

Office of the Governor | Mississippi Division of Medicaid

Quality Incentive Payment Program

**Potentially Preventable Complications,
Potentially Preventable Hospital Returns, and
Ambulatory Potentially Preventable Complications**

July 23 and July 24, 2024



Mississippi Division of Medicaid

Agenda

1. Introduction - Mississippi Medicaid Quality Incentive Payment Program (QIPP), including Potentially Preventable Hospital Returns (PPHR), Potentially Preventable Complications (PPC), and Ambulatory Potentially Preventable Complications (AM-PPC) reporting
2. QIPP Methodology
3. Sample Reports
4. Statewide Performance
5. QIPP PPHR updates
6. QIPP PPC updates
7. Hospital Success Stories
8. Coordinated Care Organizations
9. QIPP Reporting Timeline
10. Q&A

QIPP Methodology

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Quality Incentive Payment Programs

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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 2025, the QIPP program will disburse 53% 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.
- A new Value-Based Payment Program (VBP) will receive \$43.5 million in SFY25

SFY 2025 components of QIPP:

- Health Information Network (HIN) – 40% of QIPP allocation.
- Potentially Preventable Hospital Returns (PPHR) – 20% of QIPP allocation.
- Potentially Preventable Complications (PPC) (Inpatient) – 20% of QIPP allocation.
- Ambulatory Potentially Preventable Complications (AM PPC) – 20% of QIPP allocation.

What Are Potentially Preventable Hospital Returns?

A PPHR is an inpatient discharge that is followed by one or more PPR and/or PPED. Basis for clinical relationships in the PPR/PPED algorithm:

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

PPHR Exclusions

Some 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
- Planned Readmissions
- “Low Volume” Hospitals (fewer than 10 expected and/or actual PPHRs)

Identifying PPHRs

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

The **PPHR rate** measures the number of at-risk inpatient discharges that are followed by one or more PPRs and/or PPEDs.

- High rates can signal problems with premature inpatient discharge, inadequate discharge planning, poor follow-up care, or difficulty accessing care in the community.
- 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.

Cycles of QIPP PPHR Reporting

The statewide threshold will remain at 1.04 for SFY25 (Cycle 6). However, for SFY26, DOM plans to lower the threshold to 1.02. PPHR performance measurement occurs in three-year cycles.

PPHR Cycle	Cycle 3	Cycle 4	Cycle 5	Cycle 6
Statewide Threshold A/E Ratio	1.04	1.04	1.04	1.04
Baseline Period	1/1/2019-12/31/2020	1/1/2020-12/31/2021	1/1/2021-12/31/2022	1/1/2022-12/31/2023
Date of Report to determine if CAP is required	July 2022	July 2023	July 2024	July 2025
If CAP is required, due date to submit CAP	9/1/2022	9/1/2023	9/3/2024	9/2/2025
Corrective Action Plan (CAP) Period	1/1/2020-12/31/2021	1/1/2021-12/31/2022	1/1/2022-12/31/2023	1/1/2023-12/31/2024
Date of Report that Provider Performance Incentives will be assessed (1%-2% improvement from CAP period)	January 2024	January 2025	January 2026	January 2027
Performance Incentives Period	7/1/2021-6/30/2023	7/1/2022-6/30/2024	7/1/2023-6/30/2025	7/1/2024-6/30/2026

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.

What are Potentially Preventable Complications?

Hospital complications 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 Solventum (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 that 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.

- PPCs were not developed for psychiatric populations.

Hospitals that don't meet POA coding requirements.

- Hospitals are expected to refine their POA coding for PPC reporting.

Hospitals with fewer than 10 expected and/or actual 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

PPC performance measurement occurs in three-year cycles.

PPC Cycle	Cycle 1	Cycle 2	Cycle 3	Cycle 4
Statewide Threshold A/E Ratio	1.00	1.00	1.00	1.00
Baseline Period	1/1/2019-12/31/2020	1/1/2020-12/31/2021	1/1/2021-12/31/2022	1/1/2022-12/31/2023
Date of Report to determine if CAP is required	July 2022	July 2023	July 2024	July 2025
If CAP is required, due date to submit CAP	No CAP Required	9/1/2023	9/3/2024	9/2/2025
Corrective Action Plan (CAP) Period	1/1/2020-12/31/2021	1/1/2021-12/31/2022	1/1/2022-12/31/2023	1/1/2023-12/31/2024
Date of Report that Provider Performance Incentives will be assessed (1%-2% improvement from CAP period)	January 2025	January 2026	January 2027	January 2028
Performance Incentives Period	7/1/2022-6/30/2024	7/1/2023-6/30/2025	7/1/2024-6/30/2026	7/1/2025-6/30/2027

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.

What are Ambulatory Potentially Preventable Complications?

Medical services performed on an outpatient basis, without admission to a hospital or other facility, where a negative outcome developed after an ambulatory procedure was performed and is the result from processes of care rather than from natural progression of an illness. Only the components of an ambulatory claim that is billed under a hospital provider will be included in analysis.

The AM-PPC component takes a clinically based approach that uses sequenced administrative data (e.g. claims) to provide comparative rates of potentially preventable complications for outpatient procedures.

Based on the Solventum (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 outpatient facilities with higher-than-expected complication rates have room to improve the quality of care that they provide.

PPC weights reflect the relative impact on hospital cost of a given PPC, adjusted for a MS Medicaid population.

Identifying AM-PPCs

AM-PPCs are identified based on:

- A combination of procedures identified through codes reported using the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT®).
- A complication diagnosis code that is clinically related to an ambulatory procedure and meets predefined timing guidelines (e.g. 15 days).

Exclusions include:

- Exclude procedures performed in hospital emergency departments.
- Inpatient admissions that have an ambulatory procedure encounter preceding the admission date and also contain a complication indicated as Present on Admission (POA).
- Admissions with severe or catastrophic conditions are excluded from PPC consideration.
- Events where preventability is difficult to assess due to procedures being intrinsically clinically complex, not elective, or infrequently performed within the ambulatory setting.
- The specific list of excluded conditions will be evaluated and potentially updated at the start of each new reporting cycle.

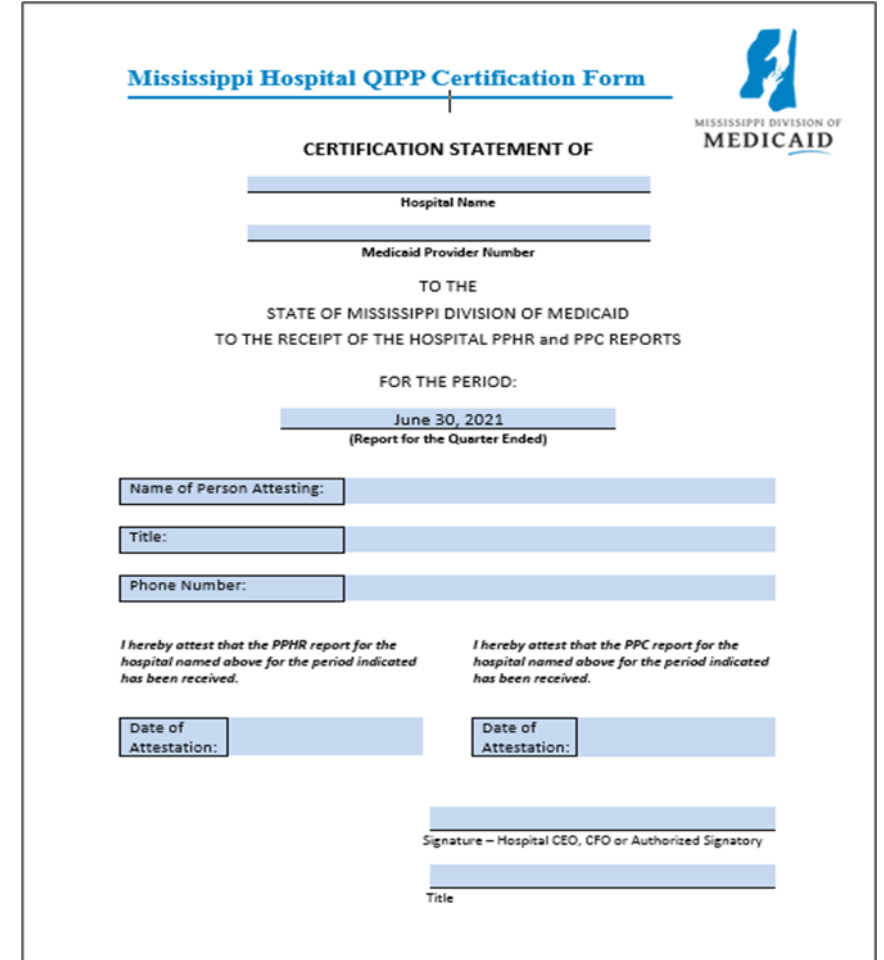
QIPP Payment Requirement: Attestation

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.
- Starting in SFY25, a cap on forfeitures will be set at 25%.

Hospitals will start receiving AM-PPC reports later this year.

- Hospitals will be required to attest each quarter.



The image shows a certification form titled "Mississippi Hospital QIPP Certification Form" with the Mississippi Division of Medicaid logo. The form is a "CERTIFICATION STATEMENT OF" a hospital, with fields for "Hospital Name" and "Medicaid Provider Number". It is addressed "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)". There are three input fields for the attesting person: "Name of Person Attesting:", "Title:", and "Phone Number:". Below these are two columns of attestation text: "I hereby attest that the PPHR report for the hospital named above for the period indicated has been received." and "I hereby attest that the PPC report for the hospital named above for the period indicated has been received.". Each column has a "Date of Attestation:" field. At the bottom right, there are fields for "Signature - Hospital CEO, CFO or Authorized Signatory" and "Title".

Mississippi Outcomes for Maternal Safety (MOMS)

DOM has rolled out a new Value-Based Payment Program (VBP) effective July 1, 2024. The VBP program awards incentive payments through the CCOs to be shared with hospitals and other providers.

The VBP program focuses on three domain areas:

- Maternal Health
- Mental Health
- Metabolic Health

The Mississippi Outcomes for Maternal Safety (**MOMS**) Assessment is a new initiative that aims to reduce Severe Maternal Morbidity (SMM), improve the quality of care, and provide expectations on timing of outpatient follow-up.

- The MOMS initiative is one of two proposed quality measures under the maternal health domain area.
- A survey to gather insights for the MOMS initiative was sent out in June 2024 to hospitals providing maternity services.
- PPHR and PPC data analyses were also used to develop the MOMS assessment and timely follow-up criteria.

