MVP Development Kick-Off Webinar
December 14, 2020

Hello, everyone. Thank you for joining today's MVP Development Kick-Off Webinar. During today's webinar, the Centers for Medicare and Medicaid Services will provide an overview of the MIPS Value Pathways, MVPs, development process for the 2022 performance year and beyond. After the webinar, CMS will take as many questions as time allows. So, now I'll turn it over to Dr. Michelle Schreiber, who is the Deputy Director of Quality and Value in the Center for Clinical Standards and Quality, and Director of the Quality Measurement and Value-Based Incentives Group within the Center of Clinical Standards and Quality at CMS to begin. You may begin, Dr. Schreiber.

Thank you very much. And to all of you on the phone, we extend each and every one of you happy holidays from CMS. We also want to say a particular thanks to all of you who are healthcare providers and work in the healthcare field. This has certainly been a most trying year. The frontline staff are clearly the heroes and we want to thank each and every one of you. I'd also like to thank the CMS MIPS team, many of whom you will hear from today, as well as our partners, Ketchum, who is leading today's conference, and other of our contractors who helped us develop this MIPS value-based pathway program. The MVP program, or the MIPS Value Pathway program, is meant to answer some of the issues with the standard MIPS program in that some providers found it confusing, some providers felt that there was too much choice that was offered. Some felt it really wasn't applicable to their particular specialty. So, the MVPs are meant to be less confusing, require less effort with less burden, and, you'll hear, perhaps less reporting requirements. They're meant to be more meaningful to specific practices and certainly to specific specialties. We will be developing the MVPs with a lot of dialogue and collaboration with specialty societies, but our general counsel reminds us that these are CMS-owned because we have the regulatory authority for rule writing. We also must keep the 4 categories of MIPS, Quality, Improvement Activities, Cost, and Promoting Interoperability, because those are statutory.

We are very excited that you've joined this call today for the MVP Development Kick-Off Webinar to learn more about how you can participate in the development of MVPs. We're very excited about this new modernization and transition to MVPs that will hopefully also lead physicians to a good transition to advance practice payment models as well. With that, I would like to turn today's conference over to Molly MacHarris, who is part of the MIPS development team at CMS and probably knows more about the MIPS program than anyone in the United States. So, Molly, I turn it to you.

Thank you, Michelle. And thank you for those very kind words. Thank you everyone for joining us here today. I don't know that I can say that I know more than anyone in the country, but I am here to share with you guys today what I do know regarding MVPs, along with my colleague Sophia Sugumar. So, with that, why don't we go ahead and dive into the next slide because, before we talk about MIPS Value Pathways, I wanted to provide an update regarding our Extreme and Uncontrollable Exception application.

So, as Dr. Schreiber noted, the COVID-19 pandemic has impacted the way that we do business really throughout the country, and really across the world. So, what we have done for our 2020 program year is we have extended our application-based Extreme and Uncontrollable application from the current

deadline of the end of this month, December 31st, to February 1st, 2021. So, again, if you are a MIPS eligible clinician and whether you have been considered a MIPS eligible clinician as a group or virtual group, or an APM Entity, if you have been impacted by the COVID-19 pandemic and you do not have the ability to participate in the MIPS program for this year, please come and file an application requesting reweighting relief. Again, you would need to cite that it is in relation to the COVID-19 pandemic. We must receive that application by no later than February 1st of next year.

I do also want to clarify our important note below this because we have received a number of questions on this. So, even though we are extending the application deadline into the program year 2020 submission period, any data that clinicians have already submitted through our submission portal - that would be scored and the application would not be overrode. So, again, please ensure that if you are looking to receive the benefits of the reweighting application, do not have any data submitted either directly or on your behalf during the submission window because that would void your application.

Two last things I want to flag here. First is that APM Entities can also submit a reweighting application permit. That is something new that they couldn't do previously in the past. And then I want to clarify our last note that we have on the slide here, which is in regards to the deadline for the Promoting Interoperability Hardship Exception. What we mean by that is if you are a clinician and let's say you need a specific Promoting Interoperability performance category reweighting. So, for example, if you are a small practice and you want to just reweight your Promoting Interoperability performance category, that request must be made by the end of the year, December 31st. If, however, you are requesting reweighting for Promoting Interoperability and any other categories due to COVID, then you have through February 1st to file. I hope that helps and if there's any questions on that, happy to take it at the end. Let's move on to the next slide where we have our agenda of what we will be covering today.

And then let's move onto the next slide again to start digging into the Quality Payment Program and our MIPS Value Pathways.

Okay, great. So, as Dr. Schreiber noted during her opening remarks, we have seen a number of successes under the Quality Payment Program and the MIPS program to-date, but we've also heard from clinicians that the current structure of the program and the reporting requirements are confusing. There's oftentimes too much choice and complexity when it comes to selecting and reporting on their measures. We often hear from people that they would simply just like to be told these are the measures that they would have to do for their given specialty. Similar to that, what we hear from people is that they feel that the measures and activities that they actually are recording, whether they're selected on behalf of them by their group or by their overall organizations, they oftentimes feel that it may not be the most relevant to their specialty. And then also it's hard for patients to compare performance information across clinicians, particularly this gets exacerbated if a clinician is reporting on measures that they don't feel are meaningful to them. Patients, of course, would not find that information meaningful either. So, in our attempt to solve this, by moving onto the next slide, we've come up with a new approach for participation which we have called MIPS Value Pathways, or MVPs.

So, while we feel that there have been incremental changes and moving the needle forward on value-based care since the Quality Payment Program began, we do believe that we need to take a new approach to really ensure that we are moving towards value-based care, and that is, again, the MIPS Value Pathways. Let's move on to the next slide.

So, what are MVPs? So, hopefully it's not brand-new information to those of you that are on this call here today, but if it is, I'll just give a brief overview of what we anticipate MVPs will look like and what they will do. So, we anticipate that MVPs will remove barriers to participation in Alternative Payment Models. Again, for those of you who are familiar with the Quality Payment Program, you know that there is the MIPS side and then there is the APM side. Ideally, we want to encourage as many clinicians to move into APM as it makes sense for them to move there. We also want to move away from the siloed field of our core performance categories towards having an aligned set of measures that may be more relevant to a clinician's scope of practice. As Dr. Schreiber noted, we must still maintain our 4 performance categories to maintain our statutory compliance. However, we believe there is more flexibility that we can do to ensure that the measures and activities across the four performance categories make sense and are focused on a particular goal for the patient. We also want to promote value by focusing on quality and cost measures, as well as improvement activities that are built on a foundation of population health measures, and, of course, maintaining our certified EHR technology performance categories, Promoting Interoperability. We always want to keep the patient at the center of our work. As you will hear throughout the presentation today, we really thought about that as we've come up with our principles and our criteria for MVPs, and, of course, to reduce reporting burden. Let's move on to the next slide where we have a diagram which, again, is not new.

