UNDERSTANDING MIPS VALUE PATHWAYS (MVPs)

The Merit-based Incentive Payment System (MIPS) is one track of the Centers for Medicare & Medicaid Services (CMS) Quality Payment Program (QPP) that moved clinicians toward value-based payment gradually by retaining a fee-for-service option and adjusting payments based on performance across four performance categories: Quality, Cost, Promoting Interoperability, and Improvement Activities.

The *MIPS Value Pathways (MVP) track* builds off the "traditional MIPS" pathway described above and aims to transition clinicians reporting MIPS towards Alternative Payment Models (APMs) over time. There will be opportunities from year to year to update MVPs and in time CMS hopes they will demonstrate improvements in specific conditions and across specialties. The AAN expects, per CMS:

MIPS Value Pathways (MVPs) are subsets of measures and activities, established through rulemaking, that can be used to meet MIPS reporting requirements beginning with the 2024 performance year. The MVP framework aims to align and connect measures and activities across the quality, cost, and improvement activities performance categories of MIPS for different specialties, clinical conditions, or episodes of care. MVPs incorporate a foundational layer that includes Promoting Interoperability measures and population health administrative claims-based quality measures. MVPs offer reduced reporting requirements, allowing MVP participants to report on a smaller, more cohesive subset of measures and activities (within the measures and activities available for traditional MIPS) that are relevant to a specialty, clinical condition, or episode of care.

CMS plans to replace "traditional MIPS" with MVPS and APMS in the future.

MVPS AVAILABLE IN 2024

CMS finalized 12 MVPs for reporting in 2024, with plans to add additional MVPs each year via rulemaking. The MVPs available for 2024 are listed below.

- *Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes*
- *Optimal Care for Patients with Episodic Neurological Conditions*
- *Supportive Care for Neurodegenerative Conditions*
- Advancing Rheumatology Patient Care
- Advancing Care for Heart Disease
- Adopting Best Practice and Promoting Patient Safety with Emergency Medicine
- Improving Care for Lower Extremity Joint Repair
- Patient Safety and Support for Positive Experiences with Anesthesia
- Advancing Cancer Care
- Optimal Care for Kidney Health
- Focusing on Women's Health (New in 2024)
- Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV (New in 2024)
- Quality Care in Mental Health and Substance use Disorders (New in 2024)
- Quality Care for the Treatment of Ear, Nose, and Throat Disorders (New in 2024)
- Rehabilitative Support for Musculoskeletal Care (New in 2024)
- Value in Primary Care MVP

PARTICIPATION

MVPs are available to individual MIPS eligible clinicians, single specialty groups, subgroups, and APM entities for 2024. The *low-volume threshold* that applies for MIPS eligibility is the same for MVPs. Multispecialty groups will be able to report in later years via subgroups.

A subgroup is a subset of clinicians within a group (identified by a single Taxpayer Identification Number, or TIN) which contains at least one MIPS-eligible clinician. Subgroup reporting can offer more meaningful data collection and feedback, particularly for clinicians in a large or multispecialty group. A subgroup may not include clinicians from a different TIN.

MVP reporting is voluntary in 2024. Only those clinicians who have a clinically relevant MVP should report an MVP. Those clinicians that do not have a clinically relevant MVP available can still report "traditional MIPS."

CMS does plan to make MVP reporting mandatory in time, eventually replacing traditional MIPS with MVPs altogether. Although CMS has not finalized a definitive timeline for sunsetting traditional MIPs, however, they have suggested that MVPs may be mandatory within the next 3-5 years.

REPORTING

MVPs are intended to reduce reporting requirements compared to traditional MIPS. The reporting requirements for each of the MVP components (the same as MIPS components) are detailed below.

QUALITY

Select and report four quality measures from the MVP, including one outcome measure. If no outcome measure is available, you may report a high priority measure. Prior to initiating MVP reporting, clinicians should ensure there are four measures that are applicable to their care setting. For example, the 2024 stroke MVP may not have four measures applicable to most outpatient neurology practices.

COST

No reporting is required for the Cost component, as CMS calculates performance on the cost measure associated with each MVP using administrative claims data. Every MVP should have a cost measure associated with the clinical topic or episode of care, although some have the global Medicare Spending Per Beneficiary–Clinician cost measure in this category.

IMPROVEMENT ACTIVITIES (IA)

Select and report using one of the options below. Attest to improvement activities as done in traditional MIPS. No documentation is required but keep documentation for six years in the event of a CMS audit.

- Report two medium-weighted improvement activities offered in the MVP
- Report one high-weighted improvement activity offered in the MVP
- Report the IA_PCMH (participation in a certified or recognized patient-centered medical home) activity, if offered in the MVP

PROMOTING INTEROPERABILITY

Submit the same Promoting Interoperability measures that are required in traditional MIPS, unless you qualify for reweighing of the Promoting Interoperability performance category.

- Are a certain type of clinician that qualifies you for automatic reweighting (e.g., APPs)
- Have a certain *special status* that qualifies you for automatic reweighting (e.g., small practice)
- Have an approved *MIPS Promoting Interoperability Performance Category Hardship Exception*

POPULATION HEALTH MEASURES

No reporting is required, as CMS calculates population health measures using administrative claims data. In addition to the four MIPS components required for MVP reporting, clinicians must also select one population health measure at the time of MVP registration. The measure options for 2024 are:

- Hospital-wide, 30-day, All-cause Unplanned Readmission (HWR) Rate for MIPS Groups
- Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

SCORING

Scoring for MVPs is similar to scoring in traditional MIPS for 2024. Component weights and scoring policies are subject to change with each year of the program.

QUALITY

- Measures are scored against benchmarks and receive between one and 10 points.
- If required measures are not reported or do not meet case minimums or data completeness requirements, they receive zero points.
- If less than four measures apply to a clinician in an MVP, report all measures that apply.
- Small practices will receive a minimum of three points for all measures. Small practices receive six bonus points in this component.
- Quality accounts for 30 percent of the total MVP score.

COST

- Cost measures receive between one and 10 points.
- Cost accounts for 30 percent of the total MVP score.
- If no cost measures apply, the component will be reweighted to zero percent and redistributed to other components.

IMPROVEMENT ACTIVITIES (IA)

- Medium-weighted activities receive 20 points each; high-weighted activities receive 40 points each. Clinicians must report two medium-weighted activities or one high-weighted activity for full credit in this component.
- Improvement Activities account for 15 percent of the total MVP score.

PROMOTING INTEROPERABILITY (PI)

- Promoting Interoperability measures will be scored as they are in traditional MIPS.
- Promoting Interoperability accounts for 25 percent of the total MVP score.

REGISTRATION

Registration for reporting year 2024 is open from from April 1 to December 2, 2024, on the *QPP website*.

If registering as an individual, a group, or APM entity you will select:

- One MVP to report
- One population health measure
- Any outcomes-based administrative claims measure (if applicable) in the quality component

If registering as a subgroup, you will select:

- One MVP to report
- One population health measure
- Any outcomes-based administrative claims measure (if applicable) in the quality component
- A list of NPI/TIN associated with the subgroup (list of clinicians from a TIN in the subgroup)
- A plain language name for the subgroup

NEUROLOGY MVPS IN 2024

For the 2024 reporting year, there are three MVPs available relevant to neurology.

Learn more about the individual neurologic MVPs on *www.aan.com/qpp*.

ADDITIONAL RESOURCES

- *CMS MIPS Value Pathways (MVPs) Implementation Guide*
- *MIPS Eligibility and Participation Quick Start Guide*