



MISSISSIPPI DIVISION OF
MEDICAID

Quality Incentive Payment Program (QIPP)

Potentially Preventable Hospital Returns

Methodology Supplement

June 2021



Glossary and Acronyms

Actual-to-expected ratio	The actual-to-expected ratio compares the number of potentially preventable hospital returns (PPHRs) that follow inpatient admissions at your hospital to the number of expected PPHRs for an average Mississippi hospital with the same mix of DRGs, age groups, and mental health/substance abuse prevalence. For more information on how the actual-to-expected ratio is calculated, see Section 2.3: Measuring readmission and hospital return performance.
All Patient Refined Diagnosis Related Groups (APR-DRGs)	3M grouping approach for inpatient admissions. APR-DRGs may also be referred to as DRGs.
At-risk inpatient admission	An initial inpatient stay that may or may not be followed by one or more inpatient readmissions or return emergency department (ED) visits. At-risk inpatient admissions exclude inpatient admissions that met the criteria for global exclusions, such as stays for APR-DRGs that have a particularly high rate of expected readmissions (see globally excluded conditions below), or where the patient was transferred to another acute care facility, died, or left against medical advice.
Corrective action plan (CAP)	Hospitals that have performance above the target actual-to-expected ratio after a year of baseline reporting will be required to submit a CAP. The Division of Medicaid will supply a template for completing the CAP.
Cycle	PPHR measurement occurs in three-year cycles. The first year of each cycle is baseline reporting. In July of the second year of each cycle, hospitals requiring a CAP are identified. Hospitals have one year to implement the CAP, and then performance incentives are allocated in the third year of the cycle. A new cycle starts each July.
ED	Emergency department
Globally excluded conditions	When measuring the PPHR (and potentially preventable readmissions (PPR) or potentially preventable ED visit (PPED)) rate, several conditions which are expected to have a high rate of unpreventable hospital return events are excluded from consideration. These conditions include major trauma, metastatic malignancies, HIV, and sickle cell anemia. In addition, this report excludes obstetric and newborn stays as they are not expected to have significant hospital return events.
Hospital return chains	Hospital return chains occur when an initial inpatient admission is followed by one or more inpatient readmissions and/or return ED visits. Hospital return chains are only measured once in the PPHR rate and actual-to-expected

	ratio, regardless of how many related inpatient readmissions and/or ED visits are included in the chain.
Initial admission	An initial admission refers to the inpatient stay that leads to a chain of one or more inpatient readmissions and/or ED visits.
Low volume hospitals	Hospitals that have fewer than 10 actual or expected PPHRs will be considered “low volume”. Such hospitals will receive a PPHR report, but the actual-to-expected ratio will not be calculated. Low volume hospitals will need to attest that they have received and reviewed their report to receive their PPHR-related funds.
Medicaid Care Categories (MCCs)	Clinical categorization scheme that groups medically similar stays.
Potentially preventable ED visits (PPEDs)	PPEDs identify emergency department (ED) visits that follow an initial inpatient admission within 15 days and are clinically related to the initial admission. The PPED rate is provided for informational purposes only.
Potentially preventable hospital returns (PPHRs)	PPHRs identify potentially preventable inpatient readmissions plus return emergency department visits that occur within 15 days of an initial admission. Hospital return events are considered potentially preventable if they are clinically related to the initial admission and the reason for the visit (as identified by the stay’s APR-DRG) is not one of the globally excluded conditions. The Quality Incentive Payment Program (QIPP) will measure performance on the PPHR actual-to-expected ratio.
Potentially preventable readmissions (PPRs)	PPRs identify inpatient readmissions that follow an initial inpatient admission within 15 days and are clinically related to the initial admission. The PPR rate is provided for informational purposes only.
Quality Incentive Payment Program (QIPP)	QIPP is a Division of Medicaid program that bases a portion of Mississippi Hospital Access Program (MHAP) payments on quality indicators.
Secondary admission/ED visit	<p>A secondary admission/ED Visit is a readmission or ED visit that occurred following an inpatient readmission at your hospital, which does not belong to a hospital return chain attributed to your hospital. These readmissions and ED visits do not count against your hospital in the performance metric, but the list of secondary readmissions is provided for informational purposes only. For example, consider the following sequence:</p> <ol style="list-style-type: none">1. Initial admission at hospital A2. Readmission at hospital B within 15 days3. Return ED Visit at hospital B within 15 days <p>The readmission at hospital B (2) would be considered as both a readmission following the initial admission at hospital A, and as a secondary initial admission at hospital B, followed by a return ED visit (3). The secondary initial</p>

admission at hospital B and the return ED visit would appear on hospital B's detail report under the Secondary Readmissions tab for informational purposes.

