

**Measure Information Form 2025 Performance
Period for the Hospital-wide, 30-Day, All-cause
Unplanned Readmission (HWR) Measure for the
Merit-based Incentive Payment System (MIPS)
Groups**

**Performance Year (PY) 2025 HWR Measure
Specifications**

January 1 – December 31, 2025



A. Measure Name

Hospital-wide, 30-Day, All-cause Unplanned Readmission (HWR) Measure for the Merit-based Incentive Payment System (MIPS) Groups.

B. Measure Description

The Hospital-wide, 30-Day, All-cause Unplanned Readmission (HWR) Measure for the Merit-based Incentive Payment System (MIPS) Groups is a risk-standardized readmission rate for Medicare Fee-for-Service (FFS) beneficiaries aged 65 or older who were hospitalized and experienced an unplanned readmission for any cause to a short-stay acute-care hospital within 30 days of discharge. The measure attributes readmissions to MIPS participating clinicians and/or clinician groups, as identified by their National Provider Identifiers (NPIs) and Taxpayer Identification Number (TIN) and assesses each clinician group's readmission rate.

C. Rationale

Some readmissions are unavoidable, but others may result from poor quality of care, inadequate coordination of care, or lack of effective discharge planning and transitional care. The Centers for Medicare & Medicaid Services (CMS) is applying this measure to MIPS and continuing to attribute outcomes to clinician groups, because reducing avoidable readmissions is a key component in the effort to promote more efficient, high-quality care.

D. Measure Outcome

Some readmissions are unavoidable, but others may result from poor quality of care, inadequate coordination of care, or lack of effective discharge planning and transitional care. The Centers for Medicare & Medicaid Services (CMS) is applying this measure to MIPS and continuing to attribute outcomes to clinician groups, because reducing avoidable readmissions is a key component in the effort to promote more efficient, high-quality care.

The outcome for this measure is any unplanned readmission to a non-federal, short-stay, acute-care or critical access hospital within 30 days of discharge from an index admission. The identification of planned readmissions is discussed in Section H. Readmissions during the 30-day period that are considered planned or follow a planned readmission are not counted in the outcome. In the case of multiple readmissions during the 30-day period, only one of the readmissions would be counted for the outcome. If a patient is readmitted to the same hospital on the same calendar day of discharge for the same condition as the index admission, the measure considers the patient to have had one single continuous admission (that is, one index admission). However, if the condition is different from the index admission, this is considered a readmission in the measure.

E. Population Measured (Denominator)

Eligible index admissions include acute care hospitalizations for Medicare Fee-for-Service (FFS)

beneficiaries aged 65 or older at non-federal, short-stay, acute-care or critical access hospitals that were discharged during the performance period. Beneficiaries must have been enrolled in Medicare FFS Part A for the 12 months prior to the date of admission and 30 days after discharge, discharged alive, and not transferred to another acute care facility. Admissions for all principal diagnoses are included unless identified as having a reason for exclusion. A hospitalization that counts as a readmission for a prior stay also may count as a new index admission if it meets the criteria for an index admission.

For the purposes of measure calculation (described in Section H), index admissions are assigned to one of five specialty cohorts - surgery/gynecology, medicine, cardiorespiratory, cardiovascular, and neurology - based on diagnoses and procedure codes on the claim mapped to Agency for Healthcare Research and Quality (AHRQ) Clinical Classifications Software (CCS); Section I provides a link to methodology reports and code tables that contain the detailed CCS categories for each cohort.

F. Exclusions

Hospitalizations are generally excluded from the denominator if the beneficiary was:

- Discharged against medical advice
- Hospitalized in a prospective payment system-exempt cancer hospital
- Hospitalized primarily for medical treatment of cancer
- Hospitalized primarily for a psychiatric disease
- Hospitalized for rehabilitation
- Was not able to be attributed to a clinician group
- Not continuously enrolled in Medicare Part A FFS for at least 12 months prior to the index admission and 30 days following discharge from the index admission; or
- With a principal or a secondary diagnosis code of COVID-19 coded as present on admission (POA) on the index admission claim.
- Note: A comprehensive list of all exclusions, including excluded CCS diagnosis codes, is available via links provided in Section I.

G. Data Collection Approach and Measure Calculation

This measure is calculated from Medicare FFS claims (Part A) and Medicare beneficiary enrollment data; no additional data submission is required. The measure uses one year of inpatient claims to identify eligible admissions and readmissions, as well as up to one-year prior of inpatient data to collect diagnoses for risk adjustment. The measure uses Part A and B final action claims from the performance period to attribute beneficiaries to TINs as described in Section H.

