

# Mississippi Medicaid

Quality Incentive Payment Program: Potentially Preventable Complications and Potentially Preventable Hospital Returns

Payment Method Development  
Government Healthcare Solutions  
MSH21050

# Topics



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1. Overview of the Mississippi Medicaid Quality Incentive Payment Program (QIPP), including Potentially Preventable Hospital Return (PPHR) and Potentially Preventable Complications (PPC) reporting
  2. Potentially Preventable Complications: Background
  3. PPC methodology
  4. Statewide PPC performance
  5. Understanding PPC reports
  6. QIPP PPC payments
  7. QIPP PPHR update
  8. Completing corrective action plans (CAPs)
  9. QIPP reporting timeline
  10. Looking to the future
  11. Appendix: Glossary

# Overview

# What is the Quality Incentive Payment Program?

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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.

The Quality Incentive Payment Program (QIPP) is designed to link a portion of Mississippi Hospital Access Program (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
- For SFY 2022, the QIPP program will disburse 46.4% of all MHAP payments
  - The Division of Medicaid (DOM) annually evaluates the percentage of MHAP to include in QIPP with the expectation that the QIPP portion will increase as more of MHAP is tied to quality metrics

# Components of QIPP

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## SFY 2022 components of QIPP

- Potentially Preventable Hospital Returns (PPHR) – 40% of QIPP allocation
- New in July 2021: Potentially Preventable Complications (PPC) (Inpatient) – 10% of QIPP allocation
- Health Information Network (HIN) – 50% of QIPP allocation

# Impact of COVID-19

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- The novel coronavirus (COVID-19) has impacted hospital utilization and payments in Mississippi
- DOM has been evaluating the effects of the COVID-19 pandemic on hospital return rates for reports covering the pandemic time period
  - There was a substantial decrease in return emergency department (ED) visits during the April through June 2020 time period which may have been impacted by COVID-19, which has rebounded
  - Some hospitals may see an improvement in their PPHR rates due to this COVID-related reduction
  - For the new cycle starting July 1, 2021, the baseline period will cover two years (1/1/2019 – 12/31/2020) to reduce the COVID-related impacts on the new baseline
- The PPC program will use a two-year period of analysis, which should reduce the impact of COVID-19 on PPC results
  - For the July 2021 report, the analytic period will be January 1, 2019 – December 31, 2020
- Inpatient stays and emergency department visits associated with COVID-19 diagnoses will be excluded from consideration in both the PPHR and PPC program

# Potentially Preventable Complications: background



Potentially preventable complications: background

# What are potentially preventable complications?

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- Hospital complications can often represent adverse healthcare outcomes, but some complications of care are unavoidable and are a natural consequence of disease progression
- The Potentially Preventable Complications (PPC) component of QIPP takes a population-based approach to identify hospitals that have more complications than would be expected based on a national benchmark
- Based on the 3M PPC algorithm
  - The algorithm identifies 57 separate complications ranging from major (myocardial infarction, pulmonary embolism) to “monitor” (renal failure without dialysis, clostridium difficile colitis)
  - Not every PPC can be prevented, even with the best possible care
  - A population approach reflects the expectation that hospitals with higher-than-expected complication rates have room to improve the quality of care they provide



Potentially preventable complications: background

# Examples of PPCs

PPCs are classified into three levels:

## Examples of Major PPCs

- Stroke and intracranial hemorrhage
- Pneumonia and other lung infections
- Acute myocardial infarction
- Shock
- Ventricular fibrillation/cardiac arrest
- Renal failure with dialysis

## Examples of Other PPCs

- Diabetic ketoacidosis and coma
- Cellulitis
- Urinary tract infection
- Poisonings (due to anesthesia or except from anesthesia)

## Examples of Monitor PPCs

- Renal failure without dialysis
- Clostridium difficile colitis

For a complete list of PPCs, please see spreadsheet posted on the Division of Medicaid quality improvement website: <https://medicaid.ms.gov/value-based-incentives/>

Potentially preventable complications: background

# PPC weights

- Some PPCs are more difficult to treat and costly than other PPCs
- PPC weights reflect the relative impact on hospital cost of a given PPC, adjusted for a MS Medicaid population
  - PPC weights are similar to DRG weights: they reflect the relative cost of a PPC
  - PPCs with higher weights are expected to be more expensive to treat than PPCs with lower weights

Examples of Common PPCs with Associated Weights				
PPC	Description	Group	Level	PPC Relative Weight
01	Stroke & Intracranial Hemorrhage	Cardiovascular-Respiratory Complications	Major	0.64
03	Acute Pulmonary Edema and Respiratory Failure without Ventilation	Cardiovascular-Respiratory Complications	Major	0.32
04	Acute Pulmonary Edema and Respiratory Failure with Ventilation	Extreme Complications	Major	1.20
05	Pneumonia & Other Lung Infections	Cardiovascular-Respiratory Complications	Major	0.91
09	Shock	Extreme Complications	Major	0.75
14	Ventricular Fibrillation/Cardiac Arrest	Extreme Complications	Major	0.36
25	Renal Failure with Dialysis	Extreme Complications	Major	2.04
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	Other Medical and Surgical Complications	Other	0.69
35	Septicemia & Severe Infections	Infectious Complications	Major	0.87
65	Urinary Tract Infection	Infectious Complications	Other	0.48

