Plan All-Cause Readmissions (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.

Metric specification version: HEDIS® Measurement Year 2020 and Measurement Year 2021 Technical Specifications for Health Plans, NCQA.

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

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).

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.

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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).
Medicaid benefit and eligibility	Includes Medicaid beneficiaries with comprehensive medical benefits. Excludes beneficiaries with primary insurance other than Medicaid. *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.*

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.

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- Assign each acute inpatient stay to an age and stratification category using the Reporting: Denominator section. See HEDIS® for specific instructions.

Required exclusions for denominator.

- Eligible population exclusions are listed in the eligible population table above.
- Metric specific exclusions:
    - Beneficiaries in hospice care.
    - Beneficiaries with hospital stays where the Index Admission Date is the same as the Index Discharge Date.
    - Beneficiaries who died during the stay.
    - 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).

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® ™ for specific instructions.
- Apply all relevant exclusions. See HEDIS® 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.

Required exclusions for numerator.

- All relevant exclusions. See HEDIS® for specific instructions.

Deviations from cited specifications for numerator.

- 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.

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August 2019 update: Some exclusions are no longer removed in the denominator, these are now removed in the numerator.

August 2020 update: Observation stays were added to inpatient admissions and direct transfer guidelines were revised to include observation discharges.