

## Plan All-Cause Readmissions Rate (30 days)

### Metric Information

**Metric Description:** The percentage of acute inpatient stays of Medicaid beneficiaries, 18 years of age and older, during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

Definition of terms used in this metric:

- *Index Hospital Stay (IHS):* An acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Exclude stays that meet the exclusion criteria in the denominator section.
- *Index Admission Date:* The IHS admission date.
- *Index Discharge Date:* The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
- *Index Readmission Stay:* An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
- *Index Readmission Date:* The admission date associated with the Index Readmission Stay.
- *Planned Hospital Stay:* A hospital stay is considered planned if it meets criteria as described in HEDIS® specification step 3 (required exclusions) of the numerator.
- *Medicaid beneficiaries with High Frequency of Index Hospital Stays:* Medicaid beneficiaries with four or more index hospital stays on or between January 1 and December 1 of the measurement year.
- *Classification Period:* 365 days prior to and including an Index Discharge Date.

**Metric specification version:** HEDIS® 2020 Technical Specifications for Health Plans, NCQA (modified).

**Data collection method:** Administrative only.

**Data source:** ProviderOne Medicaid claims/encounter and enrollment data.

**Identification window:** Measurement year (and up to one year prior to establish Medicaid enrollment).

**Claim status:** Include only final paid claims or accepted encounters in metric calculation.

**Direction of quality improvement:** Lower is better.

**URL of specifications:** [www.ncqa.org/hedis/measures](http://www.ncqa.org/hedis/measures)

### DSRIP Program Summary

**Metric utility:** ACH Project P4P ■ ACH High Performance ■ DSRIP statewide accountability ■

**ACH Project P4P – Metric results used for achievement value:** Single metric result.

**ACH Project P4P – improvement target methodology:** improvement over self (1.9% improvement over reference baseline performance).

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**ACH High Performance – methodology:** HCA will use a Quality Improvement (QI) Model to determine relative high performance among ACHs for the set of High Performance metrics. For more information, see Chapter 8: ACH High Performance Incentives.

**DSRIP statewide accountability – methodology:** HCA will use a Quality Improvement (QI) Model to determine statewide performance across the quality metric set. For more information, see Chapter 2: Statewide accountability.

**ACH regional attribution:** Residence in the ACH region for 11 out of 12 months in the measurement year.

**Statewide attribution:** Residence in the state of Washington for 11 out of 12 months in the measurement year.

### DSRIP Metric Details

Eligible Population – ACH Project P4P and DSRIP statewide accountability	
Age	18–64 years as of the Index Discharge Date.
Gender	N/A
Minimum Medicaid enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap in Medicaid enrollment	No more than one gap of one month during the 12 months prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
Medicaid enrollment anchor date	Index Discharge Date (for inpatient stay).
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries that are eligible for both Medicare and Medicaid and beneficiaries with primary insurance other than Medicaid.

Eligible Population – ACH High Performance	
Age	18–64 years as of the Index Discharge Date.
Gender	N/A
Minimum Medicaid enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap in Medicaid enrollment	No more than one gap of one month during the 12 months prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
Medicaid enrollment anchor date	Index Discharge Date (for inpatient stay).

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Medicaid benefit and eligibility	<p>Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries with primary insurance other than Medicaid.</p> <p><i>Note: for ACH High Performance Incentive calculation, Medicaid beneficiaries that are eligible for both Medicaid and Medicare (duals) are included in the eligible population for the metric.</i></p>
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### Denominator:

#### Data elements required for the denominator:

- Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement year. See HEDIS® for specific instructions, including direct transfers.
- Apply all relevant exclusions. See HEDIS® for specific instructions.
- Assign each acute inpatient stay to an age and stratification category using the Reporting: Denominator section. See HEDIS® for specific instructions.