So, just to go over this diagram, this is what we came up with when we initially came up with our MVP concept, but I will share that we do still believe that this diagram does still hold true, because this does still have our current structure and then where we would ideally like to land. So, as you can see by looking at the left-hand side first, our current structure of MIPS, we have our 4 performance categories where there are four distinct things that clinicians must do. And there's also a lot that we would require clinicians to do, or could be argued that it is a lot. So, 6-plus measures for quality, 6-plus measures for Promoting Interoperability; improvement activities, 2 to 4; and then all the cost measures. It can be a lot of things for clinicians to account for within their performance. As we move towards MVPs, as I was just noting, we anticipate even more alignment across the 3 performance categories of Quality, Cost, and Improvement Activities, while still maintaining that foundational layer. And then as we move even more forward as we work to iterate on MIPS Value Pathways, we envision a future state where the patient is still at the center of our work, where Quality and Improvement Activities, having that center of cost is still very much an item that we are focusing on. But we also are expanding our foundational layer by focusing not only on the certified EHR technology and population health measures but more patient-reported outcomes and enhanced performance feedback. Let's move on to the next slide.

So, what will MVPs do? We anticipate through this new framework we will be able to, again, provide enhanced data and feedback to clinicians so, they will be able to make more informed decisions on the care that they are providing to their patients, and also to assist them as they move to the APM. We would analyze existing Medicare information to provide clinicians

and patients with more information to improve their health outcomes, and then also reduce reporting burden by limiting the number of required specialties or condition-specific measures. And then let's move on to the next slide.

So, for our future of MVPs within the MIPS program, we do recognize that there are some concerns about the implementation timeline. I do want to be clear, the earliest MIPS Value Pathways that would be available for reporting within the program is calendar year 2022. We recognize that moving to MVPs would be a significant shift in how the program works, and so, we do anticipate that for the next few years we will still have what we have recently been calling internally our traditional MIPS reporting approach as well as our new MVP reporting approach. We are committed to working with stakeholders to develop the new framework. As part of that commitment, we really want to ensure that all of the candidate MVPs that are collaborated upon are meaningful to stakeholders. So, as part of that, we do recognize that it may take some time for us to have enough MVPs for the vast majority of MIPS eligible clinicians. So, with that, let's move on to the next slide and I will turn the rest of the presentation over to Sophia Sugumar to go over the rest of the MVP updates. Sophia.

Thanks, Molly. Let's go to the next slide, please.

And really, in the new few slides, we really want to just go through some of the updates in a bit more detail with regards to our MVP policy that we've finalized in the 2021 rule. As Molly has emphasized, we did not finalize any MVPs for the 2021 performance period. The earliest an MVP would be available would be for the 2022 performance period. With regard to what we've worked on in this rulemaking cycle, we kind of took into consideration the comments we've received through the 2020 Final Rule and finalization of that MVP framework to work and make more refinements to our MVP guiding principles. Our alignments are really made to just really emphasize, as Molly mentioned, the patient voice, how subgroup reporting would be considered, and also to really promote the use of digital measures and promoting digital performance measure data submission. We also, in addition to making some refinements to the guiding principles, we also set forth a series of criteria to be considered when you, as the stakeholder, chooses to develop an MVP and submit that to us, CMS, for our consideration. We really wanted to be transparent with that criteria, so we came up with a series of more detailed questions to really encompass what we're keeping in our minds as we evaluate MVP. Next slide please.

Okay. Really, in this slide here, you'll notice that we've emphasized or reiterated our existing MVP guidelines but have also made some refinements that are italicized within the slides. So, we've really emphasized within the first principle that we wanted MVPs to utilize connected and complementary sets of measures and activities, and really to emphasize that need for alignment. Within the second principle, we've also added additional language that emphasizes our point that MVP should enhance comparative performance data as subgroup reporting is allowed, and that performance data would comprehensively reflect the services provided by a multi-specialty group.

On the note of subgroup reporting, we know that there is a lot of interest in that topic from our constituents and stakeholders. We do want to note that we have an upcoming town hall meeting that's going to be occurring in January. I believe registration information has been shared publicly and is

available. We are also accepting verbal commentary on possibilities of what subgroup reporting should look like. We really want to take into consideration additional feedback from stakeholders and if there's any concerns we should be considerate of, if there are any recommendations or ideas you may have as a member of a multispecialty group, really want to get your input there. We're also accepting written feedback. We understand that there are limited spots available for attending the town hall, and so we are also accepting written feedback, and we will accept that up to one week after the actual MVP Town Hall, which I believe is scheduled for January 7th.

Additional changes here regarding number three, we did emphasize the inclusion of Meaningful Measures and, wherever possible, the inclusion of the patient voice. What we mean by that is really that we want -- patient voice can be utilized in 2 ways, and we would encourage the use of both ways. One being that you, as a stakeholder who is developing MVP candidates, would likely do so utilizing a group or a committee of some sort independent of us. And as part of that committee or that group that meets to kind of pull together an MVP idea, you include someone that represents the patients or the patient themselves, to really make sure that the idea that you're pulling together as a MVP contact is understandable to someone that's not a clinician and the results of that MVP would actually be meaningful to them at the patient's perspective. So, really important from our perspective as that patient voice is considered. In addition to that, from the measures perspective, we really want to emphasize that and encourage stakeholders to consider the use of patient-reported outcome measures, patient survey measures. If those are not available, then patient experience measures, of course, are just as important. We continuously want to make sure that that patient aspect is reflected by some means. So, we continue to emphasize that through the inclusion of the patient voice here.

The next guiding principle is related to the APM participation. We did not propose any changes to that within the 2021 rule, however, we still do emphasize that we would like MVPs to reduce barriers to APM participation, and that may be done by including measures that are in MVPs that are possibly already in existing APMs. And that really provides that familiarity to clinicians when they eventually transition to an APM, or if they choose to, that that learning curve is reduced because they have that familiarity to those measures. Lastly, the new guiding principle that we've included is related to digital quality measures. MVPs should support the transition to digital quality measures. And our vision is that we move to a place where measurement is less burdensome and the use of digital sources, use of digital measures will get us there to move away from more manual data sources and things like that. So, really encouraging stakeholders just to consider the use of eCQMs, Registry-based measures, really just to support that electronic reporting is something we would like to encourage stakeholders to do. Next slide, please.