# PPC methodology

Potentially preventable complications: background

# PPCs are based on present on admission coding

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- PPC Assignment depends on accurate present on admission (POA) coding for secondary diagnoses
- DOM assessed the accuracy of POA coding using five diagnostic tests recommended by 3M
  - Percent of likely pre-existing conditions marked not POA
  - Percent of secondary diagnoses marked as uncertain POA
  - Higher than expected percent of secondary diagnoses marked as POA
  - Lower than expected percent of secondary diagnoses marked as POA
  - Percent of certain secondary diagnoses marked POA for elective surgical cases
- Hospital performance on the POA criteria is included in the PPC reports

# Identifying PPCs

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- PPCs are identified based:
  - On a combination of principal and secondary diagnoses, sometimes in combination with length of stay criteria
  - Procedures that were performed within a specific time period relative to the admission date
  - A combination of secondary diagnoses that are not present on admission
- “Monitor” PPCs are excluded from QIPP PPC performance measurement due to inconsistent diagnostic coding
  - PPC 21: Clostridium difficile colitis
  - PPC 24: Renal failure without dialysis
- Not every inpatient stay is at risk for every PPC
  - For example, medical inpatient stays would not be considered at risk for perioperative PPCs such as PPC 39 – Reopening Surgical Site
  - Pediatric stays are excluded from consideration for a variety of PPCs

# PPC global exclusions

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- Admissions with severe or catastrophic conditions are excluded from PPC consideration\*:
  - Major or metastatic malignancies
  - Organ transplants
  - Multiple trauma
  - Some types of burns
  - HIV illness
  - Neonatal anomalies
  - COVID-19
- Normal newborns (DRG 626 and 640) were also excluded from analysis
- The specific list of excluded conditions will be evaluated and potentially updated at the start of each new reporting cycle

\* PPC 45 (Post-procedural foreign bodies) will be assigned regardless of global exclusions

# PPC hospital exclusions

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- Psychiatric hospitals will be excluded from PPC performance measurement as PPCs were not developed for pediatric psychiatric populations
- Hospitals that don't meet POA coding requirements are expected to refine their POA coding for PPC reporting
- Hospitals with fewer than 10 expected PPCs who meet POA coding guidelines will be identified as "Low Volume." These hospitals will be expected to attest that they have received and reviewed their reports, but will not be assessed for performance incentives



# Measuring PPCs: PPC rate

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- The PPC rate measures the number of instances of a given PPC divided by the number of at-risk stays for that PPC
- Because the number of at-risk stays varies for each PPC, the overall PPC rate is difficult to interpret
- We report the rate for each PPC to provide insights into which PPCs are most common in your hospital's population
  - The statewide rate for each PPC is available in the PPC Overview document at <https://medicaid.ms.gov/value-based-incentives/>
- However, PPC rates are expected to vary based on a hospital's mix of DRGs and severities of illness
  - Hospitals that see more acute populations are expected to have higher rates of PPCs

# Measuring PPCs: population measurement

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Hospital performance measurement compares each individual hospital's PPC performance to a national benchmark on a casemix-adjusted basis

- Performance is measured using a weighted actual-to-expected ratio (A/E ratio)
  - Actual performance is defined as the sum of a hospital's PPC weights during a given analytical period
  - Expected performance is the sum of national PPC weights for the same mix of APR-DRGs and severities of illness

$$\text{Weighted Actual-to-Expected Ratio} = \frac{\text{Sum of hospital PPC weights}}{\text{Sum of national PPC weights}}$$

Weighted A/E ratio:

- = 1 The measured hospital has the same PPC weight as the national benchmark
- < 1 The measured hospital has a lower PPC weight than the national benchmark
- > 1 The measured hospital has a higher PPC weight than the national benchmark

Weighted A/E ratios are not measured for hospitals that have fewer than 10 expected PPCs

# Casemix adjustment

**Step 1:** To calculate the actual PPC weight, multiply the count of each PPC by the PPC weight and sum across the population

**Step 2:** Determine the mix of APR-DRGs/SOIs in the target population

**Step 3:** For each APR-DRG/SOI combination in the target population, multiply the expected rate of each PPC (based on national benchmarks) by the number of stays in that APR-DRG/SOI combination

**Step 4:** Multiply the expected number of each PPC by the PPC weight to obtain the expected PPC weight and sum across the population

Example Calculation of the Actual-to-Expected Ratio									
APR-DRG	Description	PPC	PPC Weight	Number of At-Risk Stays	Actual PPCs		Expected PPCs		
					Number of PPCs	PPC Population Weight	National PPC Rate	Number of Expected PPCs	PPC Population Weight
233-1	Appendectomy	10	0.30	1,000	3	0.89	0.0023	2.30	0.68
233-1	Appendectomy	47	0.52	1,000	3	1.55	0.0023	2.30	1.19
241-2	Peptic Ulcer and Gastritis	10	0.30	1,500	4	1.19	0.0057	8.55	2.53
241-2	Peptic Ulcer and Gastritis	47	0.52	1,500	4	2.07	0.0023	3.45	1.78
420-1	Diabetes	10	0.30	2,000	0	-	0.0012	2.40	0.71
420-1	Diabetes	47	0.52	2,000	3	1.55	0.0014	2.80	1.45
<b>Total</b>					<b>17</b>	<b>7.24</b>		<b>21.8</b>	<b>8.34</b>

