MIPS Value Pathways(MVPs): The Future of the Merit-based Incentive Program

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Agenda

- **Traditional MIPS Overview**
- **MIPs Value Pathways**
- **Anesthesia MVP**
- **MVP Reporting**
  - Transition Timeline
- **Submitted Questions**

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Traditional MIPs Overview

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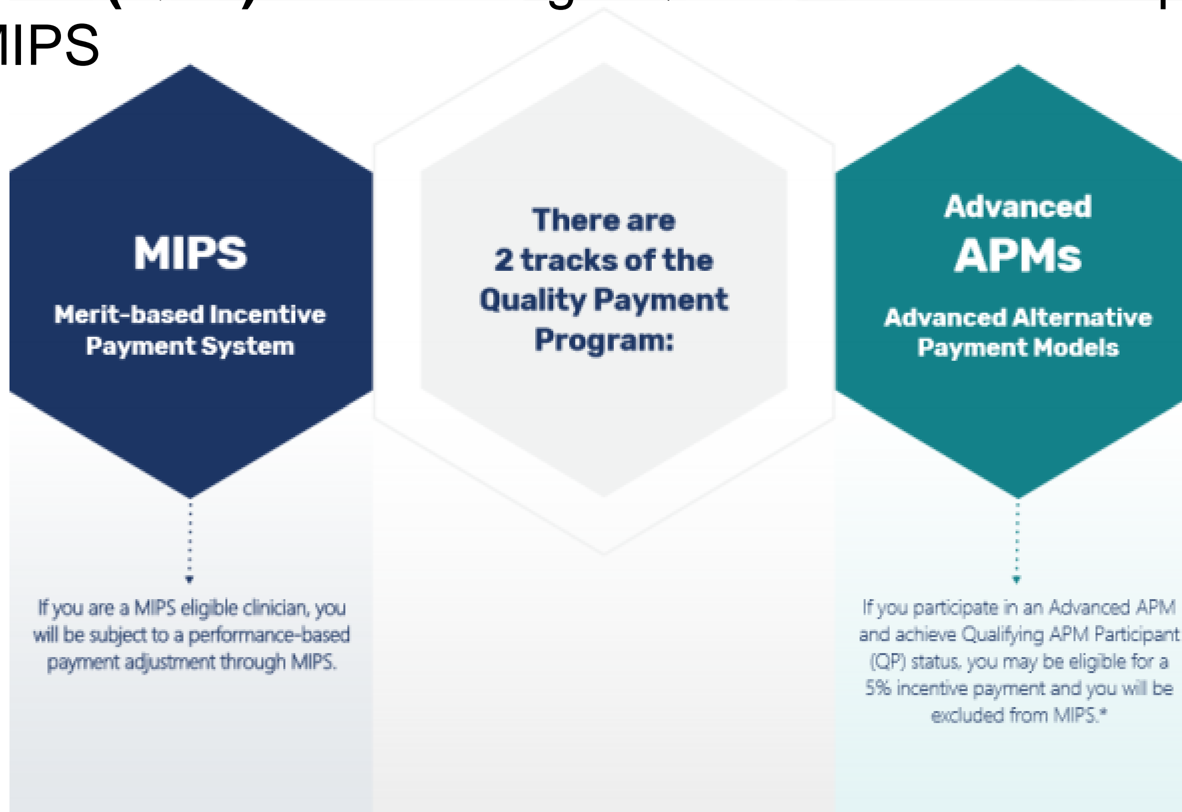
MIPs Overview

- **2015 MACRA** legislation established the **Quality Payment Program (QPP)** – combining PQRS and other CMS programs into MIPS



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MIPs Overview

The Quality Payment Program (QPP) seeks to reward clinicians for providing high-value care to beneficiaries

- **Advanced APM track –** participants receive a 5% lump sum payment

- **Merit-Based Incentive Payment Program (MIPs) track –** participants receive a payment adjustment based on MIPs score
  - Adjustment can be **positive** OR **negative**

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MIPs Overview

- Individual providers enrolled in Medicare for *at least* one year who also exceed the program's low volume threshold ***must*** participate

Low Volume Threshold (LVT):

- **$90,000** or more in Medicare part B charges **and**
- **200** or more Medicare beneficiaries **and**
- **200** or more Medicare covered services

