# MSSP Quality Metrics 2026

If you are an ACO REACH office, you do not need to attend today's session

If you are not part of the MSSP program, you do not need to attend today's session

# Seven Quality Metrics for MSSP

Today's session will focus on the first three metrics

1. Preventative Care and Screening: Screening for Depression and Follow-Up Plan
2. Hospital-wide, 30-Day, All-cause Unplanned Readmission (HWR)
3. Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC)

MSSP Metrics you are already familiar with and being reviewed in other Quality Spotlight Sessions:

4. Diabetes: Glycemic Status Assessment Greater than 9%
5. Breast Cancer Screening
6. Colorectal Cancer Screening
7. Controlling High Blood Pressure

# Preventative Care and Screening: Screening for Depression and Follow-Up Plan

## Denominator:

All patients aged 12 years and older (**FFS Medicare)** at the beginning of the performance period with **at least one qualifying visit during the performance period**

## Numerator:

Patients **screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter**

- Using an age-appropriate standardized tool AND if POSITIVE *a follow-up plan is documented on the date of or up to two days after the date* of the qualifying encounter

**Exclusion : Bipolar Disorder Diagnosis** (G9717)

# What does this mean?

Depression screening should occur on all FFS MSSP patients once yearly. Who have had at least one visit that calendar year.

Telehealth eligible in appropriate setting

# Screening for Depression & Follow-Up Plan Requirements:

Depression screening is **required once per measurement period**, not at all encounters

An age-appropriate, standardized, and validated depression screening tool must be used and **name of tool used must be documented in the medical record**

Documentation of a specific score is not required, but the **results of the depression screening tool must indicate whether the screening is considered positive or negative**.

Documented follow-up for a **positive depression** screening **must include one or more** of the following:

- o Referral to a provider for additional evaluation and assessment
- o Pharmacological interventions
- o Other interventions or follow-up for the diagnosis or treatment of depression

A suicide risk assessment or additional screening using a standardized tool will **not** qualify as a follow-up plan

# Examples of standardized depression screening tools include but are not limited to:

## Adult Screening Tools (18 years and older)

Patient Health Questionnaire (PHQ-9)

Beck Depression Inventory (BDI or BDI-II)

Center for Epidemiologic Studies Depression Scale (CES-D)

Depression Scale (DEPS)

Duke Anxiety- Depression Scale (DADS)

Geriatric Depression Scale (GDS)

Cornell Scale for Depression in Dementia (CSDD)

PRIME MD-PHQ-2

Hamilton Rating Scale for Depression (HAM-D)

Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)

Computerized Adaptive Testing Depression Inventory (CAT-DI)

Computerized Adaptive Diagnostic Screener (CAD-MDD)

# The Follow-Up Plan Must be Related to a Positive Depression Screening

**MUST be provided for and discussed** with the patient **during the visit that the screening is attributed to**

**Documentation** of the follow-up plan can occur **up to two calendar days** after the qualifying encounter (visit), in accordance with the policies of provider's practice

Additional screening and assessment during the qualifying encounter WILL NOT qualify as a follow-up plan. Ie; Suicide assessment & other screening

# The Follow-Up Plan Must be Related to a Positive Depression Screening

Examples of a follow-up plan include but are not limited to:

- Referral to a provider or program for further evaluation for positive depression screening
  - Referral Examples:
    - psychiatrist, psychiatric nurse practitioner, CoCare, psychologist, clinical social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression
- Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options

"Patient referred for psychiatric evaluation due to positive depression screening."

