MIPS Value Pathways (MVPs) 2023 Overview

April 27th, 2023
2:00 PM EST

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Agenda

- **Traditional MIPS Recap**
  - Program Overview
- **Why has MIPs become so challenging?**
- **MIPs Value Pathways**
  - Differences between MVPs and Traditional MIPs
  - MVP Reporting Structure
  - Example MVP
- **Transitioning to MVPs**
- **Submitted Questions**

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Traditional MIPs Recap

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MIPs Recap

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

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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**

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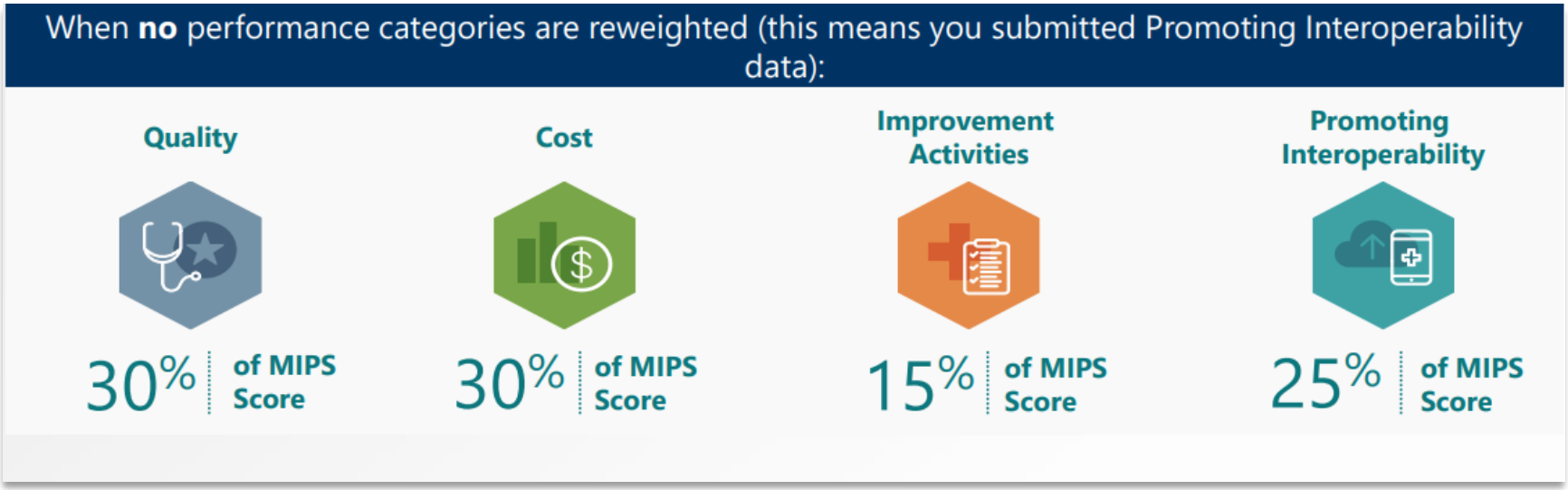
MIPs Recap

- Final MIPs score is a combination of **four performance** categories
  - **<u>Quality Category</u> is KEY for Specialties**



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

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MIPs Recap

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

Each performance year has a ‘penalty’ threshold of overall points necessary to avoid a **negative** payment adjustment

- MIPs is **budget neutral** – **positive payments** depend on how many penalties are collected

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

- 2023 scores result in payment adjustments onto 2025 Medicare claims

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MIPs Recap

Performance Year	Payment Year	Max Payment Adjustments	Performance Threshold	Exceptional Performance Threshold	+ Bonus Payment Adjustments
2023	2025	(+/ -) 9%	**75 pts**	N/A	8+%**
2022	2024	(+/ -) 9%	75 pts	89 pts	8+%**
2021	2023	(+/ -) 9%	60 pts	85 pts	**2.33%**
2020	2022	(+/ -) 9%	45 pts	85 pts	**1.88%**
2019	2021	(+/ -) 7%	30 pts	75 pts	**1.79%**
2018	2020	(+/ -) 5%	15 pts	70 pts	**1.68%**
2017	2019	(+/ -) 4%	3 pts	70 pts	**1.88%**

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Why has MIPs become so challenging?

