NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Measure Applications Partnership Coordinating Committee
Virtual Meeting

The National Quality Forum (NQF) convened a public virtual meeting for the Measure Applications Partnership (MAP) Coordinating Committee on January 25, 2021.

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 Coordinating Committee Co-chairs Charles (Chip) Kahn, III and Misty Roberts provided opening remarks. Dr. Stolpe reviewed the meeting objectives, namely, to review and provide recommendations on quality measures under consideration for measures reviewed by the MAP Hospital, Clinician and Post-Acute Care/Long-Term Care (PAC/LTC) Workgroups, to discuss measurement gaps, and to provide input on the Centers for Medicare & Medicaid Services' (CMS) Quality Action Plan.

CMS Opening Remarks and CMS Quality Action Plan

Lee Fleisher, CMS Chief Medical Officer and Director of the Center for Clinical Standards and Quality (CCSQ), offered a welcome to the Committee. Michelle Schreiber, CMS Deputy Director for Quality and Value at CCSQ, 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 and 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 leverage quality measure to highlight disparities and close performance gaps.

CMS's new paradigm as originally presented to MAP Workgroups featured 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. CMS noted recent changes made based on suggestions from MAP Workgroup discussions including the addition of "Equity" and changing "Patient Safety" to "Safety." MAP supported the change of "Patient Safety" to "Safety" as reflecting the need to have safety of healthcare workers included. MAP also suggested including emergency preparedness as part of "Safety." MAP also supported the inclusion

of “Equity,” but also suggested that “Disparities” would be an important alternative or addition, noting that the term “disparities” is focused on outcomes while “equity” typically deals with social structures and foundational causes. MAP supported the focus on behavioral health. MAP noted that digital measures, especially electronic clinical quality measures (eCQMs), give opportunities for real-time feedback to providers. MAP also emphasized the need to ensure that digital measures are visible to all entities, including health plans. MAP reviewed challenges associated with patient reported outcomes performance measures (PRO-PMs), suggesting that CMS should provide additional support for PRO-PMs, noting a need to assure high response rates, use of electronic resources, and reduction of reporting burden.

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 for confidential feedback to providers (and not for performance measurement) and invited feedback on the approach. MAP suggested that this information would be more useful for stratification rather than risk adjustment. MAP suggested that obtaining actual data would be preferred, although MAP also acknowledged the burden associated with the effort. MAP suggested that statistical imputation methods for race at the population health level may be more appropriate than more granular levels of analysis.

Overview of Pre-Rulemaking Approach

Udara Perera, NQF Senior 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 (MUC) for what they would add to the program measure set. Dr. Perera then reviewed the four decision categories for MAP members’ voting following the discussion of each measure. Finally, Dr. Perera briefly summarized the voting process and discussed the Rural Health Workgroup charge.

Public Comment on Hospital Programs

Mr. Kahn opened the floor for public comment. No public comments were received.

Pre-Rulemaking Recommendations for Hospital Programs

End-Stage Renal Disease Quality Incentive Program (ESRD QIP) Measures

MUC20-0039: Standardized Hospitalization Ratio for Dialysis Facilities (SHR)

Dr. Pickering summarized the Hospital Workgroup recommendation and the public comments received prior to the meeting. MAP had no questions and was in general agreement with the Workgroup recommendation for the measure.

MAP supported this measure for rulemaking.

Hospital Outpatient Quality Reporting Program (Hospital OQR Program) Measures

MUC20-0004: Appropriate Treatment for ST-Segment Elevation Myocardial Infarction (STEMI) Patients in the Emergency Department (ED)

Dr. Pickering summarized the Hospital Workgroup recommendation and the public comments received prior to the meeting.

MAP noted that there may be an issue with the comparison of hospitals because complying with and hitting targets will not be at the same level of difficulty across providers and the types of services provided. The need for early identification of STEMI is the key for care before interventional measures are taken. This was acknowledged but is outside of this measure. It would be too complex to include services for early identification; it may be considered in the future.

MAP offered conditional support for rulemaking, pending NQF endorsement.

MUC20-0005: Breast Screening Recall Rates Dr. Pickering summarized the Hospital Workgroup recommendation and the public comments received prior to the meeting.

MAP commended CMS for addressing this issue and indicated that this measure's focus is very important to women. MAP noted that there is a wide variety of accuracy of screening results and turnaround times by facility. MAP agreed that ranges for both over-recall and under-recall are extremely important. The potential need for the incorporation of social determinants of health as a factor in the measure was raised. MAP discussed a perceived need for more definitive recommendations for rulemaking. There was discussion concerning the possibility of inclusion of the individual measure into a composite measure or as part of a suite of measures. MAP outlined that this might be a long-term goal but it was agreed that the measure should not be delayed.