# Coding for Depression Screening & Follow Up Plan

*Performance Met:* Screening for depression is documented as being positive AND a follow-up plan is documented **(G8431)**

OR

*Performance Met:* Screening for depression is documented as negative, a follow-up plan is not required **(G8510)**

OR

*Denominator Exception:* Screening for depression not completed, documented patient or medical reason **(G8433)**

OR

*Performance Not Met:* Depression screening not documented, reason not given **(G8432)**

OR

*Performance Not Met:* Screening for depression documented as positive, follow-up plan not documented, reason not given **(G8511)**

# Best Practices for Depression Screening & Follow-Up Plan

- Integrate a standardized, validated depression screening tool (e.g.,PHQ-9) screening into annual wellness visits and new patient appointments.
- Train clinical staff on proper administration and scoring of screening tools.
- Provide screenings in the patient's preferred language when available.
- Allow patients to complete screenings electronically or on paper in the waiting room before the visit to streamline workflow.
- For positive screens, document a follow up plan such as referral to behavioral health (CoCare where available), initiation or adjustment of treatment, safety planning, or additional follow-up plan such as referral to behavioral health, initiation or adjustment of treatment, safety planning, or additional evaluation.
- Use warm handoffs to behavioral health when available.

# Key Goals & Takeaways for the Next Two Measures: HWR & MCC

Proactively prevent patient events such as unplanned admissions & readmissions

Ensure timely follow up & ongoing management after an any patient event

Manage these patients frequently- use your extended teams

Proactively refer to office care managers & care coordinators or Honest's clinical programs

**Keep high risk patients out of hospital and emergency room**

Use tools & strategies for which patients to watch and proactively manage

Start palliative care discussions early in disease process

# Hospital-wide, 30-Day, All-Cause Unplanned Readmission (HWR)

Denominator:

- Eligible index admissions include acute care hospitalizations for Enrolled in Medicare Fee-for-Service (FFS)
- Aged 65 or older
- Discharged from a non-federal, short-stay, acute-care or critical access hospitals
- Enrolled in Medicare Part A for the 12 months prior to the date of admission and 30 days after discharge
- Did not die in the hospital
- 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

Numerator:

**Any unplanned readmission** to a non-federal, short-stay, acute care or critical access **hospital within 30 days of discharge** from an index admission

# What does this mean?

Measured as a risk-standardized readmission rate for any patient in the denominator that readmits for any unplanned reason within 30 days of discharge

Some avoidable readmissions may be the result of inadequate coordination of care or less than optimal transitions of care.  This is a great aspect to focus efforts.

# HWR Best Practices

1. Keep **open appointments** so patients who are discharged from the hospital can be seen within seven to fourteen days of discharge or sooner as needed.

   If patients **have not** scheduled their discharge follow-up appointment, **reach out and schedule** an appointment.

2. **Perform transitional care management** for recently discharged patients.
3. Complete a **thorough medication reconciliation** and ask patients or caregivers to share the care plan back to you to demonstrate understanding. Ensure all medications were filled.
4. **Ask about barriers or issues** that might have contributed to patients' hospitalization and discuss how to prevent them in the future (SDOH–NDOH)
5. **Ask patients if they completed or scheduled** prescribed outpatient workups or other services.

   This could include *physical therapy*, *home health care visits* and *obtaining durable medical equipment*.

# HWR Best Practices (continued)

7. **Consider implementing a post-discharge process to track, monitor and follow up with patients.**
   - Develop process to determine which patients missed TCM appts
     - Develop auto referral process to care manager or care coordinator immediately for phone call billing
   - TCM appt marked in schedule so all staff know this is high priority if patient calls office
   - If patient calls to reschedule
     - Educate whoever takes the cancelation calls to reschedule immediately or refer to care manager or care coordinator immediately for phone call billing
8. **Target high risk** patients for
   - Proactively providing “extra” care management engagement
     - Two care management touchpoints reduces ED visits by 54% & admissions by 45%
   - Proactively providing “extra” NDOH (SDOH) screening at each visit or via phone
   - Proactively providing “extra” medication reconciliation work at each visit or via phone
   - Proactively discussing palliative care options
   - Referral to Honest Health Clinical programs
     - Provide warm handoff when able to promote patient engagement to the program
     - If not referring certain patients, determine how you will provide the “extra” management to those patients

# Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC)

