MIPS: Quality Category Deep Dive

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Agenda

- **Merit-Based Incentive Program (MIPS)**
  - Program Basics
- **Quality Category**
  - Quality Basics
  - Scoring
  - Benchmarks
  - Measure Specifications
- **Q&A**

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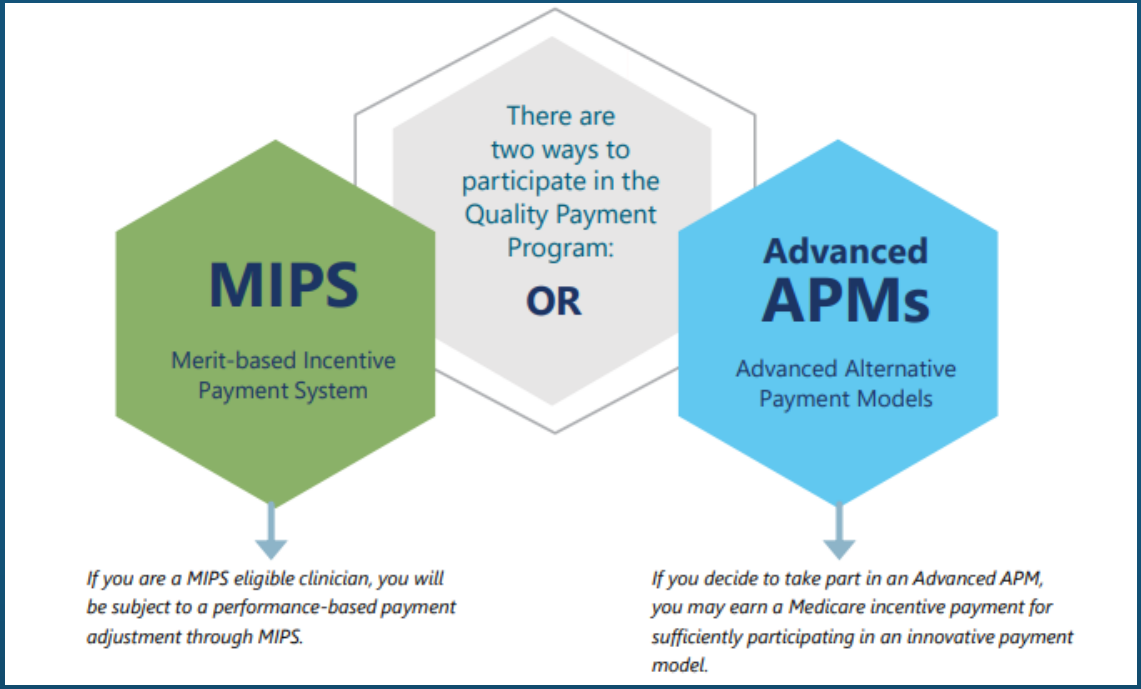
MIPS – Program Basics

Quality Payment Program – established by 2015 MACRA (Medicare Access and CHIP Reauthorization Act) which seeks to reward clinicians who provide high value/high quality care.



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MIPS – Program Basics

- QPP Participants can earn incentive payments based on performance
  - Qualifying Advanced APM Participants
    - Exempt from MIPS
    - Receive a 5% lump sum APM Incentive payment
  - MIPs Participants
    - Participants earn a payment adjustment based on a score
      - Payment adjustments can be positive (bonus) or negative (penalties)
    - Individuals exceeding the low volume threshold must participate or will receive a negative payment adjustment
    - Payment adjustments are applied to Medicare part B claims two years after a performance period

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MIPS – Program Basics

Performance Thresholds and Payment Adjustments

Performance Year	Payment Year	Max Payment Adjustments	Performance Threshold	Exceptional Performance Threshold	Payment Adjustments
2017	2019	(+/ -) 4%	3 pts	70 pts	1.88%
2018	2020	(+/ -) 5%	15 pts	70 pts	1.68%
2019	2021	(+/ -) 7%	30 pts	75 pts	(1.79%)
2020	2022	(+/ -) 9%	45 pts	85 pts	6.25% **
2021	**2023**	**(+/ -) 9%**	**60 pts**	**85 pts**	**6 – 8 % ******
2022	2024	(+/ -) 9%	75 pts ***	89***	8+%**

