

Mississippi Medicaid

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

Payment Method Development
Government Healthcare Solutions

MSH22050
July 19 & 21, 2022

Agenda

1. Introduction - Mississippi Medicaid Quality Incentive Payment Program (QIPP), including Potentially Preventable Hospital Return (PPHR) and Potentially Preventable Complications (PPC) reporting
2. QIPP Methodology
3. Statewide performance
4. QIPP PPC update
5. QIPP PPHR update
6. Hospital Success Stories
7. Coordinated Care Organizations
8. QIPP reporting timeline
9. Appendix: Glossary
10. Q&A

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QIPP Methodology

What is the Quality Incentive Payment Program?

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 2023, the QIPP program will disburse 51.9% 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

SFY 2023 components of QIPP

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

What are Potentially Preventable Complications?

- 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
- 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

Identifying PPCs

- PPCs are identified based on:
 - A combination of principal and secondary diagnoses, sometimes in combination with length of stay or present on admission
 - Procedures that were performed within a specific time period relative to the admission date
 - PPC 45 (Post-procedural foreign bodies) will be assigned regardless of global exclusions
- Exclusions include:
 - “Monitor” PPCs are excluded due to inconsistent diagnostic coding
 - 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
 - Admissions with severe or catastrophic conditions are excluded from PPC consideration
 - 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 hospital exclusions

- Psychiatric hospitals will be excluded from PPC performance measurement as PPCs were not developed for 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

Cycles of QIPP PPC reporting

Note about QIPP cycles: Performance measurement occurs in three-year cycles. A cycle is a period of three years that includes one baseline year, one year for corrective action plans, 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 corrective action plan year.

PPC Cycle	Cycle 1	Cycle 2	Cycle 3
Baseline Period	1/1/2019-12/31/2021	1/1/2020-12/31/2022	1/1/2021-12/31/2023
Date of Report to determine if CAP is required	July 2022	July 2023	July 2024
If CAP is required, due date to submit CAP	No CAP Required	9/1/2023	9/1/2024
Corrective Action Plan (CAP) Period	7/1/2022-6/30/2024	7/1/2023-6/30/2025	7/1/2024-6/30/2026
Date of Report that Provider Performance Incentives will be assessed (1%-2% improvement from CAP period)	January 2025	January 2026	January 2027
Performance Incentives Period	7/1/2022-6/30/2024	7/1/2023-6/30/2025	7/1/2024-6/30/2026

What are potentially preventable readmissions?

Basis for clinical relationships in the PPR/ED algorithm:

1. Medical readmissions for a continuation or recurrence of the reason for the initial admission, or for a closely related condition
2. Readmissions for a surgical procedure to address a continuation or a recurrence of the problem causing the initial admission
3. Medical readmission for an acute medical condition or complication that may be related to or may have resulted from care during the initial admission or in the post-discharge period after the initial admission
4. Readmissions for surgical procedure to address a complication that may be related to or may have resulted from care during the initial admission
5. Ambulatory care sensitive conditions as designated by ARHQ
6. All other readmissions for a chronic problem that may be related to care either during or after the initial admission
7. Readmissions for mental health reasons following an initial admission for a non-mental health, non-substance abuse reason
8. Readmissions for a substance abuse diagnosis reason following an initial admission for a non-mental health, non-substance abuse reason
9. Mental health or substance abuse readmissions following an initial admission for a substance abuse or mental health diagnosis

Identifying PPHRs

- The PPHR rate measures the number of at-risk inpatient discharges that are followed by one or more PPRs and/or PPEDs
- PPEDs are visits to the emergency department that follow at-risk inpatient discharges within 15 days and are clinically related to the inpatient admission
- High rates can signal problems with premature inpatient 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).
- Average performance is defined as the Mississippi statewide performance during a baseline year
- Hospital performance is compared to the statewide baseline, adjusted for each hospital's casemix, age mix, and mental health burden
- Performance is measured using the actual-to-expected ratio
 - Expected rates are calculated separately for general acute care and psychiatric care hospitals
 - Each hospital's actual rate is the number of hospital return chains

PPHR 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 include:
 - Trauma
 - Metastatic malignancy
 - HIV/AIDS
 - Neonates
 - Sickle cell crisis
 - COVID-19 (adjustments for COVID-19 to be determined when data is available)
- Patient transferred to another hospital
- Patient left against medical advice
- Patient died

Cycles of QIPP PPHR reporting

Note about QIPP 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 plans, 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 corrective action plan year.

