Performance Measurement

Centers for Medicare and Medicaid Services 2019 Merit-Based Incentive Payment System: A Review of the Performance Measures by the Performance Measurement Committee (PMC) of the American College of Physicians (ACP)

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Introduction

The Performance Measurement Committee of the American College of Physicians assessed the validity (as an indicator of quality) of measures applicable to internal medicine within the Centers for Medicare and Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) using a modified RAND/UCLA appropriateness method (1). Among 18 MIPS measures relevant to internal medicine, the committee rated 9 (50% [2 new measures proposed for adoption by CMS into MIPS for the 2021 payment year]) as valid, 7 (39% [3 new measures proposed for adoption by CMS into MIPS for the 2021 payment year]) as not valid, and 2 (11%) as uncertain validity.

Methods

Committee staff collected measure specifications, rationale and any supporting information that were publically available for each measure and made these available online to the panelists for the first-round ratings along with the ACP Performance Measure Review Criteria. Measure specifications included complete measure details and the evidence and testing reports. Panelists used an online tool to track individual assessments of whether measures met criteria within each of the five ACP measure review domains. Panelists used a 9-point scale to rate the measures where 1-3 indicated 'does not meet criteria,' 4-6'meets most criteria,' and 7-9 'meets criteria.' Panelists rated the overall measure validity after considering and rating each of these domains.

Subsequently, the committee conducted a face-to-face panel meeting at which panelists discussed and re-rated each of the measures. During that meeting, each panelist received an aggregate summary of pre-ratings, as well as the pre-rating score for each measure. The committee discussed each measure included in the analysis set. After discussing each measure, panelists re-rated each of the indicators by confidential ballot using the same 9-point rating scale used in the initial rating phase.

The committee chair served as moderator for the panel process and did not rate measures. Given the large volume of measures included in the analysis set, committee staff assigned approximately half of the measures to the remaining 11 members who were split into two groups of five and six panelists for the preliminary rating round. All panelists discussed and rated each measure during the second rating round at the in-person meeting. Panelists were recused from rating measures for which they had financial or intellectual conflicts of interest (COI) that were relevant to the measure's clinical topic area. One panelist was absent from the second round of ratings and one panelist exited the face-to-face panel meeting early. As a result, between 6 and 9 panelists voted on each measure rated at the face-to-face meeting.

Analyses

Preliminary ratings of the proposed indications were performed and analyzed in advance of a face-to-face meeting at which the indications and their preliminary ratings were discussed. Then, each of the indications was re-rated. Results are based on the final ratings for overall validity. We considered measures as valid if the median overall rating was 7, 8 or 9; and there was no disagreement. Measures were considered not valid if the median overall rating was 1, 2

or 3; and there was no disagreement. The validity of all other measures was considered uncertain. Disagreement was defined as having 3 or more ratings in each the lowest (1-3) and highest (7-9) rating tertiles. Based on these criteria, each measure was assigned to one of three rating categories: valid, uncertain, or not valid.

Conclusion

Among 18 Merit-based Incentive Payment System (MIPS) measures relevant to internists, the committee only rated 9 (50%) as valid measures of physician-level quality performance using a rigorous assessment process. Policymakers, physician organizations, and measure developers should encourage inclusion of the measures rated as valid in accountability, payment, and reporting programs. Policymakers, physician organizations, and measure developers should immediately assess the continued use of the measures rated as not valid in accountability, payment, and reporting programs.

MIPS Measure ID# TBD

Recommendation
ACP supports MIPS measure ID# TBD: "Vascular Disease: Use of Aspirin or Another Antiplatelet Therapy."

Rationale
ACP supports MIPS measure ID# TBD: "Vascular Disease: Use of Aspirin or Another Antiplatelet Therapy" because implementation will likely lead to meaningful and measureable improvements in clinical outcomes and promote appropriate use of antiplatelet therapy in patients who are diagnosed with ischemic vascular disease (IVD). Furthermore, developers cite clinical recommendations of the American College of Cardiology and the American Heart Association for the "Management of Patients who are Diagnosed with IVD" to form the basis of the measure. Additionally, the numerator and denominator specifications are well defined and the denominator includes clinically appropriate exceptions to eligibility for the measure (i.e., patients who have a history of gastrointestinal bleeding, intracranial bleeding, bleeding disorder, allergy to aspirin or antiplatelet, or patients who are prescribed non-steroidal anti-inflammatory agent therapy). While we support this measure, we note that it may be difficult for clinicians who report this measure to capture over-the-counter aspirin therapy.

Measure Specifications

NEW: MIPS ID# TBD: Ischemic Vascular Disease: Use of Aspirin or Another Platelet	
COI Management:	Dr. Shekelle was recused from voting due to a moderate-level conflict of interest
Overall Median ACP PMC rating:	7.5
Measure Steward:	Minnesota Community Measurement
NQF Status:	Not NQF-endorsed
Use in Federal Program:	MIPS
MIPS Measure Status (live, proposed new):	Proposed new
Measure Tested:	Testing information not available
Harmonization:	NQF: 0068 [MIPS: 204 (ACP supports)], NQF: 0076, MIPS: 441 (ACP does not support)

CMS Rationale for Inclusion:	We are proposing to adopt this measure because the proposed measure exclusions are more appropriate than those in the currently adopted Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic (Quality ID #204) measure. The proposed measure accounts for history of gastrointestinal bleeding, intracranial bleeding, bleeding disorder, allergy to aspirin or anti-platelets, or use of non-steroidal anti-inflammatory agents. The MAP acknowledged both that clinicians may still report Aspirin or Anti-platelet Medication measures separately from the composite to drive quality improvement. The MAP conditionally supported this measure with the condition that there are no competing measures in the program. We refer readers to Table C where we are proposing to remove Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic (Quality ID #204).
Description:	The percentage of patients 18-75 years of age who had a diagnosis of ischemic vascular disease (IVD) and were on daily aspirin or anti-platelet medication, unless allowed contraindications or exceptions are present.
Numerator Statement:	Denominator patients with documentation that the patient was on daily aspirin or anti-platelet medication during the measurement period, unless allowed contraindications or exceptions are present.
Denominator Statement:	18 years or older at the start of the measurement period AND less than 76 years at the end of the measurement period AND Patient had a diagnosis of ischemic vascular disease (Ischemic Vascular Disease Value Set) with any contact during the current or prior measurement period OR had ischemic vascular disease (Ischemic Vascular Disease Value Set) present on an active problem list at any time during the measurement period. AND At least one established patient office visit (Established Pt Diabetes & Vasc Value Set) for any reason during the measurement period
Exclusions:	▪ Prescribed anti-coagulant medication during the measurement period ▪ History of gastrointestinal bleeding ▪ History of intracranial bleeding ▪ Bleeding disorder ▪ Other provider documented reason: allergy to aspirin or anti-platelets ▪ Other provider documented reason: use of non-steroidal anti-inflammatory agents ▪ Other provider documented reason: documented risk for drug interaction with a medication taken during the measurement period.