Okay. Within the next few slides, we're actually going to get into a little bit more detail with regards to the actual development criteria that we finalized. This is all included in the rule. We really wanted to provide a deeper understanding of where we're coming from and how we like to view MVPs so, that you have as much information as you need to kind of come up with your MVP candidate. So, within the next few slides, we'll go through some of the criteria here. As Dr. Schreiber and Molly have emphasized, MVPs should include measures and activities across all 4 performance categories. You really want to be sure. It's important that that's being considered. We

definitely encourage stakeholders to take a look at those measures and activities to make sure that your given clinician type or subspecialty type is reflected within those measures and can report those given measures, especially in the area of cost measures. So, we want to make sure that when you create your MVP you're utilizing measures that are not just complementary but are really relevant and applicable for a given specialty in the topic you're trying to measure here. The MVP, in and of itself, should also have a clearly defined intent of measurement. So, we should really be able to tell, as the person who did not develop the MVP, what you're trying to measure within this concept. The measures and activities should support that and not be so different and separate from the actual topic at hand that we're not able to make that connection.

Also, you know, making sure that the MVP actually aligns with our existing Meaningful Measure Initiative that we have going on here at CMS, really to ensure that the measures are applicable, relevant. Our preference is for more outcomes-based measures, of course, within CMS, and that's what we would like to continue to encourage as we move to MVP, where possible, use of more robust measures to really reflect quality improvements. The measures should be clinically appropriate for the MVP under development. For example, when you have a specific clinical condition or clinical topic, you wouldn't necessarily use an entire list of measures that's broadly applicable, meaning they're relevant to all clinician types. You wouldn't, for example, make an MVP off a closing referral loop and advanced care planning and documentation of medication. You would want more clinically-specific measures to really make that connection of what you're trying to measure within your actual MVP.

The MVP should also be developed collaboratively across specialties in instances where an MVP is relevant to multiple specialties. So, for example, if you're utilizing or creating an MVP around surgery and you know as a part of that care continuum there is an involvement of, for example, anesthesiologists, perhaps a good approach would be to then approach a group or an organization that represents anesthesia to make sure that, if they're being included, one, that they're aware, but then, two, that they can make sure also the measures are applicable to them as well.

Also, making sure that the MVP, in its entirety, is understandable and comprehensive, not just by clinicians and groups from the clinical perspective but also by patients who will try to understand possibly what will be the result of this MVP if we receive data on these measures and activities, what will it mean to them. And as I mentioned before, encouraging the use of electronically-specified quality measures really to avoid or reduce that reporting burden is something we'll continue to encourage when available, of course. When it's not available, certainly understand the use of other measures but we definitely want to encourage, to the extent possible, the inclusion of those types of measures.

As I mentioned before, incorporating the patient voice. So, patient voice, again, taken in two concepts, we would like both concepts to be considered and implemented by you as the MVP developer, and that would be utilizing patients as a part of your group that develops the MVP itself, and so, they have an opportunity to provide their input and their voice, and then also having metrics that reflect the patient voice within your MVP, whether that be patient-reported outcomes, which we highly encourage the use of if it's available for your given clinical topic. Or patient surveys, we do have a CAHPS survey, for example, but there are other survey measures out there

that may be relevant for your given clinical concept that you're trying to measure. There's also patient experience measures that consider the patient's experience with the care given. That's also just as important. And we know that there may not be patient-reported outcome measures for every specialty at this point, that's why we want to expand the types of measures we would consider under the realm of patient outcome versus patient experience and satisfaction, to really emphasize our point of making sure the patients stand out within the MVP itself. Next slide, please.

Okay. Within our additional criteria, we want to ensure that the quality measures that are considered for the MVP align with our existing measure criteria, and that means consideration for our existing measure criteria that are -- you know, our vision is to move away from process measures and have less topped out measures in the program. Our existing criteria is to ensure that measures are meaningful and relevant to clinicians and that they are following our pre-rulemaking type of measure criteria to have fully tested measures in our program, and that includes MVPs themselves. And then whether the measures are available within the given collection type that's relevant to the MVP at hand. So, for example, collection type refers to eCQM measures or registry or, in MIPS, we refer to them as MIPS CQM, MIPS Clinical Quality Measures. And really making sure you're cognizant to the types of collection types you're including within the MVP. We wouldn't want to be in a manner where every single measure is specified in a different way, thereby requiring a clinician to utilize multiple collection types. We don't want that kind of burden associated with MVP development and MVP reporting. So, being cognizant of the types of collection types that you're utilizing within your MVP and making sure there are sufficient numbers of measures within the given collection type will help avoid that scenario. To that point, with regards to measures that fit within the quality component of an MVP, we have also finalized that QCDR measures could be utilized within the MVP for the quality component.

However, I just want to caveat here that the QCDR measures must be fully tested. So, the QCDR measures are, as more of our QCDR stakeholders know, proposed and accepted through our self-nomination process, which is a separate process outside of our rule-making cycle. I do want to emphasize here that we're not requiring the QCDR measures to go through the Call for Measures or MIPS process but, if they are being considered for inclusion in an MVP, then the entire MVP, including the QCDR measures, would have to go through notice and comment rulemaking.

Also, we would want to emphasize here that the cost measures that are included within the MVP are relatable back to the other measures and activities included in the MVP. If a relevant cost measure for a given type of care isn't available, you can possibly include the broadly applicable cost measures if it's available and applicable to the clinician type, and that would be the MSPV or the TPCC measures. And consider what additional cost measures should be prioritized for future development and inclusion in MVPs. We have heard from stakeholders of interest in their external stakeholder-developed cost measures, and that is a topic we do have set for the town hall meeting in January. So, certainly, if you're not able to attend that meeting in January, you can still submit written feedback on what that should look like. We are certainly open for ideas, so please feel free to submit feedback. I believe the team will provide additional information on how you can submit feedback through the Q&A chat. Next slide, please.

