Mississippi Medicaid

Quality Incentive Payment Program: Readmissions

DRAFT

Payment Method Development
Government Healthcare Solutions
MSH19031

Topics

1. Overview of the Mississippi Quality Incentive Payment Program (QIPP) for readmissions
2. Approach
3. Understanding a hospital’s baseline report
4. QIPP timeline
5. Looking to the future

Overview

Overview

What is QIPP

In 2016, the Centers for Medicare and Medicaid Services (CMS) introduced a requirement that federal pass-through payments transition to accountability-based models within 10 years

- This includes the Mississippi Hospital Access Program (MHAP)

QIPP is designed to link MHAP payments to utilization, quality and outcomes

- QIPP's goal is to use state and federal funds to improve the quality of care and health status of the Mississippi Medicaid population
- One of the first focus areas for QIPP is aimed at measuring and improving readmission rates
  - A fact sheet introducing the QIPP program was sent out June 28, 2019
  - The first QIPP readmission reports were disseminated June 30, 2019

Quality Incentive Payment Program (QIPP): Mississippi Medicaid program designed to link MHAP funds to care quality

QIPP Readmission reports

Each Mississippi hospital should have received on June 30, 2019:

- Hospital-specific readmissions report
- Readmissions methodology supplement

The information in this presentation is contained in the methodology supplement

For questions about the QIPP program or help interpreting your hospital's readmission report, contact the QIPP mailbox: QIPP@Medicaid.ms.gov

Measuring readmissions

There are multiple approaches to measuring readmissions

- All-cause vs. avoidable and clinically related
- Specific conditions or hospital-wide
- Different time windows (i.e. 15 days or 30 days)

QIPP uses the 3M Potentially Preventable Readmissions (PPRs) approach

- Potentially preventable means that not all readmissions could be avoided, but worse than average performance likely means performance could be improved
- Designed for an all-patient population
- Results are categorical and easy to interpret

Potentially preventable readmission (PPR): Inpatient readmissions that are clinically related to a preceding inpatient admission with a discharge within a specified time period (15 days in this analysis)

Measuring readmissions (continued)

The 3M PPR approach also allows us to measure potentially preventable return emergency department visits (PPEDs)

- PPEDs are visits to the emergency department that follow at-risk inpatient admissions within 15 days
- PPEDs are clinically related to the inpatient admission
- High rates of PPEDs can signal problems with premature discharge, inadequate discharge planning, poor follow-up care, or difficulty accessing care in the community

PPRs and PPEDs are combined into a single measure of potentially preventable hospital returns (PPHRs)

- The PPHR rate measures the number of at-risk inpatient admissions that are followed by one or more PPR and/or PPED

Potentially preventable ED visit (PPED):	Return ED visits that are clinically related to a preceding inpatient admission with a discharge within a specified time period (15 days in this analysis)
Potentially preventable hospital return (PPHR):	Hospital returns refer to both inpatient readmissions and return ED visits. The PPHR rate refers to the rate of inpatient admissions that are followed by either an inpatient readmission, or a return ED visit, or both.

Approach

Analytic dataset

At-risk stays are drawn from calendar year 2018 (discharges from Jan. 1, 2018 through Dec. 31, 2018)

- Claims for inpatient readmissions and return ED visits allow for a 15 day follow-up window (discharges from Jan. 1, 2018 through Jan. 15, 2019)
  - All claims were processed by the Medicaid payment system by 5/27/2019
  - Data include both fee-for-service claims and managed care encounter data (submitted by the coordinated care organizations)

	PPHRs				PPRs				PPEDs			
Total Stays	At-risk Stays	Chains	PPHR Rate	PPHRs	At-risk Stays	Chains	PPR Rate	PPRs	At-risk Stays	PPED Chains	PPED Rate	PPEDs
39,548	31,684	4,513	14.2%	6,385	31,684	2,213	7.0%	2,793	33,392	2,730	8.2%	3,592

