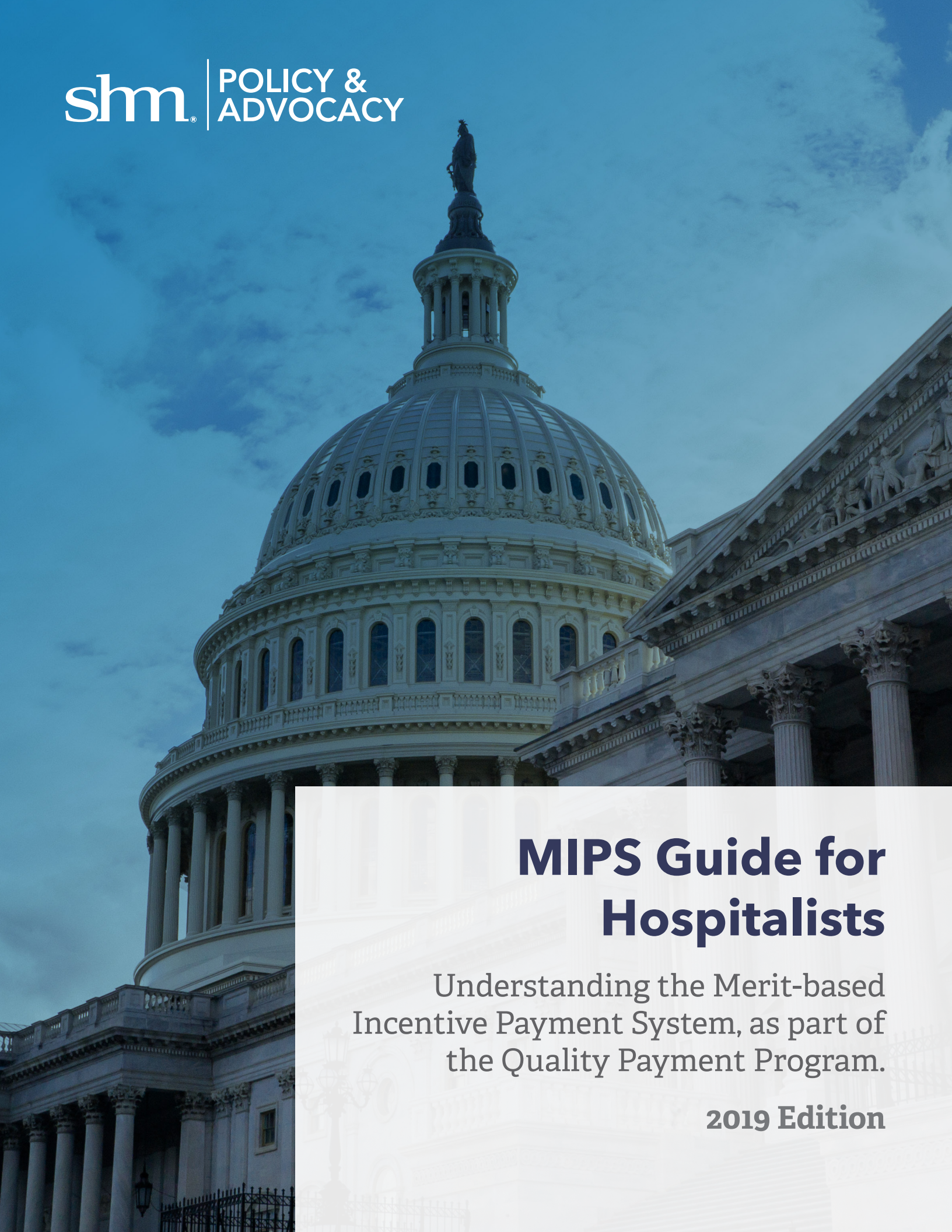

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MIPS Guide for Hospitalists

Understanding the Merit-based Incentive Payment System, as part of the Quality Payment Program.

2019 Edition

What is New to Consider in 2019?

The Quality Payment Program is a complicated, ever-changing program. From year to year, the Centers for Medicare and Medicaid Services (CMS) makes changes to the program. SHM consistently listens to your experiences, monitors upcoming policy changes and works to address issues in the program on behalf of hospitalists.

