MIPS Value Pathways(MVPs)
An Overview

May 19th, 2022
2:00 PM EST

ADVOCATE
REVENUE CYCLE MANAGEMENT

Agenda

- **Traditional MIPS Recap**
  - Program Overview
  - Performance Category Objectives
- **MIPs Value Pathways**
  - Differences between MVPs and Traditional MIPs
  - MVP Reporting Structure
- **Anesthesia MVP – example**
- **Transitioning to MVPs**
- **Submitted Questions**

ADVOCATE
REVENUE CYCLE MANAGEMENT

Traditional MIPs Recap

ADVOCATE
REVENUE CYCLE MANAGEMENT

MIPs Recap

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

ADVOCATE
REVENUE CYCLE MANAGEMENT

MIPs Recap

- 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

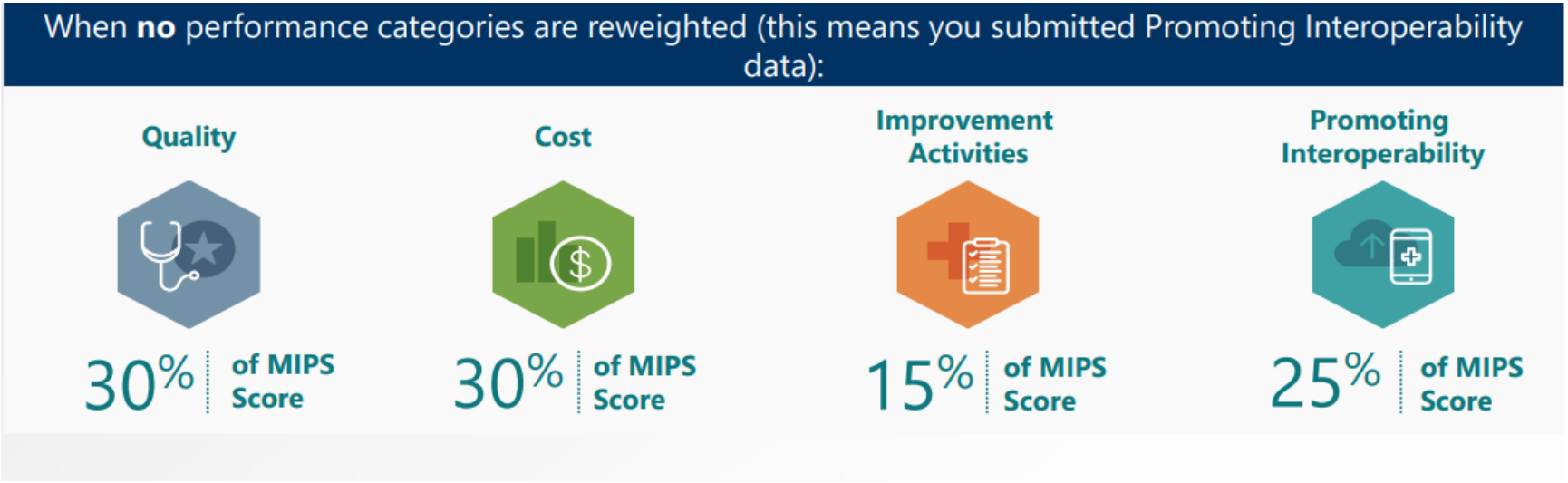
- Providers with sufficient participation within Advanced APMs are exempt from MIPs

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

ADVOCATE
REVENUE CYCLE MANAGEMENT

MIPs Recap

- Final MIPs score is a combination of four performance categories



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

ADVOCATE
REVENUE CYCLE MANAGEMENT

MIPs Recap

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

2022 MIPs Thresholds	2023 MIPs Potential Thresholds
Penalty: 75 points **Exceptional Performer:** 89 points **Maximum Payment Adjustment**: +/- 9%	**Penalty: 85** points **Exceptional Performer:** N/A **Maximum Payment Adjustment:** +/- 9%

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

- 2020 payment adjustments apply to 2022 Medicare claims

ADVOCATE
REVENUE CYCLE MANAGEMENT

MIPs Recap

- **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

ADVOCATE
REVENUE CYCLE MANAGEMENT

MIPs Recap

- **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

ADVOCATE
REVENUE CYCLE MANAGEMENT

MIPs Recap

- **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

ADVOCATE
REVENUE CYCLE MANAGEMENT

MIPs Recap

- **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

ADVOCATE
REVENUE CYCLE MANAGEMENT

MIPs Recap

- **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….

