Current and Future Status of Merit-Based Incentive Payment Systems

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KEYWORDS

• MIPS • MACRA • Quality payment program

KEY POINTS

- The Quality Payment Program established by Medicare Access and CHIP Reauthorization Act (MACRA) legislation establishes the guidelines for payments now and in the future to Medicare providers.
- The program consists of 2 current pathways (Alternative Payment Models and Merit-based Incentive Payment Systems [MIPSs]) and 1 proposed future pathway (MIPS value pathways).
- The program is complex and reporting is burdensome, and both Centers for Medicare and Medicaid Services and providers are looking for ways to achieve the goals of MACRA without creating more administrative burdens.

INTRODUCTION

The Medicare Access and CHIP Reauthorization Act (MACRA) created the Quality Payment Program (QPP), which is responsible for paying Medicare providers. The goal was to emphasize a balance between quality and cost and to assess the overall value of care delivered to the beneficiaries. Now that the QPP is in its fourth year, providers, beneficiaries, and Centers for Medicare and Medicaid Services (CMS) are reviewing its effects both for its burdens and its effects on care. The program is evolving; however, certain parts of the legislation will become absolute law in the next few years. This article is an examination of this evolution and a discussion of the future of MACRA, Alternative Payment Models (APMs), and Merit-based Incentive Payment Systems (MIPSs).

HISTORY

The history of the current physician fee schedule began in 1992 when the resource-based relative value scale (RBRVS) was put into place by the Omnibus Budget Reconciliation Act of 1989.[1] A formula would determine what each procedure performed by physicians was worth based on different costs involved in providing the service. These costs included physician work, practice expense, and malpractice. CMS is responsible for the final fee schedule but the RUC (Relative Value Scale Update Committee) advises CMS. This committee is composed of 31 volunteer physicians whose purpose is to advise Medicare on the value of the work of a physician depending on the procedure. Specialty societies advise the RUC about proposed updates to the RBRVS. The RUC then makes the recommendations to CMS, which then addresses these revisions in its final rule every year.

The Balanced Budget Act (BBA) of 1997 included key Medicare provisions meant to assure the solvency of Medicare over an extended period of time. This assurance was to be achieved by reducing spending by limiting the growth of payments to hospitals and physicians as well as

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restructuring the payment methods to rehabilitation facilities, skilled nursing facilities, home health agencies, and outpatient service agencies in the hope of improving efficiencies. Medicare managed care plans also saw a significant reduction in payments. There were also provisions to increase beneficiary premiums.[2]

One key provision of the BBA was that physicians' fee schedule was to be determined by a formula called the sustainable growth rate (SGR) payment formula. It was hoped that this formula would help to limit Medicare spending. Under the formula, if a weighted combination of annual and cumulative expenditures was less than the weighted annual and cumulative spending target for the period, the annual update was increased according to an established calculation. However, if the weighted combination of annual and cumulative spending exceeded the weighted annual cumulative spending target over a certain period, future updates were reduced to bring spending back in line with the target.[3]

For about 4 years, the expenditures were in line with the targets and the updates to the fee schedule were close to what was expected. However, eventually, starting in 2002, the expenditures were higher than the targets. Doctors were to have a 4.8% cut in 2002 and the first so-called doc fix was implemented, which temporarily delayed the cuts.[4] Congress then began to override what would have been mandated reductions with several different laws that only provided short-term relief. Most of the time these bills kept the level of payment at the current rate (0% increase) or gave a slight increase (never >2.2%). During the years leading up to 2014, there were several bills introduced in both houses that attempted to put in place a permanent fix to the SGR formula. The country faced a fiscal cliff in 2013 when the Bush tax cuts were set to expire and a set of spending cuts were going to go into effect. It was feared that the combination would throw the economy back into a recession. The spending cuts included a possible 27% cut in Medicare fees. In a last-minute deal, Congress passed the American Tax Relief Act of 2012, which kept most of the Bush tax cuts and readded the previous 39.6% tax rate for higher income earners and also included among other provisions another 1-year doc fix that avoided the 27% cut. This fix of the situation was again only temporary.[5]