Major relevant changes to the program in 2019 include:

- **Facility-based Measurement Option.** Beginning in 2019, hospitalists and hospitalist groups will have scores in the Quality and Cost categories of the MIPS automatically calculated for them. CMS will give facility-based providers a score in those categories based on their hospital's hospital value-based purchasing (HVBP) score. For providers or groups that also elect to report on measures independent of this option, CMS will use the higher of the scores for the total MIPS score.

- **Elimination of claims-based reporting of quality measures for groups.** Groups of more than 15 MIPS eligible clinicians will not be able to report on quality measures through Medicare Part B claims. This means those providers will need to report by registry, Qualified Clinical Data Registry (QCDR), GPRO web-interface or direct electronic health record (EHR) submission.

Hospitalists should also keep in mind how the **Promoting Interoperability category** may affect their MIPS score. SHM has been apprised that some groups that report as a group have been held accountable in the PI category due to individual providers in the group (including providers who practice in post-acute settings, locum tenens providers and moonlighting providers) not meeting the hospital-based exemption criteria. SHM is actively working to address this issue, but we encourage groups in the meantime to keep this in mind and be sure to apply for hardship exceptions for providers who may not qualify for an exemption from the Promoting Interoperability category.

Merit-based Incentive Payment System

The Merit-based Incentive Payment System (MIPS) combines existing physician programs (PQRS, value modifier, and Meaningful Use) into a single streamlined program. It is one pathway for provider payment as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program (QPP) and is the default pathway for Medicare provider payments. MIPS eligible clinicians will be measured and assessed on performance across four categories: Quality, Improvement Activities, Promoting Interoperability (formerly, Advancing Care Information), and Cost.

Performance in 2019 on the MIPS will determine payment adjustments in 2021. There is a potential +/- 7% payment adjustment under the MIPS depending on performance. As a budget neutral program, the pool of money for positive payment adjustments is made up of the money from negative payment adjustments.

For most hospitalists, the categories are weighted differently in comparison to other providers. Hospitalists are exempt from the Promoting Interoperability (PI) category if they fall under a hospital-based exemption, similar to their exemption under Meaningful Use in the past. This exemption means that the weight for the PI category is shifted to the Quality Category. *See Promoting Interoperability section of this guide for more information.*

Eligibility Requirements for Participation

MIPS is the default program for all providers who bill Medicare Part B. These include physicians, physician assistants, nurse practitioners, certified nurse specialists, and certified registered nurse anesthetists. Providers may be exempt from the MIPS if:

