Quality Payment PROGRAM

2020 MIPS Quality Measure Benchmarks Overview

Purpose: This resource provides an overview of how we establish MIPS Quality measure benchmarks, how benchmarks are used for scoring, and the information in the 2020 Quality Benchmarks and 2020 Multi-Performance Rate Measures files.

Updated 2/19/2020

Table of Contents

What Are Quality Measure Benchmarks?

Quality measure benchmarks are the point of comparison we use to score the measures you submit. When you submit measures for the Merit-based Incentive Payment System (MIPS) Quality performance category, your performance on each measure is assessed against its benchmark to determine how many points the measure earns.

- We compare your performance on the measure to its benchmark.
- We assign anywhere from 3 to 10 achievement points for each MIPS measure that meets the data completeness standards and case minimum requirements based on this comparison.
- Measures may also be eligible for bonus points, in addition to these achievement points.

How Are Benchmarks Established?

We establish benchmarks specific to each collection type: Qualified Clinical Data Registry (QCDR) measures, MIPS Clinical Quality Measures (MIPS CQMs), electronic clinical quality measures (eCQMs), CMS Web Interface measures, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey, and Part B Claims measures.

> Did you know?
>
> Because benchmarks are specific to collection type, a measure reported as an eCQM will be compared to a different benchmark than the same measure reported as a MIPS CQM.

eCQMs, MIPS CQMs, QCDR Measures, and Medicare Part B Claims Measures

Whenever possible, we use historical data to establish benchmarks. 2020 historical benchmarks for eCQMs, MIPS CQMs, Medicare Part B claims measures, and QCDR measures are based on actual performance data that was submitted to the Quality Payment Program (QPP) in 2018.

To establish a historical benchmark:

- The 2018 and 2020 measure specifications must be comparable (no significant changes to the measure between 2018 and 2020)
- There must be 20 instances of the measure being reported through the same collection type by individual clinicians, groups and/or virtual groups, AND
    - The clinician, group or virtual group was eligible for MIPS in 2018 (no changes to low-volume threshold for PY 2020), AND
    - The measure met PY 2020 data completeness (70%) and case minimum requirements (20 cases), AND
    - The measure had a performance rate greater than 0% (or less than 100% for inverse measures

CMS Web Interface Measures

We use benchmarks from the Medicare Shared Savings Program to assess and score CMS Web Interface measures. The 2020 Medicare Shared Savings Program benchmarks will be available in early February on this page: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-guidance-and-specifications. CMS Web Interface benchmarks are not included in the 2020 Quality Measure Benchmark file.

Updated 2/19/2020

CAHPS for MIPS Survey Measure and All Cause Hospital Readmission Measure

We are still calculating benchmarks for the CAHPS for MIPS Survey measure and All-Cause Hospital Readmission measure. Both will be calculated using historical (PY 2018) data.

For the CAHPS for MIPS Survey measure, we will establish a benchmark for each summary survey measure (SSM). A range of 3 to 10 points are assigned to each SSM by comparing performance to the benchmark (similar to other measures). The final CAHPS for MIPS score will be the average number of points across all scored SSMs.

The CAHPS for MIPS Survey measure and the All Cause Hospital Readmission measure benchmarks will be available later in 2020.

How Are Results Displayed in the Benchmark File?

Each benchmark is presented in terms of deciles, with the benchmark file displaying Deciles 3 – 10. Table 1 identifies the range of points generally available for the measure, based on which decile your performance rate falls in.

Exception: Measures that are topped out for 2 consecutive years are capped at 7 points, even if your performance rate falls in Deciles 7 - 10.)

Did you know?

For **inverse measures,** better performance is indicated by a lower performance rate. This is reflected in the benchmark file, where lower performance rates are found in higher deciles.

The 2020 benchmark file reflects the **flat benchmarks** finalized through rulemaking for **Measures 001 and 236**.

- **Measure 001:** Flat benchmarks only apply to the **MIPS CQM and Medicare Part B Claims measure collection types**. (The eCQM collection type did not meet the criteria set forth in the rule for establishing a flat benchmark*.)
- **Measure 236:** Flat benchmarks apply to all collection types. (Updated 2/14/2020)

*Flat benchmarks are applied to collection types where the top decile for a historical benchmark is higher than 90%

Updated 2/19/2020

Table 1: Using Data Benchmarks to Determine Achievement Points for Measures that Meet Data Completeness and Case Minimum Requirements

Decile	Number of Points Assigned for the 2020 MIPS Performance Period
No benchmark (historical or performance period)	3 points
Below Decile 3	3 points
Decile 3	3-3.9 points
Decile 4	4-4.9 points
Decile 5	5-5.9 points
Decile 6	6-6.9 points
Decile 7	7-7.9 points
Decile 8	8-8.9 points
Decile 9	9-9.9 points
Decile 10	10 points

Historical Benchmarks with Less Than Ten Deciles

Some benchmarks don't include a range of performance rates for every Decile. This occurs when a large percentage of clinicians in the historical benchmark data set had the maximum achievable performance rate. These benchmarks are identifiable when one or more of the deciles between Decile 3 and Decile 9 display "--" while the Decile 10 is identified at 100% (or 0% for inverse measures). The higher the percentage of individual clinicians, groups, and virtual groups that reached the maximum achievable performance rate, the more deciles that will show a value of "--".