PPHR Cycle	Cycle 1	Cycle 2	Cycle 3	Cycle 4
Statewide Threshold A/E Ratio	1.07	1.07	1.04	1.04
Baseline Period	1/1/2018-12/31/2018	1/1/2019-12/31/2019	1/1/2019-12/31/2020	1/1/2020-12/31/2021
Date of Report to determine if CAP is required	July 2020	July 2021	July 2022	July 2023
If CAP is required, due date to submit CAP	9/1/2020	9/1/2021	9/1/2022	9/1/2023
Corrective Action Plan (CAP) Period	1/1/2019-12/31/2019	1/1/2020-12/31/2020	1/1/2020-12/31/2021	1/1/2021-12/31/2022
Date of Report that Provider Performance Incentives will be assessed (1%-2% improvement from CAP period)	January 2022	January 2023	January 2024	January 2025
Performance Incentives Period	7/1/2020-6/30/2021	7/1/2021-6/30/2022	7/1/2021-6/30/2023	7/1/2022-6/30/2024

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

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

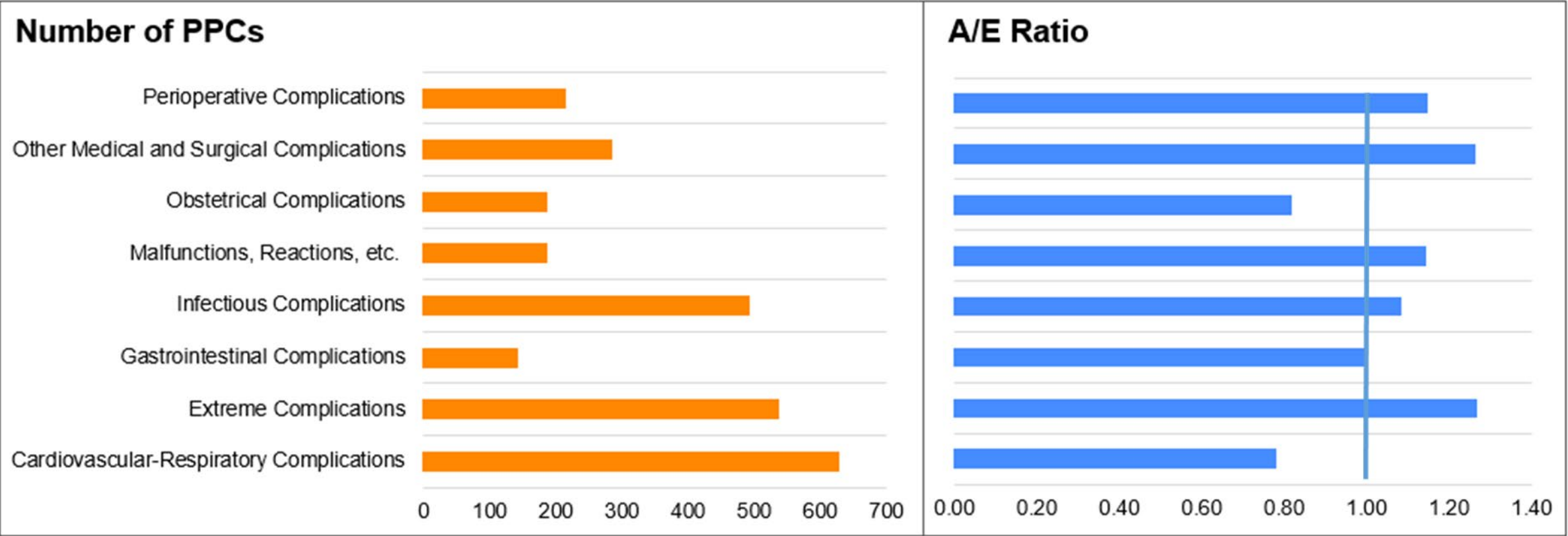
Title

Statewide performance

Statewide performance

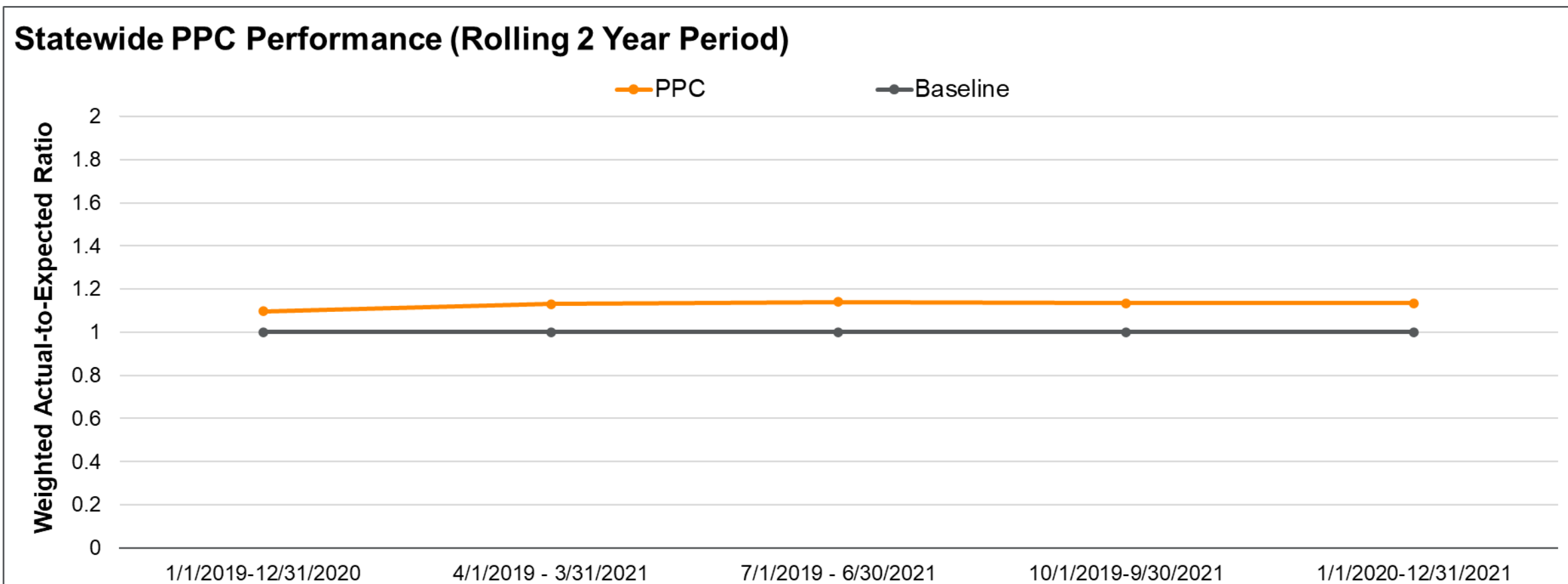
PPC performance by complication type

1/1/2020-12/31/2021 Statewide weighted A/E ratio = 1.135



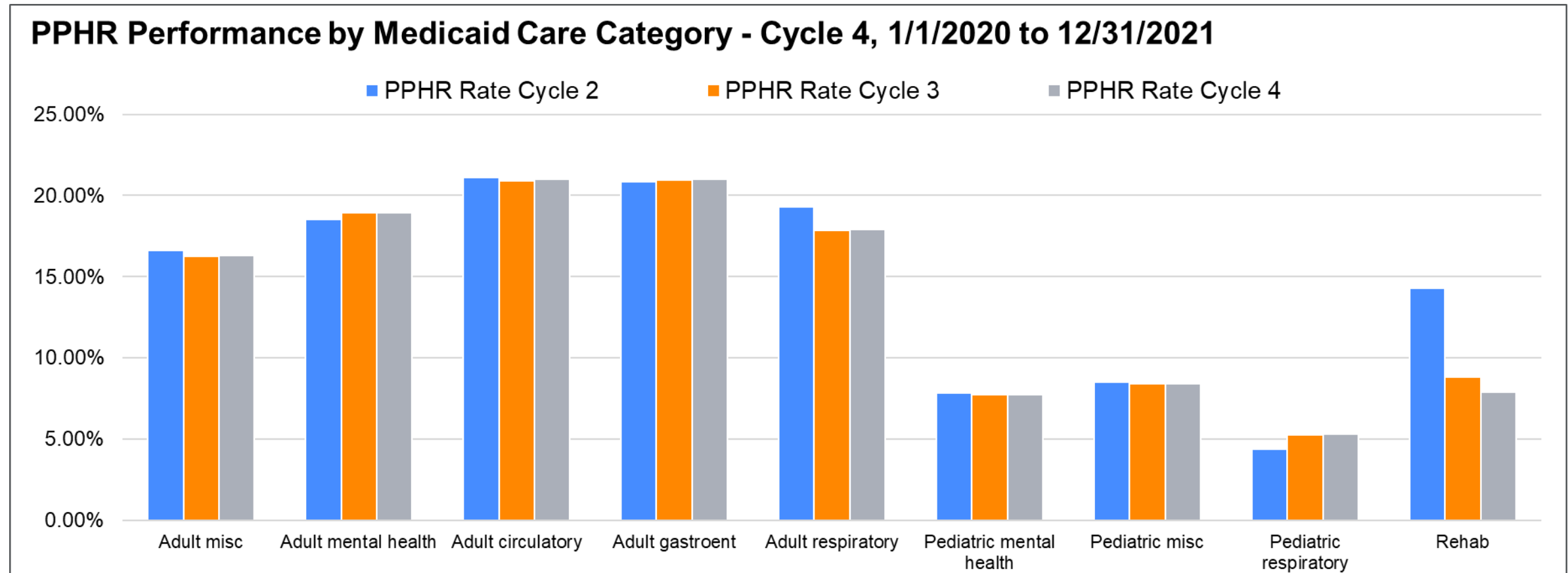
Statewide performance

PPC performance



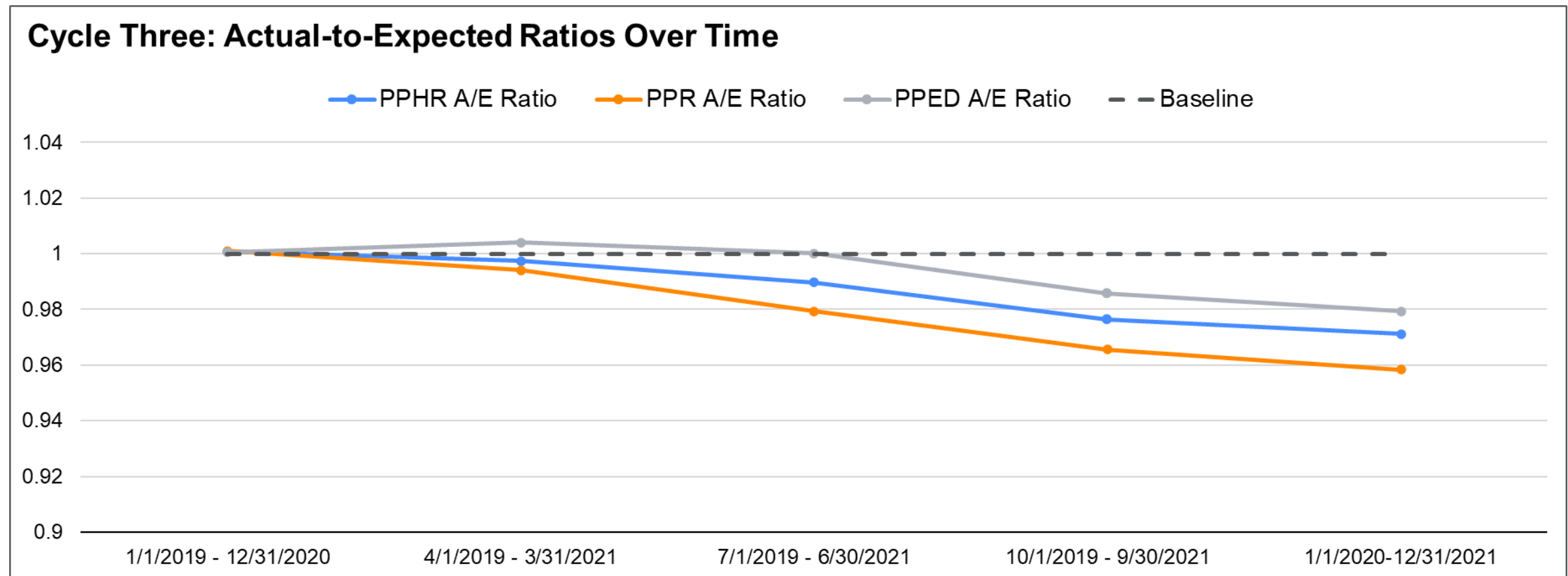
Statewide performance