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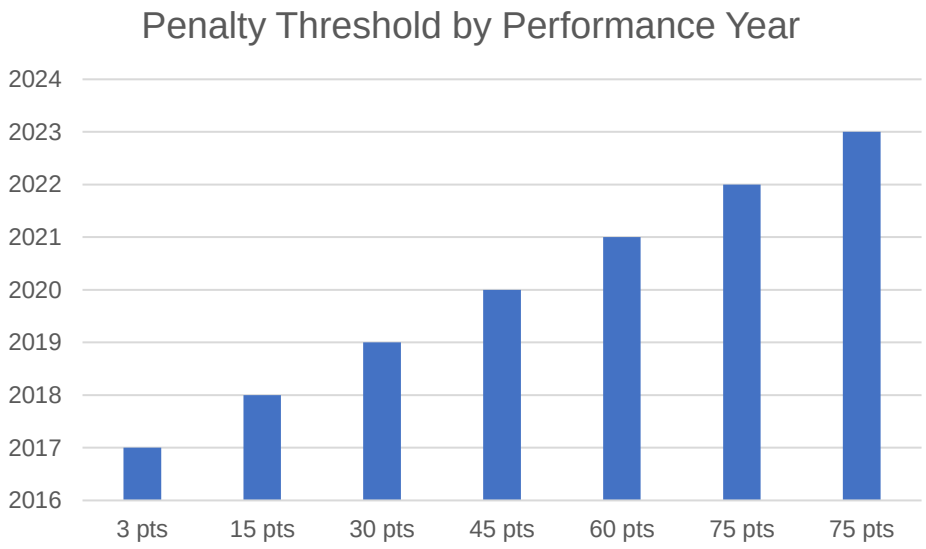
Why is MIPS challenging?

Penalty threshold has steadily increased year to year



And fewer ways to earn the points needed to succeed…

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Why is MIPS challenging?

- **Quality Performance Category**
  - Biggest **driver** of overall score for specialties/practices not commonly scored on **COST**
    - Providers have the most **control** over the outcome of this category
  - Participants must report on minimum of **6 quality measures**
  - **Quality measure inventory updated annually**
    - Measures **added/removed/changed**
    - **Benchmarks** used for scoring ***change*** based off data from prior years

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Why is MIPS challenging?

- **Quality Performance Category**
  - *Topped Out Measures*
    - QPP will designate a measure as being ‘topped out’ when there is no significant difference between top and bottom performers
    - Topped out measures required 100% performance to earn maximum points for a measure (10 points), **performance rates below 100% will lose significant amount of points**
  - *Point-Capped Measures*
    - After a measure becomes ‘topped out’, QPP applies a point reduction for future years of reporting
    - **Measure goes from earning 10 points to maximum of 7 points**

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Why is MIPS challenging?

- **Quality Performance Category**
  - *Measure Specific Bonus Points Removed*
    - Until PY 2022, participants received **additional points** for reporting *extra* **High Priority** or **Outcome** type measures and **‘end to end’** reporting for eCQM submissions
      - Maximum of **up to 6 points** added to Quality score
  - *3-point Floor Removed for Larger Practices*
    - Until PY 2023, all participants qualified for a **minimum of 3 points per measure** assuming case-minimums and data completeness are met
    - Groups of 16+ now earn 1 or 2 points for low performing measures

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Why is MIPS challenging?

Measure ID	Measure Title	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out	Seven Point Cap
145	Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy	--	--	--	--	--	--	--	--	--	--	--	--
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	33.94 - 96.10	96.11 - 99.87	99.88 - 99.99	--	--	--	--	--	--	100.00	Yes	Yes
360	Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies	5.01 - 56.09	56.10 - 98.47	98.48 - 99.84	99.85 - 99.99	--	--	--	--	--	100.00	Yes	Yes
364	Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines	13.27 - 45.33	45.34 - 68.34	68.35 - 92.10	92.11 - 99.99	--	--	--	--	--	100.00	Yes	Yes
405	Appropriate Follow-up Imaging for Incidental Abdominal Lesions	0.51 - 3.82	3.83 - 14.49	14.50 - 49.99	50.00 - 87.22	87.23 - 99.48	99.49 - 99.99	--	--	--	100.00	Yes	Yes
406	Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients	50.00 - 13.05	13.04 - 6.07	6.06 - 2.44	2.43 - 0.01	--	--	--	--	--	0.00	Yes	Yes
436	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	20.53 - 98.95	98.96 - 99.86	99.87 - 99.98	99.99 - 99.99	--	--	--	--	--	100.00	Yes	Yes

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Why is MIPS challenging?

