Quality Payment PROGRAM

MIPS Value Pathways

Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) Town Hall Preparation Guide

Table of Contents

General Town Hall Agenda

9:00am – Welcome and Background. CCSQ Senior Leadership will provide opening remarks on the broader view of the Quality Payment Program (QPP) and how its future aligns with digital quality measures, the Quality Action Plan, and Meaningful Measures 2.0.
9:30am – Session 1: Subgroup Reporting. Brief presentation from CMS and attendee verbal comment and discussion.
12:00pm – Lunch Break
1:00pm – Session 2: MVP Design. Brief presentation from CMS and attendee verbal comment and discussion.
2:30pm – Session 3: MVP Reporting Requirements and Scoring. Brief presentation from CMS and attendee verbal comment and discussion.

Attendee Verbal Feedback Guide

As described in the MVP Town Hall Notice (85 FR 74729 thru 74730), CMS wants to hear from stakeholders and get their input on policies we are considering for future implementation. Therefore, time is allotted to allow registered attendees the opportunity to provide verbal feedback for each of the sessions outlined below. Although we would like to hear from each interested attendee, we cannot guarantee that there will be time available for each interested party during the verbal feedback portion of the Town Hall. Additionally, because of the time constraints, we also cannot guarantee that we will have the ability to address or answer any questions during the meeting.

Registered attendees who would like the opportunity to provide feedback during the town hall need to email CMSMVPFeedback@ketchum.com no later than 11:59 PM EST on December 31, 2020 to indicate your desire to provide verbal feedback and to indicate which session(s) you would like to provide feedback on. The sessions are described below in this *MVP Town Hall Preparation Guide*. Given time limitations, not all who desire to provide verbal feedback may be able to do so. However, any interested party is welcome to provide written feedback by January 14, 2021 at 11:59 PM EST to CMSMVPFeedback@ketchum.com on the policies considered for future implementation.

Session 1: Subgroup Reporting Option Under Consideration for MVPs

Summary: Over the course of MIPS, we have asked stakeholders for their feedback on how groups, including multispecialty groups, should participate in MIPS (81 FR 77070-77073, 82 FR 53592-53593, 83 FR 59742 through 59741, and 84 FR 40738 and 407400-40741). Multispecialty groups, especially those groups with many clinicians, often provide an array of services that may not be captured in a single set of measures. One of the consistent themes we have heard from stakeholders, particularly specialists, is that we should allow a portion of the clinicians in a group to report as a separate subgroup.

Stakeholders have stressed the importance of being able to report on measures and activities that are more applicable to their parts of the practice, rather than the entire group, and better reflect how care is provided. Stakeholders have urged us to allow for subgroup formation and assess subgroup clinicians based on the performance of the subgroup. Additionally, if subgroup data were available in a future state, this could offer patients more meaningful information in selecting a clinician. Some stakeholders also expressed concern about extra burden for multispecialty groups who might have to report multiple MVPs and recommended that subgroup reporting be voluntary. In the 2021 Physician Fee Schedule (PFS) proposed rule, we proposed to modify the guiding principles to allow subgroups for MVP reporting (85 FR 50280 through 50281). This proposal was finalized in the CY 2021 PFS final rule.[1] We are seeking feedback on issues we should consider when implementing subgroups.

As we stated in the CY 2019 PFS final rule (83 FR 53592), there are numerous policy and operational challenges associated with subgroup implementation, such as applying eligibility rules like the low-volume threshold, scoring, and accounting for individual eligible clinicians or TIN/NPIs joining and leaving a subgroup or group practice. We continue to believe it is imperative to the success of subgroup and MVP implementation that these issues be addressed.

We are considering proposing an option for subgroup reporting of MVPs in the CY 2022 rule making cycle but are aware that implementing subgroup reporting may pose significant operational challenges to stakeholders and the agency. We want to better understand stakeholder preferences and operational challenges for subgroup reporting so that we propose a feasible option that is meaningful for all parties.

<u>Concept for Subgroup Reporting</u>

We are considering allowing subgroup reporting that is limited to the reporting of MVPs. We anticipate that this would be voluntary and that groups would have the opportunity to choose to create subgroups for assessment.

Ideally, and we anticipate in a future state, clinicians in subgroups would be assessed on performance that is specific to their subgroup. As we begin rolling out subgroups as a reporting option, we anticipate that subgroups would be assessed on a mixture of data that is from both the subgroups as well as their overall group or TIN. We anticipate that subgroups would be able to be assessed on reported quality measures and improvement activities specific to the subgroup. Depending on the timing of subgroup identification, we also anticipate that subgroups could be assessed on administrative claims-based quality measures and cost measures. However, we anticipate that for the initial year of subgroup reporting, the following elements may need to be assessed from the overall group, affiliated group or TIN:

[1] https://public-inspection.federalregister.gov/2020-26815.pdf

- Eligibility: A subgroup would have the same eligibility as the group, including whether or not clinicians in a subgroup exceed the low-volume threshold, along with any special status designations such as non-patient facing group, small practice, rural, and facility-based group.
- Overall Group Reporting: Subgroup reporting would not exclude individuals or NPIs from TIN level group reporting. In other words, if a TIN elects group reporting, the TIN would be submitting information on all the NPIs, including the subgroup participants. NPIs that are in a subgroup would not be excluded from this reporting.
- Incorporating performance of the Overall Group: During the initial years of subgroup reporting, a subgroup may be assigned the group's score on the MVP foundational layer (administrative claims measures and Promoting Interoperability measures) using performance for the entire TIN rather than the specific NPIs within the subgroup, depending on when subgroup identification takes place.

