CMS MIPS VALUE PATHWAYS WEBINAR

February 12, 2019
Online webinar

Agenda Items

- Recap of the MIPS Value Pathways (MVPs) framework
- Discuss the goals of the MVPs and benefits for clinicians
- Obtain feedback and answer questions as time allows

High-level Takeaways

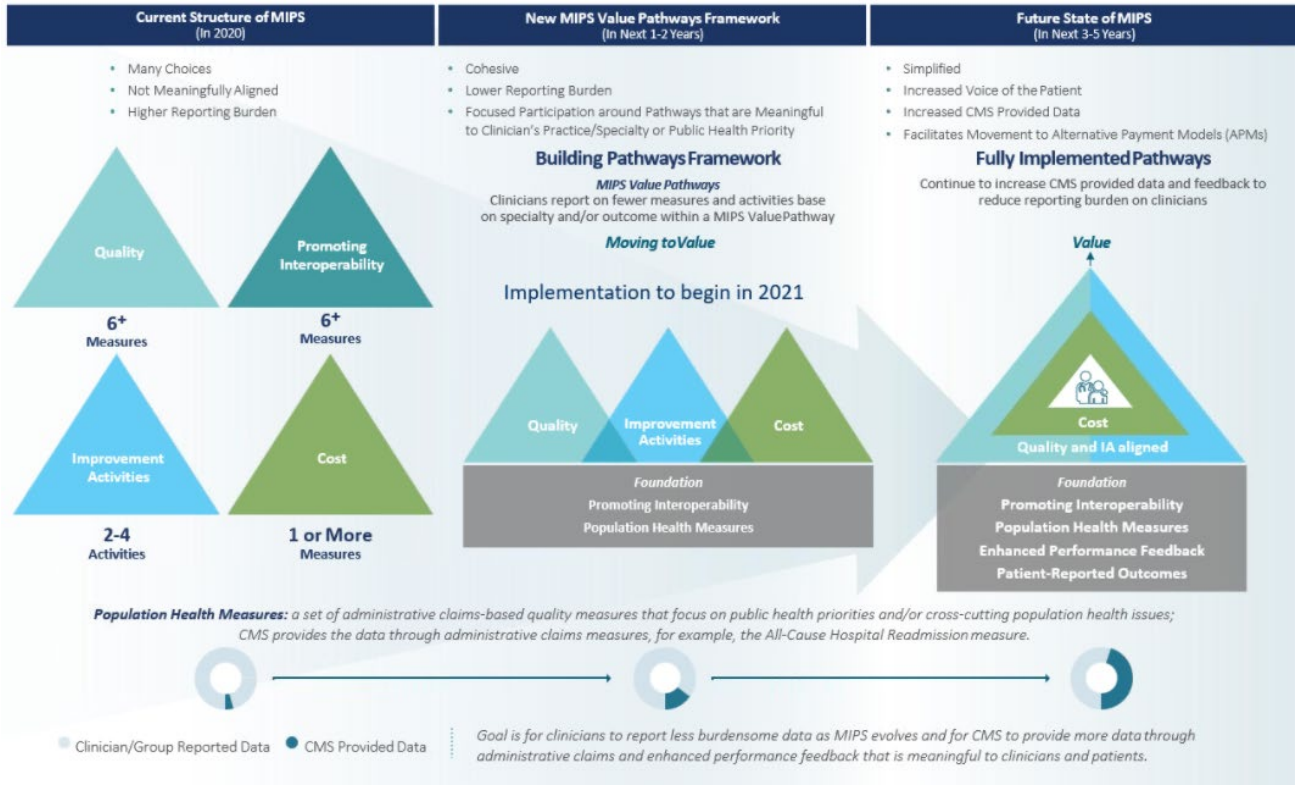
- CMS did not share any new information that has not already been publicly shared through the 2020 Physician Fee Schedule / Quality Payment Program (PFS/QPP) Final Rule, MVPs webpage, and accompanying materials such as the MVPs fact sheet and illustrative diagrams.
- CMS remains committed to implementing MVPs beginning with performance year 2021; however, CMS confirmed that there have not been any proposed or finalized MVPs to date.
- Developed MVPs may be related to a specialty, episode of care, or disease.
- All proposals for MVPs will go through formal rulemaking (PFS/QPP).
- CMS did not confirm whether MVPs will be voluntary or mandatory during the 2021 performance year. However, they insinuated that MVPs would be voluntary by saying that they have received a lot of feedback to proceed slowly when developing the MVPs.
- Multiple stakeholders during the Q&A brought up concerns with multi-specialty reporting. CMS did not provide firm answers to the concerns.

Webinar Notes

- MIPS Performance Categories in 2020
  - Quality: 45%
  - Cost: 15%
  - Improvement Activities (IA): 15%
  - Promoting Interoperability (PI): 25%
- CMS has heard the following feedback and/or concerns from clinicians:
  - Current structure of MIPS and reporting requirements are confusing.
  - There is too much choice and complexity when it comes to selecting and reporting measures and activities.
  - Measures and activities are not always relevant to a clinician's specialty.
  - It is hard for patients to compare performance across physicians.
- CMS response to feedback: MVPs- a new framework beginning in the 2021 performance year. Goals of the framework are to: remove barriers to APM participation, move away from siloed activities, promote value by focusing on Quality and Cost measures and IAs built on the foundation of population health measures, reduce reporting burden, and focus on keeping patients at the center.

