February 28, 2020

Michelle Schreiber, MD
Director, Quality Measurement and Value-Based Incentive
Centers for Medicare & Medicaid Services (CMS)
7500 Security Blvd
Baltimore, MD 21244

Re: Merit-based Incentive Payment System Value Pathway (MVP)

Dear Dr. Schreiber,

On behalf of the American College of Physicians (ACP), I am pleased to provide feedback on the Merit-based Incentive Payment System Value Pathway (MVP) and introduce ACP's proposals for two new MVPs for the 2021 performance year, which target preventive care and chronic disease management.

ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 159,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ACP strongly supports the stated goals of the MVP to reduce reporting burden and complexity within MIPS while improving the accuracy and effectiveness of performance measurement, which reflect long-standing ACP priorities. ACP also agrees that it is important to support clinicians as they transition to Advanced Alternative Payment Models (APMs).

For the MVP to achieve these goals, CMS must fully commit to burden reduction by reducing the overall number of metrics and awarding credit across multiple performance categories for innovations that touch both. In particular, the Promoting Interoperability (PI) Category must be reinvented to work in harmony with the other categories to encourage the using and exchanging of data in innovative ways to support the overarching goals of the MVP. Equally important, CMS must ensure that every measure or activity is held to the highest standards of reliability and clinical evidence base, understanding that a good performance measurement program cannot be built on a foundation of weak performance measures. This includes developing new, more targeted cost measures and in the interim either reweighting the Cost Category to zero, or, at a minimum, making necessary adjustments to the current cost measures based on the suggestions from ACP's Performance Measurement Committee (PMC).

We appreciate the CMS' openness to and desire for stakeholder input, including soliciting stakeholder submission of MVPs. We look forward to continue being an active partner in the design and implementation of MVPs. To that end, we offer the following recommendations in addition to our proposals for two new MVPs for the 2020 performance period, which focus on preventive care and chronic disease management, two areas ripe for potential improvement in a value-based system.

I. MVP Policy Recommendations

Transition Period

- **A robust, multi-year transition period will be critical to the success of the MVP.** It will allow CMS to move forward with a smaller set of MVPs that are ready for prime time with time to develop additional MVPs that will offer opportunities for participation by all specialists and subspecialists. Importantly, it will also allow for clinician education on the new requirements and specific MVP options, which is critical to successfully navigating any transition, especially one of this magnitude.

- **ACP does not support making the MVP mandatory, nor do we feel it is necessary.** If the MVP successfully reduces burden and enhances the accuracy and feedback within MIPS as it intends to, clinicians will transition to MVPs voluntarily and mandatory enforcement is not necessary.

- **If CMS does elect to move forward with making the MVPs mandatory, the Agency should wait until there is at least one applicable MVP for every MIPS eligible clinician, including all specialties and subspecialties. Under no circumstances should the MVP be made mandatory before the 2024 performance year.** CMS should accept that this process may take several years, and understand that it is more important to take time to get it right rather than rush implementation to meet external pressures or timelines. A minimum of three years will be needed to develop, test, and submit MVPs, particularly those that include relevant cost metrics.

Reporting and Scoring

- **MVPs should include some degree of choice between a small set of related, clinically meaningful, high validity measures** so clinicians can choose those that are most appropriate for their unique patient population and practice needs, as explained in greater detail in the Quality and PI sections.

- **CMS should allow reporting of data at multiple levels**, including the TIN, NPI, and sub-TIN levels so practices may choose the least burdensome and most appropriate option. Reporting at the sub-TIN level will be especially critical for multispecialty groups if MVPs are specialty- or condition-specific.

- **CMS should continue to support numerous reporting mechanisms**, including qualified registries and clinical data registries, which have been instrumental in developing specialty-specific performance measures, while understanding claims-based reporting will continue to play an important role for some practices, particularly (but not limited to) small and rural practices.

- **CMS should award automatic credit toward multiple categories for reporting a metric that is applicable to both, including the PI Category.** Clinicians who report data for other categories using Certified EHR Technology (CEHRT) should be awarded credit toward the PI Category because in so-

doing, they are actively demonstrating their use of CEHRT. Awarding cross-category credit will have a direct, immediate effect on the burden of reporting.

- **Points should be assigned based on each measure's corresponding weight to the overall MIPS composite score.** This will be more meaningful and intuitive.

- **There should be a consistent 90-day reporting period across all performance categories.** This will promote consistency, minimize reporting burden, and help to facilitate awarding multi-category credit for the same measures or activities.

Below is an overview of how reporting and scoring for the performance categories could be organized in a more cohesive and straightforward way.

Quality:* *30 points*	**Cost:*** *30 points*	**Promoting Interoperability:** *25 points*	**Improvement Activities:** *15 points*
3 performance-based measures worth 0-10 points each	1-3 performance-based measures averaged together	Selection of attestation-based measures with automatic credit for overlapping data where possible (4 required)	3 attestation-based activities worth 5 points each with automatic credit for overlapping data where possible

** The Cost Category should be reweighted to zero until more accurate cost measures can be developed. During this time, the Quality Category would be double weighted.*

Quality Category

- **MVPs should be scored on a maximum of three performance measures. However, clinicians should be able to select from a small group of related, clinically meaningful, and reliable performance measures** so they can choose measures that are most relevant to the unique needs of their practice and patients. If clinicians elect to report more than three quality measures, their highest three should be scored.

- **Performance measures should continue to be scored on a performance basis ranging from zero to ten points**, which will ensure consistency and allow current performance measures to be used, thus helping to ease the transition to MVPs.

- **CMS should encourage reporting additional performance data or new performance measures**, such as awarding Improvement Activities points or establishing a scoring floor for new measures.

- **Claims-based population measures are still in developmental stages and have yet to be field tested. It would be premature to include them in MVPs.** To date, claims-based population measures have not been tested at the physician level and do not provide actionable information. They also have lingering attribution concerns. CMS should provide the necessary claims data and work with stakeholders to develop administrative claims measures.

Cost Category

- **CMS should work to develop MVP cost measures that more accurately measure costs that are within the clinician's control and more targeted toward the focus of the specific MVP, including preventive care and chronic disease focused cost measures for ACP's two MVPs.** Measuring what is actionable could build trust with clinicians, feed a cycle of participation, and discourage dysfunctional behaviors such as avoiding attribution. Stratifying and comparing results based on costs related to 1) services that are under the direct control of the individual clinician, 2) indirect costs, and 3) services under the control of the facility could help to mitigate this concern by identifying behaviors that correspond with opportunities for improvement.

- **New cost measures should aim to capture cumulative savings over a multi-year period.** If CMS intends to create individual cost profiles to generate incentives to decrease health care costs, it is important these profiles provide insights into which care management interventions are most effective in reducing costs year-over-year, even if what is measured does not encompass the totality of the cost to Medicare for the items and services provided to a patient during an episode of care. Experience with APMs such as the Medicare Shared Savings Program prove it takes time to achieve savings from preventive care efforts or more effective chronic disease management.[1] CMS could consider establishing a baseline spending benchmark for relevant patients and/or services.

- **As it works to develop these measures, CMS should ideally use its statutory flexibility to reweight the Cost Category to zero percent of the MIPS composite score**. While we recognize the importance of valuing the efficient delivery of high quality care at low costs, performance measurement ceases to be meaningful if the soundness of its individual metrics are in question. Financially penalizing clinicians based on cost measures whose clinical relevance and statistical validity have repeatedly been brought into question could have serious consequences, including undermining physician trust in the program and penalizing physicians who treat at-risk patient populations, thereby threatening patient access.

- **If CMS does move forward with the current Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Cost (TPCC) measures in the interim as it works to develop new, more focused cost measures, the Agency should, at a minimum, improve the measures according to the ACP Performance Measurement Committee's suggestions. As currently specified, both have major flaws and are not appropriate for MVP inclusion, including our preventive care and chronic disease management MVPs.** While we acknowledge several positive changes to the redeveloped 2020 MSPB and TPCC measures, ACP continues to oppose attributing broad-based downstream costs to upstream clinicians or practices, particularly at the clinician level. In addition, we have lingering concerns with the risk adjustment, patient attribution, and physician assignment methodologies. For a more detailed description of our thoughts on the current measures, please reference our comments in response to the 2020 Physician Fee Schedule and QPP proposed rule. ACP's detailed suggested changes to both measures can be found in Appendix I (on pages 27-36). Among other changes, CMS should consider establishing a pre-mortem approach for evaluating the impact of new cost measures to combat the unintended consequences of implementation.
- **Episode-based cost measures are still in developmental stages and have yet to be field tested. As a result, it would be premature to include them in MVPs.** As CMS proceeds with developing

[1] Medicare Shared Savings Program Produces Substantial Savings: New Policies Should Promote ACO Growth. Health Affairs. Gaus, Clifton. Mechanic, Robert. September 11, 2018.

episode-based measures, it is critically important that the Agency engage with stakeholders and hold every measure to transparent, consistent validity standards. ACP has consistently suggested a floor of 0.75, which the vast majority of current episode-based measures fail to meet. Increasing case minimums could help to improve the validity of current and future cost measures.

Improvement Activities Category

- **All Improvement Activities should be evenly weighted and worth five points each. Performing three activities would maximize one's score for this category, which would be scored out of 15 points.** This would help to simplify this category and ensure the points are relative to their weight to the overall MIPS composite score.

- **Attestation-based reporting should continue** for consistency and to minimize reporting burden.

- **Automatic Improvement Activities credit should be awarded for reporting data for other performance categories that satisfies both requirements. Ideally, opportunities for automatic credits should satisfy full category requirements and not require any separate attesting on behalf of the clinician.** In cases where improvement activities support Quality and Cost Category goals and are captured in the data for those categories, or where innovative uses for emerging technologies inherently supports the collecting and transmitting of useful patient data, clinicians are implementing meaningful practice improvements that advance patient care. In many cases, there is no need for them to separately attest simply to check a box. The improvement activities included with ACP's preventive care and chronic disease management MVPs are specifically designed to be cross cutting. In particular, within the chronic disease management MVP, the MDD prevention and treatment intervention improvement activity (BMH_5) could be simultaneously satisfied with the suicide risk assessment performance measure (MIPS 107). Within the preventive care MVP, CDC training on guidelines for prescribing opioids for chronic pain (PSPA_22) would be satisfied by the evaluation or interview for risk of opioid misuse performance measure (MIPS 107), and the unhealthy alcohol use for patients with co-occurring conditions of mental health and substance abuse (BMH_9) would be satisfied by the unhealthy alcohol use: screening and brief counseling performance measure (MIPS 431).

Promoting Interoperability (PI) Category

For the 2021 Performance Year:

- **The PI Category should be transformed to include elective, attestation-based measures that support the use of electronic health records (EHRs) and health information technology (IT) to improve value-based care and facilitate effective communication across the care continuum.** While we appreciate CMS' recent efforts to streamline and simplify the PI category overall, the existing measures are the same measures that clinicians have already found to be cumbersome and inappropriate, and do little to help clinicians move forward in using health IT to improve care. The MVP provides an opportunity to transform the PI category away from the existing "functional-use measures" to a more elective, attestation-based category. This will promote the collection of data on the use of EHRs and allow comparisons of that data to health outcomes and patient satisfaction, instead of grading clinicians on the number of times they use the technology no matter the value to the clinician, patient, or practice.

- **ACP recommends CMS include existing measures but remove the thresholds and performance requirements for scoring purposes. However, the Agency should continue to collect the numerator/denominator data to assess whether these measures indicate meaningful improvements.** This approach will account for the fact that some of the PI measures are required by legislation and provide a base on which to improve and incorporate the category in the near-term. However, this approach also will recognize that many of the measures may not have meaningful distributions in performance or are not yet at a point where they are ready to be evaluated on a performance basis due to current EHR platform limitations. As CMS works towards the goal of achieving interoperability across EHR platforms, they can continue to evaluate which measures are meaningful indicators of physician performance without inadvertently penalizing physicians for technological limitations that are beyond their control.

- **In addition to the existing measures, the PI category should include a list of elective, clearly-defined health IT-specific activities from which a clinician can choose, similar to the Improvement Activities Category.** This approach would allow this category the necessary flexibility to evolve over time as innovative new technologies emerge. The incorporation of health IT activities that could focus on the specific grouping of measures within any given MVP further promotes CMS' goals to align the MIPS performance categories and reduce burden under the MVP initiative. We provide several examples in our preventive care and chronic disease management MVP proposals, including participating in the development of eCQMs, that support quality improvement or an EHR or Health IT educational activity that is developed or endorsed by a medical or professional society.

- **Similar to the Improvement Activities Category, ACP recommends that each PI measure and health IT-related activity be worth a certain number of points, calculated by attestation rather than performance rates, with 25 points as the maximum score for PI.** This way, the points for each activity would reflect their relative worth to the MIPS composite score. Reporting PI measures and activities on an attestation basis will help remove the existing process of clinicians churning out numerators and denominators for measures that are not truly advancing health IT or interoperability, and incentivize other meaningful ways clinicians are already sharing patient data and leveraging innovative technologies to improve value.