For example, consider a large, multispecialty group that is eligible for MIPS, and consists of primary care physicians, cardiologists, and surgeons. In this example, the practice's surgeons may participate as a subgroup and report to MIPS through a surgery-specific MVP while the primary care physicians and cardiologists continue to report through traditional MIPS at the group level, which also includes the surgeons.

Subgroup Identification and Election Process

We will need to have an identifier for the subgroup and a mechanism to identify the NPIs in the subgroup to accommodate individual clinicians leaving or joining a subgroup, for example, an alphanumerical combination following the TIN such as ABCD-1234Z. Additionally, we are considering that at the time of subgroup election, each subgroup would be named in a plain language manner. An example of a subgroup name could be "Mayberry Oncology."

We expect to identify the individuals within a subgroup at one point in time to avoid reconciling different lists of subgroup members provided at multiple points in time, similar to the existing process for APM participant lists. We believe that it would be easiest and the most efficient option for practices and CMS if NPIs in a subgroup are identified at a single point in time. We are considering two options for subgroup identification, election of subgroups at the time of data submission or at a specific point during the performance period. As described above, both options require the subgroup participant NPIs as well as the identifier for the subgroup.

Option 1: Election of subgroups at the time of performance data submission. Data submission would include identification of subgroup participants during the submission period after the performance period ends. There is no requirement for prior registration process to identify clinicians in a subgroup. We believe that this option would allow clinicians additional time to submit the identification information for subgroups but would result in subgroups being assessed on less information from the subgroup compared to Option 2.

- Potential Advantages:
    - Provides the most flexibility to clinicians and practices for identifying a list of clinicians participating in subgroup MVP measurement.
    - Allows comprehensive end-of-year subgroup participant list using a retrospective look, where subgroups may have a greater ability to internally account for clinicians joining or leaving their group practice.

- Potential Disadvantages
    - Insufficient operational time for CMS to pull and reconcile claims data and CAHPS beneficiary sampling for the subgroup that informs performance measurement meaning that if subgroups would like to be assessed on the subgroup level for claims data and CAHPS, this would delay feedback and scoring.
    - Alternatively, subgroup clinicians would be assessed on the overall group's administrative claims quality measures and cost measures and not be assessed as a subgroup on these measures.

Option 2: Election of subgroups during the performance period. Prior to the end of the performance period, we anticipate a subgroup would submit a participant list to CMS using the same timing as CAHPS for MIPS registration, July 1 of the performance period. We believe that this option would allow clinicians to be assessed on more information related to their subgroups but would require the submission of subgroup participant lists earlier than Option 1.

- Potential Advantages
    - Allows subgroups to be scored on administrative claims quality measures and cost measures specific to their subgroup's MVP due to increased operational time.
    - Provides increased subgroup performance data to inform quality improvement and patient choice.
    - Encourages proactive performance accountability by allowing clinicians to know what which measures they will be assessed on.
- Potential Disadvantages
    - The subgroup participant list would not be able to be modified after the July 1 registration date; new clinicians could not be added for second half of year.
        - For example, if a clinician on the subgroup participant list leaves their existing practice and joins a new practice on August 31st of the performance period, the subgroup submission would include data for this clinician for the time they were in the practice.
    - A clinician would not have the opportunity to join a subgroup if they join the practice after July 1 and may have to report MIPS as an individual or group.

Questions:
Given the desire to identify the NPIs at a single point in time, which option is more important to you?

- *Option 1: having additional time to submit the identification information for subgroups even though subgroups would be assessed on less information from the subgroup or*
- *Option 2: submitting the subgroup identification information by July 1 and then being assessed on more information from the subgroup.*

What are the practical implications to consider if clinicians were to join or leave a subgroup after the subgroup identification period?

Are there alternate options that we should consider for appropriately capturing clinicians within subgroups at a single point in time?

We envision that subgroups are assigned an identification number and believe that it would be beneficial to sustain the subgroup identification number. Are there circumstances where this number should not be

sustained from year to year for reporting? If so, what factors should we consider in determining that a subgroup can no longer use the same identifier?

As MVPs are created to be more meaningful to the care eligible clinicians provide and to generate more meaningful information for patients, how should we incentivize the continuation of team-based care within practices?

Subgroup Reporting

Ideally, we would want a subgroup to be scored on the measures and activities within the quality, improvement activity, cost, and Promoting Interoperability performance categories which are specific to the NPIs in the subgroup. We acknowledge that there are technical challenges associated with calculating the measures included in the Promoting Interoperability performance category with an identifier such as a subgroup. The relevant Certified Electronic Health Record Technology (CEHRT) standards do not currently exist. We also believe that the Promoting Interoperability performance category is part of the foundational layer of MVPs, and one that applies universally across clinicians. We anticipate that subgroups would be assessed on the Promoting Interoperability performance category measures of their associated group in order to ensure each submission is complete.

