Statewide Collaborative Quality Improvement Project

All-Cause Readmissions Interim Report

June 2011 – May 2013

Medi-Cal Managed Care Division
California Department of
Health Care Services

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HSAG HEALTH SERVICES ADVISORY GROUP

DHCS California Department of HealthCareServices

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Purpose and Scope of Report

The California Department of Health Care Services' (DHCS's) Medi-Cal Managed Care Division (MMCD) is responsible for administering Medi-Cal Managed Care (MCMC) and overseeing quality improvement activities that comply with State and federal regulations.

According to the Code of Federal Regulations (CFR) at 42 CFR §438.240, the State must require that its managed care plans (MCPs) conduct quality improvement projects (QIPs) designed to achieve, through ongoing measurement and intervention, significant improvement sustained over time. This sustained improvement must occur in both clinical and nonclinical areas to achieve improved health outcomes and enrollee satisfaction.[1]

To meet federal requirements, DHCS requires its contracted, full-scope, regular MCPs and specialty MCPs to conduct two QIPs. For full-scope, regular MCPs, DHCS requires participation in a statewide collaborative QIP. Participation by specialty MCPs in the statewide collaborative is optional if the topic is relevant and appropriate to the specialty population and approved by DHCS.

In June 2011, MMCD met with Health Services Advisory Group, Inc. (HSAG), to discuss a new collaborative QIP that focused on reducing readmissions to acute care hospitals due to all causes within 30 days of an inpatient discharge among MCMC members. Hospital readmissions have been associated with the lack of proper discharge planning and poor care transition. Improving the care transition after hospital discharge will reduce the high rates of preventable readmissions while decreasing costs and improving quality of care, leading to improved health outcomes.

DHCS contracted with HSAG, an external quality review organization (EQRO), to conduct QIP validation, an activity mandated by the Centers for Medicare & Medicaid Services (CMS). DHCS also contracted with HSAG to produce an interim report on the statewide collaborative QIP.

This interim report documents collaborative project activities conducted from June 2011 through May 2013. Additionally, the report includes the progress of the *All-Cause Readmissions* QIP through the Study Design stage, displays QIP validation findings, and presents conclusions and recommendations for the next stage of the collaborative.

[1] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol 3, October 1, 2005.

Summary of Collaborative Quality Improvement Project Activities

For the Study Design stage, the collaborative:

- Selected the project topic.
- Developed the measure specifications.
- Established the Guiding Principles.
- Developed common language for the Study Design stage.
- Submitted the Study Design stage for an initial high-level review.
- Submitted the Study Design stage for QIP validation.
- Developed an evaluation plan.
- Implemented MCP-specific interventions.
- Submitted MCP-specific barrier analyses and interventions for qualitative analysis.
- Participated on follow-up technical assistance calls related to the barrier analyses and interventions.

Next Steps

HSAG and DHCS will facilitate a conference call with the collaborative to discuss upcoming QIP submission requirements and answer any questions before the collaborative QIPs are submitted to HSAG. MCPs should submit their collaborative QIPs for validation by September 30, 2013. The submissions should include calendar year (CY) 2012 data for the baseline period. Additionally, the MCPs should document the evaluation of their interventions, which will include intermediate outcomes and measures. MCPs should incorporate the following general recommendations HSAG provided to the MCPs regarding their improvement strategies:

- Completely describe the barrier analysis process.
- Ensure that the barrier analyses are supported by MCP-specific data.
- Address the Seniors and Persons with Disabilities (SPD) population in the barrier analyses.
- Clearly prioritize the barriers.
- Link each intervention to a specific barrier.
- Provide enough details to fully describe each intervention.
- Include the implementation date of each intervention and all roll-out or piloted progressions of the intervention.
- Discuss each intervention's targeted population.
- Break down complex interventions into measureable components.
- Include an evaluation plan for each intervention.

MCPs should also address MCP-specific recommendations regarding their improvement strategy as well as recommendations provided in their QIP validation tools.

Medi-Cal Managed Care Background

DHCS administers MCMC, which serves about 62 percent of the Medi-Cal population. The remaining 38 percent of this population is enrolled in Medi-Cal fee-for-service (FFS).

During the 2011 measurement year, DHCS contracted with 22 full-scope MCPs and three specialty MCPs operating throughout California in 24 of California's 58 counties, to provide health care services to approximately 4.9-million members enrolled in MCPs. Medi-Cal MCP model types are described below.

County-Organized Health System

In a County-Organized Health System (COHS) model, DHCS contracts with a county-organized and county-operated MCP to provide medical services to MCMC beneficiaries with designated, mandatory aid codes. Under a COHS MCP, MCMC beneficiaries can choose from a wide network of managed care providers. Beneficiaries in COHS MCP counties do not have the option of enrolling in Medi-Cal FFS unless authorized by DHCS.

Geographic Managed Care

In the Geographic Managed Care (GMC) model, DHCS contracts with several commercial MCPs within a specified geographic area. This provides MCMC enrollees with more choices.

The GMC model type currently operates in San Diego and Sacramento counties.

Two-Plan Model

In a Two-Plan Model (TPM) county, DHCS contracts with two MCPs to provide medical services to Medi-Cal beneficiaries. Most TPM counties offer a local initiative (LI) plan and a nongovernmental, commercial plan (CP).

Specialty Managed Care Plans

In addition to the full-scope MCPs, DHCS contracts with several MCPs to provide health care services to specialized populations. During the review period of this report, DHCS held contracts with three specialty MCPs. DHCS requires each specialty MCP to report annually on two DHCS-approved performance measures chosen specifically for each MCP.

Quality Improvement Project Requirements

QIPs are a contract requirement for Medi-Cal MCPs. DHCS's MMCD requires each MCP to conduct two QIPs that MMCD must approve and MMCD's EQRO must validate.

