NATIONAL QUALITY FORUM
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Meeting Summary

Measure Applications Partnership Clinician Workgroup Virtual Meeting

The National Quality Forum (NQF) convened a public virtual meeting for the Measure Applications Partnership (MAP) Clinician Workgroup on January 12, 2021. There were 370 attendees at the meeting, including Workgroup members, NQF staff, government representatives, measure developers and stewards, and members of the public.

Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives

Sam Stolpe, NQF Senior Director, welcomed participants to the virtual meeting. NQF leadership including Interim President and CEO Chris Queram, Senior Vice President Sheri Winsper, and Senior Managing Director Michael Haynie also provided a welcome to the Workgroup. MAP Clinician Co-chairs Robert Fields and Diane Padden then provided opening remarks.

Dr. Stolpe reviewed the meeting objectives:

- Review and provide recommendations on quality measures under consideration for the Merit-Based Incentive Payment System (MIPS) and the Medicare Shared Savings Program (SSP),
- Discuss measurement gaps for these two programs, and
- Provide input into the Centers for Medicare and Medicaid Services (CMS) Quality Action Plan.

CMS Opening Remarks and CMS Quality Action Plan

Michelle Schreiber, CMS Deputy Director for Quality and Value, offered opening remarks and provided a presentation on the CMS Quality Action Plan. Dr. Schreiber discussed the vision of the action plan, namely to use impactful quality measures to improve health outcomes and deliver value by empowering patients to make informed care decisions while reducing burden to clinicians. Dr. Schreiber reviewed the impact of Meaningful Measures 1.0 and 2.0 outlined further goals for Meaningful Measures. Dr. Schreiber discussed CMS's intentions to use the Meaningful Measure Initiative to focus on quality goals to streamline quality measurement, drive value and outcome improvement, improve quality measures through use of digital measures and analytics, empower patients to make best healthcare choices through patient-directed quality measures and public transparency, and to leverage quality measure to highlight disparities and close performance gaps.

CMS's new paradigm features Person-Centered Care at the top of six other focus areas including Patient Safety, Chronic Conditions, Seamless Communication, Affordability and Efficiency, Wellness and Prevention, and Behavioral Health and Substance Use Disorders. MAP suggested the addition of "equity" as an overt domain rather than a cross-cutting domain, citing structural racism and disparities as ongoing issues that have been discussed at many strategic quality meetings. MAP presented the suggestion that all-payor data be a regular data source to bring forward payor-based case mix adjustment. MAP also noted the importance of digital measurement but added that many electronic

clinical quality measures (eCQMs) are not entirely ready for use in the marketplace, suggesting that electronic health record (EHR) vendors should be engaged throughout the process to ensure that measures are ready for deployment.

MAP emphasized moving beyond measure alignment between public and private payors to have identical core measures to decrease costs and burden. MAP added that this needs to be balanced with pockets for measurement innovation to allow the quality measurement enterprise to move forward. In regard to transparency and public reporting, MAP noted that the current strategies may not work if patients don't engage around public reporting platforms, and suggested CMS explore other avenues to ensure that beneficiaries are aware of care quality. With respect to patient reported outcomes performance measures (PRO-PMs) MAP noted that there is pushback on PRO-PMs because they are more burdensome. MAP encouraged CMS to provide support and infrastructure to support data collection for PRO-PMs. Related to affordability and cost, MAP suggested that cost measures should regularly be paired with quality measures to guard against stinting of care.

CMS further presented on their ability to stratify measure by race, noting poor data sensitivity in correctly identifying race but reasonable specificity. Because of the sensitivity did not achieve desirable levels, CMS noted that they are considering indirect estimation to stratify by race and invited feedback on the approach. MAP suggested that getting actual data would be preferred, although MAP also acknowledged the burden associated with it. MAP suggested that statistical imputation methods for race at the population health level may be more appropriate than more granular levels of analysis.

MAP provided feedback on "digital measures", where CMS defined digital measures to include a broad definition for both electronic clinical quality measures (eCQMs) and other measures derived from digital data sources.

Overview of Pre-Rulemaking Approach

Chris Dawson, NQF Manager, provided an overview of the three-step approach to pre-rulemaking, which includes program overview, review of current measures, and evaluation of Measures Under Consideration for what they would add to the program measure set. Mr. Dawson then reviewed the four decision categories that MAP members could vote on following the discussion of each measure. Finally, Mr. Dawson briefly summarized the voting process and discussed the Rural Health Workgroup charge.