**CMS forecast – COVID hardship not accounted for

*** Proposed rule thresholds

CMS is required to set performance thresholds to mean or median performance rates by 2022

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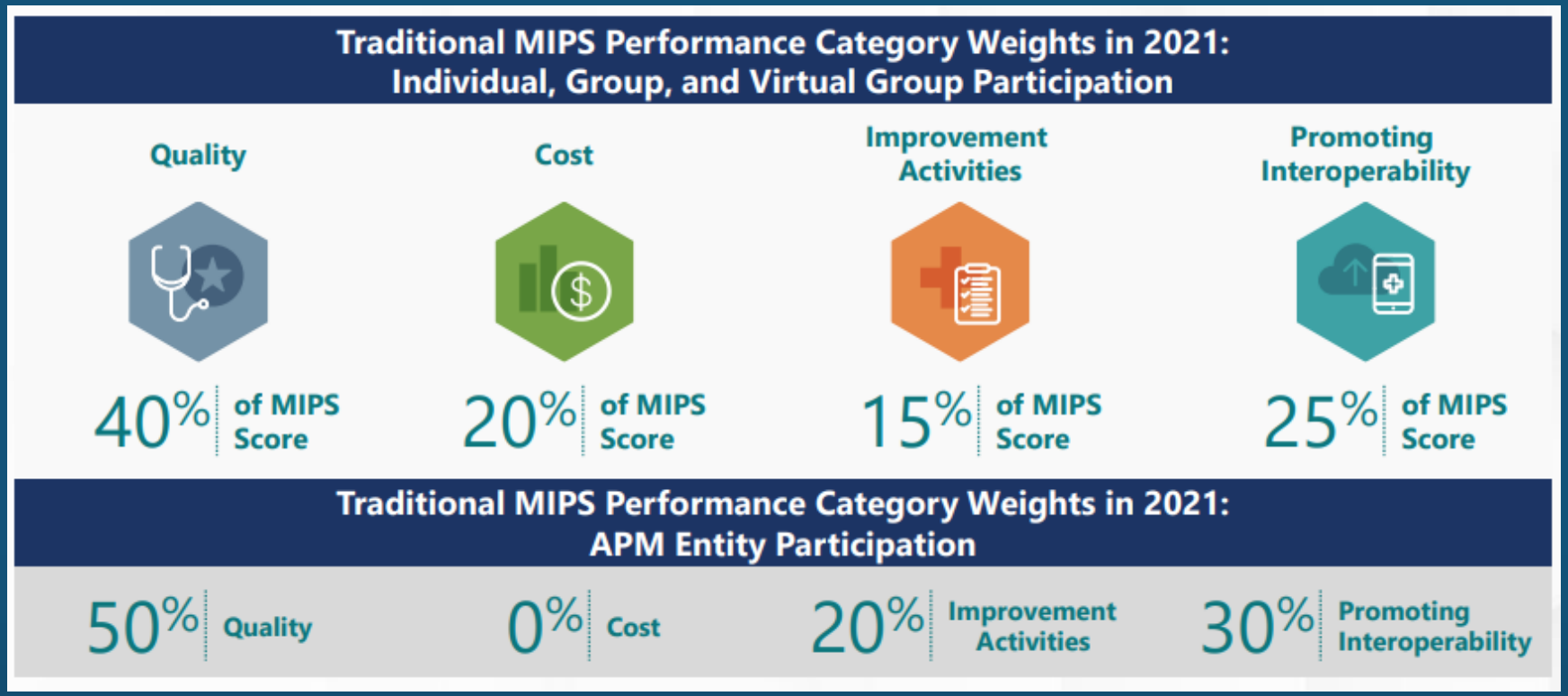
MIPS – Program Basics

Performance Categories:



*Quality and Cost weighted at 30% in 2022

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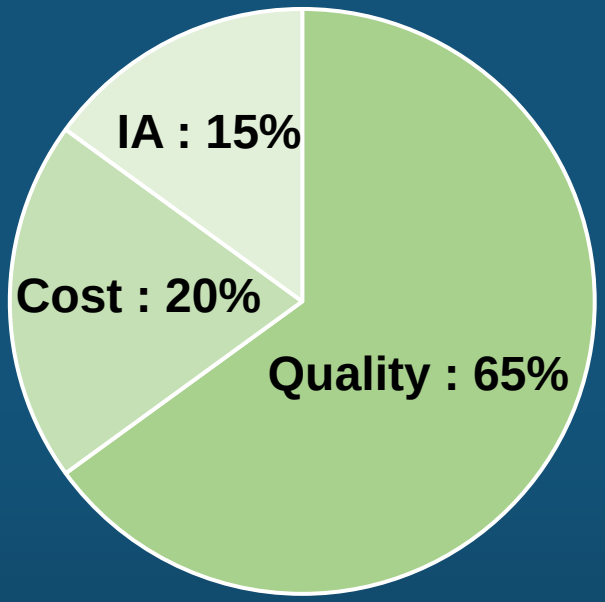
MIPS – Program Basics

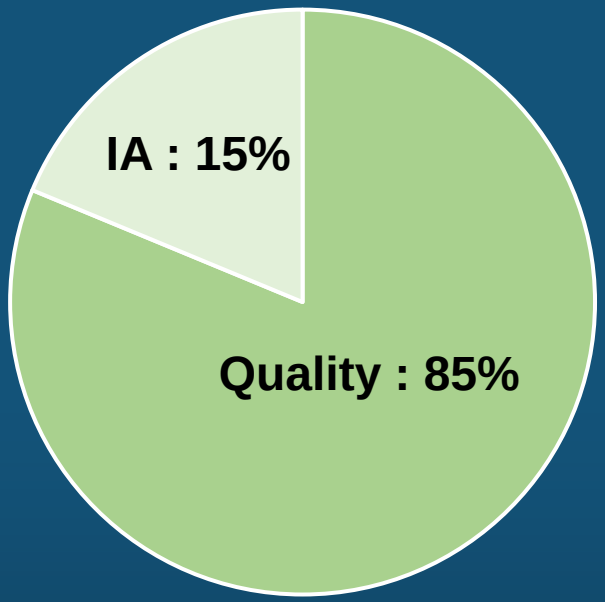
Automatically applied *special statuses* in the program impact category weighting in the final score

- Most common reporting scenarios:

Exempt from PI



Exempt from PI and Cost



https://qpp.cms.gov/mips/special-statuses

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MIPS – Program Basics

In order to avoid a penalty in 2021, participants need to earn <u>at least</u> 50% in all performance categories

Magic Numbers for 2021

- **Quality**
  - **33/60 – ensures you avoid a penalty regardless of bonus points**
  - **49/60 – ensures you're an exceptional performer (85 pts) regardless of bonus**
- **Improvement Activities**
  - **15/15 – participants should always get full credit for this category**

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Quality Category Basics

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Quality Basics

The quality performance category measures health care processes, outcomes, and patient experiences of care by collecting data outlined by approved **measures**.

Category Requirements:

- **Submit 6 or more quality measures**
  - **Some exceptions apply**
- **Collect data across 12-month performance period**
- **Report on at least 70% of eligible patients***
  - *Proposed to increase to 80% in 2022

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Quality Basics

Quality Measure Collection Types	
Medicare Part B Claims	Quality data is reported on Medicare beneficiaries only, available for **small practices only**
MIPS CQM (Registry)	Quality data is collected on all patients, participants must use a **3rd party vendor** to submit data to CMS
MIPS eCQM (EHR)	Quality data is collected on all patients within an EHR, participants must use a **3rd party vendor** or their EHR to submit data to CMS
CMS Web Interface	***Sunset in 2022/2023*** Groups, virtual groups, and APM Entities register to report on 10 measures for patients selected by CMS
CAHPS for MIPS Survey	Groups, virtual groups, and APM Entities register for a vendor conducted survey which counts as one quality measure
Administrative Claims	***New in 2021*** CMS calculated measures that are applied to individuals, groups, or virtual groups who meet case minimums

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Quality Basics

Measures are added, removed, modified annually

- CMS maintains measures inventory through rulemaking (Medicare Fee Schedule)
  - Measures themselves are updated by ‘stewards’

MIPS Participants must review yearly updates and make changes accordingly

- Can I continue to report the same measures?
- Have the documentation requirements changed?
- Have the applicable CPT codes changed?