At-risk stays: Inpatient admissions that may or may not be followed by an inpatient readmission or return ED visit, but are not excluded from analysis per the requirements on the next slide

PPHR chain: The series of an initial admission and one or more inpatient readmissions and/or return ED visits. Each chain is only counted once in the PPHR rates

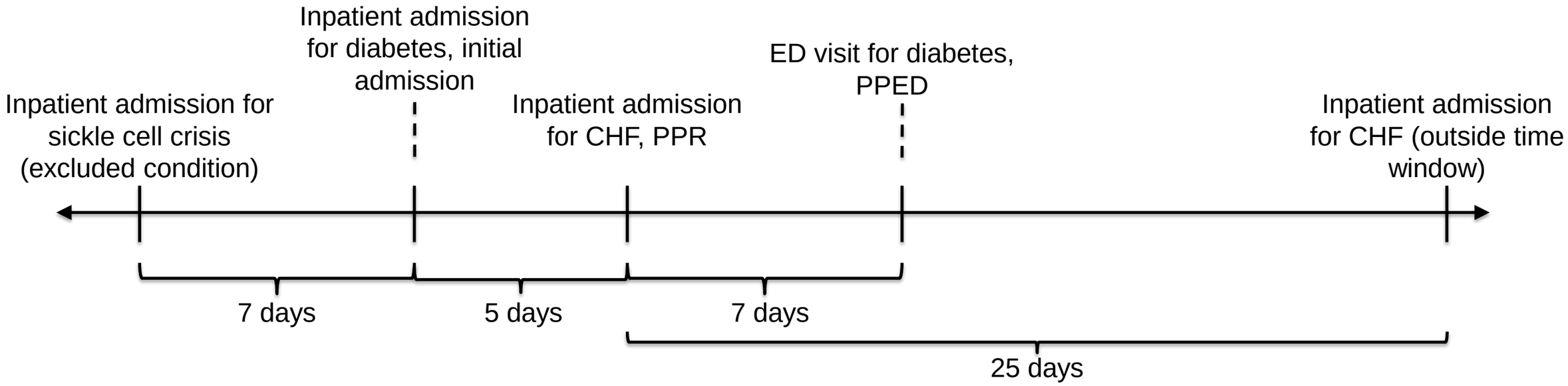
Analytic dataset: exclusions

Inpatient admissions were excluded from consideration as at-risk admissions for various reasons:

- Obstetric and newborn
- Conditions with a high rate of unpreventable readmissions
  - Trauma
  - Metastatic malignancy
  - HIV/AIDS
  - Neonates
  - Sickle cell crisis
- Patient transferred to another hospital
- Patient left against medical advice
- Patient died

Analytical Dataset Reconciliation		
Inpatient stays: CY 2018		90,117
Type of Stay		
Obstetric	24,750	65,367
Normal newborn/neonate	24,700	40,667
Sickle cell crisis	1,119	39,548
DRG with only one event statewide	1,540	38,008
Metastatic malignancies	1,531	36,477
Other medical conditions	18	36,459
Non-event admission	387	36,072
Left against medical advice	553	35,519
Transfer	676	34,843
Patient died during initial admission	366	34,477
Subtotal, exclusions	**55,640**	
Readmission	2,793	31,684
Initial admission (incl PPRs and PPEDs)	4,513	27,171
At-risk admission (excl initial admission)	27,171	-
Subtotal, included in analysis	**34,477**	

Identifying readmissions and return ED visits



Initial admission: Inpatient admission that is followed by one or more inpatient readmissions and/or ED visits

Time window: 15 days after the preceding inpatient admission's discharge, during which clinically related inpatient admissions are considered PPRs, and ED visits are considered PPEDs

