

Plan All-Cause Readmissions (PCR)

Measure title	Plan All-Cause Readmissions	Measure ID	PCR
Description	For persons 18 years of age and older, the risk-adjusted ratio of observed-to-expected unplanned acute readmissions (inpatient and observation stays) for any diagnosis within 30 days of an acute hospitalization (inpatient and observation stays).		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the publication. NCQA website: www.ncqa.org . Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	Readmission to the hospital within 30 days of discharge is frequently avoidable and can lead to adverse outcomes for patients. Any preventable hospitalization can have a negative impact on health outcomes, particularly for older adults and adults with multiple chronic conditions. Health risks associated with hospitalization include infection, adverse drug events, loss of function, isolation, lower quality of life and readmission. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	Medicare Payment Advisory Commission. “Data Book: Health Care Spending and the Medicare Program.” Baltimore, MD: MedPAC, 2015. Available at https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-june-2015-report-to-the-congress-medicare-and-the-health-care-delivery-system-pdf/ Burke, R.E., E.A. Whitfield, D. Hittle, S.J. Min, C. Levy, A.V. Prochazka, E.A. Coleman, R. Schwartz, A.A. Ginde. 2016. “Hospital Readmission from Post-Acute Care Facilities: Risk Factors, Timing, and Outcomes.” <i>J Am Med Dir Assoc</i> 17(3):249–55. doi: 10.1016/j.jamda.2015.11.005 Hakkarainen, T.W., S. Arbabi, M.M. Willis, G.H. Davidson, D.R. Flum. 2016. “Outcomes of Patients Discharged to Skilled Nursing Facilities After Acute Care Hospitalizations.” <i>Ann Surg</i> 263(2):280–5. doi:10.1097/SLA.0000000000001367.		
Characteristics			
Scoring	Ratio.		
Product lines	• Commercial. • Medicaid. • Medicare.		

Stratifications	Age as of the index discharge date for commercial and Medicaid. • 18–44 years. • 45–54 years. • 55–64 years. Age as of the index discharge date for Medicare. • 18–44 years. • 45–54 years. • 55–64 years. • 65–74 years. • 75–84 years. • 18–64 years. • 85+ years. Skilled nursing facility. Age as of the index discharge date (Medicare only). • 65–74 years. • 75–84 years. • 85+ years. SES as of the end of the continuous enrollment period for each Medicare discharge (Medicare IHS only). (Refer to General Guideline Medicare Socioeconomic Status Stratification.) • Non-LIS/DE, Nondisability. • LIS/DE. • Disability. • LIS/DE and Disability. • Other. • Unknown.
Guidance	Programming Guidance Dual enrollment: Persons with dual commercial/Medicaid enrollment may only be reported in the commercial product line. Persons with dual Medicaid and Medicare enrollment may only be reported in the Medicare product line. Dual enrollment is assessed after the continuous enrollment criteria are applied. To meet criteria for dual enrollment, persons must have dual enrollment at the end of the continuous enrollment period. Facilities: The measure includes acute discharges from any type of facility (including behavioral health care facilities). Risk Adjustment Measure-Specific Guidance Observation stays: For observation stays (Observation Stay Value Set) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.

