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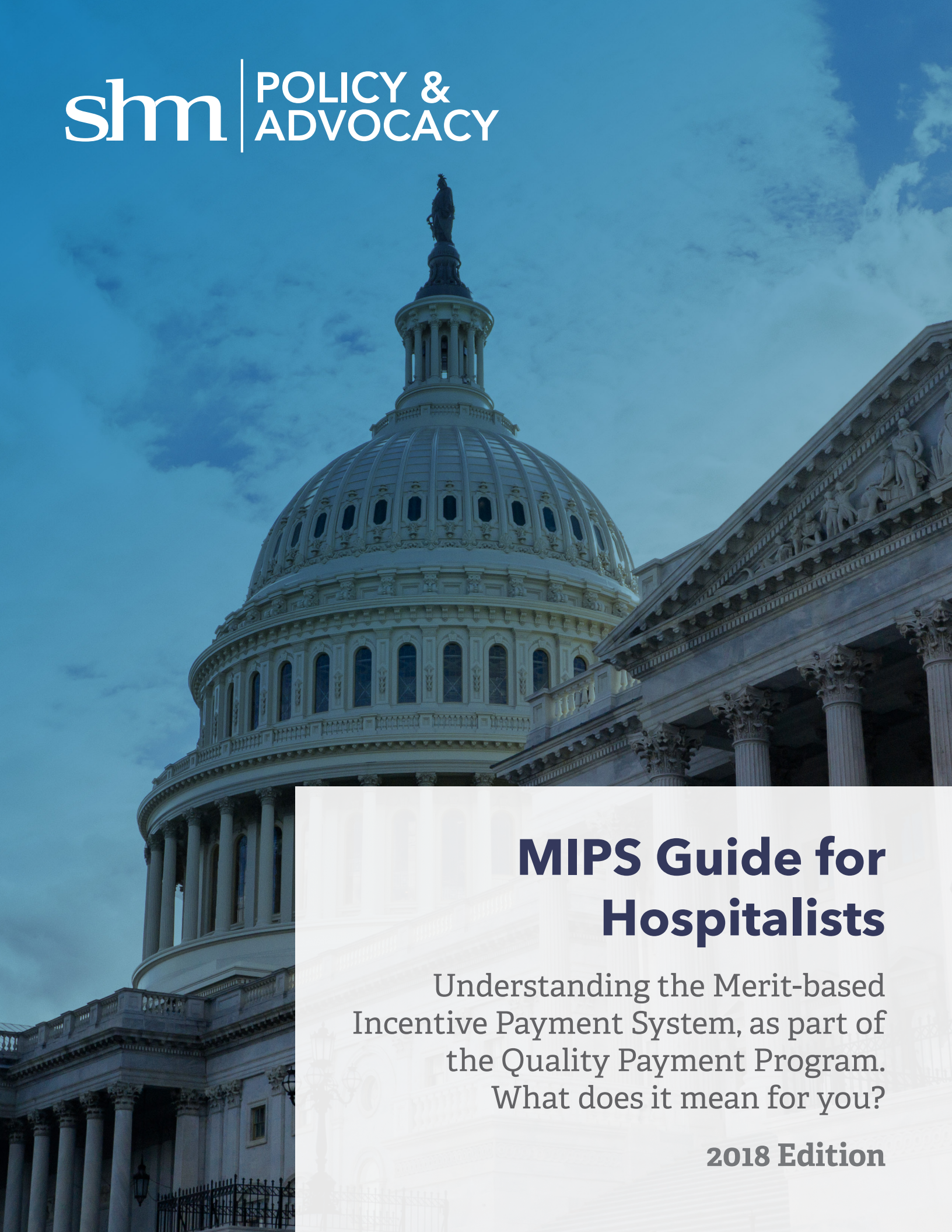


MIPS Guide for Hospitalists

Understanding the Merit-based Incentive Payment System, as part of the Quality Payment Program. What does it mean for you?

2018 Edition

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, Advancing Care Information, and Cost.

Performance in 2018 on the MIPS will determine payment adjustments in 2020. There is a potential +/- 5% 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 Advancing Care Information (ACI) category, because 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 ACI category is shifted to the Quality Category.

Eligibility Requirements for Participation

All physicians, PAs, NPs, CNS's, CRNAs who bill Medicare more than $90,000 per year and see more than 200 Medicare patients per year must participate in the QPP or face a 5% penalty under the MIPS. MIPS is the default program for all providers who bill Medicare Part B.