Sample Reports

PPC Report

The following are the tabs as labeled in the report:

- Cover
- PPC Attestation
- POA Flags
- Performance Measurement
- Hospital Summary
- Chart Performance
- PPC List
- PPC Detail, Cycle 2
- PPC Detail, Cycle 3
- PPC Detail, Cycle 4

PPC Report - Cover

Cover includes

- Report Dates
- Notes for changes in the report from prior quarter report
- Additional information on the calculation of Corrective Action Plan (CAP)

This spreadsheet does contain protected health information and should be protected accordingly	
Potentially Preventable Complications (PPC) for the Mississippi Quality Incentive Payment Program	
Report for Quarter 1 of State Fiscal Year 2025	
Report date	7/15/2024
Hospital Details	
Provider name:	
Medicaid Provider Id:	
Date range for analysis	Discharges from 1/1/2022-12/31/2023
Changes in this report:	Beginning July 1st, 2024, of State Fiscal Year 2025, MHAP forfeiture of funds is now capped at 25%. Please refer to the Performance Measurement tab to see updated Chart that defines the 'At Risk % of QIPP PPHR funds'.
	A new cycle (Cycle 4) has started. The baseline time period for this new cycle is Jan. 1, 2022 through Dec. 31, 2023. This cycle utilizes V.41 of the 3M grouper. Cycle 1 using V.38 of the 3M grouper has been phased out.
Cycle 2: Corrective plan implementation	
We utilize the calculation of the Cap Threshold and A/E Ratio Improvement to determine the potential amount of reduction in MHAP funds. In sections 1 and 2 below are the calculations for the Cap Threshold and A/E Ratio Improvement metrics. The results of these two sections are multiplied together to get the total funds at-risk for MHAP Reduction in Section 3.	
Section 1: CAP Threshold Calculation:	
This calculation utilizes the latest quarter's A/E ratio to determine the percentage of QIPP PPC funds subject to MHAP reduction. The at-risk amount of your hospital's QIPP PPC payments depends on your hospital's actual-to-expected ratio.	
Current quarter PPC Performance (actual-to-expected ratio)	0.967
Statewide target:	1.000
Hospital specific performance target, cycle two	Did not require CAP
% of QIPP PPC funds at-risk	0%
*The at-risk funds percentage is derived from the table located at the top of the "Performance Measurement" tab.	

PPC Report – Cover (Continued)

Cover (Continued)

- Outcome of CAP calculations and if provider has to submit cap for the fiscal year

Section 2: A/E Ratio Improvement Calculation:	
Hospitals receive a portion of MHAP funds based on their improvement in the A/E ratio. A 1% improvement earns them 50% of the PPC funds, while a 2% improvement earns the full 100%.	
Percent improvement in PPC actual-to-expected ratio	0%
(goal is at least 2%)	
% of QIPP PPC funds at-risk	No Reduction
*Low-volume hospitals or improvement of 2% or greater results in no reduction of PPC funds. Providers with a 1% improvement are at-risk of a reduction of their funds by 50%, while providers that see no improvement are at risk of 100% reduction of their funds.	
Section 3: Final MHAP Reduction Calculation:	
This is calculated by multiplying the at risk funds affected by the CAP Threshold (B21) and the A/E Ratio Improvement (B27) reduction together.	
Total QIPP PPC MHAP reduction	0%
Cycle 3: Corrective plan identification	
Current quarter PPC Performance (actual-to-expected ratio)	1.059
Statewide target:	1.000
Corrective Action Plan required:	No. Corrective Action Plan only required the first quarter of the state fiscal year (July 2024).
Corrective Action Plan template:	https://medicaid.ms.gov/value-based-incentives/
Note: Cycle 3 performance adjustments will be made based on the report distributed in January 2027. This is for informational purposes only.	

PPC Report – Hospital Summary

Hospital Summary provides all metrics utilized to calculate the A/E ratio and CAP throughout the report cycles.

Cycle Two: Corrective plan implementation, V.39.1 of the PPC algorithm
 Report covers time period: 1/1/2022-12/31/2023
 Hospital Performance (rolling two year analysis period):

	1/1/2022 - 12/31/2023 ^g	10/1/2021 - 9/30/2023 ^g	7/1/2021 - 6/30/2023 ^g	4/1/2021 - 3/31/2023 ^g	1/1/2021 - 12/31/2022 ^g	10/1/2020 - 9/30/2022 ^g	7/1/2020 - 6/30/2022 ^g	4/1/2020 - 3/31/2022 ^g	1/1/2020 - 12/31/2021
Number of total inpatient admissions, including global exclusions ¹ :	2,781	2,824	2,866	2,875	2,856	2,932	3,090	3,907	3,037
Number of potentially preventable complications (PPCs) ² :	15	16	15	10	11	10	16	36	15
Actual PPC weight ⁴ :	11.22	12.47	11.59	6.55	7.73	5.77	10.92	24.50	9.37
Expected PPC weight:	11.60	12.66	13.35	12.70	12.54	13.26	15.22	25.27	14.55
Cost-Weighted Actual-to-Expected Ratio⁶:	0.967	0.985	0.868	0.516	0.617	0.435	0.718	0.969	0.644
Statewide threshold for cost-weighted actual-to-expected Ratio	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000

Note:
 PPC count excludes PPCs 21 and 24, which are recommended for monitoring only. PPC count also excludes inpatient stays with more than 6 PPCs, as these are likely catastrophic stays where complications could not be avoided.

Cycle Three: Corrective plan identification, V.40 of the PPC algorithm
 Report covers time period: 1/1/2022-12/31/2023
 Hospital Performance (rolling two year analysis period):

	1/1/2022 - 12/31/2023 ^g	10/1/2021 - 9/30/2023 ^g	7/1/2021 - 6/30/2023 ^g	4/1/2021 - 3/31/2023 ^g	1/1/2021 - 12/31/2022 ^g
Number of total inpatient admissions, including global exclusions ¹ :	2,781	2,824	2,866	2,875	2,856
Number of potentially preventable complications (PPCs) ² :	16	17	16	10	11
Actual PPC weight ⁴ :	10.65	11.76	11.00	6.05	6.97
Expected PPC weight:	10.06	10.96	11.56	11.02	10.85
Cost-Weighted Actual-to-Expected Ratio⁶:	1.059	1.073	0.951	0.549	0.642
Statewide threshold for cost-weighted actual-to-expected Ratio	1.000	1.000	1.000	1.000	1.000

Note:
 PPC count excludes PPCs 21 and 24, which are recommended for monitoring only. PPC count also excludes inpatient stays with more than 6 PPCs, as these are likely catastrophic stays where complications could not be avoided.

Cycle Four: Baseline period, V.41 of the PPC algorithm
 Report covers time period: 1/1/2022-12/31/2023
 Hospital Performance (rolling two year analysis period):

	1/1/2022 - 12/31/2023 ^g
Number of total inpatient admissions, including global exclusions ¹ :	2,781
Number of potentially preventable complications (PPCs) ² :	16
Actual PPC weight ⁴ :	12.47
Expected PPC weight:	13.31
Cost-Weighted Actual-to-Expected Ratio⁶:	0.937
Statewide threshold for cost-weighted actual-to-expected Ratio	1.000

Note:
 PPC count excludes PPCs 21 and 24, which are recommended for monitoring only. PPC count also excludes inpatient stays with more than 6 PPCs, as these are likely catastrophic stays where complications could not be avoided.

PPC Report

PPC List *Partial list of 57 total PPCs*

PPC-Specific Performance - Managed Care Data Only																
PPCs Included in the PPC Performance Metric:			Discharges from 1/1/2022-12/31/2023													
PPC	Description	Group	Cycle 3							Cycle 4						
			MS Medicaid PPC Weight	At-Risk Stays	Number of PPCs	PPC Rate	Expected Number of PPCs	Excess Number of PPCs	Excess PPC Weight	MS Medicaid PPC Weight	At-Risk Stays	Number of PPCs	PPC Rate	Expected Number of PPCs	Excess Number of PPCs	Excess PPC Weight
01	Stroke & Intracranial Hemorrhage	Cardiovascular-Respiratory Complications	0.76	3,766	2	0.05%	2.3	0	-0.25	0.89	3,766	3	0.08%	2.4	1	0.55
02	Extreme CNS Complications	Extreme Complications	0.27	3,553	0	0.00%	0.5	0	-0.12	0.31	3,555	0	0.00%	0.5	-1	-0.17
03	Acute Pulmonary Edema and Respiratory Failure without Ventilation	Cardiovascular-Respiratory Complications	0.36	3,249	10	0.31%	7.1	3	1.03	0.26	3,249	10	0.31%	7.3	3	0.70
04	Acute Pulmonary Edema and Respiratory Failure with Ventilation	Extreme Complications	1.12	3,267	2	0.06%	1.8	0	0.26	0.96	3,267	2	0.06%	1.6	0	0.42
05	Pneumonia & Other Lung Infections	Cardiovascular-Respiratory Complications	1.06	1,621	2	0.12%	3.0	-1	-1.09	1.57	1,621	1	0.06%	2.4	-1	-2.23
06	Aspiration Pneumonia	Cardiovascular-Respiratory Complications	0.58	3,278	1	0.03%	1.6	-1	-0.35	0.67	3,278	1	0.03%	1.7	-1	-0.48
07	Pulmonary Embolism	Cardiovascular-Respiratory Complications	0.81	3,700	1	0.03%	0.6	0	0.29	1.03	3,700	1	0.03%	0.8	0	0.18
08	Other Pulmonary Complications	Cardiovascular-Respiratory Complications	0.63	3,036	1	0.03%	1.0	0	-0.01	0.85	3,037	1	0.03%	0.8	0	0.14
09	Shock	Extreme Complications	0.76	3,690	7	0.19%	6.0	1	0.72	1.01	3,690	7	0.19%	6.4	1	0.65
10	Congestive Heart Failure	Cardiovascular-Respiratory Complications	0.27	3,437	3	0.09%	1.0	2	0.55	0.34	3,437	2	0.06%	0.8	1	0.41
11	Acute Myocardial Infarction	Cardiovascular-Respiratory Complications	0.24	3,774	2	0.05%	3.0	-1	-0.25	0.27	3,774	2	0.05%	2.8	-1	-0.20
13	Other Acute Cardiac Complications	Cardiovascular-Respiratory Complications	0.27	3,694	1	0.03%	0.4	1	0.15	0.24	3,694	1	0.03%	0.5	0	0.12
14	Ventricular Fibrillation/Cardiac Arrest	Extreme Complications	0.31	3,281	7	0.21%	5.4	2	0.49	0.39	3,281	7	0.21%	6.4	1	0.23
15	Peripheral Vascular Complications except Venous Thrombosis	Cardiovascular-Respiratory Complications	1.60	3,828	0	0.00%	0.5	-1	-0.87	1.61	3,828	0	0.00%	0.8	-1	-1.24
16	Venous Thrombosis	Cardiovascular-Respiratory Complications	1.12	1,946	0	0.00%	0.6	-1	-0.68	1.24	1,946	0	0.00%	0.6	-1	-0.69
17	Major Gastrointestinal Complications without Transfusion	Gastrointestinal Complications	1.11	3,782	1	0.03%	0.9	0	0.06	1.24	3,782	1	0.03%	1.3	0	-0.32
18	Major Gastrointestinal Complications with Transfusion	Gastrointestinal Complications	1.08	3,678	0	0.00%	0.3	0	-0.33	1.22	3,678	0	0.00%	0.4	0	-0.52
19	Major Liver Complications	Gastrointestinal Complications	0.62	3,777	2	0.05%	0.9	1	0.70	0.56	3,777	2	0.05%	1.0	1	0.56
20	Other Gastrointestinal Complications	Gastrointestinal Complications	0.68	3,832	3	0.08%	2.3	1	0.49	0.96	3,832	3	0.08%	2.8	0	0.22
23	Genitourinary Complications except UTI	Other Medical and Surgical Complications	0.58	3,884	0	0.00%	0.4	0	-0.25	0.58	3,884	0	0.00%	0.6	-1	-0.33
25	Renal Failure with Dialysis	Extreme Complications	1.92	3,449	0	0.00%	0.1	0	-0.27	2.16	3,448	0	0.00%	0.2	0	-0.51
26	Diabetic Ketoacidosis & Coma	Other Medical and Surgical Complications	0.28	4,657	1	0.02%	0.1	1	0.26	0.38	4,996	1	0.02%	0.3	1	0.26
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	Other Medical and Surgical Complications	0.69	1,806	2	0.11%	1.8	0	0.13	0.88	1,806	2	0.11%	2.0	0	-0.03
28	In-Hospital Trauma and Fractures	Other Medical and Surgical Complications	0.24	3,915	0	0.00%	0.5	-1	-0.13	0.38	4,247	0	0.00%	0.5	-1	-0.20
29	Poisonings except from Anesthesia	Malfunctions, Reactions, etc.	0.12	3,906	0	0.00%	0.1	0	-0.01	0.11	4,239	0	0.00%	0.1	0	-0.01
30	Poisonings due to Anesthesia	Malfunctions, Reactions, etc.	0.00	3,923	0	0.00%	0.0	0	0.00	0.00	4,250	0	0.00%	0.0	0	0.00
31	Pressure Ulcer	Other Medical and Surgical Complications	2.47	1,717	1	0.06%	0.1	1	2.14	2.72	1,620	3	0.19%	1.0	2	5.38