	Which services count? • Use all paid, suspended, pending, and denied claims when applying risk adjustment comorbidity category determination and the hospice exclusion. • Do not include denied claims when identifying all other events (e.g., the IHS in the PCR measure or observed events in the other risk adjusted utilization measures); only report claims the organization paid for or expects to pay for (i.e., claims incurred but not paid). Supplemental data exceptions: Supplemental data may only be used for the hospice exclusion. Transfers: • Treat transfers <i>between</i> institutions as separate admissions. • Base transfer reports <i>within</i> an institution on the type and level of services provided. • Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/substance use disorder treatment services and non-mental health/substance use disorder treatment services. • Count only one admission when the transfer takes place within the same service category, but to a different level of care (e.g., from intensive care to a lesser level of care; from a lesser level of care to intensive care). Risk adjustment: Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for these measures. The measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification. General Rules Data collection methodology: Administrative. (Refer to General Guideline Data Collection Methods for additional information.) Date specificity: Dates must be specific enough to determine the event occurred in the period being measured. Other guidance: The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person. Improvement notation: To interpret the rate as better or worse than expected, the rate must be calibrated. Organizations can calibrate rates by dividing individual organization rates or national percentiles by the national average rate. Organizations may be more successful at achieving fewer readmissions than expected, given the types of cases treated by the organization (calibrated rate with a value <1.0), or may be less successful (calibrated rate with a value >1.0).
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Definitions	
Direct transfer	When the discharge date from the initial stay precedes the admission date to a subsequent stay by 1 calendar day or less. • <i>For example:</i> – A discharge on June 1, followed by a subsequent admission on June 1 or June 2, <i>is a direct transfer</i>. – A discharge on June 1, followed by a subsequent admission on June 3, <i>is not a direct transfer</i>; these are two distinct stays. – A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, <i>is a direct transfer</i>. Direct transfers may occur between different facilities between acute inpatient and observation, observation and acute inpatient or observation and observation.
IHS	Index hospital stay. An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement period, as identified in the denominator.
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 period.
Index readmission stay	An acute inpatient or observation 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 step 3 (exclusions) of the numerator.
Plan population	Persons in the initial population prior to exclusion of outliers. The plan population is only used as a denominator for the outlier rate. Persons must be 18 years and older as of the earliest index discharge date. The plan population is based on persons, not on discharges. Count persons only once in the plan population. Assign persons to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest IHS. If there is a gap at the beginning of this continuous enrollment period, assign the person to the product/product line in which they were enrolled as of their first enrollment segment during this continuous enrollment period.
Outlier	Enrollees in Medicaid and Medicare in the initial population with four or more IHS between January 1 and December 1 of the measurement period. Commercial enrollees in the initial population with three or more IHS between January 1 and December 1 of the measurement period.

Nonoutlier Skilled nursing care discharge	When assigning outlier status, assign enrollees to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest IHS. If there is a gap at the beginning of the continuous enrollment period, assign enrollees to the product/product line in which they were enrolled as of their first enrollment segment during the continuous enrollment period. Medicaid and Medicare enrollees in the initial population with three or fewer IHS between January 1 and December 1 of the measurement period. Commercial enrollees in the initial population with two or fewer IHS between January 1 and December 1 of the measurement period. Step 1. For Medicare nonoutlier enrollees 65 years of age and older, determine if the IHS was discharged or transferred to skilled nursing care (<u>Skilled Nursing Stay Value Set</u>). An index stay is discharged or transferred to skilled nursing care when the discharge date from the acute inpatient or observation stay precedes the admission date for skilled nursing care by 1 calendar day or less. • <i>For example:</i> – An index stay discharge on June 1, followed by an admission to a skilled nursing setting on June 1 or June 2, <i>is an IHS</i> discharged or transferred to skilled nursing care. – An index stay discharge on June 1, followed by an admission to a skilled nursing setting on June 3, <i>is not an IHS</i> discharged or transferred to skilled nursing care. Step 2. Report Medicare discharges for each IHS discharged or transferred to skilled nursing care to an age group in Table PCR-C-3.
Initial population	<i>Measure item count:</i> Episode. <i>Attribution basis:</i> Enrollment. • <i>Benefits:</i> Medical. • <i>Continuous enrollment:</i> 365 days prior to the index discharge date through 30 days after the index discharge date. • <i>Allowable gap:</i> – <i>365 days to 1 day prior to the index discharge date:</i> No more than one gap of ≤45 days. – <i>Index discharge date and 30 days following the index discharge date:</i> None. <i>Ages:</i> • <i>Commercial and Medicaid:</i> 18–64 years as of the index discharge date. • <i>Medicare:</i> 18 years and older as of the index discharge date. <i>Gender/Sex criteria:</i> • Administrative Gender of Female (AdministrativeGender code female). • Administrative Gender of Male (AdministrativeGender code male).

