



# Unplanned Readmissions

## Based on MIPS 2026 All-Cause, Unplanned Hospital-Wide Readmission (HWR) Measure

### What is it?

- Rate of unplanned readmissions to a hospital within 30 days of an eligible inpatient stay
- Includes Medicare FFS beneficiaries aged 65 or older
- Calculated using claims data
- Risk-standardized

### Why?

- Care coordination across the episode of care can reduce readmission rates
- Encourages effective discharge planning and care transitions
- Unplanned readmissions often reflect a poor beneficiary experience
- Readmissions are costly

### How You Are Scored

#### Denominator

- Medicare FFS Beneficiaries discharged alive from an acute inpatient stay
- Excludes in-hospital deaths, transfers, discharges against medical advice, cancer hospitals and admissions, and admissions for psychiatric disease or for rehabilitation

#### Numerator

- Unplanned inpatient readmissions to a short-stay acute-care or critical access hospital within 30 days of discharge
- Planned readmissions excluded

### Risk Adjustment

- Five specialty cohort regression models estimated using prior-year comorbidities and clinical factors (estimated using only Maryland Medicare FFS claims)
- Standardized readmission ratios (SRRs) calculated as observed-to-expected ratios of readmissions for each entity & specialty cohort
- Single summary score calculated by aggregating entity-cohorts to entities using a weighted average of SRRs, and multiplying the entity ratio by the average observed readmission rate in Maryland

- *See next slide for more details.*



# HWR Specialty Cohorts

## Used for Modeling, Not Separate Scoring

### Purpose of Clinical Cohorts

- Specialty cohorts are used only for risk adjustment and aggregation
- They ensure clinicians are compared to clinically similar cases
- Entities receive one final HWR score, not multiple category scores

### Goal

- To have fewer unplanned readmissions than would be expected for patients with similar clinical risk.
- *These categories exist to make the math fair, not to divide or rank entities.*

### CMS-Defined Clinical Cohorts

- Cardiorespiratory
- Cardiovascular
- Medicine
- Neurology
- Surgical/Gynecology

### How Cohorts Are Applied

- Cohort assignment is based on admission type, not reported specialty
- An NPI may contribute to more than one cohort
- Each cohort is modeled separately, then combined.

### How Scores Roll Up

- Cohort results are combined into one NPI-level score
- NPI scores are aggregated to calculate one entity-level HWR score.
- Entities are not scored by cohort or specialty.



# Advanced Care Plan (MIPS #047)

## What is it?

This quality measure evaluates the percentage of patients aged 65 and older who have:

- An **advance care plan** or a **surrogate decision maker** documented in their medical record, or
- Documentation of a discussion about advance care planning, even if the patient declined or was unable to provide a plan.

## Why?

- Helps establish medical treatment preferences prior to incapacity, reducing decision-making uncertainty.
- Enhances care coordination, reduces errors, and aligns treatment with patient goals.

## How You Are Scored

### Denominator:

- Patients aged 65+ with specific eligible encounters (CPT/HCPCS codes).

### Numerator:

- Patients with documented plans, surrogates, or discussions.

## Submission Codes

### 1123F:

- An advance care plan or a surrogate decision maker is documented in the medical record.

### 1124F:

- An Advanced care plan was discussed but patient did not wish or was not able to provide an advanced care plan or a surrogate decision maker.

*\*The EQIP quality metrics are measured ONLY through claims data.*

*\*The quality measures only needs to be billed once by any practitioner to receive credit.*



# Documentation of Current Medications in the Medical Record (MIPS #130)

## What is it?

Measures the percentage of visits for patients aged 18+ where clinicians document a complete medication list.

Includes prescriptions, over-the-counter drugs, herbals, vitamins, and dietary supplements with the name, dosage, frequency, and route of administration.

## Why?

Accurate medication lists are critical for reducing adverse drug events (ADEs) and promoting patient safety.

Minimizes risks of medication errors, especially for older adults and those with chronic conditions.

## How You Are Scored

**Denominator:** All visits for patients aged 18+ with eligible encounter codes (e.g., CPT, HCPCS).

**Numerator:**

- Documented, updated, or reviewed medication list at the time of the encounter.
- Includes medications reported by patients, caregivers, or other sources.

## Submission Codes

**G8427:** Medication list documented, updated, or Performance Met). reviewed

**G8430:** Patient not eligible (e.g., emergent situation) (Denominator Exception).

**G8428:** Medication list not documented, reason not given (Performance Not Met).



# Preventive Care and Screening: Body Mass Index (BMI)

## Screening and Follow-up Plan (MIPS #128)

### What is it?

BMI documented during the current or past 12 months. Normal range is 18.5-24.9 kg/m<sup>2</sup>

Follow up plan recorded if BMI is outside normal parameters.

- Nutrition counseling.
- Referral to specialists (e.g., dietitians, exercise physiologists).
- Pharmacological interventions or dietary supplements.
- Behavioral or exercise therapy.

### Why?

Addresses obesity and underweight issues to prevent related complications like diabetes, cardiovascular diseases, and malnutrition.

Supports the goal of population health improvement and healthcare cost reduction through preventive care.

### Submission Codes

#### Performance Met Codes:

- **G8420:** BMI within normal range, no follow-up needed.
- **G8417:** BMI above normal, follow-up documented.
- **G8418:** BMI below normal, follow-up documented.

#### Exceptions and Non-Compliance:

- **G2181:** BMI not documented due to patient refusal or medical reasons.
- **G8419:** BMI outside normal range, no follow-up documented, no reason given.

### How You Are Scored

#### Denominator:

- Patients aged 18+ with an eligible encounter during the measurement period (specific CPT/HCPCS codes).
- Exclusions:
  - Patients in hospice or palliative care.
  - Pregnant patients.

#### Numerator

- BMI documented as:
  - **Normal:** No follow-up plan required.
  - **Above or Below Normal:** Follow-up plan documented for the current or prior 12 mons