**Weighted actual-to-expected ratio = 7.24 / 8.34 = 0.87**

**Notes:**

PPC 10 - Congestive Heart Failure

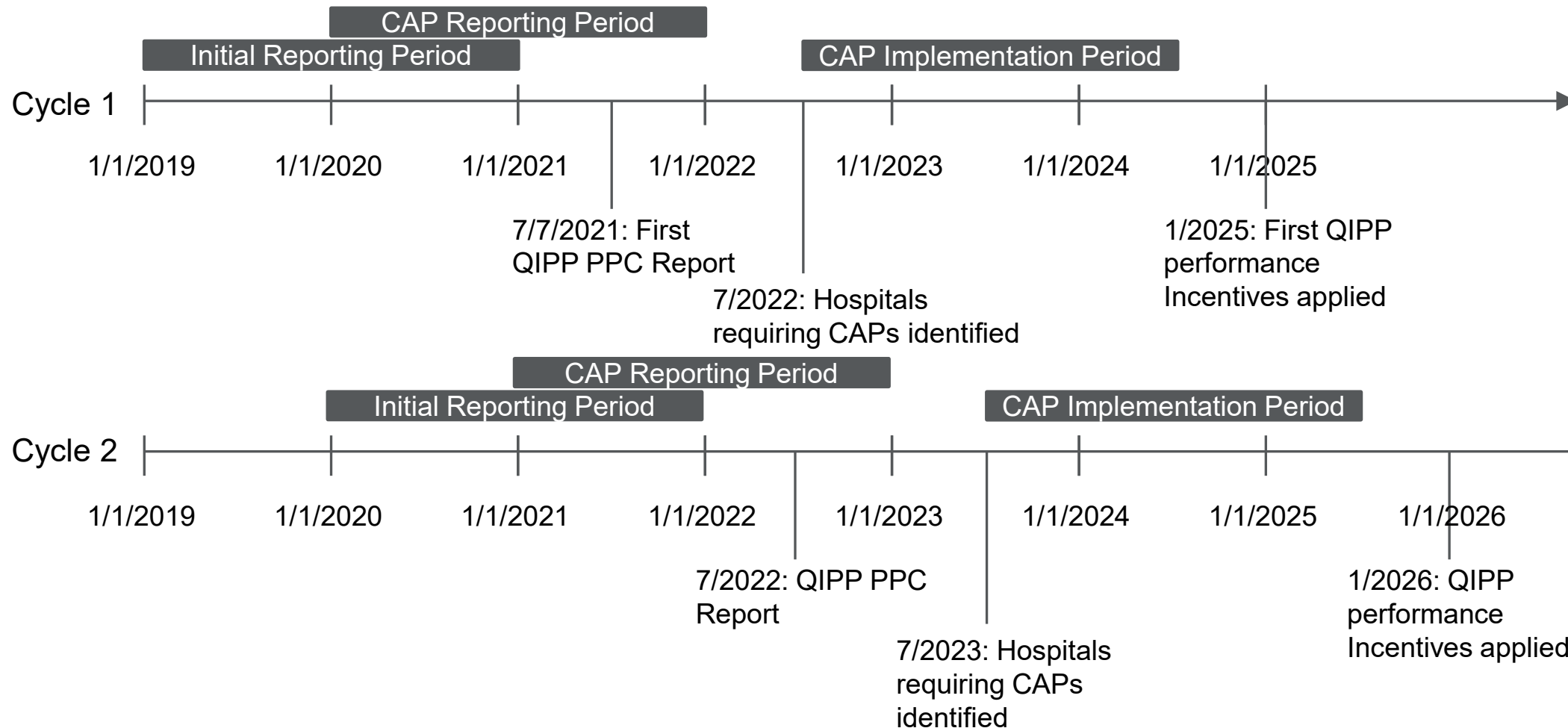
PPC 47 - Encephalopathy

# Cycles of QIPP PPC reporting

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- QIPP PPC reporting will occur in cycles with three phases, all using the same version of the PPC algorithm
  - Baseline reporting
  - Corrective action plan identification and implementation
  - Performance incentives assessment
- Each year a new cycle starts with a year of baseline reporting
  - The PPC algorithm is updated to the latest version
  - New expected rates are updated based on 3M national estimates
- The current report shows details for hospital baselines in the first cycle, with data covering calendar years 2019 and 2020