	Exclusion: Persons in hospice or using hospice services. Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.
Denominator	Acute inpatient or observation stay discharges. Step 1. Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement period. To identify acute inpatient and observation stay discharges: 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>) and observation stays (<u>Observation Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the discharge date for the stay. Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are 2 or more calendar days apart must be considered distinct stays. Step 2. For discharges with one or more direct transfers, use the last discharge. Using the discharges identified in step 1, identify direct transfers using the definition of “direct transfer.” Exclude the hospital stay if the direct transfer’s discharge date occurs after December 1 of the measurement period. Step 3. Exclude hospital stays where the index admission date is the same as the index discharge date. Step 4. Exclude hospital stays for any of the following reasons: • The person died during the stay. • A principal diagnosis of pregnancy (<u>Pregnancy Value Set</u>) or a condition originating in the perinatal period (<u>Perinatal Conditions Value Set</u>) on the discharge claim. Note: For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step. Step 5. Calculate continuous enrollment. Step 6. Remove hospital stays for outliers and report these persons as outliers in Tables PCR-A-1/2 and PCR-A-3. Note: Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outliers. Step 7. Assign each remaining acute inpatient or observation stay to an age and stratification category using the reporting instructions below.
Risk adjustment factors	Risk Adjustment Determination For each IHS among nonoutliers, identify risk adjustment weights based on observation stay status at discharge, surgeries, discharge condition, COVID-19 discharge, comorbidity, age and gender. Weights are specific to product line (Medicare Under 65, Medicare 65+, commercial, Medicaid). Refer to the

reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.

Observation stay: Determine if the IHS at discharge was an observation stay (Observation Stay Value Set). For direct transfers, determine the hospitalization status using the last discharge.

Surgeries: Determine if the person underwent surgery during the stay. Consider an IHS to include a surgery if at least one procedure code (Surgery Procedure Value Set) is present from any provider between the admission and discharge dates.

Discharge condition: Assign a discharge condition category (CC) code or codes to the IHS based on its principal discharge diagnosis, using Table CC—Mapping. For direct transfers, use the principal discharge diagnosis from the last discharge.

Exclude diagnoses that cannot be mapped to Table CC—Mapping.

COVID-19 discharge: Assign a COVID-19 discharge code to the IHS if its principal discharge diagnosis was COVID-19 (ICD-10-CM code U07.1). For direct transfers, use the principal discharge diagnosis from the last discharge.

Comorbidities:

Step 1. Identify all diagnoses for encounters during the 365 days prior to and on the date of the index discharge date. Exclude the principal discharge diagnosis on the IHS. Include the following when identifying encounters:

- Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set) with a date of service in the period from 365 days before the index discharge date to (and including) the index discharge date.
- Acute and nonacute inpatient discharges (Inpatient Stay Value Set) with a discharge date in the period from 365 days before the index discharge date to (and including) the index discharge date.

Step 2. Assign each diagnosis to one or more comorbid CC using Table CC—Mapping in the Risk Adjustment Shared Tables. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.

Exclude all diagnoses that cannot be assigned to a comorbid CC. For denominator units with no qualifying diagnoses from face-to-face encounters, skip to *Risk Adjustment Calculation*.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

Step 3. Determine the hierarchical condition category (HCC) for each comorbid CC identified. Refer to Table HCC—Rank.

For each denominator unit's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group.
- The rank.
- The HCC.

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

Step 4. Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the “Rank” column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

- *For example*, assume a denominator unit with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs).
 - CC-85 does not have a map to the ranking table and becomes HCC-85.
 - HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.

The final comorbidities for this denominator unit are HCC-17 and HCC-85.