Example of a PPHR chain

Example of a PPHR Chain					
Chain Number	Patient ID	Type of Claim	Admit Date	Discharge Date	Hospital
1	1	Initial admission	1/1/2018	1/3/2018	Hospital A
1	1	Inpatient readmission	1/5/2018	1/7/2018	Hospital B
1	1	Clinically related return ED Visit	1/10/2018	1/10/2018	Hospital B
1	1	Clinically related return ED Visit	1/15/2018	1/15/2018	Hospital B
1	1	Inpatient readmission	1/17/2018	1/19/2018	Hospital B
2	1	Initial admission	2/20/2018	2/25/2018	Hospital C
2	1	Inpatient readmission	3/1/2018		Hospital C

- PPHR Chains can include both PPRs and PPEDs
- Each chain is only counted once in the PPHR rate
- PPR and PPED chains are also reported for your information

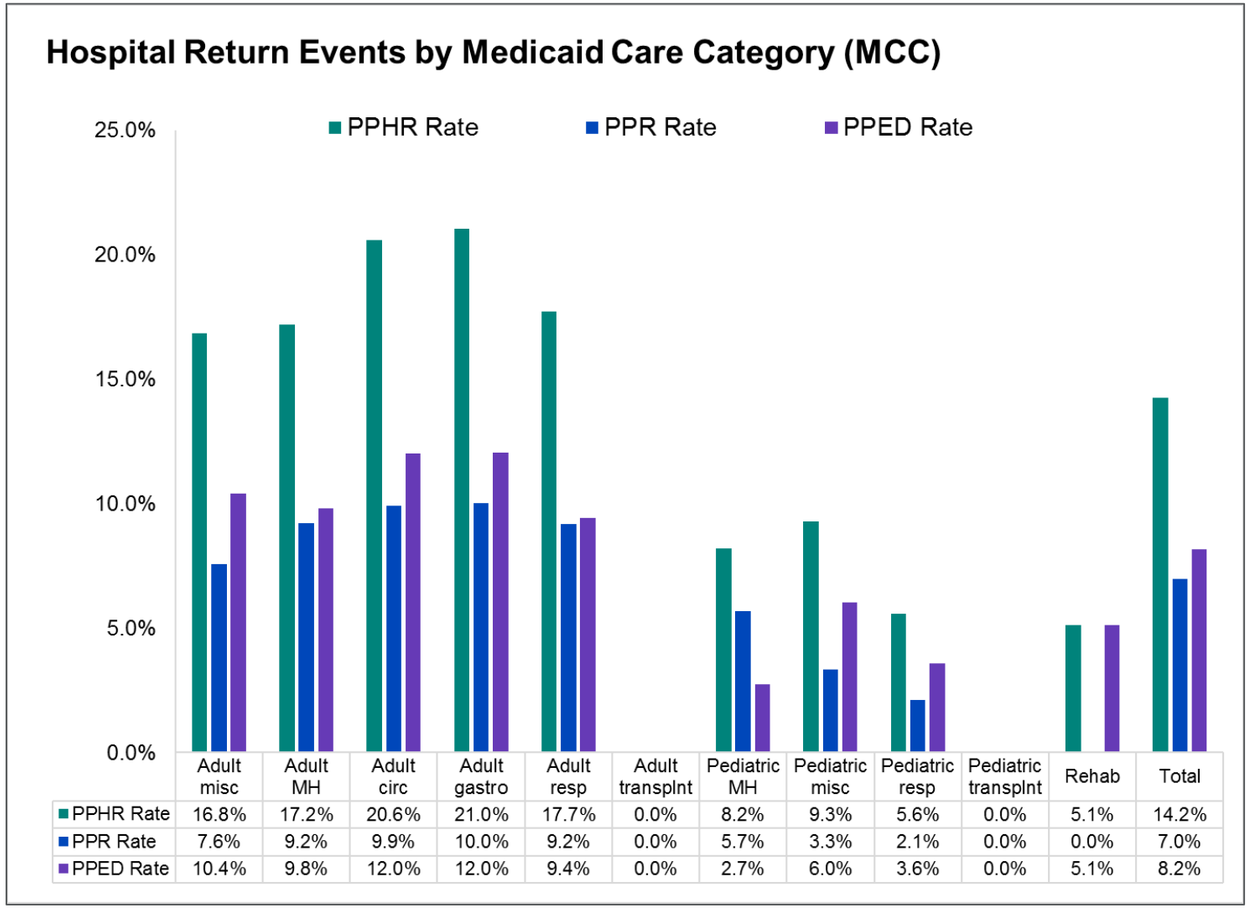
Approach

Measuring performance

Potentially preventable hospital return rates vary considerably based on patient characteristics:

- Age (pediatric vs. adult)
- Health conditions (Base DRG)
- Condition severity (Severity of illness)
- Mental health or substance abuse(MH/SA) comorbidities

Measuring PPHR performance requires adjusting for the mix of patients at a given hospital



	Adult misc	Adult MH	Adult circ	Adult gastro	Adult resp	Adult transplnt	Pediatric MH	Pediatric misc	Pediatric resp	Pediatric transplnt	Rehab	Total
PPHR Rate	16.8%	17.2%	20.6%	21.0%	17.7%	0.0%	8.2%	9.3%	5.6%	0.0%	5.1%	14.2%
PPR Rate	7.6%	9.2%	9.9%	10.0%	9.2%	0.0%	5.7%	3.3%	2.1%	0.0%	0.0%	7.0%
PPED Rate	10.4%	9.8%	12.0%	12.0%	9.4%	0.0%	2.7%	6.0%	3.6%	0.0%	5.1%	8.2%

Casemix adjustment: Mathematically adjusting the expected PPHR rate for the mix of patient characteristics at a given hospital

Approach

Casemix adjustment

Step 1: Calculate PPHR rates for each DRG/severity of illness