- **Partial PI credit should be automatically awarded when health IT is used to perform or report on measures within the Quality, Cost, and Improvement Activities Categories.** This will help to limit reporting burden while upholding the goals of the PI category to encourage the interoperability of EHR systems and sharing of patient data. Awarding credit across multiple performance categories for measures and activities that inherently apply to both does not undervalue the goals of either category, rather, it strengthens them by aligning incentives toward a unified goal, a central tenant of the new MVP. There is no reason why the PI category should remain siloed when the optimal use of health IT and exchange of data fundamentally supports the goals of each of the other performance categories. Reporting performance data through an EHR or other health IT platform demonstrates a clear use of this technology to support quality initiatives. Likewise, certain performance measures (specifically preventive and chronic condition measures) and improvement activities (e.g., Use of QCDR data for ongoing practice assessment and improvements) inherently entail use of health IT and/or the sharing of patient data should earn automatic PI credit. Arguably, no other category is as intrinsically interconnected to the other performance categories as PI.

- **By maintaining specific PI focused metrics while incorporating flexibility and awarding credit for the innovative ways clinicians are already leveraging CEHRT, ACP's recommendations strike an**

appropriate balance between holding clinicians accountable to a tangible set of metrics that promote interoperability while minimizing burden and creating more synergy among the various performance categories.

For Future Performance Years:

- **CMS should identify eCQMs mapped to the Fast Health Interoperability Resources (FHIR) specifications and provide PI credit to physicians who choose to report on the relevant set of FHIR-mapped eCQMs.** ACP supports CMS' efforts to map existing eCQMs to FHIR specifications and the US Core Data for Interoperability (USCDI) to improve the performance reporting infrastructure. The current infrastructure requires that measures be developed to meet multiple versions of a standard, with each EHR vendor implementing these standards differently, and each health system having to customize the data elements necessary for the varying measures. Moving to one standard that is mapped to a specific set of data elements (e.g., FHIR specifications using the USCDI data set) will help evolve the current performance measure development and reporting process to a more streamlined, efficient, and lower-cost system. Moreover, the quality of reporting and outcome data will improve due to the use of consistent data elements from the start.

- **The College is aware of the effort and complexity involved in moving the infrastructure for reporting performance data in this direction, and acknowledges that there are a number of issues that will need to be addressed along the way.** For example:

    - Performance measures themselves may have to be simplified. There are a number of common features and exclusion criteria within existing performance measures that have always been problematic to document and currently do not exist within the USCDI (e.g., documenting "frailty" or "medical reason not done"). If these certain features are removed from measures, the denominator is likely to rise and performance scores will shift.

    - There may be additional documentation burden associated with shifting to one set of standards and data elements. For example, relevant data may exist in reports, but not in data elements. These data may be difficult to extract from reports, or clinicians may have to re-enter the needed data in fields that are part of a currently limited USCDI, causing additional documentation burden until the USCDI is expanded.

- **Clinicians participating in an MVP should receive full credit for the PI category if they choose to report on the new set of eCQMs to recognize the complexity, time, and implications of moving performance measures to FHIR/USCDI.** Not only will this incentivize participation in the new process, it will allow CMS to assess the implications on simplifying measures (e.g. removing exclusion criteria) and documentation burden when comparing new and old measures. The College believes focusing on this aspect for future years of the MVP initiative provides an excellent roadmap for improving the PI category and Quality Payment Program overall.

Future Measure Development

- **All measures, particularly cost measures, should be tested and subject to independent standards for clinical evidence base and statistical reliability and third party review.** The current minimum reliability of 0.4 for episode-based measures is unacceptable. CMS should establish a consistent reliability rating of at least 0.75 and set case minimums accordingly. CMS should also require

approval from an independent third party such as ACP's own PMC, the Measures Application Partnership (MAP), or Core Quality Measures Collaborative. Furthermore, all measures in use by CMS ideally should be endorsed or recommended by an independent entity, such as the National Quality Forum (NQF). CMS should publish the details of the testing results on a public domain where reviewers can assess the positive or negative impacts of implementation. Maximizing transparency would build trust with clinicians and feed a cycle of participation. Additionally, CMS should consider establishing a pre-mortem approach for evaluating the impact of the performance measures to combat the unintended consequences of implementation and correctly identify reasons for future outcomes.

- **ACP recommends as part of its New Vision for the U.S. Health Care System[2] that, in most cases, measures tied to payment incentives should be evaluated at the team, practice, or system level rather than at the individual clinician level, but supports the use of additional, clinically meaningful measures for internal quality improvement.** ACP strongly supports physician-led, team-based care, particularly in a value-centric environment and believes payers and other entities that assess performance should focus on outcomes-based goals and allow physicians and their care teams to decide how to meet them. This will enable physicians to deliver care that is customized to the unique needs and preferences of their patients rather than checking process-related boxes.

- **Supporting private sector development of MVPs and new measures will be critical to developing a diverse array of MVP options in a short timeframe. Funding would help to speed the development of MVPs and cover existing gaps, particularly for certain specialties or subspecialties whose societies may have limited resources**. CMS could also act as a conduit to connect vendors that are interesting in developing similar MVPs and may be interested in collaborating and sharing resources. Allowing vendors access to Medicare claims data could help to spur development of new MVP measures, particularly condition- or specialty-specific cost measures.

- **ACP supports the inclusion of QCDR measures in specialty-specific MVPs, provided several considerations are taken into account.** A 2017 Task Force of physician experts convened by ACP provided the following recommendations:
    - QCDR measures should have clinical relevance, evidence of a performance gap, as well as evidence that improving that gap will result in improved care.
    - Measures should be appropriately attributed, and risk-adjusted if necessary.
    - Improvement on a measure should not foster under or overuse of resources.
    - In an effort to minimize burden, QCDR measures should be populated using standardized data elements through the existing clinical workflow, or a reasonably modified workflow.

- **ACP urges CMS to reconsider several new criteria for QCDR and qualified registry vendors**, including that all measures be fully tested and developed prior to submission, and that a measure's approval may be contingent on the extent to which it is available from other vendors. While ACP recognizes the intent behind these policies to protect and minimize burden on clinicians, we worry they may unintentionally deter or delay measure development, which will be especially important in this work to develop MVPs.

[2] https://annals.org/aim/fullarticle/2759528/envisioning-better-u-s-health-care-system-all-call-action?_ga=2.177330021.1193544014.1582900794-953985627.1581102466

- **"Safe harbors" should be established for clinicians who test measures that are new or undergo substantive changes. At a minimum, practices should be provided with performance results for these measures without having their payments adjusted. Ideally, there should be incentives for those willing to test new measures**, including awarding credit toward the Improvement Activities category for reporting new measures, or setting a scoring floor for new measures.

- **Performance targets should be clear, achievable, and prospective.** High quality care is objective, not relative. This should extend to performance benchmarks. Clinicians perform better when they know the targets for which they are aiming. Accordingly, benchmarks should be prospective and fixed across all participants using the most current data available. Relative benchmarks, which compare groups with their peers and are only available after the performance period, create arbitrary "winners" and "losers," tend to benefit larger practices and health systems that have more infrastructure to support performance measurement, and should be avoided.

- **Performance measures and measurement methodologies should be aligned across payers, models, and programs wherever possible.** Focusing on a limited set of accurate, meaningful measures that are consistent across programs will empower physicians to redirect resources from data reporting to direct patient care and prioritize interventions that truly move the needle on quality and/or efficiency of care delivery. Aligning metrics also facilitates the sharing of data across payers and models. Mirroring APM measures will facilitate a more seamless transition to APMs.

- **Prospective, patient-centered approaches such as voluntary patient attribution and patient relationship codes should be the preferred attribution.** Clinical care teams are in the best position to optimize patient care and meet performance targets when they know which patients they are responsible for through prospective patient assignment. Voluntary patient attribution, which enables patients to select their primary care physicians, is the patient-centered gold standard. Patient-relationship codes, which allow physicians to identify each patient they are responsible for managing, are also promising. ACP urges CMS to expedite development of these codes. If neither is possible, payers should look to establish care patterns by requiring two or more clinically relevant services to ensure patients are only assigned to physicians actively involved in their care.

Performance Feedback

- **Providing accurate, actionable, and timely performance data empowers practices to meaningfully improve quality of care for their patients. ACP has long advocated for performance feedback on a quarterly basis at a minimum, working up to a real time claims data feed.** Receiving quality data up to 18 months after-the-fact is not an effective way to drive quality improvement. Practices need frequent feedback on consistent metrics over time to be able to track their progress, target areas for improvement, develop improvement strategies, and evaluate their progress. Value-based programs should provide physicians and clinical care teams with actionable feedback and raw data to identify areas for improvement and deploy targeted interventions to improve outcomes.

- **Practices need consistent, accurate performance and financial data to confidently transition to APMs.** Practices need financial data to perform the necessary cost benefit analyses to determine if a model is financially viable, particularly when it comes to risk-bearing models. Without such data, they simply cannot justify the risk.

- Measures must be evaluated at the appropriate level of control and influence. **However- performance feedback should be provided both at an aggregate level and be available to be drilled down to an individual clinician level** so that the practice can gain more insights and leverage this data to more effectively target resources and improve individual performance.

II. ACP Proposed MVPs

Below are ACP's draft MVPs for consideration for the 2021 performance year; one centered on chronic disease management and the other on preventive care, two critical priorities in the value-based payment movement. ACP is working actively in the field of performance measurement because we recognize its importance in improving the quality of patient care.

All improvement activities have been reviewed and approved by ACP's Medical Practice and Quality Committee (MPQC) and all performance measures have been reviewed and approved by ACP's Performance Measurement Committee (PMC) based on a methodologically rigorous approach.[1] The MPQC identified six improvement activities for the preventive care MVP and nine improvement activities for the chronic disease management MVP. The PMC determined that six performance measures are appropriate for inclusion in the Chronic Disease MVP, noting that one additional performance measure and two cost measures may also be appropriate, but only if modified based on suggestions. Eight performance measures are appropriate for inclusion in the Prevention MVP, with two additional performance measures and two cost measures that may be appropriate for inclusion, but only if modified based on suggestions.

Immediately following is a summary of all of the performance measures and activities recommended for inclusion for each performance category within each MVP. Appendices I, II, and III describe the specific improvement activities, and quality and cost measures, and PI measures in greater detail, as well as our rationale for inclusion and suggestions for additional modifications where warranted.

ACP's Proposed Chronic Disease Management MVP

Quality - Performance-based measures (select 3)

Appropriate for Inclusion

1. Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (MIPS 438)
2. Beta-Blocker Therapy for LVSD (MIPS 008; NQF 0083)
3. Diabetes: Medical Attention for Nephropathy (MIPS 119; NQF 0062)
4. Adult Major Depressive Disorder: Suicide Risk Assessment (MIPS 107; NQF 0104)
5. ACE-I or ARB Therapy—Diabetes or LVSD (LVEF <40%) (MIPS 118; NQF 0066)
6. Chronic Stable CAD: Antiplatelet Therapy (MIPS 006; NQF 0067)

Appropriate for Inclusion <u>Only If Modified</u>

7. Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (MIPS 001; NQF 0059)

Cost - Performance-based measures

CMS should develop appropriate, meaningful preventive cost measures. In the interim:

- ***Ideal:*** Cost category reweighted to zero until new measures are developed, tested, and evaluated.
- ***Alternative:*** CMS adopts modified MSPB and TPCC measures based on PMC suggestions.

Improvement Activities - Attestation-based (select 3)

1. Implementation of quality improvement methods or other practice changes/improvements (PPSA_19)
2. Completion of an Accredited Safety or Quality Improvement Program (PSPA_28)
3. Use of QCDR data for ongoing practice assessment and improvements (PSPA_7)
4. Chronic Care and Preventive Care Management for Empaneled Patients (PM_13)
5. Participation in MOC Part IV (PSPA_2)
6. Implementation of condition-specific chronic disease self-management programs (BE_20)
7. Improved Practices that Disseminate Appropriate Self-Management Materials (BE_21)
8. Improved Practices that Engage Patients Pre-Visit (BE_22)
9. MDD prevention and treatment interventions (BMH_5)

Promoting Interoperability – Attestation-based measures (***** denotes a mandatory measure)

Existing PI Measures:

1. E-Prescribing *****
2. Health Information Exchange *****
3. Information Blocking Attestation *****
4. Security Risk Analysis *****
5. Clinician to Patient Exchange
6. Immunization Registry Reporting
7. Electronic Case Reporting
8. Public Health Registry Reporting
9. Clinical Data Registry Reporting
10. Syndromic Surveillance Reporting

New PI Measures:

11. Quality, Safety, Value Improvement Projects that Leverage Health IT
12. Participation in development of eCQMs that support Quality Improvement (done within QCDR)
13. EHR/Health IT educational activity developed/ endorsed by medical or professional society
14. Participation in Precision Medicine/Learning Health System (practice-based research/observational studies)
15. Clinical Informatics Improvement (via an "EHR feedback" application or EHR user group)
16. Patient Safety and Near-miss reporting from EHR

ACP's Proposed Preventive Care MVP

Quality - Performance-based measures (select 3)

Appropriate for Inclusion

1. Colorectal Cancer Screening (MIPS 113; NQF 0034)
2. Appropriate Follow-up Interval for Normal Colonoscopy in Avg. Risk Patients (MIPS 320; NQF 0658)
3. Breast Cancer Screening (MIPS 112; NQF 2372)
4. Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (MIPS 438)
5. Tobacco Use: Screening & Cessation Intervention (MIPS 226; NQF 0028)
6. Influenza Immunization (MIPS 110; NQF 0041)
7. Evaluation or Interview of Opioid Misuse (MIPS 414)
8. Unhealthy Alcohol Use: Screening & Brief Counseling (MIPS 431; NQF 2152)

Appropriate for Inclusion <u>Only If Modified</u>

9. Care for Older Adults—Medication Review (NQF 0553)
10. Preventive Care & Screening: BMI Screening and Follow-up Plan (MIPS 128; NQF 0421)

Cost - Performance-based measures

CMS should develop appropriate, meaningful preventive cost measures. In the interim:

- ***Ideal:*** Cost category reweighted to zero until new measures are developed, tested, and evaluated.
- ***Alternative:*** CMS adopts modified MSPB and TPCC measures based on PMC recommendations.