ADVOCATE
REVENUE CYCLE MANAGEMENT

MIPS Value Pathways

The Future of MIPs

ADVOCATE
REVENUE CYCLE MANAGEMENT

MVPs - Disclaimer

- **Several policies related to MVPs are still in the process of finalization through rulemaking**
  - **2023 Fee Schedule Rule pending proposed rule**
  - **Anticipate changes ahead of ‘go live’**

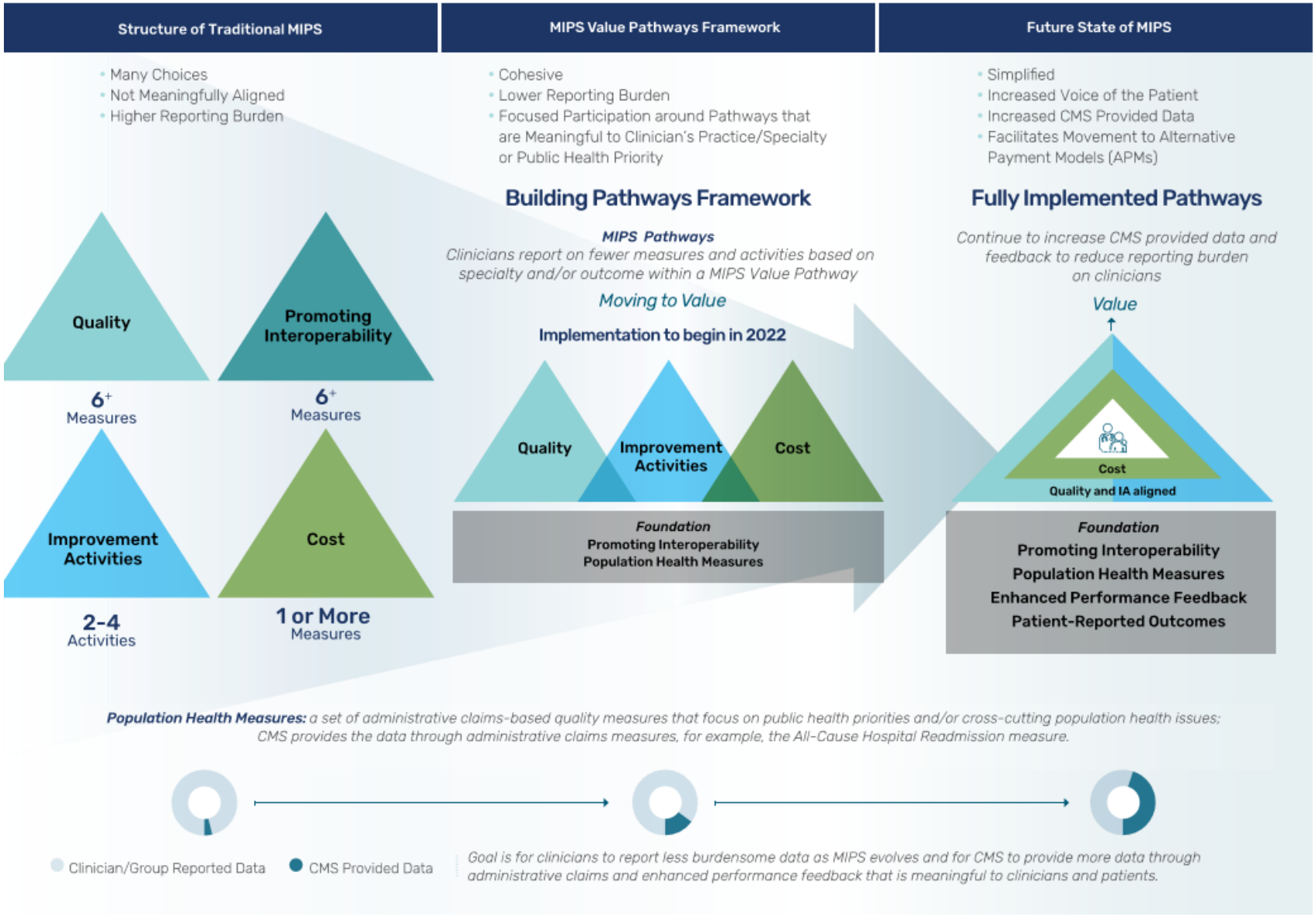
ADVOCATE
REVENUE CYCLE MANAGEMENT

MVPs

- **Introduced in 2020 rulemaking, MIPs Value Pathways are a new reporting structure available starting 2023**
  - MVPs are a subset of measures and activities specific to a *disease* or *specialty*
    - MVPs approved through annual 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’

ADVOCATE
REVENUE CYCLE MANAGEMENT

MVPs


Structure of Traditional MIPS
Many Choices
Not Meaningfully Aligned
Higher Reporting Burden
Quality
6+ Measures
Promoting Interoperability
6+ Measures
Improvement Activities
2-4 Activities
Cost
1 or More Measures
MIPS Value Pathways Framework
Cohesive
Lower Reporting Burden
Focused Participation around Pathways that are Meaningful to Clinician's Practice/Specialty or Public Health Priority
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
Future State of MIPS
Simplified
Increased Voice of the Patient
