2024 Measure Set Review (MSR): Final Preliminary Assessment

The following information was sourced in June of 2024 from the Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), the PQM Submission Tool and Repository (STAR), discussions with CMS program leads, and publicly available CMS datasets (see links below).

I. Measure Information

CMIT ID	Title
00736-01-C-MIPS	Unplanned Hospital Readmission within 30 Days of Principal Procedure
Measure Steward	**CMS Program**
American College of Surgeons	Merit-Based Incentive Payment System Program (MIPS)

Measure Overview	
Rationale: This is an adverse surgical outcome, which is often a preventable cause of harm; thus, it is important to measure and report. This measure addresses the National Quality Strategy Priorities and was identified by an expert panel of physician providers to be a critical outcome for this procedure. This measure also addresses disparities in care. The measure allows measurement across the person-centered episode of care out to 30 days after the procedure, whether an inpatient, outpatient, or readmitted. The measure addresses disparities in care. The risk adjustment is performed with a parsimonious dataset and aims to allow efficient data collection resources and data reporting.	
Description: Percentage of patients aged 18 years and older who had an unplanned hospital readmission within 30 days of principal procedure.	
Numerator: Inpatient readmission to the same hospital for any reason or an outside hospital (if known to the surgeon), within 30 days of the principal surgical procedure. **Exclusions:** None	
Denominator: Patients aged 18 years and older undergoing a surgical procedure. **Exclusions:** None	
Measure type: Outcome	**Measure is a composite:** No **Measure is digital and/or an eCQM:** Yes (a MIPS CQM is considered a dQM).
Level(s) of analysis/measured entity: Clinician	**Care setting:** Acute care facilities/hospitals
Risk adjustment and/or stratification: No	**Data source(s):** Digital-Clinical Registry[1]

[1]Note from CMS program lead on MIPS CQMs: Data may be gathered from paper, electronic charts, or collected with the assistance of a third-party intermediary

Data collection method: Electronic health record (EHR)[2]	**Reporting frequency:** Procedure[3]
All required data are collected as part of clinical workflow: Yes, collected in EHR as part of care.	**Reporting overlap with similar/related measures:** 00356 is a measure of all-cause readmissions used in several programs outside MIPS. There are also all-cause readmission measures for pneumonia, heart failure, and acute myocardial infarction.
Does this measure fill a statutorily required category for the program? No	**Is this measure included in upcoming rulemaking?** No

Measure Status	
Current CBE Endorsement Status: Not Endorsed	**CBE Endorsement History:** None

II. Measure Performance[4]

00736-01-C-MIPS Performance in MIPS 2020-2022

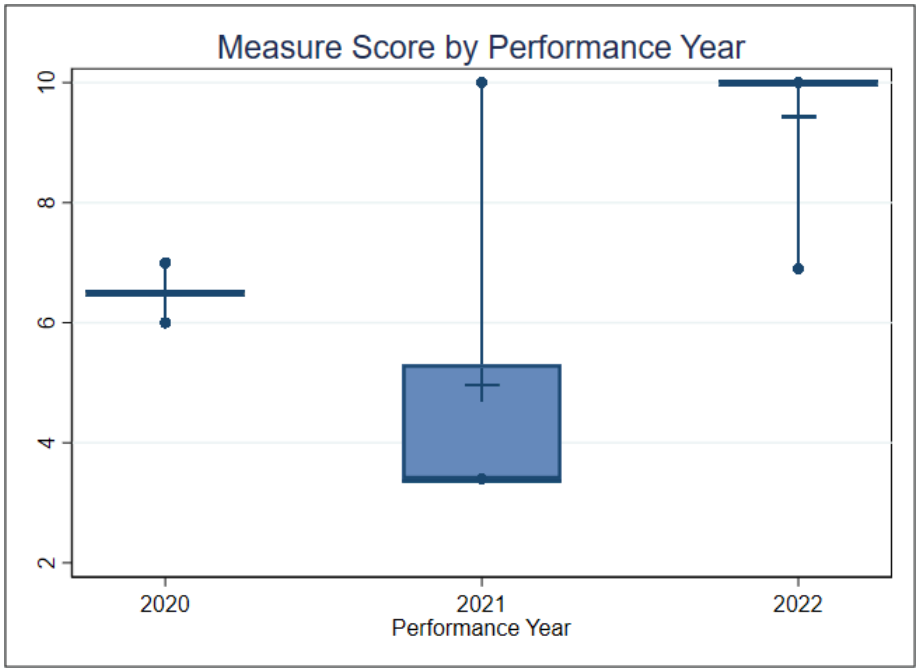
For this measure, the MSR evaluation and analysis team reviewed the following publicly available datasets at data.cms.gov: PY 2022 Clinician Public Reporting Overall MIPS Performance and the Quality Payment Program Experience.

Figure 1 is a boxplot that shows the distribution of the performance over the past 3 years (where available). For each performance year, the dots indicate the lower 5th and upper 95th percentiles, and the vertical line is the range between these values (90% of the measure scores are between the dots). The box spans the lower 25th to the upper 75th percentile (50% of the measure scores are within the box). The horizontal line in the box indicates the median score, and the "+" indicates the mean score. This plot can be used to assess overall trends in the score over time.

Interpretation: Figure 1 is a boxplot that shows that the median score decreased from about 6.5 in 2020 to about 3.5 in 2021 and then increased to 10 in 2022. The lower 25th percentile and the upper 75th percentile are the same in both 2020 and 2022, so no boxes appear for those years.

[2] Note from CMS program lead: Other data collection methods are available for use with MIPS CQMs depending on clinician/system workflow and who is collecting the data.
[3] Reporting frequency provided by CMS program lead. MIPS only allows reporting of data during the submission period January-March and ongoing reporting by episode, visit, or other defined frequency occurs during that period.
[4] Analyses presented in this PA may differ slightly from those conducted by MIPS program analysts due to variation in analytic methods. Additional resources and information about MIPS scoring and benchmarks are available at Quality Payment Program (QPP) (cms.gov).

Figure 1. Boxplot of Measure Score by Year



Importance Table

Table 1 shows the relative spread of the scores and can also be used to evaluate the impact of improving the score. For example, here, 8 of the 10 deciles have an average score of 10. Examining mean scores at the lower deciles shows the relative change required to achieve a score of 10. The impact could be significant if the 10% of the entities in Decile 1 were to achieve a score of 10, but there would be less of an impact if the 10% of the entities in Decile 2 achieved a score of 10.

Table 1. Importance (Decile by performance score, 2022)

Data Type	Overall	Min	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Max
Mean Score (SD)	9.43 (1.40)	3.00	6.04	8.31	10	10	10	10	10	10	10	10	10
Entities	507	4	51	51	51	50	51	51	50	51	51	50	426