All right. To touch upon the improvement activities, improvement activities can improve the quality of performance in a clinical practice, and that complements and/or supplements a quality action of the quality measures and cost measures within the MVP. You could possibly use, if there is no clinical specific improvement activity that directly relates to the topic being measured, you could use those widely applicable improvement activities when those specialty and subspecialty improvement activities aren't available. With regards to the Promoting Interoperability performance category, we do include that in the foundational layer of an MVP. And the foundational layer, just to note, is MVP-agnostic. So, that means that the foundational layer for every MVP is the same. One thing to note here is one area that we've received questions in is whether or not the existing Promoting Interoperability exemptions will apply when moving to MVPs, and they still will. So, if your MVP applies to a given specialty that is exempt under the PI performance category, that will still carry over as you move to MVPs. Also within the foundational layer, for the current period of time we're in and based off the 2021 final rule, we did finalize an administrative claims-based measure, the Hospital-Wide 30-Day, All-Cause Unplanned Readmission measure for MIPS Eligible Clinicians and Groups. This measure is replacing our existing measure for hospital-wide readmissions that's available for 2020. This measure, as an evidence claims-based measure, will be also a part of that foundational layer of all MVPs and would be calculated depending on those thresholds that the measure currently is specified under. Next slide, please.

So, in addition to the MVP development criteria we just went through, we actually also went into some detail about actual submission process of how you would, as a stakeholder, submit an MVP candidate that you've put together to CMS for our consideration. So, today, we're having that webinar. We did intend to really kind of go through the process and answer any questions, outline our criteria and what our intentions are for what MVPs will look like as we work collaboratively to develop these. There actually is a template we have published in the QPP Resource Library. I believe it's with the 2021 Final Rule resources, in a zip file. And that template includes all the criteria we went through thus far and also an actual blank template for you to complete to provide measures and activities for your given MVP candidate, and also an email address of where you can send that MVP candidate to in order for it to be considered and follow our review processes.

Essentially, our review criteria is all the criteria we just went over. We're looking to see that you can hit all these criteria, your MVP checks off the boxes. In all likelihood, it will be an iterative process where we will have a dialogue with you as the MVP candidate submitter. And that will be dependent on whether we feel your MVP is feasible. If we find that your MVP, for one, follows all 4 performance categories and has feasible measures across all 4 performance categories, that will make us continue our review to make sure we look into the more detailed granularity of the measure specifications of each of the measures that you've included, also the improvement activities, also to just do a compare of what other measures and activities are out there, and whether those should be considered as we provide our recommended revisions to your MVP candidate.

From that standpoint, we will reach out to the stakeholder who submits the MVP, or if it's more than one in instances where you collaborate, we will reach out to you to kind of set up a meeting where we can discuss that feedback and really give you an opportunity to talk to us about it, if you

have any concerns, voice those concerns, or questions. And also give us a chance to kind of think through potentially any other edits we want to make. To that note, we can have those iterative meetings to really talk about progress but we cannot, outside of rulemaking, inform the public or any stakeholder whether an MVP is moving forward or not. Really, the rule would be the ticket to whether an MVP is being proposed and finalized. We could not, outside of the rulemaking process, inform stakeholders or any other member of the public or guarantee than an MVP will be implemented for the upcoming year. Generally, our thought process is to accept MVP candidates on a rolling basis, but we will be considerate to the timing it takes to review the MVPs for the upcoming year. So, while we'll accept MVP candidates on a rolling basis, we are planning to have a cutoff of February 2021 to accept candidates for 2022. At that point, any candidate received after end of February 2021 would be reviewed still, it's not that they wouldn't be, it's possible that they would possibly be considered for a future year in MIPS. Next slide, please.

As I mentioned before, a few of the Town Hall topics are here. I believe our team has already provided the email address here as to where you can provide written feedback. In addition, while the town hall itself, the registration is, unfortunately, full, there was high demand and interest in it and we were happy about that, but you can email this inbox here, the CMSMVPFeedback@ketchum.com to be added to the waitlist. If a spot frees up on the attendee list, we will certainly email. I believe it should be a first-come, first-served basis. In addition to that, you will have the opportunity to provide written feedback. Even if you're not able to attend the town hall virtually, you can also just email us your written feedback and that will still be considered and reviewed and discussed. Next slide, please.

Okay. Let's go into the MVP submission criteria. Next slide, please.

As I mentioned before, we included an MVP candidate submission template as a way for interested stakeholders to have a focused view of how we would like your MVP candidate submissions to look like as they're submitted to us for our consideration. This solicitation, just to be clear, is separate from our annual Call for Measures for the quality component of MIPS and the Call for Improvement Activities, and the Solicitation for Specialty Set recommendations. So, there are several solicitations that happen throughout the year for the various performance categories. We want to emphasize that this is different. If any stakeholder chooses to include a measure in their MVP candidate that's not currently a MIPS measure, we want to emphasize that those measures would need to go through our annual Call for Quality Measures process in order to be considered for MIPS and the MVP. We do encourage your submissions to include measures and improvement activities that are currently available in MIPS, but, again, if you have ideas for new measures and improvement activities, they would still have to follow those existing processes. So, I would be mindful of those timelines when they would first have to go through these calls and then be considered for inclusion within the MVP. There is additional information on these calls if you go to the QPP Resource Library. There's also additional information on the MVP Development Template within the QPP Resource Library itself. Next slide, please.

So, the template that we've posted in the Resource Center should be reviewed and used by stakeholders who wish to have their MVP candidate considered for potential implementation beginning with 2022 and for future years. Just because your MVP candidate does not move forward for 2022 does not mean it's

not being considered for any future year. It may be possible that there is consideration to hold your MVP off for an additional year, but that will be dependent on the measures and activities that are included and the various timelines that I previously mentioned with the Call for Measures and Call for Improvement Activities, and also the approval process for QCDR measures is also a separate timeline as well. MVP candidates should include measures and activities from across the various performance categories. Again, as I mentioned, the foundational layer should include the PI measures and the Hospital-Wide 30-Day All-Cause Unplanned Readmission measure. So, that should be noticeable within the template.

You'll see that within the table itself there are several blank cells for you to complete with regards to the cost measure, the quality measures, and the improvement activities. But you'll notice that Promoting Interoperability set and the Hospital-Wide All-Cause Unplanned Hospital Readmission measures are included in the foundational layer. There's no edits to be made to the foundational layer there. As a part of your submission, you would focus in on your Cost, Quality, and Improvement Activities components. So, again, to emphasize what I mentioned earlier, if you really want your MVP to be considered for the 2022 performance period, we would encourage you to submit your MVP candidate template by February 2021 to the email address that's listed within the template. Again, we will be accepting candidate submissions on a rolling basis. You know, as we're preparing for 2022, we will continue to prepare for future years, but really we need to set a cutoff date so we can prioritize getting those MVPs reviewed, have opportunities to talk to the stakeholders, if that's needed, and make revisions if that's needed, and prepare for rulemaking for the 2022 performance period. So, please be mindful of that date if you choose to submit an MVP to be considered for 2022. Next slide, please.

