

## Endorsement & Maintenance Intent to Submit

**Instructions:** This form can be used as a worksheet to assist you in developing your **Intent to Submit (ITS)** for a new or maintenance measure. When you are ready to submit, navigate to <https://p4qm.org/> and log into your PQM account (request a PQM account [here](#)). Once logged in, click “My Account” to go to your dashboard, then scroll to the bottom of the page and click on “Submit a Measure” to begin a new ITS. To return to a draft ITS, from your dashboard select *Intent to Submit Draft* from the “Endorsement Cycle Status” drop-down list and click “Apply” to see your measures. Click [here](#) for more information on the Endorsement & Maintenance measure submission process. The ITS online submission tool is open annually, at least 2 months prior to the respective cycle’s ITS submission deadline.

- You must complete all required fields (denoted by **\***) to submit the final ITS
- You may save a draft of the ITS form before completing all required fields

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Substantive updates to the ITS form for the Fall 2024 cycle:

- New fields: Age Group (1.15d and 1.15e)
- Fields moved from the Full Measure Submission (FMS) form to ITS: Section 6.1, Use (6.1.1 Current Status; 6.1.2–6.1.3 Current/Planned Use; 6.1.4 Program Details)
- There is no longer the option to submit the Quality Measure Developer and Steward Agreement (QMDSA) form later (A.9)

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### Endorsement and Maintenance (E&M) Cycle **\***

*Select the intended measure review cycle for endorsement consideration.*

#### **Fall 2025**

ITS deadline: Wednesday,  
October 1st, 2025

Full Submission deadline:  
Monday, November 3rd, 2025

☐ Fall 2025

#### **Spring 2025**

ITS deadline: Tuesday, April  
1st, 2025

Full Submission deadline:  
Thursday, May 1st, 2025

☐ Spring 2025

#### **Fall 2024**

ITS deadline: Tuesday,  
October 1st, 2024

Full Submission deadline:  
Friday, November 1st, 2024

☒ Fall 2024

## 1. Measure Information

### 1.1 New or Maintenance \*

Select whether this is a new measure or maintenance measure. If this is a maintenance measure, provide the consensus-based entity (CBE) ID number as “0123”, or “0123e” for an eCQM. Measures seeking initial endorsement will be assigned a CBE ID after ITS.

☐ New☒ Maintenance

#### [If a maintenance measure] 1.1a Provide CBE ID \*

Start by typing CBE ID or measure title and select an autocomplete option

### 1.2 Measure Title \*

The measure title should include the type of score (e.g., rate, count, composite), the measure focus, and the target population. Title example: The rate [type of score] of 30-day all-cause mortality [measure focus] among patients discharged from an acute inpatient facility with a diagnosis of acute myocardial infarction [target population].

Hybrid Hospital-Wide (All-Condition, All-Procedure) Risk-Standardized Mortality Measure with Claims and Electronic Health Record Data

### 1.3 Measure Description \*

Briefly describe the type of score, measure focus, target population, and timeframe. **Note:** there are separate fields below for the numerator and denominator.

Hybrid Hospital-Wide (All-Condition, All-Procedure) Risk-Standardized Mortality Measure with Claims and Electronic Health Record Data measure estimates a hospital-level 30-day risk-standardized mortality rate (RSMR), defined as death from any cause within 30 days after the index admission date for Medicare fee-for-service and Medicare Advantage patients who are between the ages of 65 and 94.

Index admissions are assigned to one of 15 clinically cohesive and mutually exclusive divisions: six surgical divisions and nine non-surgical divisions, based on the reason for hospitalization. The surgical divisions are: Surgical Cancer (includes a surgical procedure and a principal discharge diagnosis code of cancer), Cardiothoracic Surgery, General Surgery, Neurosurgery, Orthopedic Surgery, and Other Surgical Procedures. The non-surgical divisions are: Cancer, Cardiac, Gastrointestinal, Infectious Disease, Neurology, Orthopedic, Pulmonary, Renal, Other Conditions. The final measure score (a single risk-standardized mortality rate) is calculated from the results of these 15 different divisions, modeled separately. Variables from administrative claims and electronic health records are used for risk adjustment.

### 1.4 Project \*

Choose the project that you expect to review the measure. To see the project descriptions and examples of project-related measures, please refer to the [E&M projects page](#) on the PQM

website. **Note:** Battelle may reassign the measure to a different project following internal review. Choose one.