PPHR performance by Medicaid Care Category



Statewide performance

PPHR performance



QIPP PPC updates

QIPP PPC Updates

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: For the second 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 3: In July 2023, hospitals having a PPC A/E ratio greater than 1.00 will be required to submit a corrective action plan (CAP)

Year 4: CAP implementation year, no additional requirements

Year 5: In January 2026, 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 2026

At-Risk Payment Thresholds

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

QIPP PPHR update

PPHR performance over time

- During the PPHR program's first improvement cycle, readmissions have been reduced by 7%
- During the first cycle, 43 hospitals met the volume criteria for performance measurement
 - 20 hospitals were required to submit corrective action plans
 - One hospital did not meet the required improvement and forfeited funds at the end of the cycle.
- During the second cycle, 40 hospitals met the volume criteria for performance measurement
 - 10 hospitals were required to submit a corrective action plan
 - Adjustments to QIPP PPHR funds for cycle 2 performance will be allocated in January of 2023
- During the third cycle 48 hospitals met the volume criteria for performance measurement
 - 15 hospitals will be required to submit corrective action plans
- The fourth cycle is currently in its baseline period

PPHR performance targets

- 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:

Cycle 1 & 2	Low Range	High Range	At Risk % of QIPP PPHR Funds
Actual-to-expected ratio:		<= 1.07	0%
	>1.07	<=1.17	25%
	>1.17	<=1.27	50%
	>1.27	<=1.37	75%
	>1.37		100%

Cycle 3 & 4	Low Range	High Range	At Risk % of QIPP PPHR Funds
Actual-to-expected ratio:		<=1.04	0%
	>1.04	<=1.14	25%
	>1.14	<=1.24	50%
	>1.24	<=1.34	75%
	>1.34		100%

- 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

PPHR payment requirements cycles 3 and 4

Requirement for the corrective action plan year (Cycle 3):

- Hospitals with an actual-to-expected ratio greater than 1.04 on the July 2022 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 4):

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


QIPP PPHR update

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 three are expected to complete and submit the corrective action plan template by September 1, 2022

Questions about completing the PPHR CAP should be directed to the QIPP mailbox at QIPP@Medicaid.ms.gov