Merit-Based Incentive Payment System (MIPS) Program Measures

Dr. Fields opened the web meeting to allow for public comment. Two public comments were offered. The American College of Medical Quality (ACMQ) noted a concern that care coordination is not included explicitly in the CMS Action Plan areas. The University of Colorado noted that the Promoting Interoperability measures are not aligned with other measures.

CMS representatives Dr. Schreiber and Ronique Evans provided an overview of the episode-based cost measures. Nirmal Choradia from Acumen, the measure developer, supplemented the presentation by describing the episode window for the measure, noting that each measure is risk-adjusted. Dr. Choradia further described the process by which the measures were developed as well as the framework for the episode-based cost measures.

Measures Under Consideration

MIPS Cost Measures

MUC20-0015: Asthma-Chronic Obstructive Pulmonary Disease (COPD) Episode-Based Cost Measure

Dr. Stolpe summarized the staff preliminary analysis as well as the public comments received prior to the meeting.

MAP expressed concerns associated with the reliability and validity of this measure and the episode-based cost measures in general, noting that previous Acumen measures that have been brought forward to NQF for endorsement consideration have had mixed reviews from the NQF Scientific Methods Panel. Addressing this concern, the developer noted that they perform empirical validity tests looking at known group analyses to ensure that expected high-cost episodes are reflected in higher cost scores as well as correlation analyses. The Workgroup also expressed concerns related to the exclusions especially related to age, which the developer noted there are no age limitations. The developer noted that exclusions were intended to remove especially high-risk patients which may represent outliers in terms of cost. MAP expressed concerns that they risk adjustment approach appropriately normalizes cost by risk. The developer noted that dual eligibility is a social risk factor included in the risk model, though other social risk factors were included in testing. The developer noted that dual status accounted for the vast majority of risk and hence is the only social risk variable included in the adjustment model. It was further noted that both Medicare Part B and Part D costs are included in the measure.

MAP did not recommend the measure for rulemaking with potential for mitigation. Mitigation is contingent on further evaluation on impact points for actionability demonstrating the connection between upstream medical interventions and downstream costs, as well as NQF endorsement. MAP noted a tension between expenses associated with good care that may result in reductions in overall cost of care but raise condition-specific care. MAP urged CMS to balance these cost measures with appropriate quality measures and to demonstrate the connection between them. MAP further noted that cost measures associated with upstream preventions should result in lowered downstream costs and expressed concerns that this is not the case for the measure, impacting its overall actionability. The developer noted that there is no specific measure that dictates that there will be lower cost, but rather that studies and other sources of evidence suggest that a given action will result in lower costs of care.

MAP noted that this measure was devised to reduce costs to Medicare claimants who experienced episodes of asthma and COPD events. While there are suggestions that effective interventions for asthma and COPD that result in lowered overall cost of care for beneficiaries and better patient outcomes, MAP suggested that these should be explicitly connected with MIPS asthma and COPD measure prior to implementation. Should testing data show that the measure appropriately measures episode-based cost while maintaining quality, this measure would be valuable to add to the program measure set.

MUC20-0016: Colon and Rectal Resection Episode-Based Cost Measure

Dr. Stolpe summarized the staff preliminary analysis as well as the public comments received prior to the meeting.

MAP introduced questions related to the risk-adjustment approach. The measure developer highlighted that dual eligible patients are not included, and that other risks in the model include left-ventricular

assist device, major bowel surgery, discharged against medical advice, transfers within 3 days, and episodes where procedure is associated with a very different stay. The developer further clarified that 90% of attributed clinicians were general and colorectal surgeon.

MAP recommended conditional support for rulemaking contingent on NQF endorsement. MAP noted that MUC20-0016 addresses the Patient-Focused Episode of Care goal of CMS's Meaningful Measures initiative, the CMS high priority area of Efficiency/Cost Reduction and MACRA statutory requirements. Currently, there are no measures that assess episode-based cost related to colectomy.

MAP noted that colorectal cancer represents 8.2% of all cancer diagnoses, impacting nearly 150,000 patients per year. Evidence suggests that surgical decision-making and treatment course related to colon and rectal resection can reduce length of hospital stay, risk of major post-operative complications, and cost. Should testing data show that the measure appropriately measures episode-based cost while maintaining quality, this measure would be valuable to add to the program measure set.

MUC20-0017: Diabetes Episode-Based Cost Measure

Dr. Stolpe summarized the staff preliminary analysis as well as the public comments received prior to the meeting.