	▪ Other provider documented reason: uncontrolled hypertension (systolic blood pressure greater than 180 mmHg and/or diastolic blood pressure greater than 110 mmHg) ▪ Other provider documented reason: gastroesophageal reflux disease (GERD) ▪ Patient was a permanent nursing home resident at any time during the measurement period ▪ Patient was in hospice or receiving palliative care at any time during the measurement period ▪ Patient died prior to the end of the measurement period ▪ Documentation that diagnosis was coded in error ▪ Patient had only urgent care visits during the measurement period
Type of Measure:	Process
Intended Level of Attribution:	Individual Clinician
Proposed Level of Attribution:	Individual Clinician
Care Setting:	Outpatient
Data Source:	Medicare Part B Claims, MIPS CQMs Specifications

MIPS Measure ID# TBD

Recommendation
ACP supports MIPS measure ID# TBD: "Appropriate Use of DXA Scans in Women under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture."

Rationale
ACP supports MIPS measure ID# TBD: "Appropriate Use of DXA Scans in Women under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture" because implementation will likely result in measureable and meaningful improvements in clinical outcomes and the developers cite clinical recommendations of the United States Preventive Services Task Force (USPSTF) on "Screening for Osteoporosis" to form the basis of the measure. While developers do not cite any performance data to describe the opportunity for improvement, our sense is that a performance gap does exist. While we support this measure, we note that healthcare institutions are aggressively working to enhance their capture of malnutrition documentation and coding, as this has a variety of implications for reimbursement and outcomes reporting (e.g., risk adjustment for expected mortality rate). Increased documentation in the inpatient setting may limit the potential for this measure to inform appropriate use of DXA scans because the traditional concept of malnutrition in the chronic context may not apply in the acute context. Furthermore, we note that the exclusion criterion for "white women" seems a bit broad. A stronger measure may promote appropriate use of screening in patients whose risk equates to an evidence-based threshold of developing an osteoporotic fracture as defined by the FRAX® or other validated assessment tool.

Measure Specifications

NEW: MIPS ID# TBD: Appropriate Use of DXA Scans in Women Under 65 Years Who do not Meet the Risk Factor Profile for Osteoporotic Fracture	
Overall Median Rating by the ACP PMC:	7
Measure Steward:	Centers for Medicare and Medicaid Services
NQF Status:	Undergoing review by NQF
Use in Federal Program:	MIPS
MIPS Measure Status (live, proposed new):	Proposed new
Measure Tested:	Testing information not available
Harmonization:	NQF: 0053 [MIPS 418 (ACP Supports)], NQF: 0046 [MIPS 039 (ACP Supports)], NQF: 0037, NQF: 0614 (NLE)

CMS Rationale for Inclusion:	We are proposing to adopt this measure because it will serve as a counterbalance to the existing measure of appropriate use (that is, Screening for Osteoporosis for Women Aged 65-85 Years of Age (Quality ID #039)). This measure addresses the inappropriate use of DXA scans for women age 50 – 64 years without risk factors for osteoporosis. The MAP recognized the need for early detection of osteoporosis but reiterated the importance of appropriate use of this screening technique and noted this measure could be complementary to the existing osteoporosis screening measure (Quality ID #039). The MAP recognized the potential need for a balancing measure to prevent the potential underuse of DXA scans. The MAP conditionally supported this measure pending NQF endorsement. While we agree with MAP that NQF endorsement of measures is preferred, it is not a requirement for measures to be considered for MIPS if the measure has an evidence-based focus. We believe this measure is evidence-based and is an important patient reported outcome.
Description:	Percentage of female patients aged 50 to 64 without select risk factors for osteoporotic fracture who received an order for a dual-energy x-ray absorptiometry (DXA) scan during the measurement period.
Numerator Statement:	Female patients who received an order for at least one DXA scan in the measurement period.
Denominator Statement:	Female patients ages 50 to 64 years with an encounter during the measurement period.
Exclusions:	Exclude from the denominator patients with a combination of risk factors (as determined by age) or one of the independent risk factors: • Ages: 50-54 (>=4 combo risk factors) or 1 independent risk factor • Ages: 55-59 (>=3 combo risk factors) or 1 independent risk factor • Ages: 60-64 (>=2 combo risk factors) or 1 independent risk factor Combination risk factors (The following risk factors are all combination risk factors; they are grouped by when they occur in relation to the measurement period): The following risk factors may occur any time in the patient's history but must be active during the measurement period: • White (race) • BMI <= 20 kg/m2 (must be the first BMI of the measurement period) • Smoker (current during the measurement period) • Alcohol consumption (> two units per day (one unit is 12 oz. of beer, 4 oz. of wine, or 1 oz. of liquor)) The following risk factor may occur any time in the patient's history and must not start during the measurement period: • Osteopenia The following risk factors may occur at any time in the patient's history or during the measurement period: • Rheumatoid arthritis

	• Hyperthyroidism • Malabsorption syndromes: celiac disease, inflammatory bowel disease, ulcerative colitis, Crohn's disease, cystic fibrosis, malabsorption • Chronic liver disease • Chronic malnutrition The following risk factors may occur any time in the patient's history and do not need to be active at the start of the measurement period: • Documentation of history of hip fracture in parent • Osteoporotic fracture • Glucocorticoids (>= 5 mg/per day) [cumulative medication duration >= 90 days] Independent risk factors (The following risk factors are all independent risk factors; they are grouped by when they occur in relation to the measurement period): The following risk factors may occur at any time in the patient's history and must not start during the measurement period: • Osteoporosis The following risk factors may occur at any time in the patient's history prior to the start of the measurement period, but do not need to be active during the measurement period: • Gastric bypass • FRAX[R] 10-year probability of all major osteoporosis related fracture >= 9.3 percent • Aromatase inhibitors The following risk factors may occur at any time in the patient's history or during the measurement period: • Type I diabetes • End stage renal disease • Osteogenesis imperfecta • Ankylosing spondylitis • Psoriatic arthritis • Ehlers-Danlos syndrome • Cushings syndrome • Hyperparathyroidism • Marfan's syndrome • Lupus
Type of Measure:	Process
Intended Level of Attribution:	Individual Clinician
Proposed Level of Attribution:	Individual Clinician
Care Setting:	Outpatient
Data Source:	TBD

MIPS Measure ID# 118

Recommendation
ACP supports MIPS measure ID# 118 (NQF ID# 0066): "Coronary Artery Disease (CAD): Angiotensin Converting Enzyme-Inhibitor (ACE-I) or Angiotensin Receptor Blocker (ARB) Therapy—Diabetes or LVSD (LVEF <40%)."

Rationale
ACP supports MIPS measure ID# 118 (NQF ID# 0066): "Coronary Artery Disease: Angiotensin Converter Enzyme-Inhibitor (ACE-I) or Angiotensin Receptor Blocker (ARB) Therapy—Diabetes or LVSD (LVEF <40%)" because implementation will likely promote appropriate use of ACE-I and ARB therapy in patients who are diagnosed with CAD, the developer cites clinical recommendations of the American College of Cardiology (ACC)/American Heart Association (AHA)/American College of Physicians (ACP) for the "Management of Stable Ischemic Heart Disease" to form the basis of the measure, the measure specifications are well-defined, and data collection is feasible and burden is acceptable for clinicians report this measure. 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.