Improvement Activities - Attestation-based (select 3)

1. Quality improvement methods, practice changes, other practice improvement processes (PSPA_19)
2. Completion of an Accredited Safety or Quality Improvement Program (PSPA_28)
3. Use of QCDR data for ongoing practice assessment and improvements (PSPA_7)
4. CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain (PSPA_22)
5. Participation in MOC Part IV (PSPA_2)
6. Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Abuse and Ambulatory Care Patients (BMH_9)

Promoting Interoperability – Attestation-based measures (* denotes a mandatory measure)

Existing PI Measures:

1. E-Prescribing *****
2. Health Information Exchange *****
3. Information Blocking Attestation *****
4. Security Risk Analysis *****
5. Clinician to Patient Exchange
6. Immunization Registry Reporting
7. Electronic Case Reporting
8. Public Health Registry Reporting
9. Clinical Data Registry Reporting
10. Syndromic Surveillance Reporting

New PI Measures

11. Quality, Safety, Value Improvement Projects that Leverage Health IT
12. Participation in development of eCQMs that support Quality Improvement (done within QCDR)
13. EHR/Health IT educational activity developed/ endorsed by medical or professional society
14. Participation in Precision Medicine/Learning Health System (practice-based research/observational studies)
15. Clinical Informatics Improvement (via an "EHR feedback" application or EHR user group)
16. Patient Safety and Near-miss reporting from EHR

III. In Conclusion

We appreciate this opportunity to provide our thoughts and recommendations concerning the future MIPS Value Pathway, particularly the opportunity to submit our own MVPs for possible 2021 implementation. For questions pertaining to the policy recommendations, proposed Improvement Activities, and/or recommended Promoting Interoperability measures, please contact Shari Erickson, Vice President, Governmental Affairs and Medical Practice, at serickson@acponline.org. For questions pertaining to the PMC's quality and cost measure recommendations, please contact Amir Qaseem, Vice President, Clinical Policy, at aqaseem@acponline.org. ACP looks forward to continuing to engage with CMS to further refine MVPs and make MIPS more actionable and less burdensome to help it work better for physicians and patients alike.

Regards,

Nick Fitterman, MD, MACP, SFHM
Chair, Performance Measurement Committee
American College of Physicians

Ryan D. Mire, MD, FACP
Chair, Medical Practice and Quality Committee
American College of Physicians

Appendix I: Quality and Cost Measures: Detailed Rationale

Table of Contents

Executive Summary

Performance measurement has a critical goal of improving the quality of healthcare services and reducing avoidable healthcare costs. As performance measurement programs evolve alongside advancements in the field, healthcare leaders face increasing opportunities to implement valid and meaningful performance measurement programs that effectively and efficiently address the most pressing performance gaps and address quality improvement.

The American College of Physicians (ACP) believes that the MIPS Value Pathways (MVPs) framework has the potential to allow for a more streamlined, cohesive reporting process, and create integrated measure sets that are meaningful to internal medicine clinicians. We also believe that CMS cannot build a good performance measurement program on a foundation of weak performance measures. Therefore, the selection of valid performance measures for all MVPs under consideration is an essential first step toward the success of this program. Measures selected for inclusion in all MVPs should be meaningful, methodologically sound, well-specified, evidence-based, feasible and actionable, and proactively tested for unintended consequences.

For this proposal, the ACP Performance Measurement Committee (PMC) evaluated the appropriateness of 18 quality measures and 2 cost measures for inclusion in the Chronic Disease MVP and 13 quality measures and 3 cost measures for inclusion in the Prevention MVP. The PMC determined 6 quality measures are appropriate for inclusion in the Chronic Disease MVP. In addition, 1 quality measure and 2 cost measures will only be appropriate for inclusion in the Chronic Disease MVP if modified based on our suggestions. The PMC recommends 8 quality measures are appropriate for inclusion in the Prevention MVP. In addition, 2 quality measures and 2 cost measures will only be appropriate for inclusion in the Prevention MVP if modified based on our suggestions.

Any additional quality and cost measures suggested for consideration by CMS (Appendix A) were not included in the proposal based on one or more of the following reasons:

- The measure is currently retired from or not included in MIPS;
- We believe it is inappropriate to tie the measure to payment as opposed to using the measure purely for the purpose on internal quality improvement efforts;
- The measure is inappropriate for attribution at the level of the individual clinician;
- High-quality evidence to form the basis of the measure does not exist and therefore, the measure should be retired until evidence exists to support measurement in this area;
- Tying the measure to payment could promote overuse of unnecessary treatment where the potential benefits for not outweigh the risk of harms.

The body of this proposal summarizes the details of the performance measures proposed for inclusion as well as PMC's suggestions to the measure developer for modifications.

Measure Summaries and ACP Suggestions for Modifications

Chronic Disease MVP

A. **Quality Measures Appropriate for Inclusion in Chronic Disease MVP**

MIPS 438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	
Measure Steward	Centers for Medicare & Medicaid Services
NQF Status:	Not Endorsed
Federal Program:	MIPS
Description:	Percentage of the following patients-all considered at high risk of cardiovascular events-who were prescribed or were on statin therapy during the measurement period: Adults aged >= 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR Adults aged >=21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.
Numerator Statement:	Patients who are actively using or who receive an order (prescription) for statin therapy at any point during the measurement period Definitions: Statin therapy - Administration of one or more of a group of medications that are used to lower plasma lipoprotein levels in the treatment of hyperlipoproteinemia. Statin Medication Therapy List (NOTE: List does NOT include dosage) is included in the clinical recommendations.
Denominator Statement:	Patients aged ≥ 21 years at the beginning of the measurement period with clinical ASCVD diagnosis Definitions: Clinical Atherosclerotic Cardiovascular Disease (ASCVD) includes: • Acute Coronary Syndromes • History of Myocardial Infarction • Stable or Unstable Angina • Coronary or other Arterial Revascularization • Stroke or Transient Ischemic Attack (TIA) • Peripheral Arterial Disease of Atherosclerotic Origin Lipoprotein Density Cholesterol (LDL-C) result - A fasting or direct LDL-C laboratory test performed and test result documented in the medical record.

MIPS 438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	
Exclusions:	Acute liver or hepatic disease of insufficiency, ESRD, documentation of medical reason(s) for not currently being a statin therapy user or receive an order (prescription) for statin therapy (e.g., patient with adverse effect, allergy or intolerance to statin medication therapy, patients who are receiving palliative or hospice care, patients with active liver disease or hepatic disease or insufficiency, and patients with end stage renal disease.
ACP Rating:	Valid
ACP suggestions to the measure developer to consider during the next measure update to improve the validity of the measure (does not need to be addressed prior to inclusion in MVP):	• While we support this measure, we note that implementation of statin therapy alone does not guarantee meaningful improvements in clinical outcomes. A more meaningful measure may examine patient adherence to prescribed statin therapy. • A high percentage of patients prescribed statin therapy for the management of cardiovascular disease exacerbations (e.g., acute MI) discontinue therapy without consulting their clinician. Therefore, the measure may unfairly penalize clinicians for lack of control over non-adherent patients.

MIPS 008; NQF 0083: Beta-Blocker Therapy for LVSD	
Measure Steward	PCPI
NQF Status:	Endorsed
Federal Program:	MIPS, CQMC
Description:	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.
Numerator Statement:	Patients who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge
Denominator Statement:	All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%
Exclusions:	Denominator Exceptions: Documentation of medical reason(s) for not prescribing beta-blocker therapy (e.g., low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, allergy, intolerance, other medical reasons). Documentation of patient reason(s) for not prescribing beta-blocker therapy (e.g., patient declined, other patient reasons). Documentation of system reason(s) for not prescribing beta-blocker therapy (e.g., other reasons attributable to the healthcare system).
ACP Rating:	Valid

MIPS 119; NQF 0062: Diabetes: Medical Attention for Nephropathy	
Measure Steward:	NCQA
NQF Status:	Endorsed
Federal Program:	MIPS
Description:	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening or monitoring test or had evidence of nephropathy during the measurement year.
Numerator Statement:	Patients receiving a nephropathy screening or monitoring test or having evidence of nephropathy during the measurement year
Denominator Statement:	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Exclusions:	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclusions (optional): -Exclude patients who did not have a diagnosis of diabetes, in any setting, AND who had a diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year -Exclude patients
ACP Rating:	Valid

MIPS 107; NQF 0104: Adult Major Depressive Disorder: Suicide Risk Assessment	
Measure Steward:	PCPI
NQF Status:	Endorsed
Federal Program:	MIPS
Description:	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.
Numerator Statement:	Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified
Denominator Statement:	All patients aged 18 years and older with a diagnosis of major depressive disorder
Exclusions:	None
ACP Rating:	Valid

MIPS 107; NQF 0104: Adult Major Depressive Disorder: Suicide Risk Assessment	
ACP suggestions to the measure developer to consider during the next measure update to improve the validity of the measure (does not need to be addressed prior to inclusion in MVP):	• The measure is close to being topped out. The measure developers cite a 96% compliance rate. However, this data only represents clinicians who chose to report on the measure for the 2010 PQRS reporting year and therefore, may inaccurately represent nationwide performance levels. Developers should include current, national performance data in the updated measure report. • The numerator is not clearly specified. In particular, it is not well defined what constitutes a "recurrent" episode. Developers should consider revising the specifications to stipulate that this is an episode associated with the initiation of new treatment for depression. As currently stated, the measure could apply to all follow-up visits with the mention of even well-controlled depression.

MIPS 118; NQF 0066: ACE-I or ARB Therapy—Diabetes or LVSD (LVEF <40%)	
Measure Steward:	AHA
NQF Status:	Endorsed
Federal Program:	MIPS
Description:	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy.
Numerator Statement:	Patients who were prescribed ACE inhibitor or ARB therapy
Denominator Statement:	All patients 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes or current or prior LVEF <40%
Exclusions:	Documentation of medical reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, allergy, intolerance, pregnancy, renal failure due to ACE inhibitor, diseases of the aortic or mitral valve, other medical reasons) Documentation of patient reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, patient declined, other patient reasons) Documentation of system reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, lack of drug availability, other reasons attributable to the health care system)
ACP Rating:	Valid
ACP suggestions to consider during next measure update (does not need to be addressed prior to inclusion in MVP):	• While we support this measure, we note that the measure is close to being topped out. Performance data suggests that 81% of clinicians who reported this measure in 2014 adhere to the interventions described in the specifications. The measure developer should include current, national performance data in the updated measure report.

MIPS 006; NQF 0067: Chronic Stable CAD: Antiplatelet Therapy	
Measure Steward:	AHA
NQF Status:	Endorsed
Federal Program:	MIPS
Description:	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) seen within a 12 month period who were prescribed aspirin or clopidogrel.
Numerator Statement:	Patients who were prescribed* aspirin or clopidogrel within a 12 month period. *Prescribed may include prescription given to the patient for aspirin or clopidogrel at one or more visits in the measurement period OR patient already taking aspirin or clopidogrel as documented in current medication list.
Denominator Statement:	All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period.
Exclusions:	Documentation of medical reason(s) for not prescribing aspirin or clopidogrel (e.g., allergy, intolerance, receiving other thienopyridine therapy, receiving warfarin therapy, bleeding coagulation disorders, other medical reasons) Documentation of patient reason(s) for not prescribing aspirin or clopidogrel (e.g., patient declined, other patient reasons) Documentation of system reason(s) for not prescribing aspirin or clopidogrel (e.g., lack of drug availability, other reasons attributable to the health care system)
ACP Rating:	Valid
ACP suggestions to the measure developer to consider during the next measure update to improve the validity of the measure (does not need to be addressed prior to inclusion in MVP):	• While high quality evidence exists to form the basis of the measure, the evidence base would benefit from re-evaluation as data surfaces on the benefits and risks of aspirin therapy in patients who are already prescribed warfarin therapy. The European Cardiology Society and the American College of Cardiology have divergent recommendations on this area. • While feasibility of data collection and implementation burden is appropriate, it may be difficult for clinicians to capture over the counter aspirin use unless explicitly stated by the patient.