MAP questioned the reliability of the measure and asked for clarification related to exclusions and risk-adjustment. MAP expressed concern that the measure is significantly less reliable for individual physicians than for groups. It was noted that there is risk adjustment for obesity and for prior bariatric surgery. Bariatric surgery that occurs during the episode is not included as a cost. The developer noted that bariatric surgery is a high cost procedure that will benefit the patient downstream. The developer also noted that physical therapy and rehabilitation costs are included in the measure, if the physical therapy or rehabilitation is specifically related to the inpatient admission that is included in the episode; otherwise, physical therapy and rehabilitation costs are not included.

MAP did not support the measure for rulemaking with potential for mitigation. Mitigation is contingent on further evaluation on impact points for actionability demonstrating the connection between upstream medical interventions and downstream costs, as well as NQF endorsement. MAP noted a tension between expenses associated with good care that may result in reductions in overall cost of care but raise condition-specific care. MAP urged CMS to balance these cost measures with appropriate quality measures that are connected with lower costs. MAP further noted that upstream preventions should result in downstream costs and expressed concerns that this is not the case for the measure, impacting its overall actionability. MAP noted that this measure aims to improve care by optimizing resource use associated with diabetes management. While there are measures in MIPS related to individual treatments for diabetes, this measure would potentially focus care on the most cost-effective interventions, but these should be connected.

This measure could improve Medicare costs of diabetes by incentivizing risk reduction treatments that are cost effective. Should testing data show that the measure appropriately measures episode-based cost while maintaining quality, this measure would be valuable to add to the program measure set.

MUC20-0018: Melanoma Resection Episode-Based Cost Measure

Dr. Stolpe summarized the staff preliminary analysis as well as the public comments received prior to the meeting.

MAP questioned the impact that the depth of a given melanoma may have on cost, especially with sentinel lymph node biopsies, and the developer noted risk adjustment associated with assessment of disease severity. Reconstruction was also noted to be included in risk adjustment. MAP noted an attribution concern, which the developer addressed by noting that costs generally align with the clinicians performing the procedure. The developer noted that Part D costs are not included in this measure unlike some of the other cost measures brought before MAP this cycle.

MAP recommended conditional support for rulemaking contingent on NQF endorsement. MUC20-0018 addresses the Patient-Focused Episode of Care goal of CMS's Meaningful Measures initiative, the MIPS high priority area of Efficiency/Cost Reduction and MACRA statutory requirements. Currently, there are no measures that assess episode-based cost related to melanoma. Melanoma is of growing concern to the Medicare population. MAP noted that the total annual treatment cost for melanoma is estimated at $3.3 billion, while melanoma resection is cited as curative in 85-90% of cases, with a 99% five-year survival rate. This measure aims to optimize resource use associated with melanoma resection. Clinician decision making is cited as being an important predictor of cost and an important pathway for risk reduction in melanoma care.

Melanoma represents 5.6% of all cancer diagnoses, impacting over 190,000 patients per year. This measure could reduce costs of melanoma treatment and incentivize reduction of treatments that are not cost effective. Should testing data show that the measure appropriately measures episode-based cost while maintaining quality, this measure would be valuable to add to the program measure set.

MUC20-0019: Sepsis Episode-Based Cost Measure

Dr. Stolpe summarized the staff preliminary analysis as well as the public comments received before the meeting.

MAP noted the exclusion of hospice patients that present with sepsis. If a patient goes to hospice during the sepsis episode, all hospice costs are excluded. Additionally, any patient who dies during the sepsis episode is excluded. MAP also noted that the measure is diagnosis related group (DRG) based. Miscoding is a concern due to issues associated with overdiagnoses to reflect lower costs. The developer noted that there are risk adjustment variables to assess the level of sickness of the patient. MAP was especially concerned that the data available to CMS may not be sufficient for them to be able to mitigate this issue.

MAP did not support the measure with potential for mitigation, with the mitigation points being NQF endorsement, an analysis of the potential for gaming associated with overdiagnosis of sepsis, and further evaluation of the correlation with clinical quality measures.

This measure was devised to reduce costs to Medicare septicemia-related events which represent a significant share of hospitalizations and Medicare cost. MAP noted that the annual number of Medicare beneficiaries with a sepsis hospitalization exceeds 1.1M, with over $22B in costs. Should testing data show that the measure appropriately measures episode-based cost while maintaining quality and a clear indication that there is not gaming through overdiagnosis, this measure would be valuable to add to the program measure set.