PPHR Report

The following are the tabs as labeled in the report:

- Cover
- PPHR Attestation
- Performance Measurement
- Hospital Summary
- Chart Hospital Return Rate
- Chart Performance
- Expected Rates, Cycle 4
- Hospital Detail, Cycle 4
- Secondary Readmissions, Cycle 4
- Expected Rates, Cycle 5
- Hospital Detail, Cycle 5
- Secondary Readmissions, Cycle 5
- Expected Rates, Cycle 6
- Hospital Detail, Cycle 6
- Secondary Readmissions, Cycle 6

PPHR Report – Cover

Cover includes

- Report Dates
- Notes for changes in the report from prior quarter report
- Additional information on the calculation of Corrective Action Plan (CAP)

This spreadsheet does contain protected health information and should be protected accordingly	
Potentially Preventable Hospital Returns (PPHR) for the Mississippi Quality Incentive Payment Program	
Report for Quarter 1 of State Fiscal Year 2025	
Report date	7/15/2024
Hospital Details	
Provider name:	
Medicaid Provider Id:	
Readmission time window:	15 days
Changes for this report:	<p>Beginning July 1st, 2024, of State Fiscal Year 2025, MHAP forfeiture of funds is now capped at 25%. Please refer to the Performance Measurement tab to see updated Chart that defines the 'At Risk % of QIPP PPHR funds'.</p> <p>A new cycle (Cycle 6) has started. The baseline time period for this new cycle is Jan. 1, 2022 through Dec. 31, 2023. This cycle utilizes V.41 of the 3M grouper. Cycle 3 using V.38 of the 3M grouper has been phased out.</p> <p>The calculation method for Low Volume has been updated. Previously, Low Volume was defined as having fewer than 10 actual PPHRs and fewer than 10 expected PPHRs. Now, Low Volume is defined as having fewer than 10 actual PPHRs or fewer than 10 expected PPHRs.</p>
Cycle 3: Corrective action plan implementation period	
Date range for analysis:	Discharges from 1/1/2022-12/31/2023, with readmissions until 1/15/2024
We utilize the calculation of the Cap Threshold and A/E Ratio Improvement to determine the potential amount of reduction in MHAP funds. In sections 1 and 2 below are the calculations for the Cap Threshold and A/E Ratio Improvement metrics. The results of these two sections are multiplied together to get the total funds at-risk for MHAP Reduction in Section 3.	
Section 1: CAP Threshold Calculation:	
This calculation utilizes the latest quarter's A/E ratio to determine the percentage of QIPP PPHR funds subject to MHAP reduction. The at-risk amount of your hospital's QIPP PPHR payments depends on your hospital's actual-to-expected ratio.	
Current quarter PPHR Performance (actual-to-expected ratio), cycle four	0.909
Corrective Action Plan threshold, cycle four:	1.040
Hospital specific performance target, cycle four	Did not require CAP
% of QIPP PPHR funds at-risk*	0%
*The at-risk funds percentage is derived from the table located at the top of the "Performance Measurement" tab.	

PPHR Report – Cover (Continued)

Cover (Continued)

- Outcome of CAP calculations and if provider has to submit CAP for the fiscal year

Section 2: A/E Ratio Improvement Calculation:	
Hospitals receive a portion of MHAP funds based on their improvement in the A/E ratio. A 1% improvement earns them 50% of the PPHR funds, while a 2% improvement earns the full 100%.	
Percent improvement in PPHR actual-to-expected ratio (goal is at least 2%)	3.6%
% of QIPP PPHR funds at-risk*	No Reduction
*Low-volume hospitals or improvement of 2% or greater results in no reduction of PPHR funds. Providers with a 1% improvement are at-risk of a reduction of their funds by 50%, while providers that see no improvement are at risk of 100% reduction in their funds.	
Section 3: Final MHAP Reduction Calculation:	
This is calculated by multiplying the at risk funds affected by the CAP Threshold (B23) and the A/E Ratio Improvement (B29) reduction together.	
Total QIPP PPHR MHAP reduction	0%
Note: Cycle 3 performance adjustments will be made based on the report distributed in January 2024.	
Cycle 5: Corrective plan identification period	
Date range for analysis:	Discharges from 1/1/2022-12/31/2023, with readmissions until 1/15/2024
Current quarter PPHR Performance (actual-to-expected ratio), cycle five	0.931
Corrective Action Plan threshold, cycle five:	1.040
Corrective Action Plan required:	No. Corrective Action Plan only required the first quarter of the state fiscal year (July 2023).
Corrective Action Plan template:	https://medicaid.ms.gov/value-based-incentives/
Cycle 6: Baseline monitoring period	
Date range for analysis:	Discharges from 1/1/2022-12/31/2023, with readmissions until 1/15/2024
Current quarter PPHR Performance (actual-to-expected ratio), cycle six	0.891
Corrective Action Plan threshold	1.040

PPHR Report – Hospital Summary

Hospital Summary provides all summary metrics utilized to calculate the A/E ratio and CAP throughout the report cycles.

Cycle Five: Corrective plan identification period, V.40 of the PPR Algorithm					
Rolling Two Years Report: 1/1/2022-12/31/2023					
Hospital Performance (rolling year):					
	1/1/2022-12/31/2023 ⁵	10/1/2021-9/30/2023 ⁵	7/1/2021-6/30/2023 ⁵	4/1/2021-3/31/2023 ⁵	1/1/2021-12/31/2022 ⁵
Potentially preventable hospital return (PPHR) rate ¹ : casemix ²	13.71%	13.37%	13.31%	13.51%	14.15%
PPHR Actual-to-expected ratio ³ :	0.931	0.903	0.922	0.916	0.944
Additional Performance Metrics:					
Potentially Preventable Inpatient Readmission (PPR) rate	5.18%	5.41%	5.31%	5.21%	5.01%
Casemix-adjusted statewide PPR rate	6.39%	6.37%	6.28%	6.46%	6.52%
PPR Actual-to-expected ratio:	0.812	0.849	0.846	0.807	0.768
Potentially Preventable Return Emergency Department Visit (PPED) rate	10.01%	9.17%	9.10%	9.41%	10.08%
Casemix-adjusted statewide PPED rate	9.39%	9.53%	9.31%	9.42%	9.60%
PPED Actual-to-expected ratio:	1.066	0.962	0.978	0.999	1.051

[Back to Top](#)

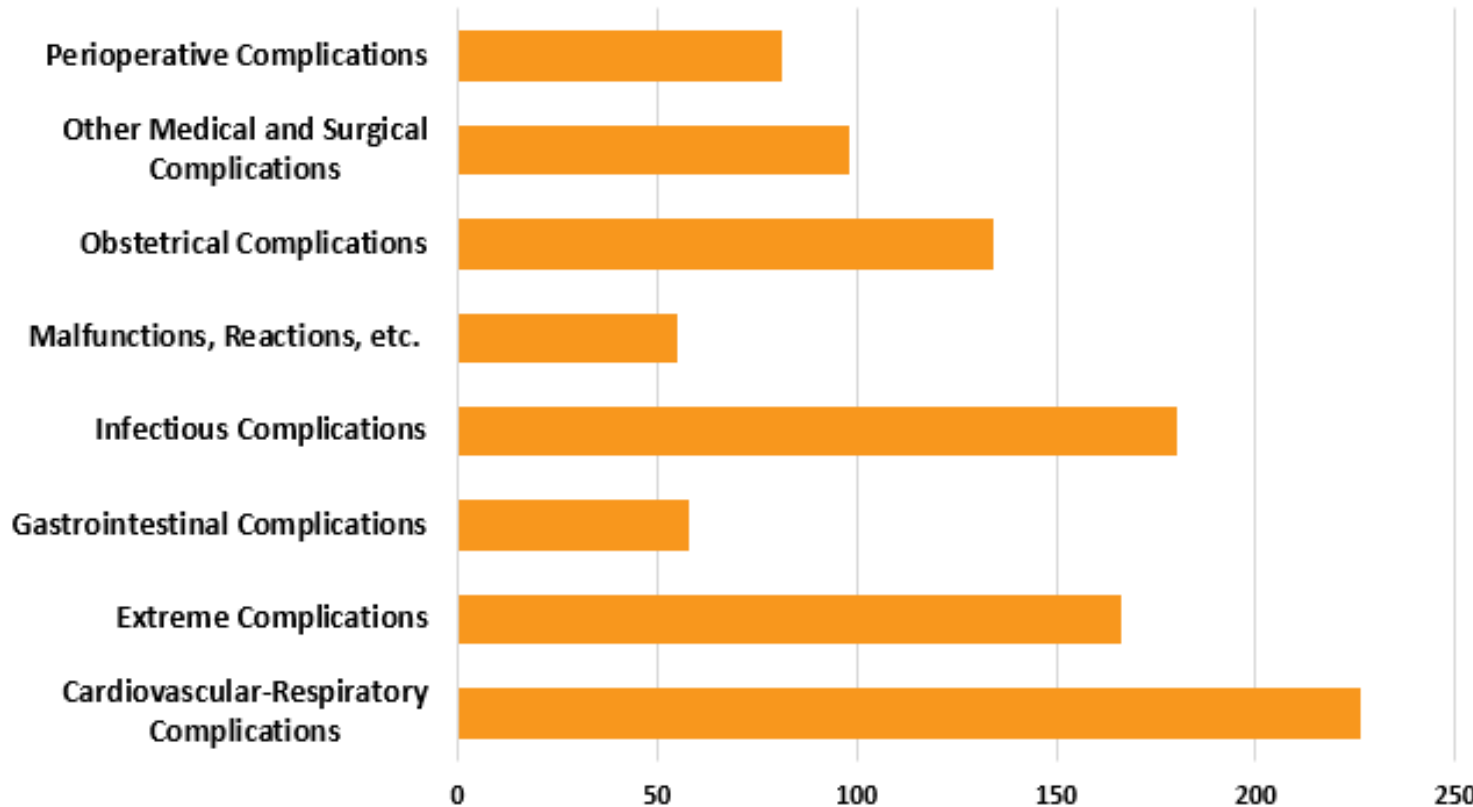
Cycle Five: Hospital Return Details (1/1/2022-12/31/2023):	
Potentially Preventable Hospital Returns	
Number of at-risk admissions:	1138
Number of at-risk admissions followed by potentially preventable hospital returns including both inpatient readmission and preventable emergency department readmissions:	156
Total number of potentially preventable hospital returns for your hospital ⁴	236
Potentially Preventable Inpatient Readmissions	
Number of at-risk admissions:	1138
Number of at-risk admissions followed by potentially preventable inpatient readmission	59
Total number of potentially preventable readmissions for your hospital ⁴	81
Potentially Preventable Return Emergency Department (ED) Visits	
Number of at-risk admissions:	1189
Number of at-risk admissions followed by potentially preventable return ED visits	119
Total number of potentially preventable return ED visits for your hospital ⁴	155