B. **Quality Measures Appropriate for Inclusion in Chronic Disease MVP Only if Modified Prior to Inclusion**

MIPS 001; NQF 0059: Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9%)	
Measure Steward:	NCQA
NQF Status:	Endorsed
Use in Federal Program:	MIPS
Description:	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.
Numerator Statement:	Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or for whom an HbA1c test was not done during the measurement year. The outcome is an out of range result of an HbA1c test, indicating poor control of diabetes. Poor control puts the individual at risk for complications including renal failure, blindness, and neurologic damage. There is no need for risk adjustment for this intermediate outcome measure.
Denominator Statement:	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Exclusions:	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
ACP Rating:	Uncertain Validity

MIPS 001; NQF 0059: Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9%)	
ACP suggestions for modifications prior to inclusion:	• There is insufficient evidence to describe an appropriate definition of poor HbA1c control, however some clinical guidance, including that of ACP, suggests that clinicians should personalize all goals for glycemic control in all patients on the basis of a discussion of benefits and harms of pharmacotherapy, patients' preferences, patients' general health and life expectancy, treatment burden, and costs of care and aim to achieve an HbA1c level 7%-8% in most patients with type II diabetes.[1] • Specifications should include appropriate exclusion criteria for patients where the potential harms outweigh the benefits of treating to a target HbA1c (e.g., patients with dementia and patients aged > 80 years). • Developers should consider revising the specifications to include some element of risk-adjustment for socioeconomic status and other unmodifiable risk factors to avoid potentially penalizing clinicians who disproportionately treat a large percentage of patients who cannot easily achieve HbA1c measurements below 9% (e.g., clinicians who specialize in dementia care). • This measure intends to assess quality performance at the health plan level and implementation at the individual clinician level could unfairly penalize certain clinicians who disproportionately treat a large percentage patients who cannot easily achieve HbA1c measurements <9%. 1. Qaseem A, Wilt TJ, Kansagara D, et al, for the Clinical Guidelines Committee of the American College of Physicians. Hemoglobin A_{1c} Targets for Glycemic Control With Pharmacologic Therapy for Nonpregnant Adults With Type 2 Diabetes Mellitus: A Guidance Statement Update From the American College of Physicians. Ann Intern Med. 2018;168:569–576. [Epub ahead of print 6 March 2018]. doi: https://doi.org/10.7326/M17-0939

C. **Cost Measures Appropriate for Inclusion in Chronic Disease MVP Only if Modified Prior to Inclusion**

MIPS MSPB_1: Medicare Spending Per Beneficiary Clinician	
Measure Steward:	Centers for Medicare & Medicaid Services
NQF Status:	Not endorsed
Use in Federal Program:	MIPS
Measure Tested (Y,N,N/A):	Yes: Individual Clinician, Group/Practice
Harmonization:	None
Description:	The MSPB Clinician measure assesses the cost to Medicare of services provided to a beneficiary during an MSPB Clinician episode (hereafter referred to as the "episode"), which comprises the period immediately prior to, during, and following the beneficiary's hospital stay. An episode includes Medicare Part A and Part B claims with a start date between 3 days prior to a hospital admission (also known as the "index admission" for the episode) through 30 days after hospital discharge, excluding a defined list of services that are unlikely to be influenced by the clinician's care decisions and are, thus, considered unrelated to the index admission. In all supplemental documentation, the term "cost" generally means the standardized[1] Medicare allowed amount.[2] 1 Claim payments are standardized to account for differences in Medicare payments for the same service(s) across Medicare providers. Payment standardized costs remove the effect of differences in Medicare payment among health care providers that are the result of differences in regional health care provider expenses measured by hospital wage indexes and geographic price cost indexes (GPCIs) or other payment adjustments such as those for teaching hospitals. For more information, please refer to the "CMS Price (Payment) Standardization - Basics" and "CMS Price (Payment) Standardization - Detailed Methods" documents posted on the Payment Standardization QualityNet webpage. (https://www.qualitynet.org/inpatient/measures/payment-standardization) 2 Cost is defined by *allowed amounts* on Medicare claims data, which include both Medicare trust fund payments and any applicable beneficiary deductible and coinsurance amounts.
Numerator Statement:	The numerator for the MSPB Clinician measure is the sum of the ratio of payment-standardized observed to expected episode costs for all episodes attributed to the clinician group, as identified by a unique Medicare Taxpayer Identification Number (TIN), or to the clinician, as identified by a unique TIN and National Provider Identifier pair (TIN-NPI). The sum is then multiplied by the national average payment-standardized observed episode cost to generate a dollar figure.

MIPS MSPB_1: Medicare Spending Per Beneficiary Clinician	
Denominator Statement:	The denominator for the MSPB Clinician measure is the total number of episodes attributed to a clinician or clinician group.
Exclusions:	Beneficiaries' episodes are excluded from the measure population if they meet any of the following conditions: • They were not enrolled in both Medicare Parts A and B for the entirety of the lookback period plus episode window. • They were enrolled in a private Medicare health plan (e.g., a Medicare Advantage or a Medicare private FFS plan) for any part of the lookback period plus episode window. • They resided outside the United States or its territories during any month of the measurement period.
Type of Measure:	Cost
Intended Level of Attribution:	Individual Clinician, Group/Practice
Proposed Level of Attribution:	Individual Clinician, Group/Practice
Care Setting:	The MSPB Clinician cost measure can be triggered at acute care facility hospitals.
Data Source:	The MSPB Clinician measure uses the following data sources: • Medicare Parts A and B claims data from the Common Working File (CWF) • Enrollment Data Base (EDB) • Long Term Care Minimum Data Set (LTC MDS) • Provider Enrollment, Chain and Ownership System (PECOS)
ACP Rating:	Individual Clinician: Not Valid Group/Practice: Not Valid

MIPS MSPB_1: Medicare Spending Per Beneficiary Clinician	
ACP suggestions for modifications prior to inclusion:	• The Medicare Spending per Beneficiary (MSPB) measure represents an important move towards cost assessment in pay-for-performance programs. However, the methods that policymakers and measure developers apply to assessing episode-based costs is critical to the success of this initiative. In this regard, several inherent limitations to the measure exist. The Centers for Medicare and Medicaid Services (CMS) should consider addressing the concerns listed below in the interest of enhancing the validity of the measure. • The PMC prefers that all cost measures be attributed to the level of the group/practice or higher for the following reasons: o If health plan administrators and government payers intend to create individual cost profiles to generate incentives to decrease health care costs, it is important that these profiles provide insights into which care management interventions are most effective in reducing costs year-over-year, even if what is measured does not encompass the totality of the cost to Medicare for the items and services provided to a patient during an episode of care. Measuring what is actionable could build trust with clinicians, feed a cycle of participation, and discourage dysfunctional behaviors such as avoiding attribution. Stratifying and comparing results based on costs related to 1) services that are under the direct control of the individual clinician, 2) indirect costs, and 3) services under the control of the facility could help to mitigate this concern by identifying behaviors that correspond with opportunities for improvement. o While improvements have been made to the attribution model, revisions do not address the possibility of multiple clinicians being held accountable for the total costs associated with a single episode. CMS attributes each MSPB episode to the Taxpayer Identification Number-National Provider Identifier (TIN-NPI) responsible for 30% of Part B Physician/Supplier services during the index admission. According to this model, multiple clinicians could be accountable for the total costs associated with a single episode of care. While we generally support the attribution model at the facility, system, and health plan levels, we caution that attributing patient costs to individual clinicians can be technically challenging. Healthcare costs are influenced not only by the actions of one clinician but often by the actions of multiple clinicians as well as a patient's social, economic, and environmental factors. It is difficult to determine the relative influence that an individual clinician has on a patient's expenses. Understanding who is responsible is essential to driving improvements in care as well as for securing long-term

MIPS MSPB_1: Medicare Spending Per Beneficiary Clinician	
ACP suggestions for modifications prior to inclusion:	buy-in from clinicians and facilitating the ability of value-based purchasing programs to influence clinician behavior. The current model does not speak to the care coordination system that most clinicians would likely endorse. For example, Accountable Care Organizations that build on the value-based purchasing framework to enhance care coordination and promote responsibility for clinical and efficiency outcomes. • Additional areas of concern are as follows: ○ We are unable to assess the benefit of assessing costs (e.g., if it helps to improve outcomes at lower costs) without assessing the evidence to support this claim. We suggest that CMS include an evidence report in the measure information form during the next measure update. ○ The implications of the risk-adjustment model as currently specified are unclear. The model estimates expected episode costs in recognition of the different levels of care beneficiaries may require due to comorbidities, disability, age and other risk factors. This model is not sufficient to control for all significant social determinants of health (SDOH) that may influence the clinical health status of patients as well as the outcome of acute admissions. The Centers for Medicare and Medicaid Services (CMS) should consider revising the risk-adjustment model to include SDOH that are most likely to influence the clinical health status of the denominator population under consideration. Aligning the model for risk-adjustment with more robust methods for statistical analyses that consider all factors that are independently and significantly associated with outcomes and that vary across measurement participant (e.g., the Society for Thoracic Surgeons Adult Cardiac Surgery Risk Model) could enhance individual clinician acceptance of outcomes measures and helps to mitigate risk aversion. ○ The 30% threshold is too low to attribute episode-based care to an individual clinician. CMS should consider increasing the attribution threshold to an evidence-based percentage that represents the majority of services during hospitalization. ○ The 30-day episode window is arbitrary. Recent literature suggests that shorter intervals of seven or fewer days might improve the accuracy and equity of episode-based costs to Medicare as a measure of facility quality for public accountability.

MIPS MSPB_1: Medicare Spending Per Beneficiary Clinician	
ACP suggestions for modifications prior to inclusion:	○ CMS did not publish the details of the testing results on a public domain and there is insufficient information available about the positive or negative impacts of implementation. We suspect that implementation would curb inappropriate use of medical resources, but without reviewing the data, we cannot be confident that the benefits of the measure in facilitating progress toward achieving efficient healthcare outweigh the potential for unintended negative consequences to patients. Maximizing transparency could build trust with clinicians and feed a cycle of participation. CMS should consider establishing a premortem approach for evaluating the impact of performance measures to combat the unintended consequences of implementation and correctly identify reasons for future outcomes. ○ While this measure aims to reduce low-value care, implementation may result in consequences directly contrary to the spirit of the measure. The measure specifies "episodes of care for a beneficiary if the beneficiary dies during the episode" as exclusion criteria. Therefore, the measure rewards clinicians for expending minimal resources on patients in stable conditions, while disregarding mortality rates, and penalizes clinicians for disbursing sufficient resources to maintain the stability of medically complex patients during an episode of care.

MIPS TPCC_1: Total Per Capita Costs	
Measure Steward:	Centers for Medicare & Medicaid Services
NQF Status:	Not endorsed
Use in Federal Program:	MIPS
Measure Tested (Y,N,N/A):	Yes: Individual Clinician, Group/Practice
Harmonization:	None
Description:	The TPCC measures the overall cost of care delivered to a beneficiary with a focus on the primary care they receive from their provider(s). The measure is a payment-standardized, risk-adjusted, and specialty-adjusted measure. The measure is attributed to clinicians, who are identified by their unique Taxpayer Identification Number and National Provider Identifier pair (TIN-NPI) and clinician groups, identified by their TIN number. The TPCC measure can be attributed at the TIN or TIN-NPI level. In all supplemental documentation, the term "cost" generally means the standardized[1] Medicare allowed amount.[2]

MIPS TPCC_1: Total Per Capita Costs	
Description:	1 Claim payments are standardized to account for differences in Medicare payments for the same service(s) across Medicare providers. Payment standardized costs remove the effect of differences in Medicare payment among health care providers that are the result of differences in regional health care provider expenses measured by hospital wage indexes and geographic price cost indexes (GPCIs) or other payment adjustments such as those for teaching hospitals. For more information, please refer to the "CMS Price (Payment) Standardization - Basics" and "CMS Price (Payment) Standardization - Detailed Methods" documents posted on the Payment Standardization QualityNet webpage. (https://www.qualitynet.org/inpatient/measures/payment-standardization) 2 Cost is defined by *allowed amounts* on Medicare claims data, which include both Medicare trust fund payments and any applicable beneficiary deductible and coinsurance amounts.
Numerator Statement:	The numerator for the measure is the sum of the risk-adjusted, payment-standardized, and specialty-adjusted Medicare Parts A and B costs across all beneficiary months attributed to a TIN or TIN-NPI during the measurement period.
Denominator Statement:	The denominator for the measure is the number of beneficiary months attributed to a TIN or TIN-NPI during the measurement period.
Exclusions:	Beneficiaries are excluded from the measure population if they meet any of the following conditions: • They were not enrolled in both Medicare Part A and Part B for every month during the measurement period, unless part year enrollment was the result of new enrollment or death. • They were enrolled in a private Medicare health plan (e.g., a Medicare Advantage or a Medicare private FFS plan) for any month during the measurement period. • They resided outside the United States or its territories during any month of the measurement period. • They are covered by the Railroad Retirement Board.
Type of Measure:	Cost
Intended Level of Attribution:	Individual Clinician, Group/Practice
Proposed Level of Attribution:	Individual Clinician, Group/Practice
Care Setting:	N/A
Data Source:	The TPCC measure uses the following data sources: • Medicare Parts A and B claims data from the Common Working File (CWF), • Enrollment Data Base (EDB), • Common Medicare Environment (CME), • Long Term Care Minimum Data Set (LTC MDS), and • Provider Enrollment, Chain, and Ownership System (PECOS).