Question: If CMS allows subgroup reporting, what are some of the modifications third-party intermediaries and practices would have to make in order to allow reporting of MVPs for submitted quality measures and improvement activities for a subset of the NPIs within a TIN? Do third-party intermediaries and practices believe they can manage supporting subgroup reporting over the short- and/or long-term? What type of modifications does CMS need to make to our technical specifications to accept data? Would these modifications be so onerous to overcome that third-party intermediaries do not think they can do this? Should we add subgroup reporting to the CEHRT requirements?
What are the circumstances, if any, where subgroup-level data would be available now to allow for subgroups to be assessed on the Promoting Interoperability performance category? If this information is available, should we work on accepting this data?

Subgroup Scoring

We will need to decide if subgroups would receive a subgroup-specific final score or if the subgroup score should be incorporated into the group score itself. We do not wish to add complexity to MIPS with additional scoring rules, beyond what is minimally required to make subgroups viable. Eligible clinicians who are identified in the subgroup submission via their NPI may receive a MIPS final score based on that subgroup submission for that TIN/NPI combination. See options under consideration below.

Option A: Subgroups receive a MIPS MVP final score that is separate from the group's final score.

- Potential Advantages: Least complex scoring option.
- Potential Disadvantages: May lead to internal competition within groups and may not align with goals around team-based care; may require duplicative reporting.

Option B: Subgroup scores are rolled up into the group's final score to result in one overall final score for the group. The subgroup scores may or may not be weighted as part of the group's final score.

- Potential Advantages: The group's score incorporates subgroup performance. May better align with team-based care.

- Potential Disadvantages: Adds complexity and the impact of more focused performance data at the subgroup level may be lessened.

As noted above, we anticipate that subgroup reporting will be voluntary, particularly in the initial years. We envision that subgroup reporting will provide an avenue for clinicians within a larger group to submit measures that are relevant to their scope of practice. Therefore, though it could be conceived that subgroups would have a significant level of independence from their overall group, subgroups would function at the behest of the overall group. We believe this to be the best initial step given the potential operational issues related to knowing who is practicing in which subgroup, and how the clinicians in subgroups would be structured, assessed and scored. Subgroups would have the same performance category reweighting and hardship exceptions as the overall group and would not need to take any additional actions to receive the reweighting of the quality, cost, improvement activities, and Promoting Interoperability performance categories in the event that their associated group qualifies for reweighting. Given the current constraints, groups would still have to report on all of their clinicians, not just those who are not in a subgroup.

Questions: Should subgroups receive their own final score or have their subgroup score rolled into the group finals score?

Are there alternate options that we should consider for appropriately scoring subgroups?

Future of Subgroups

As stated above, ideally, we anticipate that there will be a future state where subgroups are able to be assessed across MIPS MVPs at the subgroup level. We anticipate that as we aim to better meet the statute's direction of more comprehensive group reporting, there may be a future state where large, multispecialty subgroup reporting is mandatory and the TIN would no longer be assessed as an overall group, as described in Figures 1 and 2.

Questions: Should subgroup reporting ever be mandatory? What can we do to make the increased burden reasonable?