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1 Measuring Readmissions

Despite the apparent simplicity of the concept, measuring readmissions is a complex topic, with several approaches in use by Medicare, various states, commercial payers, quality improvement organizations, and researchers. “All-cause” measurements can be a crude measure of clinical care and health system performance, especially when calculated across many disparate clinical conditions.¹ Alternatively, a tight focus on specific readmissions (e.g., those deemed avoidable by at least three reviewers²) misses the many situations when care may not reflect medical error, but could potentially be improved. These approaches are not simply different methods of measuring the same thing. Rates can vary two-fold even on the same population, and performance rankings can vary sharply depending on the approach used.³

The Mississippi (MS) Quality Incentive Payment Program (QIPP) uses the “potentially preventable readmission (PPR)” approach developed by 3M™ Health Information Systems.⁴ The PPR approach strikes a balance between the poles of all-cause and clearly preventable; is clinically specific; provides categorical results that are easy to interpret; is designed for an all patient population; and has previously been used by California, Florida, Illinois, New York, Maryland, Texas, Utah, Wisconsin and the Medicare Payment Advisory Commission.⁵ This approach was chosen because we believe it provides the most balanced view into inpatient readmission performance.

In addition, the 3M approach provides a window into potentially preventable return emergency department visits (PPEDs). Similarly to readmissions, high rates of return Emergency Department (ED) visits can signal problems with premature discharge, inadequate discharge planning, poor follow-up care, or difficulty accessing care in the community.⁶ The 3M PPR/ED algorithm allows us to identify PPEDs for at-risk inpatient stays in a similar manner to identifying PPRs (“at-risk stays” refers to an initial inpatient stay that may or may not be followed by one or more readmissions or return ED visits). As with PPRs, PPEDs are clinically related to the original inpatient stay. For example, an ED visit for a surgical wound infection following an inpatient surgical procedure would be considered potentially preventable, while an ED visit for a broken leg following the same original inpatient stay would not. As with PPRs, PPEDs are considered *potentially* preventable and do not signal ED visits that could always be prevented. Rather, higher than average rates of PPRs and PPEDs suggest that better management of the originating inpatient stay and subsequent follow-up care could reduce the rate at which patients return to the hospital. We combine PPRs and PPEDs into a measure of potentially preventable hospital returns (PPHR), which identify inpatient admissions that were followed by either a PPR or a PPED.

QIPP PPHR Hospital Reports provide insight into your hospital’s overall PPHR rate, and how it compares to statewide MS Medicaid rates during the baseline period. The PPHR rate indicates the proportion of at-risk inpatient stays at your hospital that led to one or more PPRs, PPEDs, or both (see methodology section for a description of what is considered an at-risk inpatient stay). The actual-to-expected ratio compares your hospital’s performance to the statewide average during the baseline year for a hospital with the same patient mix of demographics and casemix (see Section 2.3 for a description of how the actual-to-expected ratio is calculated). Values greater than 1.0 indicate your hospital performed worse than the statewide baseline, while values less than 1.0 indicate your hospital performed better than the statewide baseline.

Each quarterly QIPP PPHR Hospital Report describes performance during the year ending two quarters prior to the report date in order to allow time for claims to be submitted to the payment system and be adjudicated. The program assesses a full year of claims in each quarterly report in

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order to promote stability in each evaluation and reduce variability between quarters. For each quarterly report, one new quarter is added to the dataset, and the oldest quarter is removed from the dataset; this is referred to as a rolling year. Statewide performance during the baseline year will be used to set performance targets for years two and three of each QIPP cycle.

2 Methodology Overview

2.1 Dataset

The data for each reporting period consists of one year of inpatient stays and ED visits, ending two quarters before the report date. For example, the initial report released in July 2019 included inpatient stays and ED visits with last dates of service from January 1, 2018 through December 31, 2018. To allow for a 15-day readmission window, readmissions and return ED visits were captured through January 15, 2019. The data were extracted five months after the close of the reporting period on May 31, 2019. The data include both fee-for-service (FFS) claims and managed care encounter data (submitted by the coordinated care organizations).

2.2 Identifying readmissions and return ED visits

The 3M PPR/ED methodology is an algorithm based on claims data submitted by hospitals. Although complex, the algorithm is available for inspection by hospitals, health plans, and others with an interest in the details of its operation.⁷ The PPR/ED methodology overview and definitions manual can be accessed at the 3M APRDRGAssign website. Please contact QIPP@medicaid.ms.gov for information on accessing the APRDRGAssign website.