In addition, in 2015 the bipartisan legislation MACRA was passed. It created the QPP, which:

- Repealed the SGR formula
- Changed the way that Medicare rewards clinicians for value rather than volume
- Streamlined the multiple quality programs under the new MIPSs
- Gave bonus payments for participation in eligible APMs

This legislation went into effect in 2017.[6]

THE QUALITY PAYMENT PROGRAM

By statute, MACRA required CMS to begin rewarding quality, value, and outcomes and penalizing providers that do not provide such value. The QPP at its start had 2 paths for providers. Providers could either participate in an APM or participate in an MIPS. A third option is being explored by CMS for implementation within the next 2 to 5 years, called the MIPS Value Pathways. The years from 2017 to 2021 were considered transition years in the original law, and CMS was given flexibility in those years to adjust thresholds and category weights for APM participation and MIPSs. In the year 2022, by law, this flexibility will no longer be available to CMS.

Alternative Payment Models

An APM is a method of payment based on quality and value. The purpose of an APM is to provide high-quality care in a way that is cost-efficient. There are several options under the APM model. These options include Advanced APMs, MIPS APMs, and all-payer APMs.[7]

Advanced Alternative Payment Models

The following are necessary for an APM to qualify for status as an Advanced APM:

- Participants must use certified electronic health record (EHR) technology
- Payment for covered professional services must be based on quality measures comparable with those used in the MIPS quality performance category
- Either (1) APM is a Medical Home Model expanded under CMS Innovation Center authority, or (2) participants bear a significant financial risk
- Starting in 2020 the Advanced APM must also satisfy the 1 of the following:
  - Receive at least 50% of its Medicare Part B payments through the Advanced APM (expected to increase to 75% in year 2021)
  - See at least 35% of its Medicare patients through the Advanced APM (expected to increase to 50% in year 2021)

A qualified provider (QP) who successfully participates in an Advanced APM:

- Is exempt from MIPSs

- Qualifies for a 5% bonus based on Part B Revenues (currently this is scheduled to expire after the 2024 payment year)
- Will receive a 0.75% Part B schedule increase in 2026 (compared with 0.25% by non-APM participants)

There is the ability for an APM to achieve partial status if the entity only meets the following thresholds:

- Receives only 40% (rather than 50%) of its Medicare Part B payments through the APM
- Sees at least 25% (rather than 35%) of its Medicare Part B patients through the APM

Participants in Partial APMs can opt to participate in MIPS (but will be scored differently because of their participation in the APM). They will not receive the 5% APM bonus but may be eligible for extra MIPS APM credit.

CMS determines whether a participant meets the thresholds for participation by looking at snapshots throughout the year using Medicare administrative claims data. These data determine whether a provider is eligible as a full QP or partial QP or whether the provider is participating in an MIPS APM.

Merit-Based Incentive Payment System Alternative Payment Models

Some clinicians do not meet the criteria for being a QP for an Advanced APM but are still participating providers during the period that is being evaluated. These clinicians have to report as MIPS providers but are scored with the APM standard. There were 10 APMs that were expected to be eligible to be MIPS APMs in 2020.

The scoring for MIPS for those subject to the APM standard eliminates the cost component because these participants are assessed for cost within the APM itself. The following is the APM standard for MIPS scoring in 2020:

- Quality: 50%
- Improvement Activities : 20%
- Promoting Interoperability : 30%
- Cost: 0%

In the proposed 2021 rule, CMS plans to replace the APM scoring standard with a new MIPS APM Performance Pathway; however, it still uses the same category weighting. It includes a 6-measure Core Quality set, the standard Promoting Interoperability measures, automatic full credit for improvement activities, and no cost measures. Those practitioners included in the APM Performance Pathway include those in MIPSs APMs and those ACOs in the Medicare Shared Savings program.