MAP offered conditional support for rulemaking, pending NQF endorsement.

Hospital Inpatient Quality Reporting Program (Hospital IQR Program) Measures

MUC20-0003: Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)

Dr. Pickering summarized the Hospital Workgroup recommendation and the public comments received prior to the meeting. MAP had no questions and was in general agreement with the Workgroup measure recommendation.

MAP supported this measure for rulemaking.

MUC20-0032: Global Malnutrition Composite Score

Dr. Pickering summarized the Hospital Workgroup recommendation and the public comments received prior to the meeting. MAP had no questions and was in general agreement with the Workgroup measure recommendation.

MAP offered conditional support for rulemaking, pending NQF endorsement.

Medicare and Medicaid Promoting Interoperability Programs for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs)

MUC20-0032: Global Malnutrition Composite Score

Dr. Pickering summarized the Hospital Workgroup recommendation and the public comments received prior to the meeting. MAP had no questions and was in general agreement with the Workgroup measure recommendation.

MAP offered conditional support for rulemaking, pending NQF endorsement.

Public Comment on Clinician Programs

Ms. Roberts opened the opportunity for public comment. A single public comment was offered from the American Academy of Family Physicians (AAFP) supporting MUC20-0044 Patient Centered Primary Care Measure for rulemaking. AAFP further expressed opposition to MUC20-0043 Preventive Care and Wellness (composite) citing CMS's intention to move toward fewer measures but suggesting that this measure disguises multiples measures by combining them into one. AAFP also voiced opposition to MUC20-0040 Intervention for Prediabetes, noting conflicts with recommendations from the NQF Primary Care and Chronic Illness Committee and suggesting that the measure presents a large potential for harm due to overtreatment with metformin.

Pre-Rulemaking Recommendations for Clinician Programs

Merit-Based Incentive Payment System (MIPS) Program Cost Measures

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

Dr. Stolpe summarized the Clinician Workgroup recommendation and the public comments received prior to the meeting.

MAP questioned the reliability of the data based on the number of cases. While the reliability is high, there were remaining questions about the threshold of cases. The importance of social risks factors for asthma and COPD was also noted.

MAP did not recommend the measure for rulemaking with potential for mitigation. Mitigation is contingent on receipt of NQF endorsement as well as further evaluation of impact points for actionability demonstrating the connection between upstream medical interventions and downstream costs.

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

Dr. Stolpe summarized the Clinician Workgroup recommendation and the public comments received prior to the meeting.

MAP questioned the measurement period of this cost measure, noting that the measure has a 15-day prior to the clinical event inclusion of services that are clinically related, rather than 30 days. It was noted that the intent is to capture the interventions that are under the reasonable influence of the

attributed clinician or clinician group and to focus only on the testing related to the colon and rectal resection.

MAP recommended conditional support for rulemaking contingent on NQF endorsement.

MUC20-0017: Diabetes Episode-Based Cost Measure

Dr. Stolpe summarized the Clinician Workgroup recommendation and the public comments received prior to the meeting.

It was noted that there had been discussions about the correlation of cost measures with quality. Diabetes is very costly and there is substantial variation in performance. MAP suggested that there is a need to advance chronic care measures and to improve the opportunity for their testing.

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.

MUC20-0018: Melanoma Resection Episode-Based Cost Measure

Dr. Stolpe summarized the Clinician Workgroup recommendation and the public comments received prior to the meeting. MAP had no questions and was in general agreement with the measure.

MAP offered conditional support for rulemaking, pending NQF endorsement.

MUC20-0019: Sepsis Episode-Based Cost Measure

Dr. Stolpe summarized the Clinician Workgroup recommendation and the public comments received prior to the meeting.

MAP highlighted concerns about defining patients who have sepsis, including patients who are in very early stages of sepsis. The potential for miscoding with overdiagnoses to reflect lower costs is a continuing situation of concern. There are, however, risk adjustment variables to assess the disease severity and to cover episodes that are not actually sepsis.

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

Merit-Based Incentive Payment System (MIPS) Program 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 Clinician Workgroup recommendation and the public comments received prior to the meeting.

The measure addresses admission of patients with heart failure and is limited to the outcome of acute unplanned cardiovascular readmissions. This measure is risk adjusted for Agency for Healthcare Research and Quality Socioeconomic Status index. The data are claims based with the goal of including patients for whom exacerbation of heart failure or chronic disease could be influenced by a clinician.