Measure Specifications

MIPS ID# 118, NQF# 0066: Coronary Artery Disease: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy—Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)	
COI Management:	Dr. Shekelle was recused from voting due to a moderate-level conflict of interest
Overall Median Rating by the ACP PMC:	8
Measure Steward:	American Heart Association
NQF Status:	NQF-endorsed, Last Updated Dec 09, 2016, Undergoing Annual Update
Use in Federal Program:	MIPS
MIPS Measure Status (live, proposed new):	Live
Measure Tested (Y, N):	Y: Individual Clinician, Group/Practice
Harmonization:	NQF: 1662, NQF: 1522 (NLE), NQF: 0081[MIPS 005 (ACP supports)], NQF: 2467 (NLE)

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 aged 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 (e.g., 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 (e.g., patient declined, other patient reasons); Documentation of system reason(s) for not prescribing ACE inhibitor or ARB therapy (e.g., lack of drug availability, other reasons attributable to the health care system).
Type of Measure:	Process
Intended Level of Attribution:	Group Practice, Individual Clinician
Proposed Level of Attribution:	Individual Clinician
Care Setting:	Home Care, Outpatient Services, Post-Acute Care
Data Source:	Registry Data

MIPS Measure ID# 024

Recommendation
ACP does not support MIPS measure ID# 024 (NQF ID# 0045 [no longer endorsed]): "Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older."

Rationale
ACP does not support MIPS measure ID# 024 (NQF ID# 0045 [no longer endorsed]): "Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older." While this measure represents an important clinical concept, it is unclear whether the act of documenting communication with the clinician who is managing on-going care will lead to measureable and meaningful improvements in clinical outcomes. Furthermore, performance scores are likely to be entirely dependent on the socio-economic and environmental factors of the patient populations for whom clinicians serve and the clinician's ability to access health information. For example, implementation could penalize clinicians who practice in rural or underserved areas, while clinicians who practice in large health systems with access to shared electronic health information are likely to score high on this measure. A more meaningful measure for improving care post-fracture for men and women could be "confirmation that that post-fracture care actually occurred."

Measure Specifications

MIPS ID# 024, NQF ID# 0045: Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 Year and Older	
Overall Median Rating by the ACP PMC:	3
Measure Steward:	National Committee for Quality Assurance
NQF Status:	NQF endorsement removed, Last updated Mar 01, 2018
Use in Federal Program:	MIPS
MIPS measure Status (live, proposed new):	Live
Measure Tested (Y,N):	Testing information not available
Harmonization:	NQF: 0053 [(MIPS: 418)ACP supports], NQF: 0048 (no longer endorsed)
Description:	Percentage of adults 50 years and older treated for a fracture with documentation of communication, between the physician treating

	the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is reported by the physician who treats the fracture and who therefore is held accountable for the communication.
Numerator Statement:	Patients with documentation of communication with the physician or other clinician managing the patient's on-going care that a fracture occurred and that the patient was or should be considered for osteoporosis testing or treatment. Communication may include documentation in the medical record indicating that the clinician treating the fracture communicated (e.g., verbally, by letter, through shared electronic health record, a bone mineral density test report was sent) with the clinician managing the patient's on-going care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.
Denominator Statement:	Adults aged 50 years and older who experienced a fracture, except fractures of the finger, toe, face or skull.
Exclusions:	Exclude members who use hospice services during the measurement period.
Type of Measure:	Process
Intended Level of Attribution:	Individual Clinician
Proposed Level of Attribution:	Individual Clinician
Care Setting:	Inpatient/Hospital, Outpatient
Data Source:	Electronic Health Records, Paper Medical Records

MIPS Measure ID# 320

Recommendation
ACP supports MIPS measure ID# 320 (NQF ID# 0658): "Appropriate Follow-up for Normal Colonoscopy in Average Risk Patients."

Rationale
ACP supports MIPS measure ID# 320 (NQF ID# 0658): "Appropriate Follow-up for Normal Colonoscopy in Average Risk Patients" because implementation will likely promote appropriate use of colonoscopy in average risk patients, developers cite the clinical recommendations of the United States Preventive Services Task Force on "Screening for Colon Cancer" to form the basis of the measure, the measure specifications are well-defined and the denominator includes well specified and clinically appropriate exceptions to eligibility for the measure, and data collection is feasible and the burden is acceptable for clinicians who report this measure. While we support this measure, 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. Also, 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. Finally, 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. A more meaningful measure may assess how often clinicians perform colonoscopies in average risk patients prior to the recommended follow-up date.

Measure Specifications

MIPS ID# 320, NQF ID# 0658: Appropriate Follow-up for Normal Colonoscopy in Average Risk Patients	
COI Management:	Drs. Saini and Vijan were recused from voting due to moderate-level conflicts of interest
Overall Median Rating by ACP PMC:	7
Measure Steward:	American Gastroenterological Association
NQF Status:	NQF-endorsed, Last updated Oct 03, 2017
Use in Federal Program:	MIPS
MIPS Measure Status:	Live

Measure Tested (Y, N):	Y: Individual Clinician
Harmonization:	NQF: 0572, NQF: 0659, NQF: 0034, ASC: 9, ASC: 10
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 (e.g., 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).
Type of Measure:	Process
Intended Level of Attribution:	Individual Clinician
Proposed Level of Attribution:	Individual Clinician
Care Setting:	Outpatient
Data Source:	Claims, Electronic Health Records, Registry Data

MIPS Measure ID# 439

Recommendation
ACP does not support MIPS measure ID# 439: "Age Appropriate Screening Colonoscopy" because of uncertain validity.

Rationale
ACP does not support MIPS measure ID# 439: "Age Appropriate Screening Colonoscopy" because of uncertain validity. Developers do not cite any performance data to form the basis of the measure and therefore, we are unable to assess the opportunity for improvement. However, performance data demonstrates that the rates of clinicians who perform colonoscopies on patients who are over the age of 85 years old are incredibly low (2, 3), so this is potentially a low impact measure. While this measure represents an important clinical concept and we do support the development of clinical recommendations that promote appropriate screening in average risk patients, the burden posed by the documentation requirements outweighs the rewards of reporting. The list of valid medical reasons for screening patients who are >85 years old is exorbitant and requires too much investigation by the reporting clinician.

Measure Specifications

MIPS ID# 439: Age Appropriate Screening Colonoscopy	
COI Management:	Drs. Saini and Vijan were recused from voting due to moderate-level conflicts of interest
Overall Median Rating by ACP:	4
Measure Steward:	Centers for Medicare and Medicaid Services
NQF Status:	Not NQF endorsed
Use in Federal Program:	MIPS
MIPS Measure Status (live, proposed new):	Live
Measure Tested (Y, N):	Testing information not available
Harmonization:	NQF: 0658, NQF: 0034, NQF: 0659
Description:	The percentage of patients greater than 85 years of age who received a screening colonoscopy from January 1 to December 31.
Numerator Statement:	All patients greater than 85 years of age included in the denominator who did NOT have a history of colorectal cancer or a valid medical reason

	for the colonoscopy, including: iron deficiency anemia, lower gastrointestinal bleeding, Crohn's Disease (i.e. regional enteritis), familial adenomatous polyposis, Lynch Syndrome (i.e., hereditary non-polyposis colorectal cancer), inflammatory bowel disease, ulcerative colitis, abnormal findings of gastrointestinal tract, or changes in bowel habits. Colonoscopy examinations performed for screening purposes only.
Denominator Statement:	Colonoscopy examinations performed on patients greater than 85 years of age during the encounter period
Exclusions:	Documentation of medical reason(s) for a colonoscopy performed on a patient greater than 85 years of age (e.g., last colonoscopy incomplete, last colonoscopy had inadequate prep, iron deficiency anemia, lower gastrointestinal bleeding, Crohn's Disease (i.e., regional enteritis), familial history of adenomatous polyposis, Lynch Syndrome (i.e., hereditary non-polyposis colorectal cancer), inflammatory bowel disease, ulcerative colitis, abnormal finding of gastrointestinal tract, or changes in bowel habits)
Type of Measure:	Process
Intended Level of Attribution:	Individual Clinician
Proposed Level of Attribution:	Individual Clinician
Care Setting:	Outpatient
Data Source:	Registry

MIPS Measure ID# 275

Recommendation

ACP supports MIPS measure ID# 275: Inflammatory Bowel Disease: "Assessment of Hepatitis B Virus (HBV) Status before Initiating Anti-Tumor Necrosis Factor (TNF) Therapy."