So, with regards to the specific quality measures and the guidance we provide, and this guidance, I believe, is similar to what we include in the template, but really to emphasize a few points here. The MIPS Quality Measure Inventory we have are mapped to 46 specialties and subspecialties that provide guidance for stakeholders developing MVP candidates based on specialties. To review the current list of MIPS measures that are available, and their associated specialty sets, because we do have that available through MIPS Quality, we do refer you to the Resource Library there. That will provide you with a comprehensive list of the MIPS quality measures in MIPS right now. Within that resource, we do also provide which measures belong to which specialty set. So, that might be helpful as a starting point if you're just starting your review of our inventory of measures.

Stakeholders may also submit an MVP candidate based on health conditions. So, for example, diabetes or chronic conditions. An emphasis where a quality measure closely related to the MVP candidate topic is not available. A broadly applicable or crosscutting measure that drives quality, care and alignment with the MVP topics would be fine. So, for example, as I mentioned before, a broadly applicable measure could include Advanced Care Planning, also measure Q226, which is Preventive Care and Tobacco Use: Screening and Cessation Intervention. Again, we're not envisioning MVPs to be entirely made up of broadly applicable measures when an MVP is measuring a specific health condition or procedure topic. But, however, if these measures are relevant to the care cycle and you feel that they should be included, certainly feel free to do so. We will evaluate and compare versus what we currently have available in MIPS. If there are any suggestions we may have to your candidate to possibly make some revisions, we will communicate those

as a part of that dialogue. So, please review. There's a separate resource for those specific cross-cutting measures that are not specific to a given specialty. It's available in the QPP Resource Library. So, if you want to take a look at that as well, that might help to support your development. Next slide, please.

So, continuing on with the quality measures, we do want to also emphasize that the measures are also categorized and identified by measure type. We encourage the inclusion of measures that fall, again, into the Outcome, Patient Reported Outcome, and Patient Engagement or Patient Experience measure types to the extent feasible. Ideally, we see a vision where we move away from process-based measures into more patient reported, outcome-based measures in our programs at CMS. However, we do realize that for some specialties or subspecialties it may be difficult. So, we do acknowledge that and we want to work with those specialties to come up with creative ideas in how we can move measurements forward but also want to expand the inclusion of measures to also reflect patient engagement and patient experience because we feel that those topics may be more relevant to all specialties. In addition to that, again, QCDR measures can be included within the MVP so long as the measure has met all of our requirements and has been fully tested through the Self-Nomination process.

So, as a part of our vetting process for self-nomination in a future year, the QCDR, in a traditional MIPS, would have only, for 2020, been required to complete safe validity testing. What we're asking for, because MVPs are moving up to a space where we're having more focused subsets of measures and activities that are supposed to be more meaningful and relevant to a given clinician practice to really ensure the measures are reliable within that set, to make sure that QCDR measures are fully tested before they're actually considered for inclusion in the MVP. We do ask those QCDRs that are considering the inclusion of their measures in MVPs to submit that testing data to demonstrate they have fully tested those measures as a part of the Self-Nomination process so, that we can work with them outside of self-nom to move that MVP candidate with those QCDR measures forward. As I mentioned before, measures that are currently used outside of the MIPS program should follow the existing pre-rulemaking website process. So, that is the Call for Measures and MUC/MAP process, which is the Measures under Consideration, and the Measure Application Partnership Committee Meeting, and then follow our typical rulemaking cycle before they are actually considered for inclusion within an MVP. Next slide, please.

With regards to improvement activities, improvement activities are broader in application and can cover a wide range of clinician types and health conditions. Improvement activities that best drive the quality of care addressed in the MVP topics should be prioritized for inclusion within the MVP. The improvement activities should really complement or supplement the quality action measures in the MVP candidate submission rather than duplicate it. Improvement activities that are currently outside of the MIPS program should follow the existing pre-rulemaking process, which is the Call for Improvement Activities process and the associated rulemaking that would follow that before they are included within the improvement MVP. Next slide, please.

We also wanted to provide some additional information with regards to one of the specific improvement activities related to the patient centered medical home. This is the electronic submission of Patient Centered Medical Home accreditation. So, the inclusion of this improvement activity in an MVP, any

clinician or group interested in attesting to the IA_PCMH as their improvement activity must meet the criteria for recognition as a patient centered medical home or comparable specialty practice participant. For clinicians in a practice that is certified or recognized as patient centered medical home or comparable specialty practice as determined by the secretary, the Improvement Activities performance category score is 100 percent. For the 2020 MIPS payment year and future years, at least 50 percent of the practice sites within a group's TIN must be recognized as a patient centered medical home or a comparable specialty practice. Next slide, please.

With regards to the cost measures, the current inventory of cost measures covers different types of care. There are procedural episode-based cost measures that apply to specialties, such as orthopedic surgeons, that perform procedures of a defined purpose or type, and acute episodic-based cost measures that cover clinicians, such as hospitalists, who provide care for specific acute inpatient conditions. There are also 2 broader types of measures, and these are population-based cost measures that assess overall cost of care for patient admission to an inpatient hospital, and that would be the MSPB-Clinician measure. For primary care services, there is also a TPCC measure. The MIPS cost measures are calculated to clinicians and clinician groups based on administrative claims-based data. Next slide, please.

Again, with the cost measures and what I've previously mentioned, if there are measures that are currently outside the MIPS program, they would need to be considered to follow the existing pre-rulemaking process before they were included in the MVP. We are exploring possibilities of cost measures that are developed by external stakeholders. We do welcome stakeholder feedback and recommendations on how this process should be laid out. Again, to the point of the town hall, we are planning to have some discussion or listen to some feedback from you all at that meeting. Again, if you are unable to attend, we welcome written feedback on how we can develop this process where we can consider externally developed cost measures. To be used effectively in MIPS and included in MVPs, any potential external cost measures must comply with standards and meet CMS goals. These standards have been developed with extensive stakeholder engagement and aligned with the meaningful measure framework, and the CMS Blueprint for measure development. These standards that are used for our existing cost measures ensure that cost measures are clinically meaningful, have well-defined patient cohorts, align with quality indicators to ensure meaningful assessment of value, and have strong opportunities to be impactful by covering large amounts of cost, clinicians, and patients. Next slide, please.