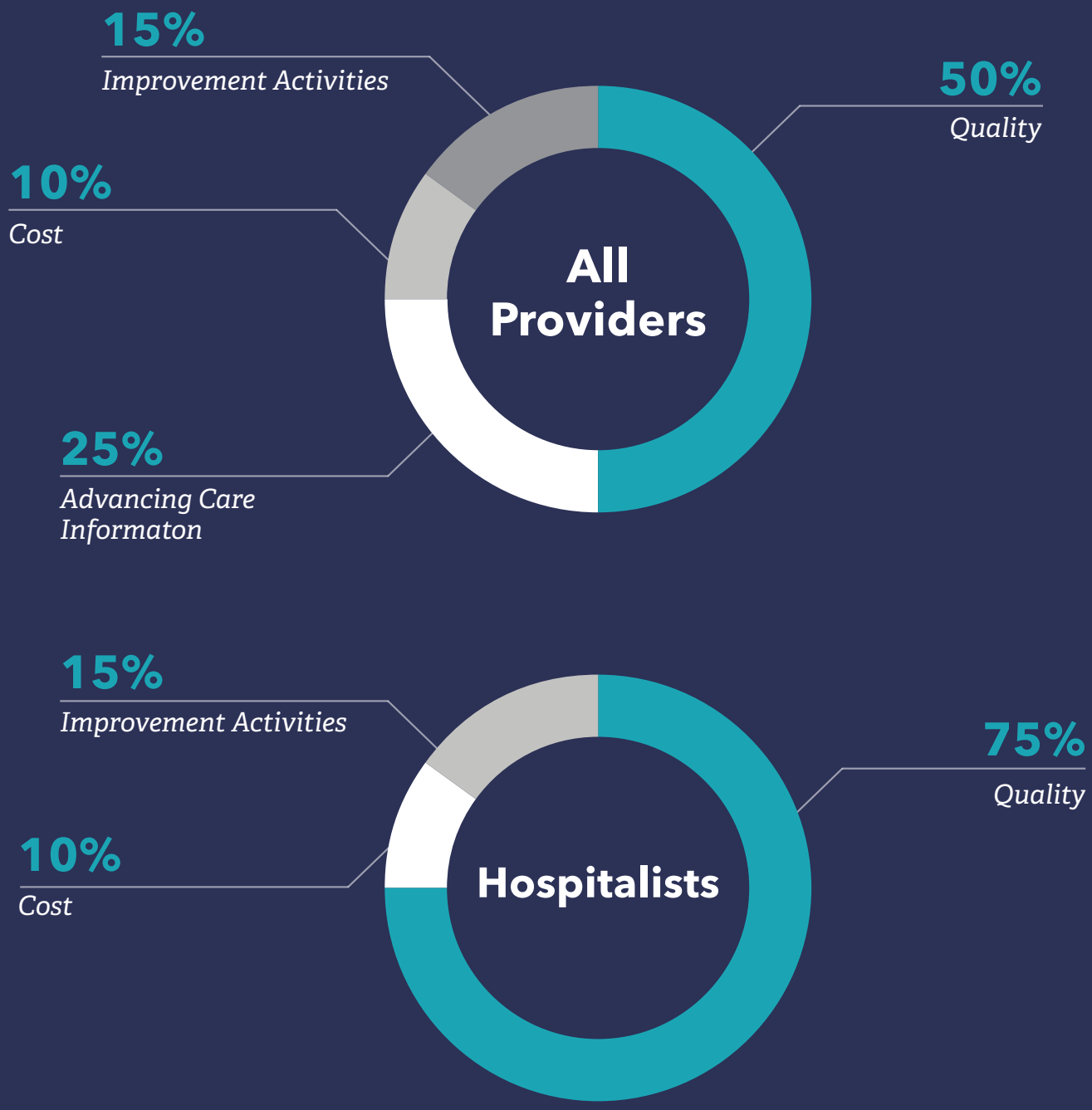
- Clinicians in their first year of participating in Medicare are exempt.
- Clinicians who bill Medicare less than $90,000 or see fewer than 200 Medicare patients per year are exempt.

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

Most hospitalists will be in the MIPS in 2018.

2018 MIPS Category Weights

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



Note: *For hospitalists who meet the definition of hospital-based provider, Advancing Care Information is 0%. Hospitalists have different category weightings due to being exempt from the Advancing Care Information category, and that category's weight shifting to Quality.*

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 75% of the MIPS final score for performance in 2018/payment in 2020. This higher category weight is due to most hospitalists being exempt from the Advancing Care Information category.

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.

Action Item:

Report on as many quality measures as you can, either as a group or individual.

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 2018/payment in 2020.

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 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 potentially applicable Improvement Activities at the end of this guide.

Advancing Care Information

Overview:

Advancing Care Information replaces Meaningful Use for providers and involves the use of certified electronic health record technology (CEHRT) as part of their practice. As hospitalists practice in acute care hospitals, which are governed by their own Meaningful Use requirements, there is a hospital-based exemption from the category.

Hospitalists who meet the definition for 'hospital-based' are automatically exempt from ACI. The 25% ACI category weight would then be shifted to Quality. This makes the Quality Category 75% of the final MIPS score. The hospital-based exemption is calculated at the individual level.

Definition of Hospital-based: 75% or more of Medicare Part B services in place of service 21 (Inpatient), 22 (hospital outpatient), and 23 (ER).

NOTE: *Hospitalists who practice significantly (>25% of services) in settings such as SNFs or other post-acute care facilities will be subject to this category. SHM recommends these providers apply for hardship exceptions if they are unable to meet the category requirements.*

Action Item:

Nothing. Hospitalists should be exempt from ACI. Those who practice significantly in other settings (more than 25%), such as SNF or other post-acute settings, would need to apply for a hardship exception and should keep watch for the application process.

Cost

Overview:

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

Current cost measures 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.

CMS is developing episode-based cost measures, which will look at costs around specific clinical conditions. We anticipate these 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 10% for all MIPS participants in 2018. In 2017, Cost was weighted at 0%.

Action Item:

Nothing. Cost measures are calculated automatically by CMS.

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 weight and added together to give you your total MIPS score. That score will be on a scale of 1 to 100 points.

In 2018, CMS has set a performance threshold of 15 points in the MIPS. Providers who are able to attain at least 15 points will avoid a penalty in 2020 from the MIPS, and providers who score higher may be eligible for incentive payments.

How can I get at least 15 points?

Providers should report as much as they possibly can in each of the categories (as many quality measures as possible, and the full number of Improvement Activities), to set themselves up to be successful. You can get to 15 points in a variety of different ways, but reporting as much as possible will give you the best shot at avoiding a penalty and, potentially, receiving bonus payments.

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.

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.

- 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 Part IV

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

Empowering hospitalists. Transforming patient care.