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Quality Scoring

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Quality Scoring

Quality measures are worth a maximum of either 7 or 10 points.

- **Category score taken out of 60 points –** *some exclusions apply*
  - Top 6 highest scoring measures comprise the category score – *some exclusions apply here too*
- **Certain types of measures are worth bonus points (high priority/outcome)**
  - **Max of 6 earned bonus points across all measures**

For a measure to be scored based on *performance*, the following must be met:

- **The measure must have a benchmark**
- **Data completeness of 70%+** *(proposed to increase to 80% in 2022)*
- **Case minimum of 20 cases**

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Quality Scoring

	PT Population case minimum of 20	Data Completeness minimum 70%	Performance Rate	Points
Measure ABC	431	100%	100%	**10**
Measure XYZ	723	100%	100%	**7**
Measure AAA	632	100%	98.76%	**6.74**
Measure BBB ***no benchmark**	621	98%	100%	**3**
Measure CCC ***under data completeness**	100	65%	100%	**3**
Measure DDD ***under case minimum**	5	100%	100%	**3**
			Total	**32.74**

**CMS is proposing to remove the 3 pt floor*

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Quality Scoring

Bonus Points*

- **Electronic Submission (end of end reporting) – 1 pt** each for EHR measures

- **Additional Priority Measures – 2 pts** for each **additional** Outcome, **1 pt** for each **additional** High Priority

- **Small Practice Bonus – 6** points added to quality category in addition to achievement and other bonus pts

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Quality Scoring

Bonus Points

Improvement Scoring – *New in 2020*

- **MIPs Participants can earn up to 10 percentage points applied to the overall category based on the rate of improvement from the past year**

- **To be eligible:**
  - **Full participation in the quality category, all measures reach data completeness**
  - **CMS has two comparable performance years**
    - **If Facility-based scoring is applied, Improvement scoring can not be calculated**

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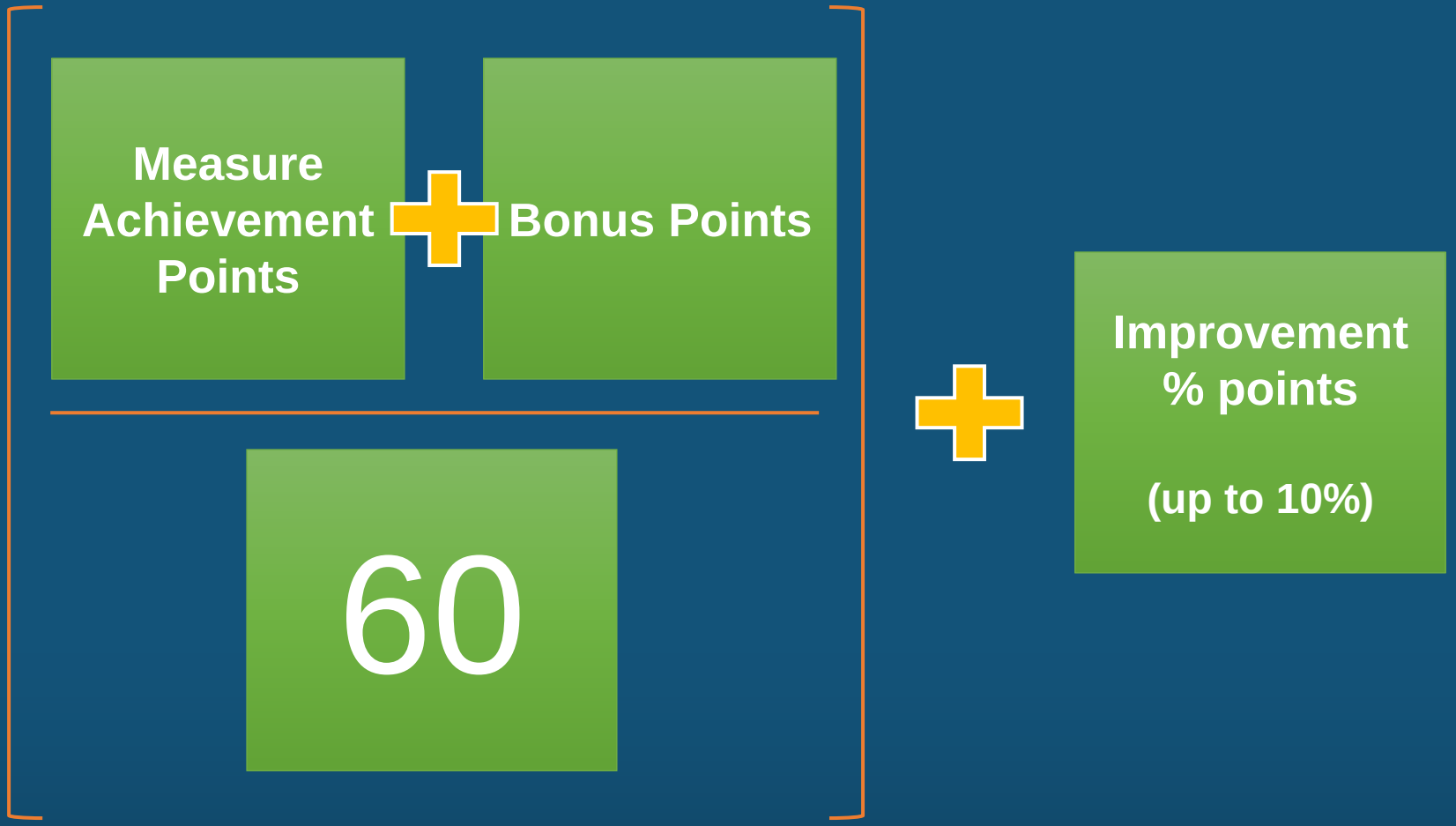
Quality Scoring