In readmission studies, an “at-risk admission” refers to an initial inpatient stay that may or may not be followed by one or more readmissions or return ED visits. Of the many ways to define and report readmissions, the simplest approach is to count all readmissions within a given time period. The 3M PPR approach is more sophisticated because it counts only readmissions for which a plausible clinical connection exists between the reason for the index admission and the reason for the readmission. Typically, studies show that about 60% of all readmissions are categorized as potentially preventable in the 3M algorithm.⁸

The 3M software categorically excludes several types of admissions and readmissions from the PPR analysis. Although some of these exclusions (such as a death) are made in almost every readmission measurement approach, the PPR methodology is more sophisticated in its efforts to exclude readmissions that are unlikely to be preventable. The “global” exclusions include the following:

- Sick newborns because the algorithm was not designed for the specific clinical needs of this population.
- Admissions for the medical (i.e., non-surgical) treatment of major metastatic malignancies, major trauma, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), sickle cell anemia crisis, and several less common conditions,⁹ because readmissions for these conditions were very likely to have been either planned or unpreventable.
- At-risk admissions where the patient self-discharged against medical advice.
- At-risk admissions during which the patient died.
- At-risk admissions where the patient was transferred to another acute care hospital. Because the receiving hospital has taken over care, the stay at the receiving hospital becomes the at-risk admission.

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We also excluded inpatient stays for obstetric and normal newborn patients, as these patients are high volume but historically have extremely low readmission rates. Including this population would make it more difficult to see changes in readmissions and return ED visits over time.

Only admissions for acute care are considered for analysis. Stays for sub-acute care, e.g., in an acute care hospital for rehabilitation or convalescence, or in a sub-acute setting such as a nursing facility, were defined as “non-events,” that is, neither an index admission nor a readmission. Observation stays that did not originate from an emergency department visit— during which a patient occupies a bed but is considered an outpatient – are excluded entirely, since an observation stay is not an inpatient admission.

Readmissions may be measured within different “windows” of time. The shorter the window, the more likely a readmission was related to the hospital care or inadequate discharge transitions. The longer the window is (e.g., 30 days or longer), the more likely a readmission may reflect deficiencies in patient compliance, in post-hospital care in the community or in the patient’s baseline health status. QIPP uses a readmission window of 15 days.

2.3 Measuring readmission and hospital return performance

The most straightforward way to measure hospital return events, including readmissions and return ED visits, is to measure the PPHR rate. The PPHR rate indicates the proportion of at-risk inpatient stays that were followed by one or more readmissions or return ED visits (or both). The sequence of the initial inpatient visit and subsequent readmissions and return ED visits is referred to as a PPHR “chain.” Table 2.3.1 shows an example of a hospital return chain. Each hospital return chain is only counted once in the PPHR rate, regardless of how many readmissions and return ED visits may be included in the chain. Each PPHR chain may include readmissions or return ED visits to multiple hospitals; the PPHR chain is attributed to the hospital responsible for the initial admission.

Table 2.3.1

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 A
1	1	Return ED Visit	1/10/2018	1/10/2018	Hospital B
1	1	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	3/3/2018	Hospital C

Your hospital’s baseline and rolling year PPHR rates are listed on your quarterly QIPP hospital report. Note that at-risk stays that are followed by multiple readmissions and return ED visits do not increase the measured hospital return rate; as a result, the PPHR rate is less sensitive to heavy utilizers of care than other readmission measures.¹⁰ Each quarterly report also lists the PPR and PPED rates for informational purposes only. All rates are calculated across Diagnosis Related Groups (DRGs) that had at least two at-risk stays in the overall statewide dataset.

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The PPHR (or PPR or PPED) rate can vary significantly from hospital to hospital based on various patient characteristics, such as the reason for the at-risk inpatient stay, the acuity of the patient's condition, the patient's age, and the presence of mental health or substance abuse comorbidities (MH/SA). Both patient age¹¹ and MH/SA comorbidities have been shown to significantly increase the risk of readmissions,¹² and readmission rates vary widely across patient conditions (see statewide performance). To account for variation in patient mix between hospitals, we calculated a baseline casemix-adjusted statewide average PPHR rate for each hospital. The baseline casemix-adjusted statewide average PPHR rate indicates the PPHR rate for an average Mississippi hospital with the same mix of conditions, age groups, and MH/SA burden during the baseline period. Baseline casemix-adjusted statewide average rates are also reported for PPRs and PPEDs.

Calculating the baseline casemix-adjusted statewide average: The first step is to calculate statewide averages, or norms, for each combination of base APR-DRGs, severity, and age category during the baseline period. We then calculate a MH/SA adjustor that allows for higher PPHR rates for hospitals whose patients have higher rates of secondary MH/SA diagnoses. Table 2.3.2 shows an example of the calculation of the actual-to-expected ratio for a hospital with just two base DRGs.

Table 2.3.2

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:

1. Hospital A PPHR rate = $30/350 = 8.6\%$
2. Average MS hospital = $31.12/350 = 8.9\%$
3. Hospital A actual-to-expected ratio = $8.6\%/8.9\% = 0.97$

For each at-risk stay in the dataset, the calculation of the expected number of PPHRs was the statewide norm x the MH/SA adjustor, where the statewide norm was the average rate for the unique combination of the base DRG, the severity of illness, and the age group during the baseline period. The MH/SA adjustor was calculated as the ratio of the statewide PPHR rate across DRGs for patients with and without mental health comorbidities (calculation of MH/SA adjustor not shown in example). The MH/SA adjustor corrects for the higher rate of expected PPHRs among stays for patients with MH/SA comorbidities; the MH/SA adjustor is not applicable for MH/SA or rehabilitation at-risk stays. The expected number of PPHRs was then summed across all the at-risk stays for your hospital during the quarterly reporting period to get the expected number of PPHRs for an average hospital with the same mix and volume of DRGs, severity, age and mental health burden. This number is divided by the number of at-risk stays at your hospital to measure the PPHR rate for an average MS hospital with the same casemix and patient demographics.