QIPs are a federal requirement. The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires that all states that operate a Medicaid managed care program ensure that their contracted MCPs conduct QIPs in accordance with the Code of Federal Regulations (CFR), at 42 CFR 438.240.[2]

DHCS requires each of its contracted Medi-Cal MCPs to conduct two MMCD-approved QIPs according to federal requirements. MCPs must always maintain two active QIPs. For full-scope MCPs, the statewide MCMC collaborative project serves as one of the two required QIPs. The second QIP can be either an individual or small-group collaborative involving at least three Medi-Cal MCPs. Although not contractually required to participate in collaborative QIPs, specialty MCPs may choose to participate in the collaborative if the topic is applicable to their Medi-Cal population and approved by DHCS.

Purpose of the Collaborative QIP

The statewide readmission collaborative provides an opportunity to collect data, share knowledge and best practices, and implement changes that will help reduce acute hospital readmissions due to all causes within 30 days of an inpatient discharge for the Medi-Cal population. Hospital readmissions have been associated with the lack of proper discharge planning and poor care transition. Improving the care transition and coordination after hospital discharge will reduce the high rate of preventable readmissions; consequently, decreasing costs and improving overall quality of care, and ultimately leading to improved health outcomes for the Medi-Cal population.

Collaborative Components and Process

During the first collaborative project meeting in June 2011, the roles and the responsibilities for the project were defined as follows:

- HSAG's role—to provide technical assistance, validate the QIPs, and provide input into QIP development.
- MMCD's role—the "owner" of the QIP is responsible for progression of the QIP, solicitation of workgroup participation, meeting planning and facilitation, and ultimate decision making.
- MCPs' role—responsible for participating in the QIP development and conducting the QIP.

[2] Balanced Budget Act of 1997. Federal Register/Vol. 67, No. 115, June 14, 2002, 2002/Rules and Regulations, p. 41109.

The collaborative process incorporated a method that first used workgroups, comprised of MCP volunteers, MMCD staff, and HSAG staff, to develop the collaborative components, which were presented to the collaborative group for feedback and approval. Collaborative components included:

- Guiding Principles.
- Evaluation plan.
- Technical specifications.
- Study Design stage common language.

In June 2011, MCPs responded to the Hospital Readmissions Collaborative Survey. The purpose of the survey was to obtain input and recommendations from MCPs regarding the collaborative process for the *All-Cause Readmissions* collaborative QIP. Results of this survey were used by a small workgroup to develop the Guiding Principles for the new collaborative. Collaborative members then had an opportunity to revise and edit the Guiding Principles before finalizing and adopting it for the new collaborative.

Topic Rationale

The following topic rationale was developed by a small workgroup and then shared with the collaborative. The collaborative approved the documentation and agreed to include the documentation as part of each MCP's QIP.

Hospital readmissions are common and costly. Research shows that in 2005, nearly one-in-five Medicare patients in the FFS program had readmissions within 30 days of discharge from a hospital stay with an estimated 12-billion dollar annual cost for potentially preventable readmissions.[3] In recent years, policy makers have highlighted readmission as an opportunity to improve quality of health care and reduce costs. The 2007 and 2008 Medicare Payment Advisory Commission reports to Congress pointed to readmission as a marker of poor quality and high cost. The report recommended measuring and reporting disease-specific, thirty-day readmissions beginning in 2009. The recommendation also outlined a payment policy that eventually became a provision of the Affordable Care Act, Section 3025, which established the Hospital Readmissions Reduction Program: to reduce payments to hospitals with excess readmissions. Beginning in federal fiscal year 2013, the Centers for Medicare & Medicaid Services (CMS) will penalize hospitals with excess readmission ratios for its patients with heart failure, acute myocardial infarction, and pneumonia (and eventually medical and surgical conditions) that are readmitted within 30 days of discharge.[4]

While the early focus centered on Medicare patients, states are now measuring hospital readmissions for Medicaid beneficiaries. Data from the 2007 Healthcare Cost and Utilization Project (HCUP) on all-cause readmissions among non-elderly Medicaid patients revealed that Medicaid readmission rates were higher than commercially insured patients. For instance, the non-obstetric 30-day readmission rate was 10.7 percent compared with 6.3 percent. Of hospitalized study patients from 21 to 64 years of age, at least 1-in-10 had at least 1 readmission within 30 days after discharge from their first hospital stay. In addition, rates increased with age and the number of co-morbidities. More than half of the readmissions involved an initial stay for circulatory diseases, mental disorders, respiratory and digestive diseases, or alcohol/substance abuse.[5]

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[3] MedPAC. Report to Congress: *Promoting Greater Efficiency in Medicare*. June 2007. http://www.medpac.gov/documents/Jun2007.
[4] Boutwell, AE, et al. An early look at a four-State initiative to reduce avoidable hospital readmissions. (2011).Health Affairs, 30(7), 1272-80.
[5] Jiang, HJ & Wier, LM. (2010). All-cause hospital readmissions among non-elderly Medicaid patients, 2007. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb89.jsp.

Discharge from a hospital is a critical transition point in a patient's care. Incomplete handoffs at discharge can lead to adverse events for patients and avoidable readmissions. Potentially preventable readmissions are readmissions directly tied to conditions that could have been avoided. Hospital readmissions may indicate poor care or missed opportunities to better coordinate care. However, determinants of readmission are varied.[6]

The Medi-Cal population is uniquely vulnerable to poor outcomes in the transition from hospital to home due to poor health literacy, language barriers, and primary care access difficulties. Medi-Cal patients may have poor understanding of red flags (when to ask for help) or how to manage medication changes. Dr. Eric Coleman's research[7] shows that 40 percent of older patients experience a medication discrepancy at the time of discharge. Organizations across the country are focused on hospital discharges as a high-yield opportunity to improve outcomes and reduce costs, with interventions focusing on improving care coordination between hospital, specialist, and PCP; improving patient/family understanding of the patient's conditions and how to manage predictable symptoms; ensuring accurate medication reconciliation; and assisting patients with accessing needed follow-up services.

