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Society of Hospital Medicine

MIPS Guide for Hospitalists

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

2020 Edition

contents

What is New to Consider in 2020?

The Quality Payment Program (QPP) 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 2020 include:

- Expanded the hospital-based exemption from Promoting Interoperability (PI) for groups. CMS finalized changes pushed by SHM to ensure that hospital medicine groups would be categorized as hospital-based and exempt from the PI category of the MIPS. Groups will now be exempt from PI if 75% or more of their individual Eligible Professionals (EPs) meet the criteria to be exempt from PI as individuals.

- Changed Improvement Activities participation requirements. CMS will now require 50% of clinicians in a group to report on the same improvement activity during any continuous 90-day period during the performance year.

- Increased the MIPS Performance Threshold. In the 2020 performance year, MIPS participants must achieve at least 45 points in the MIPS to avoid a penalty. This is an increase from 30 points last year.

Hospitalists should also keep in mind that the **Facility-based Measurement Option** will apply to their practice and will give them or their group a score in the Quality and Cost categories of the MIPS. CMS automatically calculates a score in each of these categories based on a provider or group's hospital's Hospital Value-Based Purchasing (HVBP) score. Providers or groups may also elect to report on measures in the Quality category, in which case CMS will use the higher of the scores (facility-based or self-reported measures) for the total MIPS score.

COVID-19 Update for QPP

CMS has issued administrative relief and reporting flexibilities for providers participating in the Quality Payment Program in light of the COVID-19 Public Health Emergency Declaration. We expect CMS will continue to make adjustments to the program for the 2020 reporting year and SHM will update guidance as more detail emerges.

To learn more about these flexibilities, waivers and adjustments visit the resource section of the **www.macraforhm.org** site.

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 2020 on the MIPS will determine payment adjustments in 2022. There is a potential +/- 9% 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.
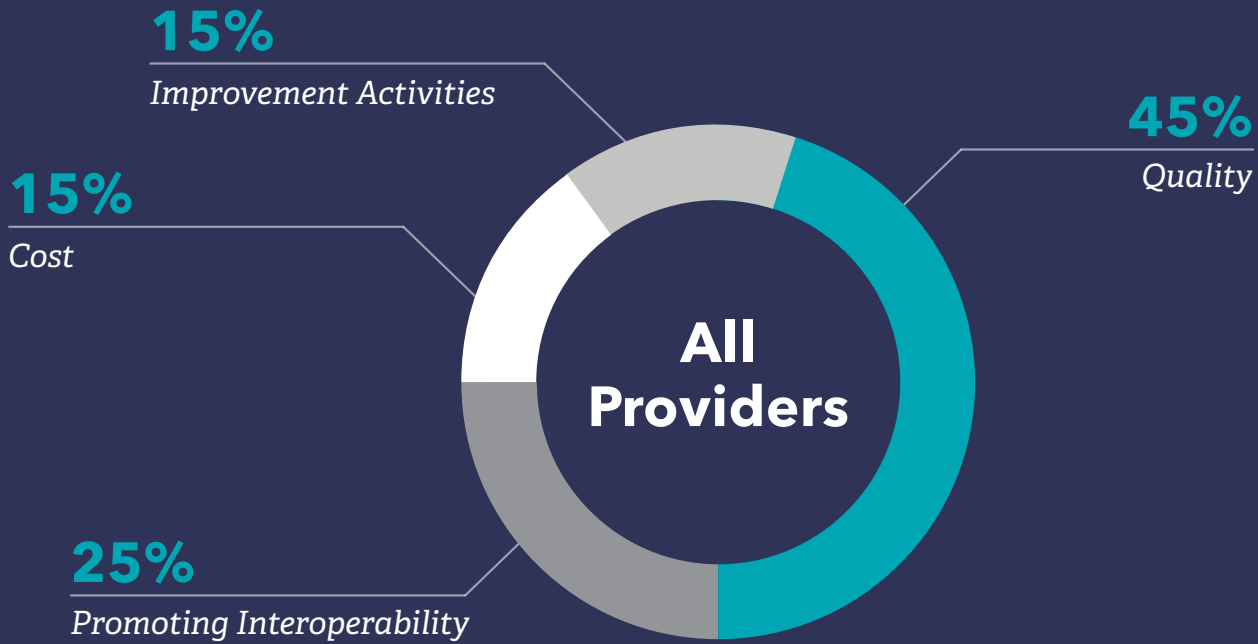
If you are unsure if you are eligible to participate in the QPP, go to **qpp.cms.gov**. Enter your National Provider Identifier (NPI) to check your participation status.

Most hospitalists will be in the MIPS in 2020.

2020 **MIPS Category Weights**

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

15%
Improvement Activities

15%
Cost

45%
Quality

All Providers

25%
Promoting Interoperability

15%
Improvement Activities

15%
Cost

70%
Quality

Hospitalists

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 2020/payment in 2022. 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. Take note that the 2020 set of measures for hospitalists only has 5 measures. Because of the case volume requirement, some measures may also be "low-volume," 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, 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.

Note: the hospitalist measure set only has 5 measures. By reporting on the full set, groups should not be penalized for not reporting on a sixth measure.

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 2020 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.

- Eighteen (18) 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. Cost measures have different attribution methodologies, depending on the measure, meaning hospitalist groups may have different cost measures applied to their MIPS scores. 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.

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 qualify 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 2020/ payment in 2022.

Examples of Improvement Activities that could apply to hospitalists:

- Implementation of regular care coordination training
- Implementation of an antibiotic stewardship program
- Utilization of 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. Individual 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. Groups must have at least 50% of their providers perform the same activity for any 90-day continuous period in the 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/mips/improvement-activities

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.

In 2020, CMS expanded the definition of hospital-based group in response to SHM's advocacy efforts to ensure all hospitalist groups would qualify as hospital-based.

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 75% of its providers qualify as hospital-based as individuals or are otherwise exempt from this category.

Action Item: Check the status of all providers in the group at **qpp.cms.gov**. If hospitalists in your group also practice in SNFs or other settings where EHR availability is beyond their control, consider applying for a hardship exemption. More information about hardship exemptions can be found at **qpp.cms.gov**.

Scoring in the 2020 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 2020, CMS set a performance threshold of 45 points in the MIPS. Providers and groups that reach 45 points will avoid a MIPS penalty in 2022. Exceeding 45 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 to make sure your group is exempt from Promoting Interoperability.
- 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 to hospitalists. Although some measures 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

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://qpp.cms.gov/about/resource-library

🔗 **SHM MACRA Resources Website:** macraforhm.org

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