Figure 1: Subgroup Reporting in Future Years

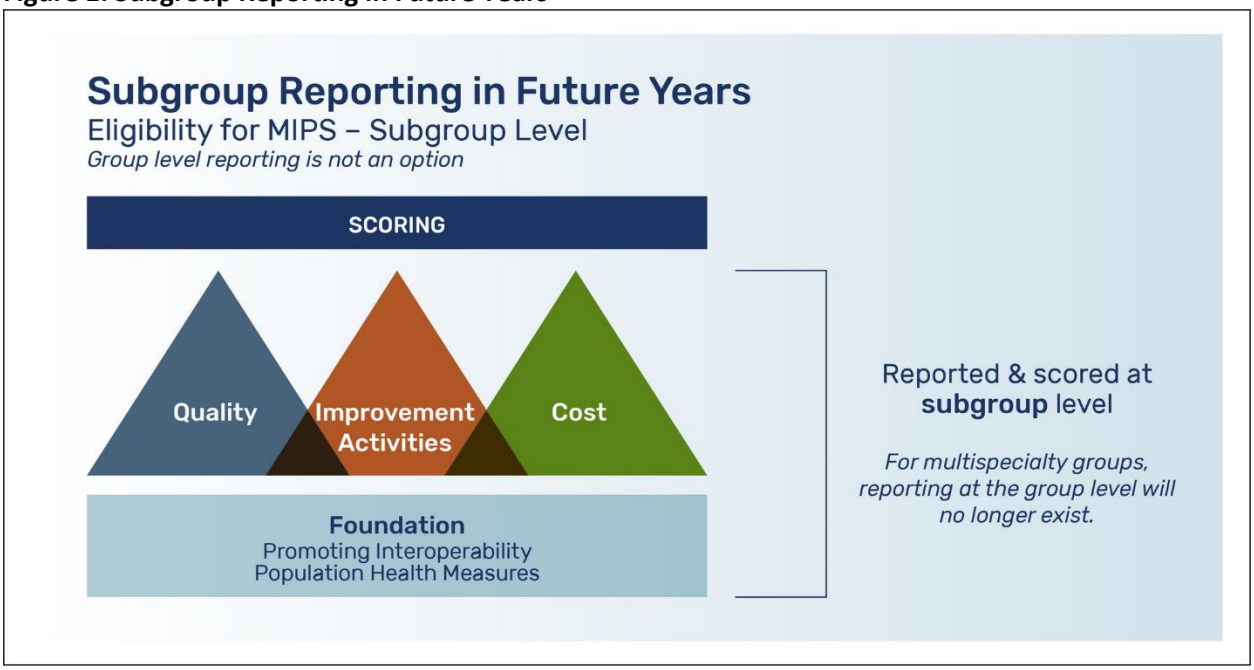
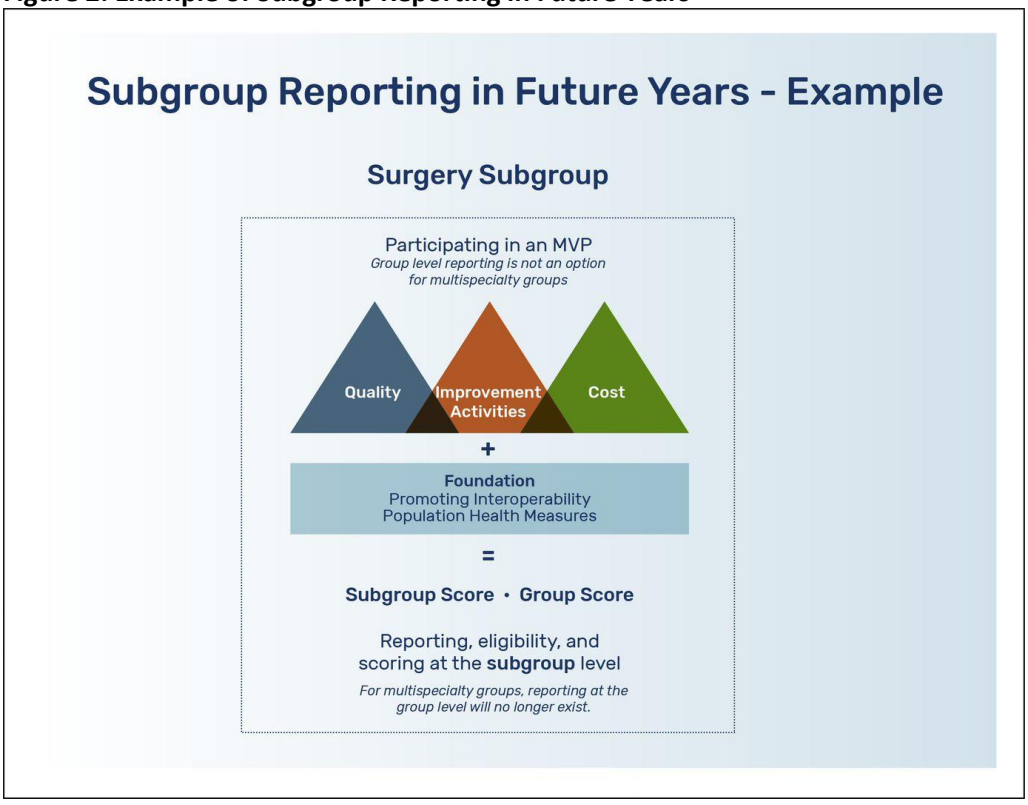


Figure 2: Example of Subgroup Reporting in Future Years



Session 2: MVP Overview

Summary

Since the CY 2020 final rule, we have worked to address how MVPs can be implemented to help drive value in care while also providing time for clinicians and other stakeholders to familiarize themselves with MVPs. Given the challenges the clinician community faces during the COVID-19 public health emergency, we have continued to assess how we can incentivize value-based care in ways that are responsive to the needs of clinicians. We want to share with stakeholders our thinking on MVPs and better understand how we can advance MVPs moving forward. To that end, sessions two and three share our current thinking on how MVPs would work from a conceptual to a more practical level. During this session, we will focus on sharing how our thinking has evolved in defining what an MVP is.

Value of MVPs to Patients

Background: One of the strategic objectives of the QPP is to improve beneficiary outcomes and engage patients through patient-centered policies (82 FR 53570). We recognize the value of patient engagement in improving care coordination and to help ensure improved health outcomes, we envision a future state where patients have the information needed to make decisions about their health care. In the CY 2020 PFS proposed rule we discussed our intent to put patients first and provide the information they need to be active decision-makers in their care (84 FR 40734). Our approach to incorporate the patient voice and enhanced information for patients into the design of MVPs build on existing practices to reflect the patient experience and the patient voice in MIPS (CAHPS for MIPS Survey) and our efforts to add patient-reported outcome measures to the MIPS quality measure inventory.