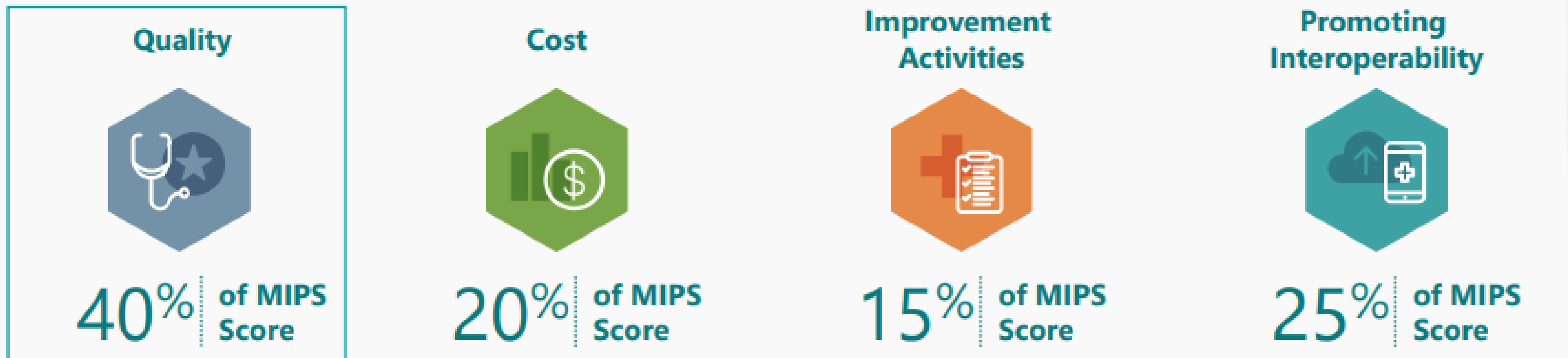
- Individuals who exceed ***some*** elements of the LVT may opt-in but are not required to report

- Providers with sufficient participation within Advanced APMs are exempt from MIPs

https://qpp.cms.gov/participation-lookup - check NPI eligibility

MIPs Overview

- Final MIPs score is a combination of four performance categories



- Each category has a unique score and category weight towards final MIPs score

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MIPs Overview

MIPS participants earn payment adjustments onto future Medicare claims based on their final MIPS score

2021 MIPs Thresholds	2022 MIPs Thresholds
Penalty: 60 points **Exceptional Performer:** 85 points **Maximum Payment Adjustment**: +/- 9%	**Penalty:** 75 points **Exceptional Performer:** 89 points **Maximum Payment Adjustment:** +/- 9%

Payment adjustments are applied **2 years** *after* a performance period.

- 2020 payment adjustments apply to 2022 Medicare claims

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MIPs Overview

- **Quality –** participants must report at least 6 Quality Measures for the category
  - At least one measure needs to be an Outcome or High Priority measure
    - Certain scenarios ***can*** allow for scoring on fewer than 6 measures
  - Over **200+** different measures to choose from
    - Measure inventory is updated annually to add/remove or change MIPs measures
    - Different submission methods available depending on measure
    - Measures must reach a required case minimum, have a benchmark, and reach data completeness in order to be scored

  - **Small Practices** can submit MIPs data on Medicare claims throughout the year
  - Non-small practices must submit data during submission window, typically with a 3rd-party vendor

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MIPs Overview

- **Improvement Activities –** participants must attest to completing program approved activities for at least 90 continuous days during the performance year
  - Over **100+** different activities to select from
  - Each activity weighted as either High or Medium, participants must report enough activities to complete the category:
    - **2 high-weighted** activities,
    - **1 high-weighted** activity and **2 medium-weighted** activities, or
    - **4 medium-weighted** activities
  - Attestations are completed on QPP website or with 3rd-party vendor submission
  - At least 50% of a group must do the same activity for the entire group to receive credit

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MIPs Overview

- **Promoting Interoperability –** participants complete a combination of attestations and submit data on category measures related to use of certified electronic health record technology (CEHRT)
  - All attestations – related to information blocking, ONC review, and conducting annual security risks – must be submitted as 'yes'

    AND

  - All measures must be reported on or have exclusions claimed, otherwise participants will not receive credit towards the category
  - Certain clinician types or special statuses granted under the program are not required to participate
    - Category weight shifts to Quality under current scoring logic