- ☐ Advanced Illness and Post-Acute Care
- ☐ Cost and Efficiency
- ☐ Initial Recognition and Management
- ☒ Management of Acute Events, Chronic Disease, Surgery, and Behavioral Health
- ☐ Primary Prevention

### 1.5 Measure Type \*

Choose one. If "Other", please specify.

- ☐ Cost/resource use
- ☐ Efficiency
- ☐ Intermediate Outcome
- ☒ Outcome
- ☐ Population Health
- ☐ Process
- ☐ Patient-reported Outcome Performance Measure (PRO-PM)
- ☐ Structure
- ☐ Other (1.5a Please specify \*)

### 1.6 Composite Measure \*

Is this a composite measure?

- ☒ No ☐ Yes

### 1.7 Electronic Clinical Quality Measure (eCQM) \*

Is this measure an eCQM (i.e., based on the Quality Improvement Core [QI-Core], the Quality Data Model [QDM], Clinical Quality Language [CQL], and specified using value sets)? Includes hybrid measures.

Title

- ☐ No ☒ Yes

### 1.8 Level of Analysis \*

Select the level(s) of analysis for which the measure is specified and tested. Choose all that apply. If "Population of Geographic Area" or "Other", please specify.

- ☐ Accountable Care Organization
- ☐ Clinician: Group/Practice

- ☐ Clinician: Individual
- ☒ Facility
- ☐ Health Plan
- ☐ Population or Geographic Area *(1.8a Specify Population or Geographic Area Level of Analysis \*)*

- ☐ Other *(1.8b Specify Other Level of Analysis \*)*

### 1.9 Care Setting \*

*Select the care setting(s) for which the measure is specified and tested. Choose all that apply. If "No Applicable Care Setting" or "Other Care Setting", please explain.*

- ☐ Ambulatory Care: Clinic
- ☐ Ambulatory Care: Clinician Office
- ☐ Ambulatory Care: Office
- ☐ Ambulatory Surgery Center
- ☐ Behavioral Health: Inpatient (e.g., Inpatient Psychiatric Facility)
- ☐ Behavioral Health: Outpatient
- ☐ Birthing Center
- ☐ Clinician Office/Clinic
- ☐ Emergency Department
- ☐ Emergency Medical Services/Ambulance
- ☐ Home Health
- ☐ Hospice
- ☐ Hospital: Acute Care Facility
- ☐ Hospital: Critical Access
- ☒ Hospital: Inpatient
- ☐ Hospital: Outpatient
- ☐ Imaging Facility
- ☐ Inpatient Rehabilitation Facility
- ☐ Long-Term Acute Care Facility
- ☐ Nursing Home/Skilled Nursing Facility
- ☐ Outpatient Rehabilitation
- ☐ Pharmacy
- ☐ Urgent Care: Ambulatory
- ☐ No Applicable Care Setting *(1.9a Please explain \*)*

- ☐ Other Care Setting *(1.9b Please specify \*)*

**[Note: Responses to items 1.10 – 1.13 and other measure specification details are to be provided in the Full Measure Submission]**

### 1.14 Numerator \*

*Provide the numerator, i.e., the measure focus. Do not include the measure rationale.*

The measure outcome is death from any cause within 30 days of the admission date of the index admission. The numerator is a binary variable (1=yes/0=no) that indicates whether the patient died within 30 days of the index admission date.

### 1.15 Denominator \*

*Provide the denominator, i.e., the target population.*

The index cohort includes all inpatient admissions for patients aged 65-94 years old that meet the following inclusion criteria:

- Enrolled in Medicare FFS/MA for one year prior to the index admission and during the month of the start date of the admission
- Aged between 65 and 94
- Not transferred in from another acute care facility
- Not primarily treated for non-acute care (psychiatric care or rehabilitation)
- Not enrolled in Medicare hospice 12 months prior to, on day of index admission, or within first 2 days of admission
- Not primarily treated for cancer and enrolled in hospice at any time during admission stay
- Not with metastatic cancer
- Not with select diagnoses for which hospitals have limited ability to influence survival

Admissions meeting the following exclusion criteria are then removed from the denominator, to produce the final measure cohort:

- Discharged against medical advice
- Inconsistent or unknown vital status
- Primarily treated for crush injury, burns, intracranial injury, spinal cord injury, skull and face fracture, or open wounds of head, neck, and trunk
- With a principal or secondary diagnosis of COVID-19
- With a principal diagnosis not assigned to any of the 15 divisions
- Hospitalizations not randomly selected (one index admission/patient/year)
- With an admission in a low volume CCS, defined as less than 100 admissions
- Admissions missing more than 5 of the 10 CCDE

\*For patients with multiple admissions, the measure selects only one admission, at random, for inclusion. There is no practical statistical modeling approach that can account or adjust for the complex relationship between the number of admissions and risk of mortality in the context of a hospital-wide mortality measure. Random selection ensures that providers are not penalized for a “last” admission during the measurement period; selecting the last admission would not be as

accurate a reflection of the risk of death as random selection, as the last admission is inherently associated with a higher mortality risk. Random selection is also used in CMS's condition-specific mortality measures. Note that random selection reduces the number of admissions, but does not exclude any patients from the measure. The cohort is defined using ICD-10 Clinical Modification codes identified in Medicare Part A Inpatient claims data.