Table HCC—Rank

Ranking Group	CC	Description	Rank	HCC
NA	CC-85	Congestive Heart Failure	NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Chronic Complications	2	HCC-18
	CC-19	Diabetes Without Complications	3	HCC-19

Step 5. Identify combination HCCs listed in Table HCC—Comb.

Some combinations suggest a greater amount of risk when observed together.

- *For example*, when diabetes and CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each denominator unit’s list of unique HCCs to those in the *Comorbid HCC* columns in Table HCC—Comb and assign any additional HCCs.

If there are overlapping combinations, use both sets of combinations. Based on the combinations, a denominator unit can have none, one or more of these added HCCs.

- *For example*, for a denominator unit with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This *does not* replace HCC-17 and HCC-85.

	Table HCC—Comb				
	Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC- Combination	HCC-Comb Description
	HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
	HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
	HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
Risk adjustment	Risk Adjustment Calculation For each IHS among nonoutliers, use the following steps to identify risk adjustment weights based on observation stays status at discharge, surgeries, discharge condition, COVID-19, comorbidity, age and gender. Note: For Medicare product lines, IHS that are discharged or transferred to skilled nursing care should be assigned two sets of risk adjustment weights: the skilled nursing care risk weights for reporting in Table PCR-C-3 and the standard set of risk weights for reporting in Table PCR-A-3 and Table PCR-B-3. For reporting IHS that are discharged or transferred to skilled nursing care, do not assign the skilled nursing care risk weights for the stays when reporting in Table PCR-A-3 and Table PCR-B-3 and do not assign the standard set or risk weights for the stays when reporting in Table PCR-C-3. Step 1. For each IHS discharge that is an observation stay, link the observation stay IHS weight. Step 2. For each IHS with a surgery, link the surgery weight. Step 3. For each IHS with a discharge CC, link the primary discharge weights. Step 4. For each IHS with a comorbidity HCC, link the comorbidity weights. Step 5. For each IHS with a COVID-19 discharge, link the COVID-19 discharge weight. Step 6. Link the age and gender weights for each IHS. Step 7. Sum all weights (observation stay, presence of surgery, principal discharge diagnosis, comorbidities, COVID-19 discharge, age and gender) associated with the IHS and use the formula below to calculate the estimated readmission risk for each IHS: $\text{Estimated Readmission Risk} = \frac{e^{(\sum \text{WeightsForIHS})}}{1 + e^{(\sum \text{WeightsForIHS})}}$ OR $\text{Estimated Readmission Risk} = [\exp(\text{sum of weights for IHS})] / [1 + \exp(\text{sum of weights for IHS})]$ Note: “Exp” refers to the exponential or antilog function. Truncate the estimated readmission risk for each IHS to 10 decimal places. Do not truncate or round in previous steps.				

	Step 8. Calculate the count of expected readmissions for each age and stratification category. The count of expected readmissions is the sum of the estimated readmission risk calculated in step 7 for each IHS in each age and stratification category. $\text{Count of Expected Readmissions} = \sum (\text{Estimated Readmission Risk})$ Step 9. Use the formula below and the estimated readmission risk calculated in step 7 to calculate the variance for each IHS. Variance = Estimated Readmission Risk x (1 – Estimated Readmission Risk) Truncate the variance <i>for each IHS</i> to 10 decimal places. • <i>For example:</i> If the estimated readmission risk is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881475. Note: Organizations must sum the variances for each stratification and age when populating the Variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.
Numerator	At least one acute readmission for any diagnosis within 30 days of the index discharge date. Step 1. Identify all acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement period: 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>) and observation stays (<u>Observation Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the admission date for the stay. Step 2. Using the stays identified in step 1, identify direct transfers between acute inpatient and observation using the definition of direct transfer. Step 3. Exclude stays with any of the following criteria on the discharge claim: • A principal diagnosis of pregnancy (<u>Pregnancy Value Set</u>) or a condition originating in the perinatal period (<u>Perinatal Conditions Value Set</u>). • A planned stay using any of the following: – A principal diagnosis of maintenance chemotherapy (<u>Chemotherapy Encounter Value Set</u>). – A principal diagnosis of rehabilitation (<u>Rehabilitation Value Set</u>). – An organ transplant (<u>Kidney Transplant Value Set</u>, <u>Bone Marrow Transplant Value Set</u>, <u>Organ Transplant Other Than Kidney Value Set</u>, <u>Introduction of Autologous Pancreatic Cells Value Set</u>). – A potentially planned procedure (<u>Potentially Planned Procedures Value Set</u>) without a principal acute diagnosis (<u>Acute Condition Value Set</u>). Note: For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.