Calculating the actual-to-expected ratio: Using the baseline casemix-adjusted statewide average rate, we then calculated the actual-to-expected ratio that measures how well your hospital performed. The actual-to-expected ratio compares the actual rate of PPHRs (or PPRs or PPEDs) for at-risk inpatient stays at your hospital to the expected rate for an average MS hospital with the same patient mix during the baseline year. Actual-to-expected ratios less than 1.0 indicate that your hospital performed better than the average MS hospital. Values greater than 1.0 indicate that your hospital performed worse than the average MS hospital. The PPHR actual-to-expected ratio is the metric that is used for overall performance measurement. Note that actual-to-expected ratios are not calculated for low-volume hospitals. Low volume hospitals are defined as having fewer than ten actual or expected PPHRs (or PPRs or PPEDs). In addition, actual-to-expected ratios are calculated separately for freestanding psychiatric hospitals, as these hospitals have a substantially different PPHR rate than non-psychiatric acute hospitals.

2.4 PPHR Cycles

PPHR performance measurement occurs in three-year cycles. A PPHR cycle is a period of three years that includes one baseline year, one year for corrective action plan (CAP) implementation, and one year for performance incentives. A new cycle starts each state fiscal year. The cycles overlap such that the second cycle's baseline year will cover the same time period as the first cycle's CAP implementation year. Each report lists your hospital's performance for each of the currently active cycles.

3 PPHR requirements and payments

QIPP PPHR payments are made based on hospitals meeting all criteria for each cycle. For example, for the report distributed in July of each year:

- All hospitals will need to attest that they have received and reviewed the report
- Hospitals with actual-to-expected ratios higher than the target on the second cycle of the report will need to submit a CAP by September 1 to receive their at-risk funds for that quarter. If a CAP is not submitted by the first quarter deadline, PPHR payments will be withheld for additional quarters until the CAP is submitted.

Performance incentives are allocated based on the January report covering the previous calendar year in order to give hospitals a full year to implement CAPs. Performance incentive adjustments are made retroactive to the first quarter of the state fiscal year.

Performance incentive payment are made based on the following conditions:

- 1) The hospital’s performance is lower than the actual-to-expected target for that cycle, OR
- 2) 50% of at-risk funds: for hospitals that had a CAP requirement in the second year of the cycle, the hospitals actual-to-expected ratio must improve by 1% relative to the actual-to-expected ratio on the CAP identification report
- 3) 100% of at-risk funds: for hospitals that had a CAP requirement in the second year of the cycle, the hospitals actual-to-expected ratio must improve by 2% relative to the actual-to-expected ratio on the CAP identification report

The at-risk amount of each hospital’s QIPP PPHR payment that is tied to CAPs and performance incentives depends on the actual-to-expected ratio. The breakdown for cycles 1 and 2, based on an actual-to-expected ratio target of 1.07, is shown in table 3.1. For example, if hospital A has \$1000 of potential QIPP PPHR funds, an actual-to-expected ratio of 1.1, and did not improve their actual-to-expected ratio by the performance incentive assignment report, they would receive \$750 of their QIPP funds. If they improved their performance and achieved an actual-to-expected ratio of 1.089 (a 1% improvement), they would receive \$875 of their QIPP PPHR funds. If they improved their performance to 1.078 (a 2% improvement), they would receive all \$1000 of their QIPP PPHR funds. See the appendix for each cycle to see the performance ranges for that cycle.

	Low Range	High Range	At Risk % of QIPP PPHR funds
Actual-to-expected ratio:		<= 1.070	0%
	>1.070	<=1.170	25%
	>1.170	<=1.270	50%
	>1.270	<=1.370	75%
	>1.370		100%

3.1 Corrective Action Plan (CAP) requirements

The Division of Medicaid has developed a template for CAPs to guide hospitals that need to submit a plan. The CAP template can be downloaded from <https://medicaid.ms.gov/value-based-incentives/>. Questions about completing the CAP can be emailed to QIPP@medicaid.ms.gov.

4 Interpreting Your Hospital's Quarterly QIPP PPHR Hospital Report

Your hospital's report contains four summary tabs (Cover, Hospital Summary, Chart Hospital Return Rate, Chart Performance) and three hospital detail tabs (Expected Rates, Hospital Detail, and Secondary Readmissions) per cycle. This section of the Methodology summary contains an overview of each section.