MIPS Quality Measures

MUC20-0034: Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System

Dr. Stolpe summarized the staff preliminary analysis as well as the public comments received prior to the meeting.

MAP noted concerns in the increased mortality associated with managing heart failure (HF) in the outpatient setting, and that the relative severity of HF may not be appropriately accounted for in the measure. MAP suggested that the measure may be more appropriate at the accountable care organization level. The developer responded by clarifying the differences between this measure and a similar measure that was used within the Shared Savings Program.

MAP recommended conditional support for rulemaking contingent on NQF endorsement. MUC20-0034 addresses MIPS high-priority areas including patient outcomes, care coordination and cost reduction, as well as the Meaningful Measures areas of admissions and readmissions to hospitals and management of chronic conditions. If included in the measure set, MUC20-0034 would be the only outcome measure in MIPS related to heart failure.

MAP noted that 6.5M Americans are living with heart failure, and a fifth of patients hospitalized with heart failure are readmitted to the hospital within 30 days. Hospitalization is costly and accounts for 79% of lifetime costs associated with heart failure. However, a 20-30% reduction in hospitalization rates can be achieved for heart failure patients through high-quality care with patient support programs. MUC20-0034 encourages clinicians to reduce readmissions through high-quality ambulatory care.

MUC20-0040: Intervention for Prediabetes

Dr. Stolpe summarized the staff preliminary analysis as well as the public comments received prior to the meeting.

MAP noted that the measure was not supported for NQF endorsement by the Primary Care and Chronic Illness Committee during their spring 2020 measure evaluation cycle and agreed that the set of interventions did not reflect the range of interventions that are available to clinicians to address prediabetes. The measure developer asserted that the measure is reflective of current evidence-based interventions and that expanding beyond them may make the available interventions to meet the numerator less evidence based. MAP noted that there are other evidence-based approaches recommended by the United States Preventive Services Task Force that the developer may consider, among others.

MAP did not recommend the measure for rulemaking with potential for mitigation. Mitigation points include re-specifying the measure to include an adequate range of interventions for prediabetes available to the clinician beyond prescription of metformin or referring the patient to an external service. The measure should also receive NQF endorsement. MUC20-0040 addresses the Meaningful Measure area of Preventive Care. Clinicians who identify patients with prediabetes can reduce risk of diabetes onset through clinical and lifestyle interventions. Prevention measures are of high value to MIPS and there are currently no prediabetes measures in MIPS.

MAP acknowledged that prediabetes and diabetes are important conditions within the Medicare

population resulting in high mortality, morbidity and cost of care. Diabetes has preventable risk factors and can be addressed through intervention. Medical Nutrition Therapy has been shown to be successful in deterring the progression of prediabetes to type 2 diabetes. Current evidence supports a role for metformin in diabetes prevention when coupled with lifestyle interventions in people with prediabetes. However, the measure was noted by the NQF Primary Care and Chronic Illness Committee to offer too few options for intervention.

MUC20-0042: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure

Dr. Stolpe summarized the staff preliminary analysis as well as the public comments received.

MAP expressed concern related to case-mix adjustment, namely that practices may vary substantially according to patient age, health status, and tenure with the index practice. MAP noted that chronic care populations rather than full primary care may be more appropriate. MAP suggested that the provider may not "need to stand up for the patient" or "coordinate across multiple providers" for instances where healthy patients just require quick check-ups. MAP also expressed concerns associated with ensuring health equity and cultural responsiveness are included as items. The developer noted that despite the fact that some items may not be as meaningful to all patients, there was still good reliability demonstrated in the measure at the data element and score level. The developer further noted that there are no differences in the measure testing according the race, ethnicity and gender, as well as no differences based on educational attainment.

MAP offered conditional support for rulemaking contingent on NQF endorsement. MAP noted that MUC20-0042 addresses the Meaningful Measurement area of Care is Personalized and Aligned with Patient's Goals, and the MIPS high-priority measurement area of Person and Caregiver-centered Experience and Outcomes. MAP considers appropriate PRO-PMs an important consideration for MIPS. Capturing the voice of the patient is an important component of delivering high-value primary care. There are a limited number of patient experience measures within the MIPS program measure set.