	Step 4. For each IHS identified in the denominator, determine if any of the stays identified in the numerator have an admission date within 30 days after the index discharge date. Note - Count each hospital stay only once toward the numerator for the last denominator event. - If a single numerator event meets criteria for multiple denominator events, only count the last denominator event. For example, consider the following events: - Acute inpatient stay 1: May 1–10. - Acute inpatient stay 2: May 15–25 (principal diagnosis of maintenance chemotherapy). - Acute inpatient stay 3: May 30–June 5. All three acute inpatient stays are included as denominator events. Stay 2 is excluded from the numerator because it is a planned hospitalization. Stay 3 is within 30 days of stay 1 and stay 2. Count stay 3 as a numerator event only toward the last denominator event (stay 2, May 15–25).
Summary of changes	- Replaced references to “chemical dependency” with “substance use disorder treatment.” This is an alignment with industry terminology, not a change to benefit requirements. - Added examples of facility types to the definition of <i>direct transfers</i>. - Replaced references to “CC” with “condition category”; replaced references to “HCC” with “hierarchical condition category.” - Simplified hospital stay language in the numerator. - Modified the numerator criteria of Observed Measurement in the <i>Rules for Allowable Adjustments</i> to allow the follow-up time frame to be shortened.
Data element tables	Reporting: Number of persons in plan population Step 1. Determine the person’s age as of the earliest index discharge date. Step 2. Report the count of persons in the plan population for each age group as the PersonCount. Reporting: Number of outliers Step 1. Determine the person’s age as of the earliest index discharge date. Step 2. Report the count of outlier persons for each age group as the OutlierPersonCount. Calculated: Outlier rate The number of outlier persons (OutlierPersonCount) divided by the number of persons in the plan population (PersonCount), displayed as a permillage (multiplied by 1,000), for each age group and totals. Calculated by IDSS as the OutlierRate. Reporting: Denominator Count the number of IHS among nonoutlier persons for each age group. Report these values as the denominator.

Reporting: SES Stratifications (Medicare only)

Step 1. Determine the persons enrolled in Medicare SES stratifications as of the end of the continuous enrollment period for each Medicare discharge:

- *Non-LIS/DE, nondisability:* Person is eligible for Medicare due to age only (does not receive LIS, is not DE for Medicaid, does not have disability status).
- *LIS/DE:* Person is eligible for Medicare due to age and receives LIS (includes persons eligible for Medicare due to DE), does not have disability status.
- *Disability:* Person is eligible for Medicare due to disability status only.
- *LIS/DE and disability:* Person is eligible for Medicare, receives LIS and has disability status.
- *Other:* Person has ESRD-only status or is assigned “9—none of the above.”
- *Unknown:* Person’s SES is unknown.

Step 2. Report Medicare discharges based on the SES stratification assigned for each Medicare index stay in Table PCR-B-3.

Reporting: Skilled nursing care stratification (Medicare 65+ only)

Report Medicare discharges for each IHS discharged or transferred to skilled nursing care to an age group in Table PCR-C-3.

Reporting: Numerator

Count the number of observed IHS among nonoutlier persons with a readmission within 30 days of discharge for each age group and report these values as the ObservedCount.