- **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

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MIPS Value Pathways

The Future of MIPs

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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’

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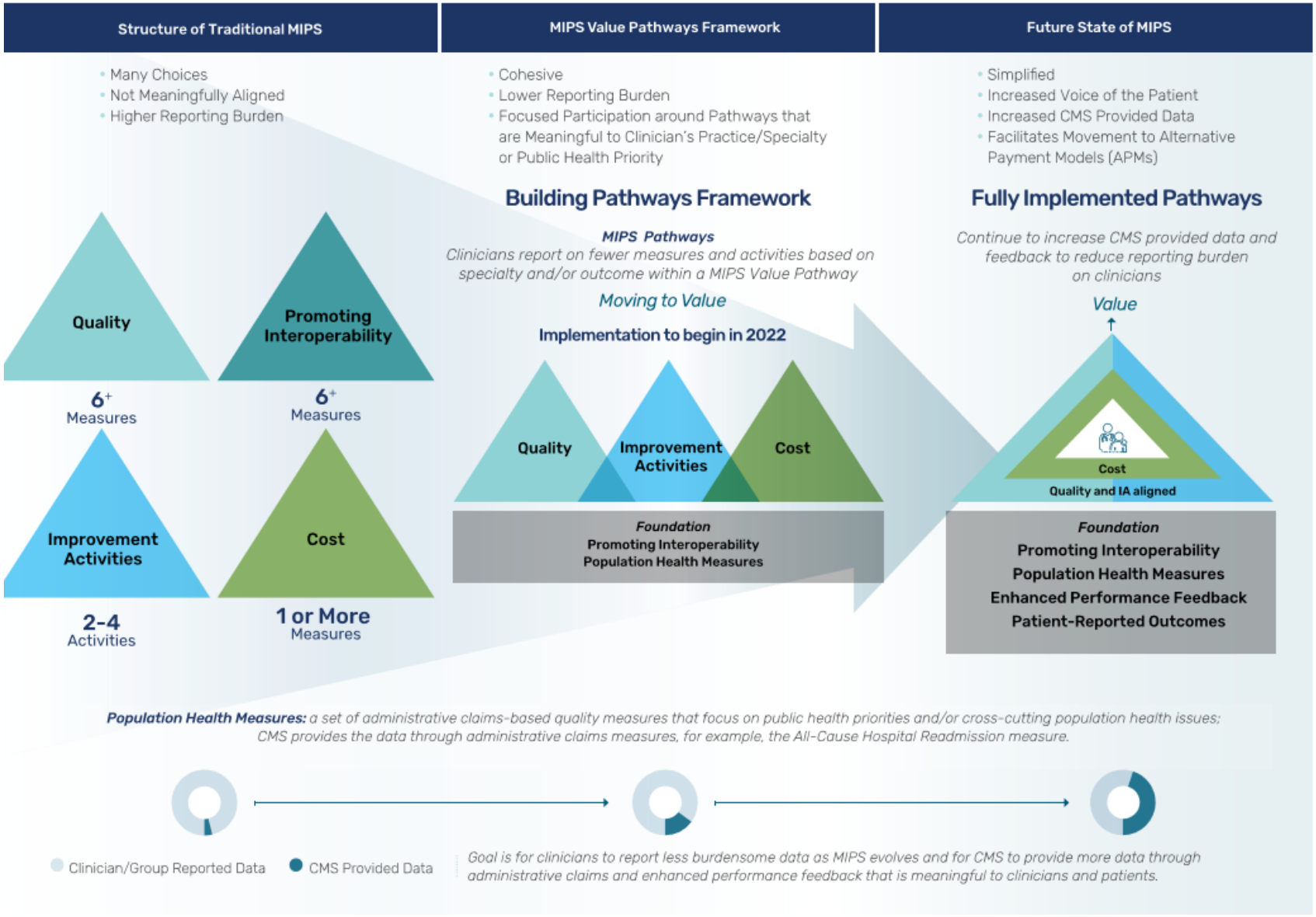
MVPs