H. Methodological Information and Measure Construction

Attribution. The measure attributes readmissions to up to three clinician groups to account for the

reality that multiple health care roles can influence readmissions. The following three types of clinician groups are included in the multiple attribution approach.

- **Discharge Clinician Group:** The group of the clinicians responsible for discharging the patient, determined by identifying a claim for a discharge procedure code which occurred within the last three days of the hospital stay
- **Primary Inpatient Care Provider Group:** The group of the clinicians responsible for the patient's medical care, determined as the clinician who billed the most charges for the patient during the hospitalization
- **Outpatient Primary Care Physician Group:** The group of the clinicians responsible for the patient's care outside of the hospital, determined as the clinician who provides the greatest number of claims for primary care services during the 12 months prior to the hospitalization

Though an admission may be attributed to up to three distinct clinician groups, two or even all three of the above roles for a given patient may be filled by clinicians assigned to the same clinician group. In such cases, the admission is included only once when measuring the clinician group.

All attributed admissions are used to construct a single score for an eligible clinician group. For example, a clinician group can have admissions attributed to them in multiple capacities – for instance, clinicians from the same group may be both a Discharge Clinician for some patients and a Primary Inpatient Care Provider for others.

Planned readmissions. This measure does not count hospitalizations that are considered planned in the outcome. Planned readmissions are identified based on the following three principles: (1) some types of care are always considered planned (transplant surgery, maintenance chemotherapy, rehabilitation); (2) otherwise, a planned readmission is defined as a non-acute readmission for a scheduled procedure; and (3) admissions for acute illness or for complications of care are never planned.

Specialty Cohorts. All admissions are classified into one of five different 'specialty cohorts': medicine, neurological, cardiovascular, cardiorespiratory, and surgery/gynecology. Principal discharge diagnosis categories (as defined by AHRQ CCSs) are used to define the specialty cohorts.

Risk adjustment and measure construction. Since the measure can assign each admission to multiple eligible clinician groups, the hierarchical logistic regression methods of the original MIPS All-Cause Readmission (ACR) measure and the Hospital Inpatient Quality Reporting (IQR) HWR measure could not be adapted to adjust for differences in eligible clinician group case mix and to account for the clustering of patients within a provider. Instead, a two-step approach is used to account for clustering of patients.

Five specialty cohort models adjust for case mix differences among providers by risk adjusting for patients' comorbid conditions identified in inpatient episodes of care for the 12 months prior to the index admission as well as those present at admission. These models include different risk factors, and do not risk adjust for diagnoses that may have been a complication of care during the index admission. CMS's complication or comorbidity codes are used as the grouper to define most

comorbid risk adjusters and risk variables are used across the different specialty cohort models. Principal discharge diagnosis categories (as defined by AHRQ CCSs) that were used to define the specialty cohorts are included to adjust for service mix differences.

The five specialty cohort models are used to calculate the ratio of observed to expected numbers of readmissions for each clinician group in each specialty cohort. These standardized readmission ratios (SRRs) are then used to estimate the between-provider variance. This parameter is then used to adjust each SRR, creating a ‘smoothed rate.’ A single summary score is derived from the results of the five specialty cohort models by calculating the volume-weighted log average of the SRRs from each model and multiplying the resulting ratio by the average national observed readmission rate.

I. For Further Information

To access additional measure specifications and the code tables referenced in Sections E, F and J, please visit <https://qpp.cms.gov/resources/resource-library>. Additional specifications information and rationale on the HWR measure as used in CMS’s Hospital IQR Program and adapted for MIPS, is available on <https://qualitynet.cms.gov/>.

J. References

1. Horwitz L, Partovian C, Lin Z, et al. Hospital-Wide All-Cause Risk-Standardized Readmission Measure: Measure Methodology Report. Prepared for the Centers for Medicare and Medicaid Services. New Haven, CT: Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation, 2011. (Original methodology report)
2. Herrin J, Altaf F, Suter L, et al. Measure Methodology Report: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System Program (MIPS) Groups. Prepared for the Centers for Medicare and Medicaid Services. New Haven, CT: Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation, 2020. (Last updated methodology report)
3. DeBuhr J, Grady J, Norton E, et al. 2024 Hospital-Wide Readmission Measure Updates and Specifications Report – Version 13. Prepared for the Centers for Medicare and Medicaid Services. New Haven, CT: Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation, 2024. (Updated annually and available in the Spring on <https://qualitynet.cms.gov/> for CMS’s Hospital IQR Program)