The Clinician Workgroup had previously recommended conditional support for rulemaking contingent on NQF endorsement. The Workgroup noted this measure 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. This measure encourages clinicians to reduce readmissions through high-quality ambulatory care. If included in the measure set, MUC20-0034 would be the only outcome measure in MIPS related to heart failure.

MAP's discussion focused on the readiness of the measure for rulemaking even with NQF endorsement, based on concerns about the risk model appropriately adjusting for clinicians dealing with more serious patients. MAP was concerned that the measure may penalize those clinicians who are taking care of the sickest heart failure patients and that the measure may have unintended consequences of mislabeling providers that are caring for sicker patients.

MAP did not support the measure with potential for mitigation. Mitigation points included that the measure receive NQF endorsement, and that CMS perform analysis to ensure that the risk model appropriately adjusts for clinicians treating more serious patients.

MUC20-0040: Intervention for Prediabetes

Dr. Stolpe summarized the Clinician Workgroup recommendation and the public comments received prior to the meeting.

MAP noted that "patients with abnormal glucose levels" is more appropriate terminology than prediabetes. It was also noted that the measure considers nonpharmacological interventions (lifestyle changes such as diet and exercise) on par with pharmacological interventions. The measure could be a burden given that referrals and lab results are not always easily obtained.

MAP did not support the measure with potential for mitigation. Mitigation points include re-specifying the measure to include an adequate range of interventions beyond pharmacological interventions available to the clinician and the receipt of NQF endorsement.

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

Dr. Stolpe summarized the Clinician Workgroup recommendation and the public comments received prior to the meeting.

MAP reviewed the differences between this measure and the Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) measure. The developer noted that there is little overlap between the CG-CAHPS questions and this performance measure. The focus of CG-CAHPS is consumer experiences with questions concerning items such as friendliness, openness, environment, and communication. This measure concerns primary care and includes items such as access and behavioral health. Eighty percent of primary care is not driven by diagnosis and not specific to a disease or guideline. This measure is needed to address outcome and not consumer experience.

The developer further explained that this measure connects to approximately 50 different quality improvement activities available on the CMS website. The survey items have high face validity and are more actionable than many other measures. Testing included 16 individual clinicians but there was a

sizable difference between them which shows that even in a small group differences are evidenced. The measure is currently being fielded among 100 clinicians for follow-up maintenance submission. Concerning cultural appropriateness, it has been validated in 28 languages and 30 different country settings and the research has recently been accepted by the Annals for Family Medicine.

MAP offered conditional support for rulemaking contingent upon receipt of NQF endorsement.

MUC20-0043: Preventive Care and Wellness (composite)

Dr. Stolpe summarized the Clinician Workgroup recommendation and the public comments received prior to the meeting.

The Clinician Workgroup had previously 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 discussed the components of this composite measure and suggested that they should not be weighted equally. MAP expressed concern that some components may result in the use of small denominators as others use large ones resulting in an average for a single measure that is not representative of the care provided. MAP noted that this situation could indicate that a clinician is doing well when they are not. Some MAP members suggested that the components were disparate and not patient centered. There was some support for keeping the components of the measure unbundled. In addition, it was suggested that the data gathering for this measure may be a heavy burden on the provider. The measure may be appropriate as data are increasingly digitized. However, it was also noted that the measure does not directly address patient outcomes.

MAP did not support the measure with potential for mitigation. Mitigation points included receipt of NQF endorsement and ensuring the appropriate weighting of components of the composite measure.

Medicare Shared Savings Program Measures

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

Dr. Stolpe summarized the Clinician Workgroup recommendation and the public comments received prior to the meeting.

MAP noted that the measure is being driven largely by inpatient stays and cost measures. Some MAP members suggested that the correlation between this measure and other measures such as rehospitalization and cost be analyzed.

MAP recommended conditional support for rulemaking contingent on NQF endorsement.

Public Comment on PAC/LTC Programs

Dr. Kahn opened the line for public comment. No public comments were received.

Pre-Rulemaking Recommendations for PAC/LTC Programs

Hospice Quality Reporting Program (HQRP) Measures

MUC20-0030: Hospice Care Index

Amy Moyer, NQF Director, summarized the PAC/LTC Workgroup recommendation and all written public comments received.

MAP indicated that there may be some concern among providers about the lack of control over the cost issues that this measure seeks to address. MAP also asked about alignment between this measure and the Hospice Outcomes and Patient Evaluation (HOPE) assessment. Dr. Levitt clarified that this claims-based measure has a different focus than HOPE, a real-time assessment of patient needs and goals.

MAP offered conditional support for rulemaking contingent on NQF endorsement.

