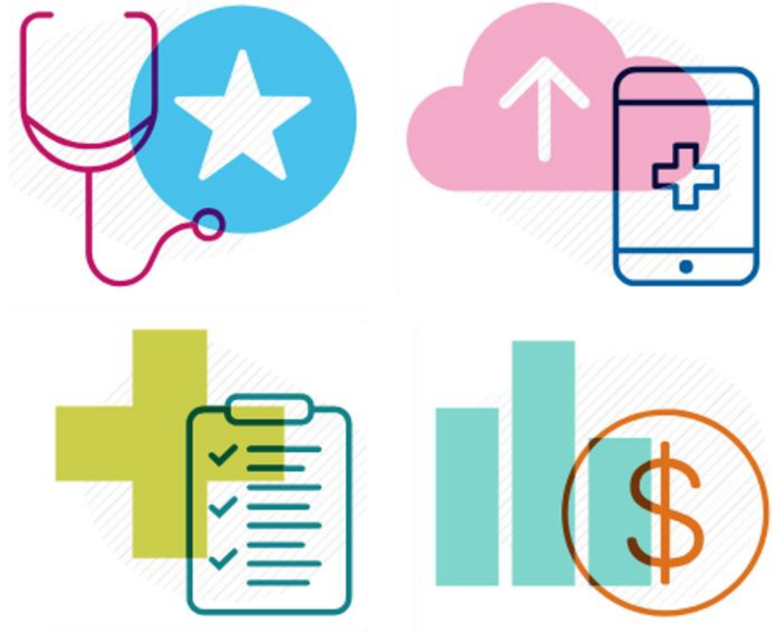
Alternatives to Traditional MIPS

11/7/2023

2:00 PM

Agenda



- MIPs Recap
  - Why is MIPs so challenging?
- MIPS Value Pathways
- Advanced Alternative Payment Models
- Alternatives to national MIPs quality measures

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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**

MIPs Recap

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

When **no** performance categories are reweighted (this means you submitted Promoting Interoperability data):

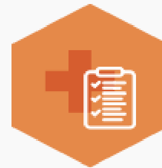
Quality

30% of MIPS Score

Cost

30% of MIPS Score

Improvement Activities



15% of MIPS Score

Promoting Interoperability

25% of MIPS Score

- 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
2024	2026	(+/ -) 9%	**75 pts**	N/A	8+%**
2023	2025	(+/ -) 9%	**75 pts**	N/A	8+%**
2022	2024	(+/ -) 9%	75 pts	89 pts	**+8.25%**
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?

- **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 **<u>'end to end'</u>** reporting for eCQM submissions
      - Maximum of **up to 6 points** added to Quality score
  - *3-point Floor Removed for <u>Larger</u> 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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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	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)

Structure of Traditional MIPS

- 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.*

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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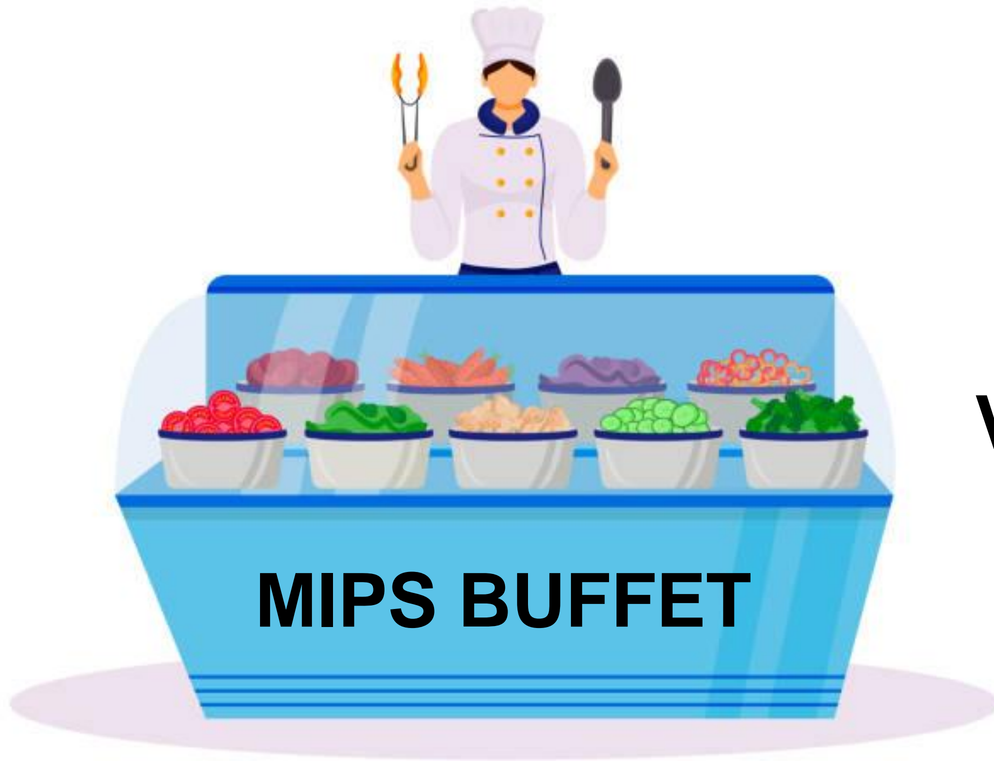
MVPs