Step 2: Calculate the PPHR rate separately for patients with and without MH/SA comorbidities

Step 3: Calculate the MH/SA adjustor as the ratio of the overall PPHR rate for pediatric and adult patients with and without MH/SA comorbidities

Step 4: Calculate the expected PPHR rate given hospital based on the number of patients with each DRG, severity of illness, age category, and level of MH/SA comorbidities

Example Calculation of the Actual-to-Expected Ratio

APR-DRG	Description	Age Category	Mental Health Comorbidities	Statewide Norm	MH/SA Adjustor	Hospital A At-Risk Stays	Hospital A Actual PPHRs	Expected PPHRs
139-1	OTHER PNEUMONIA	Adult	Yes	7.32%	1.22	25	2	2.23
139-1	OTHER PNEUMONIA	Ped	Yes	4.44%	1.77	25	1	1.96
139-1	OTHER PNEUMONIA	Adult	No	7.32%	0.93	100	6	6.83
139-1	OTHER PNEUMONIA	Ped	No	4.44%	0.97	100	5	4.30
750-1	SCHIZOPHRENIA	Adult	N/A	17.28%	N/A	50	10	8.64
750-1	SCHIZOPHRENIA	Ped	N/A	14.29%	N/A	50	6	7.14
Total						**350**	**30**	**31.12**

Notes:

Hospital A PPHR rate = 30/350 = 8.6%

Average MS hospital = 31.12/350 = 8.9%

Hospital A actual-to-expected ratio = 8.6%/8.9% = 0.97

Calculating the actual-to-expected ratio

The actual-to-expected ratio (A/E ratio) compares the number of PPHRs at a given hospital to the number of expected PPHRs for an average Mississippi hospital with the same casemix

$$\frac{\text{Actual PPHRs}}{\text{Expected PPHRs}} = \text{Actual-to-Expected Ratio}$$

A/E ratio:

= 1	The measured hospital has the same number of PPHRs as an average Mississippi hospital
< 1	The measured hospital performs better than an average Mississippi hospital
> 1	The measured hospital performs worse than an average Mississippi hospital