Mississippi Hospital PPHR Corrective Action Plan (CAP)		
 <small>MISSISSIPPI DIVISION OF MEDICAID</small>		
General Hospital Provider Data:		
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:	JUNE 30, 2020 <i>(Report for the Fiscal Year Ended)</i>	
Attestation Information:		
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

Hospital success stories

Success stories

St. Dominic Jackson Memorial Hospital

Presenter: Teri Dyess, M.D., Chief Medical Officer

Topic: Collaboration with CCOs in Readmission Reduction Efforts

North Mississippi Health Systems

Presenter: Laura McClung, MSN, RN, CPHQ, CJCP; Director, Population Outcomes and Value Based Programs

Topic: Readmission Reduction Efforts

Presenter: Shelley McArthur, MSN, RN, Meaningful Use Coordinator

Topic: Benefits of Connecting to the HIN

Coordinated Care Organizations

Magnolia Healthcare

The logo consists of a stylized flower with five petals. The petals are colored in shades of orange and purple, with a small purple dot in the center.

magnolia health™

READMISSIONS

Michael Adcock,
Vice President, Population Health and
Clinical Operations

7/19/2022

A decorative orange wave graphic at the bottom of the slide, composed of several vertical bars of varying heights and shades of orange.

Our Role in Readmission Reduction

- When does discharge planning begin:
 - The sooner the facility communicates with the health plan, the sooner we can become involved
- Serve as a resource to Discharge Planners and Social Workers at facility:
 - Contact information on last slide
- Overutilization:
 - As “frequent fliers” are recognized, reach out to Magnolia Health so we can collaborate to develop a specific plan
- Provide resource education:
 - MTM for transportation, our 24-hour Nurse Advice Line, Care Management and Pharmacy services, our Nurse Triage Line

**Contact information is provided on last slide

Magnolia Readmission Reduction Program

- Readmission reduction is high priority for Magnolia Health
 - Magnolia staff make post-discharge calls within 3-10 days of discharge
 - Medication education
 - Needed resource identification
 - Assistance with scheduling appointments and transportation
 - Home health, DME (durable medical equipment) needs and support are assessed
 - Members are stratified and referred to the appropriate level of Care Management to be followed over time

Care Management



- All Magnolia Health members have access to Care Management services delivered by a large, local Care Management staff. Including:
 - Care Management services
 - Follow-up appointment assistance and appropriate referrals
 - Medication assistance and transportation assistance when needed
- Referrals from Providers can be made in any of the following ways:
 - Providers may log into our Provider Portal and complete the Provider Referral Form for Care Management and Disease Management
 - Go to our website www.magnoliahealth.com and fill out the Provider Referral Form for Care Management and Disease Management, which is located under the Practice Improvement Resource Center (PIRC) section
 - Call Magnolia Health at 866.912.6285 Ext. 66415 to speak with the Care Management Department or choose the Provider prompt to speak with a Provider Services Representative who can assist you

Outreach

- The most effective results come from working together.

- Outreach done to all hospitals and providers in the program
- MHA/DOM webinar - 2021

Communication during Care Management calls

- Provider Relations does provider education and discuss during JOCs
- Standing readmission meetings with the following facilities:
 - St. Dominic
 - University of Mississippi Medical Center
 - Merit Health Central
 - Forest General Hospital
 - Neshoba General Hospital
 - Greenwood Leflore Hospital
 - Gulfport Behavioral Center
- Contact Magnolia Health to discuss
- Executive meetings being planned for hospitals/providers at risk

Magnolia Contact Information



- **Magnolia main number** 1-866-912-6285, ext 66415 or ask for Care Management Dept
- **Christie Moody**, Director Population Health Management Care Management **601-715-8260**
chmoody@centene.com
- **Jasmine Richardson**, Supervisor Transitional Team **601-850-2588** jarichardson@centene.com
- **Allyson McDonnieal**, Clinical Manager for Behavioral Health **601-937-7365**
amcdonnieal@centene.com
- **Angela Brown**, Manager Utilization Management **1-866-912-6285 ext 66881**
angelbrown@centene.com
- **Michael Adcock**, Vice President, Population Health Management **1-601-317-2343**
michael.Adcock@centene.com

Molina Healthcare

Molina MS Readmissions Reduction Program

Presented by: Richard Jones

Goal of Molina MS Readmissions Project

Program Overview: Identify potential readmission diagnosis, analyze trends and work with providers/members to prevent unnecessary re-admissions

Goal: Reduce unnecessary readmissions (Inpatient and ED)