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MIPs Overview

- **Cost** – calculated by CMS after the submission period
  - Category consists of two primary and 18 episode-based measures
    - Primary measures look at beneficiary spending in primary care and/or hospital settings
    - Episode-based measures are specific to procedures, diseases, or clinical areas
  - CMS must be able to calculate score for *at least one* measure to return points for the category
    - If unable to be scored, category weight shifts to Quality
  - Predicting score/performance for category extremely difficult

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MIPs Overview

- **MIPs reporting identified as burdensome from the beginning**
  - **2017 - 82%** of MGMA survey responders reported that MIPs was ‘very’ or ‘extremely’ burdensome
  - Common criticisms include:
    - Program too complex, difficult to keep up with
    - Quality reporting is not always representative of clinical practice
    - Completing annual reporting requirements increases administrative load and costs
    - Bonus payments awarded don’t offset the time/cost to report to program
  - In 2020, CMS introduced their solution….

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MIPS Value Pathways

The Future of MIPs

MVPs - Disclaimer

- Several policies related to MVPs are still in the process of finalization through rulemaking
  - 2022 Fee Schedule Rule pending final release later this year
  - Anticipate changes ahead of ‘go live’

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MVPs

- **Introduced in 2020 rulemaking, MIPs Value Pathways are a <u>new</u> reporting structure available starting 2023**
  - MVPs are a subset of measures and activities <u>specific</u> to a *disease* or *specialty*
    - MVPs approved through rulemaking
  - Goal of MVPs is to move away from ‘siloed’ reporting and streamline requirements for clinicians
    - MVPs require less data submission compared to ‘traditional MIPs’

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MVPs

Structure of Traditional MIPS	MIPS Value Pathways Framework	Future State of MIPS
• Many Choices • Not Meaningfully Aligned • Higher Reporting Burden	• Cohesive • Lower Reporting Burden • Focused Participation around Pathways that are Meaningful to Clinician's Practice/Specialty or Public Health Priority	• Simplified • Increased Voice of the Patient • Increased CMS Provided Data • Facilitates Movement to Alternative Payment Models (APMs)

Quality
6+ Measures

Promoting Interoperability
6+ Measures

Improvement Activities
2-4 Activities

Cost
1 or More Measures

Building Pathways Framework

MIPS Pathways

Clinicians report on fewer measures and activities based on specialty and/or outcome within a MIPS Value Pathway

Moving to Value

Implementation to begin in 2022

Quality **Improvement Activities** **Cost**

Foundation
Promoting Interoperability
Population Health Measures

Fully Implemented Pathways

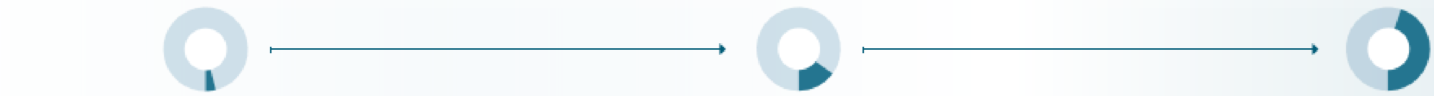
Continue to increase CMS provided data and feedback to reduce reporting burden on clinicians

Value

Cost
Quality and IA aligned

Foundation
Promoting Interoperability
Population Health Measures
Enhanced Performance Feedback
Patient-Reported Outcomes

Population Health Measures: *a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.*



Clinician/Group Reported Data   CMS Provided Data

Goal is for clinicians to report less burdensome data as MIPS evolves and for CMS to provide more data through administrative claims and enhanced performance feedback that is meaningful to clinicians and patients.

