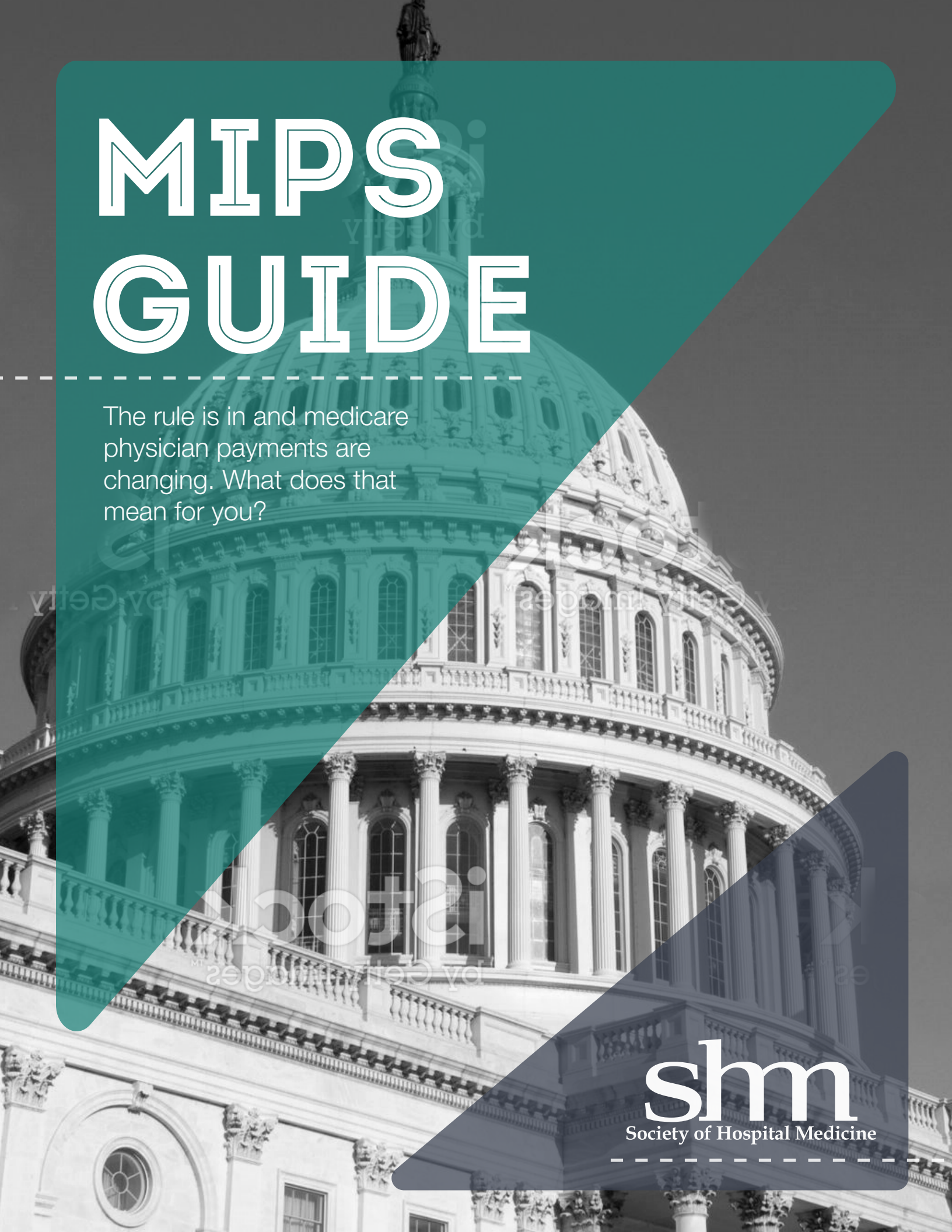


MIPS GUIDE

The rule is in and medicare physician payments are changing. What does that mean for you?