Several MCPs participating in DHCS's MCMC collaborative QIP have begun to address the issues surrounding readmissions, and data from the new collaborative-developed *All-Cause Readmissions* measure (starting with CY 2011) will provide a basis for understanding rates for participating MCPs' Medi-Cal membership. Limited preliminary data from four MCPs using various methodologies showed rates that ranged from 4.3 percent to 12.6 percent. Two of the four MCPs' rates for SPD compared with non-SPD members showed that SPD members' readmission rate was 2-to-8 percentage points higher.

MMCD required that each MCP calculate an overall Medi-Cal readmission rate, a readmission rate for the SPD population, and a readmission rate for the non-SPD population and address any disparities identified through barrier analysis with targeted interventions. Addressing hospital readmissions among Medi-Cal members with disabilities is even of more concern as published in the December 2010 brief by the Center for Health Care Strategies, Inc. (CHCS),[8] which noted that the rate of readmission among Medicaid beneficiaries with disabilities may be different than other beneficiaries as a result of state-level policies, type of chronic illness and a greater level of multi-morbidity. The subjects of the study were 941,208 Medicaid beneficiaries with disabilities in 50 states between 2003 and 2005. The goal was to identify potential opportunities to improve care and reduce readmissions. Beneficiaries in the managed care programs were excluded from the study. The CHCS study revealed that among Medicaid members with disabilities:

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[6] Kangovi, S. & Grande, D. (2011). Hospital readmissions – not just a measure of quality. *JAMA, 306(*16), 1796-7.
[7] http://www.caretransitions.org/documents/Coleman%20Senate%20Aging%20Testimony%20July%202008.pdf
[8] Hospital Readmissions among Medicaid Beneficiaries with Disabilities: Identifying Targets of Opportunity: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261200

- The 30-day readmission rate increased from 16 percent to 53 percent within one year.
- Of those readmitted within 30 days, 50 percent did not visit a physician between discharge and readmission.
- The number of readmissions increased with the number of chronic conditions present.
- Readmission rates were particularly high among beneficiaries with mental illness, substance use disorder, skin infections, and infectious disease. Additional conditions with high readmission rates included heart failure, diabetes, and persons with co-morbid cardiovascular and pulmonary diseases.

In another study, a decreased Length of Stay (LOS) for acute hospital inpatient Medicaid beneficiaries receiving rehabilitation care was associated with increased readmissions. The increased readmissions were consistent for Medicaid beneficiaries with disabilities in all rehabilitation impairment categories.[9] Consequently, reducing readmissions and providing the best care to beneficiaries with disabilities is important, especially in the current environment with limited resources.

Study Indicator Development—Specifications and Methodology

After the initial kick-off meeting with the collaborative, a small workgroup was formed to develop the specifications for the statewide measure. The workgroup determined through research of existing, standardized measures that there was no readmission measure specific to the Medicaid population and the existing standardized measures were primarily disease-specific and geared toward a Medicare population. After several meetings, the workgroup decided on a modified version of the National Committee for Quality Assurance's (NCQA's) *Plan All-Cause Readmissions* HEDIS®[10] measure. The HEDIS-like measure was renamed as the *All-Cause Readmissions* measure. The rationale for changes to the *Plan All-Cause Readmissions* HEDIS measure is provided in Appendix A. Additionally, MMCD required that the measure be reportable for three populations: the MCP's overall Medi-Cal population, the SPD population, and the non-SPD population. MCPs were instructed to discuss the modified specifications as well as the stratification of the data by SPD status with their internal staff members responsible for producing the measure or with their certified software vendors. A test of the specifications by a few volunteer MCPs demonstrated that the specifications could be met by the vendors and MCPs to calculate the rates. The final measure specifications are included in Appendix B.

In addition to the study topic and technical specifications, the workgroup also developed the study question and study population definition.

[9] Kenneth J. Ottenbacher, et.al.: LOS and Hospital Readmissions among Persons with Disabilities
[10] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Project Evaluation Plan Development

HSAG provided the lead on the development of an evaluation plan. This was a recommendation made at the end of the prior collaborative QIP to help focus the project and measure various aspects of the collaborative project. The purpose of the evaluation plan is to evaluate the MCMC's statewide collaborative QIP, *All-Cause Readmissions*, in the areas of oversight and contractual compliance, process, and merit and worth. For a well-constructed evaluation plan, three key questions should be addressed at the beginning of the collaborative project to ensure that each evaluation question can be answered.

Question 1: Were the project/contractual obligations met?

Answering this question is important because it provides MCMC a measure of accountability. It includes the federal and/or State-mandated QIP reporting requirements plus any additional measures deemed important to describe the *All-Cause Readmissions* statewide collaborative QIP.

The project obligations to be evaluated are related to the Collaborative Guiding Principles developed by collaborative partners on July 28, 2011, and the DHCS QIP requirements.

Question 2: What improvements can be made to the delivery of the project?

Evaluating delivery is important for two reasons:

- First, data gathered from ongoing monitoring of the project can inform mid-course corrections, resulting in significant resource/cost savings.
- Second, the ability to determine the impact of the *All-Cause Readmissions* statewide collaborative QIP is difficult to assess if there is uncertainty about the fidelity with which the project was implemented. If the QIP failed to have its intended effect on members, was it attributable to failures in delivery (i.e., the QIP was not given a fair chance) or because of substantive issues in conceptualization (i.e., invalid underlying assumptions in how to develop and implement interventions)? The answer to this question will lead to very different decisions, either (a) improving operations or (b) a complete restructuring of the conceptualization of the QIP.

The project delivery areas to be evaluated are related to the collaborative timeline, the adherence to the CMS protocol for conducting a QIP, and external audit results for producing valid rates.

Question 3: What difference did the *All-Cause Readmissions* statewide collaborative QIP make to the project participants?

To answer this question requires an understanding of the underlying assumptions of the QIP. What are the critical issues that contribute to readmissions? Making the programmatic assumptions explicit is essential because it is these underlying issues that the QIP activities should be trying to change. That is, the identified critical issues are the immediate and intermediate outcomes that are necessary to produce change in reducing readmissions.

Since it is uncertain whether substantive changes in reducing readmission rates will be observed and sustained over a three-year period, an assessment of the immediate and intermediate outcomes becomes even more critical in demonstrating the value of the *All-Cause Readmissions* statewide collaborative QIP.