Rationale

ACP supports MIPS measure ID# 275: "Inflammatory Bowel Disease: Assessment of Hepatitis B Virus Status before Initiating Anti-Tumor Necrosis Factor Therapy" because implementation will likely lead to measureable and meaningful improvements in clinical outcomes, the level of attribution specified in the measure (individual clinician) is appropriate, the measure addresses an intervention that is under the influence of the clinician being assessed, and the measurement results provide information that will help clinicians to improve care. While we support this measure, we note several concerns that developers should address during the next review to update the measure. First, developers do not cite current performance data and therefore, we cannot assess the opportunity for improvement. Payment and accountability programs have included this measure as an option for reporting for many years and therefore, performance data should exist to demonstrate the opportunity for improvement. Second, developers should present data on the frequency of HBV reactivation with Anti-TNF therapy to demonstrate the opportunity for improvement. Citing case reports is not sufficient to properly document the frequency of reactivation. Third, developers should revise the numerator specifications to precisely define what constitutes a "first course" of therapy. For example, "first course" could mean "first course *ever*" or, "first course of therapy for the most recent reactivation." Finally, we note that the documentation requirements pose some burden on the reporting clinician. The one-year look-back window for HBV assessment requires continuity of medical records and a fairly sophisticated review of the claims data/diagnosis codes.

Measure Specifications

MIPS ID# 275: Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-Tumor Necrosis Factor (TNF) Therapy	
Overall Median Rating by ACP:	7
Measure Steward:	Centers for Medicare and Medicaid Services
NQF Status:	Not NQF-endorsed
Use in Federal Program:	MIPS
MIPS Measure Status (live, proposed new):	Live

Measure Tested (Y, N):	Testing information not available
Harmonization:	None
Description:	Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease (IBD) who had Hepatitis B Virus (HBV) status assessed and results interpreted within one year prior to receiving a first course of anti-TNF (tumor necrosis factor) therapy.
Numerator Statement:	Patients who had HBV status assessed and results interpreted within one year prior to receiving a first course of anti-TNF therapy.
Denominator Statement:	All patients aged 18 and older with a diagnosis of inflammatory bowel disease.
Exclusions:	Documented reason for not assessing Hepatitis B Virus (HBV) status (e.g. patient not receiving a first course of anti-TNF therapy, patient declined) within one year prior to first course of anti-TNF therapy.
Type of Measure:	Process
Intended Level of Attribution:	Individual Clinician
Proposed Level of Attribution:	Individual Clinician
Care Setting:	Outpatient
Data Source:	Registry

MIPS Measure ID# 117

Recommendation
ACP supports MIPS measure ID#117 (NQF ID# 0055): "Diabetes: Eye Exam."

Rationale
ACP supports MIPS measure ID#117 (NQF ID# 0055): "Diabetes: Eye Exam" because the opportunity for improvement is well documented, developers cite the 2018 clinical recommendations of the American Diabetes Association for the "Standards of Medical Care in Diabetes" to form the basis of the measure, the specifications are well defined, and the denominator includes well specified and clinically appropriate exceptions to eligibility for the measure. While we support this measure, we suggest the developers address the following points during the next review to update the measure. First, implementation could promote overuse because some modeling studies support ≥2 year screening intervals in patients who have an HbA1c of <7% with normal prior eye exams (4-7). Second, we note that while poor interoperability across EHRs poses some data collection burden on clinicians who report this measure, the onus *should* be on the clinician who is managing the diabetes to ensure that patients who are diagnosed with diabetes are screened for diabetic retinal disease. Finally, we suggest that the developers revise the specifications to include all patients over the age of 18 years, as long as the risk of retinopathy is specified for older patients. The current American Geriatrics Society guidelines support biennial screening for all adults, including for patients who are over the age of 75 years who are at risk for retinopathy.

Measure Specifications

MIPS ID# 117, NQF# 0055: Diabetes: Eye Exam	
Overall Median Rating by ACP:	7
Measure Steward:	National Committee for Quality Assurance
NQF Status:	NQF endorsed, Last updated Jun 10, 2016
Use in Federal Program:	MIPS
MIPS Measure Status (Live, Proposed New):	Live
Measure Tested (Y, N):	Y: Individual Clinician, Group, Health Plan
Harmonization:	NQF: 2609, NQF: 0089, NQF: 0088
Description:	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.

Numerator Statement:	Patients who received an eye screening for diabetic retinal disease. This includes people with diabetes who had the following: -A retinal or dilated eye exam by an eye care professional (optometrists or ophthalmologist) in the measurement year OR –A negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. For exams performed in the year prior to the measurement year, a result must be available.
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 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.
Type of Measure:	Process
Intended Level of Attribution:	Health Plan, Integrated Delivery System
Proposed Level of Attribution:	Individual Clinician
Care Setting:	Outpatient
Data Source:	Claims, Electronic Health Data, Electronic Health Records, Paper Medical Records

MIPS Measure ID# 119

Recommendation
ACP supports MIPS measure ID# 119 (NQF ID# 0062): Diabetes: "Medical Attention for Nephropathy."

Rationale
ACP supports MIPS measure ID# 119 (NQF ID# 0062): "Diabetes: Medical Attention for Nephropathy" because the opportunity for improvement is well documented, developers cite 2018 clinical recommendations of the American Diabetes Association on "Standards of Medical Care in Diabetes" to form the basis of the measure, the numerator and denominator are well defined, the denominator includes well specified and clinically appropriate exceptions to eligibility for the measure, and measurement is repeatable and precise.

Measure Specifications

MIPS ID# 119, NQF# 0062: Diabetes: Medical Attention for Nephropathy	
Overall Median Rating by ACP:	7
Measure Steward:	National Committee for Quality Assurance
NQF Status:	NQF-endorsed, Last updated Apr 04, 2016
Use in Federal Program:	MIPS
MIPS Measure Status (live, proposed new):	Live
Measure Tested (Y, N, N/A):	Y: Individual Clinician, Group/Practice, Health Plan
Harmonization:	NQF: 2604, NQF: 0731
ACP Recommendation from AHIP Measures Review 2015:	ACP supports NQF 0062: "Comprehensive Diabetes Care: Medical Attention for Nephropathy." We suggest however, that when this measure is revised, the specifications of the current measure exclude patients with dementia and patients with life limiting diagnoses (receiving hospice and palliative care) where the intervention has the potential to cause more harms than benefits.
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 who received a nephropathy screening or monitoring test or had 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 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.
Type of Measure:	Process
Intended Level of Attribution:	Health Plan, Integrated Delivery System
Proposed Level of Analysis:	Individual Clinician
Care Setting:	Outpatient
Data Source:	Claims, Electronic Health Data, Electronic Health Records, Paper Medical Records

MIPS Measure ID# TBD

Recommendation
ACP does not support MIPS measure ID# TBD (NQF ID# 3067): "HIV Infection Screening" because of uncertain validity.