4.1 Cover

The cover tab contains information about your current quarterly performance, including whether a CAP is required. The cover tab also includes overview information helpful in reviewing the rest of the report, including notes about changes on the report relative to previous reports. Note the glossary of key terms at the bottom of the tab; this glossary will help you understand the terminology we use throughout the report.

4.2 Performance measurement

The performance measurement tab provides a breakdown of the at-risk payment ranges for the current reporting cycles, as well as the measurement details, dates, and requirements for each cycle on the report.

4.3 Hospital summary

The hospital summary tab provides an overview of your hospital's performance for all quarters since the baseline period in each cycle. For each cycle, the section titled "Hospital Performance" contains information about your PPHR rate relative to statewide averages for a hospital with the same casemix and patient demographics as your hospital during the baseline period. The PPHR actual-to-expected ratio is the key metric for performance measurement. Actual-to-expected ratios greater than 1.0 indicate that your hospital is performing worse than the baseline statewide average. Actual-to-expected ratios less than 1.0 indicate that your hospital is performing better than the baseline statewide average. If your hospital's actual-to-expected ratio is listed as "Low Volume," that means that your hospital had fewer than 10 actual or expected PPHRs, and the actual-to-expected ratio was not computed. The PPHR rate and actual-to-expected ratio are shown for each quarterly reporting period since the baseline period.

The section titled "Additional Performance Metrics" lists your hospital's PPR and PPED rates, compares these rates to the casemix-adjusted statewide rates, and provides the actual-to-expected ratio for these metrics. The PPR and PPED rates are provided for your information only, and to help you interpret your PPHR rate. For example, if the PPHR actual-to-expected ratio is higher than 1.0, the PPR and PPED rates can help you determine if the higher than average PPHR rate is due primarily to inpatient readmissions or return ED visits, or both.

The "Hospital Return Details" section provides detailed data for each of the three metrics. This section provides the number of at-risk admissions, the number of at-risk admissions that led to at

least one PPHR, PPR or PPED, and the total number of inpatient readmissions or return ED visits that followed an inpatient admission at your hospital. Note that the total number of PPHRs, PPRs, and PPEDs may include hospital return events that were part of a chain initiated at another hospital. The Details section lists the current reporting period details only (details from prior reports are not included).

4.4 Chart hospital return rate

The chart hospital return rate tab provides a graphic view of your hospital's PPHR, PPR, and PPED rates over time for each cycle. The top chart of each cycle plots PPHR rates over time, while the lower left chart shows PPR rates and the lower right chart shows PPED rates. In each case, the solid line indicates your hospital's rate, while the dashed line indicates the rate at an average MS hospital with the same demographics and casemix during the baseline period.

4.5 Chart performance

The chart performance tab illustrates the actual-to-expected ratios over time for PPHRs (orange line), PPRs (blue line), and PPEDs (green line). The dashed gray line represents average performance during the baseline period. Points above the dashed line indicate worse than expected performance, while points below the dashed line indicate better than expected performance. A separate chart is provided for each of the currently active cycles.

4.6 Expected Rates

This tab lists the statewide norm and the actual and expected number of hospital returns for each DRG in your data. There are separate expected rates tabs for each cycle on the report. The number of expected PPHR chains is calculated as the number of admits for each APR-DRG, severity of illness, age category and MH/SA category multiplied by the statewide norm for those categories, multiplied by the MH/SA adjustor. The listing only includes APR-DRGs that had admits in both your hospital's data and the expected rates table. This tab is provided to help you understand which patient conditions are at most risk for excess PPHRs.

4.7 Hospital detail

The hospital detail tab for each cycle lists all of the at-risk admissions as well as the initial admissions, inpatient readmissions, and return ED visits that occurred as part of a PPHR chain initiated at your hospital during the current reporting period. This listing may include inpatient readmissions and return ED visits that occurred at other hospitals, or that followed inpatient admissions at other hospitals, but that were part of a PPHR chain that started with an inpatient admission at your hospital. These inpatient readmissions and return ED visits are listed so that you can identify patients with frequent return visits to the hospital that may need additional care coordination in the community setting. All inpatient readmissions and return ED visits that are part of a PPHR chain are identified by the PPHR chain number in column A. There is a separate hospital detail tab for each cycle on the report.

4.8 Secondary readmissions

The secondary readmissions tabs list all readmissions and return ED visits that were preceded by an inpatient stay at your hospital that was not the initial admission that generated the PPHR chain. These readmissions and return ED visits do not count against your hospital's PPHR rate and are provided for your informational purposes only. These secondary readmissions may contribute to your overall assessment of strategies and approaches to reducing readmissions and return ED visits. There is a separate secondary readmissions tab for each cycle on the report.

