clinical relationship and therefore not considered a PPR. Should a readmission occur within 30 days that is clinically related to the broken leg, then that would create a new PPR Chain separate from the back surgery.

D) The readmission is to the same or to any other hospital.

2) Admissions data, for the purposes of determining PPRs, excludes the following circumstances:

A) The discharge was a patient initiated discharge and was Against Medical Advice (AMA) and the circumstances of the discharge and readmission are documented in the patient's medical record.

B) The admission was for the purpose of securing treatment for a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions, certain HIV APR DRGs (listed in the version of the 3M definitions manual applicable to the State fiscal year in question), alcohol or drug detoxification, non-acute events (rehabilitation admissions), or, for hospitals defined in 89 Ill. Adm. Code 148.25(d)(4), admissions with an APR-DRG code other than 740 through 760.

C) The admission was for an individual who was dually eligible for Medicare and Medicaid, or was enrolled in a Medicaid Managed Care Entity (MCE).

D) As of August 1, 2013, effective for fiscal year 2014, admissions for children defined as less than the age of 19 that have a primary diagnosis at discharge for Behavioral Health. Children treated for an acute service, but who have a secondary diagnosis of Behavioral Health are still included in the analysis, but the Pediatric/Behavioral Health Factor is applied.

E) Effective for fiscal year 2018 and each year thereafter, admission was for the purpose of securing treatment for sickle cell anemia.

3) Non-events are admissions to a non-acute care facility, such as a nursing home, or an admission to an acute care hospital for non-acute care or transfers from one acute hospital to another. Non-events are ignored and are not considered to be readmissions.

4) Planned readmissions, as defined by 3M's team of clinicians, are accounted for in the 3M PPR software as an "Only Admission" and are not considered to be readmissions.

e) Methodology to Determine Excess Readmissions

1) State fiscal year 2013

A) Rate adjustments for State fiscal year 2013 for each hospital shall be based on each hospital's 2010 medical assistance paid claims data for admissions that occurred between July 1, 2009 and June 30, 2010.

B) Except as otherwise provided in subsection (f)(8), the targeted rate of readmission for each hospital shall be reduced by the percent necessary to achieve a savings of at least $40 million in State fiscal year 2013 for hospitals other than the "large public hospitals" defined in 89 Ill. Adm. Code 148.25(a).

C) Excess readmissions for each hospital shall be calculated by multiplying a hospital's qualifying admissions by the difference between the actual rate of PPRs and the targeted rate of PPRs, as adjusted in subsection (e)(1)(B).

D) In the event the actual rate of PPRs for a hospital is lower than the targeted rate of PPRs, the excess number of readmissions shall be set at zero.

2) Effective August 1, 2013 for State fiscal year 2014 and thereafter.

A) The Targeted Rate of Readmission for the Current Year 2014 shall be based on the inpatient hospital medical assistance services provided in the Data Year 2011 for admissions that occurred between July 1, 2010 and June 30, 2011. The Data Year will be updated one year for determining the Targeted Rate of Readmission for each Current Year thereafter.

B) The average statewide expected rate of readmission will be multiplied by .85 for acute services and .90 for Behavioral Health Services. This multiplication factor sets a goal that is specific to each hospital that lowers the Target Rate of Readmission rather than maintaining the statewide average.

C) A Pediatric/Behavioral Health Factor is applied to those services provided at a Tier I PICU to account for the higher PPR rate for the higher acuity children.

D) Excess readmissions for each hospital shall be calculated by subtracting the actual number of PPR Chains from the targeted number of PPR Chains as adjusted in subsection (e)(2)(B) and (e)(2)(C).

E) In the event the actual number of PPR Chains for a hospital is lower than the targeted number of PPR Chains, the excess number of readmissions shall be set at zero.

f) Payment Reduction Calculation for State fiscal year 2013

1) An average readmission payment per PPR Chain for each hospital shall be calculated by dividing the total medical assistance net liability attributable to the readmissions associated with the hospital's PPR Chains (excluding the liability associated with the initial admission) by the number of PPR Chains for the hospital.

2) The total excess readmission payments shall equal the average readmission payment per PPR Chain, as determined in subsection (f)(1) multiplied by the number of PPR Chains above the target as determined in subsection (e)(1)(C).

3) The total annual payment reduction for each hospital shall be the lesser of:

A) The total excess readmission payments as determined in subsection (f)(2); or

B) The total medical assistance payments for all hospital admissions, including admissions that were excluded from the PPR analysis, multiplied by 7%.