Statewide Performance

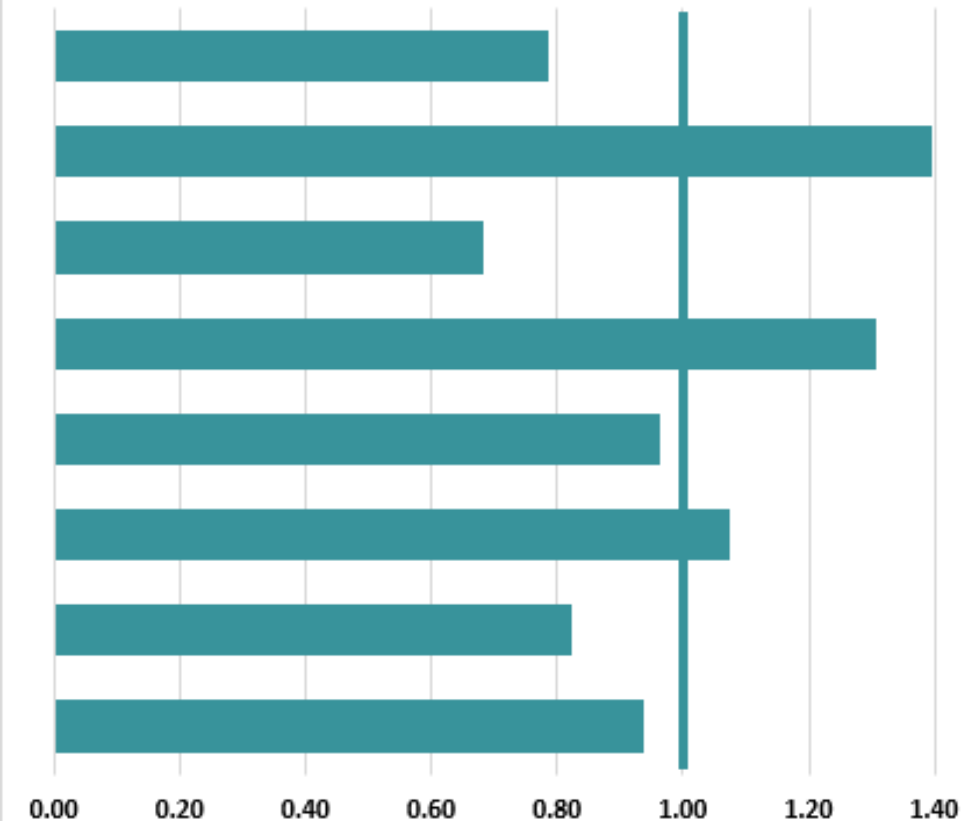
PPC Performance by Complication Type

1/1/2022-12/31/2023 Statewide weighted A/E Ratio = 0.977

Number of PPC's

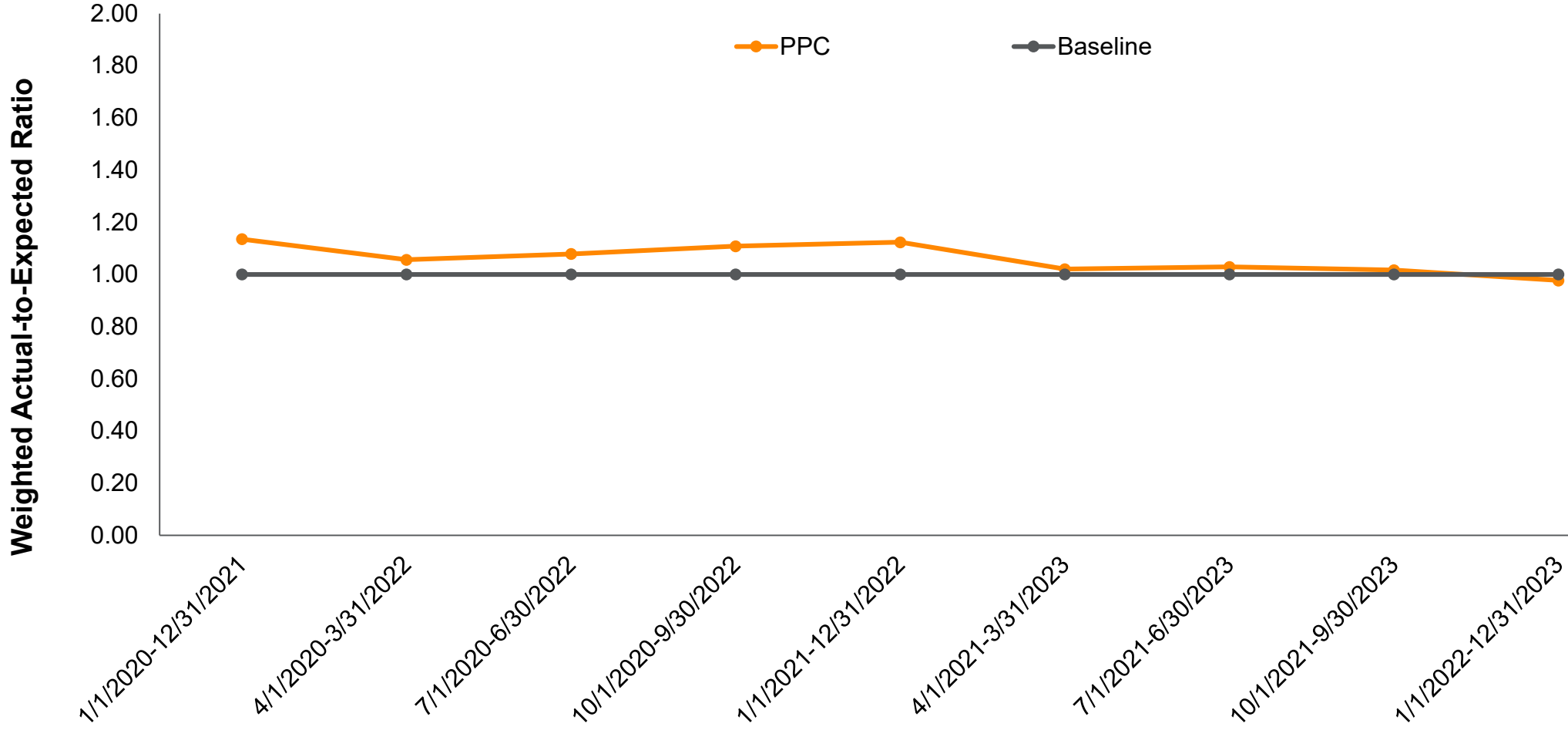


A/E Ratio



PPC Performance

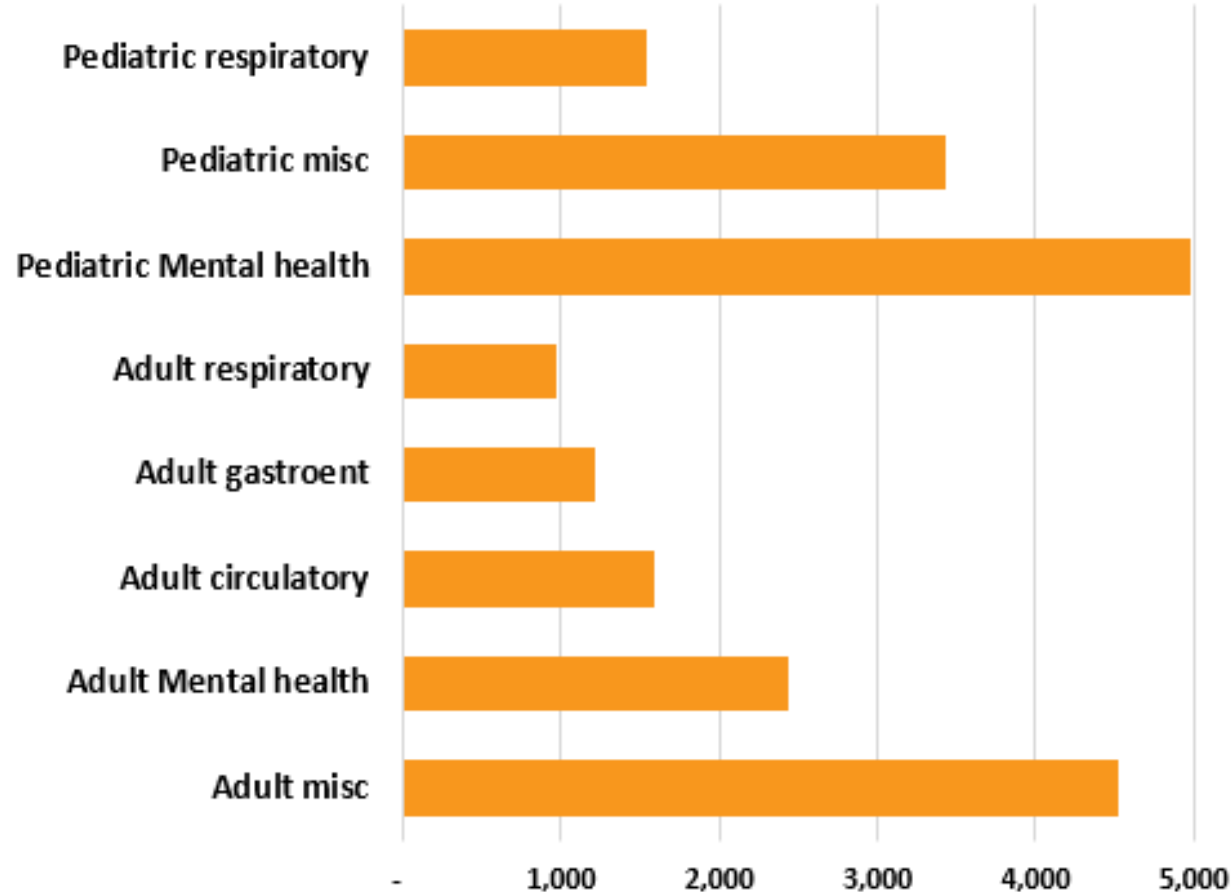
Statewide PPC Performance (Rolling 2 Year Period)