MIPS TPCC_1: Total Per Capita Costs	
ACP Rating:	Individual Clinician: Not Valid Group/Practice: Not Valid
ACP suggestions for modifications prior to Inclusion:	• The Total per Capita Cost measure represents an important move towards cost assessment in pay-for-performance programs. However, the methods that policymakers and measure developers apply to assessing costs is critical to the success of this initiative. In this regard, several inherent limitations to the measure exist. The Centers for Medicare and Medicaid Services (CMS) should consider addressing the concerns listed below in the interest of enhancing the validity of the measure. • The PMC prefers that all cost measures be attributed to the level of the group/practice or higher for the following reasons: o If health plan administrators and government payers intend to create individual cost profiles to generate incentives to decrease health care costs, it is important that these profiles provide insights into which care management interventions are most effective in reducing costs year-over-year, even if what is measured does not encompass the totality of the cost to Medicare for the items and services provided to a patient during an episode of care. Measuring what is actionable could build trust with clinicians, feed a cycle of participation, and discourage dysfunctional behaviors such as avoiding attribution. Stratifying and comparing results based on costs related to 1) services that are under the direct control of the individual clinician, 2) indirect costs, and 3) services under the control of the facility could help to mitigate this concern by identifying behaviors that correspond with opportunities for improvement. o While improvements have been made to the attribution model, revisions do not address the possibility of multiple clinicians being held accountable for the total costs associated with a single episode. CMS attributes each beneficiary to a single Taxpayer Identification Number-National Provider Identifier (TIN-NPI) if the beneficiary received more primary care services from primary care clinicians in that TIN-NPI than any other TIN-NPI or CMS Certification Number (CCN). If two TIN-NPIs tie for the largest share of a beneficiary's primary care services, CMS attributes the beneficiary to the TIN-NPI that provided primary care services most recently. According to this model, multiple clinicians could be accountable for the annualized costs of care for beneficiaries attributed to the

MIPS TPCC_1: Total Per Capita Costs	
ACP suggestions for modifications prior to Inclusion:	TIN-NPI. While it is reasonable to apply this model to health plans, it is unclear how this approach will provide meaningful information to individual clinicians that will appropriately inform quality improvements. While we generally support the attribution model at the facility, system, and health plan levels, we caution CMS that attributing patient costs to individual clinicians can be technically challenging. Healthcare costs are influenced not only by the actions of one clinician but often by the actions of multiple clinicians as well as a patient's social, economic, and environmental factors. It is difficult to determine the relative influence that an individual clinician has on a patient's expenses. Understanding who is responsible is essential to driving improvements in care as well as for securing long-term buy-in from clinicians and facilitating the ability of value-based purchasing programs to influence clinician behavior. The current model does not speak to the care coordination system that most clinicians would likely endorse. For example, Accountable Care Organizations that build on the value-based purchasing framework to enhance care coordination and promote responsibility for clinical and efficiency outcomes. • Additional areas of concern are as follows: o The implications of the risk-adjustment model as currently specified are unclear. The model estimates expected episode costs in recognition of the different levels of care beneficiaries may require due to comorbidities, disability, age and other risk factors. This model is not sufficient to control for all significant social determinants of health (SDOH) that may influence the clinical health status of patients as well as the outcome of acute admissions. The Centers for Medicare and Medicaid Services (CMS) should consider revising the risk-adjustment model to include SDOH that are most likely to influence the clinical health status of the denominator population under consideration. Aligning the model for risk-adjustment with more robust methods for statistical analyses that consider all factors that are independently and significantly associated with outcomes and that vary across measurement participant (e.g., the Society for Thoracic Surgeons Adult Cardiac Surgery Risk Model) could enhance individual clinician acceptance of outcomes measures and helps to mitigate risk aversion.

MIPS TPCC_1: Total Per Capita Costs	
ACP suggestions for modifications prior to Inclusion:	○ CMS did not publish the details of the testing results on a public domain and there is insufficient information available about the positive or negative impacts of implementation. We suspect that implementation would curb inappropriate use of medical resources, but without reviewing the data, we cannot be confident that the benefits of the measure in facilitating progress toward achieving efficient healthcare outweigh the potential for unintended negative consequences to patients. Maximizing transparency could build trust with clinicians and feed a cycle of participation. Additionally, CMS should consider establishing a premortem approach for evaluating the impact of performance measures to combat the unintended consequences of implementation and correctly identify reasons for future outcomes. ○ CMS should independently establish a robust minimum average reliability rating and evaluate all future cost measures based on that same standard, not pre-determine a set of measures the Agency wishes to use then selecting whatever low reliability standard allows them to adopt all of those measures without raising case minimums. ○ CMS designed this measure to seemingly reward the creation of Patient-Centered Medical Homes; however, PCMH models have not been uniformly successful in achieving care quality improvements.

Prevention MVP

D. **Quality Measures Appropriate for Inclusion in Prevention MVP**

MIPS 113; NQF 0034: Colorectal Cancer Screening	
Measure Steward:	NCQA
NQF Status:	Endorsed
Federal Program:	MIPS, CQMC
Description:	The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.
Numerator Statement:	Patients who received one or more screenings for colorectal cancer according to clinical guidelines.
Denominator Statement:	Patients 51–75 years of age
Exclusions:	This measure excludes patients with a history of colorectal cancer or total colectomy. The measure also excludes patients who use hospice services or are enrolled in an institutional special needs plan (SNP) or living long-term in an institution any time during the measurement year.
ACP Rating:	Valid
ACP suggestions to the measure developer to consider during the next measure update to improve the validity of the measure (does not need to be addressed prior to inclusion in MVP):	• While we support this measure, as currently specified, it is a crude translation of a guideline recommendations into a performance measure. The developer should update the measure specifications to align with current clinical recommendations on colorectal cancer screening. Specifically, numerator specifications could be more robust and should include the option for clinicians to document cancer screening tests (e.g., stool FIT-DNA,colonoscopy).[1] • The measure specifications do not include appropriate exclusion criteria and could promote overuse of screening in patients where the benefits do not outweigh the risk of harms. A better measure would include exclusion criteria for patients diagnosed with dementia, patients with limited life expectancy, patients with advanced comorbidities, and patient refusal. • We suggest the developers revise the measure specifications to include some element of risk-adjustment to determine whether the screening benefits outweigh the potential harms. 1. Qaseem A, Crandall CJ, Mustafa RA, et al, for the Clinical Guidelines Committee of the American College of Physicians. Screening for Colorectal Cancer in Asymptomatic Average-Risk Adults: A Guidance Statement From the American College of Physicians. Ann Intern Med. 2019; 171:643–654. doi: https://doi.org/10.7326/M19-0642

MIPS 320; NQF 0658: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients	
Measure Steward:	AGA
NQF Status:	Endorsed
Federal Program:	MIPS
Description:	Percentage of patients aged 50 years to 75 years receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.
Numerator Statement:	Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report
Denominator Statement:	All patients aged 50 years to 75 years and receiving screening a screening colonoscopy without biopsy or polypectomy
Exclusions:	Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (eg, inadequate prep, familial or personal history of colonic polyps, patient had no adenoma and age is >= 66 years old, or life expectancy < 10 years, other medical reasons)
ACP Rating:	Valid
ACP suggestions to the measure developer to consider during the next measure update to improve the validity of the measure (does not need to be addressed prior to inclusion in MVP):	• We note that the developers cite outdated performance data to form the basis of the measure and therefore; we cannot assess the opportunity for improvement. Developers should include current national performance date in the updated measure report • Developers should consider revising the verbiage of the numerator specifications from “at least 10 years” to “10 years.” “At least 10 years” implies that it is appropriate for clinicians to recommend a repeat colonoscopy beyond a 10-year interval when 10 years is the only recommended interval for repeat colonoscopy. • While this measure focuses on documentation rather than performing an intervention, it is a good starting point to educate clinicians on their performance compared to their peers. However, a more meaningful measure may assess how often clinicians perform colonoscopies in average risk patients prior to the recommended follow-up date.

MIPS 112; NQF 2372: Breast Cancer Screening	
Measure Steward:	NCQA
NQF Status:	Endorsed
Federal Program:	MIPS, CQMC
Description:	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.

MIPS 112; NQF 2372: Breast Cancer Screening	
Numerator Statement:	Women who received a mammogram to screen for breast cancer.
Denominator Statement:	Women 50-74 years of age.
Exclusions:	This measure excludes women with a history of bilateral mastectomy. The measure also excludes patients who use hospice services or are enrolled in an institutional special needs plan or living long-term in an institution any time during the measurement year.
ACP Rating:	Valid
ACP suggestions to the measure developer to consider during the next measure update to improve the validity of the measure (does not need to be addressed prior to inclusion in MVP):	• We note the importance of shared decision-making to weigh the benefits, harms, and patient's preferences regarding screening tests. Therefore, developers should consider revising the specifications to include exclusion criteria for patient refusal and patients with limited life expectancy. • While implementation has demonstrated improvements at the level of the health plan, testing results indicate that this measure has failed to demonstrate improvements in clinical outcomes when applied to the individual clinician level of attribution.

MIPS 438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	
Measure Steward:	Centers for Medicare & Medicaid Services
NQF Status:	Not Endorsed
Federal Program:	MIPS
Description:	Percentage of the following patients-all considered at high risk of cardiovascular events-who were prescribed or were on statin therapy during the measurement period: Adults aged >= 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR Adults aged >=21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.

MIPS 438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	
Numerator Statement:	Patients who are actively using or who receive an order (prescription) for statin therapy at any point during the measurement period Definitions: Statin therapy - Administration of one or more of a group of medications that are used to lower plasma lipoprotein levels in the treatment of hyperlipoproteinemia. Statin Medication Therapy List (NOTE: List does NOT include dosage) is included in the clinical recommendations.
Denominator Statement:	Patients aged ≥ 21 years at the beginning of the measurement period with clinical ASCVD diagnosis Definitions: Clinical Atherosclerotic Cardiovascular Disease (ASCVD) includes: • Acute Coronary Syndromes • History of Myocardial Infarction • Stable or Unstable Angina • Coronary or other Arterial Revascularization • Stroke or Transient Ischemic Attack (TIA) • Peripheral Arterial Disease of Atherosclerotic Origin Lipoprotein Density Cholesterol (LDL-C) result - A fasting or direct LDL-C laboratory test performed and test result documented in the medical record.
Exclusions:	Acute liver or hepatic disease of insufficiency, ESRD, documentation of medical reason(s) for not currently being a statin therapy user or receive an order (prescription) for statin therapy (e.g., patient with adverse effect, allergy or intolerance to statin medication therapy, patients who are receiving palliative or hospice care, patients with active liver disease or hepatic disease or insufficiency, and patients with end stage renal disease.
ACP Rating:	Valid
ACP suggestions to the measure developer to consider during the next measure update to improve the validity of the measure (does not need to be addressed prior to inclusion in MVP):	• We note that implementation of statin therapy alone does not guarantee meaningful improvements in clinical outcomes. A more meaningful measure may examine patient adherence to prescribed statin therapy. • A high percentage of patients prescribed statin therapy for the management of cardiovascular disease exacerbations (e.g., acute MI) discontinue therapy without consulting their clinician. Therefore, the measure may unfairly penalize clinicians for lack of control over non-adherent patients.

MIPS 226; NQF 0028: Tobacco Use: Screening & Cessation Intervention	
Measure Steward	PCPI
NQF Status:	Endorsed
Federal Program:	MIPS, CQMC

MIPS 226; NQF 0028: Tobacco Use: Screening & Cessation Intervention	
Description:	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user
Numerator Statement:	Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user
Denominator Statement:	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
Exclusions:	Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason)
ACP Rating:	Valid

MIPS 110; NQF 0041: Influenza Immunization	
Measure Steward:	PCPI
NQF Status:	Endorsed
Use in Federal Program:	MIPS, CQMC
Description:	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization
Numerator Statement:	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization
Denominator Statement:	All patients aged 6 months and older seen for a visit between October 1 and March 31
Exclusions:	Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons) Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons) Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons)
ACP Rating:	Valid

MIPS 110; NQF 0041: Influenza Immunization	
ACP suggestions to the measure developer to consider during the next measure update to improve the validity of the measure (does not need to be addressed prior to inclusion in MVP):	• While we support this measure we suggest developers consider revising the specifications to include exclusion criteria for patient, medical, and system reasons for vaccination not given. • We note that the measure is nearly topped out with a narrow opportunity for improvement. Developers should include updated performance data in the NQF submission materials for re-endorsement. • We note that electronic health record (EHR) information blocking could prevent the transmission of immunization information between competing electronic systems.

MIPS 414: Evaluation or Interview for Risk of Opioid Misuse	
Measure Steward:	American Academy of Neurology
NQF Status:	Not endorsed
Federal Program:	MIPS
Description:	All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, SOAPP-R) or patient interview documented at least once during Opioid Therapy in the medical record.
Numerator Statement:	Patients evaluated for risk of misuse of opiates by using a brief validated instrument (e.g., Opioid Risk Tool, Opioid Assessment for Patients with Pain, revised (SOAPP-R)) or patient interview at least once during opioid therapy
Denominator Statement:	All patients 18 and older prescribed opiates for longer than six weeks duration
Exclusions:	Patients who were in hospice at any time during the performance period
ACP Rating:	Valid
ACP suggestions to the measure developer to consider during the next measure update to improve the validity of the measure (does not need to be addressed prior to inclusion in MVP):	• Evidence exists to suggest that opioid addiction develops in less than 6 weeks duration of prescribed therapy. As such, this measure could unfairly penalize clinicians who do not initiate opioid therapy (e.g., therapy initiated as part of a post-operative care program). Measure developers should consider updating the denominator specifications to include an evidence-based therapy duration. • The opioid measures would benefit from additional testing to determine which interventions are most impactful in preventing opioid misuse and abuse. • A better measure may include exclusion criteria for patients receiving active cancer treatment, palliative care, and end-of-life care.

