Washington State Health Care Authority
Potentially Preventable Readmissions (PPR) Policy
Frequently Asked Questions (FAQ) – CY 2016

1. *What is the purpose of HCA's readmissions policy?*

   HCA believes that reducing avoidable readmissions is an important goal that will contribute to improved quality of care for individuals receiving inpatient care. HCA seeks to improve the identification and reporting of readmission patterns and performance beyond the capabilities of the current readmission policy, and to create appropriate and actionable fiscal incentives tied to patient outcomes. Partnering with hospitals and our managed care plans, we intend to reduce potentially preventable readmissions by sharing reports and data that will allow these partners to identify opportunities for improving quality of care and care outcomes.

2. *What are PPRs?*

   3M™'s Potentially Preventable Readmissions (PPR) software is a patient classification system that uses a clinically-based algorithm to identify initial inpatient hospital admissions preceding subsequent readmissions that are potentially preventable. PPR software uses historical inpatient discharge data to:

   - Assign APR-DRGs to claims data.
   - Identify specific types of excluded admissions (for example, "intrinsically clinically-complex and extensive" DRGs).
   - Identify the readmissions which are clinically related and that a reasonable clinician would believe to be potentially preventable.
   - Identify readmission "chains" (initial admissions and potentially preventable readmissions following the initial admission) for the entire Medicaid population and across hospitals.

3. *What is an APR-DRG?*

   HCA uses 3M ™ All-Patient Refined Diagnosis Related Groups (APR-DRGs) in its Medicaid inpatient prospective payment system to classify patients according to their reason for admission and discharge severity of illness. APR-DRGs use data from computerized discharge abstracts to assign patients to one of 314 "base APR-DRGs" that are determined either by the principal diagnosis, or, for surgical patients, the most important surgical procedure performed in an operating room. Each base APR-DRG is then divided into 4 risk subclasses, determined primarily by secondary diagnoses that reflect both co-morbid illnesses and the severity of the underlying illness, creating the final set of 1,256 groups.

4. *Does my provider need to license the PPR software?*

   Licensing the PPR software by providers is not required under the new policy. HCA will share longitudinal patient level data with providers. Providers may choose to independently license PPR software for their own tracking purposes.

5. *Does the new PPR policy replace the current 14-day readmission policy?*

   Yes, the new PPR-based readmissions policy replaces any current readmissions policy(s) for FFS and managed care.

6. *Will HCA use the PPR software to deny payment for readmissions?*

   No, the PPR software does not deny payment of claims that represent readmissions. The new PPR-based policy uses a more holistic assessment of each provider's overall readmission performance to offer financial incentives to reduce readmissions.

7. *What is the effective date of the new PPR policy?*

   The implementation date of the new policy is January 1, 2016, as established in WAC 182-550-3840.

8. *How will readmissions be measured under this new policy?*

   For the first year of this new PPR-based policy, HCA will use SFY 2014 inpatient claims data ("PPR model claims data") processed under PPR software version 31 with default options and a 30-day readmission window. HCA will use the results of this PPR model to determine, for each hospital, expected readmission chains, actual readmission chains and excess readmission chains (actual readmission chains less expected readmission chains – see questions 14 and 15 for more detail). In turn, providers with excess readmissions will be subject to a prospective DRG base rate reduction under this policy (effective January 1, 2016). Providers with actual readmissions equal to or less than expected readmissions will not be subject to a DRG base rate reduction under this policy.

9. *What experience period is the PPR model based on?*

   PPR model claims data includes SFY 2014 FFS claims and MCO encounter claim records for services with discharge dates occurring between 7/1/2013 through 6/30/2014, with the following exceptions:

   - Readmissions associated with an initial admission where the initial admission discharge date was prior to 7/1/2013 were excluded.
   - Readmissions with a discharge date after 6/30/2014, if associated with an initial admission between 7/1/2013 through 6/30/2014, were included.

10. *What claims data are excluded from the PPR model?*

    The following SFY 2014 claims were excluded from the PPR model claims data prior to processing the data through the PPR software:

    - Out-of-state non-border providers
    - Medicare crossover claims
    - State program claims (without Federal match)
    - Psychiatric and substance abuse claims (based on APR-DRG assignment)

11. *What types of readmissions are considered not preventable in the PPR model?*

    The standard PPR software algorithm excludes the following "intrinsically clinically-complex and extensive" DRGs from the identification of readmissions (see PPR manual for a full list of globally excluded DRGs):

    - Neonatal DRGs (except for normal newborn APR-DRGs 626 and 640)
    - Major HIV conditions (HIV DRGs 890, 891 and 893)
    - Eye care
    - Malignancy (ex: leukemia, lymphoma, and chemotherapy admissions are globally excluded). Note that admissions with a non-metastatic, non-immunocompromised APR-DRG are eligible as candidate admissions unless there is a chemotherapy or radiotherapy procedure code.