# Cycles of QIPP PPC reporting



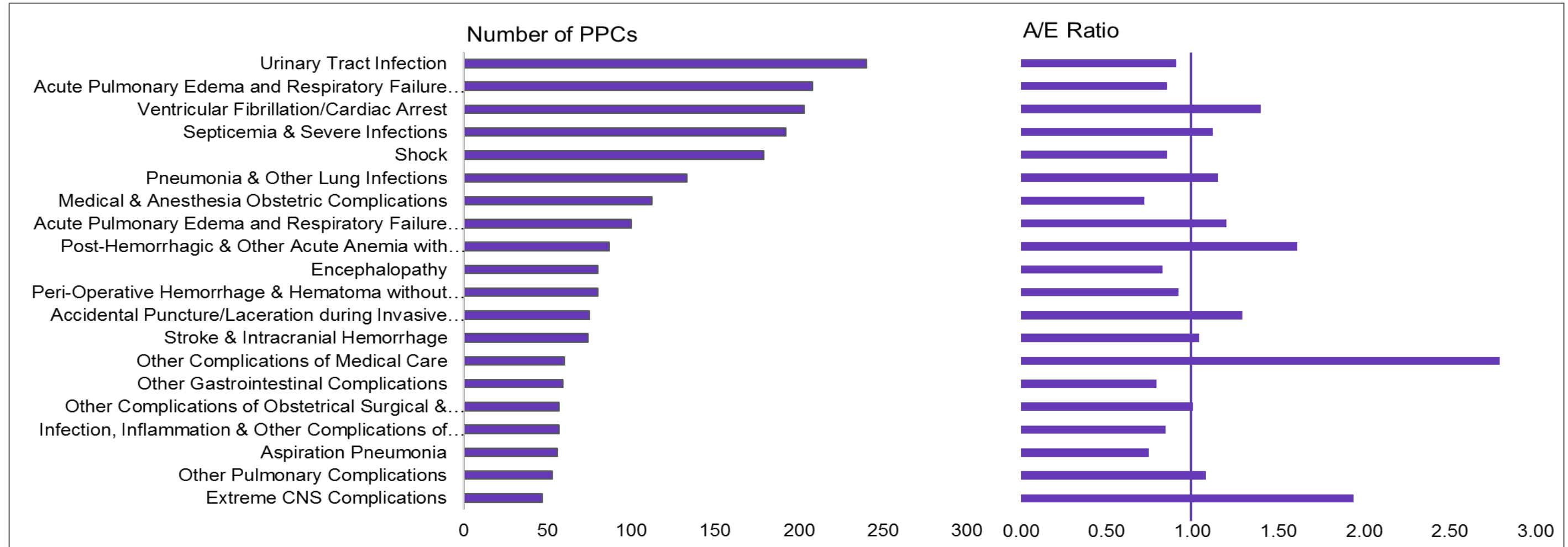
- Each reporting period will cover two years of data (i.e., January 1, 2019 – December 31, 2020)
- Reports will be disseminated quarterly to aid hospitals in tracking performance
- Performance incentives will be assessed after a two-year CAP implementation period

# Statewide PPC performance

Statewide PPC performance

# Measuring PPCs: most common PPCs

Statewide weighted A/E ratio = 1.10



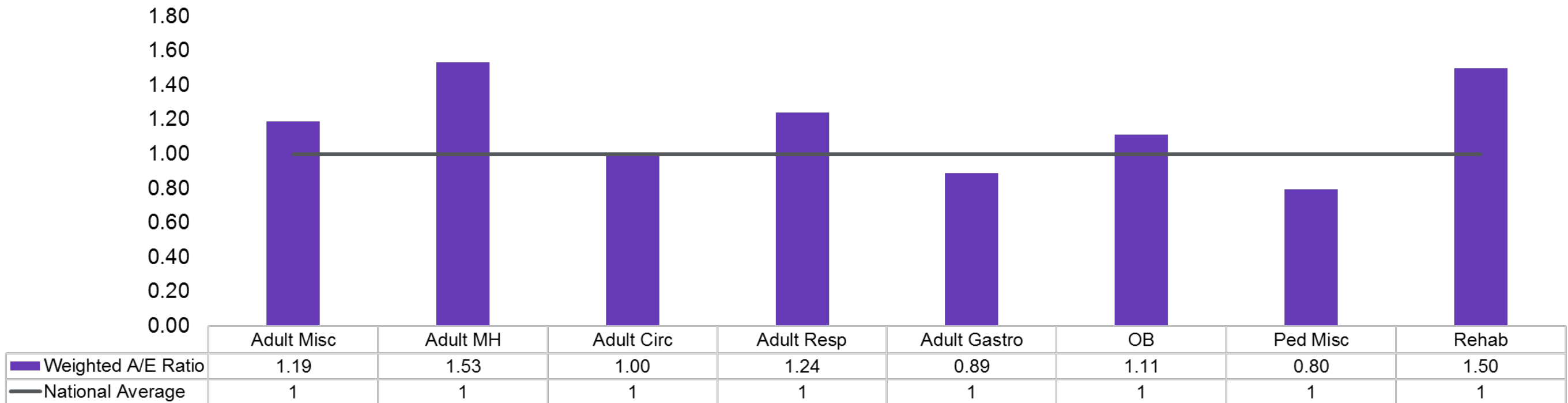


Statewide PPC performance

# PPC performance by Medicaid Care Category

- PPCs are not designed for a newborn or transplant population, so there are virtually no PPCs in those categories
- Pediatric categories also tend to have relatively few expected PPCs