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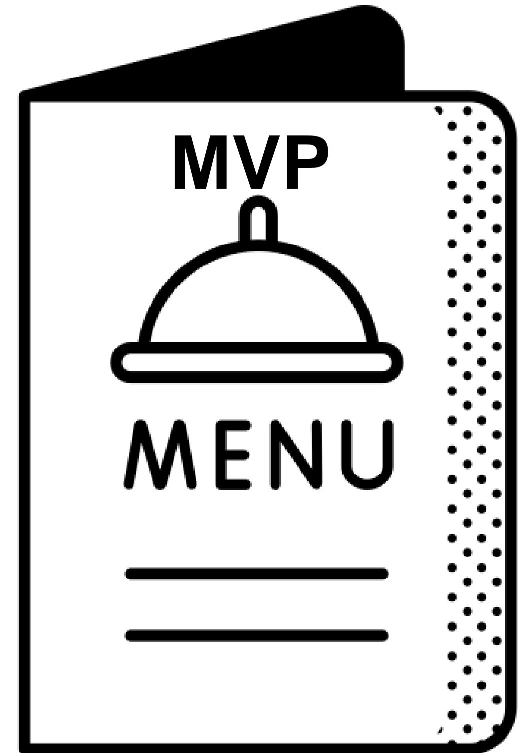

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MVPs

- **How are MVPs different than 'traditional' MIPs?**
  - **CMS will attempt to score 'population health' measures based on administrative claims data:**
    - 479: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Systems (MIPS) Eligible Clinician Groups
    - 484: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
  - **Less data required to fulfill Quality and Improvement Activity categories**
    - Participants select **4** Quality measures offered under the MVP
    - Participants select between reporting 1 high weighted OR 2 medium weighted activities

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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 - Summary

- Biggest ‘draw’ of MVPs comes down to being able to **submit less data overall** and still be eligible for bonus adjustments

- **Scoring challenges** of the program are generally NOT solved by MVPs
  - Quality measure status (topped out/point caps) still the biggest factor in ability to score well with MIPS
  - Since MVPs use same scoring policies, you will still face the same/similar challenges as traditional MIPs…*just dealing with a little bit less…*

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Advanced Alternative Payment Models

The other side of the QPP…

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Advanced APMS

An ***Alternative Payment Model*** (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care.

- APMs can apply to a specific clinical condition, a care episode, or a population
- Basically…something DIFFERENT than a ***fee for service payment arrangement***

An **ADVANCED APM** involves both **QUALITY** reporting requirements ***and*** some type of **financial risk**

- Not all APMS qualify as being 'advanced' for the purposes of the QPP

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Advanced APMS

What if an APM isn’t advanced?