MIPS 431; NQF 2152: Unhealthy Alcohol Use: Screening & Brief Counseling	
Measure Steward:	PCPI
NQF Status:	Endorsed
Federal Program:	MIPS
Description:	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.
Numerator Statement:	Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user
Denominator Statement:	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
Exclusions:	Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)
ACP Rating:	Valid
ACP suggestions to the measure developer to consider during the next measure update to improve the validity of the measure (does not need to be addressed prior to inclusion in MVP):	• We suggest the developers revise the numerator specifications to clearly define "brief counseling."

E. Quality Measures Appropriate for Inclusion in Prevention MVP Only if Modified Prior to Inclusion

NQF 0553: Medicare Part C Star Rating: Care for Older Adults—Medication Review	
Measure Steward	NCQA
NQF Status:	Endorsed
Federal Program:	Medicare Part C Star Rating
Description:	Percentage of adults 65 years and older who had a medication review during the measurement year. A medication review is a review of all a patient's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.
Numerator Statement:	At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record.
Denominator Statement:	All patients 66 years and older as of the end (e.g., December 31) of the measurement year.
Exclusions:	Exclude members who use hospice services.
ACP Rating:	Health Plan (intended attribution): Uncertain Validity Individual Clinician (proposed attribution): Uncertain Validity
ACP suggestions for modifications prior to inclusion:	• This measure represents a significant clinical concept and implementation could facilitate reduction of medication-related problems more than the medication reconciliation measures currently included in the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program (QPP) (i.e., QPP ID #130: Documentation of Current Medications in the Medical Record, QPP ID# 046: Medication Reconciliation Post-Discharge). • This measure moves away from "check-box" measures focused on medication reconciliation, where the benefit of attestation of reconciliation on improvements to the medication management process is unclear. Evidence suggests the process of reviewing (as opposed to reconciling) a patient's medication list, including a structured evaluation of a patient's medicines with the aim of optimizing medicines' use, reduces the risk of adverse drug interactions being overlooked and helps clinicians minimize the duplication and complexity of the patient's medication regimen (12-13). • We commend the developers for considering patient variables that may impede the clinician's ability to document complete and accurate medications lists (e.g., incomplete information supplied by the patient). • While we support the measure concept, we question the ability for implementation to lead to meaningful improvements in care. Developers cite a mean performance score of 88% from the 2016 Healthcare Effectiveness and Information Set (HEDIS) measurement

NQF 0553: Medicare Part C Star Rating: Care for Older Adults—Medication Review	
ACP suggestions for modifications prior to inclusion:	• year. Furthermore, most integrated health systems already enable this process through the electronic health record (EHR) at every visit. Therefore, the value of implementation on meaningful improvements to care processes is unclear. • Additionally, while once a year is a good start, it may be insufficient given the possibility that medication lists may change more frequently, especially in older adults diagnosed with multiple chronic diseases.

MIPS 128; NQF 0421: Preventive Care & Screening: BMI Screening and Follow-up Plan	
Measure Steward:	Centers for Medicare & Medicaid Services
NQF Status:	Endorsed
Federal Program:	MIPS
Description:	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter.
Numerator Statement:	Patients with a documented BMI during the encounter or during the previous twelve months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter.
Denominator Statement:	All patients aged 18 and older on the date of the encounter with at least one eligible encounter during the measurement period.
Exclusions:	Not Eligible for BMI Calculation or Follow-Up Plan (Denominator Exclusion) – A patient is not eligible if one or more of the following reasons are documented: Patient is receiving palliative care on the date of the current encounter or any time prior to the current encounter Patient is pregnant on the date of the current encounter or any time during the measurement period prior to the current encounter Patients who refuse measurement of height and/or weight or refuse follow-up on the date of the current encounter. Patients with a documented BMI outside normal limits and a documented reason for not completing BMI follow-up plan during the current encounter or within the previous 12 months of the current encounter (Denominator Exception):

MIPS 128; NQF 0421: Preventive Care & Screening: BMI Screening and Follow-up Plan	
Exclusions:	The Medical Reason exception could include, but is not limited to, the following patients as deemed appropriate by the health care provider. Elderly Patients (65 or older) for who weight reduction/weight gain would complicate other underlying health conditions such as the following examples: Illness or physical disability Mental illness, dementia, confusion Nutritional deficiency, such as vitamin/mineral deficiency Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient's health status
ACP Rating:	Uncertain Validity
ACP suggestions for modifications prior to inclusion:	• The urgency posed by the obesity epidemic underscores the need for evidence based and clinically meaningful performance measures. However, this is a "check box" measure and the numerator specifies obesity interventions that do not necessarily lead to meaningful improvements in quality outcomes. For example, documenting a nutritionist referral may not be an effective intervention for weight loss management. • There is insufficient evidence to support implementation of obesity interventions for patients with a BMI measurement between 25-30 kg/m^2. The measure developers should update the measure specifications to align with current United States Preventive Services Task Force (USPSTF) recommendations. We prefer that whether and how often clinicians address weight for patients with a BMI from 25-30 be at the discretion of the clinician. • Developers should revise the specifications to include waist circumference as a screening tool.

F. **Cost Measures Appropriate for Inclusion in Prevention MVP Only After Modifications**

MIPS MSPB_1: Medicare Spending Per Beneficiary Clinician	
Measure Steward	Centers for Medicare & Medicaid Services
NQF Status:	Not endorsed
Federal Program:	MIPS
Measure Tested (Y,N,N/A):	Yes: Individual Clinician, Group/Practice
Harmonization:	None
Description:	The MSPB Clinician measure assesses the cost to Medicare of services provided to a beneficiary during an MSPB Clinician episode (hereafter referred to as the "episode"), which comprises the period immediately prior to, during, and following the beneficiary's hospital stay. An episode includes Medicare Part A and Part B claims with a start date between 3 days prior to a hospital admission (also known as the "index admission" for the episode) through 30 days after hospital discharge, excluding a defined list of services that are unlikely to be influenced by the clinician's care decisions and are, thus, considered unrelated to the index admission. In all supplemental documentation, the term "cost" generally means the standardized[1] Medicare allowed amount.[2] 1 Claim payments are standardized to account for differences in Medicare payments for the same service(s) across Medicare providers. Payment standardized costs remove the effect of differences in Medicare payment among health care providers that are the result of differences in regional health care provider expenses measured by hospital wage indexes and geographic price cost indexes (GPCIs) or other payment adjustments such as those for teaching hospitals. For more information, please refer to the "CMS Price (Payment) Standardization - Basics" and "CMS Price (Payment) Standardization - Detailed Methods" documents posted on the Payment Standardization QualityNet webpage. (https://www.qualitynet.org/inpatient/measures/payment-standardization) 2 Cost is defined by *allowed amounts* on Medicare claims data, which include both Medicare trust fund payments and any applicable beneficiary deductible and coinsurance amounts.
Numerator Statement:	The numerator for the MSPB Clinician measure is the sum of the ratio of payment-standardized observed to expected episode costs for all episodes attributed to the clinician group, as identified by a unique Medicare Taxpayer Identification Number (TIN), or to the clinician, as identified by a unique TIN and National Provider Identifier pair (TIN-NPI). The sum is then multiplied by the national average payment-standardized observed episode cost to generate a dollar figure.
Denominator Statement:	The denominator for the MSPB Clinician measure is the total number of episodes attributed to a clinician or clinician group.

MIPS MSPB_1: Medicare Spending Per Beneficiary Clinician	
Exclusions:	Beneficiaries' episodes are excluded from the measure population if they meet any of the following conditions: • They were not enrolled in both Medicare Parts A and B for the entirety of the lookback period plus episode window. • They were enrolled in a private Medicare health plan (e.g., a Medicare Advantage or a Medicare private FFS plan) for any part of the lookback period plus episode window. • They resided outside the United States or its territories during any month of the measurement period.
Type of Measure:	Cost
Intended Level of Attribution:	Individual Clinician, Group/Practice
Proposed Level of Attribution:	Individual Clinician, Group/Practice
Care Setting:	The MSPB Clinician cost measure can be triggered at acute care facility hospitals.
Data Source:	The MSPB Clinician measure uses the following data sources: • Medicare Parts A and B claims data from the Common Working File (CWF) • Enrollment Data Base (EDB) • Long Term Care Minimum Data Set (LTC MDS) • Provider Enrollment, Chain and Ownership System (PECOS)
ACP Rating:	Individual Clinician: Not Valid Group/Practice: Not Valid
ACP suggestions for modifications prior to inclusion:	• The Medicare Spending per Beneficiary (MSPB) measure represents an important move towards cost assessment in pay-for-performance programs. However, the methods that policymakers and measure developers apply to assessing episode-based costs is critical to the success of this initiative. In this regard, several inherent limitations to the measure exist. The Centers for Medicare and Medicaid Services (CMS) should consider addressing the concerns listed below in the interest of enhancing the validity of the measure. • The PMC prefers that all cost measures be attributed to the level of the group/practice or higher for the following reasons: o If health plan administrators and government payers intend to create individual cost profiles to generate incentives to decrease health care costs, it is important that these profiles provide insights into which care management interventions are most effective in reducing costs year-over-year, even if what is measured does not encompass the totality of the cost to Medicare for the items and services provided to a patient during an episode of care. Measuring what is actionable could build trust with clinicians, feed a cycle of participation, and discourage dysfunctional behaviors such as avoiding attribution.

MIPS MSPB_1: Medicare Spending Per Beneficiary Clinician	
ACP suggestions for modifications prior to inclusion:	Stratifying and comparing results based on costs related to 1) services that are under the direct control of the individual clinician, 2) indirect costs, and 3) services under the control of the facility could help to mitigate this concern by identifying behaviors that correspond with opportunities for improvement. o While improvements have been made to the attribution model, revisions do not address the possibility of multiple clinicians being held accountable for the total costs associated with a single episode. CMS attributes each MSPB episode to the Taxpayer Identification Number-National Provider Identifier (TIN-NPI) responsible for 30% of Part B Physician/Supplier services during the index admission. According to this model, multiple clinicians could be accountable for the total costs associated with a single episode of care. While we generally support the attribution model at the facility, system, and health plan levels, we caution that attributing patient costs to individual clinicians can be technically challenging. Healthcare costs are influenced not only by the actions of one clinician but often by the actions of multiple clinicians as well as a patient's social, economic, and environmental factors. It is difficult to determine the relative influence that an individual clinician has on a patient's expenses. Understanding who is responsible is essential to driving improvements in care as well as for securing long-term buy-in from clinicians and facilitating the ability of value-based purchasing programs to influence clinician behavior. The current model does not speak to the care coordination system that most clinicians would likely endorse. For example, Accountable Care Organizations that build on the value-based purchasing framework to enhance care coordination and promote responsibility for clinical and efficiency outcomes. • Additional areas of concern are as follows: o We are unable to assess the benefit of assessing costs (e.g., if it helps to improve outcomes at lower costs) without assessing the evidence to support this claim. We suggest that CMS include an evidence report in the measure information form during the next measure update. o The implications of the risk-adjustment model as currently specified are unclear. The model estimates expected episode costs in recognition of the different levels of care beneficiaries may require due to comorbidities, disability, age and other risk factors. This model is not sufficient to control for all significant social determinants of health (SDOH) that may influence the clinical health status of patients as well as the outcome of acute

MIPS MSPB_1: Medicare Spending Per Beneficiary Clinician	
ACP suggestions for modifications prior to inclusion:	○ admissions. The Centers for Medicare and Medicaid Services (CMS) should consider revising the risk-adjustment model to include SDOH that are most likely to influence the clinical health status of the denominator population under consideration. Aligning the model for risk-adjustment with more robust methods for statistical analyses that consider all factors that are independently and significantly associated with outcomes and that vary across measurement participant (e.g., the Society for Thoracic Surgeons Adult Cardiac Surgery Risk Model) could enhance individual clinician acceptance of outcomes measures and helps to mitigate risk aversion. ○ The 30% threshold is too low to attribute episode-based care to an individual clinician. CMS should consider increasing the attribution threshold to an evidence-based percentage that represents the majority of services provided during hospitalization. ○ The "30-day episode window" is arbitrary. Recent literature suggests that shorter intervals of seven or fewer days might improve the accuracy and equity of episode-based costs to Medicare as a measure of facility quality for public accountability. ○ CMS did not publish the details of the testing results on a public domain and there is insufficient information available about the positive or negative impacts of implementation. We suspect that implementation would curb inappropriate use of medical resources, but without reviewing the data, we cannot be confident that the benefits of the measure in facilitating progress toward achieving efficient healthcare outweigh the potential for unintended negative consequences to patients. Maximizing transparency could build trust with clinicians and feed a cycle of participation. Additionally, CMS should consider establishing a premortem approach for evaluating the impact of performance measures to combat the unintended consequences of implementation and correctly identify reasons for future outcomes. • While this measure aims to reduce low-value care, implementation may result in consequences directly contrary to the spirit of the measure. The measure specifies "episodes of care for a beneficiary if the beneficiary dies during the episode" as exclusion criteria. Therefore, the measure rewards clinicians for expending minimal resources on patients in stable conditions, while disregarding mortality rates, and penalizes clinicians for disbursing sufficient resources to maintain the stability of medically complex patients during an episode of care.