All-Payer Alternative Payment Models

Since 2019, clinicians can become qualified participants through an all-payer option. The qualified participants must participate in a combination of Advanced APM with Medicare and an Other-Payer APM with similar criteria to the Medicare APM.

The Alternative Payment Model Outlook for Urology

According to CMS in performance year 2019, 195,564 clinicians were able to reach status as Qualified APM Participants in an Advanced APM and 27,995 clinicians received partial status. This number was an increase from 183,306 in 2018 for full status in Advanced APMs and 47 with partial status in 2018.

In 2017, less than 1% of urologists were participants in an Advanced APM. With that in mind, Large Urology Group Practice Association (LUGPA) presented a proposed APM centered on active surveillance for men with newly diagnosed prostate cancer. In accordance with MACRA, in December 2017 the proposal was presented to the PTAC (Payment Model Technical Advisory Committee). PTAC did not recommend testing of the APM to HHS (Health and Human Services) Secretary Azar.[8] LUGPA has continued to engage with the Secretary in order to move toward modification of the process of APM adoption. At this time, only 1 surgical specialty APM model is in place (Comprehensive Care for Joint Replacement Model).

MERIT-BASED INCENTIVE PAYMENT SYSTEMS

For those who were not eligible to participate in an Advanced APM, the other path in the QPP is an MIPS.

Each year CMS establishes a minimum participation threshold for clinicians for MIPS based on Medicare Part B billing and the number of patients seen. **Table 1** shows the thresholds through 2020.

In addition, beginning in 2019, to be eligible clinicians must deliver at least 200 covered professional services.[9]

Clinicians may participate either as an individual or as a group. A group is a set of clinicians who share a common TIN (Tax Identification Number). Beginning in 2018, CMS allowed the option of individual clinicians to form and participate in MIPS as a virtual group. The virtual group is only applicable to clinicians in groups that have 10 or fewer eligible

Table 1
Minimal participation thresholds for merit-based incentive payment systems

Year	Medicare Spend Threshold ($)	Part B Patient Threshold
2017	30,000	100 patients
2018–2020	90,000	200 patients

clinicians. The virtual group establishes its own TIN for MIPS reporting, which allows small groups to pool resources for reporting and aggregate data for reporting on quality measures. There must be a written agreement among the participants in a virtual group that includes all the rules established by CMS for forming a virtual group.

The MIPS program includes 4 distinct categories. These categories are Quality, Advancing Care Information (formally Meaningful Use and now titled Promoting Interoperability), Improvement Activities, and Cost. These 4 categories contribute to a final score. The weight of each category changes yearly. The purpose of the changes is to promote balancing quality and cost as the program progresses by increasing the contribution of the Cost category and decreasing the contribution of the Quality category. By law, the Cost and Quality performance categories must be equally weighed at 30% beginning in the 2022 performance year.[10]

Quality

The assessment of the quality of care is based on certain measures of performance. These measures are created by CMS as well as other stakeholders, such as specialty groups. Newer measures have been developed by specialty societies so that specialty clinicians have measures that are more relevant to their practices. It takes several years to develop historical benchmarks, and therefore these measures contribute minimal points for the clinician in the first 2 to 3 years they are available.

The following are the key points to achieving success in the Quality category:

- Each clinician, group, or virtual group must report on at least 6 quality measures.
- One of the measures must be an outcome or high-priority measure.
- The reporting period is 365 days.
- There is a threshold for completeness of data established yearly by CMS.
  - The provider or group must submit data on a certain percentage of eligible patients or encounters for each measure. For 2018, this was 60%, and 70% for 2020.
- The eligible encounters or patients that meet the measure represent the denominator for the score, and the numerator is the number of patients or encounters that fulfill the criteria of the measure.
- CMS provides benchmarks for each measure based on historical data it has received. These benchmarks provide the basis for the score received for each measure (0–10). Measures that do not have enough historical data and therefore do not have benchmarks have a maximum score of 3. In 2021, CMS proposed not to use historical benchmarks because it is thought the data for 2020 will not be accurate because of the pandemic. Instead, performance-based benchmarks will be used, meaning the benchmarks will be based on combined actual data submitted for the year 2020 and 2021.
- Some measures are considered topped out, which occurs when there is little room for improvement for performance from previous years. Some of the topped-out measures have a maximum score of 7, whereas others require 100% to achieve a top score of 10, with anything less than that receiving a score of 6 or less. In 2020, 61 measures were designated as topped out.
- One bonus point is available for each high-priority measure reported after the first one reported.
- One bonus point is available for each measure reported via certified EHR technology (CEHRT) 2015 EMR using end-to-end reporting.
- The maximum number of points for quality is 60.[11]