**PPC Performance by Medicaid Care Category**

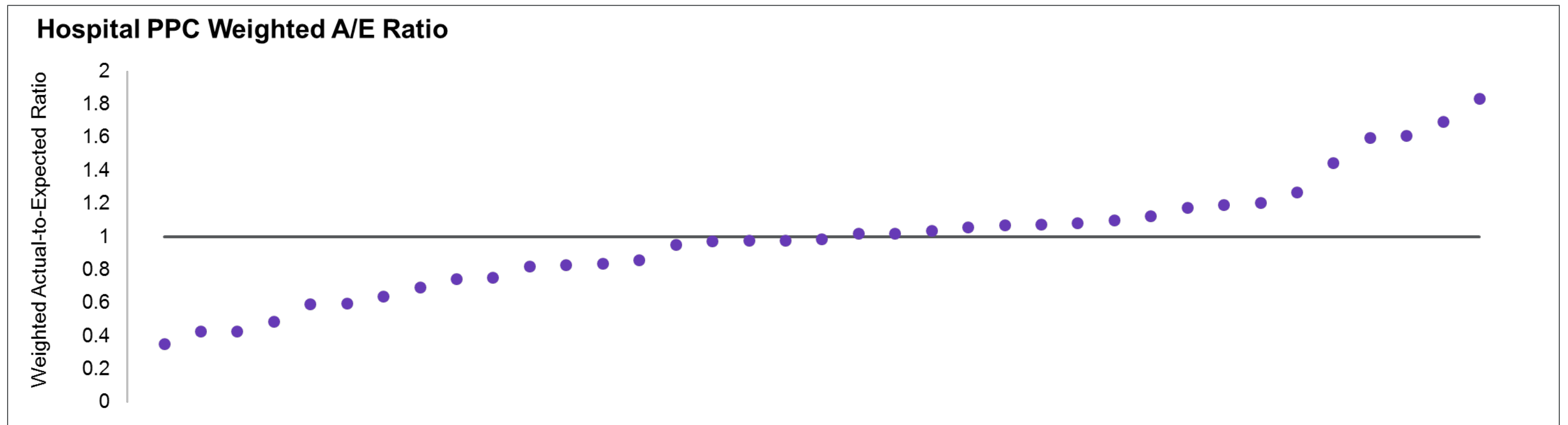


Note: Categories with fewer than 10 expected PPCs were excluded from this chart. These categories include transplants, newborns, pediatric mental health and pediatric respiratory stays

Statewide PPC performance

# PPC performance across hospitals

- Mississippi hospital PPC performance ranges from 0.35 to 1.83
- There is considerable variation in performance across hospitals, suggesting that there are opportunities for many hospitals to improve



# Understanding PPC reports

# Understanding the hospital reports

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Cover	Overview information including a table of contents and a glossary of key terms.
POA Flags	Hospital performance on the five POA coding criteria. 0, 1 or 2 points are assigned for each criterium. Hospitals that receive 2 or more points across the criteria are expected to improve their POA coding.
Performance Measurement	Indicates the dates and criteria that will be used for each current cycle of QIPP PPC performance measurement.
Hospital summary	Overview of hospital performance for all current cycles. This first report covers a single cycle. The PPC weighted actual-to-expected ratio is the metric that will be used to measure each hospital's performance relative to national benchmarks.
Chart Performance	Charts showing the PPC weighted actual-to-expected ratio over time. For reports covering multiple cycles, this tab will have one chart for each reporting cycle. The first report will cover a single time point.

# Understanding the hospital reports

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## PPC List

Provides performance details for each PPC that is included in the QIPP PPC program. Details include the PPC weight, the number of at-risk stays, the number of actual PPCs, the number of expected PPCs and the number and weight of excess PPCs as compared to the national benchmark.

## PPC Detail

Listing of claim details for all inpatient stays at your hospital that included a PPC. The detail list includes the patient's Medicaid ID, medical record number where available, and dates of service to help you match the data to your own record system.

# QIPP PPC payments

# PPC-related payments

Year 1: For the first year of the QIPP PPC program, hospitals will need to attest that they have received and reviewed their report to receive their QIPP PPC-related payments

Year 2: In July 2022, hospitals having a PPC A/E ratio greater than 1.00 will be required to submit a corrective action plan (CAP)

Year 3: CAP implementation year, no additional requirements

Year 4: In January 2025, hospitals with a CAP will be required to improve their performance by 2% to receive their at-risk QIPP PPC funds for state fiscal year 2025


At-Risk Payment Thresholds			
	Low Range	High Range	At Risk % of QIPP PPC Funds
<b>Actual-to-expected ratio:</b>		<=1.00	0%
	>1.00	<=1.10	25%
	>1.10	<=1.20	50%
	>1.20	<=1.30	75%
	>1.30		100%