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Quality Scoring

Radiology: Reminder System for Screening Mammograms

Measure ID: 225

100.00%

10.00

Lowest Benchmark

29.83 -- -- -- -- -- -- -- -- -- -- -- -- >=100.00

Highest Benchmark

Performance Rate 100.00%

High Priority Bonus Ignored

This measure meets the requirement to receive the high priority bonus but has been selected as the first measure and is not eligible for the high priority bonus.

Measure Type

Structure

Collection Type

MIPS clinical quality measures (CQMs)

Download Specifications

Details

Numerator	10715
Denominator	10715
Data Completeness	99.57%
Eligible Population	10761

Performance Points

Points from Benchmark Decile	10.00

Bonus Points

High Priority Outcome or Patient Experience	0.00
Other High Priority	0.00
End-to-End Reporting	0.00

Measure Score **10.00**

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Quality Scoring

Topped Out Quality Measures

- **Topped-Out – quality measures with a national median performance rate is 95% or better**
  - **"Extremely Topped Out" – national median performance rate is 98% or better**
    - **These measures can be removed at any time**
  - **Once a measure becomes 'topped-out' it starts process of potential removal**
  - **Performance is so high that meaningful distinctions and improvement in performance can no longer be made**

Year 1 - 2	Year 3	Year 4
100% performance to earn 10 pts	Measure devalued	Measure can be eliminated
One case of 'not met' decreased point value significantly	Points capped at 7 (bonus pts still eligible)	Rule-making process removes measures

****CMS does not ALWAYS follow this lifecycle****

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Quality Scoring

Topped Out Quality Measure Considerations

- A measure can be ‘topped out’ and still be worth 10 pts
- Topped out measures require perfect performance to return the maximum amount of points
  - Even one encounter counting against the measure can significantly lower the amount of points returned
- Achieving ‘exceptional performer’ status is still possible if even if all measures are capped at 7 pts
  - Possible does not equal easy!!

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Benchmarks

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Benchmarks

Using historical performance across two performance years, CMS calculates ranges of performance across deciles

Benchmarks are unique to the collection type of the measure

Measure Title	Measure ID	Collection Type	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out	Seven Point Cap
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	1	MIPS CQM	79.99-70.01	70 - 60.01	60 - 50.01	50 - 40.01	40 - 30.01	30 - 20.01	20 - 10.01	<= 10	N	N
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	1	eCQM	>= 99.46	99.45 - 92.62	92.61 - 74.48	74.47 - 59.09	59.08 - 46.85	46.84 - 37.89	37.88 - 31.41	<= 31.40	N	N
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	1	Medicare Part B Claims	79.99-70.01	70 - 60.01	60 - 50.01	50 - 40.01	40 - 30.01	30 - 20.01	20 - 10.01	<= 10	N	N

