SENATE DOCKET, NO. 475 FILED ON: 1/16/2013

SENATE . . . . . No. 1018

The Commonwealth of Massachusetts

PRESENTED BY:

Jennifer L. Flanagan

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act to reduce preventable hospital readmissions.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Jennifer L. Flanagan	*Worcester and Middlesex*

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SENATE . . . . . No. 1018

By Ms. Flanagan, a petition (accompanied by bill, Senate, No. 1018) of Jennifer L. Flanagan for legislation relative to preventable hospital readmissions. Public Health.

The Commonwealth of Massachusetts

In the Year Two Thousand Thirteen

An Act to reduce preventable hospital readmissions.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1: Chapter 12C of the General Laws is hereby amended by inserting after Section 23, the following new language:-

Chapter 12C: Section 24. Reduction of Potentially Preventable Readmissions

As used in this section, the following words shall have the following meanings:

"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.

"Observed rate of Readmission" shall meant the number of admissions in each hospital that were actually followed by at least one PPR divided by the total number of admissions.

"Expected Rate of Readmission" shall mean a risk adjusted rate for each hospital that accounts for the severity of illness, and age of patients at the time of discharge preceding the readmission.

"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.

(a) Potentially Preventable Readmission criteria.

(1) A hospital 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 hospitalization 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.

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 potentially preventable readmissions, excludes the following circumstances:

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

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

(b) The center shall develop a methodology to calculate the expected rate of potentially preventable readmissions for each hospital, and calculate the excess rate of readmission.

(c) The center shall measure the observed rate of readmission, and on a regular and ongoing basis; publish on its website the rates of potentially preventable hospital readmission rates for each hospital licensed in the commonwealth using the definitions and criteria set for in this section. The center shall calculate and publish, both by individual hospital and statewide, the observed rate of readmission, the expected rate of readmission and the excess rate of readmission for each hospital. In compiling the data necessary for the calculation, the center shall, to the maximum extent feasible, utilize existing data collected from hospitals and carriers.

(d) The center shall convene an advisory committee to develop a standardized methodology to be applied to payments to hospitals that report excess readmissions and make

recommendations for a consistent methodology to be adopted across all payers to reduce hospital payments for those hospitals with excess readmissions. The advisory committee shall consist of the commissioner of the center for health information and analysis, who shall serve as chair; the commissioner of the group insurance commission, or designee; the director of the office of Medicaid, or designee; the commissioner of the department of public health, or designee; the executive director of the commonwealth connector, or designee; one member representing the Massachusetts association of health plans, one member representing the Massachusetts hospital association, one member representing the Massachusetts medical society, one members with expertise in hospital billing and payment, and one member with expertise in hospital reimbursement.

The advisory committee shall convene no later than January 1, 2013 and shall develop its recommendation by no later than April 1, 2013, which shall include a plan to implement the recommended methodologies in all state programs including the state Medicaid program, the health safety net care pool, and the commonwealth care program.

SECTION 2. Chapter 111 of the General Laws is hereby amended by inserting after Section 70H, the following new language:-

Chapter 111: Section 70I. Reduction of Duplicate Diagnostic Services

Section 70I. Each hospital in the Commonwealth shall file with the department, within thirty (30) days of the start of the hospital fiscal year, a written plan designed to eliminate the duplication of unnecessary diagnostic services performed on a patient by another hospital or diagnostic facility when there is knowledge of a prior test. The plan shall include the following:

(1) Current procedures for sending and receiving diagnostic, imaging and other test results from or to another hospital or provider of care;

(2) A defined procedure for determining whether any such test results can be appropriately used in the patient's treatment;

(3) A plan to improve the hospital's ability to send and receive such test results from or to other providers of care. The Department shall notify the hospital that the plan has been approved or disapproved within thirty (30) days after filing, based on a determination as to whether the plan adequately addresses the issues of patient safety and costs of duplicating diagnostic tests. If such plan has not been acted upon by the department within thirty (30) days, the plan shall be deemed approved. If the department disapproves of such plan, the hospital shall submit a revised plan within thirty (30) days. If the revised plan continues to be disapproved, or if a hospital fails to submit a plan, the commissioner may issue an order that such a plan be submitted immediately. If such an order is issued, health insurance carriers may deny payment for any duplicate services furnished unless the hospital can establish that the duplicate service was

medically necessary and appropriate. In the event that a carrier denies payment for duplicate services, the hospital may not bill the insured for those services.