# QIPP payment requirement: attestation

- All years: complete the PPHR and PPC certification form to attest that the hospital has received and reviewed the QIPP PPHR and PPC reports
  - Attestation is due 30 days after QIPP reports are distributed to hospitals
  - If attestation is not received within 30 days of QIPP report delivery, 100% of the QIPP PPHR and PPC funds may be withheld

Mississippi Hospital QIPP Certification Form



MISSISSIPPI DIVISION OF  
**MEDICAID**

**CERTIFICATION STATEMENT OF**

\_\_\_\_\_

Hospital Name

\_\_\_\_\_

Medicaid Provider Number

TO THE

STATE OF MISSISSIPPI DIVISION OF MEDICAID

TO THE RECEIPT OF THE HOSPITAL PPHR and PPC REPORTS

FOR THE PERIOD:

\_\_\_\_\_

June 30, 2021

(Report for the Quarter Ended)

Name of Person Attesting: \_\_\_\_\_

Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_

*I hereby attest that the PPHR report for the hospital named above for the period indicated has been received.*

*I hereby attest that the PPC report for the hospital named above for the period indicated has been received.*

Date of Attestation: \_\_\_\_\_

Date of Attestation: \_\_\_\_\_

\_\_\_\_\_

Signature – Hospital CEO, CFO or Authorized Signatory

\_\_\_\_\_

Title

June 2021

Mississippi Medicaid QIPP: PPC and PPHR

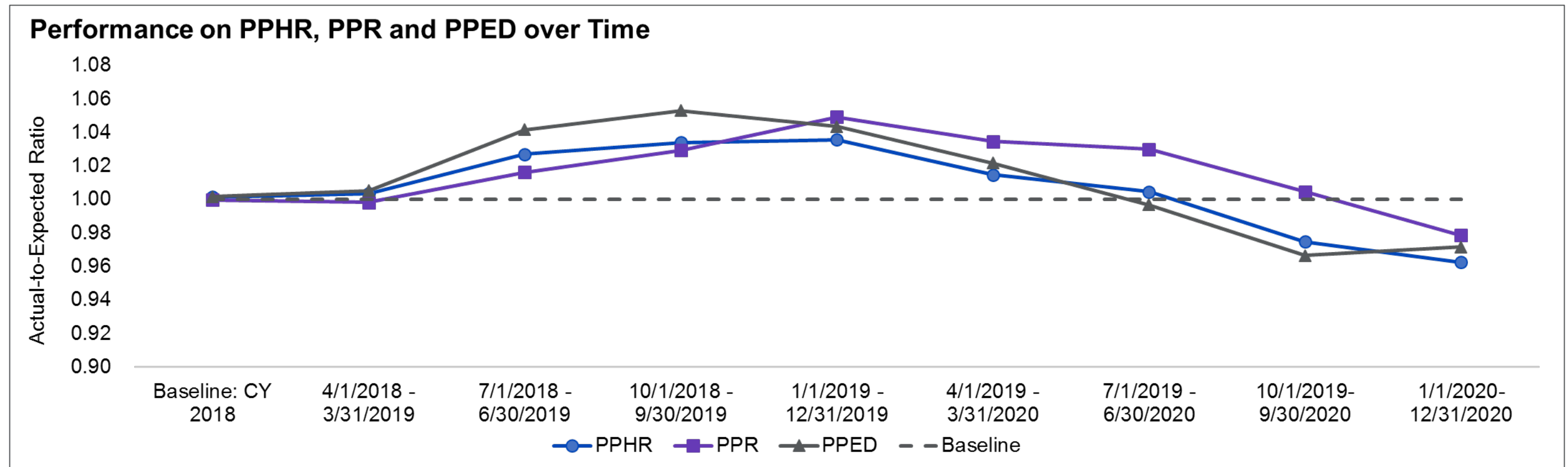
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# QIPP PPHR update