    The standard PPR software algorithm also excludes the following "non-preventable" readmissions from the identification of readmission rates under this policy:

    - Not clinically related readmission
    - Clinically related readmission, but not preventable
    - Planned readmission
    - Obstetrical-related readmission (based on DRG)
    - Trauma-related readmission (based on DRG)
    - Same day transfer to an acute care hospital for non-acute care, e.g. hospice care
    - Admission to an acute care hospital for clients assigned to the base APR-DRG for rehabilitation, aftercare, and convalescence
    - Hospitalizations with a discharge status of "left against medical advice" (AMA)

    In additional to the standard PPR software algorithm, HCA also excluded the following claims from the identification of readmission rates under this policy:

    - Trauma cases meeting HCA's ISS threshold for supplemental payment (and all admissions linked by the PPR algorithm to the trauma admission)
    - Newborn cases with mother's patient information reported in claim
    - Newborn jaundice cases

- Transplants and subsequent admissions within 180 days of the transplant
- Ungroupable DRGs

12. *How does the PPR software algorithm use patient discharge status code?*

    The PPR software algorithm makes the following adjustments based on patient discharge status codes:

    - 07 - Left Against Medical Advice: Excludes the record if it otherwise would have been an initial admission
    - 20 - Expiration of the Patient: Terminates a readmission chain

    In addition, the standard PPR software algorithm does not count as a readmission a same-day transfer to another facility:

    - 03 – Transfer to Skilled Nursing Facility
    - 04 – Transfer to Custodial/Supportive Care
    - 05 - Transfer to Another Facility
    - 21 – Transfer to Court/Law Enforcement
    - 51 – Transfer to Hospice Medical Facility
    - 61 – Transfer to Swing Bed
    - 62 – Transfer to Rehabilitation Facility/Unit
    - 63 – Transfer to Long Term Care Hospital
    - 64 – Transfer to Nursing Facility
    - 65 – Transfer to Psychiatric Hospital or Unit
    - 70 - Transfer to Another Type of Healthcare Institution

13. *How does the PPR software algorithm identify planned readmissions?*

    The PPR software algorithm identifies planned readmissions based on the APR-DRG combinations found between the initial admissions and the subsequent re-hospitalization(s). There are certain combinations of DRGs that are considered probably planned readmissions, and thus are not considered readmissions. These combinations can be found in the PPR definitions manual.

To be support accurate identification of other planned readmissions not identified based on specific APR-DRG combinations, instructions regarding how to prepare claims associated with a planned readmission have been provided in the HCA Apple Health Inpatient Hospital Provider Guide found at: http://hca.wa.gov/medicaid/billing/documents/guides/inpatient_hospital_mpg.pdf

14. *How are expected readmission chains determined?*

Expected readmission chains have been calculated for each hospital based on each hospital's mix of services provided.

To calculate expected readmission chains, we first calculate statewide readmission rates for each APR-DRG. Next, we calculate adjustment factors that will be applied to the statewide readmission rates when determining each hospital's expected number of readmission chains, in order to account for variation in patient age and the presence of a secondary mental health diagnosis. Specifically, adjustment factors are calculated for:

- Pediatric patients (age 17 and under)
- Patients with a mental health secondary diagnosis (as identified by the PPR software algorithm)

Each hospital's total number of expected readmission chains is calculated as the sum of the statewide readmission rates for all qualifying admissions occurring at the hospital, with adjustment for patient age and presence of secondary mental health diagnoses, and with a statewide expected readmission chain adjustment factor of 85 percent applied.

15. *How are excess readmissions determined?*

Excess readmission chains for each hospital are based on a provider's actual readmission chains less expected readmission chains. Actual readmission chains are attributed to a hospital where the initial admission in a readmission chain occurred at that hospital, even if one or all readmissions following the initial admission occurred at different hospitals. Hospitals with actual readmission chains less than expected readmission chains have no excess readmission chains.

16. *How are PPR payment reductions determined?*

    PPR payment reductions are calculated as each hospital's number of excess readmission chains multiplied by the average payment per readmission chain. For hospitals with zero excess readmission chains, there is not PPR payment reduction. A Readmission Reduction Factor—which is an adjustment factor applied to a hospital's DRG base rate—is calculated as the PPR payment reduction divided by total DRG-based inpatient payments made to the hospital. For 2016, the Readmission Reduction Factor is "capped" at a **1 percent reduction to the DRG base rate** for any single hospital. The Readmission Reduction Factor will always be applied as a prospective reduction to HCA-published DRG base rates in the subsequent calendar year.

17. *How will this affect my provider's reimbursement from Medicaid managed care plans?*

    HCA does not directly determine payments made by the MCO plans. However, HCA's adjustment to published DRG base rates may impact payments made by MCOs.

18. *Will there be retroactive adjustments or settlements on readmission payment reductions?*

    No. Readmission payment reductions will be applied prospectively without any retroactive adjustments or settlements.

19. *Will HCA share my provider's PPR results?*

    Yes, HCA will share PPR model summary reports and patient-level claim extracts with each hospital. The summary reports will summarize each hospital's readmission performance and show the calculation of the hospital's Readmission Reduction Factor, if applicable. The claim extracts will allow providers to determine which claims are identified as potentially preventable readmissions, and provide each hospital's quality, clinical and administrative staff with insights into the factors that may be driving readmission performance.

20. *Where can I get my PPR model data?*

    HCA will post claims data extracts onto each provider's Washington State SFTP site or send them via secure email.

21. *How can I identify readmissions due to PPR chains attributed to my facility in the claims data extracts?*

    To identify the number of initial admissions (the start of a readmission chain), filter the data by:

    - Claim in performance measurement = 1, and
    - Claim final record type = Initial Admission (IA)

    To review the entire readmission chain, filter the data by:

    - Claim in performance measurement = 1, and
    - Claim final record type = Initial Admission (IA) and Potentially Preventable Readmission (RA, RT)
    - Note that this criteria identifies readmissions both at your facility and at other facilities.

    To review readmissions occurring at your facility, filter the data by:

    - Claim MedicareID = (Insert your facility), and
    - Claim in performance measurement = 1, and
    - Claim final record type = Potentially Preventable Readmission (RA, RT)

22. *How will the PPR model and Readmission Reduction Factors be updated going forward?*

    To calculate Readmission Reduction Factors effective January 1, 2017, HCA will use SFY 2016 claims data. Readmission Reduction Factors will be updated on a calendar year basis using the most recent prior fiscal year's claims data.