Oversight and Compliance

The collaborative participants developed and agreed upon two measures in the area of Oversight and Compliance.

Oversight and Compliance Measures

Table 4.1—Oversight and Compliance Outcome Measures

Implementation Outcomes	Measures
1. Medi-Cal MCPs will participate in the statewide collaborative QIP activities according to the collaborative-developed Guiding Principles.	◆ MCP attendance at collaborative QIP meetings (a minimum of one key member to attend all meetings) ◆ Log of collaborative meeting facilitator/co-facilitator and minute-keeper.
2. Medi-Cal MCPs will prepare and submit their QIPs for validation according to DHCS-identified due dates and requirements.	◆ EQRO log of QIP submission dates.

All MCPs attended collaborative QIP meetings (a minimum of one member in attendance for all meetings). MMCD-approved meeting agendas were distributed prior to each meeting, and MMCD documented attendance at the beginning of each meeting. The meetings followed the agenda and included a facilitator/co-facilitator. MMCD documented minutes and identified action items for timely follow-up.

HSAG tracked all QIP submissions as well as the barrier analyses and intervention grid submissions for timeliness.

Collaborative Project Improvement—Process

As part of the evaluation plan, process improvement relates to quality assurance measures and improving the delivery of the project as the collaborative progresses.

Process Measures

Table 4.2—Process Outcome Measures

Process Outcomes	Measures
1. The QIP will be implemented according to the collaborative timeline.	◆ Completion date of QIP milestones against the timeline targeted due dates.
2. Medi-Cal MCPs will achieve *Met* validation scores for the study design and implementation stages of their QIP.	◆ QIP validation scores. ◆ EQRO qualitative analysis of barriers and interventions.
3. Medi-Cal MCPs will report valid *All-Cause Readmission* rates consistent with the collaborative-defined specifications.	◆ EQRO validation of performance measure—final audit report.

MMCD tracked the completion date of QIP milestones against the timeline targeted due dates. A revised timeline was created which included additional activities; however, the original dates for the milestones were not changed. The revised timeline is provided in Appendix C.

HSAG reviewed preliminary Study Design QIP submissions to evaluate the incorporation of the common language developed by the workgroup and provided *Pass/Fail* scores. Additionally, HSAG verified that MCPs received overall *Met* validation scores for their Study Design QIP submissions.

HSAG conducted a qualitative analysis of barriers and interventions for each MCP to ensure MCPs were on track with the targeted intervention implementation in January 2013.

HSAG provided validation of performance measures, although the final audit report was not available for the period covered by this report.

Merit and Worth

Critical to understanding the appropriate outcomes to evaluate is first understanding the program theory. Theory Driven Evaluation (TDE) is a valid and widely used approach in evaluation (Donaldson, 2002)[11] across all sectors of government programs and policies. TDE consists of three steps designed to ensure there is a logical connection between program activities and evaluation. TDE begins by making the assumptions underlying the program explicit. These

[11] Donaldson, S. I. (2002). Theory-driven program evaluation in the new millennium. *Evaluating social programs and problems* (pp109-141) Mahwah, NJ.

assumptions are often depicted visually and show the chain of conditions that the program is trying to change. Once the programmatic assumptions are understood, programmatic activities are aligned to them. Finally, indicators and measures are sought to evaluate those conditions being targeted by the program activities. It is the summary of these three steps that is the basis for the logic model (Renger & Titcomb, 2002).[12]

The ideal process with using a program evaluation theory model is to develop the theory, ensure the Medi-Cal MCPs are targeting the identified issues, and then develop the measures. The evaluation workgroup created a logic model that identified conditions related to readmissions. Appendix B shows the logic model that was shared with the collaborative.

MCPs used the collaborative logic model as the basis for their MCP-specific barrier analyses. Based on the results of their analyses, MCPs developed interventions to address the barriers. The evaluation of the interventions is documented as intermediate measures, and the outcomes of these measures will determine the effectiveness of the MCPs' improvement strategy.

For the current time period, MCPs have not progressed to the point of reporting intermediate and long-term measures and outcomes. MCPs began implementing interventions in January 2013; therefore, MCP-specific intermediate outcomes and measures will be reported by the MCPs in their September 28, 2013, QIP submissions.

Impact Outcomes

Table 4.3—Merit and Worth Outcome Measures

Long-Term Outcomes	Measures
1. Medi-Cal MCPs will achieve a statistically significant decrease in their *All-Cause Readmissions* rate between the baseline and remeasurement period.	◆ Activity IX validation results for statistically significant improvement.
2. Medi-Cal MCPs will achieve Met validation scores for sustained improvement.	◆ Activity X validation results for sustained improvement.
Immediate/Intermediate MCP-Specific Outcomes—TBD Dependent on Targeted Barriers	
1. Example: Medi-Cal MCPs will improve the discharge planning process.	◆ Percentage of members discharged from a facility with a complete discharge plan.

[12] Renger, R., & Titcomb, A. (2002). A three-step approach to teaching logic models. *American Journal of Evaluation*, 23(4), 493-503.

Throughout the Study Design stage, HSAG collected results for the oversight and compliance measures.

Collaborative Partner Participation

MCPs participated on all collaborative calls according to the Guiding Principles. Additionally, MCPs readily volunteered to participate in the various workgroups, which demonstrated their interest and commitment to the project.

QIP Submission Timeliness

Preliminary Study Design collaborative QIP submissions were due March 30, 2012. For the purpose of the preliminary submission, each MCP submitted one QIP, even if it operated in multiple counties. All 23 QIPs were received by the due date.

Study Design collaborative QIP submissions were due September 28, 2012. Forty-three QIPs were received on time; only one MCP missed the due date and submitted its QIP on October 1, 2012. Two MCPs were required to resubmit their QIPs by November 16, 2012. Both QIP resubmissions were received on time.