MVPs

- **How are MVPs different than ‘traditional’ MIPs?**

  - Measures/activities reported under MVP are ***defined***

    - Participants no longer select from *ALL* measures/activities available and choose from measures/activities within an MVP

  - Participants submit fewer Quality measures and Improvement Activities to fulfill category requirements

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MVPs

- **What are the first proposed MVPs available for reporting?**
  - Rheumatology
  - Stroke Care and Prevention
  - Heart Disease
  - Chronic Disease Management
  - Emergency Medicine
  - Lower Extremity Joint Repair
  - Anesthesia

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MVPs

- **MVP Reporting Structure**
  - **'Foundation Layer' for all MVPs includes:**
    - One Population Health Measure – selected by participant to be scored on, if possible
      - Currently, only two population health measures exist
    - Promoting Interoperability Category – full reporting required unless participants qualify for reweighting
  - **Quality**
    - Participants select **4 Quality measures** offered under the MVP
    - One must be an outcome or high priority measure
  - **Improvement Activities**
    - Participants select between reporting **1 high weighted OR 2 medium weighted** activities
  - **Cost**
    - Participants are calculated on Cost measures included in MVP, if possible

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Proposed Anesthesia MVP

Example MVP

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Proposed Anesthesia MVP

- **Foundational Layer**
  - **Population Health Measure Options:**
    - Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPs Eligible Clinician Groups
      - Looks at unplanned readmission rates for patients 65 or older
    - Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
      - Looks at acute, unplanned hospital admissions for Medicare patients 65 or older
    - These measures **do NOT** require data submission, CMS calculates score based on administrative claims data
  - **Promoting Interoperability:** full participation, unless exempt

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Proposed Anesthesia MVP

- **Quality**
  - **Select 4 from the following:**

Measure Options	Submission Methods
404: Anesthesiology Smoking Abstinence	**MIPs CQM**
424: Perioperative Temperature Management	**MIPs CQM**
430: Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy	**MIPs CQM**
463: Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics)	**MIPs CQM**
477: Multimodal Pain Management	**MIPs CQM**
AQI48: Patient-Reported Experience with Anesthesia	**QCDR**
AQI69: Intraoperative Antibiotic Redosing	**QCDR**
AQI70: Prevention of Arterial Line Infection	**QCDR**

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Proposed Anesthesia MVP

- **Improvement Activities**
  - **Select 1 High or 2 Medium from the following:**

Activity ID	Weight	Title
IA_PSPA_7	**Medium**	Use of QCDR data for ongoing practice assessment and improvements
IA_PSPA_20	**Medium**	Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes
IA_PSPA_16	**Medium**	Use of decision support and standardized treatment protocols
IA_PSPA_1	**Medium**	Participation in an AHRQ-listed patient safety organization.
IA_EPA_1	**High**	Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record
IA_CC_2	**Medium**	Implementation of improvements that contribute to more timely communication of test results
IA_CC_19	**High**	Tracking of clinician relationship to and responsibility for a patient by reporting MACRA patient relationship codes.
IA_CC_15	**Medium**	PSH Care Coordination
IA_BMH_2	**Medium**	Tobacco use
IA_BE_6	**High**	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
IA_BE_22	**Medium**	Improved Practices that Engage Patients Pre-Visit

Proposed Anesthesia MVP

- **Cost**
  - **MSBP – Medicare Spending Per Beneficiary**
    - Looks at the costs associated with clinician care for the period 3 days prior to the patient's hospital stay through 30 days after discharge.
      - Non-surgical patients are attributed to any clinician group rendering at least 30% of evaluation and management (E&M) services during inpatient stay and to any clinician who billed at least one evaluation and management (E&M) services within the group
      - Surgical patients are attributed to the clinician and clinician group rendering any main procedure determined to be clinically relevant to the inpatient stay
    - Selected by MVP Steward due to applicability to a small subset of Anesthesiologists and no other episode-based cost measures applicable for specialty
    - Category is reweighted if CMS can not calculate a score

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MVP Reporting

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MVP Reporting

- **MVPs can be submitted at the following levels:**
  - **Individual Clinician**
  - **Single Specialty Group**
  - **Multi-Specialty Group***
  - ***Sub-Groups***
    - Submission level unique to MVPs – a subset of NPIs under a TIN or a "group within a group"
  - **APM Entity**

*Beginning 2025, Multi-Specialty Groups would be required to submit MVPs as sub-groups

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MVP Reporting

- **Participants must register to report an MVP**
  - Between April 1st and November 30th of a performance year
    - Groups, sub-groups, and APM Entities that select CAHPS for MIPS surveys as part of their MVP will need to register by June 30th
  - **Participants select:**
    - Which MVP they intend to report
    - Which population health measure to be scored on
    - If available under an MVP, an administrative claims-based outcome measure for the Quality category
      - Unclear if participants must define other Quality Measures or Improvement Activities during registration
  - If sub-group reporting, participants must define which NPIs are included and name the sub-group