Increased CMS Provided Data
Facilitates Movement to Alternative Payment Models (APMs)
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.

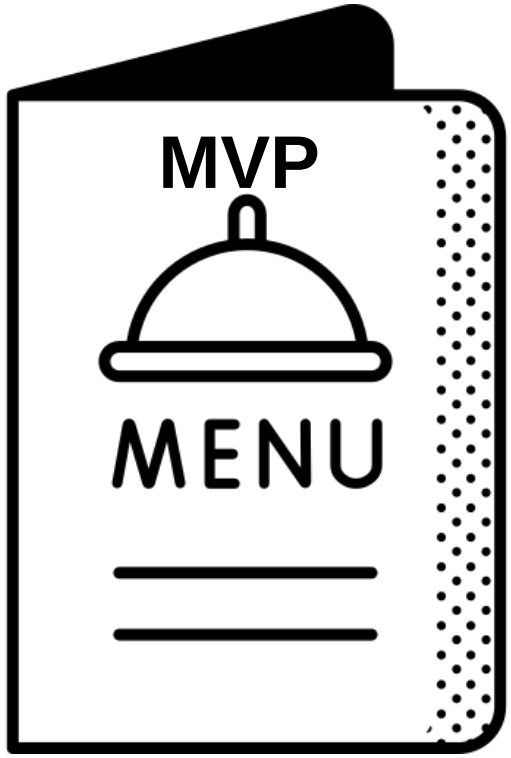
MVPs

- **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 the MVP
  - Participants are required to register to report an MVP during a performance year
    - *April 1st – November 30th of a performance year*
  - Data collection automated where possible
  - Sub-group/Multi-specialty reporting

ADVOCATE
REVENUE CYCLE MANAGEMENT

MVPs

VS



ADVOCATE
REVENUE CYCLE MANAGEMENT

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

ADVOCATE
REVENUE CYCLE MANAGEMENT

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
      - Small practices can continue to submit via Medicare part B Claims within 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

ADVOCATE
REVENUE CYCLE MANAGEMENT

MVPs

- **MVP Scoring**
  - Scoring logic for MVPs will follow the same policies as traditional MIPs
  - No special MVP scoring features at this time

  - **Quality**
    - Case minimums/data-completeness thresholds same as MIPs
    - Quality measures will use same benchmarks as MIPs
    - Can report more than required measures and QPP will take highest scoring