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

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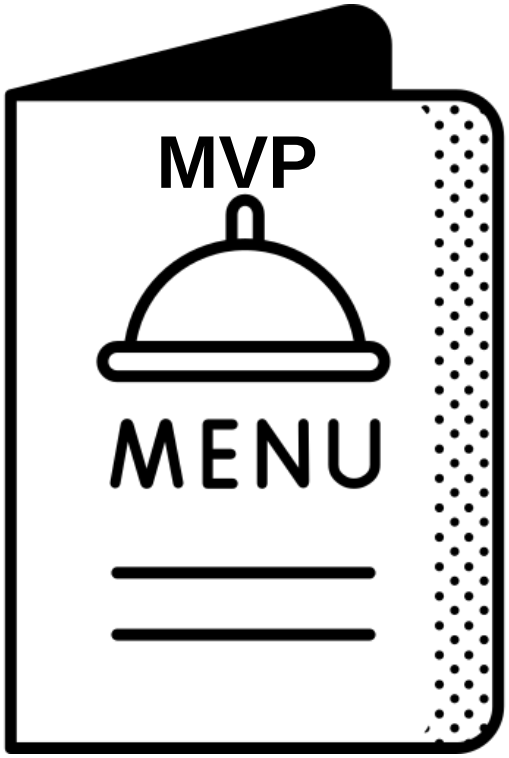
MVPs

VS



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MVPs

- **MVP Reporting Structure**
  - **'Foundation Layer' for <u>all</u> MVPs includes:**
  - Choice of **<u>One</u>** Population Health Measure
    - **479: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Systems (MIPS) Eligible Clinician <u>Groups</u>**
      - Readmission rate for beneficiaries age 65 or older who were hospitalized and experienced an unplanned readmission for any cause to a short-stay acute-care hospital within 30 days of discharge
    - **484: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions**
      - Unplanned hospital admissions among Medicare Fee-for-Service (FFS) patients aged 65 years and older with multiple chronic conditions
  - **Promoting Interoperability Category** – full reporting required unless participants qualify for reweighting

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MVPs

- **MVP Reporting Structure**
  - **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

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MVPs

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

  - **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

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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

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MVPs

- **What are the first MVPs available for reporting?**

  - Rheumatology
  - Stroke Care and Prevention
  - Heart Disease
  - Chronic Disease Management
  - Emergency Medicine
  - Lower Extremity Joint Repair
  - Anesthesia
  - Advancing Cancer Care
  - Optimal Care for Kidney Health
  - Optimal Care for Patients with Episodic Neurological Conditions
  - Supportive Care for Neurodegenerative Conditions
  - Promoting Wellness

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MVPs

- **MVPs candidates for 2024:**

  - Quality Care in Mental Health and Substance Use Disorder
  - Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
  - Musculoskeletal Care and Rehabilitative Support
  - Quality Care for Otolaryngology
  - Focusing on Women's Health

**Would be proposed for program in MPFS rulemaking

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Example MVP

Quality, Improvement Activity, and Cost Measures

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Example MVP – Promoting Wellness

QUALITY MEASURES – PICK 4
39: Screening for Osteoporosis for Women Aged 65-85 Years of Age
112: Breast Cancer Screening
113: Colorectal Cancer Screening
128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan
226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
309: Cervical Cancer Screening
310: Chlamydia Screening for Women
321: CAHPS for MIPS Clinician/Group Survey (Collection Type: CAHPS Survey Vendor)
400: One-Time Screening for Hepatitis C Virus (HCV) for all Patients
431: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
475: HIV Screening
483: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)
493: Adult Immunization Status

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Example MVP – Promoting Wellness

Improvement Activities – Pick 1 High or 2 Medium
IA_AHE_3: Promote Use of Patient-Reported Outcome Tools (High)
IA_BE_4: Engagement of Patients through Implementation of Improvements in Patient Portal (Medium)
IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings (High)
IA_BE_12: Use Evidence-Based Decision Aids to Support Shared Decision-Making (Medium)
IA_BMH_9: Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Abuse and Ambulatory Care Patients (Medium)
IA_CC_2: Implementation of Improvements that Contribute to More Timely Communication of Test Results (Medium)
IA_CC_13: Practice Improvements for Bilateral Exchange of Patient Information (Medium)
IA_CC_14: Practice Improvements that Engage Community Resources to Support Patient Health Goals (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_PCMH: Electronic Submission of Patient Centered Medical Home Accreditation
IA_PM_11: Regular Review Practices in Place on Targeted Patient Population Needs (Medium)
IA_PM_13: Chronic Care and Preventative Care Management for Empaneled Patients (Medium)
IA_PM_16: Implementation of Medication Management Practice Improvements (Medium)
IA_PSPA_19: Implementation of Formal Quality Improvement Methods, Practice Changes, or Other Practice Improvement Processes (Medium)

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Example MVP – Promoting Wellness

COST
Total Per Capita Cost (TPCC)
The TPCC measures the overall cost of care delivered to a patient with a focus on the primary care they receive from their provider(s). The measure is a payment-standardized, risk-adjusted, and specialty-adjusted measure