There are very few urology-specific measures. Most of the measures that are used by urology practices have either been developed for primary care or general surgery. The American Urological Association (AUA) is promoting urology-specific measures through the AQUA (AUA Quality) Registry. However, only 2 urology-specific measures

were available on the CMS measures list. These measures are combination androgen deprivation therapy in patients with high-risk prostate cancer receiving radiation (AUA measure), which is topped out in 2020, and IPSS or AUA-SI change 6 to 12 months after diagnosis of benign prostatic hyperplasia (LUGPA and the Oregon Institute), which has no benchmarks and therefore has a maximum point score of 3. These measures leave providers looking for other appropriate measures in other specialty sets, such as general surgery, gynecology, and oncology.

Promoting Interoperability

This category replaced Meaningful Use, which was part of the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH proposed meaningful use of interoperable EHRs throughout the United States health care delivery system as a critical national goal.[12] The measures for Promoting Interoperability have been based on the CEHRT of the EHR used by clinician or group. For 2017 and 2018, many EHRs had not been certified for 2015, so a set of transition objectives and measures were available for such clinicians. If the EHR used by the clinicians was CEHRT 2015, then a different set of measures were applied. Beginning in the year 2019, CEHRT 2015 was required for participation in the Promoting Interoperability category.

There are many exceptions for this category, including clinician types such as advanced practice practitioners, allied professionals (physical, occupational, and speech-language therapists; clinical psychologists; and registered dieticians). Also included are ASC and hospital-based clinicians and non–patient-facing clinicians.

In addition, practices of clinicians may request an exception if:

- The practice is small
- The EHR in use is decertified
- There are Internet connectivity issues
- There are extreme and uncontrollable circumstances, such as a disaster, practice closure, or severe financial distress
- The practice has no control over the availability of CEHRT

The practice or clinician must submit a hardship exception by December 31 of the performance year.

The reporting period for Promoting Interoperability is any continuous 90-day performance period. The following are the measures for performance year 2020.

1. E-prescribing (worth up to 10 points)
2. Query of prescription drug monitoring program (bonus measure, worth 5 points)
3. Support electronic referral loops by sending health information (worth up to 20 points)
4. Support electronic referral loops by receiving and incorporating health information (worth up to 20 points)
5. Provide patients electronic access to their health information (worth up to 40 points)
6. Report to 2 different public health agencies or clinical data registries (worth 10 points)

There are exceptions to all of these measures (except for providing electronic access) based on volume of patients or availability of registries or agencies. If the EHR of a practice cannot support some of the measures, the points sometimes can be reassigned to other measures.

In addition to the measures listed earlier, the clinician or practice must:

- Use CEHRT 2015 functionality (certified by the last day of the performance period)
- Submit “Yes” to the prevention of information blocking attestations
- Submit “Yes” to ONC direct review attestation
- Submit “Yes” to performance of a security risk analysis in the performance year

The scoring for Promoting Interoperability is as follows.

Measures 1, 3, 4, and 5 listed earlier are scored based a numerator and denominator. The scoring is then based on the percentage achieved for the measure. Registries can usually provide an estimated score but the scores are based on the percentage, but the final score is based on how the clinician or group performs against others submitting data. The other measures are simple attestations.

The maximum score for Promoting Interoperability is 100 points.

Promoting Interoperability accounts for 25% of the final MIPS score.[13]

Improvement Activities

Improvement Activities are meant to show participation in activities that improve clinical practice.