Barrier analyses and intervention grid submissions were due to HSAG by January 31, 2013. Twenty-two MCPs submitted their documentation on or before the deadline. One MCP submitted its documentation on February 6, 2013. Follow-up technical assistance calls were held with each MCP from February 1, 2013, through February 19, 2013. Five MCPs were required to resubmit their barrier analyses and interventions based on deficiencies identified during the calls. Four of the MCPs' resubmissions were timely, and one MCP requested an extension. By May 17, 2013, all resubmissions were received by HSAG and DHCS. Four of the five MCPs participated on follow-up technical assistance calls between May 16 and May 24, 2013. The final technical assistance call was held June 3, 2013.

The MCPs' baseline submission for the *All-Cause Readmissions* QIP is due September 30, 2013.

As part of the evaluation plan, the collaborative process was evaluated to determine if improvement was related to quality assurance measures and if improvement of the delivery of the project was achieved as the collaborative progressed.

Collaborative Timeline

The collaborative project remained on schedule throughout the Study Design stage. The collaborative was able to meet all milestone due dates as shown in Table 6.1.

Table 6.1—Completion Status for Statewide *ACR* Collaborative Components

QIP Stage	Milestones	Targeted Due Date	Status
Study Design	QIP proposal validation	April–May 2012	Complete
	Evaluation plan development—logic model	May–June 2012	Complete
	MCPs conduct barrier analysis and design interventions.	July–December 2012	Complete
	MCPs submit QIP study design stage historical data	September 28, 2012	Complete
	Evaluation plan development	October–December 2012	Complete
	EQRO collaborative interim report	June 2013	Complete

QIP Validation Scores

For the preliminary QIP submission, HSAG performed a high-level review of Activities I through VI. The purpose of the review was to ensure that MCPs had correctly incorporated the common language developed by the workgroup for Activities I to V and had completed Activity VI, which was MCP-specific. Of the 23 submissions, 22 received a *Pass* score, and one MCP received a *Fail* score. The MCP that had initially received a *Fail* score resubmitted the QIP after correctly documenting the collaborative study indicator and received a *Pass* score.

For the Study Design collaborative QIP submissions, 44 QIPs received an overall *Met* validation status. Two MCPs received *Partially Met* scores and were required to resubmit their QIPs by November 16, 2012. Both of the resubmitted QIPs received a *Met* validation status.

Table 6.2 provides the aggregate percentages for each activity within the CMS protocols.

Table 6.2—Validation Results for Statewide *ACR* Collaborative QIP (20 MCPs, 48 QIPs)

QIP Study Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Appropriate Study Topic	100%	0%	0%
	II. Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III. Clearly Defined Study Indicator(s)	98%	2%	0%
	IV. Correctly Identified Study Population	100%	0%	0%
	V. Valid Sampling Techniques (if sampling was used)	Not Applicable	Not Applicable	Not Applicable
	VI. Accurate/Complete Data Collection	65%	10%	25%
Design Total		**86%**	**4%**	**10%**
Implementation	VII. Appropriate Improvement Strategies	Not Assessed	Not Assessed	Not Assessed
	VIII. Sufficient Data Analysis and Interpretation	Not Assessed	Not Assessed	Not Assessed
Implementation Total		**Not Assessed**	**Not Assessed**	**Not Assessed**
Outcomes	IX. Real Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
	X. Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**Not Assessed**	**Not Assessed**	**Not Assessed**
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**86%**		
Percentage of QIPs with a Validation Status of *Met*		**96%**		

HSAG assessed Activities I through VI for all 48 QIP submissions. The MCPs scored the highest for the first four activities; however, common language for these activities was provided to all of the MCPs. Activity VI was the only activity that was entirely MCP-specific. MCPs were scored down in Activity VI for not defining a systematic process for collecting data. Additionally, MCPs did not include an analysis plan.

Performance Measure Validation

HSAG reviewed and approved 20 MCPs' source code, either internal or vendor created, for the statewide collaborative *All-Cause Readmissions* QIP measure since this measure is not included under software certification for Medicaid. All MCPs were able to produce valid and reliable rates for CY 2011. The CY 2011 historical data for the *All-Cause Readmissions* measure rate were MCMC Average—12.8 percent; SPD—16.0 percent; and non-SPD—10.3 percent.

From February to April 2013, HSAG conducted an NCQA HEDIS Compliance Audit™[13], for the CY 2012 measurement period, which included the *All-Cause Readmissions* collaborative QIP outcome measure. The final audit report was not completed during the time period covered by this report.

[13] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

HSAG evaluated the merit and worth (impact) during the collaborative QIP's Study Design stage.

Intermediate Plan-Specific Outcomes

The Evaluation Plan workgroup developed a logic model of the barriers related to high readmission rates. The logic model provided to all of the MCPs is included in Appendix D. HSAG had the MCPs submit their barrier analyses and interventions so that it could conduct qualitative analyses of the MCPs' improvement strategies. Feedback was provided to each MCP during an MCP-specific technical assistance call. Common issues were identified for most of the MCPs' submissions. General recommendations to the MCPs included:

- Completely describe the barrier analysis process.
- Ensure that the barrier analyses are supported by MCP-specific data.
- Address the SPD population in the barrier analyses.
- Clearly prioritize the barriers.
- Link each intervention to a specific barrier.
- Provide enough details to fully describe each intervention.
- Include the implementation date of each intervention and all roll-out or piloted progressions of the intervention.
- Discuss each intervention's targeted population.
- Break down complex interventions into measureable components.
- Include an evaluation plan for each intervention.

Five MCPs with additional deficiencies were identified and required to resubmit their barrier analyses and interventions. Follow-up technical assistance calls were held with each of these MCPs.

To further facilitate the importance of a data-driven process, HSAG also presented the findings and recommendations of the review at the medical directors' meeting on April 11, 2013.

Long-Term Outcomes

Since the QIP is in the Study Design stage, MCPs had not fully defined their improvement strategies and implemented all proposed interventions; therefore, HSAG could not assess the impact on the long-term project outcome.

Conclusions and Recommendations

The development and processes implemented for the *All-Cause Readmissions* project have been well received and have resulted in a timely, well-defined project. Workgroups were an efficient method to develop project components. The collaborative partners have been receptive and vested in the process.