Transition of Care for Molina Member's with PPHR

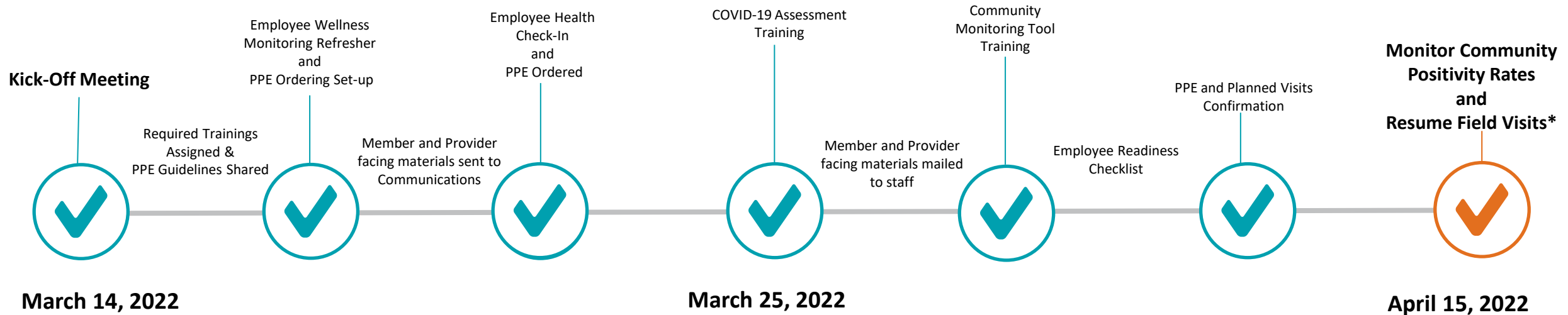
Molina Healthcare of Mississippi's Care Management program enrolls members who are hospitalized, including those members that have potentially preventable hospital readmissions and emergency department returns. We work with hospitals to address the needs of your Molina patients through *daily ADT transmissions, warm hand-offs*, and collaborative *performance improvement meetings* with hospitals, OP providers and CBOs.

Top Five (5) APR-DRGS Causing Readmissions

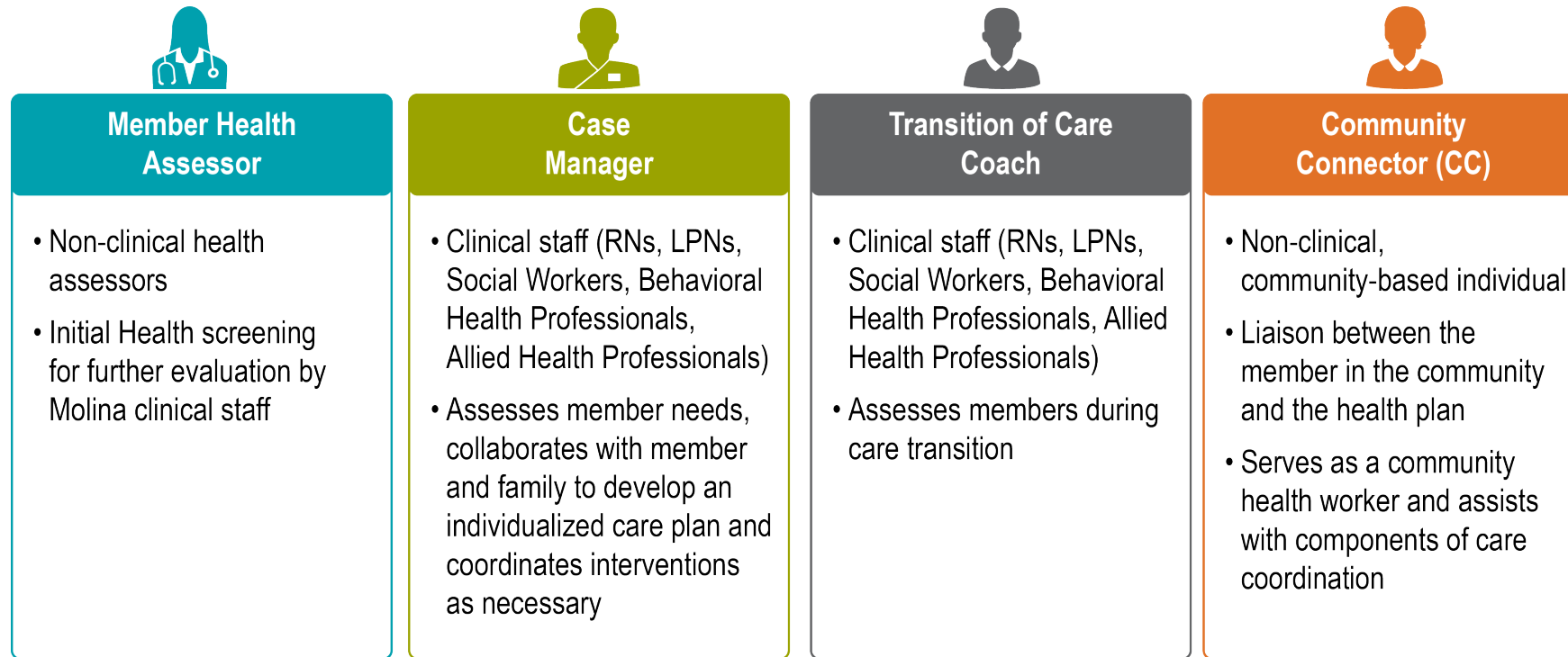
TOP 5	194-Heart Failure
	720-Septicemia
	420-Diabetes
	753-Bi-Polar Disorder
	750-Schizophrenia

Roadmap to Resuming Hospital Visits

Molina Healthcare of Mississippi understands the importance of engaging face-to-face with our hospitalized members. This roadmap illustrates the steps that Molina deployed to protect our communities and reduce the spread of COVID-19 as we resume our field-based Care Management interventions, meet with hospital staff on site and engage our hospitalized members. The safety of our members, providers, and employees are top priority for Molina Healthcare of Mississippi!