**Assigning admissions to clinical divisions; (AHRQ) Clinical Classifications System (CCS).** There are a total of about 300 mutually exclusive AHRQ condition categories, most of which are single, homogenous diseases such as pneumonia or acute myocardial infarction. Some are aggregates of conditions, such as "other bacterial infections". There are about 230 mutually exclusive procedure categories. Using the AHRQ CCS procedure and condition categories, the measure assigns each index hospitalization to one of 15 mutually exclusive divisions. The divisions were created based upon clinical coherence, consistency of mortality risk, adequate patient and hospital case volume for stable results reporting, and input from clinicians, patients, and patient caregivers on usability.

The measure first assigns admissions with qualifying AHRQ procedure categories to one of six surgery divisions by identifying a defining surgical procedure. The defining surgical procedure is identified using the following algorithm: 1) if a patient only has one major surgical procedure then that procedure is the defining surgical procedure; 2) if a patient has more than one major surgical procedure, the first dated procedure performed during the index admission is the defining surgical procedure; 3) if there is more than one major surgical procedure on that earliest date, the procedure with the highest mortality rate is the defining surgical procedure. These divisions include admissions likely cared for by surgical teams.

The surgical divisions are: Surgical Cancer (see note below), Cardiothoracic Surgery, General Surgery, Neurosurgery, Orthopedic Surgery, and Other Surgical Procedures.

Note: For the Surgical Cancer division, any admission that includes a surgical procedure and a principal discharge diagnosis code of cancer is assigned to the Surgical Cancer division.

The measure then assigns the remaining admissions into one of the nine non-surgical divisions based on the AHRQ diagnostic CCS of the principal discharge diagnosis. The non-surgical divisions are: Cancer, Cardiac, Gastrointestinal, Infectious Disease, Neurology, Orthopedic, Pulmonary, Renal, Other Conditions.

The full list of the specific diagnosis and procedure AHRQ CCS categories used to define the divisions are attached in the Data Dictionary. Please see attached figure Hybrid HWM Flow Diagram of Inclusion and Exclusion Criteria and Division Assignment for the Index Admission.

### 1.15d Age Group \*

*Select the age group(s) that are reflected in your measure's target population (choose all that apply). Choose an age group only if the entire range is included in your measure's target population. If only part of one or more listed age ranges applies, select "Other" and enter the correct age range (e.g., 14 - 50).*

- ☐ Children (0-17 years)
- ☐ Adults (18-64 years)
- ☐ Older Adults (65 years and older)
- ☒ Other (1.15e Provide age range in years \*)

Older Adults (between 65 and 94)

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**6.1.1. Current Status \****Is this new or maintenance measure currently in use?*

☐ No ☒ Yes

**6.1.2 [If initial endorsement] Current or Planned Use(s) \****Choose all that apply*

- ☐ Public Reporting  
☐ Public Health/Disease Surveillance  
☐ Payment Program  
☐ Regulatory and Accreditation Programs  
☐ Professional Certification or Recognition Program  
☐ Quality Improvement with Benchmarking (external benchmarking to multiple organizations)  
☐ Quality Improvement (Internal to the specific organization)  
☐ Other

**6.1.2a** Please specify other current or planned use**6.1.3 [If maintenance review] Current Use(s) \****Choose all that apply*

- ☒ Public Reporting  
☐ Public Health/Disease Surveillance  
☐ Payment Program  
☐ Regulatory and Accreditation Programs  
☐ Professional Certification or Recognition Program  
☒ Quality Improvement with Benchmarking (external benchmarking to multiple organizations)  
☒ Quality Improvement (Internal to the specific organization)  
☐ Other

**6.1.3a** Please specify other use \*

☐ Not in use

**6.1.3b** Provide more information as to why the measure is not in use and whether there is a near-term (within one year) plan for its use within an accountability application<sup>1</sup> \*

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<sup>1</sup> Accountability applications are uses of measure performance results about identifiable, accountable entities to make judgments and decisions because of performance. This can be as confidential reporting, reward, recognition, punishment, payment, or selection (e.g., public reporting, accreditation, performance-based payment, network inclusion/exclusion).