For example, in the benchmark for Measure #176 (MIPS CQM) presented below, historical benchmarking identified that the top 40% of clinicians performed at the maximum rate. Therefore, clinicians submitting through this collection type that performed above the 6th decile would receive the maximum performance score of 10 points.

Table 2: Example of a Measure Benchmark with Less than Ten Deciles

Measure Title	Measure ID	Collection Type	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Rheumatoid Arthritis (RA): Tuberculosis Screening	176	MIPS CQM	2.04 - 27.93	27.94 - 52.79	52.8 - 89.14	89.15 - 99.99	--	--	--	100

Did you know?

The **Scoring Examples** tab of the 2020 Benchmark file provides examples for various scoring scenarios.

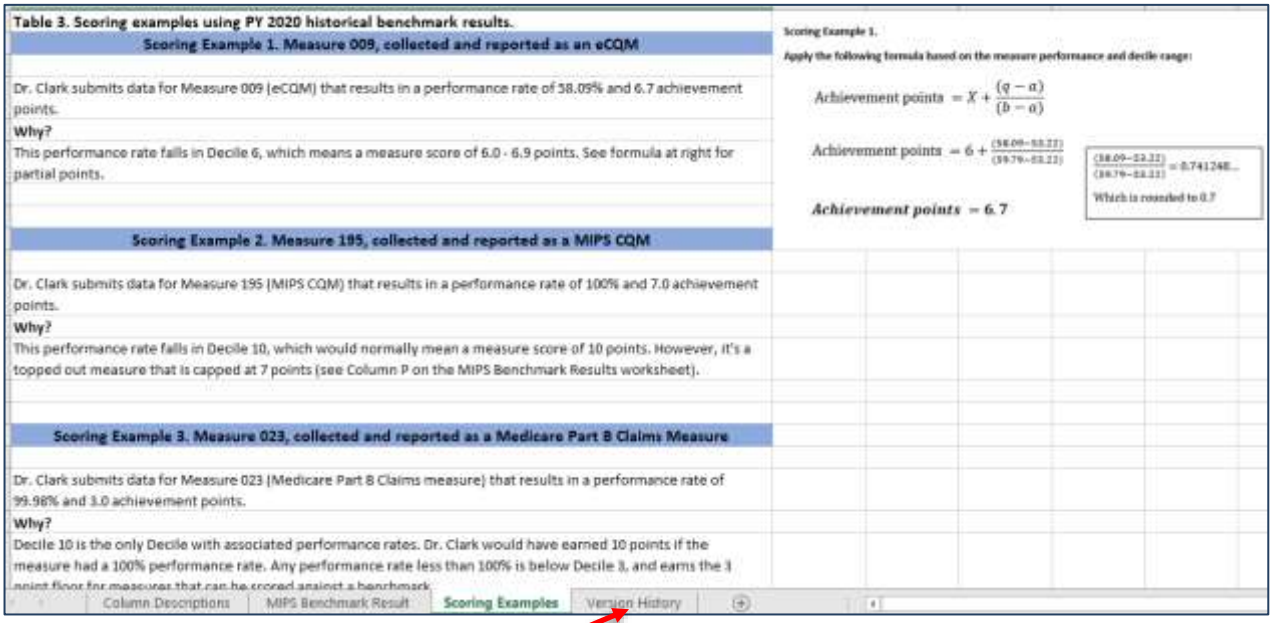


Table 3. Scoring examples using PY 2020 historical benchmark results.
Scoring Example 1. Measure 009, collected and reported as an eCQM
Dr. Clark submits data for Measure 009 (eCQM) that results in a performance rate of 58.09% and 6.7 achievement points.
Why?
This performance rate falls in Decile 6, which means a measure score of 6.0 - 6.9 points. See formula at right for partial points.
Scoring Example 2. Measure 195, collected and reported as a MIPS CQM
Dr. Clark submits data for Measure 195 (MIPS CQM) that results in a performance rate of 100% and 7.0 achievement points.
Why?
This performance rate falls in Decile 10, which would normally mean a measure score of 10 points. However, it's a topped out measure that is capped at 7 points (see Column P on the MIPS Benchmark Results worksheet).
Scoring Example 3. Measure 023, collected and reported as a Medicare Part B Claims Measure
Dr. Clark submits data for Measure 023 (Medicare Part B Claims measure) that results in a performance rate of 99.98% and 3.0 achievement points.
Why?
Decile 10 is the only Decile with associated performance rates. Dr. Clark would have earned 10 points if the measure had a 100% performance rate. Any performance rate less than 100% is below Decile 3, and earns the 3

Scoring Example 1.