Okay. At this point, I think we're going to start to get into a bit more detail as to the varying fields within the actual template itself and really kind of go over what our expectations are for each of these fields here. So, beginning with table one of the candidate submission template, you would need to describe at a high level information to address the following general topics, the MVP name, primary and alternative points of contact from your perspective of how we can get in contact with you, the intent of your measurement. And, again, going through those same criteria that we mentioned before, what are you trying to measure within this MVP? Whether you consider clinicians who report the MVP at the individual level versus the group level, making sure the intent is consistent there, regardless of whether they report individually or through a group mechanism.

Are there opportunities to improve the quality of care and value in the area being measured? We're looking for MVPs to really, again, progress our quality improvement initiatives. We don't want to recreate the wheel and have MVPs that are heavily process-based, that are very easily going to top out and can be considered standard of care. We're looking to really push the needle forward and moving our quality initiatives and quality improvement desires forward with MVPs. Why is the topic of measurement meaningful to clinicians? Many of you represent clinicians and clinician cohorts. You know, why would this given topic be relevant to them? Why would they find this meaningful? It would be helpful for us to understand, especially if it's an area that's a gap in care or there's a need for quality improvement, and there's scientific evidence or evidence out there that supports that need.

Does the MVP act as a vehicle to incrementally phase clinicians into APMs? How so? Have you considered the use of measures that are currently in APMs that would be still relevant to your clinicians that you intend to measure within the MVP? Having that familiarity with measures that are used in the APM space will help those clinicians as they transition to APMs eventually. It's one less thing that they would have to have that education on because they have that familiarity of how the measures are specified, what's needed of them to meet the quality action. That familiarity there is what we're trying to encourage. Is the MVP reportable by small and rural processes? Would you consider as the stakeholder who developed the MVP the reporting burden associated to those small and rural practices? So, again, if your MVP requires that you -- you know, reporting of measures, for example, and you try to submit an MVP that only includes just QCDR measures, do you think your QCDR is available and accessible to those clinicians who work in small and rural practices? I think there's definitely a need to consider that. And then also, you know, tying our MVP work back to our Meaningful Measure framework, what Meaningful Measure Domain does your MVP address? Really want to make sure that connection and alignment is there, and emphasize you all to, as you're constructing your MVPs, take that into consideration and make sure that you're keeping in alignment with that framework. Next slide, please.

Table 1 continues into the more descriptive information, so really identifying those linkages between the measures and activities within the MVP and describing how you feel those links exist. Really, the links between the measures and activities should show complementary relationships to the measures. We're not looking for duplication, where you're doing one quality action and getting credit for both. We're really looking for one to support the other. Both quality actions within the measure and activity would complement one another in a manner that would strengthen the type of care that's given to the patient. We want to make sure that all the measures and activities that are being considered, they're relevant to the continuum of care offered by the clinicians, they're not items that are just broadly applicable, that don't necessarily contribute to stronger quality of care that the clinicians would provide for the given clinical topic in measure. We want to make sure also that the measures and activities that are chosen are really relevant to the specialties. Again, the example of MVP being made up of all broadly applicable measures, it's difficult to justify that that necessarily supports the specific clinical concept we're trying to measure and we want to make sure that they're really relevant and really reflect the clinical quality actions that the clinicians take on a daily basis.

Appropriateness is another area, and we do have several questions here that really emphasize if the measures and activities are clinically appropriate for the clinicians you intend to capture within your MVP. So, we do highly recommend, as you work your way through the development process, that you consider these questions when you look at the measures specifically. We do encourage, to the extent you can, to look at the details of the measure specifications to make sure your clinician types do fall within the specifications of the measure and the measures are currently available to your specialty type. If the measures that we have in MIPS are not currently specified in a manner that includes your specialty type, we would have to separately look into that, whether that's possible. Of course, many of the measures are owned by measure stewards outside of CMS. That would require another level of work and processes if that could be done. So, again, taking a look at that and being mindful of that before you pull together a subset of measures is very important. I did mention earlier the criteria related to comprehensibility, and that's, again, wanting to make sure clinicians understand what you're trying to measure but then also making sure the patients can understand what you're trying to measure there as well. Patient voice we already went through. Again, patients should be involved in the development process, but then we leave it up to you to define how that's been done. We also want metrics that reflect the patients, whether that be patient-reported outcome measures, patient experience measures, patient survey measures, and/or patient satisfaction measures. So, really make sure you have the patient represented both ways is really important. Next slide, please.

Here, you'll see this table. It's also included -- table 2 is included within the template. This is really the area within -- we did post a PDF version and a Word version of this template. So, within the Word version, you can delete these fields and kind of fill out the specific measures and activities for each of your MVPs. Again, there is flexibility for you to add rows or delete rows, depending on the number of measures. We will certainly -- we have not been prescriptive on the number of measures and activities that should be included, however, we will take a look and, if there are additional measures and/or improvement activities, or if we feel like certain ones should be removed, we will certainly provide that feedback through our dialogue. Next slide, please.

As I mentioned before, the foundational layer is the same across all the MVPs. So, again, those details have been provided within the MVP template for you to look at with those detailed measure descriptions and titles, but that's just provided more as informational purposes. Next slide, please.

This is just a continuation of that. Next slide, please.

We do have several additional questions for you to consider as you develop your MVPs. Again, keeping in mind our existing criteria that we have for measures and activities within the MIPS program when we finalize measures for inclusion versus remove measures based off of their status in the program. I know for quality specifically, try to move away from topped-out measures as well, so measures that have a high-performance rate, and that may be between 95 to 100 percent. We've identified many of those measures as topped out. We've noticed many of our process measures top out as well, quickly. So, really trying to raise the bar on the measures we have within the program and as we move to MVPs, continue that. Continue to support that effort. We want to make sure you're all mindful of, to the extent possible, avoiding including topped-out measures. I did mention a reference to

collection types earlier, and that relates to the methods in which a given quality measure is available. So, being mindful of the measures and the collection types that they are specified under as you put together an MVP is certainly a good thing to keep in mind. Especially if clinicians are reporting, we don't want to be setting up MVPs in a manner where we're forcing them to use multiple collection types because that adds additional burden because it's counterintuitive to what we're trying to do here with the MVPs. Let me see. I think that's all we have to cover here. We did emphasize the point in including relevant specialty and subspecialty measures. You can complement those with cross-cutting measures, if needed. But, again, try to avoid a scenario where an MVP is just solely made up of cross-cutting measures if that's not relevant to the topic being measured. We don't want to -- you know, it would be hard to see why that would be meaningful to a very specific condition or procedure. Next slide, please.

