



# Merit-based Incentive Payment System Measures

For Hospitalists

Visit [QPP.CMS.gov](https://www.cms.gov/qpp) to understand program basics, including submission timelines and how to participate.



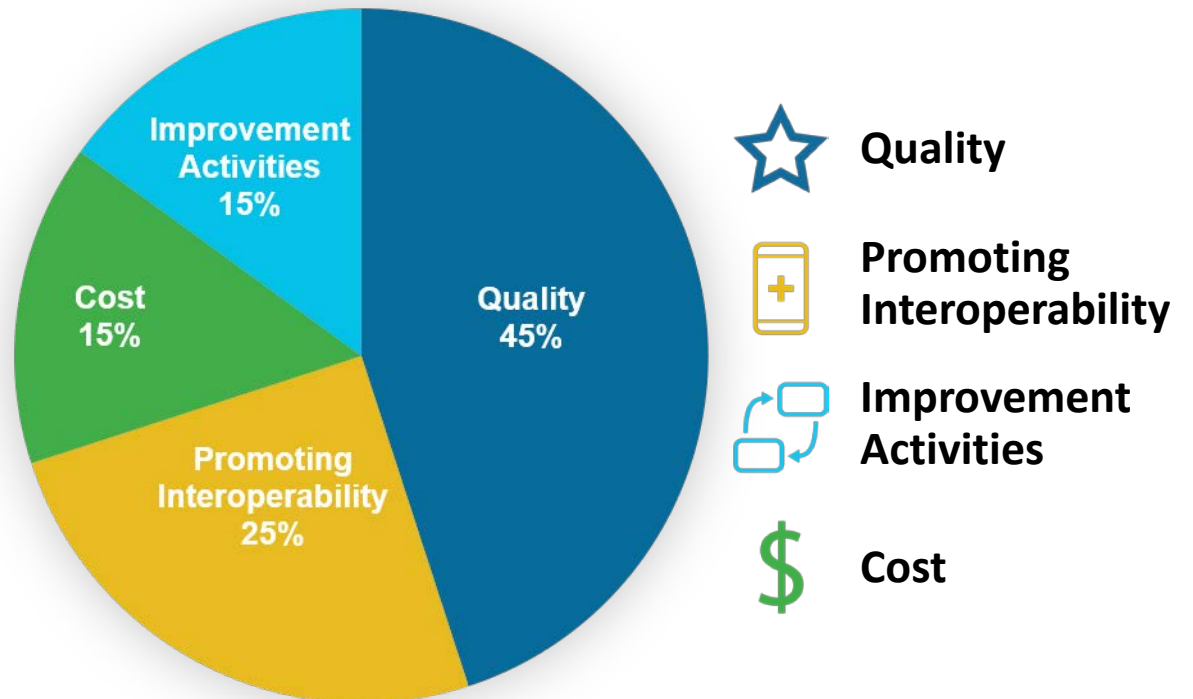
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## What is MIPS?

The Merit-based Incentive Payment System (MIPS) is one of the two tracks of the Medicare Quality Payment Program (QPP), which implements provisions of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA).

## What must be submitted to successfully participate in MIPS?

If you are participating in QPP through MIPS, you must submit a full year of Quality measures, full year of Cost measures, 90 days of Promoting Interoperability measures and 90 days of Improvement Activities measures. Your MIPS payment adjustment in 2022 will be based on submitting data and your performance for the following MIPS categories in 2020:





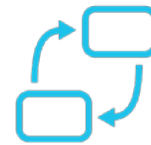
## Quality Category - 45%

The reporting period for the Quality category is a 12-month period (January 1 through December 31, 2020). During this 12-month period, six measures must be reported and at least one outcome measure or another high-priority measure.

Clinicians choose measures on which they may report from among a list. Some include:

- **Quality ID-005:** Heart Failure (HF): Angiotensin-converting enzyme (ACE) Inhibitor, Angiotensin-Receptor Blocker (ARB) or Angiotensin Receptor-Nepriylsin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- **Quality ID-008:** HF: Beta-Blocker for LVSD
- **Quality ID-047:** Advance Care Plan
- **Quality ID-076:** Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections
- **Quality ID-130:** Documentation of Current Medications in the Medical Record
- **Quality ID-226:** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- **Quality ID-431:** Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling

Red: high-priority measures



## Improvement Activities - 15%

The reporting period for the Improvement Activities category is a 90-day to a full-calendar-year period (January 1 through December 31, 2020).

