

# Five Steps for Hospital-based Clinician Success in the 2018 MIPS Performance Year

Although most Merit-based Incentive Payment System (MIPS) eligible clinicians practice in ambulatory locations, it is essential for health care organizations to understand the requirements for hospital-based clinicians. This resource outlines five steps to support hospital-based clinicians' success, and includes updates to MIPS hospital-based policies for the 2018 performance period.

STEP

1



**REMEMBER** that hospital-based clinicians who bill Medicare Part B professional services are subject to MIPS payment adjustments, unless otherwise excluded (e.g., new Medicare-enrolled clinicians, low-volume clinicians or groups, or Qualifying Participants in the Advanced Alternative Payment Model [APM] track).

STEP

2



**DETERMINE** which clinicians qualify as hospital-based under MIPS. CMS plans to notify MIPS eligible clinicians of their hospital-based status.

- **Definition.** A MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in Place of Service (POS) 19 (off campus outpatient hospital), POS 21 (inpatient hospital), POS 22 (on campus outpatient hospital), or POS 23 (emergency room). **Note:** CMS added POS 19 to the hospital-based definition starting with the 2018 performance year
- **Designation.** At the individual clinician (i.e., TIN<sup>1</sup>/NPI<sup>2</sup>) level; if reporting as a group (i.e., TIN), a group may qualify for hospital-based designation if all MIPS eligible clinicians in the group are deemed hospital-based
- **Determination.** For the 2018 reporting year, based on Medicare claims data with dates of service from September 1, 2016 through August 31, 2017

1) TIN = Tax Identification Number.  
2) NPI = National Provider Identifier.

STEP

3



**COMPARE AND CONTRAST** individual and/or group reporting options. The decision to report MIPS as an individual or as a group must be applied consistently across all performance categories. Many clinicians will find group reporting policies favorable.

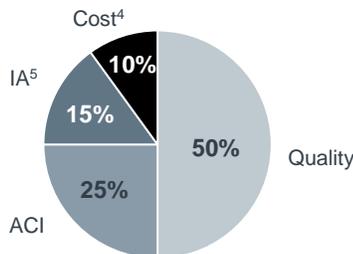
STEP

4



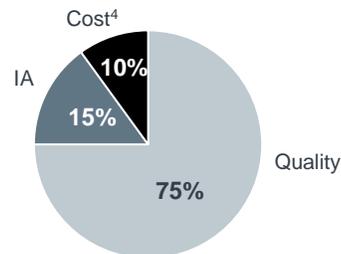
**CONFIRM** applicable MIPS performance category weighting. CMS assumes hospital-based clinicians do not have sufficient Advancing Care Information (ACI) measures applicable to them. In some cases, the ACI category will be automatically reweighted to 0%. See below for two potential MIPS performance category weighting scenarios<sup>3</sup>.

SCENARIO 1  
**Default Category Weighting**



Applies to hospital-based clinicians reporting as part of a group that also includes other clinicians for whom ACI measures are applicable. CMS expects groups to include available ACI performance for all eligible clinicians that bill under the same TIN when the group reports their aggregate ACI performance.

SCENARIO 2  
**ACI Reweighted to 0%**



Applies to hospital-based clinicians reporting individually, or as part of a group that does not include any clinicians for whom ACI measures are applicable (e.g., all clinicians in the group are hospital-based). CMS will automatically reweight<sup>6</sup> the ACI category to 0%.

3) Different category weights apply to MIPS APM participants.

4) The Cost category may be reweighted to 0% if an EC or group does not meet the case minimum for any Cost measures, and the 10% weight is redistributed to the Quality category.

5) IA = Improvement Activities.

6) If a hospital-based EC or group chooses to report ACI, CMS will include their ACI performance in the MIPS final score.



**ASSESS** MIPS reporting strategy and maximize performance. For a full list of available measures and activities, see our [2018 MIPS Measures List](#).

- **Consider reporting method options.** For more information on reporting options refer to slide 22 from our [2018 MACRA Detailed Analysis webconference](#).
- **Choose Quality measures based on performance.** Quality performance plays a significant role in the overall MIPS score, especially in scenarios where the ACI category is reweighted to 0%. Compare likely performance [against available 2018 MIPS Quality benchmarks](#) and identify opportunities for improvement. Hospital-based clinicians may wish to consider the following:
  - *Report hospital-based specialty-specific measures.*  
For example, CMS finalized specialty measure sets for hospitalists, radiology, anesthesiology, pathology, and emergency medicine.
  - *Report other specialty-specific measures if part of a multispecialty group.*  
Clinicians that report MIPS as a group are scored on measures that the group selects to report, regardless of whether those measures are applicable to each individual clinician in the group.
  - *Report broadly applicable measures.*  
Clinicians are not limited to measures included in their specialty measure set.