5 Statewide Performance during the Initial Baseline Period

Across the state of Mississippi during the CY 2018 initial baseline period, the overall PPHR rate was 14.2%, indicating that 4,513 out of 31,684 at-risk stays led to at least one PPR, a PPED, or both. Among at-risk stays, 7.0% were followed by at least one PPR, while 8.2% were followed by at least one PPED. Table 5.1 below shows how the PPHR, PPR and PPED rates were distributed across Medicaid Care Categories (MCCs). MCCs are a clinical categorization scheme that groups medically similar stays. The 11 MCCs shown in the table reflect the policy areas of a typical Medicaid program and the internal organization of a typical hospital (with the exceptions of obstetrics and newborns, who are excluded from the QIPP population). MCCs are similar to the Major Diagnostic Category (MDC) scheme used by Medicare, although MCCs differentiate pediatric from adult patients (adult patients are categorized as those 21 years of age and older).

Table 5.1 also demonstrates that adult populations tended to have higher PPHR, PPR and PPED rates than pediatric patients. Note that the same stays are considered at-risk for PPHRs and PPRs; the reason the PPHR rate is higher is that it includes PPED visits in addition to PPRs. The number of at-risk stays for the PPED metric is higher than the number of at-risk stays for PPHRs and PPRs as some inpatient readmissions are also considered at-risk for a return ED visit.

For adult patients, the highest hospital return event rates were for circulatory and gastroenterology conditions, while for pediatric patients, mental health stays had the highest PPR rates, while pediatric miscellaneous stays had the highest PPED rates.

Medicaid Care Category	Number of Patients	At-Risk Stays	PPHR Rate	At-Risk Stays	PPR Rate	At-Risk Stays	PPED Rate
Adult Misc	6,794	8,555	16.8%	8,555	7.6%	8,999	10.4%
Adult Mental Health	2,890	4,189	17.2%	4,189	9.2%	4,558	9.8%
Adult Circulatory	2,147	2,784	20.6%	2,784	9.9%	2,983	12.0%
Adult Gastroent	1,857	2,195	21.0%	2,195	10.0%	2,358	12.0%
Adult Respiratory	1,677	2,126	17.7%	2,126	9.2%	2,309	9.4%
Adult Transplant	2	2	0.0%	2	0.0%	2	0.0%
Adult Subtotal	13,574	19,851	18.0%	19,851	8.7%	21,209	10.6%
Pediatric Mental Health	4,278	5,351	8.2%	5,351	5.7%	5,613	2.7%
Pediatric Misc	3,364	3,793	9.3%	3,793	3.3%	3,853	6.0%
Pediatric Respiratory	2,400	2,650	5.6%	2,650	2.1%	2,678	3.6%
Pediatric Transplant	-	-	0.0%	-	0.0%	-	0.0%
Pediatric subtotal	9,830	11,794	8.0%	11,794	4.1%	12,144	4.0%
Rehab	38	39	5.1%	39	0.0%	39	5.1%
Total	23,420	31,684	14.2%	31,684	7.0%	33,392	8.2%

Note:

1. Patients may have at-risk inpatient admissions, inpatient readmissions and/or ED visits in more than one Medicaid Care Category. For this reason, the total number of patients is lower than the sum of patients across Medicaid Care Categories.

6 Appendix

6.1 Cycle 3 Updates

6.1.1 Performance target updates

The goal of the QIPP PPHR program is to incentivize hospitals to improve hospital return performance over time. During the first two cycles of the program, the performance target was set at 1.07, or 7% more PPHRs than statewide baseline performance. For cycle 3, the performance target will decrease to 1.04. This means that hospitals with a PPHR actual-to-expected ratio greater than 1.04 on the July 2022 report will be asked to submit a CAP, and hospitals that continue to exceed the 1.04 threshold and do not improve their performance by 1 – 2% on the January 2024 report will have their QIPP PPHR at-risk funds withheld. The at-risk performance ranges will be updated to reflect the new performance target, as shown in table 6.1.1 below:

	Low Range	High Range	At Risk % of QIPP PPHR funds
Actual-to-expected ratio:		<= 1.040	0%
	>1.040	<=1.140	25%
	>1.140	<=1.240	50%
	>1.240	<=1.340	75%
	>1.340		100%

6.1.2 COVID-19 updates

COVID-19 has significantly disrupted the delivery of healthcare, resulting in decreased inpatient admissions and emergency department visits. Statewide analysis of PPR and PPED performance during the COVID-19 pandemic indicated that PPEDs dropped significantly in the April through June 2020 time period, rebounding in July through September. We anticipate some hospitals may see reductions in their PPHR rates due to the COVID-19 pandemic, which could result in a lower than normal baseline estimate for cycle 3. To reduce the effect of COVID-19 on the baseline calculation for cycle 3, the Division of Medicaid has opted to use a two-year analytical period for cycle 3. Thus, the baseline for cycle 3 will cover inpatient discharges from 1/1/2019 through 12/31/2020. All subsequent reports for cycle 3 will also use a two-year analytical period.