**6.1.4 [If Current Status = Yes (6.1.1)] Program Details \***

*Please provide the following information describing the program(s) in which the measure is currently used:*

Name of the program and sponsor

Hospital inpatient quality reporting program (IQR), CMS

URL of the program

<https://qualitynet.cms.gov/inpatient>

Purpose of the program

Implemented by CMS for inpatient services, the Hospital IQR is a national pay-for-quality-data-reporting program mandated by the Medicare Modernization Act of 2003. This act requires hospitals to submit data on measures on the quality of care furnished by hospitals in inpatient settings. The Hospital IQR program provides hospitals with a financial incentive to report their quality-of-care measure data and CMS with data to help Medicare beneficiaries make more informed decisions about their health care.

Geographic area and percentage of accountable entities and patients included

*The Hospital IQR program includes acute care hospitals across the nation with nearly 4,500 hospitals and 70 million Medicare Beneficiaries*

Applicable level of analysis and care setting

The level of measurement is the facility; the setting is the Hospital Inpatient.

*[To add details for another program, click “Add Measure Submission Program” button; To remove a program record entered in error, click “Remove Program” at the top right of the appropriate program details section]*

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## Attestations: Preparing for Full Measure Submission for Endorsement Consideration

*Check the boxes to attest this information will be available and submitted to Battelle by the Full Measure Submission (FMS) deadline of the intended review cycle. The measure may be insufficient for endorsement review if this information is not available by the FMS deadline. Please review the PQM E&M Rubric [\[Endorsement and Maintenance \(E&M\) Guidebook\]](#) for full measure submission evaluation criteria.*

### ☒ **A.1 Detailed Measure Specifications \***

I will provide detailed measure specifications, including how to calculate the measure, data dictionaries, and code sets.

### ☒ **A.2 Logic Model \***

I will provide a logic model and evidence that support the link between structures / processes / intermediate outcomes and the desired outcome.

### ☒ **A.3 Impact and Gap \***

- For initial endorsement, I will provide a description of the measure's anticipated impact on important outcomes supported by the scientific literature and other sources (e.g., functional improvement, disease prevented, adverse events or costs avoided).
- For maintenance endorsement, I will supply evidence of a continued performance or measurement gap by providing performance scores on the measure as specified (current and over time) at the specified level of analysis.

### ☒ **A.4 Feasibility assessment methodology and results \***

I will provide feasibility assessment methodology and results. I will show how the assessment considered the people, tools, tasks, and technologies necessary to implement the measure, and if an eCQM, I will provide the completed feasibility scorecard.

### **A.5 Measure Testing (reliability and validity)**

*Check the boxes to attest to which testing (person/encounter-level or accountable entity-level) for reliability and validity will be available and submitted for each level of analysis by the FMS deadline of the intended review cycle. **Note:** For initial endorsement, you must provide a rationale if empirical person or encounter-level will not be presented in the FMS. For maintenance endorsement, you must provide a rationale if measured/accountable entity testing will not be presented in the FMS.*

**A.5a Empirical person- or encounter-level<sup>2</sup> \***

Will empirical person- or encounter-level evidence, testing, methodology, and results be presented for this endorsement?

☐ No

☒ Yes

*[If A5a = No and this is an initial endorsement] A.5a1 Why not presented \**

*Provide a rationale for why empirical person- or encounter-level testing for reliability and validity will not be presented for this initial endorsement.*

**A.5b Empirical accountable entity-level \***

Will empirical accountable entity-level evidence, testing, methodology, and results be presented for this endorsement?

☐ No

☒ Yes

*[If A5a = No and this is a maintenance endorsement] A.5b1 Why not presented \**

*Provide a rationale for why empirical accountable entity-level testing will not be presented for this maintenance endorsement.*

***[If an initial endorsement] A.5c Systematic assessment of face validity of performance measure score \****

Will systematic assessment of face validity of performance measure score (i.e., accountable entity-level) as an indicator of quality or cost/resource use (i.e., the score is an accurate reflection of performance on quality or resource use and can distinguish good from poor performance) be presented for this initial endorsement?

☐ No

☐ Yes
**☒ A.6 Address health equity (optional)**

I will describe how this measure contributes to efforts to address inequities in health care. This is an optional criterion for FMS.