  - **Category Reweighting**
    - Same principles still apply for participants exempt from Promoting Interoperability or not scored on Cost

ADVOCATE
REVENUE CYCLE MANAGEMENT

MVPs

- **Sub-Group Reporting**
  - Targeted towards Multi-specialty groups to promote reporting which reflects all services
    - Will eventually be mandatory
  - Clinicians under one TIN can form smaller groupings of NPIs for reporting purposes
  - Sub-groups are defined when registering for MVP
    - Sub-group is named/given an ID at that time
  - Any group level special statuses are applied to Sub-groups

ADVOCATE
REVENUE CYCLE MANAGEMENT

Anesthesia MVP

Example

ADVOCATE
REVENUE CYCLE MANAGEMENT

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

ADVOCATE
REVENUE CYCLE MANAGEMENT

Anesthesia MVP

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

Measure Options
404: Anesthesiology Smoking Abstinence
424: Perioperative Temperature Management ***(outcome measure)***
430: Prevention of Post-Operative Nausea and Vomiting (PONV) – Combination Therapy
463: Prevention of Post-Operative Vomiting (POV) – Combination Therapy (Pediatrics)
477: Multimodal Pain Management:
AQI48: Patient-Reported Experience with Anesthesia*
AQI69: Intraoperative Antibiotic Redosing*

***QCDR Measure**

ADVOCATE
REVENUE CYCLE MANAGEMENT

Anesthesia MVP

- **Improvement Activities**
  - **Select 1 High or 2 Medium Weighted Activities:**

ID #	Activity title	Activity Weighting
IA_BE_6	Regularly Assess Patient Experience of Care and Follow Up on Findings	High
IA_BE_22	Improved practices that engage patients pre-visit	Medium
IA_BMH_2	Tobacco use	Medium
IA_CC_2	Implementation of improvements that contribute to more timely communication of test results	Medium
IA_CC_15	PSH Care Coordination	High
IA_CC_19	Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes	High
IA_EPA_1	Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record	High
IA_PSPA_1	Participation in an AHRQ-listed patient safety organization	Medium
IA_PSPA_7	Use of QCDR data for ongoing practice assessment and improvements	Medium
IA_PSPA_16	Use of decision support and standardized treatment protocols	Medium
IA_PSPA_20	Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes	Medium

Anesthesia MVP

- **Cost**
  - **Does not require data submission, QPP calculates score**
  - **If category is not scored, points are reweighted**
    - **Anesthesia MVP Cost Measure:**

MSPB_1 - Medicare Spending Per Beneficiary (MSPB) Clinician
The MSPB Clinician measure assesses the cost to Medicare of services provided to a patient during an MSPB Clinician episode (hereafter referred to as the “episode”), which comprises the period immediately prior to, during, and following the patient’s hospital stay. An episode includes Medicare Part A and Part B claims with a start date between 3 days prior to a hospital admission (also known as the “index admission” for the episode) through 30 days after hospital discharge, excluding a defined list of services that are unlikely to be influenced by the clinician’s care decisions and are, thus, considered unrelated to the index admission. In all supplemental documentation, the term “cost” generally means the standardized Medicare allowed amount.