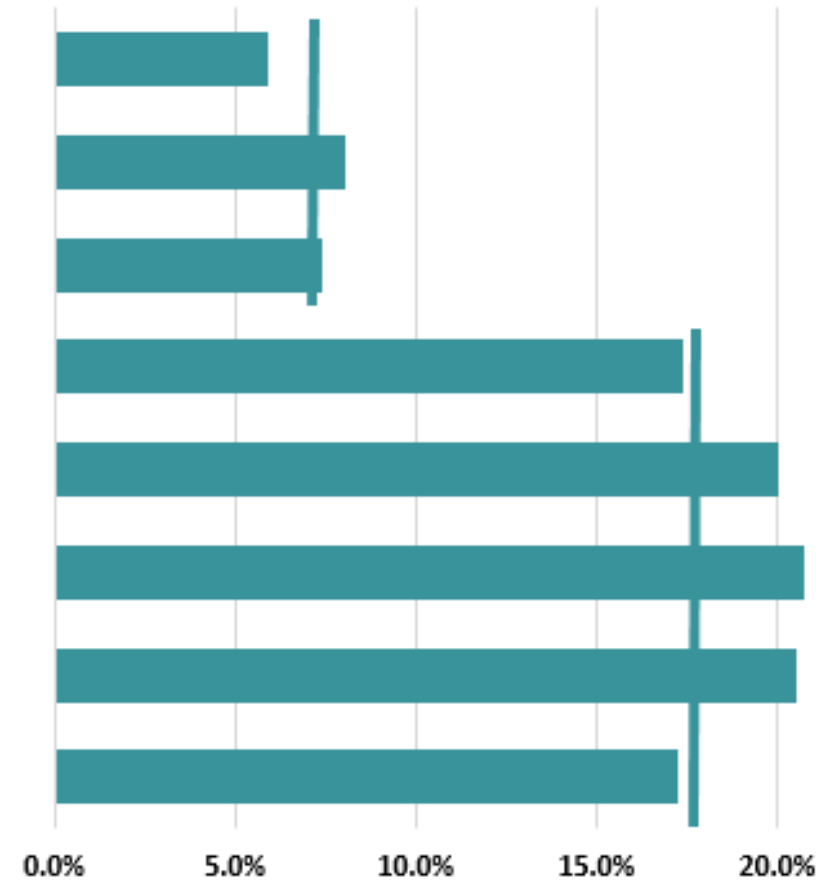
PPHR Performance by Medicaid Care Category

1/1/2022-12/31/2023 Statewide Ped PPHR Rate 7.3%, Adult PPHR Rate 18.8%

Number of PPHR's



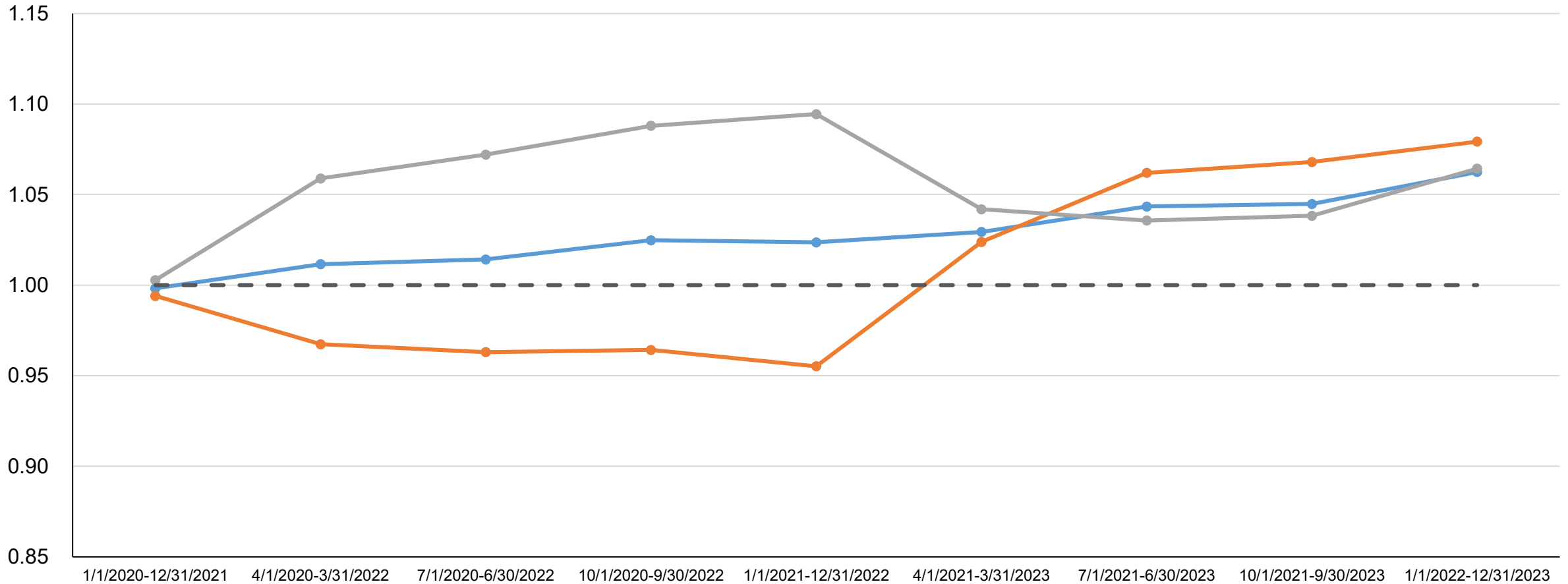
PPHR Rate



PPHR Performance

Cycle Four: Actual-to-Expected Ratios Over Time

PPHR A/E Ratio PPR A/E Ratio PPED A/E Ratio Baseline



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

- Starting July 2024, MHAP forfeiture of funds is capped at 25%.

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.

SFY25 Cycle Threshold

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	10%
	>1.10	<=1.20	15%
	>1.20	<=1.30	20%
	>1.30		25%


Prior Cycles Threshold

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%

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 PPC CAP requirement for Cycle 3 are expected to complete and submit the Corrective Action Plan template by September 3, 2024.
- Questions about completing the PPC CAP should be directed to the QIPP mailbox at QIPP@Medicaid.ms.gov.

Mississippi Hospital PPC Corrective Action Plan (CAP)



MISSISSIPPI DIVISION OF
MEDICAID

General Hospital Provider Data:

Hospital Name:

Medicaid Provider Number:

STATE OF MISSISSIPPI DIVISION OF MEDICAID
TO THE PROVISION OF THE ATTACHED PLAN

For the Period: **JUNE 30, 2023**
(Report for the Fiscal Year Ended)

Attestation Information:

Name of Preparer:

Title:

Phone Number:


I hereby attest that the Corrective Action Plan for the hospital named above for the period indicated has been reviewed and approved.

<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 PPHR Updates

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 5 are expected to complete and submit the Corrective Action Plan template by September 3, 2024.
- 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) 

MISSISSIPPI DIVISION OF
MEDICAID

General Hospital Provider Data:

Hospital Name:

Medicaid Provider Number:

STATE OF MISSISSIPPI DIVISION OF MEDICAID
TO THE PROVISION OF THE ATTACHED PLAN

For the Period: **JUNE 30, 2020**
(Report for the Fiscal Year Ended)

Attestation Information:

Name of Preparer:

Title:

Phone Number:

I hereby attest that the Corrective Action Plan for the hospital named above for the period indicated has been reviewed and approved.

<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

Health Information Network (HIN)

To receive the HIN portion of the QIPP payment in SFY 2025, hospitals must certify their connection to and participation in a statewide Health Information Network (HIN); Mississippi Hospital Association (MHA) or Mississippi State Medical Association (MSMA).

The HIN must be capable of the following:

- Receiving and transmitting admit, discharge, and transfer (ADT) information to Medicaid or its designee.
- Support clinical and ADT data sharing for Medicaid beneficiaries.

Hospitals participating in HIN:

- By the end of the first quarter (September 30, 2024), hospitals must submit ADT information to the HIN and attest to this submission to receive the HIN component of QIPP.
- By the end of the second quarter (December 31, 2024), hospitals must include DOM-required specifications in their ADT submissions.
- Must submit the attestation form timely, or hospital funds are subject to possible forfeiture of the HIN portion of the MHAP.
- DOM will not require copies of HIN contracts each quarter.

Hospitals not participating in a HIN, the HIN portion of the MHAP funds may be forfeited.

Additional information is located DOM's site: [Value-Based Incentives - Mississippi Division of Medicaid \(ms.gov\)](https://www.ms.gov/value-based-incentives) under the SFY 2025 QIPP Resources.

Accessing QIPP Reports and Attestations

DSH PSR SharePoint site: <https://msmedicaid.sharepoint.com/sites/DSHPSR/>.

Please see the **QIPP calendar for Attestation deadlines** under SFY 2025 QIPP Resources: [Value-Based Incentives - Mississippi Division of Medicaid \(ms.gov\)](#).

Attestation Forms:

- PPHR and PPC reports are sent quarterly to the DSH PSR SharePoint site. Each report contains the Attestation form required to be submitted via the SharePoint site in the QIPP/FY2025 folder. The PPHR and PPC attestations both affect the third month of each quarter's MHAP payment.
- HIN Attestation is required to be submitted via the DOM Smartsheet. Support for the hospital participation in a HIN must be provided with the first quarter's HIN Attestation. HIN attestations affect the first month of each quarter's MHAP payment.
 - HIN Attestation link: [Health Information Network \(HIN\) Quarterly Attestation State Fiscal Year 2025 \(smartsheet.com\)](#).

Access to SharePoint:

- All hospitals participating in MHAP should have access to the DSH PSR SharePoint site.
- New user requests or access error issues should be sent to the QIPP mailbox at QIPP@medicaid.ms.gov.
- All users are granted 90-day access (no permanent access).