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Benchmarks

As MIPS participant performance improves, the harder the benchmark becomes from year to year

Measure Title	Measure ID	Collection Type	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out	Seven Point Cap
Radiology: Reminder System for Screening Mammograms	225	Medicare Part B Claims	3.45 - 99.16	99.17 - 99.99	--	--	--	--	--	100	N	N
Radiology: Reminder System for Screening Mammograms	225	MIPS CQM	29.83 - 99.99	--	--	--	--	--	--	100	N	N
Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	436	Medicare Part B Claims	2.36 - 90.17	90.18 - 98.48	98.49 - 99.89	99.9 - 99.99	--	--	--	100	Y	Y
Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques	436	MIPS CQM	0.84 - 85.15	85.16 - 98.36	98.37 - 99.91	99.92 - 99.99	--	--	--	100	Y	Y

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Measure Specifications

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Measure Specifications

- **Each measure and collection type has a unique specification**
  - **Measures with multiple collection types (claims vs MIPS CQM) may have variations between specification documents**
- **Specifications outline the intent of the measure and the instructions on how to report data to CMS**
- **Measure specification can change from year to year with annual updates**
- MIPS Explore Measures - QPP (cms.gov)

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Measure Specifications

Quality ID #147: Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
– National Quality Strategy Domain: Communication and Care Coordination
– Meaningful Measure Area: Transfer of Health Information and Interoperability

2021 COLLECTION TYPE:
MEDICARE PART B CLAIMS

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, Magnetic Resonance Imaging (MRI), Computed Tomography (CT), etc.) that were performed

INSTRUCTIONS:
This measure is to be submitted **each time** bone scintigraphy is performed during the performance period. There is no diagnosis associated with this measure. It is anticipated that Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the professional component of the bone scintigraphy study will submit this measure.

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians using Medicare Part B claims. The listed denominator criteria are used to identify the intended patient population. The numerator quality-data codes included in this specification are used to submit the quality actions allowed by the measure on the claim form(s). All measure-specific coding should be submitted on the claim(s) representing the denominator eligible encounter and selected numerator option.

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Measure Specifications

DENOMINATOR:
All final reports for patients, regardless of age, undergoing bone planar and whole body scintigraphy

Denominator Criteria (Eligible Cases):
Patient encounter during the performance period (CPT): 78300, 78305, 78306, 78315

NUMERATOR:
Final reports that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT, etc.)

Definition:
Relevant Imaging Studies – Relevant imaging studies are defined as studies that correspond to the same anatomical region in question.

Numerator Quality-Data Coding Options:
Bone Scintigraphy Report Correlated with Existing Studies
Performance Met: **CPT II 3570F**: Final report for bone scintigraphy study includes correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT) corresponding to the same anatomical region in question

OR

Bone Scintigraphy Report not Correlated for System Reasons
Append a submission modifier (3P) to CPT Category II code 3570F to submit documented circumstances that appropriately exclude patients from the denominator.

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Measure Specifications

***Denominator Exception:* 3570F *with* 3P**: Documentation of system reason(s) for not documenting correlation with existing relevant imaging studies in final report (e.g., no existing relevant imaging study available, patient did not have a previous relevant imaging study)

Note: *Correlative studies are considered to be unavailable if relevant studies (reports and/or actual examination material) from other imaging modalities exist but could not be obtained after reasonable efforts to retrieve the studies are made by the interpreting physician prior to the finalization of the bone scintigraphy report.*

OR

Bone Scintigraphy Report not Correlated, Reason not Otherwise Specified

Append a submission modifier (8P) to CPT Category II code 3570F to submit circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

***Performance Not Met:* 3570F *with* 8P**: Bone scintigraphy report not correlated in the final report with existing relevant imaging studies, reason not otherwise specified

CLINICAL RECOMMENDATION STATEMENTS:

Bone scintigraphy abnormalities should be correlated with appropriate physical examination and imaging studies to ascertain that osseous or soft-tissue abnormalities, which might cause cord or other nerve compression or pathologic fracture in an extremity, are not present. (SNM, 2003)

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Questions

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Thank You!