For more information on Quality category scoring, see slide 50 from our [2018 MACRA Detailed Analysis webconference](#).

- **Aim for full Improvement Activities credit.** Hospital-based clinicians may wish to consider the activities in Appendix A based on their scope of practice. For more information on scoring and special considerations, see slide 55 from our [2018 MACRA Detailed Analysis webconference](#).
- **Determine potential impact of Cost measures.** 2018 is the first year the MIPS score includes performance on Cost measures. Hospital-based clinicians may be held accountable on Medicare spending for attributed patients. For more information on Cost measures and attribution, see slide 53 from our [2018 MACRA Detailed Analysis webconference](#).

## APPENDIX A: Improvement Activities for Hospital-based Clinicians to Consider

Improvement Activity	Weight
<p>Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., MIPS eligible clinician and care team access to medical record, cross -coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following:</p> <ul style="list-style-type: none"> <li>Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care);</li> <li>Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or</li> <li>Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management.</li> </ul>	<b>High</b>
<p>Participation in a QCDR, clinical data registries, or other registries run by other government agencies such as FDA, or private entities such as a hospital or medical or surgical society. Activity must include use of QCDR data for quality improvement (e.g., comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcome).</p>	<b>Medium</b>
<p>Provide episodic care management, including management across transitions and referrals that could include one or more of the following:</p> <ul style="list-style-type: none"> <li>Routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings, including symptom and disease management, and medication reconciliation and management; and/or</li> <li>Managing care intensively through new diagnoses, injuries and exacerbations of illness.</li> </ul>	<b>Medium</b>
<p>Membership and participation in a CMS Partnership for Patients Hospital Engagement Network.</p>	<b>Medium</b>
<p>Implementation of practices/processes for care transition that include documentation of how a MIPS eligible clinician or group carried out a patient-centered action plan for first 30 days following a discharge (e.g., staff involved, phone calls conducted in support of transition, accompaniments, navigation actions, home visits, patient information access, etc.).</p>	<b>Medium</b>
<p>Establish standard operations to manage transitions of care that could include one or more of the following:</p> <ul style="list-style-type: none"> <li>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</li> <li>Partner with community or hospital-based transitional care services.</li> </ul>	<b>Medium</b>

APPENDIX A, continued.

Improvement Activity	Weight
<p>Clinicians attest that they are consulting specified applicable AUC through a qualified clinical decision support mechanism for all applicable imaging services furnished in an applicable setting, paid for under an applicable payment system, and ordered on or after January 1, 2018. This activity is for clinicians that are early adopters of the Medicare AUC program (2018 performance year) and for clinicians that begin the Medicare AUC program in future years as specified in our regulation at §414.94. The AUC program is required under section 218 of the Protecting Access to Medicare Act of 2014. Qualified mechanisms will be able to provide a report to the ordering clinician that can be used to assess patterns of image-ordering and improve upon those patterns to ensure that patients are receiving the most appropriate imaging for their individual condition.</p>	<p><b>High</b></p>
<p>Completion of all modules of the Centers for Disease Control and Prevention antibiotic stewardship course.</p> <p><b>Note:</b> This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.</p>	<p><b>High</b></p>
<p>Implement a Patient Navigator Program that offers evidence-based resources and tools to reduce avoidable hospital readmissions, utilizing a patient -centered and team-based approach, leveraging evidence-based best practices to improve care for patients by making hospitalizations less stressful, and the recovery period more supportive by implementing quality improvement strategies.</p>	<p><b>High</b></p>
<p>Completion of greater than 50 percent of the modules of the Centers for Disease Control and Prevention antibiotic stewardship course.</p> <p><b>Note:</b> This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis , but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.</p>	<p><b>Medium</b></p>
<p>A MIPS eligible clinician providing unscheduled care (such as an emergency room, urgent care, or other unplanned encounter) attests that, for greater than 75 percent of case visits that result from a clinically significant adverse drug event, the MIPS eligible clinician provides information, including through the use of health IT to the patient’s primary care clinician regarding both the unscheduled visit and the nature of the adverse drug event within 48 hours. A clinically significant adverse event is defined as a medication-related harm or injury such as side-effects, suprathereapeutic effects, allergic reactions, laboratory abnormalities, or medication errors requiring urgent/emergent evaluation, treatment, or hospitalization.</p>	<p><b>Medium</b></p>
<p>MIPS eligible clinician leadership in clinical trials, research alliances or community-based participatory research (CBPR) that identify tools, research or processes that can focuses on minimizing disparities in healthcare access, care quality, affordability, or outcomes.</p>	<p><b>Medium</b></p>

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