Hospital Success Stories

- **University Mississippi Medical Center**

Lisa Didion, MD Chief Medical Officer

- **Gulfport Behavioral Health System**

Dean Doty, Chief Executive Officer

QIPP Update

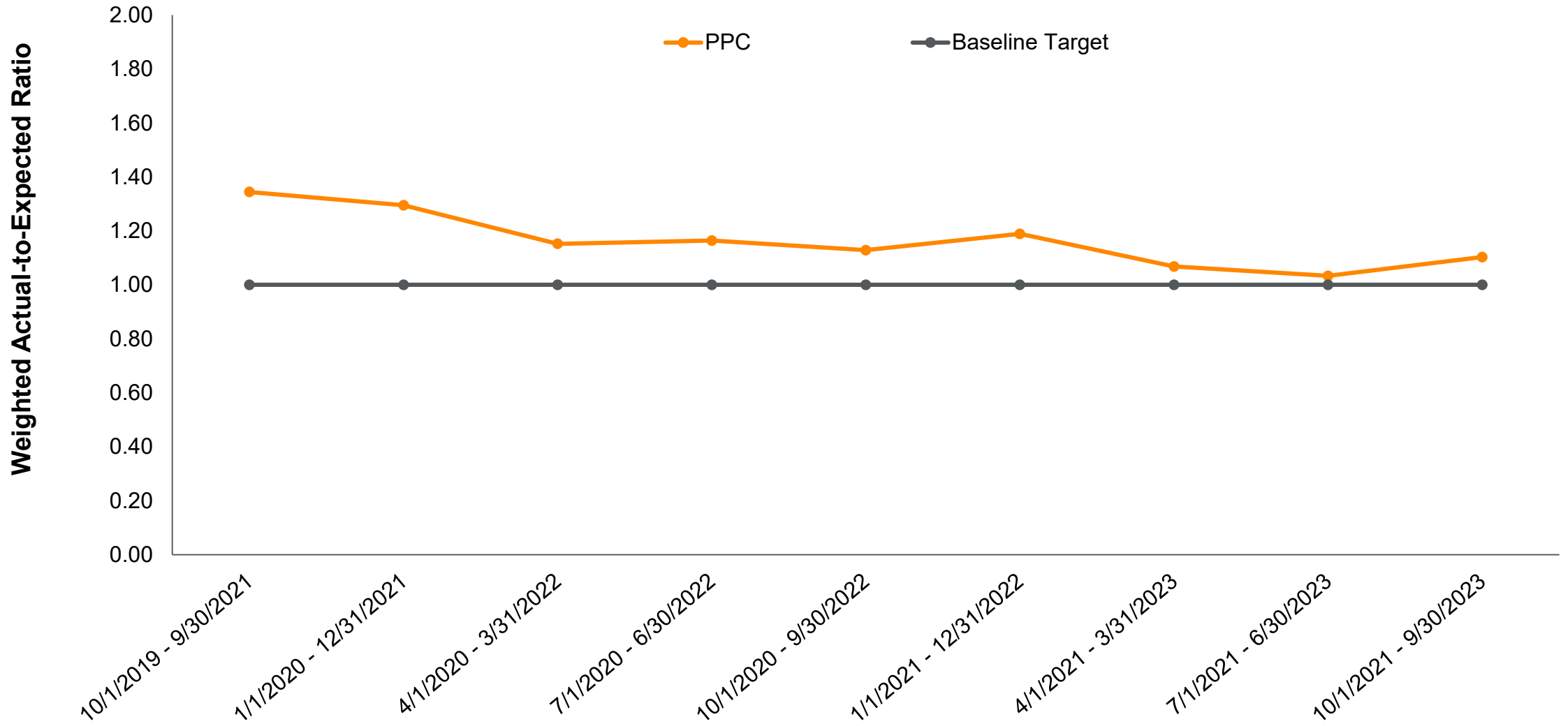
Lisa Didion, MD

Chief Medical Officer



THE UNIVERSITY OF MISSISSIPPI
MEDICAL CENTER™

Hospital PPC Performance (Rolling 2 Year Period)



Action Highlight

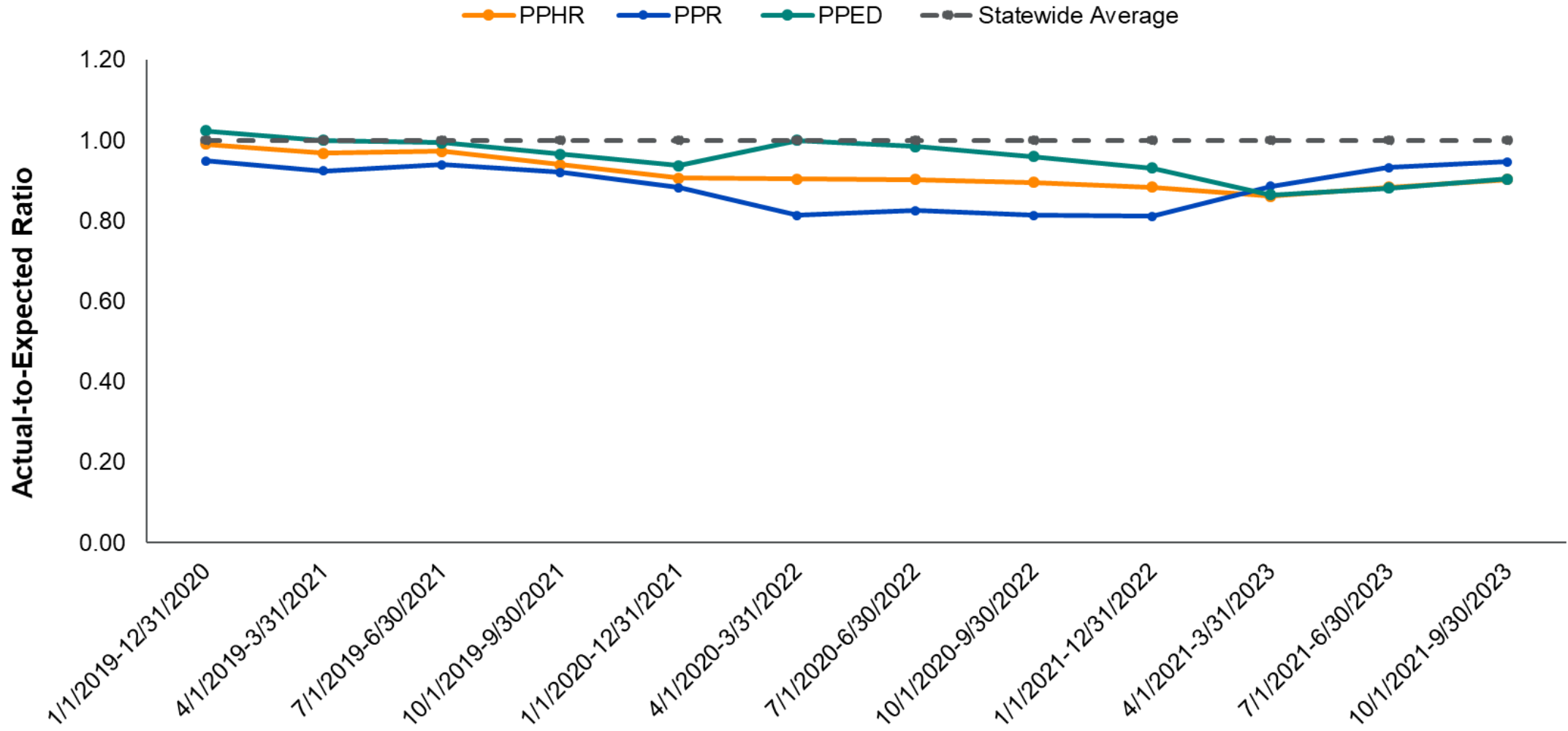
1. Pressure Injury

- Cycle 1: Excess PPC Weight **8.35**
- Multidisciplinary performance improvement team
 - Standards for risk assessment, prevention, intervention, and event review
 - Executive sponsorship and data transparency
- Cycle 3: Excess PPC Weight **3.54**

2. Documentation and Coding

- Accurately capture acuity and present on admission
- Leverage expertise and the EHR
 - Clinical Documentation Integrity RN and Physician Champions

Hospital Performance (Rolling Year): Cycle Three



Action Highlight

Pediatric Complex Care Program

- Care coordination program with Magnolia Health Plan
- Fixed, per-member per-month fee
- Shared savings if quality goals achieved

Quality Metrics **	2021	2022	2023*
Wellness Visit (EPSDT)	↑18%	↑15%	↑6.8%
ER Utilization (visits/mbr/yr)	↓1.14	↓0.16	↓0.16
ER Follow-up	↑53%	↑28%	↑31%
Hospital Follow-up	↑69%	↑28%	↑30%
All-Cause 30 Day Readmit	N/A	↓2.6%	↑1.3%

*Preliminary

**Change in performance compared to baseline

Financial Savings

- Program Year 2021 (91 members) 21.8% reduction in cost
- Program Year 2022 (315 members) 10.5% reduction in cost
- Program Year 2023 (315 members) 15.3% reduction in cost (preliminary)

Update on Potentially Preventable Hospital Returns (PPHR) program

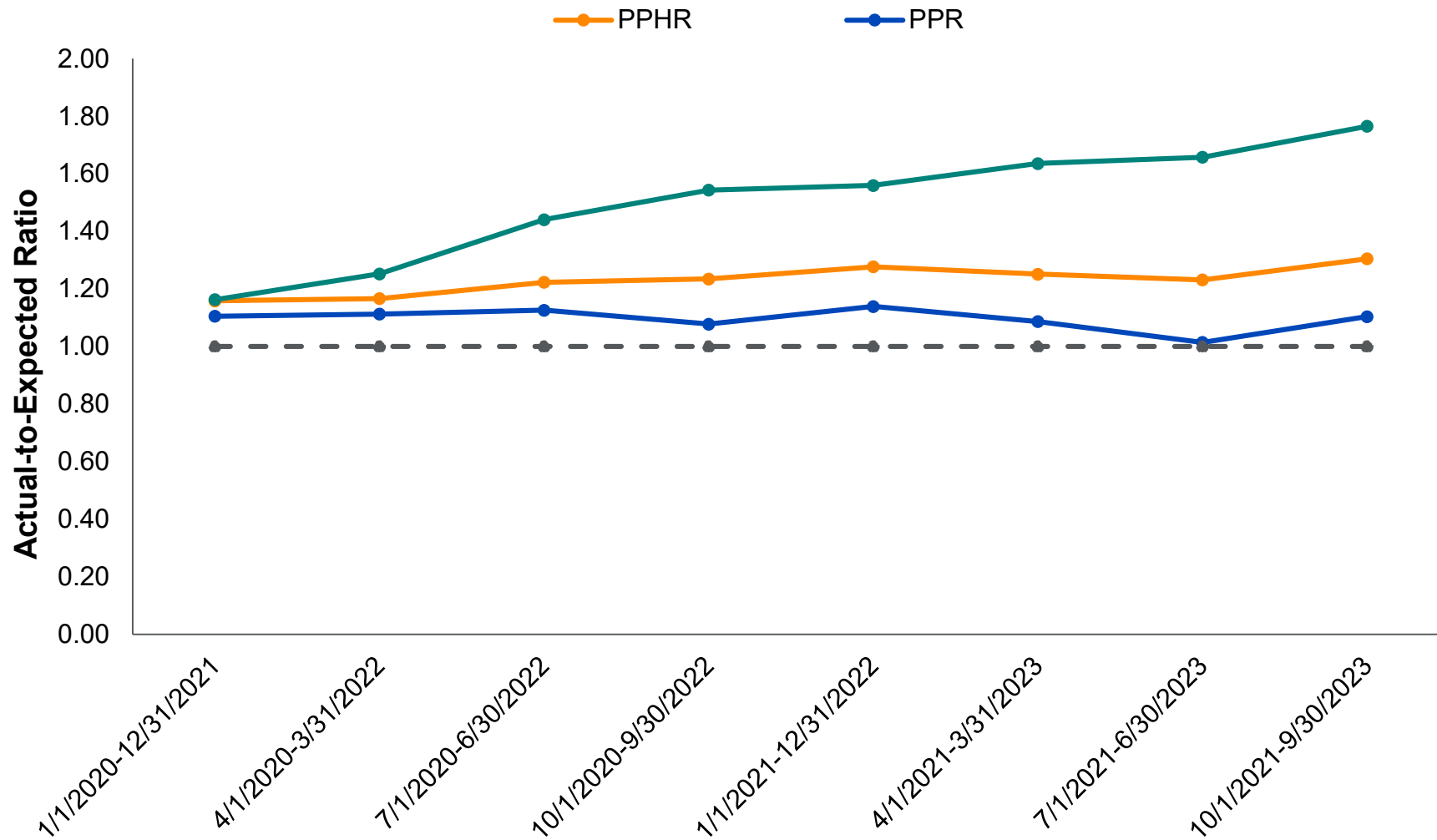
Gulfport Behavioral Health System of MS

Dean Doty, CEO

July 24, 2024

 Universal Health Services, Inc.