Rationale
ACP does not support MIPS measure ID# TBD (NQF ID# 3067): "HIV Infection Screening" because of uncertain validity. To the extent the intent of this measure is to standardize HIV screening, thereby increasing early diagnosis and reducing stigma of testing, including some measure of "ever tested" seems like a reasonable first step. However, we note several implementation and methodological flaws that reduce the measure's ability to lead to measureable and meaningful improvements in clinical outcomes. First, while evidence suggests the benefit of screening for HIV in all adults on clinical outcomes is high, the patient's consent to testing is often beyond the clinician's control. Second, poor interoperability across EHRs poses significant burden on clinicians who report this measure. Additionally, clinicians may encounter confidentiality barriers to retrieving patient sensitive information around test results. If clinicians are unable to retrieve previous results, they may feel inclined to order additional tests. Second, the specifications should include exclusion criteria for patient refusal, patients who are diagnosed with limited life-expectancy, and patients who are already infected with HIV. Finally, developers not cite any evidence to form the basis of the annual screening frequency described in the denominator specifications. Data are far better for frequent screening of high-risk patients (8, 9). One-time screening is an odd idea for an infectious disease—patients are either at risk, in which case they should be screened, or not at risk with limited benefit of screening. Additionally, one-time screening in low-risk patients has mixed data on effectiveness and is highly dependent on the assumptions about the underlying prevalence. For example, two major papers on the topic conclude that the cost-effectiveness is >$100,000 per quality-adjusted life-year per (QALY) and >$15,000 per QALY (10).

Measure Specifications

NEW: MIPS ID# TBD, NQF# 3067: HIV Infection Screening	
Overall Median Rating by the ACP PMC:	5
Measure Steward:	Centers for Disease Control and Prevention
NQF Status:	Under review by NQF
Use in Federal Program:	MIPS
MIPS Measure Status (live, proposed new):	Proposed New

Measure Tested (Y, N):	Y: Group/Practice
Harmonization:	NQF: 0573 (NLE)
CMS Rationale for Inclusion:	We are proposing to adopt this measure because HIV screening is a national and global priority. While there are three currently adopted HIV measures in MIPS, they do not include screening the general population. The MAP acknowledged the importance of HIV screening from a population health perspective, but also questioned whether encouraging HIV screening through the MIPS program is the most effective strategy for improving this population health goal. It also expressed concern about how this measure under consideration identified individuals who may have a HIV screening in the community. Additionally, several MAP members expressed concern regarding the specifications requiring one time lifetime screening. The MAP conditionally supported this measure pending NQF endorsement. While we agree with MAP that NQF endorsement of measures is preferred, it is not a requirement for measures to be considered for MIPS if the measure has an evidence-based focus. We believe this measure is evidence-based and is an important patient reported outcome.
Description:	Percentage of patients 15-65 years of age who were tested at least once for HIV.
Numerator Statement:	Patients with either documentation of an HIV test after their 15th birthday or evidence of HIV infection.
Denominator Statement:	Patients 15 to 65 years of age who had a visit in the measurement period*. *The measurement period refers to a defined, 12 month interval that begins and ends prior to the measure calculation date.
Exclusions:	None
Type of Measure:	Process
Intended Level of Attribution:	Group/Practice, Facility
Proposed Level of Attribution:	Individual Clinician
Care Setting:	Outpatient
Data Source:	Registry

MIPS Measure ID# TBD

Recommendation
ACP does not support MIPS measure ID# TBD (NQF ID# 3175): "Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)."

Rationale
ACP does not support MIPS measure ID# TBD (NQF ID# 3175): "Continuity of Pharmacotherapy for Opioid Use Disorder." While a strong argument exists for measurement of continuity of OUD pharmacotherapy, the developers present performance data at the levels of the state and plan to describe the opportunity for improvement and we query how impactful this measure could be at the level of the individual clinician. Moreover, attribution is not clearly stated. It is unclear which clinician is accountable for this measure. For example, is it the responsibility of the primary care clinician or the clinician who prescribes the medication assisted therapy (MAT) to ensure that patients adhere to therapy for a period of 180 continuous days? Furthermore, we are not sure that the "individual clinician" is an appropriate unit of analysis for this measure. The discontinuity of Suboxone, Subtex, and methadone is rarely, if at all, under the influence of the individual clinician. Furthermore, while evidence suggests the benefit of pharmacotherapy for a period of 180 days on clinical outcomes in patients with OUD is high (11-14), the underlying assumption that clinicians can convince opioid-dependent patients to abstain from opioid use for an extended period is questionable. The statistical results for success at the state level are low (median success = ~25%). Finally, the total number of eligible patients is relatively small (<1000 patients per state in the most recent data presented) (15, 16), which could be problematic when adjusting for individual clinician level assessment. As OUD pharmacotherapy increases, this may become less of an issue. Finally, insurance type often drives patient adherence and therefore, developers should consider revising the specifications to include some element of risk adjustment.

Measure Specifications

NEW: MIPS ID# TBD, NQF# 3175: Continuity of Pharmacotherapy for Opioid Use Disorder	
COI Management:	Dr. Asch was recused from voting due to a moderate-level conflict of interest
Overall Median Rating by ACP:	3
Measure Steward:	University of Southern California
NQF Status:	NQF-endorsed, Last updated Jun 28, 2017, Undergoing annual update
Use in Federal Program:	MIPS

MIPS Measure Status (live, proposed new):	Proposed new
Measure Tested (Y, N):	Y: Health Plan
Harmonization:	NQF: 0004 [MIPS: 305 (ACP does not support)], NQF: 1664 (ACP does not support)
CMS Rationale for Inclusion:	We are proposing to adopt this measure because the opioid epidemic is immensely affecting the nation and it is imperative to measure opioid use. This clinical concept is currently not represented within MIPS. There are three existing opioid use related measures for MIPS but none cover the topic of pharmacotherapy. This measure captures patients diagnosed with opioid use disorder (OUD) who are receiving and adhering to the prescribed therapy. The performance data provided by the measure steward supports there is opportunity for improvement. Based on the measure steward research, only about a quarter to a third of individuals with commercial insurance or Medicaid coverage taking medication for OUD remained on the medication for at least 180 days without a gap of more than seven days. The MAP acknowledged the public health importance of measures that address opioid use disorder and noted the gap in this area. However, the MAP recognized that the current measure is specified and tested at the health plan and state level and recommended the measure be refined and resubmitted prior to rulemaking because the measure has not been tested or endorsed at the clinician or clinician group level. While we agree that the measure should be tested at the clinician level, we believe there is an urgent need for measures that address the opioid epidemic affecting the nation. We believe that the health plan level version of the measure can be adapted to the clinician level by revising the measure analytics to assess the proportion of patients with opioid use disorder that achieve continuity of pharmacotherapy aggregated at the clinician level.
Description:	Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.
Numerator Statement:	Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days.
Denominator Statement:	Individuals 18-64 years of age who had a diagnosis of OUD and at least one claim for an OUD medication.
Exclusions:	None

Type of Measure:	Process
Intended Level of Attribution:	Health Plan, Population: Regional and State
Proposed Level of Attribution:	Individual Clinician
Care Setting:	Outpatient
Data Source:	Claims, Electronic Health Data

MIPS Measure ID# TBD

Recommendation
ACP does not support MIPS measure ID# TBD: "Zoster (Shingles) Vaccination."