Skilled Nursing Facility Quality Reporting Program (SNF QRP) Measures

MUC20-0002: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization

Ms. Moyer summarized the PAC/LTC Workgroup recommendation and all written public comments received. Gerri Lamb, PAC/LTC Workgroup Co-chair, agreed with the summary and had no additional remarks.

MAP offered strong support for this measure. The measure is based on claims data which can have limitations. MAP expressed concerns that some diagnoses may be over coded. MAP members questioned why the developer chose to use claims data when all other infection measures in CMS programs use National Healthcare Safety Network (NHSN) data. A skilled nursing facility (SNF) member clarified that SNFs are not currently required to use NHSN for infection reporting.

MAP offered conditional support for rulemaking, contingent on NQF endorsement.

CMS Presentation on COVID-19 Measures and Q&A

Dr. Schreiber provided an overview of the three COVID-19 measures presented to MAP. She noted that the measures are in the very early stages of development and the full measure specifications have not been developed. Not enough information exists concerning the types or number of vaccines that may be available or the required doses. Exclusions have not been fully developed and the vaccines are still under Emergency Use Authorization rather than full approval from the Food and Drug Administration. CMS expressed their intent as to bring the measures to the Committee for early feedback. MAP requested that as CMS continues to evolve these measures, they come back to the Committee with revisions. CMS noted that the earliest that the measures could be implemented would be 2022 and there will presumably be many advances in both vaccine development and deployment, as well as the development of the measures by that time. It is anticipated that the vaccine may need to be administered on a continuing basis, much like the flu vaccine. There were three specific types of measures for COVID-19 that were presented for MAP's consideration.

The first measure concerns the vaccination of healthcare personnel. The data source for the measure is the National Healthcare Safety Network COVID vaccination module. It will measure personnel's completed vaccine series. Exclusions will be contraindications (such as allergic reactions). There will be no exclusions for refusals. The measure will be reported quarterly.

The second measure addresses the vaccination of patients in ESRD programs. The exclusions again are contraindications. CMS does not have the authority to collect this data from skilled nursing facilities and is focusing on ESRD.

The third measure is for patients that are at served by MIPS eligible clinicians. It includes all patients older than 18 seen during the measurement period. This measure will be patient self-reported receipt of either a full or partial series. The exclusion is contraindications and refusals will be included in the measure.

These measures are being presented to MAP for feedback on the principles and programs.

Public Comment on COVID-19 Measures Under Consideration

There were no public comments on these measures.

COVID-19 Measures Under Consideration Discussion

The Hospital, PAC/LTC, and Clinician Workgroups previously did not support the COVID measures under consideration for rulemaking with the potential for mitigation. The Workgroups' mitigation points for this measure prior to implementation were that the evidence should be well documented, the measure specifications should be finalized followed by testing, and NQF endorsement. The Workgroups noted that the proposed measures represent a promising effort to advance measurement for an evolving national pandemic. The incomplete specifications were suggested to require immediate mitigation and the MAP Workgroups noted that further development should continue. The Workgroups stated that the measures would add value to the program measure sets by providing visibility into an important intervention to limit COVID-19 infections.

An issue raised by MAP was the inclusion of refusals for clinicians. This was seen as unfair unless vaccination were mandated, and that is not recommended. It was clarified that the measures would be used for reporting and not payment.

MAP's final consensus was that these measures are vitally important and should be implemented quickly. On the other hand, data are lacking, and MAP wondered if it is premature for them to consider these measures. There was discussion concerning the possibility of CMS resubmitting the measures to MAP at a later date, when more data are available. The discussion focused on the critical nature and immediacy of the issue; MAP did not want to delay the use of these measures.

MAP decided to vote on all three measures with one vote. MAP offered conditional approval to all three measures with the conditions being that: MAP would consider these measures again when additional information is available, including completed technical specifications; an expedited review process would be considered for both NQF and CMS; and CMS would explore their authority to include pediatric hospitals.

MUC20-0045: CoV-2 Vaccination by Clinicians

Merit-Based Incentive Payment System (MIPS) Program

MUC20-0048: SARS-CoV-2 Vaccination Coverage for Patients in End-Stage Renal Disease (ESRD) Facilities

End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel

End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

Hospital Outpatient Quality Reporting Program (Hospital OQR Program)

Hospital Inpatient Quality Reporting Program (Hospital IQR Program)

Ambulatory Surgical Center Quality Reporting Program (ASCQR)

Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)

PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)

Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

Future Direction of the MAP Process

The Coordinating Committee felt that the MAP process went very well and that it was clear that earlier efforts to develop decision-making rules were effective in providing a clear and efficient process.