The Improvement Activities are divided into those that are high weighted and those that are medium weighted. In order to receive the maximum points for this category, the clinician or group must attest to either:

- Two high-weighted activities
- One high-weighted and 2 medium-weighted activities, or
- Four medium-weighted activities

For group reporting, 50% of the clinicians must participate in the activity. The reporting period for this category is a continuous 90-day period. For 2020, there are a total of 104 Improvement Activities across the following categories:

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety and Practice Assessment
- Achieving Health Equity
- Behavioral and Mental Health

Improvement Activities are worth 15% of the total MIPS score in 2020. With the variety of activities available, most clinicians and groups can easily achieve a maximum score in this category.

Cost

There are no submission data by clinicians or groups for the Cost category.

The calculation of cost is based on formulas under 3 different Cost performance category measures. These include Total cost per capita cost, Medicare spending per beneficiary clinician, and episode-based attribution. The calculations of cost are based on formulas that in the past did not always distinguish the clinician who was responsible for most of the care of the patient. These calculations have now been changed. For instance, the total per-capita cost now excludes nonprimary care services (eg, surgical) and certain specialty services. It also attributes costs to the TIN responsible for most of the events for the patient.

Episode attribution is either medical or surgical. For a medical episode, the episode is attributed to the TIN billing at least 30% of the inpatient Evaluation and Management (EM) services on Part B claims during the inpatient stay and is attributed to each clinician within the TIN that bills at least 1 EM service during the episode. For a surgical episode, the episode is attributed to the clinician who performed the procedure and the TIN of the that clinician.

Cost accounted for 0% of the final score in the initial MIPS year. The percentage that cost has contributed to the final MIPS score has slowly increased and for 2020 is up to 15%. By law, this must be at 30% by 2022.[14] Most providers have difficulty understanding the cost formulas and, more importantly find that there is little that can be done to affect the final score in this category.

Submission of Data and Final Merit-Based Incentive Payment System Score

Data may be submitted for the QPP in several ways:

- Qualified Clinical Data Registry
- MIPS Clinical Quality Measures (CQMs)
- Electronic CQMs: requires use of data from an EHR that is CEHRT 2015
- Medicare Part B claims (for small practices <16 clinicians)
- CMS Web interface (CMS plans to sunset this in 2021 under the proposed rule)
- CAHPS for MIPS survey, which is an optional measure that entities can use to evaluate the patient experience

Before 2019, individuals could only submit data via 1 method. However, in 2019, CMS allowed more flexibility in that data could be submitted via multiple methods and be aggregated for the final MIPS score.

The final MIPS score for a clinician or group is based on a composite score for the 4 categories. Groups or clinicians can apply for a redistribution between categories for hardships. For instance, this application can occur for the Promoting Interoperability category when a practice has Internet problems, or the EHR does not maintain its certification. Also, if a practice is involved in a natural disaster, it can file for hardship relief. For 2020, because of coronavirus disease 2019 (COVID-19), practices can apply for reweighting of any of the categories to 0%. CMS provides guidance each year on allowable hardship cases.[15] Each year the performance threshold increases. The performance threshold is the minimum number of points that must be achieved (out of a possible 100) to prevent receiving a negative adjustment in the payment year (**Table 2**).

For example, in 2021, the clinician's or group's MIPS score must be 50 or more to avoid a penalty. To give an example of the scoring for 2021:

Quality maximum points toward MIPS is 40. A score of 54 out of the allowable 60 points for MIPS results in a Quality score of 36 (0.90×40) toward the MIPS score. Scoring 90 out of 100 points for Promoting Interoperability results in a score of 22.5 (0.9×25) points toward the final MIPS score for Promoting Interoperability. A score for improvement activities of 40 out of 40 results in 15 points toward the final MIPS score.

The score before including Cost would then be 73.5. CMS then would assign a score out of 20 for the Cost component. The final MIPS score in this example would be maximum of 93.5.