Calculated: Observed readmission rate

The count of observed 30-day readmissions (ObservedCount) divided by the count of index stays (Denominator) for each age group and totals. Calculated by IDSS as the ObservedRate.

Reporting: Count of expected 30-day readmissions

Step 1. Calculate the count of expected readmissions among nonoutliers for each age group.

Step 2. Round to 4 decimal places using the .5 rule and report these values as the ExpectedCount.

Calculated: Expected readmissions rate

The count of expected 30-day readmissions (ExpectedCount) divided by the count of index stays (Denominator) for each age group and totals. Calculated by IDSS as the ExpectedRate.

Reporting: Variance

Step 1. Calculate the total (sum) variance (*Risk Adjustment Calculation*, step 9) for each SES stratification (Medicare only), skilled nursing stratification (Medicare only) and age group.

Step 2. Round to 4 decimal places using the .5 rule and report these values as the CountVariance.

Calculated: O/E ratio

The count of observed 30-day readmissions (ObservedCount) divided by the count of expected 30-day readmissions (ExpectedCount) for each age group and totals. Calculated by IDSS as the OE. The O/E ratio is not calculated for SES stratification.

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table PCR-A-1/2: Data Element for Plan All-Cause Readmissions

Metric	Age	Data Element	Reporting Instructions
PlanAllCauseReadmissions	18-44	PersonCount	For each Stratification
	45-54	OutlierPersonCount	For each Stratification
	55-64	OutlierRate	OutlierPersonCount / PersonCount (Per mille)
	18-64	Denominator	For each Stratification
		ObservedCount	For each Stratification
		ObservedRate	ObservedCount / Denominator (Percent)
		ExpectedCount	For each Stratification
		ExpectedRate	ExpectedCount / Denominator (Percent)
		CountVariance	For each Stratification
		OE	ObservedCount / ExpectedCount

Table PCR-A-3: Data Elements for Plan All-Cause Readmissions

Metric	Age	Data Element	Reporting Instructions
PlanAllCauseReadmissions	18-44	PersonCount	For each Stratification
	45-54	OutlierPersonCount	For each Stratification
	55-64	OutlierRate	OutlierPersonCount / PersonCount (Per mille)
	18-64	Denominator	For each Stratification
	65-74	ObservedCount	For each Stratification
	75-84	ObservedRate	ObservedCount / Denominator (Percent)
	85+	ExpectedCount	For each Stratification
	65+	ExpectedRate	ExpectedCount / Denominator (Percent)
		CountVariance	For each Stratification
		OE	ObservedCount / ExpectedCount

Table PCR-B-3: Data Elements for Plan All-Cause Readmissions by SES Stratifications

Metric	SES Stratifications	Age	Data Element	Reporting Instructions
PlanAllCauseReadmissions	NonLisDeNondisability	18-64	Denominator	For each Stratification
	LisDe	65+	ObservedCount	For each Stratification
	Disability		ObservedRate	ObservedCount / Denominator (Percent)
	LisDeAndDisability		ExpectedCount	For each Stratification
	Other		ExpectedRate	ExpectedCount / Denominator (Percent)
	Unknown		CountVariance	For each Stratification

Table PCR-C-3: Data Elements for Plan All-Cause Readmissions for Skilled Nursing Care Stratifications

Metric	Age	Data Element	Reporting Instructions
SkilledNursingCare	65-74	Denominator	For each Stratification
	75-84	ObservedCount	For each Stratification
	85+	ObservedRate	ObservedCount / Denominator (Percent)
	65+	ExpectedCount	For each Stratification
		ExpectedRate	ExpectedCount / Denominator (Percent)
		CountVariance	For each Stratification
		OE	ObservedCount / ExpectedCount

Rules for Allowable Adjustments

Copyright and use: The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

The measures under the Risk Adjusted Utilization domain allow two types of *Rules for Allowable Adjustments* sections:

1. *Rules for Allowable Adjustments for Risk-Adjusted Measurement.* This section must be followed for adjustments when calculating the full measure specifications, which includes all risk adjusted rates (expected rates, risk adjustment, O/E) and calculation components (count of index stays, observed events).