Rationale
ACP does not support MIPS measure ID# TBD: "Zoster (Shingles) Vaccination." While this measure represents an important clinical concept, the measure steward does not present detailed information on the measure specifications, opportunity for improvement, testing results, or evidence reviewed by the developers to form the basis of the measure, therefore; we cannot meaningfully assess the validity of this measure. That said, we do note some concerns for the developers to consider prior to submitting this measure to payment, accountability, and reporting programs for adoption. First, specifying the age parameter as ≥50 years could be problematic as vaccine availability rates across the country are low. Second, the fact that the specifications do not include any exclusion criteria is challenging. Developers should consider revising the specifications to include exclusion criteria for socio-economic and environmental factors affecting accessibility; patients with limited life-expectancy; and patient refusal. Third, developers should identify vaccines that meet the reporting requirements in the numerator details. Many patients refuse vaccination because they cannot afford treatment or, they cannot withstand the side effects of treatment or the pain associated with the injection. Finally, poor interoperability across electronic systems poses some burden on clinicians who report this measure.

Measure Specifications

NEW: MIPS ID# TBD: Zoster (Shingles) Vaccination	
Overall Median Rating by ACP:	1.5
Measure Steward:	PPRNet
NQF Status:	Under review by NQF
Use in Federal Program:	MIPS
MIPS Measure Status (live, proposed new):	Proposed new
Measure Tested (Y, N):	Testing information not available
Harmonization:	N/A
CMS Rationale:	We are proposing to adopt this measure because there are no measures currently in MIPS that address shingles vaccination for patients 60 years and older as recommended by the CDC. The MAP concluded that this

	measure would address the important topic of adult immunization. It discussed the new guidelines under development for the Zoster vaccination that could impact the amount of doses, the age of administration, and the specific vaccine that is used, but also noted that guidelines are constantly evolving and measures should be routinely updated based on changing guidelines. The MAP conditionally supported this measure pending NQF endorsement, and specifically requested evaluating the measure to ensure it has appropriate exclusions and reflects the most current CDC guidelines given the concerns about the cost of the vaccine and potential concerns about administering to immunocompromised patients. While we agree with MAP that NQF endorsement of measures is preferred, it is not a requirement for measures to be considered for MIPS if the measure has an evidence-based focus. We believe this measure is evidence-based and is an important patient reported outcome.
Description:	The percentage of patients 50 years of age and older who have a Varicella Zoster (shingles) vaccination.
Numerator Statement:	Patients with a shingles vaccine ever recorded.
Denominator Statement:	Patients 50 years of age and older.
Exclusions:	None
Type of Measure:	Process
Intended Level of Attribution:	Individual Clinicians
Proposed Level of Attribution:	Individual Clinician
Care Setting:	Outpatient
Data Source:	TBD

MIPS Measure ID# 338

Recommendation
ACP supports MIPS measure ID# 338 (NQF ID# 2082): "HIV: Viral Load Suppression."

Rationale
ACP supports MIPS measure ID# 338 (NQF ID# 2082): "HIV: Viral Load Suppression" because implementation will likely lead to measureable and meaningful improvements in clinical outcomes, the target viral load of <200 copies/mL is reasonable and appropriate, developers cite clinical recommendations of the National Institute of Health (NIH) and the World Health Organization (WHO) to form the basis of the measure, and the data presented in the measure background materials supports reliability at the level of the individual clinician. While we support this measure, we suggest that developers revise the specifications to include some element of risk adjustment. The disparities data presented in the background materials states that ~30% of patients who are living with HIV are not covered by insurance. Therefore, the specifications should include exclusion criteria for patient refusal.

Measure Specifications

MIPS ID# 338, NQF# 2082: HIV: Viral Load Suppression	
COI Management:	Dr. Asch was recused from voting due to a moderate-level conflict of interest
Overall Median Rating by the ACP PMC:	7
Measure Steward:	Health Resources and Services Administration—HIV/AIDS Bureau
NQF Status:	NQF-endorsed, Last updated Jul 13, 2017, Undergoing Annual Update
Use in Federal Program:	MIPS
MIPS Measure Status (live, proposed new):	Live
Measure Tested (Y, N):	Y: Hospital/Facility/Agency
Harmonization:	NQF: 0407, NQF: 3210
Description:	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year A medical visit is any visit in an outpatient/ambulatory care setting

	with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.
Numerator Statement:	Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.
Denominator Statement:	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year.
Exclusions:	None
Type of Measure:	Outcome
Intended Level of Attribution:	Facility
Proposed Level of Attribution:	Individual Clinician
Care Setting:	Outpatient
Data Source:	Electronic Health Data, Paper Medical Records

MIPS Measure ID# 277

Recommendation
ACP does not support MIPS measure ID# 277: "Sleep Apnea: Severity Assessment at Initial Diagnosis."

Rationale
ACP does not support MIPS measure ID# 277: "Sleep Apnea: Severity Assessment at Initial Diagnosis" because implementation poses significant burden with very little yield. Developers do describe the opportunity for improvement in the measure background materials. The apnea hypopnea index (AHI) and the respiratory disturbance index (RDI) are standard tests routinely reported during sleep studies. Furthermore, without a threshold level of abnormality for AHI and RDI, the measure lacks the specification to lead to measureable and meaningful improvements in clinical outcomes. Developers do cite evidence to describe the correlation of an AHI >15 with a higher risk of cardiovascular events, but they fail to note that the best trials of CPAP showed no reduction in cardiovascular event (17, 18). While this measure represents a good clinical concept, it is purely a reporting measure with limited opportunity for improving clinical outcomes. A more meaningful quality improvement effort may work through other avenues to standardize sleep study conduct and reporting by certifying sleep labs rather than including this concept in payment-level reporting.

Measure Specifications

MIPS ID# 277: Sleep Apnea: Severity Assessment at Initial Diagnosis	
Overall Median Rating by the ACP PMC:	2
Measure Steward:	American Academy of Sleep Medicine
NQF Status:	Not NQF-endorsed
Use in Federal Program:	MIPS
MIPS Measure Status (live, proposed new):	Live
Measure Tested (Y, N):	Testing information not available
Harmonization:	N/A
Description:	Percentage of patients aged 18 years and older with a diagnosis of obstructive sleep apnea who had an apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) measured at the time of initial diagnosis.

Numerator Statement:	Patients who had an apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) measured at the time of initial diagnosis.
Denominator Statement:	All patients aged 18 years and older with a diagnosis of sleep apnea.
Exclusions:	Documentation of reason(s) for not measuring an apneahypopnea index (AHI) or a respiratory disturbance index (RDI) at the time of initial diagnosis (e.g., psychiatric disease, dementia, patient declined, financial, insurance coverage, test ordered but not yet completed).
Type of Measure:	Process
Intended Level of Attribution:	Individual Clinician
Proposed Level of Attribution:	Individual Clinician
Care Setting:	Outpatient
Data Source:	Registry

MIPS Measure ID# 279

Recommendation
ACP does not support MIPS measure ID# 279: "Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy."