**☒ A.7 Measure's use or intended use \***

I will provide the measure's use or intended use and actions measured entities must take to improve performance on this measure. For a maintenance measure, I will provide a summary of any progress improvement.

<sup>2</sup> For patient- or encounter-level testing, prior evidence of reliability and validity of data elements for the data type specified in the measure (e.g., hospital claims) can be used as evidence for those data elements. Prior evidence could include published or unpublished testing that: includes the same data elements, uses the same data type (e.g., claims, chart abstraction), and is conducted on a sample as described above (i.e., representative, adequate numbers, and randomly selected, if possible).

**A.8 Risk-adjustment or stratification \***

*Choose the correct option to attest to whether the measure is risk-adjusted and/or stratified, and to attest that each component of the respective information will be available and submitted by the FMS deadline of the intended review cycle, as applicable.*

☐ No, neither risk-adjusted nor stratified

☒ Yes, risk-adjusted only

☒ **Conceptual model for risk adjustment**

I will present the conceptual model for risk adjustment, including supporting evidence from literature, internal analyses, and/or expert panels, AND

☒ **Risk adjustment approach**

I will present the risk adjustment approach, including the methodology, specifications, results, and interpretation of results

☐ Yes, stratified only

☐ **All information required to stratify the measure results**

I will present all information required to stratify the measure results, including the stratification variables, definitions, specific data collection items/responses, and code/value sets

☐ Yes, both risk-adjusted and stratified

☐ **Conceptual model for risk adjustment**

I will present the conceptual model for risk adjustment, including supporting evidence from literature, internal analyses, and/or expert panels, AND

☐ **Risk adjustment approach**

I will present the risk adjustment approach, including the methodology, specifications, results and interpretation of results, AND

☐ **All information required to stratify the measure results**

I will present all information required to stratify the measure results, including the stratification variables, definitions, specific data collection items/responses, and code/value sets, and the risk-model covariates and coefficients for the adjusted version of the measure

**A.9 Quality Measure Developer and Steward Agreement (QMDSA) Form \***

*The QMDSA and Additional and Maintenance Measures Forms are contractual agreements that must be signed by Battelle Memorial Institute (Battelle) and any measure steward that is submitting one or more measures to be evaluated for endorsement via the consensus endorsement process. If the measure is not owned by a government entity, the measure steward will also complete and submit a QMDSA Form. For more information about QMDSA requirements, please see the [QMDSA Submission Instructions](#). Choose one.*

☐ I already submitted a [QMDSA Form](#) to Battelle

*Provide the date submitted*

☐ I would like to submit the QMDSA form now

*Attach form; One file only; 256 MB limit; Allowed types: pdf.*

☒ The measure is owned by a government entity; therefore, the QMDSA Form is not applicable at this time.

**A.10 Additional and Maintenance Measures Form \***

*Choose one. Note: Measure stewards with current measures endorsed by Battelle, who wish to add additional measures to their current QMDSA, will need to complete this form.*

☐ I have submitted or will submit an [Additional and Maintenance Measures Form](#)

☐ The Additional and Maintenance Measures Form is not applicable at this time.

☒ **A.11 508 Compliance \***

I will ensure that the measure information that will be submitted at FMS, including all attachments, will be prepared in accordance with Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d), as amended by the Workforce Investment Act of 1998 and the Architectural and Transportation Barriers Compliance Board Electronic and Information (EIT) Accessibility Standards (36 CFR part 1194).

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## Measure Points of Contact (POC) Information

### Steward Organization:

*Choose from the drop-down menu. If your organization does not appear on the list, select "Other" and enter the name of the organization in the box provided.*

Steward organization URL: <https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/inpatient-reporting-program>

Steward POC email: [amy.moyer@yale.edu](mailto:amy.moyer@yale.edu)

Steward POC phone number: (203) 497-1239

Country: United States

First Name: Amy

Last Name: Moyer

Street Address: 195 Church St.

City, State, Zip: New Haven, Connecticut, 06510

Steward Organization Copyright: Not Applicable

☐ The measure developer is different from the measure steward

☒ Do you have a secondary **measure developer** point of contact?

*The user account completing this form is the primary Measure Developer Point of Contact*

*[If there is a secondary measure developer POC]*

Secondary POC email: [raquel.myers@cms.hhs.gov](mailto:raquel.myers@cms.hhs.gov)

Secondary POC phone number: 214-767-6450

Country: United States

First Name: Raquel

Last Name: Myers

Organization: Centers of Medicare & Medicaid (CMS)

Street Address: 7500 Security Blvd

City, State, Zip: Windsor Mill, Maryland, 21244