**Denominator:**

Patient is 65+, alive at the start of the measurement period and has **two or more of nine chronic condition disease groups** in the **year prior** to the measurement period:

- Acute myocardial infarction (AMI)
- Alzheimer's disease and related disorders or senile dementia
- Atrial fibrillation
- Chronic kidney disease (CKD)
- Chronic obstructive pulmonary disease (COPD) and asthma
- Depression
- Diabetes
- Heart failure
- Stroke and transient ischemic attack (TIA)

**Numerator:**

**The number of acute unplanned admissions per 100 pers**on-years* at risk for admission during the measurement period

* 100 person year is a calculation to determine the time patients are at risk for hospitalization.

# What Does This Measure Definition Mean?

Graded on any unplanned admission, NOT readmissions, of patients that have two or more of the listed chronic conditions and is risk standardized.

These patients are at high risk for admission often for PREVENTABLE exacerbations of chronic conditions.

Patients receiving optimal, coordinated high quality care should use fewer inpatient services than patients receiving fragmented inconsistent care.  This is a great aspect to be proactive with care.

# MCC Best Practices:

## Key to success is being PROACTIVE with these patients are high risk

Partner with your GLPO & Honest team to identify high risk patients who are eligible for care management.

- Utilize lists provided by Honest Health to target these patients
- Utilize the “grey exclamation points” on your Health Focus TCM tracker to target these patients
  - Proactively provide “extra” care management engagement
    - Two care management touchpoints reduces ED visits by 54% & admissions by 45%
  - Proactively provide “extra” NDOH (SDOH) screening at each visit or via phone
  - Proactively provide “extra” medication reconciliation work at each visit or via phone
  - Proactively discuss palliative care options
  - Refer to Honest Health Clinical programs
    - Provide warm handoff when able to promote patient engagement to the program
    - If not referring certain patients, determine how you will provide the “extra” management to those patients

Ensure you are following up with patients within 14 days of discharges for a TCM visit.

All strategies should anticipate and respond to patient’s needs and preferences

# Appendix
# Exclusions for Measures

# Preventative Care and Screening: Screening for Depression and Follow-Up Plan:

## Exclusions

Documentation stating the patient has had a diagnosis of **bipolar disorder**

Patient **refuses to participate** in or complete the depression screening

Documentation of **medical reason for not screening patient for depression**

(E.g., cognitive, functional, or motivational limitations that may impact accuracy of results;

Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status)

# Hospital-wide, 30-Day, All-Cause Unplanned Readmission (HWR): **Exclusions**

Discharged **against medical advice**

Hospitalized in a prospective payment system-exempt cancer hospital

Hospitalized primarily for **medical treatment of cancer or 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

With a **principal or a secondary diagnosis code of COVID-19 coded** as present on admission (POA) on the index admission claim

# What are considered planned admissions?

Defined as a non-acute readmission for a scheduled procedure

Some types of care are considered planned

transplant surgery, maintenance chemotherapy, rehabilitation.

Admissions for acute illness or for complications of care are NEVER PLANNED.

# Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC)

## Exclusions

**Planned** hospital admissions

Admissions that **occur directly from a skilled nursing facility**

Admissions that occur **within a 10-day "buffer period" after discharge from a hospital, SNF, or acute rehabilitation facility**

Admissions that occur after the patient has entered **hospice**

Admissions related to **complications from procedures or surgeries**

Admissions related to **accidents or injuries**

Admissions that **occur prior to the first visit with the assigned clinician** or clinician group

Admissions with a principal **discharge diagnosis of COVID-19**

# MCC **Exclusions** Continued…

- Patients without continuous enrollment in Medicare Part A or B during the measurement period
- Patients who were in **hospice** at any time during the year prior to the measurement year or at the start of the measurement year
- Patients who had no Evaluation & Management (E&M) visits to a MIPS eligible clinician type
- Patients attributed to hematologists and oncologists

# QUESTIONS??