MAP noted that the developer referenced a body of evidence that demonstrates a strong connection between patient experience of care and traditional health care outcomes, such as improved intermediate outcomes, greater adherence to recommended treatment, and reduced use of health care services. The assessment of patient experience of care is a critical element in care quality. Patient experience measures focus important attention to the consumer experience of care delivery and receipt of services but fall short of focused attention to the broad scope of primary care.

MUC20-0043: Preventive Care and Wellness (composite)

Dr. Stolpe summarized the staff preliminary analysis as well as the public comments received prior to the meeting.

MAP expressed support of upstream preventive healthcare, screening, and preventive care. However, MAP also expressed concerns that the measure may be a checkbox measure and may be more meaningful if directly connected to outcomes. MAP also expressed concern that some of the components may be topped out measures. MAP further suggested that the measure encourages practice integration, wholistic patient care, parsimony of measures. MAP also noted a linear weighting of the measures, suggesting that there may be more priority and emphasis considered by CMS on some of the components over others.

MAP offered conditional support for rulemaking contingent upon receipt of NQF endorsement and addressing redundancy issues from duplicative component measures in MIPS. The seven components of this composite measures are all currently used in MIPS and Part C and D program. The resolution of potential redundancy with the singular measures for the composite measure already in MIPS may improve data interpretability burden for reporting entities and would make tracking of preventive care easier and comprehensive. CMS has noted their intention to remove the individual component measures.

MAP noted that this measure may impact the 37 million Medicare beneficiaries who receive one or more preventive services, and the 1 in 6 Medicare beneficiaries who are younger than 65 years old who would seek preventive services (Fox, et al; 2015).

MUC20-0045: CoV-2 Vaccination by Clinicians

Ms. Winsper provided an overview of NQF's position on the measure, namely that while NQF staff did not support the measure with potential for mitigation through adherence to the preliminary analysis algorithm, but this is not reflective of NQF's support for vaccination overall. CMS representatives Dr. Schreiber and Joel Andress provided a presentation that explained their approach for the measure.

MAP noted that the rate of vaccination is helpful, but qualitative data associated with patient refusal is also important to understand and address vaccine hesitancy. CMS asked if the measure should be mandatory in MIPS to which MAP responded that it should perhaps be mandatory but initially not connected to payment. MAP recognized that the measure was introduced during a time of national emergency and encouraged CMS to move forward with development and implementation. MAP expressed concerns over the alignment of the MIPS measure with the measures considered by the MAP Hospital and PAC/LTC workgroups for healthcare personnel and for patients in dialysis facilities in that this measure does not require an "up to date" vaccination status. MAP encouraged CMS to consider alignment with the other two measures. MAP also expressed concern that patients who have "ever received" a COVID vaccination are included in the measure as this may have implications over multiple years should COVID vaccines prove to be an annual need.

MAP did not support this measure for rulemaking with the potential for mitigation. The mitigation points for this measure prior to implementation are that the evidence should be well documented, the measure specifications should be finalized, followed by testing and NQF endorsement. MAP noted that the proposed measure represents a promising effort to advance measurement for an evolving national pandemic. The incomplete specifications require immediate mitigation and further development should continue. This measure would add value to the program measure set by providing visibility into an important intervention to limit COVID-19 infections.

Collecting information on SARS-CoV-2 vaccination coverage and providing feedback to clinicians will facilitate benchmarking and quality improvement. Vaccination overage will reduce transmission and associated mortality and morbidity. Prior to use in MIPS, this important measure should have the supporting evidence well-documented, be fully developed, followed by testing and receipt of NQF endorsement.

Program Measure Gaps

MAP had a limited discussion on measure gaps within the MIPS program. Within the MIPS measure set, MAP emphasized the need for measures associated with racism and equity rather than simply stratifying existing measures.

Medicare Shared Savings Program (SSP) Program Measures

Dr. Padden opened the web meeting to allow for public comment. Hearing none, the Workgroup moved to the discussion of the SSP Program Measure.

MUC20-0033 ACO-Level Days at Home for Patients with Complex, Chronic Conditions

Dr. Stolpe summarized the staff preliminary analysis as well as the public comments received prior to the meeting.

MAP expressed concerns related to how residents in nursing homes may impact the measure. It was noted that ACOs results on this measure are adjusted based on use of nursing facilities, and that patients who reside in nursing facilities are only included when they transition to acute settings.