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MVP Reporting

- **MVP Scoring aligned with 'Traditional MIPs'**
  - Category weights stay the same
    - **2023:**
      - **Quality: 30%**
      - **Cost: 30%**
      - **Promoting Interoperability: 25%**
      - **Improvement Activities: 15%**
  - MVPs will follow same reweighting policies
    - Cost and Promoting Interoperability shift to Quality if not scored
  - Category specific scoring rules still apply

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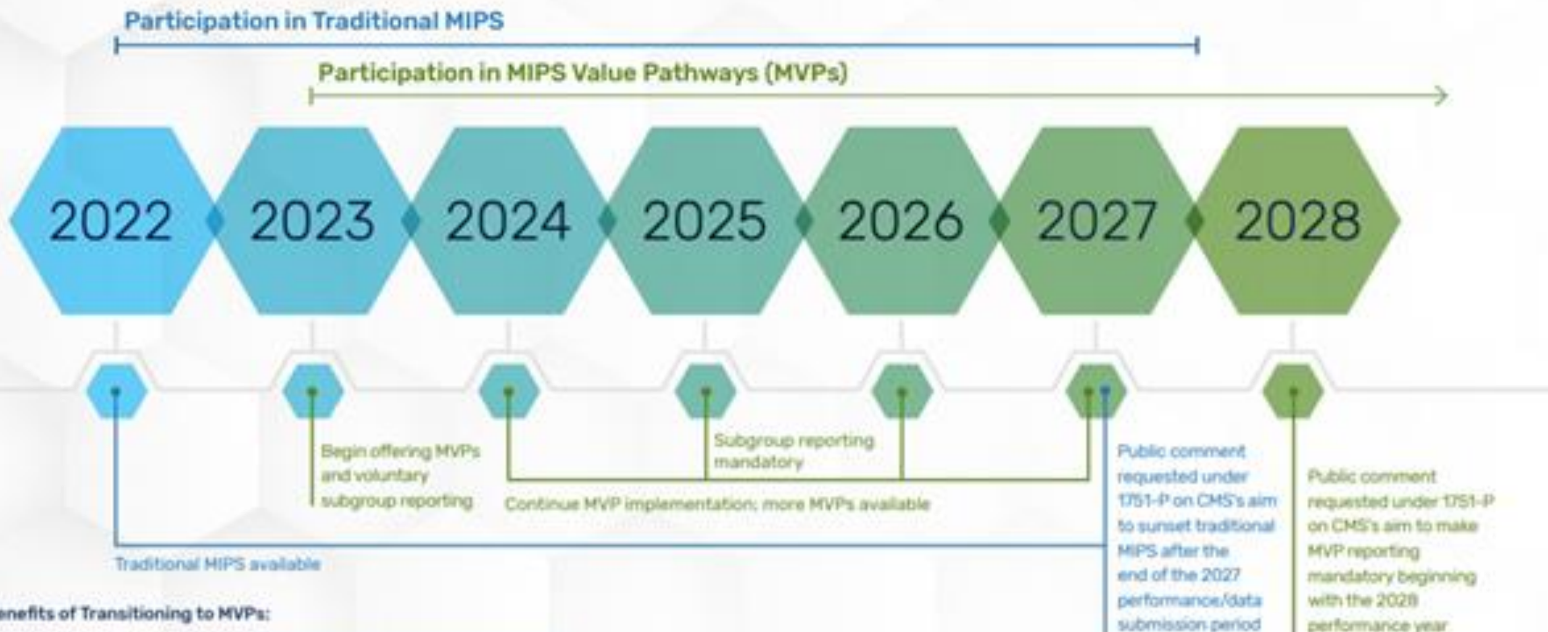
MVPs - Transition



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MVPs - Reminders

- **Still many ‘unknowns’ but more information expected within next rulemaking cycle**
  - Now is a good time to start considering if MVPs are a good option and start gathering info/questions to make decision

- **MVPs will continue to evolve**
  - More MVPs introduced through annual rulemaking
  - Continued focus on population health measures and measures that can overlap performance categories
  - Shift to digital measures and reduced data submission

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Questions

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