2024 Measure Set Review (MSR): List of Measures

MSR Overview

The Measure Set Review (MSR) process, statutorily enabled by the Consolidated Appropriations Act, 2021 Public Law 116–260, is an annual opportunity to consider measures for removal from Centers for Medicare & Medicaid Services (CMS) quality programs. Battelle, the consensus-based entity (CBE), convenes interested parties across existing Pre-Rulemaking Measure Review (PRMR) committees for the purpose of discussing measures and developing recommendations for retention or removal from CMS quality programs.

MSR Measure Cycles

Battelle aims to strategically consider all measures used in CMS quality programs for MSR over the course of a 5-year period. To make the MSR process manageable, the portfolio has been divided into 3 cycles using the Cascade of Meaningful Measures as a guide (see Table 1). Battelle will publish the anticipated schedule for reviewing each cycle in the forthcoming update to the *Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review (PRMR) and Measure Set Review (MSR),* which will be posted for public comment on the PQM website in June 2024.

Table 1. Cycles of MSR measures

Cycle	Cascade of Meaningful Measures Priorities Covered	Description
Cycle A: Patient-Centered and Outcome-Focused Care	• Person-Centered Care • Chronic Conditions • Wellness and Prevention • Behavioral Health	This group of measures focuses on the individualized needs of patients, emphasizing personalized care plans, preventive measures, and chronic disease management.
Cycle B: Safety, Quality, and Equity in Health Care Delivery	• Safety • Seamless Care Coordination • Equity	This group of measures focuses on creating a safe, equitable, and coordinated health care environment.
Cycle C: Cost-Effectiveness and Efficiency in Health Care Utilization	• Affordability and Efficiency	This group of measures addresses the financial and operational aspects of health care delivery.

Based on input from 2023-2024 PRMR committee members and expressed interest in understanding the actionability and impact of resource-related measures, Battelle and CMS propose that the 2024 MSR process focus on the **Cycle C** measures.

Public Comment Instructions

To provide a comment on the list of measures, including suggestions for alternative/replacement measures listed in Appendix A, please go to https://p4qm.org/media/2656 and complete the comment form. You are welcome to submit attachments along with your comment form using the attachment function. When finished, select "submit". Note that the list in Appendix A includes 34 measures; the 35th measure for this year's MSR cycle will be determined by public comment.

Please note, your name and organization will be visible on the PQM website alongside your public comment after comments are posted.

Measures Selected for MSR Review

Within this cycle, we prioritized for discussion 34 measures used in CMS quality programs that participate in pre-rulemaking. The 34 measures share characteristics that align with the selection considerations described in the next section. We will review 35 measures during the 2024 MSR cycle; public comment will determine the 35th. Appendix A includes the measure descriptions and links to the CMS Measures Inventory (CMIT)[1] where additional details (e.g., measure type, specifications) on the selected measures may be found. Appendix B also includes the measure descriptions and links to CMIT[1] for Cycle C measures that were not prioritized for review this year. Please note that measure performance data were not reviewed as part of this initial selection process but will be reviewed as part of the MSR process. Battelle will analyze and evaluate these performance data for measures that are selected for MSR and publish summaries in publicly available preliminary assessments for public comment (estimated to be released in July) in advance of the MSR review meeting (estimated to take place late September/early October). At that meeting, committee members will vote to recommend measures for retention or removal from their respective programs.

Measure Group 1 (9 measures)

Measures in this first group meet at least one of the following selection considerations:

- **Questions surrounding actionability** where there seem to be a myriad of ways a measured entity might improve, or the ways are not well defined, or there may be many other reasons besides these ways that influence entity performance. The purpose of the review will be to ensure that measured entities have a well-articulated path to improvement.

[1] Please note that CMIT data are currently undergoing review and update.

- **Monitoring performance on established clinical guidelines** where the purpose of the review will be to determine whether there is still an opportunity for impact, and/or whether the reasons that measured entities are not compliant with established guidelines are well understood.

Measures are organized by program within each PRMR/MSR committee type (i.e., Clinician, Hospital, PAC/LTC).

Clinician

Merit-Based Incentive Payment System

1. (00033-01-C-MIPS) Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)
2. (00039-01-C-MIPS) Age Appropriate Screening Colonoscopy
3. (00076-02-E-MIPS) Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture
4. (00487-01-C-MIPS) Overuse of Imaging for the Evaluation of Primary Headache
5. (00101-01-C-MIPS) Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients
6. (00419-01-C-MIPS) Maternity Care: Elective Delivery (Without Medical Indication) at less than 39 Weeks (Overuse)

Medicare Part D Star Ratings

7. (00452-01-C-PARTD) MPF Price Accuracy

Hospital

Hospital Outpatient Quality Reporting

8. (00097-01-C-HOQR) Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
9. (00453-01-C-HOQR) MRI Lumbar Spine for Low Back Pain

Measure Group 2 (25 measures)

Measures in this second group meet at least one of the following selection considerations:

- **Questions surrounding actionability** where there seem to be more selective and well-defined ways a measured entity might improve, and fewer reasons besides these ways that influence entity performance than the measure in Group 1, but there is still an opportunity to ensure that measured entities have a well-articulated path to improvement.
- **Questions surrounding impact** where, as measures in a public reporting program, there is an opportunity to ensure that the measure has the potential for impact.
- **Potentially duplicative measure focus** across similar measures in the same or different quality reporting program. This group contains many emergency department (ED) utilization measures and readmission measures that may be candidates for alignment, harmonization, consolidation, or reduction.

- Measures are organized by program within each PRMR/MSR committee type (i.e., Clinician, Hospital, PAC/LTC).