Molina's Care Management Team



Robust internal training: MI, Cultural Competency, Assessment Probing and Engagement

At Admission Notification and/or Care Management Referral

Molina Healthcare of MS ToC Coaches:

- ☐ Coordinate the care for hospitalized Molina members
- ☐ Introduce Molina's Care Management programs to the member during their hospitalization, if the member is not already enrolled in a CM program
- ☐ Attempt to coordinate an in-person visit with hospitalized members
- ☐ Outreach to hospital Discharge Planners or designated staff during a member's hospitalization
- ☐ Participate in warm handoffs with member and the hospital discharge planner
- ☐ Fax you the Discharge Planning Checklist
- ☐ Assist Hospital Discharge Planners with scheduling post-hospitalization follow up care and non-emergency transportation
- ☐ Addresses and/or connects members with social risk factors to available community-based resources and Community Connectors



Transition of Care Coach

- Clinical staff (RNs, LPNs, Social Workers, Behavioral Health Professionals, Allied Health Professionals)
- Assesses members during care transition

TOC cases may also be assigned to a CM

- ✓ Hospitals can return the completed **Post-Discharge Checklist** to ToC by secure email MHMS_CM_Referrals@MolinaHealthCare.Com or Fax to 1-844-209-0435

Connecting with Care Management to Reduce PPHR

- CM/TOC Coaches need ongoing access to hospital discharge planners for the most successful collaboration of post-discharge care. We want to engage with you!
- Hospital discharge planners may direct dial the assigned CM/TOC Coach when barriers arise or note these on the Discharge Planning Checklist
- If CM assignment is unknown, hospital discharge planners are able to direct message inquires and or referrals to Care Management at: MHMS_CM_Referrals@MolinaHealthCare.Com or Contact Us through Provider Services at 1-844-826-4335, Option 5
- Hospitals with PPHR rate concerns may reach out to Molina HCS leadership directly
 - Demetria Young, Manager, CM
Demetria.Young@MolinaHealthcare.com
 - Shamekias Lampkin, Manager, BH
Shamekias.Lampkin@MolinaHealthcare.com
 - Shira Brownell, Director CM/Population Health
Shira.Brownell@MolinaHealthcare.com
 - Richard Jones, AVP, Healthcare Services
Richard.Jones@MolinaHealthcare.com

Past Examples of when Hospital Discharge Planners have reached out to Care Management

- Hospital staff encountering barriers with scheduling FUH or FUH care is not timely (within 7 days of discharge)
- Member unable to obtain post-discharge medication(s)- Rx requires PA
- Member has ongoing social risk factors (i.e., lack of stable housing)
- Hospital discharge planners encountering barriers scheduling NET
- Hospital discharge planners needs to alert and/or refer a member to Care Management

United Healthcare



Potentially Preventable Hospital Returns

Provider Webinar July 2022

*Dana Carbo-Bryant, MD,
FAAP*

Chief Medical Officer

**United
Healthcare**

Our Approach

Physical & Behavioral Health Integration



Member Centric

- Enhanced Care Management
- Transitions of Care/Discharge Planning
- Interdisciplinary Rounds
- Genoa Healthcare® Meds to Beds Program



Hospital Focused

- Collaborative relationships
- Data-informed feedback
- Identification and solutioning of barriers
- Value-based contracting

PROVIDER ENGAGEMENT



OCEANS HEALTHCARE



- Merit Central- MS Collaborative Aftercare Planning Pilot. This is a RACI-lite initiative which uses weekly rounds between the Optum/UHC and Merit Central to provide enhanced case management and follow up for members. CM is also back in the facility.
- St. Dominic- monthly check in calls to discuss UM/CM issues. Enhanced CM at that location includes daily calls and CM in the facility. This facility also utilized meds-to-beds.
- Forrest General/Pine Grove- monthly meeting to discuss UM/CM issues. CM are back in the facility.
- Oceans Behavioral Health- Discussed follow up after hospital data. Conversations just starting.
- Gulfport Memorial- Discussed follow up after hospital data. Also, fairly new discussions have begun.
- UMMC Remote Patient Monitoring-Partnering with UMMC to offer to offer RPM to members with Type I&II Diabetes. Implementation will start soon.