The one area that will require ongoing focus is the MCPs' improvement strategies. Using MCP-specific data to identify barriers is not the common approach used by the MCPs. Additionally, recognizing the importance of continual monitoring and tracking of interventions to evaluate intermediate outcomes and the effectiveness of the interventions is not a standard practice. The following recommendations should be incorporated in the MCPs' *ACR* QIP submissions in September 2013:

- Completely describe the barrier analysis process.
- Ensure that the barrier analyses are supported by MCP-specific data.
- Address the SPD population in the barrier analyses.
- Clearly prioritize the barriers.
- Link each intervention to a specific barrier.
- Provide enough details to fully describe each intervention.
- Include the implementation date of each intervention and all roll-out or piloted progressions of the intervention.
- Discuss each intervention's targeted population.
- Break down complex interventions into measureable components.
- Include an evaluation plan for each intervention.

Without the incorporation of these recommendations, it will be difficult for the MCPs to achieve sustained improvement throughout the project and successfully reduce their readmission rates.

Next Steps

Collaborative next steps include the following:

- Continue to implement and evaluate interventions.
- Conduct new barrier analyses using CY 2012 data.
- Collect, report, and submit baseline data in the *ACR* QIP submissions due to HSAG for validation by September 30, 2013.

HSAG will complete the next statewide collaborative QIP report, including the baseline data and analyses, in June 2014.

Table A.1—*All-Cause Readmissions* Specification Modification Rationale

Traditional HEDIS *Plan All-Cause Readmissions (PCR)* Measure	Medi-Cal *All-Cause Readmissions* Measure	Rationale for Modification
Product Line: Commercial and Medicare only	**Product Line:** Medi-Cal	No HEDIS specification available for Medicaid.
Age Requirement: 18 years and older as of the Index Discharge Date	**Age Requirement:** 21 years and older as of the Index Discharge Date	Resolves issues with California Children's Services (CCS) carve-out for some MCPs.
Continuous Enrollment (CE) Requirement: 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.	**Continuous Enrollment (CE) Requirement:** 120 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.	CE requirement was necessary for readmission probability/weighting calculations. Maintaining a one-year CE would eliminate all newer SPDs and other members. Recommend 120 days to allow for MCPs to contact and establish care for new members after enrollment.
Allowable Gap: No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge date.	**Allowable Gap:** None	Aligns with approach to allow MCPs 45 days to contact new enrollees.
Risk Adjustment Weighting: Includes an algorithm for risk adjustment weighting based on surgery, discharge diagnosis, and co-morbidities.	**Risk Adjustment Weighting:** Eliminated	Based on feedback from several Medicaid MCPs and NCQA, the risk adjustment weighting does not produce accurate results when to applied to Medicaid populations.

All-Cause Readmissions (ACR)

Medi-Cal Managed Care Program – Statewide Collaborative Quality Improvement Project

FINAL Specifications Revised 2/21/13 - Modified from HEDIS® Specifications

Note: Plans should follow the most current HEDIS specifications each year and apply the collaborative defined modifications as outlined in this document.

Description

For members 21 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days. Data are reported in the following categories:

1. Count of Index Hospital Stays (IHS) (denominator)
2. Count of 30-Day Readmissions (numerator)

Gray Shading indicates deviation from the HEDIS®[1] specification.

Definitions

IHS	Index hospital stay. 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.

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Eligible Population

Product line	**Medi-Cal**
Ages	**21** years and older as of the Index Discharge Date.
Continuous enrollment	**120** days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap	**None**.
Anchor date	Index Discharge Date.
Benefit	Medical.
Event/ diagnosis	An acute inpatient discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all acute inpatient discharges for members who had one or more discharges on or between January 1 and December 1 of the measurement year. The organization should follow the steps below to identify acute inpatient stays.

Administrative Specification

Denominator The eligible population.

Step 1 Identify all acute inpatient stays with a discharge date on or between January 1 and December 1 of the measurement year.

Include acute admissions to behavioral healthcare facilities. Exclude nonacute inpatient rehabilitation services, including nonacute inpatient stays at rehabilitation facilities.

Step 2 ***Acute-to–acute transfers:*** Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date.

Step 3 Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4 Exclude any acute inpatient stay with a discharge date in the 30 days prior to the Index Admission Date.

Step 5 Exclude stays for the following reasons.

- Inpatient stays with discharges for death
- Acute inpatient discharge with a principal diagnosis for pregnancy or for any other condition originating in the perinatal period in Table 1.

Step 6 Calculate continuous enrollment.

Table 1: Codes to Identify Maternity Related Inpatient Discharges

Description	ICD-9-CM Diagnosis
Pregnancy	630-679, V22, V23, V28
Conditions originating in the perinatal period	760-779, V21, V29-V39

Numerator At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1 Identify all acute inpatient stays with an admission date on or between January 2 and December 31 of the measurement year.

Step 2 ***Acute-to-acute transfers:*** Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date.

Step 3 Exclude acute inpatient hospital discharges with a principal diagnosis using the codes listed in Table 1.

Step 4 For each IHS, determine if any of the acute inpatient stays have an admission date within 30 days after the Index Discharge Date.

Reporting: *Denominator*

Count the number of IHS for the total eligible population.

Reporting: *Numerator*

Count the number of IHS with a readmission within 30 days for the total population.

Quality Improvement Project Reporting Requirements

Plans are required to report on three distinct populations for members enrolled in the plan for each county:

1. Overall readmission rate
2. Seniors and Persons with Disabilities (SPDs) readmission rate*
3. Non-SPD readmission rate

* Seniors and Persons with Disabilities are defined in Table 2.