MAP conditionally supported the measure for rulemaking contingent on NQF endorsement. MAP noted that MUC20-0033 addresses the Meaningful Measures areas of Management of Chronic Conditions and Preventive care, and the healthcare priority to Promote Effective Prevention and Treatment of Chronic Disease. The measure aims to promote high-quality coordinated care to keep adults with complex, chronic conditions in home or community settings and out of acute care or long-term care settings.

MAP noted that remaining in the home is generally preferred by patients and associated with other important outcomes, including social activity and reduced depression. Timely and appropriate primary care and end-of-life care services can increase the number of days patients spend at home. Improved care coordination and care transitions can prevent unplanned hospital visits, leading to more days at home and high-quality timely care.

Program Measure Gaps

MAP identified measure gaps within SSP, namely that the shift in quality measures disagreed with the choice to move to eCQMs, and suggested that there has been an over-reduction in the number of measures within the program. MAP suggestions also included the need for both MIPS and SSP measures to consider racism and equity rather than simply stratifying existing measures. A comment concerning the MIPS measure set noted that outcome measures tie meaningfully to quality improvement.

Public Comment

Dr. Fields opened the web meeting to allow for public comment. The American College of Medical Quality (ACMQ) offered a comment, noting that for MUC20-0019, there is a clear difference between patients who present with sepsis on admission and those who do not. For MUC20-0034 ACMQ noted a lack of ability for ICD-10 codes to keep up with the staging of HF and cautioned against using the ICD-10 set alone. ACMQ provided general caution associated with MUC20-0043 due to its complexity. ACMQ further noted that MUC20-0045 would likely exhibit a high degree of variability and that CMS should conduct field testing of the measure prior to implementation.

The National Association of Accountable Care Organizations (NAACOS) concurred with many of the concerns raised in the discussion about MUC20-0033 and questioned if the measure is in addition to the existing measures or in place of a measure currently used. Additionally, it was asked what data concerning this measure will be shared with ACOs in quarterly reports. NAACOS supported the concept but had concerns with the exceptions and risk adjustment for the measure. NAACOS did not support addition of the measure.

Next Steps

Dr. Stolpe summarized next steps. Workgroup recommendations for the eleven MAP Clinician measures will be opened for public comment on January 15, 2021. The MAP Coordinating Committee will convene to finalize MAP recommendations for all measures on January 25, 2021.

Appendix A: MAP Clinician Workgroup Attendance

The following members of the MAP Clinician Workgroup were in attendance:

Organizational Members

- American Academy of Family Physicians
- American College of Cardiology
- American College of Radiology
- American Occupational Therapy Association
- Atrium Health
- Blue Cross Blue Shield of Massachusetts
- Consumers' Checkbook
- Council of Medical Specialty Societies
- Genentech
- HealthPartners, Inc.
- Kaiser Permanente
- Louise Batz Patient Safety Foundation
- Magellan Health, Inc.
- OCHIN, Inc.
- Patient Safety Action Network
- Pacific Business Group on Health
- Pharmacy Quality Alliance
- St. Louis Area Business Health Coalition

Individual Subject Matter Experts

- Amy Nguyen Howell, MD, MBA, FAAFP
- William Fleischman, MD, MHS,
- Stephanie Fry, MHS
- Robert Fields, MD
- Diane Padden, PhD, CRNP, FAANP

Appendix B: Full Voting Results

	Measure Name	Program	Yes	No	Total	Percent
1	MUC20-0015: Asthma-Chronic Obstructive Pulmonary Disease (COPD) Episode-Based Cost Measure	MIPS	16	3	19	84%
2	MUC20-0016: Colon and Rectal Resection Episode-Based Cost Measure	MIPS	13	6	19	68%
3	MUC20-0017: Diabetes Episode-Based Cost Measure	MIPS	16	3	19	84%
4	MUC20-0018: Melanoma Resection Episode-Based Cost Measure	MIPS	15	4	19	79%
5	MUC20-0019: Sepsis Episode-Based Cost Measure	MIPS	14	5	19	80%
6	MUC20-0034: Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System	MIPS	12	8	20	60%
7	MUC20-0040: Intervention for Prediabetes	MIPS	13	7	20	65%
8	MUC20-0042: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure	MIPS	13	5	18	72%
9	MUC20-0043: Preventive Care and Wellness (Composite)	MIPS	15	4	19	78%
10	MUC20-0033: ACO-Level Days at Home for Patients with Complex, Chronic Conditions	Medicare Shared Savings Program	16	2	18	88%
11	MUC20-0045: CoV-2 Vaccination by Clinicians	MIPS	17	2	19	89%