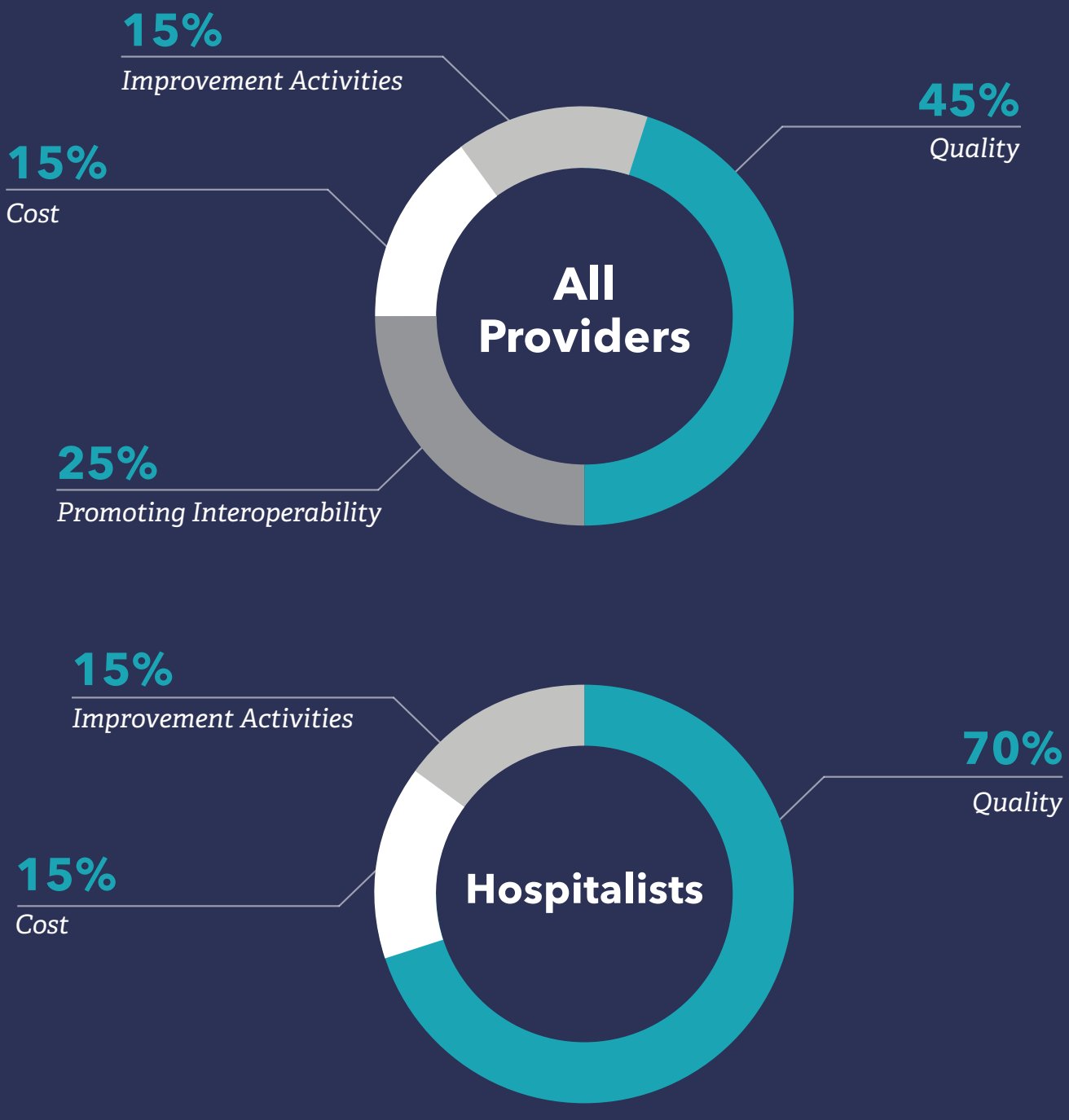
- They do not exceed one or more of the low volume thresholds, which are:
  - Billing $90,000 or less in Medicare Part B allowed charges for covered professional services; or
  - Provide covered professional services for 200 or fewer Part B-enrolled individuals; or
  - Provide 200 or fewer covered professional services to Part B-enrolled individuals.
- They are in their first year of participating in the Medicare program.
- They are participating in a qualifying Advanced Alternative Payment Model and meet the thresholds for participation.

If you are unsure if you are eligible to participate in the QPP, go to qpp.cms.gov. Enter your National Provider Identifier (NPI) to check your participation status.

Most hospitalists will be in the MIPS in 2019.

2019 MIPS Category Weights

Each of the four MIPS categories is weighted a proportion of the overall MIPS score.



Note: *For hospitalists that meet the definition of hospital-based provider or group, the Promoting Interoperability (formerly, Advancing Care Information) category weight is shifted to the Quality category. See the Promoting Interoperability section of this guide for more information about the hospital-based status.*

Quality

Overview:

The Quality category builds off existing policies for quality reporting from PQRS and will be familiar for hospitalists who currently report quality measures. For most hospitalists, the Quality Category will be weighted 70% of the MIPS final score for performance in 2019/payment in 2021. This higher category weight is because to most hospitalists will be exempt from the Promoting Interoperability category (for information about this exemption, see the Promoting Interoperability section of this guide).

Requirement:

Providers must report on 6 quality measures. The minimum number of cases for each measure is 20. Because of this case volume requirement, SHM notes that some measures may be "low-volume measures", particularly if you report at the individual level. We encourage hospitalists to keep this in mind as they are selecting measures.

Quality measures are scored individually on performance against benchmarks and aggregated to make the category score. Since hospitalists will likely not have the requisite 6 measures to report, they will be subject to a validation process to ensure there were no other available measures to report.

Beginning in 2019, groups with more than 15 MIPS eligible clinicians will not be able to report on quality measures by Medicare Part B claims.

Beginning in 2019, facility-based clinicians and groups will be automatically granted a score in the Quality category aligned with their hospital's Hospital Value-Based Purchasing score. They may accept this score or elect to report on quality measures normally. For more information, see the Facility-based Measurement page of this guide.

Action Item: Assess whether the facility measurement reporting option applies to and makes sense for your practice. Decide whether to report on quality measures separately, either as a group or an individual. Report on as many quality measures as you can, either as a group or individual.

Cost

Overview:

The Cost category incorporates elements of the value modifier program to assess the costs and resource use of providers.