Clinician

Merit-Based Incentive Payment Program

10. (00237-01-C-MIPS) Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older
11. (00237-02-C-MIPS) Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years
12. (00736-01-C-MIPS) Unplanned Hospital Readmission within 30 Days of Principal Procedure
13. (00737-01-C-MIPS) Unplanned Reoperation within the 30 Day Postoperative Period
14. (00543-01-C-MIPS) Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (lower score better)

Medicare Part C Star Ratings

15. (00561-02-C-PARTC) Plan All-Cause Readmissions

Hospital

Ambulatory Surgical Center Quality Reporting Program

16. (00045-01-C-ASCQR) All-Cause Hospital Transfer/ Admission
17. (00253-01-C-ASCQR) Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
18. (00345-02-C-ASCQR) Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures
19. (00346-02-C-ASCQR) Hospital Visits After Urology Ambulatory Surgical Center Procedures

Hospital Outpatient Quality Reporting Program

20. (00253-01-C-HOQR) Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
21. (00021-02-C-HOQR) Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy

Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program

22. (00021-01-C-PCHQR) Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
23. (00004-01-C-PCHQR) 30-Day Unplanned Readmissions for Cancer Patients

Rural Health Emergency Quality Reporting Program

24. (00253-01-C-REHQRP) Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

PAC/LTC

Home Health Quality Reporting Program

25. 00012-01-C-HHQR) Acute Care Hospitalization During the First 60 Days of Home Health (Claims-based)

26. (00233-01-C-HHQR) Emergency Department Use without Hospitalization During the First 60 days of Home Health (Claims-based)
27. (00210-05-C-HHQR) Discharge to Community - Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)
28. (00575-04-C-HHQR) Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH Quality Reporting Program

Inpatient Rehabilitation Facility Quality Reporting Program

29. (00575-01-C-IRFQR) Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program
30. (00576-01-C-IRFQR) Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program

Long-Term Care Hospital Quality Reporting Program

31. (00210-03-C-LTCHQR) Discharge to Community-Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
32. (00575-02-C-LTCHQR) Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)

Skilled Nursing Facility Quality Reporting Program

33. (00210-02-C-SNFQRP) Discharge to Community (DTC) - Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
34. (00575-03-C-SNFQRP) Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

Appendix A: Measure Descriptions and Links to Additional Measure Information for Cycle C Prioritized Measures for 2024 MSR

1. Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)

CMIT ID: 00033-01-C-MIPS
Description: Percentage of patients, aged 18 years and older, with a diagnosis of acute viral sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms.

2. Age-Appropriate Screening Colonoscopy

CMIT ID: 00039-01-C-MIPS
Description: The percentage of screening colonoscopies performed in patients greater than or equal to 86 years of age from January 1 to December 31.

3. Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture

CMIT ID: 00076-02-E-MIPS
Description: Percentage of female patients 50 to 64 years of age without select risk factors for osteoporotic fracture who received an order for a dual-energy x-ray absorptiometry (DXA) scan during the measurement period.

4. Overuse of Imaging for the Evaluation of Primary Headache

CMIT ID: 00487-01-C-MIPS
Description: Percentage of patients for whom imaging of the head (CT or MRI) is obtained for the evaluation of primary headache when clinical indications are not present.

5. Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients

CMIT ID: 00101-01-C-MIPS
Description: Percentage of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed in low-risk surgery patients 18 years or older for preoperative evaluation during the 12-month submission period.

6. Maternity Care: Elective Delivery (Without Medical Indication) at less than 39 Weeks (Overuse)

CMIT ID: 00419-01-C-MIPS
Description: Percentage of patients, regardless of age, who gave birth during a 12-month period, delivered a live singleton at< 39 weeks of gestation, and had elective deliveries (without medical indication) by cesarean birth or induction of labor.

7. MPF Price Accuracy

CMIT ID: 00452-01-C-PARTD
Description: A score comparing the prices members actually pay for their drugs to the drug prices the plan provided for this website (Medicare's Plan Finder Website). Higher scores are better because they mean the plan provided more accurate prices.

8. Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery

CMIT ID: 00097-01-C-HOQR
Description: This measure calculates the percentage of stress echocardiography, single photon emission computed tomography myocardial perfusion imaging (SPECT MPI), stress magnetic resonance imaging (MRI), or cardiac computed tomography angiography (CCTA) studies performed at hospital outpatient facility in the 30 days prior to an ambulatory non-cardiac, low-risk surgery performed at any location. The measure is calculated based on a one-year window of Medicare Claims; denominator studies can occur from July 01 through May 31 of each year. The measure has been publicly reported, annually, by the measure steward, the Centers for Medicare & Medicaid Services (CMS), since 2012, as a component of its Hospital Outpatient Quality Reporting (HOQR) Program.

9. MRI Lumbar Spine for Low Back Pain

CMIT ID: 00453-01-C-HOQR
Description: This measure evaluates the percentage of magnetic resonance imaging (MRI) of the lumbar spine studies for patients with low back pain performed in the outpatient setting where antecedent conservative therapy was not attempted prior to the MRI. Antecedent conservative therapy may include claim(s) for physical therapy in the 60 days preceding the lumbar spine MRI, claim(s) for chiropractic evaluation and manipulative treatment in the 60 days preceding the lumbar spine MRI, or claim(s) for evaluation and management at least 28 days but no later than 60 days preceding the lumbar spine MRI. The measure is calculated based on a one-year window of Medicare Claims. The measure has been publicly reported, annually, by the measure steward, the Centers for Medicare & Medicaid Services (CMS), since 2011, as a component of its Hospital Outpatient Quality Reporting (HOQR) Program.

10. Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older

CMIT ID: 00237-01-C-MIPS
Description: Percentage of emergency department visits for patients aged 18 years and older who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care provider who have an indication for a head CT.

11. Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older

CMIT ID: 00237-01-C-MIPS

Description: Percentage of emergency department visits for patients aged 18 years and older who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care provider who have an indication for a head CT.

12. Unplanned Hospital Readmission within 30 Days of Principal Procedure

CMIT ID: 00736-01-C-MIPS
Description: Percentage of patients aged 18 years and older who had an unplanned hospital readmission within 30 days of principal procedure.

13. Unplanned Reoperation within the 30 Day Postoperative Period

CMIT ID: 00737-01-C-MIPS
Description: Percentage of patients aged 18 years and older who had any unplanned reoperation within the 30 day postoperative period.

14. Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (lower score better)

CMIT ID: 00543-01-C-MIPS
Description: Percentage of patients who died from cancer receiving systemic cancer-directed therapy in the last 14 days of life.

15. Plan All-Cause Readmissions

CMIT ID: 00561-02-C-PARTC
Description: The percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days, for members 65 years of age and older using the following formula to control for differences in the case mix of patients across different contracts.

16. All-Cause Hospital Transfer/Admission

CMIT ID: 00045-01-C-ASCQR
Description: The percentage of ASC admissions (patients) who are transferred or admitted to a hospital upon discharge from the ASC.

17. Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

CMIT ID: 00253-01-C-ASCQR
Description: Rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of an outpatient colonoscopy among Medicare fee-for-service (FFS) patients aged 65 years and older.

18. Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures

CMIT ID: 00345-02-C-ASCQR

Description: The population included in the measure is Medicare FFS patients aged 65 years and older, undergoing outpatient orthopedic procedures at ASCs. The measure's outcome is any unplanned hospital visit (ED visit, observation stay, or unplanned inpatient admission) by a patient occurring within 7 days of an index procedure (a patient's initial procedure).

19. Hospital Visits After Urology Ambulatory Surgical Center Procedures

CMIT ID: 00346-02-C-ASCQR
Description: The measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of a urology surgery at an ASC among Medicare fee-for-service (FFS) patients aged 65 years and older.

20. Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

CMIT ID: 00253-01-C-HOQR
Description: Rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of an outpatient colonoscopy among Medicare fee-for-service (FFS) patients aged 65 years and older.

21. Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy

CMIT ID: 00021-02-C-HOQR
Description: The Admission and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy Measure, hereafter referred to as the chemotherapy measure, estimates hospital-level, risk-adjusted rates of inpatient admissions or ED visits for cancer patients greater than or equal to 18 years of age for at least one of the following diagnoses - anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia or sepsis-within 30 days of hospital-based outpatient chemotherapy treatment. Rates of admission and ED visits are calculated and reported separately.

22. Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy

CMIT ID: 00021-01-C-PCHQR
Description: The measure estimates hospital-level, risk-standardized rates of inpatient admissions or ED visits for cancer patients (excluding leukemia patients) ages 18 years or older for at least one of the following diagnoses - anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis - within 30 days of outpatient chemotherapy treatment at a short-stay, acute care hospital.

23. 30-Day Unplanned Readmissions for Cancer Patients

CMIT ID: 00004-01-C-PCHQR
Description: 30-Day Unplanned Readmissions for Cancer Patients measure is a cancer-specific measure. It provides the rate at which all adult cancer patients covered as Fee-for-

Service Medicare beneficiaries have an unplanned readmission within 30 days of discharge from an acute care hospital. The unplanned readmission is defined as a subsequent inpatient admission to a short-term acute care hospital, which occurs within 30 days of the discharge date of an eligible index admission and has an admission type of emergency or urgent.

24. Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

CMIT ID: 00253-01-C-REHQRP
Description: Facility-level risk-standardized rate of acute, unplanned hospital visits within 7 days of a colonoscopy procedure performed at a Rural Emergency Hospital among Medicare Fee-For-Service (FFS) patients aged 65 years and older. An unplanned hospital visit is defined as an emergency department (ED) visit, observation stay, or unplanned inpatient admission.

25. Acute Care Hospitalization During the First 60 Days of Home Health (Claims-based)

CMIT ID: 00012-01-C-HHQR
Description: Percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the home health stay.

26. Emergency Department Use without Hospitalization During the First 60 days of Home Health (Claims-based)

CMIT ID: 00233-01-C-HHQR
Description: Percentage of home health stays in which patients used the emergency department but were not admitted to the hospital during the 60 days following the start of the home health stay.

27. Discharge to Community - Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)

CMIT ID: 00210-05-C-HHQR
Description: Percentage of home health stays in which patients were discharged to the community and do not have an unplanned admission to an acute care hospital or LTCH in the 31 days and remain alive in the 31 days following discharge to community. The term community, for this measure, is defined as home/self-care, without home health services, based on Patient Discharge Status Codes 01 and 81 on the Medicare FFS claim.

28. Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH Quality Reporting Program

CMIT ID: 00575-04-C-HHQR
Description: Percentage of home health stays in which patients who had an acute inpatient discharge within the 30 days before the start of their home health stay and were admitted to

an acute care hospital or LTCH for unplanned, potentially preventable readmissions in the 30-day window beginning two days after home health discharge.

29. Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program

CMIT ID: 00575-01-C-IRFQR
Description: This set of potentially preventable readmission (PPR) measures for post-acute care (PAC) estimates the risk-standardized rate of unplanned, potentially preventable readmissions for patients (Medicare fee-for-service [FFS] beneficiaries) who receive services in one of the following post-acute care provider types: skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCH). This measure is conceptualized uniformly across the PAC settings, in terms of the definition of the PPR outcome, the approach to risk adjustment, and the measure calculation. These outcome measures reflect readmission rates for patients who are readmitted to a short-stay acute-care hospital or an LTCH with a principal diagnosis considered to be unplanned and potentially preventable.

30. Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program

CMIT ID: 00576-01-C-IRFQR
Description: This set of potentially preventable readmission (PPR) measures for post-acute care (PAC) estimates the risk-standardized rate of unplanned, potentially preventable readmissions for patients (Medicare fee-for-service [FFS] beneficiaries) who receive services in one of the following post-acute care provider types: skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCH). This measure is conceptualized uniformly across the PAC settings, in terms of the definition of the PPR outcome, the approach to risk adjustment, and the measure calculation. These outcome measures reflect readmission rates for patients who are readmitted to a short-stay acute-care hospital or an LTCH with a principal diagnosis considered to be unplanned and potentially preventable.

31. Discharge to Community-Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)

CMIT ID: 00210-03-C-LTCHQR
Description: This measure assesses successful discharge to the community from a PAC setting, with successful discharge to the community including no unplanned rehospitalizations and no death in the 31 days following discharge. This measure reports an LTCH's risk-standardized rate of Medicare FFS patients who are discharged to the community following an LTCH stay, and do not have an unplanned readmission to an acute care hospital or LTCH in the 31 days following discharge to community, and who remain alive during the 31 days following discharge to community. Community, for this measure, is defined as home/selfcare, with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, and 86 on the Medicare FFS claim.

32. Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)

CMIT ID: 00575-02-C-LTCHQR
Description: This set of potentially preventable readmission (PPR) measures for post-acute care (PAC) estimates the risk-standardized rate of unplanned, potentially preventable readmissions for patients (Medicare fee-for-service [FFS] beneficiaries) who receive services in one of the following post-acute care provider types: skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCH). This measure is conceptualized uniformly across the PAC settings, in terms of the definition of the PPR outcome, the approach to risk adjustment, and the measure calculation.

33. Discharge to Community (DTC) - Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

CMIT ID: 00210-02-C-SNFQRP
Description: This measure assesses successful discharge to the community from a PAC setting, with successful discharge to the community including no unplanned rehospitalizations and no death in the 31 days following discharge. Specifically, this measure reports a SNF's risk-standardized rate of Medicare FFS residents who are discharged to the community following a SNF stay, and do not have an unplanned readmission to an acute care hospital or LTCH in the 31 days following discharge to community, and who remain alive during the 31 days following discharge to community. Community, for this measure, is defined as home or self care, with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, and 86 on the Medicare FFS claim.

34. Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

CMIT ID: 00575-03-C-SNFQRP
Description: The risk-standardized rate of unplanned, potentially preventable readmissions for SNF Medicare FFS beneficiaries within 30 days of discharge from the SNF. (Measure Specifications for Measures Adopted in the FY 2017 SNF QRP Final Rule, Pg. 17-18)

Appendix B: Measure Descriptions and Links to Additional Measure Information for Cycle C Measures Not Prioritized for 2024 MSR

1. Abdomen Computed Tomography (CT) - Use of Contrast Material

CMIT ID: 00005-01-C-HOQR
Description: This measure calculates the percentage of abdomen and abdominopelvic computed tomography (CT) studies that are performed without and with contrast, out of all abdomen and abdominopelvic CT studies performed (those without contrast, those with contrast, and those with both) at each facility. The measure is calculated based on a one-year window of Medicare Claims. The measure has been publicly reported, annually, by the measure steward, the Centers for Medicare & Medicaid Services (CMS), since 2011, as a component of its Hospital Outpatient Quality Reporting (HOQR) Program.

2. Abdomen Computed Tomography (CT) Use of Contrast Material

CMIT ID: 00005-01-C-REHQRP
Description: This measure calculates the percentage of abdomen studies that are performed with and without contrast out of all abdomen studies performed (those with contrast, those without contrast, and those with both).

3. Appropriate Follow-up Imaging for Incidental Abdominal Lesions

CMIT ID: 00069-01-C-MIPS
Description: Percentage of final reports for imaging studies for patients aged 18 years and older with one or more of the following noted incidentally with a specific recommendation for no follow up imaging recommended based on radiological findings: Cystic renal lesion that is simple appearing* (Bosniak I or II) Adrenal lesion less than or equal to 1.0 cm Adrenal lesion greater than 1.0 cm but less than or equal to 4.0 cm classified as likely benign or diagnostic benign by unenhanced CT or washout protocol CT, or MRI with in- and opposed-phase sequences or other equivalent institutional imaging protocols.

4. Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients

CMIT ID: 00070-01-C-MIPS
Description: Percentage of final reports for computed tomography (CT), CT angiography (CTA) or magnetic resonance imaging (MRI) or magnetic resonance angiogram (MRA) studies of the chest or neck for patients aged 18 years and older with no known thyroid disease with a thyroid nodule < 1.0 cm noted incidentally with follow-up imaging recommended.

5. Appropriate Workup Prior to Endometrial Ablation

CMIT ID: 00077-01-C-MIPS

Description: Percentage of patients, aged 18 years and older, who undergo endometrial sampling or hysteroscopy with biopsy and results are documented before undergoing an endometrial ablation.

6. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

CMIT ID: 00084-01-C-MIPS
Description: The percentage of episodes for patients ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.

7. Cesarean Birth (eCQM)

CMIT ID: 00508-03-E-HIQR
Description: Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth.

8. Asthma/Chronic Obstructive Pulmonary Disease (COPD)

CMIT ID: 01626-01-C-MIPS
Description: The Asthma/COPD episode-based cost measure evaluates a clinician's or clinician group's risk-adjusted and specialty-adjusted cost to Medicare for patients who receive medical care to manage and treat asthma or COPD. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during an Asthma/COPD episode.

9. Diabetes

CMIT ID: 01628-01-C-MIPS
Description: The Diabetes episode-based cost measure evaluates a clinician's or clinician group's risk-adjusted and specialty-adjusted cost to Medicare for patients who receive medical care to manage and treat type 1 or type 2 diabetes. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Diabetes episode.

10. Hemodialysis Access Creation

CMIT ID: 01304-01-C-MIPS
Description: The Hemodialysis Access Creation episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who undergo a procedure for the creation of graft or fistula access for long-term hemodialysis during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This procedural measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from 60 days prior to the clinical event that opens, or "triggers," the episode through 90 days after the trigger.

11. Lower Gastrointestinal Hemorrhage

CMIT ID: 01593-01-C-MIPS
Description: The Lower Gastrointestinal Hemorrhage episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who receive inpatient non-surgical treatment for acute bleeding in the lower gastrointestinal tract during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This acute inpatient medical condition measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from the clinical event that opens, or "triggers," the episode through 35 days after the trigger.

12. Total Per Capita Cost

CMIT ID: 01414-02-C-MIPS
Description: The TPCC measures the overall cost of care delivered to a patient with a focus on the primary care they receive from their provider(s). The measure is a payment-standardized, risk-adjusted, and specialty-adjusted measure. The measure is attributed to clinicians, who are identified by their unique Taxpayer Identification Number and National Provider Identifier pair (TIN-NPI) and clinician groups, identified by their TIN number. The TPCC measure can be attributed at the TIN or TIN-NPI level. In all supplemental documentation, the term "cost" generally means the standardized1 Medicare allowed amount.

13. Facility-Level 7-Day Hospital Visits After General Surgery Procedures Performed at Ambulatory Surgical Centers

CMIT ID: 00254-01-C-ASCQR
Description: The measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of a general surgery at an ASC among Medicare fee-for-service (FFS) patients aged 65 years and older.

14. 30-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)

CMIT ID: 00003-01-C-IPFQR
Description: This facility-level measure estimates an unplanned, 30-day, risk-standardized readmission rate for adult Medicare fee-for-service (FFS) patients discharged from an inpatient psychiatric facility with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The performance period used to identify cases in the denominator is 24 months. Data from 12 months prior to the start of the performance period through the performance period are used to identify risk factors.

15. Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Acute Myocardial Infarction (AMI) Hospitalization

CMIT ID: 00015-01-C-HRRP
Description: This measure estimates a hospital-level, 30-day risk-standardized readmission rate (RSRR) for patients discharged from the hospital with a principal discharge diagnosis of acute myocardial infarction (AMI). Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. The Centers for Medicare & Medicaid Services (CMS) annually reports this measure for patients who are 65 years or older and are either Medicare fee-for-service (FFS) beneficiaries hospitalized in non-federal short-term acute care hospitals and critical access hospitals or VA beneficiaries hospitalized in VA facilities. The index admission is the eligible hospitalization to which the readmission outcome is attributed.

16. Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)

CMIT ID: 00034-01-C-MIPS
Description: Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis.

17. Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

CMIT ID: 00071-02-C-HOQR
Description: Percentage of patients aged 45 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.

18. Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

CMIT ID: 00071-02-C-ASCQR
Description: Percentage of patients aged 45 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

19. Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

CMIT ID: 00071-02-C-MIPS

Description: Percentage of patients aged 45 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

20. Appropriate Testing for Pharyngitis

CMIT ID: 00072-01-C-MIPS
Description: The percentage of episodes for patients 3 years and older with a diagnosis of pharyngitis that resulted in an antibiotic order on or within 3 days after the episode date and a group A Streptococcus (Strep) test in the seven-day period from three days prior to the episode date through three days after the episode date.

21. Appropriate Testing for Pharyngitis

CMIT ID: 00072-02-E-MIPS
Description: The percentage of episodes for patients 3 years and older with a diagnosis of pharyngitis that resulted in an antibiotic order on or within 3 days after the episode date and a group A Streptococcus (Strep) test in the seven-day period from three days prior to the episode date through three days after the episode date.

22. Appropriate Treatment for Patients with Stage I (T1c) - III HER2 Positive Breast Cancer

CMIT ID: 00073-01-C-MIPS
Description: Percentage of female patients aged 18 to 70 with stage I (T1c) - III HER2 positive breast cancer for whom appropriate treatment is initiated.

23. ST-Segment Elevation Myocardial Infarction (STEMI) Electronic Clinical Quality Measure (eCQM)

CMIT ID: 01625-01-E-HOQR
Description: The percentage of emergency department (ED) encounters for patients 18 years and older with a diagnosis of ST-segment elevation myocardial infarction (STEMI) that received appropriate treatment, defined as fibrinolytic therapy within 30 minutes of ED arrival, percutaneous coronary intervention (PCI) within 90 minutes of ED arrival, or transfer within 45 minutes of ED arrival.

24. Appropriate Treatment for Upper Respiratory Infection (URI)

CMIT ID: 00074-01-C-MIPS
Description: Percentage of episodes for patients 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic order.

25. Appropriate Treatment for Upper Respiratory Infection (URI)

CMIT ID: 00074-02-E-MIPS

Description: Percentage of episodes for patients 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic order.

26. Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use

CMIT ID: 00137-01-C-MIPS
Description: Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of prior adenomatous polyp(s) in previous colonoscopy findings, which had an interval of 3 or more years since their last colonoscopy.

27. Acute Kidney Injury Requiring New Inpatient Dialysis

CMIT ID: 01507-01-C-MIPS
Description: The Acute Kidney Injury Requiring New Inpatient Dialysis episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who receive their first inpatient dialysis service for acute kidney injury during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This procedural measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from the clinical event that opens, or "triggers," the episode through 30 days after the trigger.

28. Colon and Rectal Resection

CMIT ID: 01627-01-C-MIPS
Description: The Colon and Rectal Resection episode-based cost measure evaluates clinicians' risk-adjusted cost to Medicare for patients who receive colon or rectal resections for either benign or malignant indications during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This procedural measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during each episode from 15 days prior to the clinical event that opens or "triggers" the episode through 90 days after the trigger.

29. Elective Outpatient Percutaneous Coronary Intervention (PCI)

CMIT ID: 01510-01-C-MIPS
Description: The Elective Outpatient PCI episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who undergo elective outpatient PCI surgery to place a coronary stent for heart disease during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This procedural measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from the clinical event that opens, or "triggers," the episode through 30 days after the trigger.

30. Elective Primary Hip Arthroplasty

CMIT ID: 01596-01-C-MIPS
Description: The Elective Primary Hip Arthroplasty episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who receive an elective primary hip arthroplasty during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This procedural measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from 30 days prior to the clinical event that opens, or "triggers," the episode through 90 days after the trigger.

31. Femoral or Inguinal Hernia Repair

CMIT ID: 01589-01-C-MIPS
Description: The Femoral or Inguinal Hernia Repair episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who undergo surgical procedure to repair a femoral or inguinal hernia during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This procedural measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from 30 days prior to the clinical event that opens, or "triggers," the episode through 90 days after the trigger.

32. Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation

CMIT ID: 01588-01-C-MIPS
Description: The Inpatient COPD Exacerbation episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who receive inpatient treatment for an acute exacerbation of COPD during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This acute inpatient medical condition measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from the clinical event that opens, or "triggers," the episode through 60 days after the trigger.

33. Intracranial Hemorrhage or Cerebral Infarction

CMIT ID: 01509-01-C-MIPS
Description: The Intracranial Hemorrhage or Cerebral Infarction episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who receive inpatient treatment for cerebral infarction or intracranial hemorrhage during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This acute inpatient medical condition measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from the clinical event that opens, or "triggers," the episode through 90 days after the trigger.

34. Knee Arthroplasty

CMIT ID: 01514-01-C-MIPS
Description: The Knee Arthroplasty episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who receive an elective knee arthroplasty during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This procedural measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from 30 days prior to the clinical event that opens, or "triggers," the episode through 90 days after the trigger.

35. Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels

CMIT ID: 01590-01-C-MIPS
Description: The Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who undergo surgery for lumbar spine fusion during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This procedural measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from 30 days prior to the clinical event that opens, or "triggers," the episode through 90 days after the trigger.

36. Lumpectomy, Partial Mastectomy, Simple Mastectomy

CMIT ID: 01592-01-C-MIPS
Description: The Lumpectomy, Partial Mastectomy, Simple Mastectomy episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who undergo partial or total mastectomy for breast cancer during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This procedural measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from 30 days prior to the clinical event that opens, or "triggers," the episode through 90 days after the trigger.

37. Medicare Spending Per Beneficiary (MSPB) Clinician

CMIT ID: 00434-10-C-MIPS
Description: The MSPB Clinician measure assesses the cost to Medicare for services provided to a patient during an MSPB Clinician episode ("episode"), which comprises the period immediately before, during, and after the patient's hospital stay. An episode includes Medicare Part A and Part B claims with a start date between 3 days prior to a hospital admission (also known as the "index admission" for the episode) through 30 days after hospital discharge, excluding a defined list of services that are unlikely to be influenced by the clinician's care decisions and are, thus, considered unrelated to the index admission.