6.1.3 Statewide performance during the cycle 3 baseline period

Across MS Medicaid, the statewide PPHR rate was 14.7% in the cycle 3 baseline, covering 1/1/2019 through 12/31/2020. This reflects a total of 8,036 inpatient admissions that led to one or more PPR, PPED or both. Among at-risk stays, 7.5% were followed by at least one PPR, while 8.3% of PPED

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at-risk stays were followed by one more PPED. Table 6.1.3 shows how the PPHRs, PPRs, and PPED were broken out by MCCs. Consistent with prior results, PPHR rates are consistently higher for adult patients. Adult circulatory and adult gastroenterology patients had the highest PPHR rates in the MS Medicaid population, followed by adult mental health.

Table 6.1.3
Statewide Performance by Medicaid Care Category, Cycle 3 (1/1/2019 - 12/31/2020)

Medicaid Care Category	Number of Patients	At-Risk Stays	PPHR Rate	At-Risk Stays	PPR Rate	At-Risk Stays	PPED Rate
Adult Misc	10,842	15,032	16.7%	15,032	7.7%	15,852	10.2%
Adult Mental Health	4,582	7,816	19.5%	7,816	11.4%	8,698	10.1%
Adult Circulatory	3,437	4,938	20.9%	4,938	10.2%	5,297	12.4%
Adult Gastroent	2,967	3,782	20.9%	3,782	10.1%	4,042	12.3%
Adult Respiratory	2,525	3,437	17.5%	3,437	8.5%	3,743	10.2%
Adult Transplant	3	3	0.0%	3	0.0%	3	0.0%
Adult Subtotal	20,674	35,008	18.5%	35,008	9.2%	37,635	10.7%
Pediatric Mental Health	7,045	10,111	7.7%	10,111	5.7%	10,623	2.4%
Pediatric Misc	5,471	6,503	9.0%	6,503	3.7%	6,640	5.7%
Pediatric Respiratory	2,662	3,076	6.9%	3,076	2.3%	3,131	4.8%
Pediatric Transplant	1	1	0.0%	1	0.0%	1	0.0%
Pediatric Subtotal	14,790	19,691	8.0%	19,691	4.5%	20,395	3.8%
Rehab	40	40	7.5%	40	0.0%	41	7.3%
Total	35,452	54,739	14.7%	54,739	7.5%	58,071	8.3%

Note:

1. Patients may have at-risk inpatient admissions, inpatient readmissions and/or ED visits in more than one Medicaid Care Category. For this reason, the total number of patients is lower than the sum of patients across Medicaid Care Categories.

6.1.4 Top 10 DRGs during the statewide baseline period

Table 6.1.4 shows the top 10 base DRGs by PPHR volume. The top three DRGs in terms of PPHR volume are all related to mental health.

Table 6.1.4
Top 10 Base DRGs by PPHR Volume

DRG	DRG Description	PPHR/PPR At Risk	PPHRs	PPHR Rate	PPRs	PPR Rate	PPED At Risk	PPEDs	PPED Rate
750	Schizophrenia	2,767	621	22.4%	429	15.5%	3,223	324	10.1%

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Table 6.1.4

Top 10 Base DRGs by PPHR Volume

DRG	DRG Description	PPHR/ PPR At Risk	PPHRs	PPHR Rate	PPRs	PPR Rate	PPED At Risk	PPEDs	PPED Rate
753	Bipolar Disorders	5,244	521	9.9%	347	6.6%	5,582	216	3.9%
751	Major Depressive Disorders And Other Or Unspecified Psychoses	4,414	481	10.9%	309	7.0%	4,670	220	4.7%
194	Heart Failure	1,831	406	22.2%	230	12.6%	2,113	258	12.2%
720	Septicemia And Disseminated Infections	2,345	378	16.1%	221	9.4%	2,538	193	7.6%
420	Diabetes	1,483	286	19.3%	151	10.2%	1,639	168	10.3%
140	Chronic Obstructive Pulmonary Disease	923	179	19.4%	89	9.6%	993	111	11.2%
139	Other Pneumonia	1,598	165	10.3%	72	4.5%	1,684	106	6.3%
469	Acute Kidney Injury	664	126	19.0%	63	9.5%	729	84	11.5%
754	Depression Except Major Depressive Disorder	956	117	12.2%	74	7.7%	1,012	53	5.2%
Subtotal		22,225	3,280	14.8%	1,985	8.9%	24,183	1,733	7.2%
Total		54,739	8,036	14.7%	4,126	7.5%	58,071	4,813	8.3%

Notes

¹ K.E. Joynt and A.K. Jha, “Thirty-day Readmissions—Truth and Consequences,” *New England Journal of Medicine* 366:15 (2012), pp. 1366-1369.

² C. Van Walraven, C. Bennett, A. Jennings, et al., “Proportion of Hospital Readmissions Deemed Avoidable: A Systematic Review,” *Canadian Medical Association Journal* 183:7 (2011), pp. E391-E402.