A/E ratios are not measured for hospitals that have fewer than 5 actual or expected PPHRs

A/E ratio: Performance metric that compares a given hospital to an average Mississippi hospital with the same casemix

Hospital reports

Understanding the hospital reports

Open Hospital Report

Each hospital report has four tabs

- **Cover** — Overview information including a glossary of key terms
- **Hospital summary** — Overview of hospital performance, including performance metrics for PPHRs, PPRs, and PPEDs. The PPHR actual-to-expected ratio is the metric that will be used to judge each hospital's performance relative to its peers. Information on PPR and PPED rates and actual-to-expected ratios are provided to help each hospital understand its pattern of hospital returns
- **Hospital detail** — Listing of individual claims for PPHR chains initiated in each hospital. Each PPHR chain is only counted once in the PPHR rate, regardless of how many hospital returns are included in the chain
- **Secondary readmissions** — Listing of individual readmission and ED visit claims that were preceded by an inpatient admission at the report hospital, but which belong to a PPHR chain initiated at a different hospital. These are provided for the hospital's use in a data-driven approach to understanding practices and approaches that may help reduce future readmissions and return ED visits

QIPP timeline

Upcoming dates of interest

- June 30, 2019: Baseline reports distributed to hospitals (calendar year 2018)
- July 30, 2019: Hospital deadline to attest receipt and review of the baseline report
- Sept. 30, 2019: Quarterly update report distributed to hospitals (Apr. 1, 2018 – Mar. 31, 2019)
- Oct. 30, 2019: Hospital deadline to attest receipt and review of the quarterly report
- Dec. 31, 2019: Quarterly update report distributed to hospitals (Jul. 1, 2018 – Jun. 30, 2019)
- Jan. 30, 2020: Hospital deadline to attest receipt and review of the quarterly report
- Mar. 31, 2020: Quarterly update report distributed to hospitals (Oct. 1, 2018 – Sep. 30, 2019)
- Apr. 30, 2020: Hospital deadline to attest receipt and review of the quarterly report
- Jun. 30, 2020: Quarterly update report distributed to hospitals (Jan. 1, 2019 – Dec. 31, 2019)
- Jul. 30, 2020: Hospital deadline to attest receipt and review of the quarterly report
- Sep. 1, 2020: Hospitals above performance threshold required to submit corrective action plans

Looking to the future

Looking to the future

1. Each hospital is required to email QIPP@Medicaid.ms.gov to attest that they have received and reviewed their report
2. Next reports will be released September 30, 2019
3. September reports will include performance metrics for the quarter January 1, 2019 – March 31, 2019, as well as a rolling year (April 1, 2018 – March 31, 2019)
4. For questions or copies of QIPP documents (including the methodology supplement and this presentation) email QIPP@Medicaid.ms.gov

Questions for DOM

1. Does there need to be a section on logistics of the program to address questions you may be receiving?
   - Keith to check on questions that have come in from providers to determine if we need to add a slide to the presentation.
2. When will providers get an invite to the training? Who will they invite (should be the same people who got the report)
   - Lisa has sent the provider training registration links to Keith, Christy and Jennifer who will send an email to invitees.
3. Will DOM talk about the QIPP program overview at the start?
   - DOM will introduce the QIPP program on slide 4. DOM to let Conduent know of any needed changes to slide 4.
4. When will DOM set performance thresholds and identify which hospitals need a CAP? Should we include the CAP timeline on the QIPP Timeline slide?
   - CAP deadline to be included in QIPP Timeline. Keith to determine if a date can be provided for when performance thresholds will be set.
5. What questions have you received – are there any that we need to address in the training? If there are a lot of questions, we may need to do a FAQ document
   - Keith to check on what questions have come in for inclusion in the presentation. The second presentation is scheduled for a week after the first to allow time to include questions from the initial presentation.

Appendix

Glossary

A/E ratio: Performance metric that compares a given hospital to an average Mississippi hospital with the same casemix

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For further information

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