The MIPS score is then used to calculate payment adjustments for the year 2 years after the performance year. The MIPS score for 2021 will affect payments for the year 2023.

MIPS payments adjustments must be revenue neutral, meaning that the total negative adjustment

Table 2
Performance thresholds and category scoring percentages

Year	Performance Threshold	Quality (%)	Promoting Interoperability (%)	Improvement Activities (%)	Cost (%)
2017	3	60	25	15	0
2018	15	50	25	15	10
2019	30	45	25	15	15
2020	45	45	25	15	15
2021(proposed)	50	40	25	15	20
2022(by law)	70	30	25	15	30

must equal the total positive adjustment. Table 3 shows the maximum possible adjustments as well as the real adjustments for the first 3 years of MIPS.

To understand why the maximum positive adjustments predicted by MACRA are not what is actually requires an understand of how the payment adjustments are determined. Table 4 shows the participation numbers for 2018 and 2019 (excluding those participating in MIPS APM).[16]

Most negative MIPS payments to date have resulted from individually eligible clinicians who do not submit data. There are instances of CMS applying the Extreme and Uncontrollable Circumstances exception when clinicians are located in a CMS-designated region affected by an uncontrollable event (such as a natural disaster). These clinicians receive a neutral payment adjustment.

MIPS-eligible clinicians with a score of 30.01 to 74.99 in performance year 2019 are also receiving 0% payment adjustment in 2021. MIPS-eligible clinicians with a final score more than 75.00 are eligible for an additional positive adjustment. Although the exception performance group is not subject to budget neutrality, there are only certain funds available to distribute to this group. Therefore, the positive adjustment for 2021 in this group ranges from 0.09% to 1.79%, which is far less than the expected adjustment when MACRA was first introduced.

THE FUTURE OF ALTERNATIVE PAYMENT MODELS AND MERIT-BASED INCENTIVE PAYMENT SYSTEMS

Both CMS and clinicians have used the transition period to assess MACRA. At the time of its passing, Congress's goal was to improve the quality of care and at the same time provide this quality care with value. That balance between quality and cost is what drives the QPP.

From the outset, MIPSs have been a clerical burden for providers who participate in the QPP via this option. Performance in the Quality measures is often related to the ability to document in the EHR rather the true quality of care for patients. Practitioners do not really have control over the cost of care of patients yet the formula. Until the current proposed formula, there were costs attributed to providers even in instances when the provider had no control over certain costs. The current methods do not seem to be driving quality and controlling costs as expected.

Both CMS and stakeholders have recognized that adjustments need to be made to the program as it now exists. The Final Rule for 2021 addresses some of these concerns. In the 2021 Final Rule, CMS expands on its goals after the transition period for the QPP. One key point that is stated

Table 3
Adjustments and incentives for quality payment program by year

Performance Year	Payment Year	Maximum Negative/Positive Adjustment (%)	Predicted Maximum Incentive (%)	Actual Maximum Incentive (%)
2017	2019	−4/+4	2.3	1.88
2018	2020	−5/+5	2.05	1.68
2019	2021	−7/+7	4.69	1.79
2020	2022	−9/+9	TBA	TBA
2021	2023	−9/+9	TBA	TBA

Table 4
Merit-based incentive payment system participation numbers outside of merit-based incentive payment system alternative payment models

	2018	2019
Total clinicians receiving an MIPS score and payment adjustment (negative, positive, or neutral)	559,230	538,186
Clinicians with final score above exception threshold (%)	73.83	74.00
Clinicians above the performance threshold and below the exceptional threshold (%)	22.10	20.02
Clinicians with a final score at the performance threshold (%)	0.74	5.43
Clinicians with a final score below the performance threshold (%)	3.30	0.55

numerous times is that the QPP is intended to pay for health care services in a way that drives value by linking performance on cost, quality, and the patient's experience of care.