ADVOCATE
REVENUE CYCLE MANAGEMENT

Transitioning to MVPs

MVPs - Transition

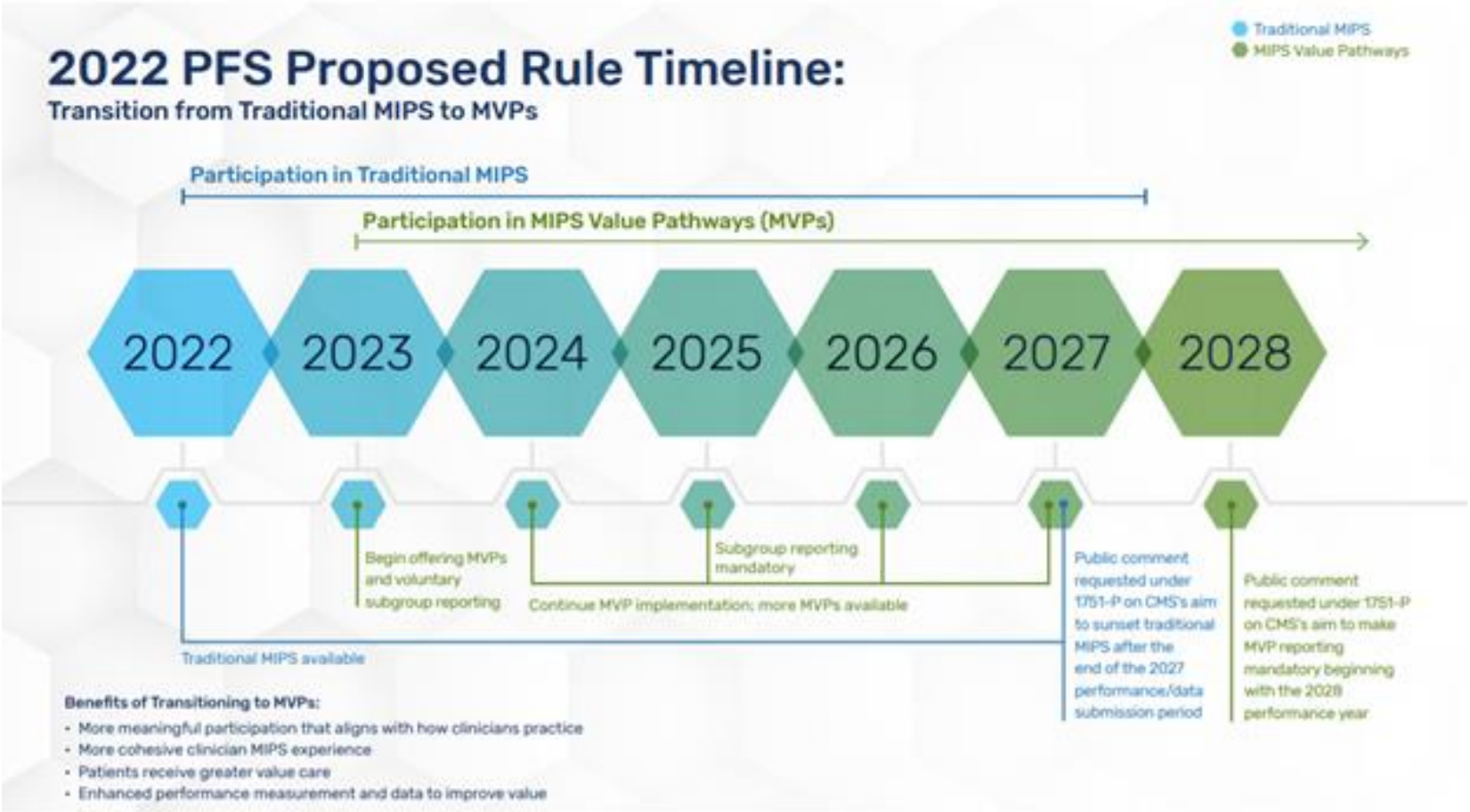
- **MVP reporting begins as voluntary**
  - Consider adopting prior to MVPs being mandatory

- **MVPs and Traditional MIPs will be available in tandem at first**
  - Participants can report both ways and QPP will take the higher of the two scores

- **Review current MVPs for potential adoption**
  - **MVP Toolkits available on** - https://qpp.cms.gov/resources/resource-library
  - Consider submission options for Quality measures
  - More MVPs anticipated to be proposed in this year's rulemaking

ADVOCATE
REVENUE CYCLE MANAGEMENT

MVPs - Transition



ADVOCATE
REVENUE CYCLE MANAGEMENT

Submitted Questions

ADVOCATE
REVENUE CYCLE MANAGEMENT

Thanks!

Kayley Jaquet | Manager of Regulatory Affairs

ADVOCATE Radiology Billing
5475 Rings Rd | Dublin, OH 43017
Kayley.jaquet@advocatercm.com | www.advocatercm.com

ADVOCATE
REVENUE CYCLE MANAGEMENT