- ***Providers in regular APMS are still required to report to MIPS, but interact with the program a little differently***
  - *Partial credit given for improvement activity category*
  - *Different final score weighting*
  - *APM Entity typically executes an aggregated submission of data which fulfills requirements for reporting*
  - *Providers can also submit ‘outside’ of the APM and be scored on traditional MIPS*

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Advanced APMS

Participants who are part of an Advanced APM are **exempt** from *MIPS reporting* as long as **'sufficient participation'** is reached

- ***This is called reaching the QP (Qualifying Participant) status***
  - ***FULL QP STATUS Threshold:***
    - *At least* ***50% of Medicare part B payments OR 35% of Medicare patients*** *go through the Advanced APM entity during the QP performance period* (January 1 - August 31)
    - Exempts participants from MIPS, 2023 and prior received the AAPM Incentive payment (lump sum amount)
      - ***Shifting to an increase to MPFS conversation factor for 2024***
  - ***PARTIAL QP STATUS Threshold:***
    - *At least* ***40% of Medicare part B payments OR 25% of Medicare patients*** *go through the Advanced APM entity during the QP performance period*
    - *Exempt from MIPS but no incentive payment, participants can still OPT in to MIPS reporting and be eligible that way*

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Advanced APMS - Summary

- **Consider <u>all</u> aspects of joining an APM and impact on practice**
  - Being exempt from MIPs should not be primary reason as the nature of APMs adjusts the ‘normal’ revenue cycle
  - Review contract thoroughly for requirements of the practice (KPIs, etc) and duration (some APMs have expiration dates)

- **QP/Partial QP Status is made available in OCTOBER on QPP website**
  - Providers will show eligibility under traditional MIPS until then

- See CMS Innovation Center for more information on Medicare specific APMS and enrollment

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Alternatives to national MIPS measures

Other ways to make traditional MIPs ‘easier’…

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Alternatives to *national* measures

- As we know, the **QUALITY category** is the biggest driver of the overall score for specialties
  - **Participants control the outcome, unlike COST**

- The **QUALITY category** includes *several different types* of MIPs measures that can be used to earn points towards the category score
    - **Medicare part B Claims**
    - **MIPS CQM (Registry)**
    - **eCQM (electronic quality measure)**
    - **QCDR (qualified clinical data registry) Measure**

- **Medicare part B and MIPS CQM measure types are considered 'nationally' available measures**

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Alternatives to *national* measures

- **What are MIPs eCQMs?**

  - **Electronic clinical quality measures (eCQMs)** use data electronically extracted from electronic health records (EHRs) and/or health information technology systems to measure the quality of healthcare provided.

  - eCQM submissions must be produced with end-to-end certified software
    - "End-to-end" means that once the data is collected from a patient, it's documented in an EHR, then calculated and aggregated through an automated process. **There can be no manual chart abstraction or correction of data or scores in the process.**

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Alternatives to *national* measures

- **What are QCDR measures?**

  - **<u>Qualified Clinical Data Registry</u>** (QCDR) measures are developed by a special designation of vendor approved for data submission to the MIPS program.

  - QCDR measures are *<u>only allowed</u>* to be reported by a **QCDR vendor**
    - Either by licensing from one QCDR to another or by developing their own measures approved thru rulemaking

  - QCDR measures are typically geared towards specialties and have better correlation with clinical practices

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Alternatives to *national* measures

- **What's the advantage of using eCQMS or QCDR measures?**
  - **BENCHMARKS!** – eCQMs and QCDR measures are benchmarked separately from national measures and 'easier' to earn points for Quality
    - Less utilization of these types of measures earlier in the program has resulted in these measure types being **FAR** less likely to be ***topped out or point-capped***
  - **MORE OPTIONS!** – both eCQMs and QCDR measures can be reported in addition to national measures, meaning more flexibility in scoring options

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Alternatives to *national* measures – Summary

- *eCQMs* are more appropriate for practices performing face-to-face patient visits
  - *Less measures out there for specialties*

- *QCDR* measures are better aligned for specialty areas of medicine or disease – better option for non-patient facing provider types

- COST to report a consideration for both options as you need a special vendor type to submit data

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Summary

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Summary

- *Traditional MIPS* reporting increasingly difficult to achieve scores above penalty threshold
  - National measures generally topped out and point capped
- *Other options exist to either become MIPS exempt or provide alternative to traditional MIPS reporting*
  - *APM participation*
  - *QCDR/eCQM Measures*
  - *MVPs*
- Many considerations to find solution best for practice

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Thanks!

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