In the Final Rule of 2020, CMS had intended to initiate MIPS Value Pathways (MVPs) in 2021. The definition of an MVP in the rule is a subset of measures and activities established through rule making.[17] The year 2021 was intended to be a transition year for MVPs; however, because of the COVID-19 pandemic, the proposal for initial MVPs will be delayed until at least the 2022 performance year. MVPs are expected to be a bridge to participation in Advanced APMs. CMS has used the 2021 rule to expand on its plan to develop MVPs. It addresses comments of stakeholders and has given detail as to what will be key provisions in the development of the MVPs. The provisions are guided by a set of principles:

- Using measures that have meaning to clinicians and connecting measures between the 4 MIPS categories with the hope of limiting clinicians' burden
- The measures and activities must result in providing comparative performance data that are valuable to patients and caregivers (including the development of subgroup reporting)
- Include measures selected using the Meaningful Measures approach, and include patient voices in the development when possible
- Include measures from APMs in an effort to reduce barriers to APM participation
- Support the transition to digital quality measures: digital quality measures would be measures that would be reported directly from the EHRs, health information exchange, registries, and similar entities

In addition to value and cost, the rule emphasizes the role of the patient experience in the development of MVPs. One of the issues addressed with MVPs is to allow different subgroups of physicians to report separately, which will allow patients to evaluate physicians in multispecialty groups by the individual specialty of the physician. In the current system, when any group reports as a group in MIPS, the final score is attributable to each member. Patients are unable to evaluate an individual physician using the MIPS metrics. By having subgroups report separately in the MVPs, it is thought that CMS is attempting to move away from group reporting to individual reporting for certain metrics so that patients can evaluate an individual provider.

CMS is requesting stakeholders, in particular specialty societies and experts, to begin the development of MVPs and has specified in the 2021 rule the intent of MVPs and the key points that must be included in the structure of an MVP. The most important points that are addressed in the rule are the link between quality and cost and the ability of MVPs to serve as a link to the participation of providers in Advanced APMs. CMS also has heard from providers about the burden of MIPS reporting. An example of the burden for urologists is that there are only 2 quality measures that are specific for urology, neither of which had benchmarks to allow optimal scoring. Urologists must then align themselves with measures that do not really address the quality of care in a urologic practice. CMS believes that, by allowing specialty societies to contribute to the development of MVPs, this will allow specialists to participate in a pathway that addresses cost and quality similar to an Advanced APM.

One of the other provisions of interest is the inclusion of patients in the development of MVPs. CMS believes that patients should have a voice in the process and is proposing that stakeholders use various processes to include the patient voice, including satisfaction surveys, focus groups, listening sessions, and patient interviews. The proposal includes the patient voice as a prerequisite for the development of MVPs.

The MVP process will be complex and, recognizing this, CMS proposes that a template will be provided to assist in the development of MVPs. By using a template, MVP developers will be

assured that benchmarks are met during the development process. For example, there may be new quality measures introduced with a particular MVP that has not been previously used. The developer will use the template to ensure that the measure meets the criteria that makes the measure meaningful and relevant both from a data analytical standpoint and a reporting standpoint.[18]

As MACRA moves forward, it seems that participation in Advanced APMs will be difficult for most urologists. MVPs provide an opportunity for urologists to engage in the process of development of measures that are relevant to urologic practice rather than trying to squeeze urologic practice into measures and pathways better suited for other specialties or primary care. It is important that these societies and stakeholders are engaged early in this process so that measurement of urologic care and its value is about urologists and their patients. Because the cost of care is obviously an important component of MVPs and MIPS going forward, urologists will have to embrace concepts and ideas that include this in any pathway or model in which there is participation. The first 5 years of MIPS was meant to be a transition and the sixth year is approaching, and at that time quality and cost will have equal footing and all providers will need to embrace that concept going forward.

CLINICS CARE POINT

- As urologic practices transition to value-based care models, it is important that the use of MVPs will not only allow urologic physicians to report on MIPS measures in a more streamlined manner but will also include the patient voice in their care, which is a key component to the pathways.

DISCLOSURE

The authors have no relationship with a commercial company that has a direct financial interest in this subject matter, and have nothing to disclose.

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