Apply the following formula based on the measure performance and decile range:

$$\text{Achievement points} = X + \frac{(q-a)}{(b-a)}$$

$$\text{Achievement points} = 6 + \frac{(58.09-53.22)}{(59.79-53.22)}$$

$$\frac{(58.09-53.22)}{(59.79-53.22)} = 0.741248\ldots$$

Which is rounded to 0.7

$$\textit{Achievement points} = 6.7$$

Column Descriptions | MIPS Benchmark Result | Scoring Examples | Version History

You can also check the **Version History** tab for information about changes made to the benchmark file during the performance period.

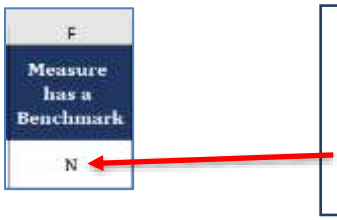
What If A Quality Measure Does Not Have A Historical Benchmark?

If a quality measure or collection type doesn't have a historical benchmark, we will attempt to calculate benchmarks based on data submitted for the 2020 performance period. We can establish performance period benchmarks when at least 20 instances of the measure are reported through the same collection type and meet data completeness and case minimum requirements and have a performance rate greater than 0% (or less than 100% for inverse measures).

Updated 2/19/2020

Performance period benchmarks will be established using data submitted by individual clinicians, groups and virtual groups that are eligible for MIPS in the 2020 performance period.

- This includes individual clinicians and groups that are opt-in eligible and elect to opt-in to MIPS participation.
- Voluntary submissions are excluded from benchmark data.



If no historical benchmark exists and no performance period benchmark can be calculated, then the measure will receive 3 points as long as data completeness and case minimums have been met.

Measures/collection types without **historical** benchmarks display “N” (for “NO”) in the “Measure has a Benchmark” column (Column F).

Are All Topped Out Measures Capped At 7 Points?

No. A measure is capped at 7 points when it is topped out through the same collection type for 2 consecutive years. The 7-point cap is applied in the second year the measure is identified as topped out.

A measure may be topped out without being capped at 7 points. A “Y” (for “YES”) in the **Seven Point Cap** column (column P) of the benchmark file indicates the measure is capped at 7 points.

Example 1. Measure ID 104 (MIPS CQM)

A maximum of 10 achievement points is available for the measure.

Topped Out	Seven Point Cap
Y	N

Updated 2/19/2020

Example 2. Measure ID 320 (MIPS CQM and Medicare Part B Claims Measure)

A maximum of 7 achievement points is available for the measure, even if your performance rate is found in Deciles 7 – 10.

Topped Out	Seven Point Cap
Y	Y

Did you know?
The benchmark file displays the range of performance rates associated with Deciles 7 – 10, even though scoring is capped at 7 points.

How Do Benchmarks Work for Multi-Performance Rate Measures?

Several MIPS quality measures and QCDR measures require the collection and submission of data for multiple populations. This means that there can be multiple performance rates associated with a single measure.

- Historical benchmarks for multi-performance rate measures were created based on an "overall performance rate" (based on a weighted average, simple average or CMS-specified performance rate).
- When you are scored on a multi-performance rate measure, we will compare the "overall performance rate" of your submitted measure to the measure's benchmark which is also based on the "overall performance rate".

The **2020 Multi-Performance Rate Measure file** identifies the method used to determine the "overall performance rate" for each multi-performance rate measure.

- It is NOT intended to specify an additional performance rate that must be submitted. Measures should be submitted according to their specification.
- Only multi-performance rate QCDR measures allow for the submission of an "overall performance rate".

This file also provides an example for each of the 3 methods for determining the overall performance rate. (Click the tabs at the bottom of the file.)

Where Can I Find Performance Period Benchmarks?

We do not publish performance period benchmarks on the QPP Resource Library because the results are specific to the 2020 performance period. When you report measures without a historical benchmark, you should review your final PY 2020 performance feedback in July 2021 for your score in comparison to the performance period benchmark (if available based on the data submitted).

Where You Can Go for Help

- Contact the Quality Payment Program at 1-866-288-8292, Monday through Friday, 8:00 AM-8:00 PM ET or by e-mail at: QPP@cms.hhs.gov.
    - Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.
- Connect with your local technical assistance organization. We provide no-cost technical assistance to small, underserved, and rural practices to help you successfully participate in the Quality Payment Program.
- Visit the Quality Payment Program website for other help and support information, to learn more about MIPS, and to check out the resources available in the Quality Payment Program Resource Library.

Version History

If we need to update this document, changes will be identified here.

Date	Change Description
2/19/2020	Updated fact sheet to reflect that flat benchmarking applies to the eCQM collection type for Measure 236 and added criteria for applying flat benchmarks.
1/30/2020	Original posting

Updated 2/19/2020