Hospital Performance (Rolling Year): Cycle Four



GBHS Interventions to Improve Care

Patient Navigator- Staff assist with coordination along the continuum of care within GBHS. Helps to address disparities to improve engagement. Contacts frequently post discharge

Wellness Disparities- each patient has comprehensive assessment to identify disparities they face including food, housing, transportation, education/literacy, financial, interpersonal, and health

New Programming- have implemented new outpatient programs

Discharge Planning- patients are scheduled to be seen in outpatient care within 7 days of discharge with their preferred providers

Advocacy- monthly calls with MCOs to identify at risk persons

Barriers- chronic and generational conditions, poverty, little social/familial support, CMHCs

Coordinated Care Organizations

Magnolia Health Plan



magnolia health™

READMISSIONS

Michael Adcock,
**Vice President, Population Health and Clinical
Operations**

7/24/2024

Magnolia Readmission Reduction Program



- Readmission reduction is a high priority for Magnolia Health
 - Magnolia staff make post-discharge calls within 3-10 days of discharge to identify any barriers/risk for readmission.
 - Medication review and education.
 - Needed SDOH resource identification.
 - Assistance with scheduling appointments and transportation to ensure follow up within 7 and 30 days of discharge.
 - Home health and 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:

- Education on follow-up appointments and assistance with scheduling when needed, ensuring appropriate referrals are made, SDOH needs are met, medication assistance and transportation assistance when needed.
- Members are stratified and referred to the appropriate level of Care Management to be followed.

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 Forms and Resources 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.
- Reach out to one of our contacts via email or phone to refer a member.

Magnolia Contact Information



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

Molina Healthcare

Molina Healthcare of MS

Care Coordination and Provider Partnership to reduce PPHR

Chris Cauthen
Director of Utilization Management

2024

Introduction to Molina's Care Management Team



Case Manager

- Clinical staff (RNs, LPNs, Social Workers, Behavioral Health Professionals, Allied Health Professionals)
- Assesses member needs, collaborates with member and family to develop an individualized care plan and coordinates interventions as necessary



Transition of Care Coach

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



Community Connector (CC)

- Non-clinical, community-based individual
- Liaison between the member in the community and the health plan
- Serves as a community health worker and assists with components of care coordination

Connecting with Care Management (CM) to Reduce PPHR

- Care Management/Transition of Care (CM/TOC) Coaches need ongoing access to hospital discharge planners for the most successful collaboration of post-discharge care.
- Hospital discharge planners may direct dial the assigned CM/TOC Coach when barriers arise or note these on the BH Discharge Checklist.
- If assignment is unknown, hospital discharge planners are able to direct message Molina Care Management department at: MHMS_CM_Referrals@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)
- Member discharged on a Friday or Saturday and, FUH needs to be scheduled
- Hospital discharge planners encountering barriers scheduling NET
- Hospital discharge planners needs to alert and/or refer a member to Care Management

Partnering with you on PPHR

- Connecting with hospital discharge planners within 24 hours of admission notification
- Coordinating timely “Follow-Up after Hospitalization” (FUH) care post-hospitalization (7/30 days) includes scheduling FUH with new or previously established community providers
- Medication Reconciliation
- Coordinating with Pharmacy to reduce risk of members being unable to obtain running out of RX post-discharge
- Coordinating “Non-Emergency Transportation” (NET)
- Coordinating with Primary Care Provider (PCP)
- Connecting with Community Connectors to address social risk and provide resources
- Coordinating Readmission Conferences with the hospital’s treatment team
- Faxing BH Discharge Planning Checklist
- [Monthly or Quarterly meetings and data-sharing](#)

Data-Sharing

Readmissions by Anchor Facility

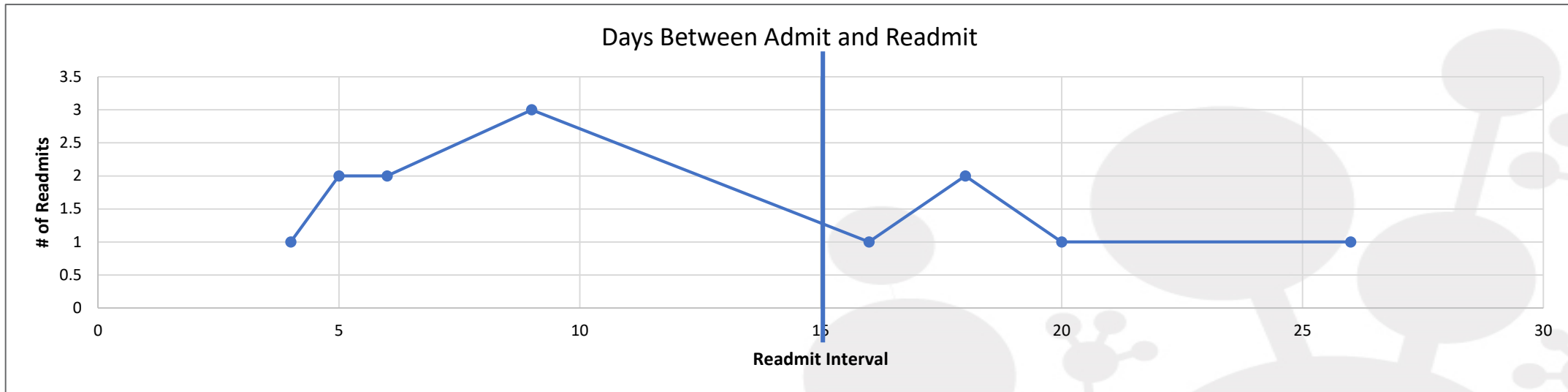
Anchor Admit Facility

Hospital A



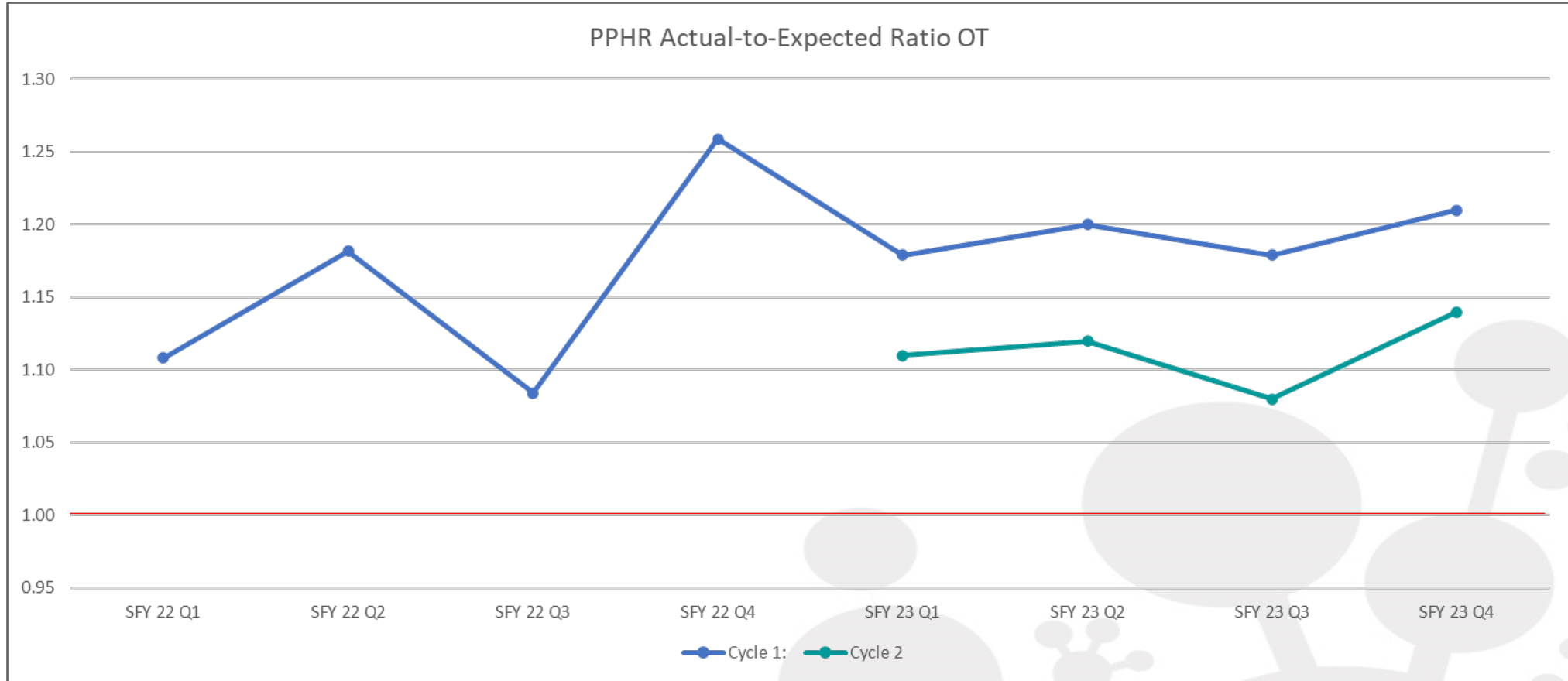
Readmission(s) to:

- Hospital A (2)
- Hospital B (1)
- Hospital C (1)



Source: Readmissions Report- June 2023

PPHR Over Time




Molina Healthcare of MS Care Management Contacts

Molina Care Management Referrals/General CM Questions

1-844-826-4335, **Option 5** for Case Management *OR Email Us at*
MHMS_CM_Referrals@MolinaHealthCare.Com