MIPS TPCC_1: Total Per Capita Costs	
Measure Steward:	Centers for Medicare & Medicaid Services
NQF Status:	Not endorsed
Federal Program:	MIPS
Measure Tested (Y,N,N/A):	Yes: Individual Clinician, Group/Practice
Harmonization:	None
Description:	The TPCC measures the overall cost of care delivered to a beneficiary with a focus on the primary care they receive from their provider(s). The measure is a payment-standardized, risk-adjusted, and specialty-adjusted measure. The measure is attributed to clinicians, who are identified by their unique Taxpayer Identification Number and National Provider Identifier pair (TIN-NPI) and clinician groups, identified by their TIN number. The TPCC measure can be attributed at the TIN or TIN-NPI level. In all supplemental documentation, the term "cost" generally means the standardized[1] Medicare allowed amount.[2] 1 Claim payments are standardized to account for differences in Medicare payments for the same service(s) across Medicare providers. Payment standardized costs remove the effect of differences in Medicare payment among health care providers that are the result of differences in regional health care provider expenses measured by hospital wage indexes and geographic price cost indexes (GPCIs) or other payment adjustments such as those for teaching hospitals. For more information, please refer to the "CMS Price (Payment) Standardization - Basics" and "CMS Price (Payment) Standardization - Detailed Methods" documents posted on the Payment Standardization QualityNet webpage. (https://www.qualitynet.org/inpatient/measures/payment-standardization) 2 Cost is defined by *allowed amounts* on Medicare claims data, which include both Medicare trust fund payments and any applicable beneficiary deductible and coinsurance amounts.
Numerator Statement:	The numerator for the measure is the sum of the risk-adjusted, payment-standardized, and specialty-adjusted Medicare Parts A and B costs across all beneficiary months attributed to a TIN or TIN-NPI during the measurement period.
Denominator Statement:	The denominator for the measure is the number of beneficiary months attributed to a TIN or TIN-NPI during the measurement period.

MIPS TPCC_1: Total Per Capita Costs	
Exclusions:	Beneficiaries are excluded from the measure population if they meet any of the following conditions: • They were not enrolled in both Medicare Part A and Part B for every month during the measurement period, unless part year enrollment was the result of new enrollment or death. • They were enrolled in a private Medicare health plan (e.g., a Medicare Advantage or a Medicare private FFS plan) for any month during the measurement period. • They resided outside the United States or its territories during any month of the measurement period. • They are covered by the Railroad Retirement Board.
Type of Measure:	Cost
Intended Level of Attribution:	Individual Clinician, Group/Practice
Proposed Level of Attribution:	Individual Clinician, Group/Practice
Care Setting:	N/A
Data Source:	The TPCC measure uses the following data sources: • Medicare Parts A and B claims data from the Common Working File (CWF), • Enrollment Data Base (EDB), • Common Medicare Environment (CME), • Long Term Care Minimum Data Set (LTC MDS), and • Provider Enrollment, Chain, and Ownership System (PECOS).
ACP Rating:	Individual Clinician: Not Valid Group/Practice: Not Valid
ACP suggestions for modifications prior to inclusion:	• The Total per Capita Cost measure represents an important move towards cost assessment in pay-for-performance programs. However, the methods that policymakers and measure developers apply to assessing costs is critical to the success of this initiative. In this regard, several inherent limitations to the measure exist. The Centers for Medicare and Medicaid Services (CMS) should consider addressing the concerns listed below in the interest of enhancing the validity of the measure. • The PMC prefers that all cost measures be attributed to the level of the group/practice or higher for the following reasons: o If health plan administrators and government payers intend to create individual cost profiles to generate incentives to decrease health care costs, it is important that these profiles provide insights into which care management interventions are most effective in reducing costs year-over-year, even if what is measured does not encompass the totality of the cost to

MIPS TPCC_1: Total Per Capita Costs	
ACP suggestions for modifications prior to inclusion:	Medicare for the items and services provided to a patient during an episode of care. Measuring what is actionable could build trust with clinicians, feed a cycle of participation, and discourage dysfunctional behaviors such as avoiding attribution. Stratifying and comparing results based on costs related to 1) services that are under the direct control of the individual clinician, 2) indirect costs, and 3) services under the control of the facility could help to mitigate this concern by identifying behaviors that correspond with opportunities for improvement. ○ While improvements have been made to the attribution model, revisions do not address the possibility of multiple clinicians being held accountable for the total costs associated with a single episode. CMS attributes each beneficiary to a single Taxpayer Identification Number-National Provider Identifier (TIN-NPI) if the beneficiary received more primary care services from primary care clinicians in that TIN-NPI than any other TIN-NPI or CMS Certification Number (CCN). If two TIN-NPIs tie for the largest share of a beneficiary's primary care services, CMS attributes the beneficiary to the TIN-NPI that provided primary care services most recently. According to this model, multiple clinicians could be accountable for the annualized costs of care for beneficiaries attributed to the TIN-NPI. While it is reasonable to apply this model to health plans, it is unclear how this approach will provide meaningful information to individual clinicians that will appropriately inform quality improvements. While we generally support the attribution model at the facility, system, and health plan levels, we caution CMS that attributing patient costs to individual clinicians can be technically challenging. Healthcare costs are influenced not only by the actions of one clinician but often by the actions of multiple clinicians as well as a patient's social, economic, and environmental factors. It is difficult to determine the relative influence that an individual clinician has on a patient's expenses. Understanding who is responsible is essential to driving improvements in care as well as for securing long-term buy-in from clinicians and facilitating the ability of value-based purchasing programs to influence clinician behavior. The current model does not speak to the care coordination system that most clinicians would likely

MIPS TPCC_1: Total Per Capita Costs	
ACP suggestions for modifications prior to inclusion:	endorse. For example, Accountable Care Organizations that build on the value-based purchasing framework to enhance care coordination and promote responsibility for clinical and efficiency outcomes. • Additional areas of concern include the following: o The implications of the risk-adjustment model as currently specified are unclear. The model estimates expected episode costs in recognition of the different levels of care beneficiaries may require due to comorbidities, disability, age and other risk factors. This model is not sufficient to control for all significant social determinants of health (SDOH) that may influence the clinical health status of patients as well as the outcome of acute admissions. The Centers for Medicare and Medicaid Services (CMS) should consider revising the risk-adjustment model to include SDOH that are most likely to influence the clinical health status of the denominator population under consideration. Aligning the model for risk-adjustment with more robust methods for statistical analyses that consider all factors that are independently and significantly associated with outcomes and that vary across measurement participant (e.g., the Society for Thoracic Surgeons Adult Cardiac Surgery Risk Model) could enhance individual clinician acceptance of outcomes measures and helps to mitigate risk aversion. o CMS did not publish the details of the testing results on a public domain and there is insufficient information available about the positive or negative impacts of implementation. We suspect that implementation would curb inappropriate use of medical resources, but without reviewing the data, we cannot be confident that the benefits of the measure in facilitating progress toward achieving efficient healthcare outweigh the potential for unintended negative consequences to patients. Maximizing transparency could build trust with clinicians and feed a cycle of participation. Additionally, CMS should consider establishing a premortem approach for evaluating the impact of performance measures to combat the unintended consequences of implementation and correctly identify reasons for future outcomes. o CMS should independently establish a robust minimum average reliability rating and evaluate all future cost measures based on that same standard, not pre-determine a set of measures the Agency wishes to use then selecting whatever

MIPS TPCC_1: Total Per Capita Costs	
ACP suggestions for modifications prior to inclusion:	low reliability standard allows them to adopt all of those measures without raising case minimums. o CMS designed this measure to seemingly reward the creation of Patient-Centered Medical Homes; however, PCMH models have not been uniformly successful in achieving care quality improvements.

ACP Members who served on the Performance Measurement Committee from the Initiation to the Completion of this Proposal

Nick Fitterman, MD, MACP, SFHM, *Chair*
CEO, Huntington Hospital Northwell Health
Professor of Medicine
Donald and Barbara Zucker School of Medicine
Hofstra/Northwell
Huntington Hospital
270 Park Ave Huntington NY 11743

J. Thomas Cross, Jr., MD, MPH, FACP, *Vice Chair*
Censeo Health
President, A-Cross Medicine Reviews
P.O. Box 38744
Colorado Springs, CO 80937

Eileen D. Barrett, MD, MPH, FHM, FACP
Regent, American College of Physicians
Division of Hospital Medicine
Department of Internal Medicine
MSC 10-5550
University of New Mexico School of Medicine
Albuquerque, NM 87131-0001

Peter Basch, MD, MACP
Regent, American College of Physicians
Senior Director for IT Quality and Safety, Research and National Health IT Policy
MedStar Health
3007 Tilden Street NW Suite 5N
Washington, DC 20008

Robert M. Centor, MD, MACP
Chair-Emeritus, ACP Board of Regents
Professor-Emeritus, General Internal Medicine
1530 3rd Ave S
Birmingham, AL 35294-3407

Andrew Dunn, MD, MPH, SFHM, MACP
Immediate Past Chair, ACP Board of Regents
Professor of Medicine
Chief, Division of Hospital Medicine
Mount Sinai Health System
1468 Madison Ave, Box 1086
New York, NY

Catherine H. MacLean, MD, PhD, FACP
Chief Value Medical Officer & Senior VP
Center for the Advancement of Value in Musculoskeletal Care
Hospital for Special Surgery
535 East 70th Street
New York, NY 10021

Danny Allen Newman, MD, FACP
Private Practice, Augusta, GA
Clinical Assistant Professor Augusta University
1443 Anthony Rd
Augusta, GA 30904

Matthew E. Nielsen, MD, MS, FACS
Associate Professor of Urology, Adjunct Associate Professor of Epidemiology and Health Policy & Management
University of North Carolina at Chapel Hill
2107 Physicians Office Building, Box 7235
Chapel Hill, NC 27599

Sameer D. Saini, MD, MS
Research Scientist, VA HSR&D Center for Clinical Management Research
Associate Professor, Division of Gastroenterology
University of Michigan Hospitals
1500 E. Medical Center Drive
Ann Arbor, MI 48109

Paul G. Shekelle, MD, MPH, PhD, FACP
Co-director, South California Evidence-Based Practice Center,
RAND Corporation
1776 Main Street PO Box 2138
Santa Monica, CA 90407-2138

Sandeep Vijan, MD, MS
Professor of Internal Medicine, U. of Michigan
Physician Scientist, Ann Arbor VA CCMR
North Campus Research Complex
2800 Plymouth Road Building 16, Room 344E
Ann Arbor, MI 48109-2800

Additional Quality and Cost Measures Suggested for Consideration by CMS But Not Included in this Proposal

Chronic Disease

A. Additional Quality Measures Suggested for Consideration by CMS but not Included in this Proposal
   - **End of Life Care**: MIPS 047; NQF 0326: Advance Care Plan
   - **Hypertension**: MIPS 236; NQF 0018: Controlling High Blood Pressure
   - **Hypertension**: MIPS 373: Hypertension: Improvement in Blood Pressures
   - **PREM**: MIPS 321; NQF 0005: CAHPS for MIPS Clinician/Group Survey
   - **PRO-PM**: NQF 0700: Health Related Quality of Life in COPD Patients Before and After Pulmonary Rehabilitation
   - **Readmission**: NQF 2887; MSSP: Risk-Standardized Acute Admission Rates for Patients with Diabetes
   - **Readmission**: NQF 2886; MSSP: Risk-Standardized Acute Admission Rates for Patients with Heart Failure
   - **Readmission**: NQF 2888; MSSP: Risk Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions
   - **Readmission**: MIPS 458: Hospital-Wide Readmission Measure for MIPS Eligible Clinicians
   - **Readmission**: MIPS 458: Hospital-Wide Readmission Measure for MIPS Eligible Clinicians
   - **Shared Decision Making**: NQF 2962: Shared Decision Making Process

Prevention

Additional Quality Measures Suggested for Consideration by CMS but not Included in this Proposal

- **PREM**: MIPS 321; NQF 0005: CAHPS for MIPS Clinician/Group Survey
- **Medication Management**: MIPS 238; NQF 0022: Use of High-Risk Medications in the Elderly
- **Medication Management**: NQF 2993: Potentially Harmful Drug-Disease Interactions in the Elderly

Additional Cost measures Suggested for Consideration by CMS but Rejected by PMC

- **MIPS SPH_1:** Simple Pneumonia with Hospitalization

Appendix II: Improvement Activities Detailed Rationale

Chronic Disease Management MVP

Activity Name	Activity ID	Description	Relevant Measures in ACP's Chronic Disease MVP Proposal	Rationale for inclusion
Implementation of formal quality improvement methods, practice changes, or other practice improvement processes	IA_PSPA_19	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following, such as: • **Participation in multisource feedback;** • **Train all staff in quality improvement methods;** • **Integrate practice change/quality improvement into staff duties;** • **Engage all staff in identifying and testing practices changes;** • **Designate regular team meetings to review data and plan improvement cycles;** • Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; • **Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data;** • Participation in Bridges to Excellence; • Participation in American Board	All measures	This cross-cutting improvement activity provides the foundation for clinicians to improve their performance across all measures in ACP's Chronic Disease MVP. ACP's ACP Advance quality improvement curriculum could be used as a resource to meet these activity requirements. The curriculum was developed to provide all members of the clinical team with a core educational foundation of quality improvement methodology that integrates patient engagement and using a team-

Activity Name	Activity ID	Description	Relevant Measures in ACP's Chronic Disease MVP Proposal	Rationale for inclusion
		of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.		based approach. ACP's QI curriculum is an accredited, CME activity.
Completion of an Accredited Safety or Quality Improvement Program	IA_PSPA_28	Completion of an accredited performance improvement continuing medical education (CME) program that addresses performance or quality improvement according to the following criteria: • The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity; • The activity must have specific, measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information. An example of an activity that could satisfy this improvement activity is completion of an accredited continuing medical education program related to opioid analgesic risk and		