Cost measures in 2019 include:

- Total Per Capita Cost Measure, which uses a two-step primary care attribution methodology, and measures the overall cost of care for beneficiaries attributed to the clinician.
- Medicare Spending Per Beneficiary Measure, which uses a plurality of Medicare Part B services during the index admission attribution methodology, and measures the cost of services performed by a clinician during a hospital stay episode. The measure window includes 3 days prior the index admission and 30 days post-discharge.
- Eight episode-based cost measures, which are condition-specific. Potential episode-measures relevant to hospitalists include simple pneumonia with hospitalization, intracranial hemorrhage or cerebral infarction, and ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI).

CMS is continuing to develop episode-based cost measures, which look at costs around specific clinical conditions. New measures will be incorporated into the MIPS in the coming years.

Requirement:

Cost measures are calculated automatically by CMS based on administrative claims. The Cost category has been weighted at 15% for all MIPS participants in 2019.

Action Item: Nothing. Cost measures are automatically calculated by CMS. For hospitalists, scores in the Cost category may be based on these measures or based on the facility-based measurement score.

New

Facility-based Measurement

Overview:

Beginning in 2019, CMS will automatically calculate a score in the Quality and Cost categories for facility-based providers. This scoring takes the percentile of hospital performance in the Hospital Value-Based Purchasing (HVBP) program and gives the provider the score associated with the same performance percentile in the Quality and Cost categories of the MIPS. Individuals and groups may also report measures in the Quality and Cost category through traditional MIPS reporting and CMS will use the highest score for MIPS payment adjustments. Either way, providers will still need to report Improvement Activities and Promoting Interoperability (unless exempt). Most hospitalists will qualify for this scoring. In addition, providers using facility-based measurement will have a minimum score floor of 30% in the Quality category—regardless of their hospital's HVBP performance.

Definition of facility-based:

- Individuals: Providers who bill more than 75% of their Medicare Part B services in Place of Service 21 (inpatient), 22 (hospital outpatient), and 23 (ER); bill a least 1 service in POS 21 or 23; and work in a hospital that receives a HVBP score.
- Groups: 75% or more of the individual eligible clinicians in the group quality as facility-based.

Which hospital's score?

CMS will attribute the score from the hospital at which individuals provide services to the most Medicare beneficiaries. For groups, CMS will use the score for the single hospital for which the plurality of clinicians in the group are attributed.

Action Item: Check using the participation lookup tool on qpp.cms.gov to see if you qualify as facility-based. Decide whether to keep the facility-attributed score or to report quality measures through traditional MIPS reporting. Make sure you continue to report Improvement Activities and determine what you need to do in Promoting Interoperability.

Improvement Activities

Overview:

Improvement Activities require completing specific activities that focus on care coordination, beneficiary engagement, and patient safety. The category will be weighted 15% for performance in 2019/payment in 2021.

Examples of Improvement Activities that could apply to hospitalists:

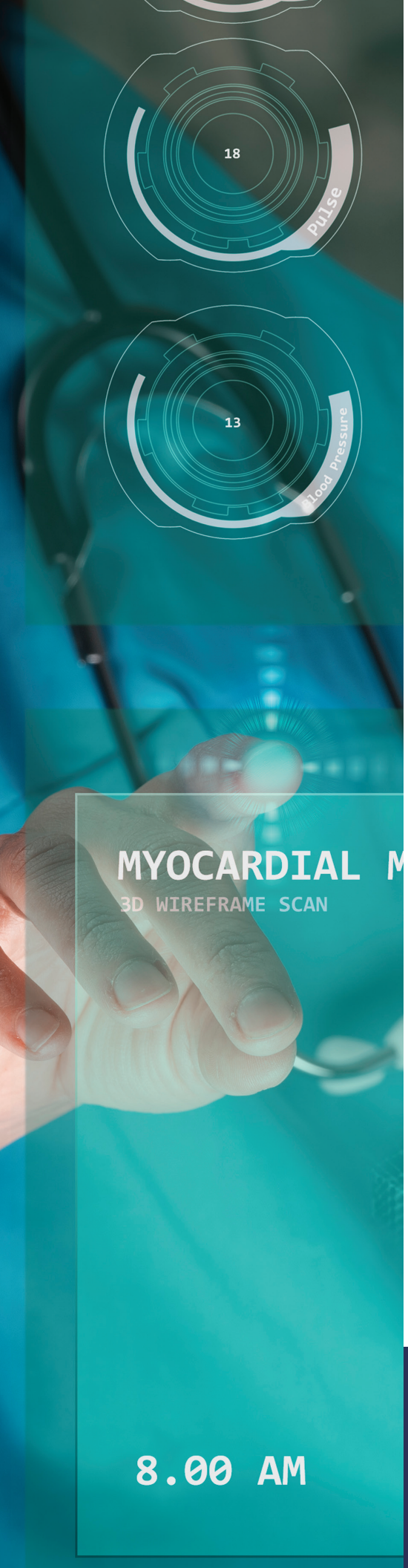
- Implementation of regular care coordination training
- Implementation of an antibiotic stewardship program
- Use decision support and standardized treatment protocols to manage workflow
- Participation in Maintenance of Certification (MOC) Part IV