Then these additional questions really emphasize the need for improvement activities to drive quality care and to really complement those quality measures or quality actions rather than just simply duplicate them. If there are -- can the MVP consider the use of improvement activities that can conduct the use of certified EHR technology functions? We certainly promote and emphasize the use of CEHRT functionality with Promoting Interoperability but also within the MVP itself, and our vision of moving to a more digital manner, having IAs that are relevant to CEHRT functions is certainly something, if it's relevant to your clinician type, something we should consider. Next slide, please.

For the cost measures, again, we do want to focus in on the quality of care and improving value. So, how does the cost measure you selected really drive that quality of care? We would ask that you provide a rationale as to why each cost measure was selected, similar to our quality and improvement activities. And how that selected cost measure relates to the other measures in the other performance categories. If there isn't a relevant or specialty-specific cost measure for a specific type of care being provided, does the MVP include a broadly applicable cost measure? Did you make sure that that broadly applicable measure is relevant to the clinician that you're trying to measure here? If there are additional cost measure types or cost measure topics that you feel we should prioritize as a part of our development efforts, we are certainly open to that feedback as well. That's something the team is continuously listening in on and listening in for. So, feel free to provide that. Again, that is a topic for our town hall on January 7th, so, we do plan on listening to more feedback from our stakeholders on how we can consider cost measure development by external stakeholders. Next slide, please.

Okay. As I mentioned before, we will determine when an MVP is ready for proposal and inclusion for the upcoming performance period. We will utilize the evaluation criteria that we just went over to really be our guide to make sure the MVP is ready for implementation. In instances where we find a given MVP is feasible, we will reach out to select stakeholders with feasible candidates to schedule meetings to discuss our review, our feedback, our recommended revisions, you know, give them an opportunity to voice any additional concerns or if there are additional feedback they'd like us to consider as potential additional revisions, that would be the time to have those discussions. Submission of an MVP candidate does not guarantee it will be accepted or implemented through the rulemaking process. To ensure that we have a fair rulemaking process that is respectful of our rulemaking cycle and our rulemaking construct that we are confined to, we

will not directly communicate prior to the rule being published any decisions with regard to whether or not an MVP will move forward or not. The inbox to which you can submit a completed MVP candidate submission template is provided here, and that will be where we will, from that point onwards, take your MVP for internal review, have a chance to review that feedback. We do always work with our leadership teams to get their input on your MVP candidates as well. So, certainly, when we provide you all and meet with you all on a one-to-one basis, it's with consideration of our feedback from our leadership team. And we want to hear your thoughts and your feedback on our recommended revisions. Next slide, please.

With regards to additional resources, as you kind of think through the MVP candidate and the possible areas that you'd like to create an MVP candidate, we do have additional resources and past webinars that are available for you to review. So, there is a MIPS Value Pathways video available, as well as some diagrams. I believe we had one that Molly went over earlier in the presentation. We also have our previous MVP webinar slide decks and recordings that are located in the QPP Webinar Library. You can find more information on MVPs within the QPP website. We have a specific page, I believe, dedicated to MVPs. I believe -- next slide, please.

Okay. Next slide.

So, there are several resources available. So, our help and resources that are available on a nationwide basis, we do have technical assistance resources that are available, and specific ones that are available to small, underserved, and rural practices. And there is technical support available through our service center, our regional offices, and our learning system. So, please, if you need additional information or additional help that's a bit more local to the area in which you're located or based, that is certainly available to you and we have links here to kind of show you how to get access to that assistance. Next slide, please.

And I think we're ready to begin our Q&A session. So, we know that many of you have been submitting questions to us through the Q&A inbox, and we are working to answer those. But if you'd like to ask a question, you can dial this number and use the associated passcode to actually verbally ask your question on the call, and you know, we'll be able to provide you a response on the call. But if you feel more comfortable using the chat box, that is certainly an option that's available to you. We will try to answer as many questions as time allows. However, if we're not able to get to your question, certainly feel free to follow up with a ticket to the QPP Service Center. We do have the MVP Development team on standby to help triage those questions. If you are working through your MVP candidate and you feel like you need to follow up with us on a specific component and you want to send us a question, you can certainly do so through the QPP Service Center and we will get to that as well. So, Ketchum team, I think we're ready to get started with Q&A.

Great. Thanks, Sophia. Okay, great. So, as Sophia mentioned, if you do want to ask a question over the phone line, just dial 1-833-376-0535. And you can use the passcode 5219639. So, in the meantime, we do have a few questions that came in over the chat box. So, we'll begin with those. So, Sophia, can you please clarify if the goal for traditional MIPS is to disappear entirely and be replaced by the MVP reporting system?

In the ideal world, we do envision a place where there are MVPs available for all clinicians, regardless of specialty type in MIPS to then move to an MVP. Again, we have heard feedback through our 2020 MIPS framework of caution of how quickly we do that. We are aware of that and we are mindful of that. So, for the time being, until we can get to a point where there are MVPs available for all clinician types within MIPS, we are aware that there is a need to maintain both traditional MIPS and MIPS Value Pathways.

Great. Thank you. Okay. Additionally, can any relevant stakeholders submit MVP candidates for consideration or should only specialty societies submit candidates?

We did not limit MVP candidates to be just from specialty societies, however, we do want to note, if you are submitting your MVP candidate, to be mindful of if your MVP covers other clinician types or a larger umbrella of clinicians that you don't necessarily work with. So, kind of be proactively collaborating with those organizations. We would not want to be in a place where we're implementing MVPs that come from several societies or organizations or healthcare systems that are duplicative of one another. So, having organizations work collaboratively and proactively from the get-go to work on development, it helps to kind of avoid the rework and also, if you do that proactively, when we review your MVP candidate, we'll know that that was considered, versus if we receive separate candidates from multiple entities that cover the same specialty type and we see the overlap there, you will most likely hear from us that we would like you all to work collaboratively with one another. So, we might sync you all up to kind of look at our revisions and work from there. But, generally, our point of view is being proactive and working with others that either cover a broader population of the clinicians you support or are working with complementary specialty types that work within the topic you're trying to measure is something we would encourage.

Great. Thank you. Okay. Stephanie, do we have any questions on the phone line?

We do have a question from Gabby Segovia.

Yes, hello.

Hello. You can go ahead.

Yes. I have a question. I understand you mentioned that the main purpose of the MVP is to help transition into an APM. So, I would like to know if this applies to us since we've been part of an APM since 2019.