38. Melanoma Resection

CMIT ID: 01629-01-C-MIPS
Description: The Melanoma Resection episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who undergo an excision procedure to remove a cutaneous melanoma during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This procedural measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from 30 days prior to the clinical event that opens, or "triggers," the episode through 90 days after the trigger.

39. Non-Emergent Coronary Artery Bypass Graft (CABG)

CMIT ID: 01776-02-C-MIPS
Description: The Non-Emergent CABG episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who undergo a CABG procedure during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This procedural measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from 30 days prior to the clinical event that opens, or "triggers," the episode through 90 days after the trigger.

40. Renal or Ureteral Stone Surgical Treatment

CMIT ID: 01594-01-C-MIPS
Description: The Renal or Ureteral Stone Surgical Treatment episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who receive surgical treatment for renal or ureteral stones during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This procedural measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from 90 days prior to the clinical event that opens, or "triggers," the episode through 30 days after the trigger.

41. Revascularization for Lower Extremity Chronic Critical Limb Ischemia

CMIT ID: 01512-01-C-MIPS
Description: The Revascularization for Lower Extremity Chronic Critical Limb Ischemia episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who undergo elective revascularization surgery for lower extremity chronic critical limb ischemia during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This procedural measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from 30 days prior to the clinical event that opens, or "triggers," the episode through 90 days after the trigger.

42. Routine Cataract Removal with Intraocular Lens (IOL) Implantation

CMIT ID: 01515-01-C-MIPS
Description: The Routine Cataract Removal with IOL Implantation episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who undergo a procedure for routine cataract removal with IOL implantation during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This procedural measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from 60 days prior to the clinical event that opens, or "triggers," the episode through 90 days after the trigger.

43. Screening/Surveillance Colonoscopy

CMIT ID: 01118-01-C-MIPS
Description: The Screening/Surveillance Colonoscopy episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who undergo a screening or surveillance colonoscopy procedure during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This procedural measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from the clinical event that opens, or "triggers," the episode through 14 days after the trigger.

44. Sepsis

CMIT ID: 01386-02-C-MIPS
Description: The Sepsis episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who receive inpatient medical treatment for sepsis during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This acute inpatient medical condition measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from the clinical event that opens, or "triggers," the episode through 45 days after the trigger.

45. Simple Pneumonia with Hospitalization

CMIT ID: 01508-01-C-MIPS
Description: The Simple Pneumonia with Hospitalization episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who receive inpatient treatment for simple pneumonia during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This acute inpatient medical condition measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from the clinical event that opens, or "triggers," the episode through 30 days after the trigger.

46. ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)

CMIT ID: 01513-01-C-MIPS
Description: The STEMI with PCI episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who present with STEMI indicating complete blockage of a coronary artery who emergently receive PCI as treatment during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This acute inpatient medical condition measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode from the clinical event that opens, or "triggers," the episode through 30 days after the trigger.

47. Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival

CMIT ID: 00299-01-C-HOQR
Description: This measure calculates the percentage of acute ischemic stroke or hemorrhagic stroke patients who arrive at the ED within two hours of the onset of symptoms and have a head computed tomography (CT) or magnetic resonance imaging (MRI) scan interpreted within 45 minutes of ED arrival.

48. Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Heart Failure (HF) Hospitalization

CMIT ID: 00304-01-C-HRRP
Description: This measure estimates a hospital-level, 30-day risk-standardized readmission rate (RSRR) for patients discharged from the hospital with a principal discharge diagnosis of heart failure (HF). Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. The Centers for Medicare & Medicaid Services (CMS) annually reports this measure for patients who are 65 years or older and are either Medicare fee-for-service (FFS) beneficiaries hospitalized in non-federal short-term acute care hospitals and critical access hospitals or VA beneficiaries hospitalized in VA facilities. The index admission is the eligible hospitalization to which the readmission outcome is attributed.

49. Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction

CMIT ID: 00247-01-C-HIQR
Description: This measure estimates days spent in acute care (i.e., time spent in ED, unplanned readmission and observation stays) within 30 days of discharge from an inpatient hospitalization for AMI. This measure is intended to capture the quality of care transitions provided to patients discharged from the hospital with a principal discharge diagnosis of

acute myocardial infarction (AMI) by collectively measuring a set of adverse acute care outcomes that can occur post-discharge: 1) emergency department (ED) visits, 2) observation stays, and 3) unplanned readmissions at any time during the 30 days post-discharge. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. Days spent in each care setting are aggregated for the 30 days post-discharge with a minimum of half-day increments (e.g., an ED visit lasting 2 hours would be counted as 0.5 days). The Centers for Medicare & Medicaid Services (CMS) annually reports this measure for patients who are 65 years or older and are either Medicare fee-for-service (FFS) beneficiaries hospitalized in non-federal short-term acute care hospitals and critical access hospitals or VA beneficiaries hospitalized in VA facilities. The index admission is the eligible hospitalization to which the EDAC outcome is attributed.

50. Excess Days in Acute Care after Hospitalization for Heart Failure

CMIT ID: 00248-01-C-HIQR
Description: This measure estimates days spent in acute care (i.e. time spent in ED, unplanned readmission and observation stays) within 30 days of discharge from an inpatient hospitalization for HF. This measure is intended to capture the quality of care transitions provided to patients discharged from the hospital with a principal discharge diagnosis of heart failure (HF) by collectively measuring a set of adverse acute care outcomes that can occur post-discharge: 1) emergency department (ED) visits, 2) observation stays, and 3) unplanned readmissions at any time during the 30 days post-discharge. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. Days spent in each care setting are aggregated for the 30 days post-discharge with a minimum of half-day increments (e.g., an ED visit lasting 2 hours would be counted as 0.5 days). The Centers for Medicare & Medicaid Services (CMS) annually reports this measure for patients who are 65 years or older and are either Medicare fee-for-service (FFS) beneficiaries hospitalized in non-federal short-term acute care hospitals and critical access hospitals or VA beneficiaries hospitalized in VA facilities. The index admission is the eligible hospitalization to which the EDAC outcome is attributed.