Rationale
ACP does not support MIPS measure ID# 279: "Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy." While this measure represents an important clinical concept, we note several concerns that the developers should address during the next review to update the measure. First, as currently specified, this measure is subject to gaming and it is unlikely that implementation will lead to measureable and meaningful improvements in clinical outcomes. The exclusion criterion for "patient did not bring card" is inappropriate. For example, if 95% of patients forget to bring the card to their appointment, clinicians can document that the patient forgot to bring the card and achieve a near perfect score on this measure. Furthermore, while obstructive sleep apnea (OSA) is a common condition, developers cite performance data that is based on patient reports for CPAP use as opposed to citing objective data. Second, the numerator and denominator are not clearly defined. It is unclear how clinicians should document an objective measure. For example, should clinicians scan an image of the card and post this image in the chart? Or, should clinicians record actual values to demonstrate the rate of patient adherence? Third, success with this measure relies on patient factors that are beyond the clinician's control rather than an intervention performed by the clinician in the clinic setting. If health plans adopt this measure to evaluate patient compliance, which could drive improvements in outcomes related to costs, measurement could lead to meaningful and measureable improvements in clinical outcomes. Additionally, measure for assessing whether the reporting clinician works to improve compliance or offers second line therapies in patients who are not compliant with CPAP therapy could lead to meaningful improvements in clinical outcomes.

Measure Specifications

MIPS ID# 279: Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy	
Overall Median Rating by the ACP PMC:	2
Measure Steward:	American Academy of Sleep Medicine
NQF Status:	Not NQF-endorsed
Use in Federal Program:	MIPS

MIPS Measure Status (live, proposed new):	Live
Measure Tested (Y, N):	Testing information not available
Harmonization:	N/A
Description:	Percentage of visits for patients aged 18 years and older with a diagnosis of obstructive sleep apnea who were prescribed positive airway pressure therapy who had documentation that adherence to positive airway pressure therapy was objectively measured.
Numerator Statement:	Patient visits with documentation that adherence to positive airway pressure therapy was objectively measured.
Denominator Statement:	All patients aged 18 years and older with a diagnosis of sleep apnea.
Exclusions:	Documentation of reason(s) for not objectively measuring adherence to positive airway pressure therapy (e.g., patient didn't bring data from continuous positive airway pressure [CPAP], therapy not yet initiated, not available on machine).
Type of Measure:	Process
Intended Level of Attribution:	Individual Clinician
Proposed Level of Attribution:	Individual Clinician
Care Setting:	Outpatient
Data Source:	Registry

MIPS Measure ID# 337

Recommendation
ACP does not support MIPS measure ID# 337: Psoriasis: "Tuberculosis (TB) Prevention for Patients with Psoriasis, Psoriatic Arthritis, and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier."

Rationale
ACP does not support MIPS measure ID# 337: "Psoriasis: Tuberculosis Prevention for Patients with Psoriasis, Psoriatic Arthritis, and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier" because the measure addresses a very narrow scope with limited opportunity for improvement. Furthermore, developers cite soft evidence (level B) to form the basis of the measure. Moreover, we are concerned with some aspects of the specifications. First, the developers do not define which TB tests are acceptable to meet the requirements of the measure. Second, it seems that confirmation of TB test through the EHR would be reasonable as opposed to confirmation via letter. Third, the time interval is consensus based. While we agree it is important for clinicians to screen for TB prior to initiation of treatment with anti-tumor necrosis factor therapy, we are not aware of any evidence to support the annual testing frequency. Fourth, developers should revise the specifications to include QuantiFERON®-TB Gold as a screening option. Finally, the documentation requirements are illogical unless this measure is facilitated by a registry.

Measure Specifications

MIPS ID# 337: Psoriasis: Tuberculosis (TB) Prevention for Patients with Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier – National Quality Strategy Domain: Effective Clinical Care	
Overall Median Rating by the ACP PMC:	2.5
Measure Steward:	American Academy of Dermatology
NQF Status:	Not NQF-endorsed
Use in Federal Program:	MIPS
Description:	Percentage of patients whose providers are ensuring active tuberculosis prevention either through yearly negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test.
MIPS Measure Status (live, proposed new):	Live

Measure Tested (Y, N):	Testing information not available
Harmonization:	N/A
Numerator Statement:	Patients who have a documented negative annual TB screening or have documentation of the management of a positive TB screening test with no evidence of active tuberculosis, confirmed through use of radiographic imaging (i.e., chest x-ray, CT).
Denominator Statement:	All patients with a diagnosis of psoriasis and/or psoriatic arthritis and/or rheumatoid arthritis who are on a biologic immune response modifier.
Exclusions:	Documentation of patient reasons(s) for not having records of negative or managed positive TB screen (e.g., patient does not return for Mantoux (PPD) skin test evaluation).
Type of Measure:	Process
Intended Level of Attribution:	Individual Clinician
Proposed Level of Attribution:	Individual Clinician
Care Setting:	Outpatient
Data Source:	Registry

MIPS Measure ID# 383

Recommendation
ACP does not support MIPS measure ID# 383 (NQF ID# 1879): "Adherence to Antipsychotic Medications for Individuals with Schizophrenia."

Rationale
ACP does not support MIPS measure ID# 383 (NQF ID# 1879): "Adherence to Antipsychotic Medications for Individuals with Schizophrenia." While this measure represents an important clinical concept, the reliability data proposed by the measure developers in the use case scenario is low for patient thresholds of <45 people. This measure may be more meaningful if implemented in plan-level reporting programs where it could promote improvement in care management, rather than targeting individual clinicians who are doing their best to treat a difficult population. Furthermore, developers should consider revising the specifications to include some element of risk adjustment to avoid penalizing clinicians who treat a larger proportion of patients who are diagnosed with severe schizophrenia. We would be more supportive of this measure if the developers cited strong evidence for how best to improve adherence among individuals with schizophrenia.

Measure Specifications

MIPS ID# 383, NQF# 1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia	
Overall Median Rating by the ACP PMC:	3
Measure Steward:	Health Services Advisory Group
NQF Status:	NQF-endorsed, Last updated Jun 28, 2017, Undergoing annual update
Use in Federal Program:	MIPS
MIPS Measure Status (live, proposed new):	Live
Measure Tested (Y, N):	Y: Group/Practice, Health Plan, Population: State
Harmonization:	NQF: 0542 (NLE), NQF: 0544 (NLE)
Description:	Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days

	Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).
Numerator Statement:	Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.
Denominator Statement:	Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).
Exclusions:	Individuals with any diagnosis of dementia during the measurement period.
Type of Measure:	Process
Intended Level of Attribution:	Group/Practice, Health Plan, Population; Regional and State
Proposed Level of Attribution:	Individual Clinician
Care Setting:	Outpatient
Data Source:	Claims, Electronic Health Data

MIPS Measure ID# 112

Recommendation
ACP supports MIPS measure ID# 112 (NQF ID# 2372): "Breast Cancer Screening."