shm
Society of Hospital Medicine

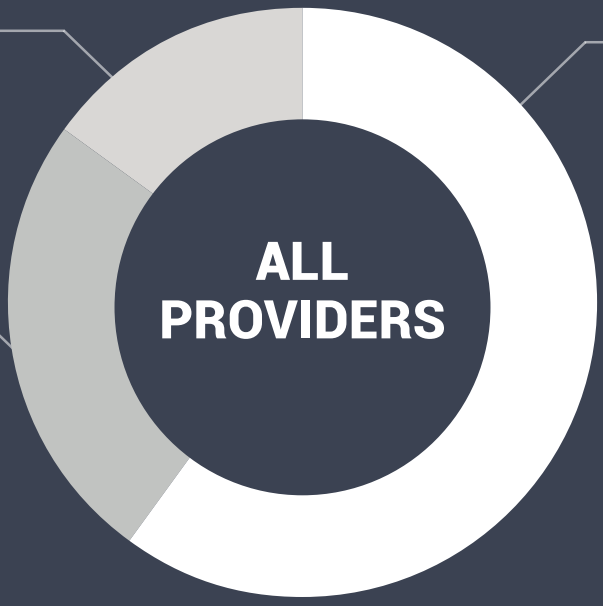
MERIT-BASED INCENTIVE PAYMENT SYSTEM

The Merit-based Incentive Payment System (MIPS) combines existing physician programs (Physician Quality Reporting System (PQRS), Value Modifier and Meaningful Use) into a single streamlined program. Providers will be measured on performance across four categories:

1. Quality
2. Improvement Activities
3. Advancing Care Information (ACI)
4. Cost

For most hospitalists, the categories will be weighted differently in comparison to other providers. Hospitalists are exempt from the Advancing Care Information category, because they fall under a hospital-based exemption definition, as they have been exempt under Meaningful Use in the past. This exemption means that the weight for this category is shifted to the Quality category.

2017 MIPS CATEGORY WEIGHTS



15%
Improvement Activities

25%
Advancing Care Information

60%
Quality

15%
Improvement Activities

85%
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 85% of the MIPS final score for performance in 2017/ payment in 2019.

Requirement:

Providers must report on six quality measures. Quality measures are scored individually on performance and aggregated to make the category score. Since hospitalists will likely not have the requisite six measures to report, they will be subject to a validation process to ensure there wequalre no other available measures to report.

ACTION ITEM

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

RELEVANT QUALITY MEASURES FOR HOSPITALISTS

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 #32

Stroke: DC on Antithrombotic Therapy

Reporting Method: Claims, Registry

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

IMPROVEMENT ACTIVITIES

Overview:

This is a new performance category. The Improvement Activities category will be weighted 15% for performance in 2017/payment in 2019.

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 days during the calendar year.

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.

ADVANCING CARE INFORMATION

Overview:

Advancing Care Information replaces Meaningful Use for providers.

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 85% of the final MIPS score.

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

Note:

Hospitalists who practice significantly (>25% of services) in settings such as skilled nursing facilities (SNF) 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.

Requirement:

Cost measures are calculated automatically by the Centers for Medicare & Medicaid Services (CMS) based on administrative claims. The Cost category has been reweighted to 0% for all MIPS participants in 2017. Cost measures will not be scored under the MIPS. However, CMS will be providing participants with information about their performance on the cost measures in the MIPS feedback reports.