- Considering the Health Care Payment Learning and Action Network (LAN) Summit Goal – By 2025, 100% of the payments will be associated with APMs. CMS is keeping that goal in mind as they implement these policies.
- Looking to expand metrics that have low reporting burden (e.g., foundational metrics including population health metrics).
- Keeping patients at the center (e.g., through patient-reported measures, patient-reported outcome measures).

- MVPs (see diagram below)
  - Shift from current to future of the QPP
  - Future of MVPs: Keeping the foundation while expanding to improve patient-reported measures and enhanced feedback



- CMS currently does NOT have any MVPs that have been proposed or finalized for 2021. They presented two example MVPs—diabetes and surgery. It was emphasized that these were examples ONLY.
  - Through MVPs, CMS intends to:
    - Provide enhanced data and feedback to clinicians,
    - Reduce the total number of measures and reporting items in order to reduce clinician burden, and
    - Create MVPs relevant to specialty, episode of care, or disease.

- Next steps for MVPs
  - Finalized the definition of MVPs in the 2020 PFS/QPP Final Rule.
  - Any policies and changes related to MVPs will have to go through the rulemaking process.
  - Keep in mind comments around not moving too abruptly to MVPs and having a slow transition process.
- Future MVPs Collaborations
  - CMS is just beginning to work with "a few groups" to develop MVPs for the 2021 performance year.
  - More information and resources are available at https://qpp.cms.gov/mips/mips-value-pathways.

Q&A

Multi-specialty reporting—Can you clarify how multi-specialty groups will be able to participate?

- Majority of clinicians are choosing to participate as groups. For clinicians that are choosing to participate as groups, they are mostly selecting preventative or primary care measures.
- They envision that an MVP could be specialty-specific, multi-specialty, etc.
- Thinking about it at group and sub-group levels.

Concerns around reporting of the specialty providers—Are you recommending that there will be a subset of quality measures that providers will be required to report in addition to group reporting?

- CMS recognizes that for organizations that participate as a group and may be multi-specialty in nature, they could be reporting on measures and IAs that could be different or similar.
- CMS is still working through this. No set answer on this yet.
- Stay tuned for the PFS/QPP proposed and final rules this year. They will be sharing a lot more detail through those rules.

Concerns about patient-reported outcomes and surveys—How does CMS plan to complement that within the program?

- CAHPS for MIPS survey and other patient-reported outcome tools currently in the program

What is the timeline to implement this framework in 2021 and would it be mandatory or voluntary?

- For the MVPs themselves, CMS will be addressing the details on how MVPs will be constructed, how clinicians would select an MVP, how they will be scored, and how multi-specialties would or would not work in MVPs through the upcoming PFS/QPP rulemaking cycle. The rule typically comes out around end of June or beginning of July.
- Those policies would be finalized in this year's final rule and would be effective the following year.
- For mandatory vs. optional–CMS is hearing concerns and feedback from the public that they should be moving slowly. The presenter did not give an answer to this as it will be addressed in the rulemaking, but recognized the concerns they have heard around transition to MVPs.

Other concerns shared by a caller:

- Multi-specialty—MVP program would not work unless there are virtual groups.
- Multiple electronic health records (EHRs) with different tax identification numbers (TINs)/groups—Combining quality from multiple EHRs is nearly impossible.
    - Registries are expensive—have to pay by provider—may be cost prohibitive
- Finding quality measures that are certified across multiple EHRs is challenging/nearly impossible.
    - For example, the quality measures in one EHR may be certified from 1 to 10 and in a second EHR may be certified from 11-20, so finding measures that are certified across EHRs is impossible.

Will accountable care organizations (ACOs) be candidates to participate in MVPs? For MVPs and how they interact with APMs, those are still things that CMS is working through.

- Feedback from a caller on submission method:
    - Each submission method is burdensome and costly to set up. If you prescribe providers to MVPs and then prescribe to submission methodology, that would increase the burden (especially for multi-specialties and small practices).
    - When your organization is not fully in an APM (not all providers are Qualifying APM Participants [QPs]), you would have to track which ones are QPs and which ones meet the criteria. That could add burden as well.
    - When providers are enrolled in a certain specialty which is not their practice, the measures you select for that provider actually are not relevant to their practice. The ability to have that choice is important.
    - Most groups submit primary care measures. Specialty groups also work in preventative care and collaborative work.

How will CMS ensure a level playing field for different MVPs and different specialties?

- They will still need to have the four separate performance categories. There are legal requirements to keep certain components within those categories as well. The goal of MVPs is to further unite the categories.
- Anticipate to craft MVPs to ensure equity for clinicians. Still working on it.
- Revisiting the scoring rules if they would make sense for MVPs. Some MVPs may have more measurement activities than others.

Have you considered specialties such as general pathology? Specialty vs. condition specific

- There is flexibility for both specialty- and condition-specific specialties.
- They do not anticipate for example, having only five MVPs or have 500-1000 MVPs. Looking to find a balance.
- Based on feedback with specialty societies, CMS knows there needs to be a fair amount of flexibility with the composition of the MVP.

Comment from a caller: There is an overhead to build out each of the submission types (whether you have one or 1,000 clinicians for specialty). The build out of those submission types per specialty is a major list. CMS needs to consider teaching institutes that are doing everything (e.g., multi-specialty practices, ACOs).