³ A.E. Boutwell and S. Jencks, “It’s Not Six of One, Half-Dozen the Other,” presentation at the Academy Health 2011 annual meeting. The authors analyzed a dataset of 717,688 Massachusetts stays using the 3M PPR method, the Medicare method, and an all-cause method developed by United Healthcare.

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⁵ See, for example:

- Florida: www.FloridaHealthFinder.gov, especially the methodological discussion at www.floridahealthfinder.gov/Researchers/Reference/Methodology/Methodology.aspx.
- Illinois: <https://www.illinois.gov/hfs/MedicalProviders/hospitals/PPRReports/Pages/default.aspx>
- New York: M. Lindsey, W. Patterson, K. Ray and P. Roohan, *Potentially Preventable Hospital Readmissions among Medicaid Recipients: New York State, 2007*, Statistical Brief No. 2 Albany, NY: New York Department of Health; M. Lindsey, W. Patterson, K. Ray and P. Roohan, *Potentially Preventable Hospital Readmissions among Medicaid Recipients with Mental Health and/or Substance Abuse Health Conditions Compared with All Others: New York State, 2007*. Statistical Brief No. 3. Albany, NY: NYDOH. See also W. Patterson, M. Lindsey and P. Roohan, *A Comparison of Potentially Preventable Hospital Readmissions where Preceding Admission Was a Behavioral Health, Medical or Surgical Admission: New York State Medicaid Program, 2007*. Statistical Brief No. 4. Albany, NY: NYDOH.
- Maryland: Maryland Health Services Cost Review Commission, *Maryland Hospital Preventable Re-Admissions*, https://hscrc.state.md.us/Pages/init_qi_mhpr.aspx.
- MedPAC: Medicare Payment Advisory Commission, *Report to the Congress: Promoting Greater Efficiency in Medicare* (Washington, DC: MedPAC, June 2007).
- Texas: Texas Health and Human Services Commission, *Potentially Preventable Readmissions in the Texas Medicaid Population, State Fiscal Year 2012* (Austin, TX: HHSC, November 2013). Available at <https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/medicaid-chip-qei/PPR-FY2012.pdf>.
- Minnesota: Minnesota Department of Health, Health Economics Program, *An Introductory Analysis of Potentially Preventable Health Care Events in Minnesota* (Saint Paul, MN: July, 2015). Available at www.health.state.mn.us/data/apcd/docs/potentially_preventable_events_072115.pdf.
- Utah: Utah Department of Health, Utah Health Status Update: Potentially Preventable Hospital Readmissions (Salt Lake City, Department of Health, 2010). Available at http://health.utah.gov/opha/publications/hsu/10Nov_HospRE.pdf. Technical documentation regarding Readmissions to Utah Hospitals: 2005 – 2007 at http://stats.health.utah.gov/reports/readmission/readmission_Tech.pdf.

⁶ K. Quinn, P. Brown, “3M™ PPR ED: Potentially Preventable Revisits to the Emergency Department Methodology Overview,” Personal communication: April 4, 2019.

⁷ This section is a summary of the PPR/ED methodology developed by 3M Health Information Systems and used for this analysis. No changes were made to the methodology for this analysis. For details about the PPR/ED methodology, licensed users can reference the PPR Classification System Definitions Manual at https://apps.3mhis.com/download/3m_docs_secured/groupers/ppr/defman/v36_ppred/index.htm#acknowledgements.htm.

⁸ K. Quinn, D. Weimar, J. Gray, B. Davies, “Thinking about Clinical Outcomes in Medicaid,” *Journal of Ambulatory Care Management* 39:2 (April-June 2016), pp. 125-135.

⁹ Licensed users of the 3M PPR/ED algorithm can review details of the globally excluded conditions in the PPR Classification System Definitions Manual at

https://apps.3mhis.com/download/3m_docs_secured/groupers/ppr/defman/v36_ppred/index.htm#acknowledgements.htm.

- ¹⁰ A.E. Boutwell and S. Jencks, “It’s Not Six of One, Half-Dozen the Other,” presentation at the Academy Health 2011 annual meeting. The authors analyzed a dataset of 717,688 Massachusetts stays using the 3M PPR method, the Medicare method, and an all-cause method developed by United Healthcare.
- ¹¹ N. I. Goldfield, E. C. McCullough, J. S. Hughes et al., “Identifying Potentially Preventable Readmissions,” *Health Care Financing Review* 30:1 (2008), pp. 75-91; Fuller et al., “Hospital Readmission Rates.”
- ¹² B. K. Ahmedani, L.I. Solberg, L. Copeland, et al, “Influence of Psychiatric Comorbidity on 30-Day Readmissions for Heart Failure, Myocardial Infarction, and Pneumonia,” *Psychiatric Services* 66:2 (February, 2015).