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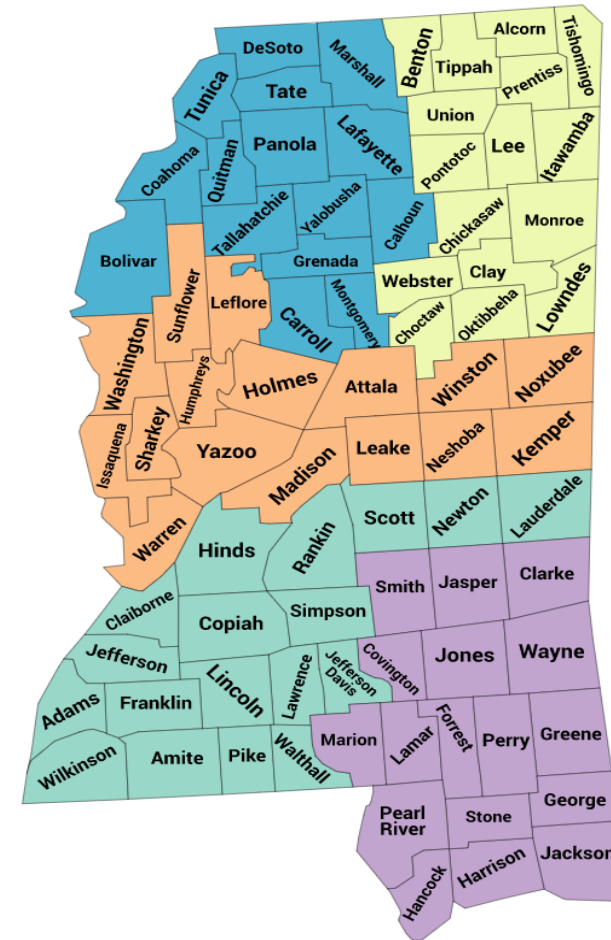
Proposed Initiatives



- Expanding collaborative relationships with providers and hospitals to equally address physical and behavioral health readmissions.
- Exploring Health Information Exchange platforms to help maximize care coordination and improve outcomes
- Expansion of Remote Patient Monitoring Opportunities

How to Reach Us

UnitedHealthcare Provider Advocate Account Managers



- Jamille Bernard
jamille_bernard@uhc.com
 - Adrian Hagan
adrian_d_hagan@uhc.com
 - Jenny Ford
jennyt_ford@uhc.com
 - Tekima Beamon
tekima_beamon@uhc.com
 - Ashley Clarke
ashley_clarke@uhc.com
- FQHC | RHC Statewide**
Curtis Burroughs
curtis_burroughs@uhc.com





Thank You!

QIPP reporting timeline

Upcoming dates of interest: QIPP payments

- In SFY 2023, QIPP payments will be made quarterly by the coordinated care organizations to hospitals who meet QIPP PPHR reporting requirements
- For each quarter in SFY 23:
 - 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 2022
 - December 2022
 - March 2023
 - June 2023

Upcoming dates of interest: QIPP reporting

- July 6, 2022: Quarterly PPHR and PPC reports distributed to hospitals
Hospitals required to submit a PPHR corrective action plan for Cycle 3 identified
- August 5, 2022: Hospital deadline to attest receipt and review of the quarterly reports
- September 1, 2022: PPHR corrective action plan (CAP) for Cycle 3 deadline

- September 30, 2022: Quarterly PPHR and PPC reports distributed to hospitals
- October 31, 2022: Hospital deadline to attest receipt and review of the quarterly reports

- January 4, 2023: Quarterly PPHR and PPC reports distributed to hospitals
Performance incentives for PPHR Cycle 2 allocated
- February 3, 2023: Hospital deadline to attest receipt and review of the quarterly reports

- April 4, 2023: Quarterly PPHR and PPC reports distributed to hospitals
- May 3, 2023: Hospital deadline to attest receipt and review of the quarterly reports

Looking to the future

1. Each hospital is required to complete the PPHR and PPC Certification form, located within the PPHR and PPC reports in the DSH PSR SharePoint site, by August 5, 2022, to attest that they have received and reviewed their July 6, 2022 quarterly reports. The signed attestation forms should be uploaded to the SharePoint site, which is located here: <https://msmedicaid.sharepoint.com/sites/DSHPSR/>.
2. For hospitals with an PPHR actual-to-expected ratio greater than 1.04 in cycle three of their July 6, 2022, report, corrective action plans will be due September 1, 2022
3. Beginning with the upcoming October 2022 QIPP reports, all metric calculations will only use Managed Care visits for calculation of the performance metrics. The Fee-for-service visits will continue to be displayed on the Detail tabs in the reports for reference purposes.

For copies of QIPP documents (including the PPHR and PPC methodology supplements and this presentation) or access to the DSH PSR site, please email QIPP@Medicaid.ms.gov, or visit the QIPP website: <https://medicaid.ms.gov/value-based-incentives/>.

Appendix

Glossary: PPC

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

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

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

Questions?

For further information

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