With a focus on our strategic vision to transform MIPS by empowering patients, we made the following patient-focused proposals in the CY 2021 PFS proposed rule (85 FR 50281):

- Update the third guiding principle to say that wherever possible, the patient voice must be included.
- Update the second guiding principle to highlight the importance of more comprehensive multispecialty reporting from subgroups as a step in improving comparative performance data.
- Stakeholders that are developing candidate MVPs should include patients as a part of the MVP development process.

Amplifying the Patient Voice: We are considering ways to expand the inclusion of the patient voice beyond the existing CAHPS Survey and the patient reported outcome measures now in the MIPS quality measure inventory. We believe there may be better ways to integrate the patient experience in measuring performance and improvement in MVPs. For instance, within the quality performance category, in addition to the existing quality measures, we are considering creating and adding more patient centered measures, such as measures related to patient safety, patient experience measures that involve shared decision-making and advance care planning. We are also interested to hear from stakeholders on their perspectives in defining what it means to incorporate the patient voice into MVPs and if the patient experience measure types mentioned here are sufficient or if there are other strategies and measure types we should consider.

Question: *What additional steps should CMS consider in making MVPs more impactful to patients and to better integrate the voice of patients? Within the context of MVPs, how should we define inclusion of patient voice for non-patient facing clinicians? Are there other types of patient focused measures we should consider?*

MVP Alignment with APMs

Background: Our fourth MVP guiding principle states that MVPs will "reduce barriers to APM participation by including measures that are part of APMs where feasible, and by linking cost and quality measurement" (84 FR 40734). CMS has an overarching goal to accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk alternative payment models.[2] We recognize that clinicians practice in various ways and that not all clinicians have a clinically appropriate Advanced APM.

We have heard that stakeholders would like more information on how MVPs will help reduce the barriers to APM participation and how MVPs relate to APMs overall. According to the Health Care Payment Learning Action Network, which was established by the Centers for Medicare and Medicaid Innovation in 2015, there has been a steady increase in the percentage of payments tied to APMs over the years. As of 2018, 35.8% of total U.S. health care payments are tied to APMs[3] compared to 33.6% in 2017.[4] Furthermore, one of CMS' objectives and key results is to increase the proportion of payments going to clinicians participating in 2-sided risk models. Recently, the unprecedented COVID-19 public health emergency has underscored the need to transition to payment models that enable the healthcare system to respond adequately in a pandemic and support population health. In order to increase participation in APMs, and especially Advanced APMs, we believe that MVPs can help remove barriers between traditional MIPS and MIPS APMs, which may include some clinicians in Advanced APMs who participate in MIPS because they do not meet the thresholds needed to be a QP or a partial QP.

A single MVP will not be able to replicate the full APM experience, as models include greater financial risks and rewards and in exchange, give more flexibility with reporting requirements. However, we anticipate some MVPs could cover a similar population, quality measurement, or clinical topic as an APM. Additionally, we realize that not all clinicians currently have an applicable APM and therefore not all MVPs will have a natural pathway to an existing APM.

In an effort to better align MVPs to APMs, we are considering if it would be valuable to group MVPs into larger categories, including: 1) MVPs that have a related existing APM and 2) MVPs that don't have a related existing APMs. Such a breakdown could allow us to introduce MVPs that may not have a corresponding APM, but continue to support the shift to value. Though we are looking into grouping MVPs in relation to APMs, we do not believe an MVP would transform into an APM. We do not think this is an appropriate expectation to set – given the various timelines of APM models, constraints of MIPS, and innovation that is intrinsic to APM model development.

We anticipate these low burden, meaningful MVPs will move clinician along the value continuum and facilitate movement into APMs by leveraging APM measures, where feasible and linking cost and quality. We also continue to believe that the MVP experience with cost and quality measurement may help improve clinician readiness to take on financial risk in APMs, however, we know that there are additional elements that must be taken into consideration as we continue to shift towards value.

[2] https://hcp-lan.org/workproducts/faqs.pdf
[3] http://hcp-lan.org/workproducts/apm-methodology-2019.pdf
[4] http://hcp-lan.org/workproducts/apm-methodology-2018.pdf

Questions:
We believe that a grouping concept, such as categorizing MVPs based on if there is a corresponding APM or not, can help us clearly articulate how MVPs can help reduce barriers to APMs. How could this concept be utilized to help facilitate movement to APMs? How could the grouping concept be helpful to stakeholders who are developing MVPs? What other criteria could we consider as part of these groupings? For example, should we categorize MVPs based on if they are procedure based or episode based MVPs compared to population based MVPs?

Should CMS prioritize development of MVPs in areas where an APM exists or in areas where APMs do not exist to fill in gaps*?*

In the CY 2020 PFS proposed rule, we solicited feedback on ways to reduce barriers to APM participation and generally heard from commenters that barriers could be reduced by providing more robust performance feedback, increase APM availability, streamline reporting by MVPs to MIPS, increase risk experience, and offer risk education (84 FR 40732). What elements of APM design might we consider in developing MVPs (e.g. similar measures or activities) that would make clinicians feel more confident in making the decision to continue moving towards value in an APM? Are there additional tools that CMS could provide to help clinicians further prepare to take on more risks? Is there anything more that CMS needs provide (i.e. access to more data)?