It was noted that developers gathered a great deal of information from patients and families. It was requested that in the future this information be shared with CMS and MAP.

MAP noted that there is language in adopted legislation for CMS to consider the removal of measures. MAP formally recommended to CMS and NQF that they develop, and that CMS funds, a separate rigorous process for the removal of measures, including the development of thresholds for the identification of measures that should be considered for removal. It was noted that the current process for recommendations concerning new measures works well and can be a model for the development of a process for measure removal.

Public Comment

There were no public comments.

Closing Remarks and Next Steps

Dr. Schreiber thanked the group and the co-chairs.

Co-chairs thanked the NQF staff and the Committee for a well-run meeting.

Dr. Stolpe offered thanks on behalf of NQF as well and then reviewed the next steps. NQF staff will capture the contents of the discussion and provide a final set of recommendations to CMS. NQF will also provide a final report to CMS. NQF and CMS will be meeting in the next few weeks to review the process. That will close out the MAP 2020-21 cycle.

Appendix A: MAP Coordinating Committee Attendance

The following members of the MAP Coordinating Committee were in attendance:

Organizations

American Academy of Hospice and Palliative Medicine

American College of Physicians

American Health Care Association

American Medical Association

American Nurses Association

America's Health Insurance Plans

AmeriHealth Caritas

BlueCross BlueShield Association

HCA Healthcare

The Joint Commission

The Leapfrog Group

National Committee on Quality Assurance

Network for Regional Healthcare Improvement

Pacific Business Group on Health

Subject Matter Experts

Charles Kahn, III

Misty Roberts

Harold Pincus, MD

Jeff Schiff, MD, MBA

Janice Tufte

Ronald Walters

Appendix B: Full Voting Results

Measure Name	Program	Yes	No	Total Votes	Percent
Clinician Measures					
MUC20-0015: Asthma-Chronic Obstructive Pulmonary Disease (COPD) Episode-Based Cost Measure	MIPS	17	1	18	94%
MUC20-0016: Colon and Rectal Resection Episode-Based Cost Measure	MIPS	13	5	18	72%
MUC20-0017: Diabetes Episode-Based Cost Measure	MIPS	15	3	19	79%
MUC20-0018: Melanoma Resection Episode-Based Cost Measure	MIPS	16	3	19	84%
MUC20-0019: Sepsis Episode-Based Cost Measure	MIPS	18	0	18	100%
MUC20-0034: Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System	MIPS	7	11	18	39% (Cond. Support
		16	3	18	89% (DN Support w/ Mit)
MUC20-0040: Intervention for Prediabetes	MIPS	18	0	18	100%
MUC20-0042: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure	MIPS	17	1	18	94%
MUC20-0043: Preventive Care and Wellness (Composite)	MIPS	11	8	19	57% (Cond. Support)

		18	1	19	95% (DN Support w/ Mit)
MUC20-0033: ACO-Level Days at Home for Patients with Complex, Chronic Conditions	Medicare Shared Savings Program	14	2	16	94%
Hospital Measures					
MUC20-0039: Standardized Hospitalization Ratio for Dialysis Facilities (SHR)	ESRD QIP	15	1	16	94%
MUC20-0032: Global Malnutrition Composite Score	Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs) Measures	18	0	18	100%
MUC20-0032: Global Malnutrition Composite Score	Hospital IQR Program	18	0	18	100%
MUC20-0003: Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)	Hospital IQR Program	17	1	18	94%
MUC20-0004: Appropriate Treatment for ST-Segment Elevation Myocardial Infarction (STEMI) Patients in the Emergency Department (ED)	Hospital OQR Program	18	0	18	100%
MUC20-0005: Breast Screening Recall Rates	Hospital OQR Program	17	2	19	89%
PAC/LTC Measures					

MUC20-0030: Hospice Care Index	HQRP	17	1	18	89%
MUC20-0002: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization	SNF QRP	19	0	19	100%
CoV-2 Measures					
MUC20-0045: CoV-2 Vaccination by Clinicians	MIPS	18	0	18	100%
MUC20-0048: SARS-CoV-2 Vaccination Coverage for Patients in End-Stage Renal Disease (ESRD) Facilities	ESRD QIP	Vote included MUC20-0045, MUC20-0048, and MUC20-0044. MAP approved Conditional Support for all three measures.			
MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	ESRD QIP				
MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	ASCQR				
MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	Hospital OQR Program				
MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	Hospital IQR Program				
MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	IPFQR				
MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	PCHQR				
MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	IRF QRP				
MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	LTCH QRP				

MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	SNF QRP	