Clinicians choose activities they may participate in from a list. Some activities include:

- **IA\_BE\_6:** Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
- **IA\_BE\_14:** Engage patients and families to guide improvement in the system of care
- **IA\_EPA\_3:** Collection and use of patient experience and satisfaction data on access
- **IA\_CC\_1:** Implementing the use of specialist reports back to referring clinician or group to close referral loop
- **IA\_CC\_5:** Centers for Medicare & Medicaid Services (CMS) partner in patients Hospital Engagement Network
- **IA\_CC\_8:** Implementation of documentation improvements for practice/process improvements
- **IA\_CC\_10:** Care transition documentation practice improvements
- **IA\_PM\_21:** Advance care planning
- **IA\_PSPA\_2:** Participation in Maintenance of Certification (MOC) Part IV
- **IA\_PSPA\_8:** Using patient safety tools
- **IA\_PSPA\_11:** Participation in Consumer Assessment of Healthcare Providers and Systems (CAHPS) or other supplemental questionnaire
- **IA\_PSPA\_16:** Using decision support and standardized treatment protocols
- **IA\_PSPA\_20:** Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes
- **IA\_PSPA\_22:** Centers for Disease Control and Prevention (CDC) training on CDC's Guideline for Prescribing Opioids for Chronic Pain
- **IA\_PSPA\_26:** Communication of unscheduled visit for adverse drug event and nature of event

Blue: medium-weighted measures

Green: high-weighted measures

# \$ Cost - 15%

## Why report cost?

For the 2020 performance year, the Cost category is 15 percent of the MIPS final score. Reporting on Cost measures in 2020 will help you understand the Cost category before the percentage increases in future performance years.

## No Cost category? What happens?

If you do not meet either or the case minimums for either measure of the Cost category, it will be reweighted to the Quality category. This will then result in the Quality category being worth 60 percent of your MIPS final score, instead of 45 percent.

## How will you be scored?

- If only one measure can be scored, that score will be the performance score.
- There is no reporting required. The Centers for Medicare & Medicaid Services (CMS) automatically calculates from claims submitted for payment.
- No score will be given to eligible clinicians who are not attributed any cost measures because of case minimum requirement or lack of benchmark.

## Medicare Spend per Beneficiary Clinician (35 case minimum)

- Risk-adjusted Part A and B costs per inpatient admission
- Attributed based on service volume during hospitalization
- Assesses the cost of care for services related to qualifying in patient hospital stay (immediately prior to, during and after) for Medicare patient
- Includes all Part A and Part B claims

## Total per Capita Cost (20 case minimum)

- Risk-adjusted per capita Part A and B costs
- Attributed based on primary care service volume
- Assesses the primary care clinician's overall care for a Medicare patient during the performance period

## Episode-Based Measures

- Electronic Outpatient Percutaneous Coronary Intervention (PCI)
- Knee Arthroplasty
- Revascularization for Lower Extremity Chronic Limb Ischemia
- Routine Cataract Removal with Intraocular Lens (IOL) Implantation
- Screening/Surveillance Colonoscopy
- Acute Kidney Injury Requiring New Inpatient Dialysis
- Elective Primary Hip Arthroplasty
- Femoral or Inguinal Hernia Repair
- Hemodialysis Access Creation
- Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels
- Lumpectomy Partial Mastectomy, Simple Mastectomy
- Non-Emergent Coronary Artery Bypass Graft (CABG)
- Renal or Ureteral Stone Surgical Treatment
- Intracranial Hemorrhage or Cerebral Infarction
- Simple Pneumonia with Hospitalization
- ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)
- Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
- Lower Gastrointestinal Hemorrhage (applies to groups only)

$$\text{COST PERFORMANCE} = \frac{\text{Total points scored on each measure}}{\text{Total possible points available}}$$



# Promoting Interoperability (PI) - 25%

The Promoting Interoperability (PI) performance category score is now performance-based (100 points with optional 10 bonus points). The score is based on “objectives” that have measures included in them.

## Submit YES to:

- Prevention of Information Blocking Attestation
- Office of the National Coordinator (ONC) Direct Review Attestation
- Security Risk Analysis (SRA) Completion:
  - No score attached
  - Must be during calendar year in which reporting
  - Required to receive PI score

## Certified Electronic Health Record Technology (CEHRT) Requirements:

- 2015 edition
- Be in place for the 90-day reporting period chosen
- Be certified to 2015 edition by the last day of the selected reporting period

## How is PI scored?

Provider-to-Patient Exchange	
Measure Name	Points
Provide Patient Electronic Access to Their Health Information	40

Public Health and Clinical Data Exchange (Choose 2 – Reported with “YES” or “NO.”)	
Measure Name	Points
Immunization Registry Reporting	10
Electronic Case Reporting	10
Public Health Registry Reporting	10
Syndromic Surveillance Reporting	10
Clinical Data Registry Reporting	10

Electronic Prescribing (Green measures are bonus measures.)	
Measure Name	Points
E-Prescribing	10
Query of Prescription Drug Monitoring Drug Program (PDMP)	5

Health Information Exchange	
Measure Name	Points
Support Electronic Referral Loops by Sending Health Information	20
Support Electronic Referral Loops by Receiving and Incorporating Health Information	20

Learn more at [qpp.cms.gov](http://qpp.cms.gov).