4) A fiscal year 2013 hospital specific payment reduction factor for each hospital shall be computed as one minus the arithmetic operation of 25% of the total annual payment reduction, as determined in subsection (f)(3), divided by 50% of the total estimated medical assistance payments for all hospital clean claims received in fiscal year 2013.

5) The hospital specific payment reduction factor, as determined in subsection (f)(4), shall be applied to the final payment amount for each clean claim received in fiscal year 2013.

6) In order to achieve a savings of 25% of the annual payment reduction for each hospital, the hospital specific payment reduction factor may be adjusted to account for variances between the estimated payments to the hospital and the actual payments to the hospital.

7) For those hospitals that have a payment reduction amount in State fiscal year 2013, a reconciliation of fiscal year 2013 claims will be calculated after January 1, 2014, after all inpatient hospital claims have been received by the Department, to determine how much of the remaining annual payment reduction must be recovered from the hospital. This reconciliation will determine how much of the annual payment reduction was offset in fiscal year 2013 by comparing the fiscal year 2013 rate of readmission to the base year (fiscal year 2010), as determined by subsection (e)(1)(B). In addition, the reconciliation will account for changes in the average readmission payment per PPR Chain from fiscal year 2010 to fiscal year 2013.

8) After the Department verifies that all hospitals have achieved $40 million savings in aggregate for FY2013 when compared to the base year, no further payment reductions will be applied to individual hospitals.

g) Effective August 1, 2013, Payment Penalty Calculation for State Fiscal Year 2014 and Thereafter

1) An average readmission penalty payment per PPR Chain for each hospital shall be calculated by dividing the total medical assistance net liability attributable to the readmissions associated with the hospital's PPR Chains (excluding the liability associated with the initial admission) by the number of PPR Chains for the hospital.

2) The total excess readmission penalty payments shall equal the average readmission payment per PPR Chain, as determined in subsection (g)(1) multiplied by the number of PPR Chains above the target as determined in subsection (e)(2)(D).

3) The total annual payment penalty for each hospital shall be the lesser of:

A) The total excess readmission payments as determined in subsection (g)(2); or

B) The total inpatient medical assistance payments per hospital, including admissions that were excluded from the PPR analysis (that includes all static and assessment payments net of the annual assessment tax), multiplied by 3%.

4) Prior to collection of the payment penalty, an analysis will be conducted of the Current Year data to determine if any of the payment penalty was cost avoided. Once the Current Year is complete and all inpatient hospital claims data has been received and adjudicated by the Department, the Department will calculate the hospital's Actual Rate of Readmission using the same version of the PPR software that was used to calculate the Base Year. A comparison of the Base Year to the Current Year will be done to see if hospitals were able to reduce their readmissions and their average cost per PPR Chain.

A) The payment penalty can be cost avoided in full if a hospital lowers its Actual Rate to at or below its Targeted Rate of Readmission.

B) Hospitals that did not meet their Targeted Rate of Readmission but lowered their Actual PPR rate can have a portion of their payment penalty cost avoided. In order to have a portion of the payment penalty cost avoided, hospitals must reduce the variance between their Actual Rate and their Targeted Rate of Readmission and lower their average medical assistance payment per PPR Chain for the Current Year.

C) Based on the analysis performed in subsection (g)(4)(B), hospitals that are able to reduce their readmissions compared to the Base Year will have the cost avoided amount deducted from their payment penalty.

D) Should a hospital have a higher rate of readmission when compared to the Base Year, the payment penalty will not be more than the original amount calculated.

E) If an aggregate application of the cost avoidance calculation shows that hospitals have reduced the cost of readmissions for the Current Year when compared to the Base Year by more than the total payment penalty owed by all hospitals, then payment penalties will not be charged to any hospital for that year. This aggregate calculation must factor in the hospitals that performed worse in the Current Year.

5) After the application of any cost avoidance pursuant to subsection (g)(4), hospitals will pay 50% of the remaining payment penalty to the Department. This amount shall be paid in 12 equal installments beginning on July 1, of the next fiscal year.

6) Hospitals that are delinquent in paying any amounts due will have adjustments applied to future claims until the full amount of the payment penalty due has been recouped.

h) Effective July 1, 2017, admissions data will no longer exclude individuals enrolled in a managed care organization (MCO) as described in subsection (d)(2)(C). Analysis will be calculated on both FFS and encounter data. Results of the analysis described in subsection (g)(4) will be reported to both the MCO and the hospital, but no penalty payments will be collected.

(Source: Amended at 43 Ill. Reg. 5734, effective May 2, 2019)