Requirement:

Providers must report on 40 points worth of activities for full credit in this category. Activities are weighted at 20 points for a high-weight activity and 10 points for a medium-weight activity. Providers will need to select activities from the Inventory and attest to doing the activity for at least 90 continuous days during the calendar year. Eligible clinicians or groups must submit IA data by registry, electronic health record (EHR), qualified clinical data registry (QCDR), CMS web interface, or attestation.

The full list of Improvement Activities can be viewed at https://qpp.cms.gov/measures/ia.

Action Item: Review available Improvement Activities. Match actions and activities you are doing to improve patient care to those available in the CMS-published inventory. Attest to activities during the performance year. There is a list of potential Improvement Activities at the end of this guide.



Promoting Interoperability

Overview:

Promoting Interoperability (formerly, Advancing Care Information) involves the use of certified electronic health record technology (CEHRT) as part of a provider's practice. As hospitalists practice in acute care hospitals, which are governed by their own Promoting Interoperability (PI) eligible hospital requirements, there is a hospital-based exemption from this category.

Hospitalists who meet the definition for 'hospital-based' are automatically exempt from PI. The 25% PI category weight would then shift to Quality. This makes the Quality Category 70% of the final MIPS score.

Definition of Hospital-based:

- Individual: provider who bills 75% or more of their Medicare Part B services in Place of Service 21 (Inpatient), 22 (hospital outpatient), and 23 (ER).
- Group: a group where 100% of its providers qualify as hospital-based as individuals or otherwise are exempted from this category.

NOTE: *Hospitalists who practice significantly (>25% of services) in settings such as SNFs or other post-acute settings will be subject to this category. Groups should also monitor their practices and ensure all of their providers, including those practicing as locum tenens providers, qualify for the hospital-based exemption. SHM recommends that hardship exceptions be requested for providers who may not meet the definition of hospital-based.*

Action Item: Check the status of all providers in the group at qpp.cms.gov. If they do not qualify as hospital-based or if you are unsure, consider applying for a hardship exception for these providers. More information about hardship exceptions can be found at qpp.cms.gov.

Scoring in the 2018 MIPS

How is the MIPS scored?

CMS will create a score in each of the categories based on your performance. Those scores will then be given the category MIPS score. That score will be on a scale of 1 to 100 points.

In 2019, CMS set a performance threshold of 30 points in the MIPS. Providers and groups that reach 30 points will avoid a MIPS penalty in 2021. Exceeding 30 points may make providers eligible for bonus payments.

What do I need to consider for maximum points?

- Providers should report on a much as they possibly can in each of the categories, particularly Improvement Activities.
- Consider how facility-based measurement may affect your score and decide whether to report on quality measures separately.
- Check the Promoting Interoperability exemption for all of your providers in a reporting group. If some are not hospital-based, make sure you apply for hardship exemptions for them.
- Make a plan for reporting and stay informed of changes to policies and measures.

Applicable Quality Measures for Hospitalists

SHM worked with CMS to ensure that the "Hospitalist-Specific Specialty Measure Set" only contained measures that are applicable for hospitalists. Although some will remain low volume measures for some providers, as long as providers report as many measures as apply to their practice, they should avoid a penalty.