#### Value sets required for denominator.

Name	Value Set
Inpatient Stay Value Set	See HEDIS®
Observation Stay Value Set	See HEDIS®
Nonacute Inpatient Stay Value Set	See HEDIS®
Pregnancy Value Set	See HEDIS®
Perinatal Conditions Value Set	See HEDIS®

#### Required exclusions for denominator.

- Eligible population exclusions are listed in the eligible population table above.
- Metric specific exclusions:
  - o Beneficiaries in hospice care.
  - o Beneficiaries with hospital stays where the Index Admission Date is the same as the Index Discharge Date.
  - o Beneficiaries who died during the stay.
  - o All other all relevant exclusions. See HEDIS® for specific instructions.

#### Deviations from cited specifications for denominator.

- HEDIS® specifications require no more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, as is the case for the ProviderOne data source, the Medicaid beneficiary may not have more than a 1-month gap in coverage (i.e., a Medicaid beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

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### Numerator:

Beneficiaries must qualify for inclusion in the denominator to be eligible for inclusion in the numerator.

*Data elements required for numerator:* At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

- Identify all acute inpatient and observation stays on or between January 3 and December 31 of the measurement year (if the measurement year is a calendar year). See HEDIS<sup>®</sup>™ for specific instructions.
- Apply all relevant exclusions. See HEDIS<sup>®</sup> for specific instructions.
- For each IHS, determine if any of the acute inpatient stays have an admission date within 30 days after the Index Discharge Date.

*Value sets required for numerator.*

Name	Value Set
Inpatient Stay Value Set	See HEDIS <sup>®</sup>
Observation Stay Value Set	See HEDIS <sup>®</sup>
Nonacute Inpatient Stay Value Set	See HEDIS <sup>®</sup>
Pregnancy Value Set	See HEDIS <sup>®</sup>
Perinatal Conditions Value Set	See HEDIS <sup>®</sup>
Chemotherapy Value Set	See HEDIS <sup>®</sup>
Rehabilitation Value Set	See HEDIS <sup>®</sup>
Kidney Transplant Value Set,	See HEDIS <sup>®</sup>
Bone Marrow Transplant Value Set	See HEDIS <sup>®</sup>
Organ Transplant Other Than Kidney Value Set	See HEDIS <sup>®</sup>
Introduction of Autologous Pancreatic Cells Value Set	See HEDIS <sup>®</sup>
Potentially Planned Procedures Value Set	See HEDIS <sup>®</sup>
Acute Condition Value Set	See HEDIS <sup>®</sup>

*Required exclusions for numerator.*

- All relevant exclusions. See HEDIS<sup>®</sup> for specific instructions.

*Deviations from cited specifications for numerator.*

## Plan All-Cause Readmissions Rate (30 days)

- This is a modified HEDIS® metric. The original HEDIS® metric requires risk adjustment and reporting as a ratio. However, a ratio is reported instead as there were no Medicaid specific risk adjustment specifications provided by HEDIS® at the start of the DSRIP.

### Version Control

**July 2018 release:** The specification was updated to HEDIS® 2018 specifications.

**January 2019 update:** Minor formatting updates were made to the metric specification sheet. This includes updating the URL of the source specification and changing HEDIS™ to HEDIS®. No substantive changes were made to the specification.

**August 2019 update:** The specification sheet has been updated to reflect the current version of the HEDIS® technical specification (from HEDIS® 2018 to HEDIS® 2019). Some exclusions are no longer removed in the denominator, these are now removed in the numerator. Note that while the names of the value sets included in the specifications have not changed, the underlying values may have been updated. See HEDIS® for specific instructions.

**August 2020 update:** The specification sheet has been updated to reflect the current version of the HEDIS® technical specification (from HEDIS® 2019 to HEDIS® 2020). Observation stays were added to inpatient admissions and direct transfer guidelines were revised to include observation discharges. Note that while the names of the value sets included in the specifications have not changed, the underlying values may have been updated. See HEDIS® for specific instructions.