If you're already in an APM, I would think, you know, if that's a pathway you continue to be interested in, we would continue to encourage you to utilize your APM. Our goal is to have clinicians and groups that are currently in MIPS, in the traditional MIPS and reporting to MIPS, using the traditional mechanisms to kind of utilize MVPs to head them in that direction. So, it seems like you're already there. If you guys are all happy with reporting through the APM and the APM Pathway, then that's what you would continue to do. Our intention with MVPs is really for those that are not currently utilizing APMs, encourage them to find a manner that would possibly lead them there in the future.

Okay. And just to complement the questions, we are part of an advanced APM. That will be the same, right?

I believe so, but I know, Brittany, you're on, is that correct? That is my understanding.

Okay. I appreciate it. Thank you very much.

Thank you.

Okay. Great. So, back to the chat box. We had a question that asked, "Certain specialty societies do not have a cost score calculated, nor do they have any of the new cost measures that are applicable. So, how do we handle this category in MVP development?"

I believe we have our cost team on. Do you guys want to handle this question?

Sure. Yeah. We do envision that MVPs have at least one cost measure. If there are no specific episode-based cost measures that are applicable, there are the broadly applicable or population-based measures that can be used in the meantime until more measures are available through future cost measure development. I do believe that this topic will be brought up during the town hall meeting in January, and we would welcome feedback from stakeholders on this issue.

Great. Thank you. All right. Next, do all measures need to be previously approved by CMS via the Meaningful Measures submission process or as part of a QCDR Health Nomination Process, or can MVPs include novel measures?

So, all measures, before they're considered for inclusion in the MVP candidate, should have either gone through the Call for Measures process where they would have been proposed and finalized through rulemaking as a MIPS quality measure, or they were an approved QCDR measure that has been fully tested. So, that is separate from our pre-rulemaking requirements. The QCDR measure Self-Nomination process happens typically from July 1st to September 1st of the year prior to the performance period. At that point, we would want the QCDR measure to be fully tested in order for it to be considered. So, if there is a measure that you would like to consider that does not fall within one of those two buckets, then you would just have to be mindful of those timelines because they would either have to become a QCDR measure, which means you, as the entity, would have to qualify as a QCDR to become one, or they would have to follow our typical pre-rulemaking processes.

Great. Thank you. Okay. Stephanie, do we have any other questions on the phone line?

There are no other questions on the phone line.

Okay. We'll give those a few more minutes. Next question asks, “Can you only participate in an MVP if you create your own, or are there going to be standard MVPs for clinicians to choose from?”

So, in order to participate in the MVP, you don't need to create your own. The idea is to have them applicable and available -- sorry, available to all clinicians within that given clinician type. The only caveat to that is if a

MVP includes some QCDR measures, those QCDR measures are typically only reportable through a QCDR. So, just a nuance about MVPs that include QCDR measures, that component, the QCDR measures specifically are specifically only available through a qualified clinical data registry.

Great. Thank you. Okay, we had a few questions about PI exceptions. So, can you please clarify, in MVPs, are clinicians still able to apply for a PI exception just as a small practice exception?

Yes, from what I understand, the existing exceptions and exemptions in traditional MIPS for PI would continue forward for MVPs as well.

Okay. Great. Thank you. Next, can you please clarify the timeline for the submission of an MVP candidate? Specifically, must a relatively finalized version of an MVP be submitted to CMS by February of 2021 or are you saying that simply a basic template is due by that time?

So, if you were thinking to submit something to us and you would like us to consider it for the 2022 performance period, we would look for you to submit a fully complete template by the end of February, to the associated email address that's listed. That will give us an opportunity, and having completed all the measures you feel that should be included, all the activities, the relevant cost measure, and providing the necessary information, including the rationales as to why you feel those measures and activities are relevant and applicable, from that point of view, you have submitted your candidate. It's not considered final yet because it has to go through CMS review. As a part of CMS review, we might recommend there be revisions. So, we will have a dialogue with you as the stakeholder who submitted the candidate MVP as to what these revisions should be and why we feel certain measures and activities should be included or not included. So, typically with that, we would like to have a meeting with you to kind of discuss that, those updates, and give you a chance to really provide feedback on our updates. If there is any items you would like to flag for us or any concerns, that would be the point of discussion at those meetings, and then we would work from that point to -- CMS, we would determine when the MVP is ready. Again, generally, we will accept submissions on a rolling basis, but really, if you have a timeframe in mind in which you'd like your MVP to be considered for the immediate year, so, for example, the first year of MVPs would be 2022, then you would just keep in mind that you would need to submit it by the end of February. If you don't have that constraint or you don't feel strongly that it must be implemented by 2022, if it does meet all our criteria and you feel you don't have that urgency, then you can submit it even February, March timeframe, and it would still be reviewed. It's just that it may not be considered for 2022.

Great. Thank you, Sophia. Okay. In the time that we have left, Stephanie, are there any questions on the phone line?

There are no questions on the phone lines.

All right. Thank you. So, just a few more questions before we wrap up then. Sophia, can you please clarify whether an MVP and its associated measures must be submitted through the MIPS process, because if that is the case, it looks like we'll be looking at least three years until there are new MVPs, as the time period to submit for the --.

No.

Yeah, continue.

To clarify what needs to go -- so the Call for Measures, the typical process that we -- the pre-rulemaking process that we require of quality measures, for example, we would not have that same process in place for the MVPs. This is separate from all of that. We would assume that -- we would hope that all the measures you include in your MVP would have either have gone through that Call for Measures process in pre-rulemaking and have been finalized and are available, or the improvement activity, same thing, they've gone through a Call for IAs. If it's a QCDR measure, it would have already gone through the process of being approved. It has been fully tested because you do plan on including it in an MVP. So, really, this is separate from all of that. There is no review by, for example, the NQS. This is separate from quality measure review. We would look for you to have measures and activities that have already gone through that process included in your candidate submission.

Great. Thank you. Okay. Well, that looks like all the time that we have for questions today. So, Sophia, I will pass it back to you to conclude the webinar.

Yeah, thank you so much. And thank you all for attending. Really appreciate your time and your ability to listen in on all our exciting movement towards MIPS Value Pathways. If you have any questions as you work on your MVP candidate, feel free to submit questions through the Service Center, the QPP Service Center. We do have a team that is heavily involved with the MVP vetting process and they will certainly be happy to answer any questions you may have. Otherwise, we look forward to receiving, those of you who intend to submit candidates, by February 2021, end of February. And those of you we have started working with, we look forward to continue to working with you all. So, happy holidays and we will talk to you all soon. Thank you.

Thank you. This concludes today's conference call. You may now disconnect. Speakers, please hold the line.