What, if any, are the scenarios where similar APM and MVP topics should utilize different measures? For example, should a cancer care MVP have similar measures to the Oncology Care Model? Would practices performing on these measures in MIPS make practices feel more confident about joining an APM with similar measures in the future?

How do we ensure that MVPs are meaningful to specialty clinicians that have limited applicable APM models available to them?

MVP Participation
Background: In the MVP RFI included in the 2020 PFS proposed rule, we noted that if technically feasible, we would like to establish a methodology that allows us to identify and assign in advance the relevant MVP(s) for MIPS eligible clinicians or groups and require the clinicians or groups to report on those MVPs. We also noted that we would consider self-assignment as an alternative (84 FR 40738). We asked how we would identify which MVP(s) are most appropriate for a clinician (84 FR 40740). In response, many stakeholders did not support assignment of MVPs and felt MVPs should be optional.

In the 2021 PFS proposed rule, we stated we intend to implement the MVPs while maintaining the current MIPS participation options (which we called Traditional MIPS). We also noted that we envision that MVPs will be optional for clinicians when the included measures and activities within the MVP are applicable and available to their practice (85 FR 50279). Additionally, we said that over the course of future performance periods, the traditional MIPS participation option will continue to be available (85 FR 50279 . These were finalized in the 2021 PFS final rule[5] and we anticipate that at the end of the transition period, we will retire the traditional MIPS options.

[5] https://public-inspection.federalregister.gov/2020-26815.pdf

Question: We are planning to retire traditional MIPS in a future state but recognize that due to the COVID-19 public health emergency, clinicians may be at different stages of readiness to move to MVP reporting. How has the PHE impacted clinicians' ability to move along the continuum of value, increasing the quality of care provided while taking on greater financial risk? In thinking towards the future, what criteria should be met before traditional MIPS is retired? Should there be a certain threshold of MVPs which are available and applicable for eligible clinicians to report before traditional MIPS is retired?

Clinician Choice of MVPs: In response to stakeholder feedback in the MVP RFI and based on our approach to make MVPs voluntary, we are considering not assigning MVPs. Instead, we would provide guidance around the type of practices, clinician types, and groups which should report a given MVP and allow the clinician or group to voluntarily select the MVP.

We also want to ensure that we do not create incentives that would encourage clinicians to select MVPs that are not appropriate. For example, we would not expect a clinician or group to elect an MVP if they do not have any applicable patients for the measures and activities in an MVP, and if there are other MVPs or measures and activities in traditional MIPS which would be better suited.

Questions: We have received requests from stakeholders to guarantee that MVP reporters receive at least a neutral or positive payment adjustment under MIPS, without the potential to receive a negative payment adjustment. We note that this is not possible under the MIPS statute and we must maintain assessment under the 4 performance categories and a composite score. Since reporting MVPs is voluntary, how would you suggest encouraging participation in MVPs over traditional MIPS reporting? How can CMS help clinicians, groups, or third-party intermediaries overcome barriers to be able to report an MVP?

Clinicians and groups expressed concern about the operational burden associated with transitioning to MVPs from MIPS. How can we minimize these operational challenges as we implement MVPs?
We have heard from stakeholders that clinicians do not want to be assigned to an MVP. If MVPs are optional, how do we make sure that clinicians are choosing appropriate MVPs to report? For example, should CMS assume that a clinician electing an MVP would be able to report on all measures and activities within a given MVP, a minimum number of measures or activities, or at least one measure or activity from the quality, cost, and improvement activities performance category (recognizing that the Promoting Interoperability performance category is required no matter the MVP)? What kind of information can CMS provide to help facilitate the choice?

Mechanics of Participation: We anticipate that groups and individual eligible clinicians who are interested in reporting through an MVP will need to identify their intent to report on a specific MVP. We anticipate that clinicians and groups that intend to participate in an MVP will notify CMS of their intent to report a given MVP either at the time of submission or during the performance period on July 1, which is the same as the registration deadline for CAHPS for MIPS.

Session 3: MVP Reporting and Scoring

Summary: The MVP reporting option for MIPS is intended to improve value, reduce burden, help patients compare clinician performance to inform patient choice in selecting clinicians, and reduce barriers to movement into APMs. We finalized in the CY 2020 PFS final rule (84 FR 62946) the definition of an MVP at § 414.1305 as ''a subset of measures and activities established through rulemaking.'' When thinking about improving value through MVPs, we have previously defined ''value'' as a measurement of quality and patient experience of care as related to cost, and intend to promote value by paying for health care services in a manner that directly links performance on cost, quality, and the patient's experience of care (84 FR 40732 through 40734). We believe MVPs should include a foundational layer consisting of Promoting Interoperability measures and administrative claims-based quality measures focused on population health (85 FR 50279). In addition, we have stated that MVPs will – if feasible – avoid topped out measures, include digital measures, and incorporate the patient voice (85 FR 50282 through 85 FR 50283).

Stakeholders have previously voiced a high level of support for voluntary reporting of MVPs and have provided feedback for potential reporting and scoring approaches. We heard from stakeholders that there should be consideration of ensuring reduced reporting burden and scoring equity across MVPs. In addition, stakeholders asked to ensure that there are enough meaningful quality and cost measures to allow participation of all eligible clinicians in MVPs. Stakeholders also requested the removal of reporting and scoring silos between MIPS performance categories to simplify participation.