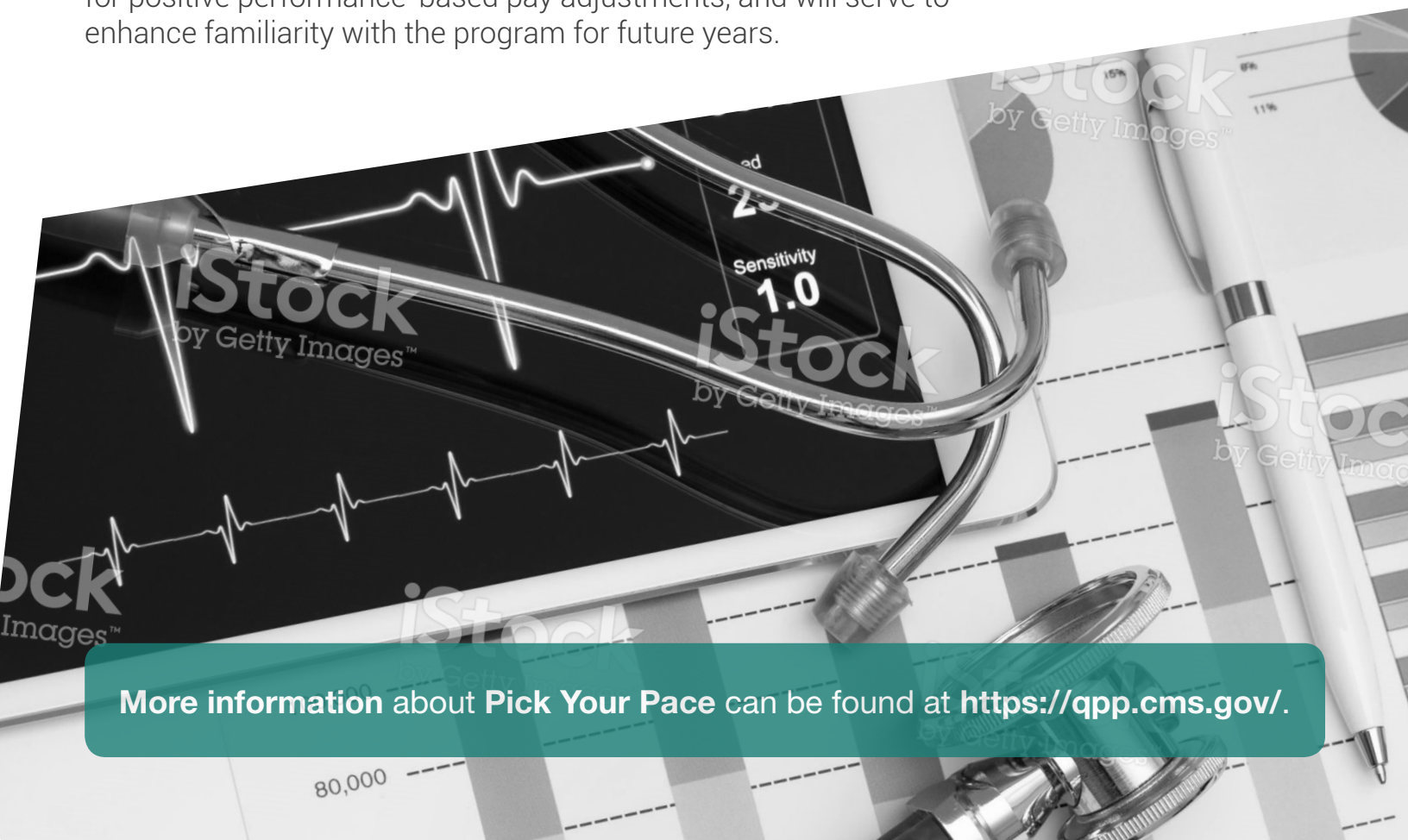
ACTION ITEM:

Nothing. Cost measures are calculated automatically by CMS. Performance on cost measures in 2017 will not affect the 2019 MIPS score and payment adjustment, but shouldn't be disregarded because cost measures will be scored as part of the program in future years.

REPORTING FLEXIBILITY FOR 2017:

PICK YOUR PACE

CMS has created reporting flexibility for the first year of the MIPS, to enable providers to engage with the program at the level they are most comfortable and able. If providers do **anything**, they will be protected from downside penalties under the MIPS. Reporting one measure or one improvement activity would meet these criteria. However, submitting more data gives physicians a better opportunity for positive performance-based pay adjustments, and will serve to enhance familiarity with the program for future years.



More information about **Pick Your Pace** can be found at **https://qpp.cms.gov/**.