QIPP PPHR update

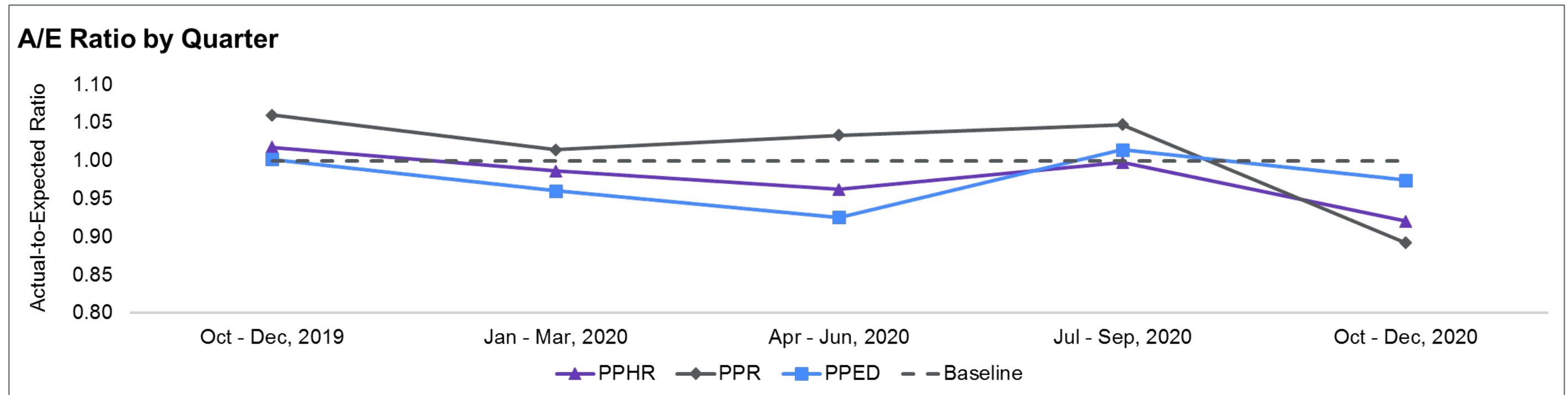
# PPHR performance over time

- Hospital returns, inpatient readmissions and return emergency department visits increased during SFY 19, but have been decreasing in recent quarters
- COVID-19 may have reduced return ED visits during the April – June 2020 period



# Effect of COVID-19

- There is a substantial dip in the PPHR A/E ratio during April – June of 2020, which rebounds in the July – September time period
  - While this could be normal quarter-to-quarter variability, it coincides with national reductions in ED usage due to COVID-19
- The substantial decline of the PPR A/E ratio in October - December 2020 may not be due to COVID-19 and may reflect genuine performance improvement as at-risk inpatient stays increased during this period



# Adjustments for COVID-19

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- All inpatient stays and return ED visits with a COVID-19 principal or secondary diagnosis (U07.1) are excluded from analysis
- We anticipate that the effect of COVID-19 will be to reduce A/E ratios, potentially improving estimates of performance for cycles 1 and 2
- For cycle 3, to avoid setting unreasonable baseline estimates due to the COVID-19 effect, DOM is using two years of data for all measurements to minimize the COVID-19 effect

QIPP PPHR update

# Cycles of QIPP PPHR reporting

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PPHR reports now include three cycles of QIPP PPHR reporting

- Cycle one:
  - Corrective action plan implementation in preparation for performance incentive allocation
  - Uses V.36 of the PPR/ED algorithm
- Cycle two:
  - Corrective action plan identification
  - Uses V.37 of the PPR/ED algorithm
- Cycle three
  - Baseline reporting
  - Uses V.38 of the PPR/ED algorithm
  - Each report will be based on two years of data to reduce the impact of COVID-19-related utilization changes

# QIPP PPHR payment requirement: cycle one

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Performance incentives will be allocated January 1, 2022

Hospitals that were required to submit a corrective action plan by September 1, 2020 will be required to improve their performance over the following year to receive their at-risk funds

- Either:
  - Improve performance to below the 1.07 threshold to receive at-risk payments, or
  - Improve performance by 2% relative to the July, 2020, report of the corrective action plan year to receive 100% of their QIPP at-risk funds, or
  - Improve performance by 1% relative to the July, 2020, report of the corrective action plan year to receive 50% of their QIPP at-risk funds
- Hospitals are also required to meet all other requirements for that report to receive their funds:
  - Submit the PPHR certification form to attest that they have received and reviewed their report
  - Submit a corrective action plan for the second cycle on the report (if required)

# PPHR payment requirements cycles two and three

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## Requirement for the corrective action plan year (Cycle 2):

- Hospitals with an actual-to-expected ratio greater than 1.07 on the July 2021 report of the corrective action plan year will be required to complete the corrective action plan template
  - Corrective action plans are due by September 1 of the corrective action plan year
  - If a corrective action plan is not received by the deadline:
    - That quarter's PPHR funds may be withheld
    - If the corrective action plan is still not received by subsequent quarters' attestation deadlines, those quarters' QIPP PPHR funds may be withheld

## Requirement for the baseline year (Cycle 3):

- Complete the PPHR/PPC certification form to attest that the hospital has received and reviewed the QIPP PPHR and PPC reports



# PPHR performance targets: cycles one and two

- For all performance-related payments, the proportion of each hospital’s QIPP PPHR payments that are at-risk depends on the hospital’s PPHR actual-to-expected ratio:

	Low Range	High Range	At Risk % of QIPP PPHR Funds
<b>Actual-to-expected ratio:</b>		<= 1.07	0%
	>1.07	<=1.17	25%
	>1.17	<=1.27	50%
	>1.27	<=1.37	75%
	>1.37		100%

# PPHR performance targets: cycle three

- To reflect DOM’s commitment to improving care quality over time, the performance target for cycle three will be reduced from 1.07 to 1.04
- At-risk performance ranges will be updated accordingly

	Low Range	High Range	At Risk % of QIPP PPHR Funds
<b>Actual-to-expected ratio:</b>		<=1.04	0%
	>1.04	<=1.14	25%
	>1.14	<=1.24	50%
	>1.24	<=1.34	75%
	>1.34		100%


# Completing corrective action plans

# Completing corrective action plans

The Division of Medicaid has developed a template for CAPs to guide hospitals that need to submit a plan

Hospitals that have a PPHR CAP requirement for cycle two are expected to complete and submit the corrective action plan template by September 1, 2021