Activity Name	Activity ID	Description	Relevant Measures in ACP's Chronic Disease MVP Proposal	Rationale for inclusion
		evaluation strategy (REMS) to address pain control (that is, acute and chronic pain).		
Use of QCDR data for ongoing practice assessment and improvements	IA_PSPA_7	Participation in a Qualified Clinical Data Registry (QCDR) and use of QCDR data for ongoing practice assessment and improvements in patient safety, including: • **Performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventive screening and vaccinations that can be shared across MIPS eligible clinician or groups);** • Use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment); • Use of standardized processes for screening for social determinants of health such as food security, employment, and housing; • Use of supporting QCDR modules that can be incorporated into the certified EHR technology;	All measures	This cross-cutting improvement activity provides the foundation for clinicians to improve on all measures in ACP's Chronic Disease MVP. ACP's Genesis Registry could be used as a resource to meet this activity's requirements. ACP's Genesis Registry allows clinicians to assess their performance across a variety of MIPS and custom measures. The performance feedback dashboard allows clinicians to identify patient

Activity Name	Activity ID	Description	Relevant Measures in ACP's Chronic Disease MVP Proposal	Rationale for inclusion
		or • Use of QCDR data for quality improvement such as comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcomes.		outliers, compare performance to peer benchmarks, and link to tools and resources to support quality improvements, including the ACP Advance QI Curriculum.
Chronic Care and Preventive Care Management for Empaneled Patients	IA_PM_13	In order to receive credit for this activity, a MIPS eligible clinician must manage chronic and preventive care for empaneled patients (that is, patients assigned to care teams for the purpose of population health management), which could include one or more of the following actions: • Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; and plan of care for chronic conditions; • Use evidence based, condition-specific pathways for care of chronic conditions (for example, hypertension, diabetes, depression, asthma, and heart failure). These might include, but are not limited to, the NCQA Diabetes Recognition Program (DRP) and the NCQA Heart/Stroke Recognition Program (HSRP);	All measures	ACP provides resources to support this improvement activity, including: • ACP Advance QI curriculum – provides methodology for implementing pre-visit planning workflows • Patient education resources • ACP Genesis registry, which can be used to track performance on population of patients

Activity Name	Activity ID	Description	Relevant Measures in ACP's Chronic Disease MVP Proposal	Rationale for inclusion
		• Use pre-visit planning, that is, preparations for conversations or actions to propose with patient before an in-office visit to optimize preventive care and team management of patients with chronic conditions; • Use panel support tools, (that is, registry functionality) or other technology that can use clinical data to identify trends or data points in patient records to identify services due; • Use predictive analytical models to predict risk, onset and progression of chronic diseases; and/or • Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals, and community health workers where available) to alert and educate patients about services due; and/or routine medication reconciliation.		
Participation in MOC Part IV	IA_PSPA_2	In order to receive credit for this activity, a MIPS eligible clinician must participate in Maintenance of Certification (MOC) Part IV. Maintenance of Certification (MOC) Part IV requires clinicians to perform monthly activities across practice to regularly assess performance by reviewing outcomes addressing identified areas for improvement and evaluating the results. Some examples of activities that can be completed to receive MOC Part IV credit are: the American	All measures	This activity is a cross-cutting activity that provides the foundation for clinicians to improve performance across all measures.

Activity Name	Activity ID	Description	Relevant Measures in ACP's Chronic Disease MVP Proposal	Rationale for inclusion
		Board of Internal Medicine (ABIM) Approved Quality Improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Performance Improvement Module or American Society of Anesthesiologists (ASA) Simulation Education Network, for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program; specialty-specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE); American Psychiatric Association (APA) Performance in Practice modules.		
Implementation of condition-specific chronic disease self-management support programs	IA_BE_20	Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community.	All measures	ACP supports engaging patients in all aspects of treatment of their care. These improvement activities focus on engaging patients to make them more equipped

Activity Name	Activity ID	Description	Relevant Measures in ACP's Chronic Disease MVP Proposal	Rationale for inclusion
Improved Practices that Disseminate Appropriate Self-Management Materials	IA_BE_21	Provide self-management materials at an appropriate literacy level and in an appropriate language.		to manage their chronic conditions.
Improved Practices that Engage Patients Pre-Visit	IA_BE_22	Implementation of workflow changes that engage patients prior to the visit, such as a pre-visit development of a shared visit agenda with the patient, or targeted pre-visit laboratory testing that will be resulted and available to the MIPS eligible clinician to review and discuss during the patient's appointment.		
MDD prevention and treatment interventions	IA_BMH_5	Major depressive disorder: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including suicide risk assessment (refer to NQF #0104) for mental health patients with co-occurring conditions of behavioral or mental health conditions.	MIPS 107; NQF 0104: Adult Major Depressive Disorder: Suicide Risk Assessment	This improvement activity is directly linked to Adult MDD: Suicide Risk Assessment measure that will be included in ACP's Chronic Disease MVP proposal.

Preventive Care MVP

Activity Name	Activity ID	Description	Relevant Measures in ACP's Prevention MVP Proposal	Rationale for inclusion
Implementation of formal quality improvement methods, practice changes, or other practice improvement processes	IA_PSPA_19	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following, such as: • **Participation in multisource feedback;** • **Train all staff in quality improvement methods;** • **Integrate practice change/quality improvement into staff duties;** • **Engage all staff in identifying and testing practices changes;** • **Designate regular team meetings to review data and plan improvement cycles;** • Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; • **Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families, including activities in which clinicians act upon**	All measures	This cross-cutting improvement activity provides the foundation for clinicians to improve their performance across all measures in ACP's Prevention MVP. The ACP Advance quality improvement curriculum could be used as a resource to meet these activity requirements. The curriculum was developed to provide all members of the clinical team with a core educational foundation of quality improvement methodology that integrates patient engagement and using a team-based approach. ACP's QI curriculum is an accredited, CME activity.

Activity Name	Activity ID	Description	Relevant Measures in ACP's Prevention MVP Proposal	Rationale for inclusion
		patient experience data; • Participation in Bridges to Excellence; • Participation in American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.		This activity is a cross-cutting activity that provides the foundation for clinicians to improve performance across all measures.
Completion of an Accredited Safety or Quality Improvement Program	IA_PSPA_28	Completion of an accredited performance improvement continuing medical education (CME) program that addresses performance or quality improvement according to the following criteria: • The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity; • The activity must have specific, measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their		

Activity Name	Activity ID	Description	Relevant Measures in ACP's Prevention MVP Proposal	Rationale for inclusion
		activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information. An example of an activity that could satisfy this improvement activity is completion of an accredited continuing medical education program related to opioid analgesic risk and evaluation strategy (REMS) to address pain control (that is, acute and chronic pain).		
Use of QCDR data for ongoing practice assessment and improvements	IA_PSPA_7	Participation in a Qualified Clinical Data Registry (QCDR) and use of QCDR data for ongoing practice assessment and improvements in patient safety, including: • **Performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventive screening and vaccinations that can be shared across MIPS eligible clinician or groups);** • Use of standard questionnaires for assessing improvements in health disparities	All measures	This cross-cutting improvement activity provides the foundation for clinicians to improve on all measures in ACP's Prevention MVP. ACP's Genesis Registry could be used as a resource to meet this activity's requirements. ACP's Genesis Registry allows clinicians to assess their performance across a variety of MIPS and custom measures. The performance

Activity Name	Activity ID	Description	Relevant Measures in ACP's Prevention MVP Proposal	Rationale for inclusion
		related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment); • Use of standardized processes for screening for social determinants of health such as food security, employment, and housing; • Use of supporting QCDR modules that can be incorporated into the certified EHR technology; or • Use of QCDR data for quality improvement such as comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcomes.		feedback dashboard allows clinicians to identify patient outliers, compare performance to peer benchmarks, and link to tools and resources to support quality improvements, including the ACP Advance QI Curriculum.
CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain	IA_PSPA_22	Completion of all the modules of the Centers for Disease Control and Prevention (CDC) course "Applying CDC's Guideline for Prescribing Opioids" that reviews the 2016 "Guideline for Prescribing Opioids for Chronic Pain." Note: This activity may be selected once every 4 years, to	Opioid Misuse: MIPS 414: Evaluation or Interview of Opioid Misuse	ACP supports the CDC's guidelines for prescribing opioids for patients with chronic pain. The CDC's guidelines include recommendations for evaluation of opioid misuse. ACP believes

Activity Name	Activity ID	Description	Relevant Measures in ACP's Prevention MVP Proposal	Rationale for inclusion
		avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.		completion of this improvement activity will support improved performance on the measure, MIPS 414: Evaluation or Interview of Opioid Misuse.
Participation in MOC Part IV	IA_PSPA_2	In order to receive credit for this activity, a MIPS eligible clinician must participate in Maintenance of Certification (MOC) Part IV. Maintenance of Certification (MOC) Part IV requires clinicians to perform monthly activities across practice to regularly assess performance by reviewing outcomes addressing identified areas for improvement and evaluating the results. Some examples of activities that can be completed to receive MOC Part IV credit are: the American Board of Internal Medicine (ABIM) Approved Quality Improvement (AQI) Program, National Cardiovascular Data	All measures	This activity is a cross-cutting activity that provides the foundation for clinicians to improve performance across all measures.

Activity Name	Activity ID	Description	Relevant Measures in ACP's Prevention MVP Proposal	Rationale for inclusion
		Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Performance Improvement Module or American Society of Anesthesiologists (ASA) Simulation Education Network, for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program; specialty- specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE); American Psychiatric Association (APA) Performance in Practice modules.		
Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Abuse and Ambulatory Care Patients	IA_BMH_9	Individual MIPS eligible clinicians or groups must regularly engage in integrated prevention and treatment interventions, including screening and brief counseling (for example: NQF #2152) for patients with co-occurring conditions of mental health and substance abuse. MIPS eligible clinicians would attest that 60 percent for the	Unhealthy Alcohol Use: MIPS 431; NQF 2152: Screening & Brief Counseling	This improvement activity is directly linked to the Unhealthy Alcohol Use measure that is proposed to be included in ACP's Prevention MVP.

Activity Name	Activity ID	Description	Relevant Measures in ACP's Prevention MVP Proposal	Rationale for inclusion
		CY 2018 Quality Payment Program performance period, and 75 percent beginning in the 2019 performance period, of their ambulatory care patients are screened for unhealthy alcohol use.		

Appendix III: Detailed Ideas for New Promoting Interoperability Measures

1) **Quality, Safety, Value Improvement Projects that Leverage Health IT (e.g. a data quality improvement project aimed at fixing variation in how a particular data element is collected at the point of care for preventive and chronic condition MVP measures):** CMS should create a measure for reporting on an innovation involving health IT that clinicians could report each year using a specified format. A simple example might be a data quality improvement project aimed at fixing variation in how a particular data element is collected at the point of care.

2) **Participation in development of eCQMs that support Quality Improvement (done within a QCDR) – with a focus on the specific Quality/Cost/IA measures within the preventive or chronic condition MVPs:** There is not a broad enough set of performance measures and many existing measures are of such poor quality that they should not be used. Further, attempts to create eMeasures have resulted in an entirely new set of data quality problems. Clinicians should get credit for proposing measures that conform to the constraints of a defined template and that use existing EHR data. These eMeasures should measure implementation of evidence-based care. Registry technologies, such as QCDRs, offer a way for clinicians and practices to collect encounter data and analyze them for opportunities to measure and improve quality. Such a platform will provide the opportunity to focus on what truly matters at the individual- and practice-level.

3) **EHR/Health IT educational activity developed/endorsed by medical specialty or professional societies:** Clinicians are facing a steep learning curve when it comes to implementing new health IT in their practices. Providing an incentive to participate in educational courses and continuing medical education in basic use of health IT (particularly when it comes to supporting patient engagement, safety, quality, and cost) would be beneficial to the clinician, the health IT community, and most importantly, the patient. The ACP continues to support such programs where CMS and ONC partner with the medical specialty and professional societies – who could create or endorse such educational programs for its membership.

4) **Participation in Precision Medicine/Learning Health System (e.g., participation in practice-based research or other observational study efforts**): Precision medicine and the learning health system is the future of meaningful use of health IT and no matter what their specialty, clinicians may find value in getting involved with an observational study or any other activity that might be considered as evidence-generating medicine. Clinicians could run phenotyping algorithms on their data and contribute the results or use existing data collections to identify appropriate treatment patterns for specific patients based upon social determinants they have collected.

5) **Clinical Informatics Improvement (e.g., support of iterative improvement in practical informatics via use of an "EHR feedback" application; or participation in an EHR user group):** Certified EHR systems should have a "Feedback" mechanism available so that EHR users can quickly and easily collect context sensitive thoughts for submission to a vendor-managed improvement process or user group, or for later consideration and elaboration. Having this type of bottom-up approach to health IT design allows for clinicians to have the opportunity to contribute to the software personalization that helps them consistently deliver better care.

6) **Patient Safety and Near-miss Reporting:** ECs should have the ability to easily report patient safety, adverse events, and near miss reports directly from the EHR system. While the point value would be expected to be low for a single completed report, the value to health care is sufficient to make this a PI activity. Safety reporting levels are unacceptably low, and the PI program can help to resolve this problem.