MVP Reporting Requirements

MVPs should include measures and activities across the quality, cost, and improvement activities performance categories. All the measures and objectives under the Promoting Interoperability performance category would be included in the foundational layer for all MVPs.

To address selection fatigue within the MIPS program, we originally anticipated MVPs would include a small set of required measures and activities and that clinicians selecting the MVP would report all included measures and activities. The benefit of having no choice of measures in MVPs would be that we would not need special scoring policies and we would not need bonus points to incentivize choice of outcome measures. This approach would have less complex scoring and would help us obtain comparable data on all measures in the MVP. However, based on the feedback we received from the MVP Request for Information (84 FR 40741-40742), this approach did not offer clinicians enough flexibility to select measures within an MVP.

Based on stakeholder feedback, we now envision MVPs would allow some clinician choice from a set of related measures and activities.

- For the quality performance category in MVPs, we are considering having clinicians choose from and report on a set number of quality measures among the available measures (for example, they would need to report 4 quality measures from the available 10 measures within a MVP).
- For the improvement activities performance category, we are considering having clinicians choose from a curated list of activities and select either 1 high- weighted or 2 medium- weighted activities. We would like to include improvement activities that complement the quality and cost measures within the MVP.

- We also envision that each MVP would have at least 1 cost measure and clinicians would select MVPs where there are applicable cost measures for the type of care they provide. Measures that are not contained within the MVP would not be part of the cost performance category score. If there are no specific measures for a given MVP topic, we would include the established cost measures, the total per capita cost (TPCC) and the Medicare spending per beneficiary (MSPB) measures in the MVP. We do recognize that some clinicians do not meet the case minimum for any cost measures and some clinicians do not have cost measures that they feel focus on their patient population. However, we envision that as more cost measures become available, clinicians selecting the MVP reporting option will be able to select an MVP with meaningful cost measures.
- In the Promoting Interoperability performance category, clinicians would report the same measures required in traditional MIPS.

We believe that this balances choice within the MVP and our ability to obtain comparative information. For example, if a clinician chooses a specific MVP, we expect that they would be able to report on a minimum of at least 4 of the quality measures, applicable cost measure(s), or either 1 high weighted or 2 medium weighted improvement activities within the MVP. If clinicians cannot meet the requirements of a given MVP, we would assume that the clinician would select another MVP or opt for traditional MIPS reporting. If a clinician fails to report the required number of measures or activities within an MVP, they would receive a score of 0 for those measures or activities.

Table 1: MVP Reporting Requirements by Performance Category

Performance Category	Clinician Reports Measures/Activities	No Submission is Required, Automatically Calculated for Clinician
Quality	Clinician chooses and reports a pre-specified number of measures, such as 4 measures	CMS calculates population health measure, at least one for each MVP that is separate from the 4 selected measures for performance
Improvement Activities	Clinician chooses and reports a pre-specified number of activities, such as 1 high- or 2 medium-weighted activities	
Cost		CMS calculates cost measures, at least one for each MVP
Promoting Interoperability	All measures reported	

Questions: We have heard from stakeholders that clinicians want the ability to select measures and activities within an MVP. If clinicians have the choice to select measures and activities in an MVP, how do we ensure that a clinician elects an appropriate MVP? Is it reasonable for CMS to assume that a clinician electing an MVP will report on a minimum number of measures or activities for cost, quality, and improvement activities (recognizing that the Promoting Interoperability is included in the foundational layer for all MVPs and thus will also be reported)? If not, what are the alternative assumptions CMS should be working under?

We've heard clearly that clinicians and groups want choice yet want the program to be simple. Are there other ways we can maintain a degree of flexibility while achieving greater simplicity through the MVP reporting option?

Measure Objectives within the Quality Performance Category

For the quality performance category, we realize that MVPs will cover a variety of public health priorities, procedures, and medical conditions. We are considering an approach to the quality performance category that is similar to the Promoting Interoperability performance category where measures are arranged around objectives that address these priorities, with required and/or optional measures falling under each objective. We believe this could help ensure that each measure included under an MVP addresses these important objectives and could help foster equity across the various MVPs.

The three draft objectives we are considering for MVPs are as follows:

Table 2: MVP Quality Measure Objectives

Draft Measure Objective	Description
Improving Care Relevant to Clinician Specialty	Specialty or condition specific measures that are meaningful to clinicians, with a focus on outcome measures. We plan to continue the quality performance category requirement where at least one outcome measure must exist, to the extent feasible. We believe it makes the most sense for these measures to fall within this objective.
Incorporating the Patient Voice	Patient survey measures, patient reported outcome measures, and other measures which are more patient centered, such as measures related to patient safety, patient experience measures, measures that involve shared decision-making or advance care planning.
Improving Population Health (Foundational Layer)	Administrative claims based measures assessing care for a population. Measurement set will remain consistent across all MVPs, regardless of MVP area of focus.