2. *Rules for Allowable Adjustments for Observed Measurement (rates without risk adjustment)*. This section must be followed when adjusting the calculation of observed events only. When applying these adjustments, organizations must not include risk adjustment logic.

The intent of including two types of Rules is to allow organizations to adjust measures without compromising measure validity. Risk adjustment is based on statistical prediction models specifically calibrated to each measure.

The following are the Rules for Allowable Adjustments for Risk-Adjusted Measurement of the Plan All-Cause Readmissions measure (count of index stays, count of observed 30-day readmissions, observed readmission rate, risk adjustment determination, risk adjustment weighting, count of expected 30-day readmissions, O/E).

ADJUSTMENTS ALLOWED

- *Benefits*. Organizations are not required to use a benefit.
- *Plan population*. Organizations are not required to use plan population to identify outlier rates.
- *Telehealth*. Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

ADJUSTMENTS ALLOWED WITH LIMITS

- *Other*. Organizations may only adjust the initial population criteria to focus on an area of interest defined by gender, sociodemographic characteristics or geographical region. NCQA recommends evaluating risk model performance and validity within adjusted populations. Organizations may not adjust for a clinical subpopulation (e.g., persons with a diabetes diagnosis).
- *Measurement period adjustments*. Organizations may only change the measurement period by 1 year.
- *SES stratification, skilled nursing care stratification*. Stratifications are not required, but if they are used the value sets, logic and product lines may not be changed.
- *Outlier*. Organizations may include denied claims to calculate these events. Organizations may not adjust the outlier logic.
- *Denominator*. Organizations may include denied claims to calculate denominator events. Value sets and logic may not be changed.
- *Risk adjustment determination, risk adjustment weighting, expected readmissions, variance*. Organizations may include denied claims to calculate these events. Risk adjustment determinations, weighting, expected readmissions, variance and calculations of expected events logic may not be changed.
- *Numerator*. Organizations may include denied claims to calculate the numerator. Value sets and logic may not be changed.

ADJUSTMENTS NOT ALLOWED

- *Product lines.* Organizations may not adjust product lines.
- *Attribution.* Organizations are required to use enrollment criteria.
- *Ages.* The age determination dates may not be changed.
- *Supplemental data.* Supplemental data may not be used to identify initial population, denominator and numerator events.
- *Exclusions.* The hospice exclusion must be applied. Logic may not be changed.

The following are the Rules for Allowable Adjustments for Observed Measurement of the Plan All-Cause Readmissions measure observed events (count of index stays, count of observed 30-day readmissions, observed readmission rate).

ADJUSTMENTS ALLOWED

- *Product lines.* When adjusting this measure to assess for observed events only, organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Ages.* The observed event age range may be expanded. Age determination dates may be changed (e.g., select, "age as of June 30").
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may adjust the initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* Hospice exclusion is not required.
- *Outlier.* Organizations may adjust the outlier logic. The outlier logic is not required to be applied. The outlier thresholds may be expanded or reduced. Denied claims may be used to calculate these events.
- *Plan population.* Organizations are not required to use plan population to identify outlier rates.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

ADJUSTMENTS ALLOWED WITH LIMITS

- *SES stratification, skilled nursing care stratification.* Stratifications are not required, but if they are used, the value sets, logic and product lines may not be changed.

	• <i>Denominator.</i> Organizations may include denied claims to calculate denominator events. Value sets and logic may not be changed. • <i>Numerator.</i> Organizations may include denied claims to calculate the numerator. The timing of the acute hospitalization may be shortened to any time between 2 and 30 days post IHS (assessing for readmissions that occur within 7 days or within 14 days). Value sets and logic may not be changed.
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