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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 method** and options for Quality measures

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MVPs - Transition

- **How will my score differ if reporting an MVP vs Traditional MIPS?**
  - **Depends! Similar to the current state of the program, there are numerous variables that impact reporting**
    - Score variance comes from the ability to exclude 2 Quality measures from score
  - **Big appeal of MVP reporting is reporting less data**
    - **Specialties or Smaller practices already benefit from similar policies with 'traditional MIPS'**
  - **MVPs have potential to score ~5 points higher (depending on Quality)**

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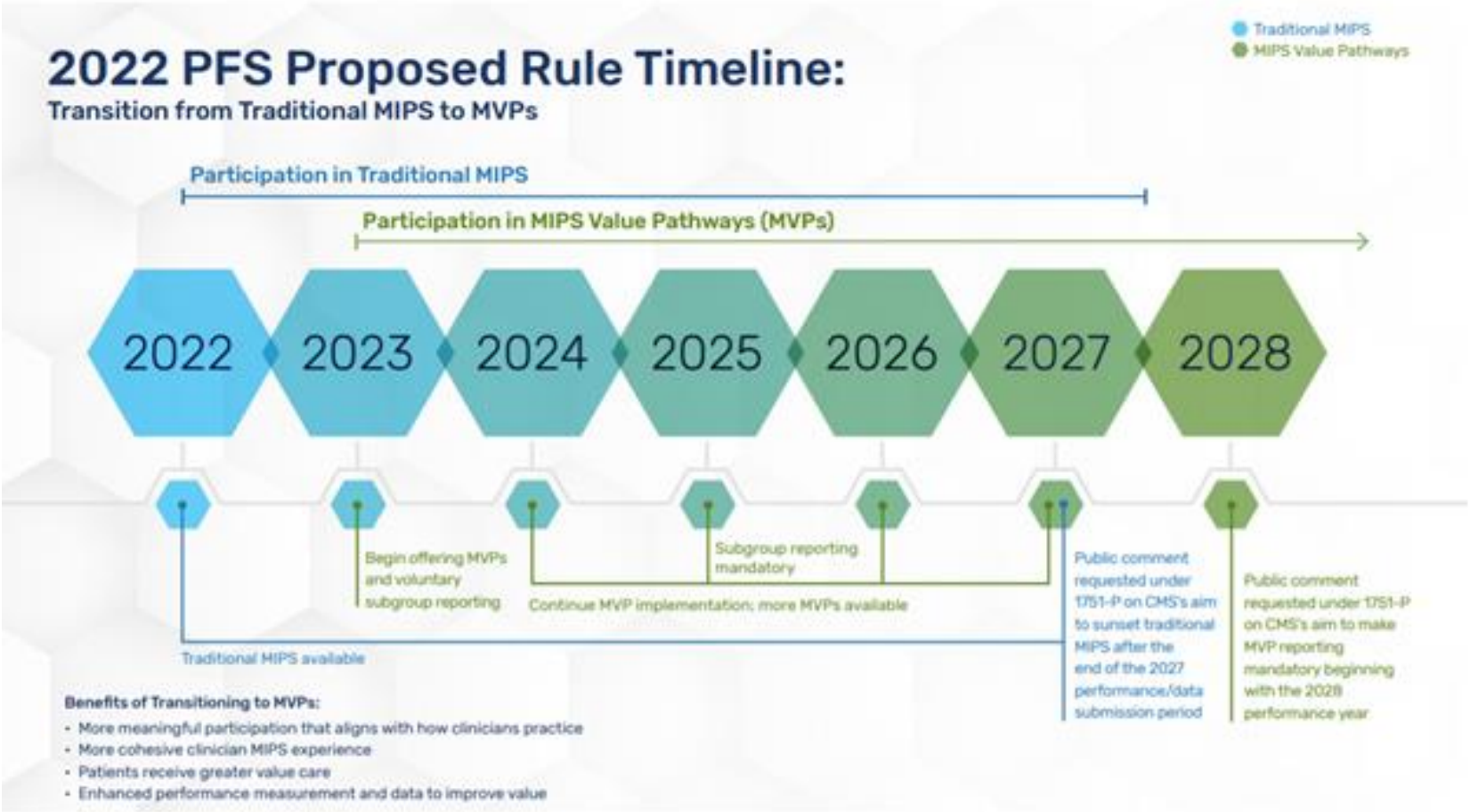
MVPs - Transition



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Submitted Questions

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Thanks!

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