Provider Collaborations and/or Escalations

Demetria Young- Manager, Care Management

 601-647-9085


 Demetria.Young@Molinahealthcare.com

Shamekias Lampkin- Manager, Behavioral Health

 601-281-5561

 Shamekias.Lampkin@Molinahealthcare.com

Shira Brownell- AVP, Healthcare Services

 601-281-5072

 Shira.Brownell@Molinahealthcare.com

UnitedHealthcare



Potentially Preventable Hospital Returns Provider Webinar July 2024

**Kimberly Bollman, RN Health Services
Director**

**Lesa McGillivray, LCSW Behavioral
Health Executive Director**

**United
Healthcare**

SFY 24 Quarter 4 Outcomes

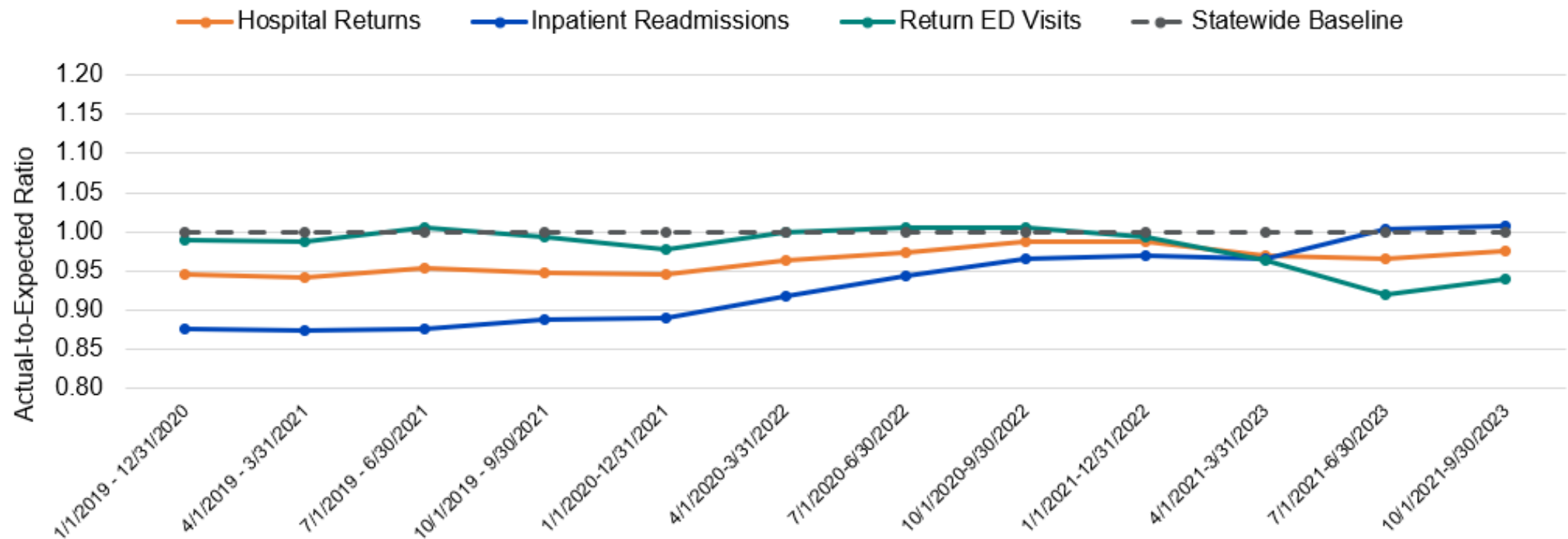
Corrective Action Plan Implementation Report, V.38 of the PPR/ED Algorithm
 Rolling Year Report: 10/1/2021-9/30/2023

	10/1/2021- 9/30/2023	7/1/2021- 6/30/2023	4/1/2021- 3/31/2023	1/1/2021- 12/31/2022	10/1/2020- 9/30/2022	7/1/2020- 6/30/2022	4/1/2020- 3/31/2022	1/1/2020- 12/31/2021	10/1/2019 - 9/30/2021	7/1/2019 - 6/30/2021	4/1/2019 - 3/31/2021	Baseline: 1/1/2019 - 12/31/2020
Potentially Preventable Hospital Returns:												
Potentially preventable hospital return (PPHR) rate ¹ :	12.88%	12.76%	13.14%	13.45%	13.70%	13.66%	13.58%	13.37%	13.33%	13.41%	13.22%	13.16%
Casemix-adjusted statewide PPHR rate (based on calendar year 2019-2020 baseline with updated casemix)	13.22%	13.23%	13.54%	13.61%	13.86%	14.03%	14.10%	14.14%	14.06%	14.08%	14.02%	13.90%
PPHR Actual-to-expected ratio:	0.97	0.97	0.97	0.99	0.99	0.97	0.96	0.95	0.95	0.95	0.94	0.95
Additional Performance Metrics:												
Potentially Preventable Inpatient Readmission (PPR) rate	6.45%	6.45%	6.49%	6.60%	6.76%	6.70%	6.54%	6.34%	6.24%	6.15%	6.09%	5.99%
Casemix-adjusted statewide PPR rate	6.40%	6.42%	6.72%	6.81%	7.01%	7.10%	7.13%	7.12%	7.03%	7.03%	6.97%	6.83%
PPR Actual-to-expected ratio:	1.01	1.00	0.97	0.97	0.97	0.94	0.92	0.89	0.89	0.88	0.87	0.88
Potentially Preventable Return Emergency Department Visit (PPED) rate	7.35%	7.20%	7.57%	7.79%	7.97%	8.04%	8.07%	7.94%	8.03%	8.17%	8.01%	8.04%
Casemix-adjusted statewide PPED rate	7.82%	7.82%	7.85%	7.84%	7.93%	8.00%	8.08%	8.12%	8.09%	8.13%	8.12%	8.12%
PPED Actual-to-expected ratio:	0.94	0.92	0.96	0.99	1.00	1.01	1.00	0.98	0.99	1.01	0.99	0.99

SFY 24 Quarter 4 Outcomes

Corrective Action Plan Implementation

Actual-to-Expected Ratios Over Time



Improving Hospital Returns

Care Manager Interventions

- Improved ADT/HIE data tool. Care managers receive real time ADT data sooner and make outreach to members within 1 business day of the discharge notification.
- Initiate care education and assessment of members understanding of their diagnosis, prognosis, and goals of care upon discharge.
- Identify and address closing gaps in care/SDOH needs to prevent unplanned hospitalizations.
- Education/provide resources to members how to identify/monitor for signs/symptoms of reported symptoms to prevent ER hospital return.
- Medication support (i.e., medication reconciliation, assess for compliance, educate on proper use, collaborate with pharmacy/provider).
- Collaborate/consult with provider (PCP, specialist) to facilitate timely f/u provider appointment.
- Notification to providers they can review a members POC if enrolled in Care Management Program through the UHC Provider Portal link.
- Care management and utilization management collaboration continues for members with complex care management needs.
- Behavioral and medical care management integration for members with comorbid acute and chronic conditions to promote whole health engagement model.



Facility Collaboration:

Brentwood: Teams meet monthly to discuss all issues that impact our members' transition of care. We continue routine discussion regarding quality level data such as readmission rate and follow-up after hospitalization compliance.

Oceans Behavioral Health: Regular engagement continues with discussion of hospital data. This has been consistent in the last several years.

Forrest General / Pine Grove: Our teams continue engagement in this monthly meeting to discuss member needs, barriers and solution. Issues discussed can include transportation, case management, utilization management, and aftercare transition or compliance. The facilities have since began to meet more frequently outside of the partnered engagement with UHC/Optum.

Merit Central: The MS Collaborative Aftercare Planning includes weekly engagement with UHC/Optum and the facility. This forum targets members with frequent inpatient behavioral health admissions allowing a deep dive to address barriers and enhance discharge planning. There is an additional implementation of a monthly meeting with the facility in which we discuss hospital data.

Gulfport Behavioral Health: The teams meet monthly to discuss transitions of care and share quality level data. Additionally, there is an upcoming discussion related to possible MCAP expansion with the facility.





Success Story - Behavioral Health

52 y/o male MSCAN

Diagnosis: Major Depressive Disorder severe recurrent w/o psychotic features



Prior Utilization:

3 inpatient psychiatric admissions in the last year. The most recent admission was to Merit Health Central.

Behaviors Leading to recent acute episode:

Suicidal ideation, depressed mood, cocaine and alcohol abuse.

Stressors:

The member was experiencing family and financial stressors that were being exacerbated by his using substance abuse.

Interventions:

The assigned Behavioral Health Advocate discussed the member at the MCAPP staffing (MS Collaborative Aftercare Planning Pilot) while he was admitted to Merit Health. A review of the members conditions and potential barriers for discharge were discussed and solutioned for. A referral for residential rehab and recovery program were offered. The BHA consulted with medical partners related to diabetes management and the members need for a PCP. A Peer Support Specialist referral was also submitted.

Outcomes:

Post discharge the member began participating in a recovery program where he ultimately also began working in a transitional program. The member engaged with a Peer Support Specialist during face-to-face visits and established care with a PCP. The member has had period of MH wellness for 6 months with no Acute psych admissions.



HOW TO REACH US

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Mississippi Optum Network Management Assignment

- Assigned Area
Dawn Teeter
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QIPP Reporting Timeline

Upcoming dates of interest: QIPP Payments

In SFY 2025, QIPP payments will be made quarterly by the Coordinated Care Organizations to hospitals who meet QIPP PPHR reporting requirements

For each quarter in SFY 25:

- 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 2024
 - December 2024
 - March 2025
 - June 2025

Upcoming dates of interest: QIPP PPHR and PPC Reporting

Date	Event
July 9, 2024	<ul style="list-style-type: none">Quarterly PPHR and PPC reports distributed to hospitalsHospitals required to submit a PPHR and PPC corrective action plan identified
August 14, 2024	<ul style="list-style-type: none">Hospital deadline to attest receipt and review of the quarterly reports for Q1
September 3, 2024	<ul style="list-style-type: none">PPHR and PPC corrective action plan (CAP) deadline
October 7, 2024	<ul style="list-style-type: none">Quarterly PPHR and PPC reports distributed to hospitals for Q2
November 6, 2024	<ul style="list-style-type: none">Hospital deadline to attest receipt and review of the quarterly reports for Q2
January 8, 2025	<ul style="list-style-type: none">Quarterly PPHR and PPC reports distributed to hospitals for Q3Performance incentives for PPHR allocated for Cycle 3
February 7, 2025	<ul style="list-style-type: none">Hospital deadline to attest receipt and review of the quarterly reports for Q3
April 7, 2025	<ul style="list-style-type: none">Quarterly PPHR and PPC reports distributed to hospitals for Q4
May 7, 2025	<ul style="list-style-type: none">Hospital deadline to attest receipt and review of the quarterly reports for Q4

Appendix

Glossary: PPCs

- **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: PPHRs

- **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
- **Low Volume:** Hospitals with fewer than 10 expected and/or actual PPHRs

Questions

For Further Information

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For QIPP Resources including the presentation, see the following link: [Value-Based Incentives - Mississippi Division of Medicaid \(ms.gov\)](#)