Table 2: Aid Codes to Identify Seniors and Persons with Disabilities

Aid Codes	Aid Code Calculated Desc (E1r)	Two Plan	GMC	COHS-1	COHS-2
10	Aged	X	X	X	X
13	Aged - LTC -SOC			X	X
14	MN Aged	X	X	X	X
16	Pickle-Aged	X	X	X	X
17	Aged - SOC			X	X
20	Blind-SSI/SSP-Cash	X	X	X	X
23	Blind - LTC			X	X
24	MN Blind	X	X	X	X
26	Pickle-Blind	X	X	X	X
27	Blind MN SOC			X	X
36	Disabled Widow/ers	X	X	X	X
60	SSI/SSP Disabled	X	X	X	X
63	Disabled - LTC - SOC			X	X
64	Disabled - MN	X	X	X	X
65	Disabled Substantial Gainful Activity/Aged, Blind, Disabled-Medically Needy IHSS *12/21/12 Update – Removed aid code 65.*			X	X
66	Pickle-Disabled	X	X	X	X
67	Disabled - SOC			X	X
1E	Eligibility for the Aged	X	X	X	X
1H	Aged-FPL Program	X	X	X	X
2E	Eligibility for the Blind	X	X	X	X
2H	Disabled - Federal Poverty Level for the Blind Prog	X	X	X	X
6A	Disabled Ad/Chld Blind	X	X	X	X
6C	Disabled Ad/Chld Disabled	X	X	X	X
6E	Eligibility for the Disabled	X	X	X	X
6G	Disabled - 250 Percent Working Disabled Program	X	X	X	X
6H	Disabled-FPL Program	X	X	X	X
6J	Pending Disability Determination	X	X	X	X
6N	No Longer Disabled Bene in Appeal (Not 6R)	X	X	X	X
6P	PRWORA/No Longer Disabled Children	X	X	X	X
6R	Potential Grandfathered SSI Disabled Children			X	X
6V	DDS Waiver	X	X	X	X
6W	DDS Regional Waiver			X	X
6X	IHO Waiver			X	X
6Y	IHO Waiver - SOC			X	X
C1	OBRA Aged Medically Needy (MN) - Aliens				X
C2	OBRA Aged MN - Aliens - SOC				X
C3	OBRA Blind MN - Aliens				X
C4	OBRA Blind MN - Aliens - SOC				X
C7	OBRA Disabled MN - Aliens				X
C8	OBRA Disabled MN - Aliens - SOC				X
D2	OBRA Aged LTC - Aliens				X
D3	OBRA Aged LTC - Aliens - SOC				X
D4	OBRA Blind LTC - Aliens				X
D5	OBRA Blind LTC - Aliens - SOC				X
D6	OBRA Disabled LTC - Aliens				X
D7	OBRA Disabled LTC - Aliens - SOC				X

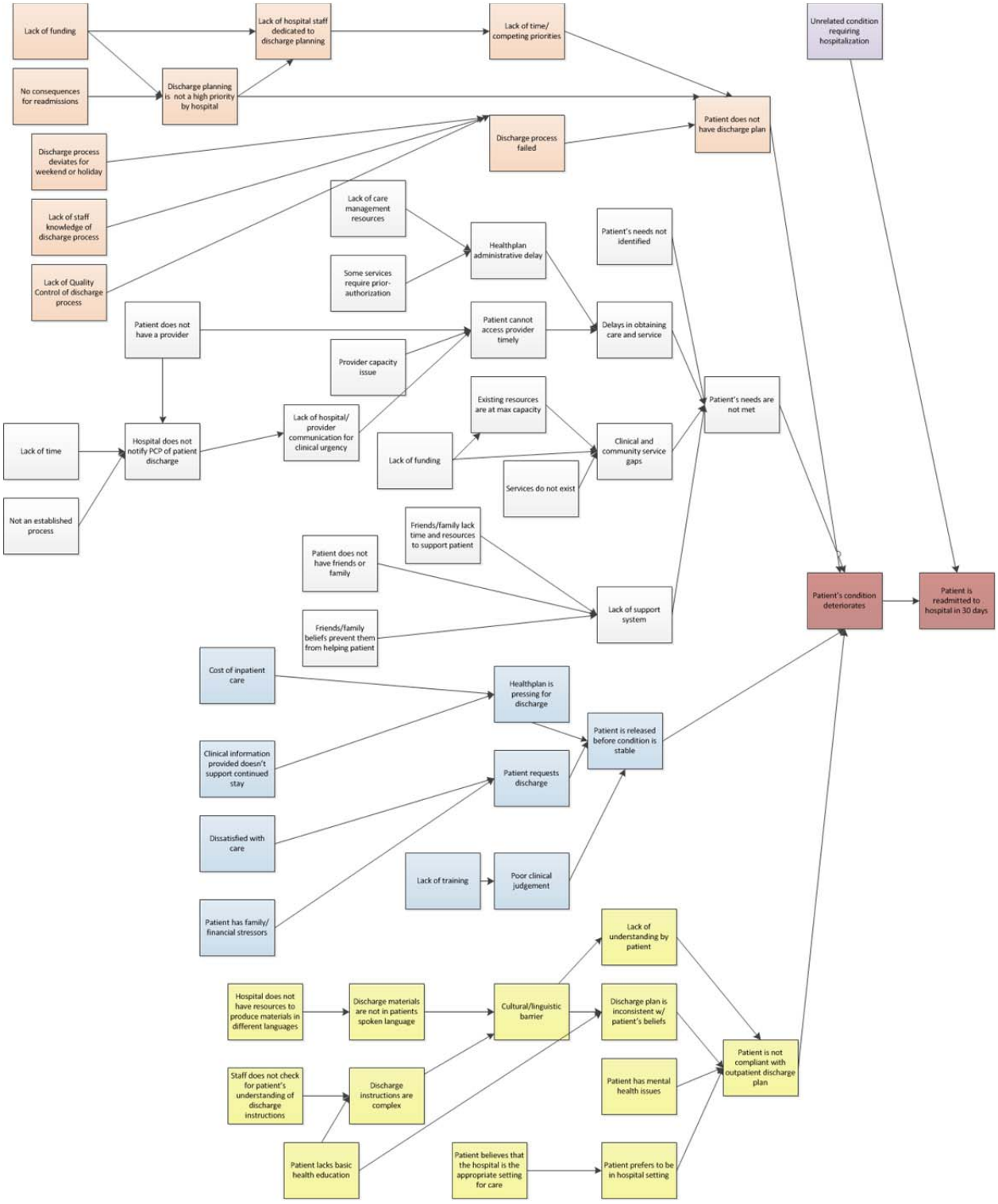
Appendix C. Timeline for the *ACR* Statewide Collaborative QIP