51. Excess Days in Acute Care after Hospitalization for Pneumonia

CMIT ID: 00249-01-C-HIQR
Description: This measure estimates days spent in acute care (i.e. time spent in ED, unplanned readmission and observation stays) within 30 days of discharge from an inpatient hospitalization for pneumonia. This measure is intended to capture the quality of care transitions provided to patients discharged from the hospital with diagnosis coding that meets one of the two following requirements: 1. Principal discharge diagnosis of pneumonia; or, 2. a. Principal discharge diagnosis of sepsis (that is not severe); and b. A secondary diagnosis of pneumonia coded as present on admission (POA); and c. No secondary diagnosis of sepsis that is both severe and coded as POA. The quality of care transitions is captured by collectively measuring a set of adverse acute care outcomes that can occur post-discharge: 1) emergency department (ED) visits, 2) observation stays, and 3) unplanned readmissions at any time during the 30 days post-discharge. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. Days spent in each care setting are aggregated for the 30 days post-discharge with a minimum of

half-day increments (e.g., an ED visit lasting 2 hours would be counted as 0.5 days). The Centers for Medicare & Medicaid Services (CMS) annually reports this measure for patients who are 65 years or older and are either Medicare fee-for-service (FFS) beneficiaries hospitalized in non-federal short-term acute care hospitals and critical access hospitals or VA beneficiaries hospitalized in VA facilities. The index admission is the eligible hospitalization to which the EDAC outcome is attributed.

52. Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Coronary Artery Bypass Graft (CABG) Surgery

CMIT ID: 00337-01-C-HRRP
Description: This measure estimates a hospital-level, 30-day risk-standardized readmission rate (RSRR) for patients discharged from the hospital after a qualifying isolated coronary artery bypass graft (CABG) surgery. Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. The Centers for Medicare & Medicaid Services (CMS) annually reports this measure for patients who are 65 years or older and are Medicare fee-for-service (FFS) beneficiaries hospitalized in non-federal short-term acute care hospitals and critical access hospitals. The index admission is the eligible hospitalization to which the readmission outcome is attributed.

53. Hospital-Level, 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization

CMIT ID: 00351-01-C-HRRP
Description: This measure estimates a hospital-level, 30-day risk-standardized readmission rate (RSRR) for patients discharged from the hospital with either a principal discharge diagnosis of Chronic Obstructive Pulmonary Disease (COPD) or a principal discharge diagnosis of acute respiratory failure with a secondary discharge diagnosis of COPD with exacerbation. Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. The Centers for Medicare & Medicaid Services (CMS) annually reports this measure for patients who are 65 years or older and are either Medicare fee-for-service (FFS) beneficiaries hospitalized in non-federal short-term acute care hospitals and critical access hospitals or VA beneficiaries hospitalized in VA facilities. The index admission is the eligible hospitalization to which the readmission outcome is attributed.

54. Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Hospitalization

CMIT ID: 00349-01-C-HRRP
Description: This measure estimates a hospital-level, 30-day risk-standardized readmission rate (RSRR) for patients discharged from the hospital after an elective primary total hip

arthroplasty (THA) and/or total knee arthroplasty (TKA). Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. The Centers for Medicare & Medicaid Services (CMS) annually reports this measure for patients who are 65 years or older and are either Medicare fee-for-service (FFS) beneficiaries hospitalized in non-federal short-term acute care hospitals and critical access hospitals or VA beneficiaries hospitalized in VA facilities. The index admission is the eligible hospitalization to which the readmission outcome is attributed.

55. Hospital-Level Risk-Standardized Payment Associated with a 30-Day Episode of Care for Acute Myocardial Infarction (AMI)

CMIT ID: 00352-02-C-HIQR
Description: This measure estimates a hospital-level, risk-standardized payment for an AMI episode of care starting with an inpatient admission and extending 30 days from the start of that index admission for patients discharged from the hospital with a principal discharge diagnosis of acute myocardial infarction (AMI). The Centers for Medicare & Medicaid Services (CMS) annually reports this measure for patients who are 65 years or older and are Medicare fee-for-service (FFS) beneficiaries hospitalized in non-federal short-term acute care hospitals and critical access hospitals. The index admission is the hospitalization that begins the episode of care payment window.

56. Hospital-Level Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF)

CMIT ID: 00353-01-C-HIQR
Description: This measure estimates a hospital-level, risk-standardized payment for an HF episode of care starting with an inpatient admission and extending 30 days from the start of that index admission for patients discharged from the hospital with a principal discharge diagnosis of heart failure (HF). The Centers for Medicare & Medicaid Services (CMS) annually reports this measure for patients who are 65 years or older and are Medicare fee-for-service (FFS) beneficiaries hospitalized in non-federal short-term acute care hospitals and critical access hospitals. The index admission is the hospitalization that begins the episode of care payment window.

57. Hospital-Level Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF)

CMIT ID: 00353-01-C-HIQR
Description: This measure estimates a hospital-level, risk-standardized payment for an HF episode of care starting with an inpatient admission and extending 30 days from the start of that index admission for patients discharged from the hospital with a principal discharge diagnosis of heart failure (HF). The Centers for Medicare & Medicaid Services (CMS) annually reports this measure for patients who are 65 years or older and are Medicare fee-for-service (FFS) beneficiaries hospitalized in non-federal short-term acute care hospitals

and critical access hospitals. The index admission is the hospitalization that begins the episode of care payment window.

58. Hospital-Level Risk-Standardized Payment Associated with a 90-Day Episode-of-Care for Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty

CMIT ID: 00355-01-C-HIQR
Description: This measure estimates a hospital-level, risk-standardized payment for an elective primary total hip and/or knee arthroplasty (THA/TKA) episode of care starting with an inpatient admission and extending 90 days from the start of that index admission for patients discharged from the hospital after a THA/TKA. The Centers for Medicare & Medicaid Services (CMS) annually reports this measure for patients who are 65 years or older and are Medicare fee-for-service (FFS) beneficiaries hospitalized in non-federal short-term acute care hospitals and critical access hospitals. The index admission is the hospitalization that begins the episode of care payment window.

59. Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data

CMIT ID: 00356-07-C-HIQR
Description: This measure estimates a hospital-level, risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission within 30 days of hospital discharge for any eligible condition. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts based on groups of discharge condition categories or procedure categories: surgery/gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology. The outcome is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission (the admission included in the measure cohort). A specified set of readmissions are planned and do not count in the readmission outcome. The target population is Medicare Fee-for-Service (FFS) beneficiaries who are 65 years or older, and hospitalized in non-federal short-term acute care hospitals and critical access hospitals. This Hybrid HWR measure is a re-engineered version of the HWR measure 1789, the Hospital-Wide Readmission Measure, which was developed for patients 65 years and older using Medicare claims and is currently publicly reported in the Hospital Inpatient Quality Reporting Program. This reengineered measure uses clinical data elements from the electronic health record in addition to Claims for risk adjustment.

60. Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Groups

CMIT ID: 00356-09-C-MIPS
Description: This measure is a re-specified version of the measure, “Risk-adjusted readmission rate (RARR) of unplanned readmission within 30 days of hospital discharge for any condition” (NQF 1789), which was developed for patients 65 years and older using Medicare claims. This re-specified measure attributes outcomes to MIPS participating

clinician groups and assesses each group's readmission rate. The measure comprises a single summary score, derived from the results of five models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): medicine, surgery/gynecology, cardio-respiratory, cardiovascular, and neurology.

61. Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)

CMIT ID: 00356-03-C-HIQR
Description: This measure estimates a hospital-level, 30-day risk-standardized readmission rate (RSRR) for patients discharged from the hospital after an admission for any eligible condition. Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. The Centers for Medicare & Medicaid Services (CMS) annually reports this measure for patients who are 65 years or older and are either Medicare fee-for-service (FFS) beneficiaries hospitalized in non-federal short-term acute care hospitals and critical access hospitals or VA beneficiaries hospitalized in VA facilities. This measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts based on groups of discharge condition categories or procedure categories: surgery/gynecology; general medicine; cardiorespiratory; cardiovascular; and neurology. The measure also calculates the hospital-level standardized risk ratios (SRR) for each of these five specialty cohorts. The index admission is the eligible hospitalization to which the readmission outcome is attributed.

62. Medicare Spending Per Beneficiary (MSPB) – Hospital

CMIT ID: 00434-12-C-HIQR
Description: The measure evaluates hospitals' efficiency relative to the efficiency of the national median hospital and assesses the cost to Medicare for Part A and Part B services performed by hospitals and other healthcare providers during an MSPB Hospital episode, which is comprised of the periods 3-days prior to, during, and 30-days following a patient's hospital stay. The measure is not condition specific and uses standardized prices when measuring costs. Eligible beneficiary populations include beneficiaries enrolled in Medicare Parts A and B who were discharged between January 1 and December 1 in a calendar year from short-term acute hospitals paid under the Inpatient Prospective Payment System.

63. Total Estimated Medicare Spending Per Beneficiary (MSPB)

CMIT ID: 00434-06-C-HHQR
Description: The assessment of the Medicare spending of a home health agency's MSPB-PAC HH episodes, relative to the Medicare spending of the national median home health agency s MSPB-PAC HH episodes across the same performance period. Note: An MSPB-PAC HH measure score of less than 1 indicates that a given home health agency s resource use is less than that of the national median home health agency during the same performance period.

64. Medicare Spending per Beneficiary (MSPB) - Post-Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

CMIT ID: 00434-04-C-SNFQRP
Description: The MSPB measure evaluates SNFs resource use relative to the resource use of the national median SNF. The measure assesses the Medicare spending performed by the SNF and other healthcare providers during an MSPB episode. The measure is calculated as the ratio of the payment-standardized, risk-adjusted MSPB Amount for each SNF divided by the episode-weighted median MSPB Amount across all SNFs.

65. Medicare Spending Per Beneficiary (MSPB) - Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP)

CMIT ID: 00434-05-C-IRFQR
Description: This measure evaluates IRF providers' efficiency relative to the efficiency of the national median IRF provider. Specifically, the measure assesses the cost to Medicare for services performed by the IRF provider during an MSPB-PAC IRF episode. The measure is calculated as the ratio of the price-standardized, risk-adjusted MSPB-PAC amount for each IRF divided by the episode-weighted median MSPB-PAC amount across all IRF providers.

66. Medicare Spending Per Beneficiary (MSPB)-Post-Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)

CMIT ID: 00434-03-C-LTCHQR
Description: The MSPB measure evaluates LTCHs resource use relative to the resource use of the national median LTCH. The measure assesses the Medicare spending performed by the LTCH and other healthcare providers during an MSPB episode. The measure is calculated as the ratio of the payment-standardized, risk-adjusted MSPB Amount for each LTCH divided by the episode-weighted median MSPB Amount across all LTCHs.

67. Non-Recommended Cervical Cancer Screening in Adolescent Females

CMIT ID: 00464-01-C-MIPS
Description: The percentage of adolescent females 16-20 years of age who were screened unnecessarily for cervical cancer.

68. Otitis Media with Effusion: Systemic Antimicrobials - Avoidance of Inappropriate Use

CMIT ID: 00486-01-C-MIPS
Description: Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials.

69. Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Pneumonia Hospitalization

CMIT ID: 00568-01-C-HRRP
Description: This measure estimates a hospital-level, 30-day risk-standardized readmission rate (RSRR) for patients discharged from the hospital with diagnosis coding that meets one of the two following requirements: 1. Principal discharge diagnosis of pneumonia; or, 2. a. Principal discharge diagnosis of sepsis (that is not severe); and b. A secondary diagnosis of pneumonia coded as present on admission (POA); and c. No secondary diagnosis of sepsis that is both severe and coded as POA. Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. The Centers for Medicare & Medicaid Services (CMS) annually reports this measure for patients who are 65 years or older and are either Medicare fee-for-service (FFS) beneficiaries hospitalized in non-federal short-term acute care hospitals and critical access hospitals or VA beneficiaries hospitalized in VA facilities. The index admission is the eligible hospitalization to which the readmission outcome is attributed.

70. Home Health Within-Stay Potentially Preventable Hospitalization Measure

CMIT ID: 01222-02-C-HHQR
Description: This measure reports a home health agency (HHA)-level rate of risk-adjusted potentially preventable hospitalizations or observation stays that occur within a home health (HH) stay for all eligible stays at each agency.

71. Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

CMIT ID: 00614-01-C-MIPS
Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy who did not have a bone scan performed at any time since diagnosis of prostate cancer.

72. Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

CMIT ID: 00614-03-E-MIPS
Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy who did not have a bone scan performed at any time since diagnosis of prostate cancer.

73. Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-Based Incentive Payment System Program

CMIT ID: 01016-01-C-MIPS
Description: Annual risk-standardized rate of acute, unplanned cardiovascular-related admissions among Medicare Fee-for-Service (FFS) patients aged 65 years and older with heart failure (HF) or cardiomyopathy.