We are considering providing weights for each measure objective within the quality performance category (for example, 50 percent for "Improving Care Relevant to Clinician Specialty" and 25 percent for "Incorporating the Patient Voice" and "Improving Population Health" objectives). If we standardized the weight of each measure objective, we believe this could also help further the concepts of reporting and scoring equity across MVPs. For example, a specialty focused MVP may have a maximum of 5 measures within the "Improving Care Relevant to Clinician Specialty" objective, whereas a preventive focused MVP may have a maximum of 10 measures within this same objective. In both instances, the MIPS eligible clinician would report on a maximum of 4 measures. We recognize that the number of quality measures to choose from may vary across MVPs, and believe this approach of establishing objectives within the quality performance category would help ensure that each MVP drives value and is meaningful.

Questions:
We noted an example above to illustrate how the objectives within the quality performance category could be weighted. How should the objectives within the quality performance category be weighted? Do the objectives we are considering adequately address MIPS priorities? Are there other objectives we should consider including instead?

Should we allow objectives to be reweighted if a clinician does not have sufficient case volume to report? Should we require that clinicians report on a minimum number of measures in the objectives, "Improve Care Relevant to Clinician Specialty" and "Incorporating Patient Voice"? Should measures have a different number of available measure points similar to how the Promoting Interoperability performance category works?

We anticipate there may be a time when we require reporting, such as a measure related to a public health issue, by everyone who reports the MVP. What kinds of measures should be required for MVP reporting?

MVP Reporting Example
In the table below, we have included a reporting example for a sample MVP. The MVP in the example has 9 quality measures, including 6 in the Improving Care Relevant to Clinician Specialty, 2 in the Incorporating the Patient Voice objective and 1 in the Improving Population Health objective. The Improving Population Health measure would be automatically calculated from administrative claims with no reporting required from the clinician. The clinician would select and report 4 quality measures from the other two objectives in the quality performance category. If the clinician reports fewer than the required 4 measures, the clinician would receive a score of 0 for each measure not reported. The clinician also reports 2 medium weight improvement activities and all Promoting Interoperability measures.

Table 3: MVP Reporting Example

	MVP Example Measures/ Activities	**Clinician Reporting Example** (clinician reports 4 quality measures)	**Automatically Calculated for Clinician**
Quality			
Improving Care Relevant to Clinician Specialty Objective	6 measures (3 available collection types)	Clinician reports 3 eCQM measures	
Incorporating the Patient Voice Objective	2 measures	Clinician reports 1 measure	
Improving Population Health Objective	1 measure, foundational layer		1 measure automatically calculated (no reporting required)
Improvement Activities	8 Improvement Activities	Clinician reports 2 of the available medium weighted Improvement Activities	

Cost	2 cost measures (relevant cost measures for topic or broadly applicable cost measures)		2 cost measures automatically calculated Reweighting *possible if no cost measures can be attributed to the clinician.*
Promoting Interoperability	All Promoting Interoperability measures (same as traditional MIPS), foundational layer	Same as traditional MIPS *Clinicians who qualify for reweighting for PI can still report an MVP*	

Questions:
Are there any concerns we should take into consideration on including only a subset of improvement activities (as compared with the full inventory of improvement activities)?

We anticipate that it will take some time to identify or develop applicable cost measures for all clinician/specialty types. What do we do in the interim for MVPs in which clinicians do not have an applicable cost measure?

How do we develop MVPs for Non-Patient Facing clinicians?

MVP Scoring
Each of the performance categories will have the same weighting as in traditional MIPS, as discussed in the MIPS Scoring Guide,[6] where:

- For the quality performance category scoring in MVPs, we envision that we will score each measure from 1 to 10 points. We do not anticipate any bonuses for MVP reporting, as we want to measure clinicians based on performance without score inflation (we also plan to phase out bonuses for traditional MIPS (83 FR 35950, 59851).
- For the cost performance category scoring in MVPs, we envision that we will score each measure from 1 to 10 points.
- For the improvement activities performance category, we envision that it would follow the special scoring rules in traditional MIPS where activities are worth double points.
- For the Promoting Interoperability performance category, we envision that we would score the same way that we do in traditional MIPS.

We assume that clinicians will have the ability to report applicable measures and activities. In the example above, the clinician reported 4 of the required measures from the quality performance category and the improving population health measure was automatically calculated which means the clinician had the ability to score 50 out of 50 points. If the eligible clinician had reported 3 of the

[6] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1201/2020%20MIPS%20Scoring%20User%20Guide.pdf

required measures from the quality performance category the clinician would have had the ability to score up to 40 out of 50 points in the quality performance category.

If a clinician reports both an MVP and reports under traditional MIPS, we anticipate that we would take the higher of the final scores from both reporting options.

Question: In the absence of bonuses, are there adjustments we need to make within traditional MIPS or MVPs to facilitate equitable scoring?

Are there any scenarios where we should consider reweighting the cost performance category for clinicians who do not meet the case minimum for cost measures included in the MVP? If not, should we require that clinicians report a different MVP or traditional MIPS?

Should we develop MVPs that anticipate reweighting the Promoting Interoperability performance category given that this category has been automatically reweighted for certain clinician types, including but not limited to physical therapists, occupational therapists, speech language pathologists, registered nutritionists?