Table C.1—Statewide Collaborative QIP: *All-Cause Readmissions* Timeline
(Revised January 11, 2013)

QIP Stage/Measurement Period	Milestones	Targeted Due Date	Comments	Status
Study Design/ Pre-baseline	Kick-Off Meeting	July 21, 2011	Teleconference; see attached agenda.	Complete
	Finalize Guiding Principles	July–August 2011	Formation of a small workgroup to develop Guiding Principles.	Complete
	Review existing readmission measures and develop draft QIP measure specifications	August 31, 2011	Formation of a small workgroup to review/modify potential readmissions measures.	Complete
	Plan testing of draft measure specifications	August 31, 2011		Complete
	Provide Guiding Principles and draft measure specifications to collaborative for input/comment	September 13, 2011	Discuss measure at September Medical Directors' Meeting.	Complete
	Finalize measure specifications	October 1, 2011		Complete
	Collaborative QIP development	January–February 2012	Development of study topic background, study question, defining the study population and study indicator.	Complete
	Evaluation plan development—Oversight and Compliance	January–February 2012	Small group of subject matter experts to work with HSAG and DHCS on oversight and compliance for evaluation.	Complete
	Collaborative QIP Meeting	March 1, 2012	Provide common language for study design.	Complete
	Plans submit statewide collaborative QIP Proposal	March 30, 2012	QIP activities populated through Activity VI.	Complete
	Plans undergo performance measure audit	March–June 2012	HSAG conducts audit.	Complete
	QIP validation	April–May 2012	HSAG conducts QIP validation of plan project proposals.	Complete

QIP Stage/Measurement Period	Milestones	Targeted Due Date	Comments	Status
	Evaluation plan development—Logic Model	May–June 2012	Small group of subject matter experts to work with HSAG and DHCS on logic model for evaluation.	Complete
	Plans conduct barrier analysis and design interventions	July–December 2012	Plans develop interventions for January 2013 implementation.	In process
	Plans submit QIP study design stage data	September 28, 2012	HEDIS 2012 (CY 2011 data as historical data = study design stage data).	Complete
	QIP validation	October–November 2012		Complete
	Evaluation plan development	October–December 2012	Small group of subject matter experts to work with HSAG and DHCS on logic model for evaluation.	Complete
	EQRO collaborative interim report	June 2013	Initial report that details the activities of the collaborative through the study design stage.	Complete
Implementation/ Baseline	Barrier analysis and planned interventions	January 31, 2013	Plans submit their barrier analysis and planned interventions grid to HSAG for review.	Complete
	Barrier analysis and intervention feedback with plans	February 2013	HSAG provides technical assistance calls with plans to provide feedback on barrier analysis and interventions.	Complete
	Plans implement interventions	January–April 2013	Plans implement interventions early in 2013 in an effort to impact HEDIS 2014 rates.	In process
	Health plans undergo performance measure audit	March–June 2013		In process
	Plans submit QIP with baseline data (CY 2012)	September 30, 2013	HEDIS 2013	
	QIP validation	October–November 2013	HSAG conducts validation of plans' baseline QIPs.	
	EQRO Baseline Report	May 2014		

QIP Stage/Measurement Period	Milestones	Targeted Due Date	Comments	Status
Outcomes/ Remeasurement 1	Health plans undergo performance measure audit	March–June 2014		
	Plans submit QIP with Remeasurement 1 data (CY 2013)	September 30, 2014	HEDIS 2014. Reflects interventions initiated beginning January 1, 2013.	
	QIP validation	October–November 2014	HSAG conducts validation of plan Remeasurement 1 QIPs.	
	EQRO's first remeasurement report	May 2015		
Outcomes/ Remeasurement 2	Health plans undergo performance measure audit	March–June 2015		
	Plans submit QIP with Remeasurement 2 data (CY 2014)	September 2015	HEDIS 2015	
	QIP validation	October–November 2015	HSAG conducts validation of plan baseline QIPs.	
	EQRO's final remeasurement report	May 2016		


Lack of funding
Lack of hospital staff dedicated to discharge planning
Lack of time/ competing priorities
Unrelated condition requiring hospitalization
No consequences for readmissions
Discharge planning is not a high priority by hospital
Patient does not have discharge plan
Discharge process deviates for weekend or holiday
Discharge process failed
Lack of care management resources
Lack of staff knowledge of discharge process
Healthplan administrative delay
Patient's needs not identified
Some services require prior-authorization
Lack of Quality Control of discharge process
Patient does not have a provider
Patient cannot access provider timely
Delays in obtaining care and service
Provider capacity issue
Existing resources are at max capacity
Patient's needs are not met
Lack of time
Hospital does not notify PCP of patient discharge
Lack of hospital/ provider communication for clinical urgency
Lack of funding
Clinical and community service gaps
Services do not exist
Not an established process
Friends/family lack time and resources to support patient
Patient does not have friends or family
Patient's condition deteriorates
Patient is readmitted to hospital in 30 days
Friends/family beliefs prevent them from helping patient
Lack of support system
Cost of inpatient care
Healthplan is pressing for discharge
Patient is released before condition is stable
Clinical information provided doesn't support continued stay
Patient requests discharge
Dissatisfied with care
Lack of training
Poor clinical judgement
Patient has family/ financial stressors
Lack of understanding by patient
Hospital does not have resources to produce materials in different languages
Discharge materials are not in patients spoken language
Cultural/linguistic barrier
Discharge plan is inconsistent w/ patient's beliefs
Patient is not compliant with outpatient discharge plan
Staff does not check for patient's understanding of discharge instructions
Discharge instructions are complex
Patient has mental health issues
Patient lacks basic health education
Patient believes that the hospital is the appropriate setting for care
Patient prefers to be in hospital setting