Rationale
ACP supports MIPS measure ID# 112 (NQF ID# 2372): "Breast Cancer Screening" because implementation promotes appropriate use of screening tools, current evidence supports the benefit of biennial screening for women ages 50 to 74 years old, and the measure poses low burden because most health systems have robust networks in place to specifically address this issue. While we support this measure, we note that implementation could promote overuse of screening in patients who are at average risk of developing breast cancer. Also, 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. Finally, while this measure represents an important clinical concept, there is less opportunity for improvement for this area as compared to other cancer screening areas where a clear opportunity for improvement exists (e.g., MIPS ID# 113: Colorectal Cancer Screening). Finally, 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.

Measure Specifications

MIPS ID# 112, NQF# 2372: Breast Cancer Screening	
Overall Median Rating by the ACP PMC:	7
Measure Steward:	National Committee for Quality Assurance
NQF Status:	NQF-endorsed, Last updated Jun 10, 2016, Endorsement maintenance
Use in Federal Program:	MIPS
MIPS Measure Status (Live, Proposed New):	Live
Measure Tested (Y, N, N/A):	Y: Health Plan
Harmonization:	N/A
Description:	The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.

Numerator Statement:	Women who received a mammogram to screen for breast cancer.
Denominator Statement:	Women 52-74 years as of December 31 of the measurement year Note: this denominator statement captures women age 50-74 years; it is structured to account for the look-back period for mammograms.
Exclusions:	Bilateral mastectomy any time during the member's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy: 1) Bilateral mastectomy 2) Unilateral mastectomy with a bilateral modifier 3) Two unilateral mastectomies on different dates of service and 4) Both of the following (on the same date of service): Unilateral mastectomy with a right-side modifier and unilateral mastectomy with a left-side modifier.
Type of Measure:	Process
Intended Level of Attribution:	Health Plan, Integrated Delivery System
Proposed Level of Analysis:	Individual Clinician
Care Setting:	Outpatient
Data Source:	Claims, Electronic Health Records

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Disclosure of Interests and Management of Conflicts:

At each meeting and conference call, ACP staff and PMC committee members declared all financial and intellectual interests relevant to health or healthcare. A record of disclosures of interest is kept for each Performance Measurement Committee meeting and conference call and can be viewed at https://www.acponline.org/about-acp/who-we-are/leadership/committees-boards-councils/performance-measurement-committee/performance-measurement-committee-disclosures-of-interest.

Some committee members were recused from voting on specific measures due to moderate-level (intellectual) conflicts of interest. Please refer to the measure specifications tables for details.

APPROVED BY THE ACP BOARD OF REGENTS ON: November 4, 2018

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References

1. Fitch, Kathryn, Steven J. Bernstein, Maria Dolores Aguilar, Bernard Burnand, Juan Ramon LaCalle, Pablo Lazaro, Mirjam van het Loo, Joseph McDonnell, Janneke Vader, and James P. Kahan, The RAND/UCLA Appropriateness Method User's Manual. Santa Monica, CA: RAND Corporation, 2001. https://www.rand.org/pubs/monograph_reports/MR1269.html. Also available in print form.

2. Sheffield KM, Han Y, Kuo Y, Riall TS, Goodwin JS**.** Potentially inappropriate screening colonoscopy in medicare patients: Variation by physician and geographic region. JAMA Internal Medicine. 2013;173(7):542-50.

3. Powell AA, Saini SD, Breitenstein MK, Noorbaloochi S, Cutting A, Fisher DA, et al. Rates and Correlates of Potentially Inappropriate Colorectal Cancer Screening in the Veterans Health Administration. Journal of General Internal Medicine. 2015;30(6):732-41.

4. Aspelund T, Þórisdóttir Ó, Ólafsdottir E, Gudmundsdottir A, Einarsdóttir AB, Mehlsen J, et al. Individual risk assessment and information technology to optimise screening frequency for diabetic retinopathy. Diabetologia. 2011;54(10):2525.

5. Mehlsen J, Erlandsen M, Poulsen PL, Bek T**.** Individualized optimization of the screening interval for diabetic retinopathy: a new model. Acta Ophthalmologica. 2012;90(2):109-14.

6. Looker HC, Nyangoma SO, Cromie DT, Olson JA, Leese GP, Philip S, et al. Predicted impact of extending the screening interval for diabetic retinopathy: the Scottish Diabetic Retinopathy Screening programme. Diabetologia. 2013;56(8):1716-25.

7. Lund SH, Aspelund T, Kirby P, Russell G, Einarsson S, Palsson O, et al. Individualised risk assessment for diabetic retinopathy and optimisation of screening intervals: a scientific approach to reducing healthcare costs. The British Journal of Ophthalmology. 2016;100(5):683-7

8. Branson BM, Handsfield HH, Lampe MA, et al**.** Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. The Centers for Disease Control and Prevention. Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 1600 Clifton Road, N.E., MS D-21, Atlanta, GA 30333; 2006. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

9. Moyer VA on behalf of the U.S. Preventive Services Task Force**.** Screening for HIV: U.S. Preventive Services Task Force Recommendation Statement. Ann Intern Med. 2013;159:51-60.

10. Geue C, Wu O, Xin Y, Heggie R, Hutchinson S, Martin NK, et al. Cost-Effectiveness of HBV and HCV Screening Strategies – A Systematic Review of Existing Modelling Techniques. PLoS ONE. 2015;10(12):e0145022.

11. Cornish R, Macleod J, Strang J, Vickerman P, Hickman M**.** Risk of death during and after opiate substitution treatment in primary care: prospective observational study in UK General Practice Research Database. BMJ. 2010;341.

12. Cousins G, Boland F, Courtney B, Barry J, Lyons S, Fahey T**.** Risk of mortality on and off methadone substitution treatment in primary care: a national cohort study. Addiction. 2016;111(1):73-82.

13. Davoli M, Bargagli AM, Perucci CA, Schifano P, Belleudi V, Hickman M, et al. Risk of fatal overdose during and after specialist drug treatment: the VEdeTTE study, a national multi-site prospective cohort study. Addiction. 2007;102(12):1954-9.

14. Degenhardt L, Randall D, Hall W, Law M, Butler T, Burns L**.** Mortality among clients of a state-wide opioid pharmacotherapy program over 20 years: Risk factors and lives saved. Drug & Alcohol Dependence. 2009;105(1):9-15.

15. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality (2015)**.** Behavioral health trends in the United States: results form the 2014 National Survey on Drug Use and Health. 7-12. (http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014-NSDUH-FRR1-2014.pdf).

16. Substance Abuse and Mental Health Services Administration, Center for Behavioral health Statistics and Quality (2016)**.** Treatment Episode Data Set (TEDS): 2004-2014. National Admissions to Substance Abuse Treatment Services. BHSIS Series S-84, HHS Publication No. 9SMA) 16-4986. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at http://www.samhsa.gov/data/sites/default/files/2014_Treatment_Episode_Data_Set_National_Admissions_9_19_16.pdf

17. Yu J, Zhou Z, McEvoy R, et al. Association of positive airway pressure with cardiovascular events and death in adults with sleep apnea: A systematic review and meta-analysis. JAMA. 2017;318(2):156-66.

18. McEvoy RD, Antic NA, Heeley E, Luo Y, Ou Q, Zhang X, et al. CPAP for Prevention of Cardiovascular Events in Obstructive Sleep Apnea. New England Journal of Medicine. 2016;375(10):919-31.