QUALITY #5

Heart Failure: ACE/ARB for LVSD

Reporting Method: Registry, EHR

QUALITY #8

Heart Failure: Beta-blocker for LVSD

Reporting Method: Registry, EHR

QUALITY #47

Advanced Care Plan

Reporting Method: Claims, Registry

QUALITY #76

Prevention of CRBSI: CVC Insertion Protocol

Reporting Method: Claims, Registry

QUALITY #130

Documentation of Current Medications

Reporting Method: Claims, Registry

QUALITY #407

Appropriate Treatment of MSSA Bacteremia

Reporting Method: Claims, Registry

Potential Improvement Activities for Hospitalists

The Society of Hospital Medicine's Performance Measurement and Reporting Committee reviewed the list of MIPS Improvement Activities and offers this shortlist as a starting point for practices to consider as they are selecting measures. These activities reflect common initiatives and projects undertaken by hospitalists crosswalked to activities in the Improvement Activities list. We encourage groups to look at the full list of Improvement Activities to see if other activities may be relevant to their practice. The full list of activities can be viewed at qpp.cms.gov.

For full credit in the Improvement Activities category, a provider or group will need to attest to 40 points worth of activities. Medium weighted activities are worth 10 points and high weighted activities are worth 20.

Activity ID	Description	Weight	Examples
IA_PSPA_16	Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.	Medium	Consistent use of EMR-driven protocols and order sets, such as readmission risk scores to tailor coordination tactics, use of a sepsis screening tool, use of other risk calculators

Activity ID	Description	Weight	Examples
IA_PSPA_19	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following: Train all staff in quality improvement methods; Integrate practice change/quality improvement into staff duties; Engage all staff in identifying and testing practices changes; Designate regular team meetings to review data and plan improvement cycles; Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; and/or Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families.	Medium	Multidisciplinary quality improvement efforts. This activity could be an impetus for groups to tackle a project that has been on their “to do list.”

Activity ID	Description	Weight	Examples
IA_PSPA_18	Measure and improve quality at the practice and panel level that could include one or more of the following: regularly review measures of quality, utilization, patient satisfaction and other measures that may be useful at the practice level and at the level of the care team or MIPS eligible clinician or group (panel); and/or use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.	Medium	Use of dashboards, target performance metrics, or balanced scorecards at the department or practice level.
IA_PSPA_15	Implementation of an antibiotic stewardship program that measures the appropriate use of antibiotics for several different conditions (URI Rx in children, diagnosis of pharyngitis, Bronchitis Rx in adults) according to clinical guidelines for diagnostics and therapeutics.	Medium	Use of dashboards, target performance metrics, or balanced scorecards at the department or practice level.

Activity ID	Description	Weight	Examples
IA_PSPA_5	Annual registration by eligible clinician or group in the prescription drug monitoring program of the state where they practice. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups must participate for a minimum of 6 months.	Medium	Implementation of protocols to use PDMPs during discharge planning or medication reconciliation.
IA_PSPA_6	Clinicians would attest that, 60 percent for first year, or 75 percent for the second year, of consultation of prescription drug monitoring program prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription that lasts for longer than 3 days.	High	Research and interventions for palliative care, geriatric care, "frequent flyers," readmitted patients or patients with risk factors for readmissions. SHM's Project BOOST. "Care path" projects.
IA_BE_14	Engage patients and families to guide improvement in the system of care.	Medium	Patient/family councils. Engaging patients on hospitalist program committees. Focus groups. Family based-rounds.

Activity ID	Description	Weight	Examples
IA_BE_21	Provide self-management materials at an appropriate literacy level and in an appropriate language.	Medium	Patient education materials developed/ implemented by the hospitalist group.
IA_BE_16	Incorporate evidence-based techniques to promote self-management into usual care, using techniques such as goal setting with structured follow-up, teach back, action planning or motivational interviewing.	Medium	SHM Project BOOST. Incorporating teach back into the discharge process. Intervention for self-management as part of transitions of care and readmission reductions efforts.
IA_CC_11	Establish standard operations to manage transitions of care that could include one or more of the following: establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information and seamless transitions in care; and/or partner with community or hospital-based transitional care services.	Medium	Automated discharge summary routing. Communication templates for discharges to SNF and other post-acute discharges. "Warm handoffs" for post-acute patients.

Help us help hospitalists.

We want to hear from you!

If there are other quality measures, improvement activities, or examples that you feel are appropriate for hospitalists, let us know. Share your experiences with the program to help us develop more detailed resources for your fellow hospitalists.

advocacy@hospitalmedicine.org

Resource Links

- **CMS Quality Payment Program Website:** https://qpp.cms.gov
- **CMS QPP Resource Library:** https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html
- **SHM MACRA Resources Website:** www.macraforhm.org

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