Questions about completing the PPHR CAP should be directed to the QIPP mailbox at [QIPP@Medicaid.ms.gov](mailto:QIPP@Medicaid.ms.gov)

Mississippi Hospital PPHR Corrective Action Plan (CAP)		
 MISSISSIPPI DIVISION OF <b>MEDICAID</b>		
<b>General Hospital Provider Data:</b>		
Hospital Name:	<input type="text"/>	
Medicaid Provider Number:	<input type="text"/>	
STATE OF MISSISSIPPI DIVISION OF MEDICAID TO THE PROVISION OF THE ATTACHED PLAN		
For the Period:	<b>JUNE 30, 2020</b> <i>(Report for the Fiscal Year Ended)</i>	
<b>Attestation Information:</b>		
Name of Preparer:	<input type="text"/>	
Title:	<input type="text"/>	
Phone Number:	<input type="text"/>	
<i>I hereby attest that the Corrective Action Plan for the hospital named above for the period indicated has been reviewed and approved.</i>		
<input type="text"/>	<input type="text"/>	<input type="text"/>
Hospital CEO or CFO Signature	Title	Attestation Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
CEO or CFO Printed Name	CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

# QIPP reporting timeline

# Upcoming dates of interest: QIPP payments

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- In SFY 2022, QIPP payments will be made quarterly by the coordinated care organizations to hospitals who meet QIPP PPHR reporting requirements
- For each quarter in SFY 22:
  - The Health Information Network (HIN) portion of QIPP will be paid the first month of the quarter
  - The PPHR and PPC portions of QIPP will be paid the last month of the quarter
    - September, 2021
    - December, 2021
    - March, 2022
    - June, 2022

# Upcoming dates of interest: QIPP reporting

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- July 7, 2021: Quarterly PPHR and PPC reports distributed to hospitals  
Hospitals required to submit a PPHR corrective action plan for cycle two identified
- August 6, 2021: Hospital deadline to attest receipt and review of the quarterly reports
- September 1, 2021: PPHR Corrective action plan (cycle two) deadline
  
- October 5, 2021: Quarterly PPHR and PPC reports distributed to hospitals
- November 4, 2021: Hospital deadline to attest receipt and review of the quarterly reports
  
- January 10, 2022: Quarterly PPHR and PPC reports distributed to hospitals  
Performance incentives for PPHR cycle one allocated
- February 7, 2022: Hospital deadline to attest receipt and review of the quarterly reports
  
- April 5, 2022: Quarterly PPHR and PPC reports distributed to hospitals
- May 5, 2022: Hospital deadline to attest receipt and review of the quarterly reports

# Looking to the future



# Looking to the future

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1. Each hospital is required to complete the PPHR and PPC Certification form and email it to [QIPP@Medicaid.ms.gov](mailto:QIPP@Medicaid.ms.gov) by August 6, 2021 to attest that they have received and reviewed their July 7, 2021 quarterly reports
2. For hospitals with an actual-to-expected ratio greater than 1.07 in cycle two of their July 7, 2021 report, corrective action plans will be due September 1, 2021
3. For copies of QIPP documents (including the PPHR and PPC methodology supplements and this presentation) email [QIPP@Medicaid.ms.gov](mailto:QIPP@Medicaid.ms.gov), or go to the QIPP website: <https://medicaid.ms.gov/value-based-incentives/>
5. DOM plans to begin posting statewide and hospital-specific data for the reporting period of calendar year 2019 on its website, including:
  - PPR percentages
  - PPED percentages
  - Actual-to-expected ratios

# Appendix

# Glossary: PPC

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**At-risk stays:** Inpatient admissions that may or may not include a potentially preventable complication (PPC), but do not meet the clinical exclusion criteria. Each PPC has a different pool of at-risk stays, depending on the clinical characteristic of the stay. For example, only inpatient stays that included a procedure are at-risk for surgical PPCs.

**Casemix adjustment:** Mathematically adjusting the expected PPC rate for the mix of DRGs and severities of illness at a given hospital

**Corrective action plan (CAP):** Document that describes strategies for reducing potentially preventable complications. CAPs will be required from hospitals with a weighted actual-to-expected ratio greater than 1.00 on the July 2022 report

**Monitor PPCs:** PPC 21 (clostridium difficile colitis) and 24 (renal failure without dialysis) are excluded from the PPC performance metric. Coding of these PPCs is inconsistent across hospitals, making it difficult to compare performance across hospitals

**Potentially preventable complication (PPC):** Patient conditions that develop during an inpatient stay that may reflect adverse outcomes

**Present on admission flag (POA flag):** POA flags are used to identify conditions that develop during an inpatient stay. Only conditions identified as not present on admission are used to identify PPCs

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

**Weighted actual-to-expected ratio:** Performance metric that compares the relative cost of potentially preventable complications at a given hospital to the expected relative cost nationwide during the baseline period

# Glossary: PPHR

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**Actual-to-expected ratio:** Performance metric that compares a given hospital to an average Mississippi hospital with the same casemix

**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

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

**Corrective action plan (CAP):** Document that describes strategies for reducing potentially preventable hospital returns

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

**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

**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)

**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

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

**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

# For further information

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