Quality Payment PROGRAM

2022 Merit-based Incentive Payment System (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 2022 Quality Benchmarks and 2022 Multi-Performance Rate Measures files.

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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 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.

Did you know?

Beginning in the 2023 performance period, measures will earn between 1 and 10 achievement points if they can be scored against a benchmark.

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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 measure, 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. Historical benchmarks for the 2022 performance period 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) for the 2020 performance period. We won't use data submitted for measures that were suppressed in the 2020 performance period to create historical benchmarks for those measures in the 2022 performance period.

To establish a historical benchmark:

- The 2020 and 2022 measure specifications must be comparable (no significant changes to the measure between 2020and 2022)
- 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 2020 (no changes to low-volume threshold for performance year 2022), AND
    - The measure met performance year 2022 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.

We **didn't** finalize our proposal to use performance period benchmarks exclusively or establish a different baseline period for scoring quality measures in the 2022 performance period. Based on our analysis of 2020 submission data, we determined that we have sufficient data to calculate historical benchmarks.

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CMS Web Interface Measures

We use benchmarks from the Shared Savings Program to assess and score CMS Web Interface measures. These benchmarks will be available on the QPP Resource Library. (NOTE: These benchmarks are also used for groups, virtual groups and APM Entities that register to report CMS Web Interface measures for traditional MIPS.)

CAHPS for MIPS Survey Measure

We established a benchmark for each scored summary survey measure (SSM) in the CAHPS for MIPS Survey measure. (Refer to the 2022 CAHPS for MIPS Benchmarks file in the 2022 Quality Benchmarks (ZIP).) These benchmarks were calculated using historical data from the 2020 performance period. A range of 3 to 10 points will be assigned to each SSM by comparing performance to the benchmark (similar to other measures). The final CAHPS for MIPS Survey score will be the average number of points across all scored SSMs.

Administrative Claims Measures

There are 3 administrative claims measures that were added in the 2021 and 2022 performance periods:

- **Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (NEW in 2022)**
- **Hospital-Wide, 30-Day, All-Cause Unplanned Readmission Rate for MIPS Groups**
- **Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty for MIPS**

Because these measures were added after the 2020 baseline period, historical benchmarks won't be available for the 2022 performance period. Instead, we'll attempt to calculate performance period benchmarks.

> **Did you know?**
> The new scoring policies for new measures **don't** apply to administrative claims measures.
>
> Clinicians who meet case minimum will receive between 3 and 10 achievement points for these measures if a benchmark can be created.

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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 achievement points, even if your performance rate falls in Deciles 7 - 10. The benchmark file still displays values for Deciles 7 – 10 even though the measure can't earn more than 7 achievement points.

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 2022 benchmark file also reflects the **flat benchmarks** finalized through previous rulemaking for **Measures 001 and 236**.

- **Measure 001:** We established flat benchmarks for **all collection types**.
- **Measure 236:** We established flat benchmarks for the **MIPS CQM and Medicare Part B Claims measure collection types.** (The eCQM collection type didn't meet the criteria set forth in the rule for establishing a flat benchmark*.)

*Flat benchmarks are applied to collection types where the top decile for a historical benchmark is greater than 90% (or less than 10% for inverse measures).

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 2022 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

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Decile	Number of Points Assigned for the 2022 Performance Period
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 10 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 have 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 reach the maximum achievable performance rate, the more deciles that will show a value of "--".

For example, in the benchmark results for the Elder Maltreatment Screen and Follow-Up Plan measure (Measure ID 181, MIPS CQM) presented below, historical benchmarking identified that the top 50% of clinicians performed at the maximum rate. Therefore, clinicians submitting through this collection type that performed above the 5th decile would receive the maximum performance score of 10 points.

Table 2: Example of a Measure Benchmark with Less than 10 Deciles

Measure Title	Measure ID	Collection Type	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Elder Maltreatment Screen and Follow-Up Plan	181	MIPS CQM	92.48 - 97.8	97.81 - 99.59	99.60 - 99.99	--	--	--	--	100

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What If a Quality Measure Doesn't Have a Historical Benchmark?

Did you know?

The **Scoring Examples** tab of the 2022 Benchmark file provides examples for various scoring scenarios.

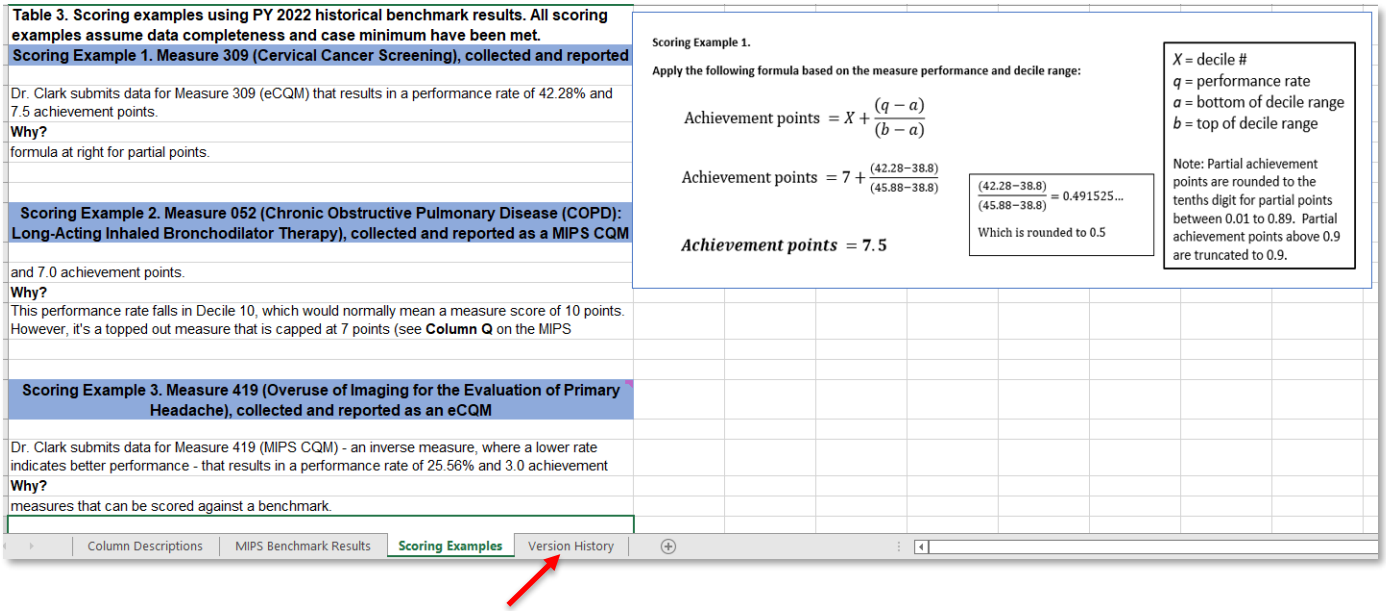

Table 3. Scoring examples using PY 2022 historical benchmark results. All scoring examples assume data completeness and case minimum have been met.

Scoring Example 1. Measure 309 (Cervical Cancer Screening), collected and reported

Dr. Clark submits data for Measure 309 (eCQM) that results in a performance rate of 42.28% and 7.5 achievement points.

Why?

formula at right for partial points.

Scoring Example 2. Measure 052 (Chronic Obstructive Pulmonary Disease (COPD): Long-Acting Inhaled Bronchodilator Therapy), collected and reported as a MIPS CQM

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 Q** on the MIPS

Scoring Example 3. Measure 419 (Overuse of Imaging for the Evaluation of Primary Headache), collected and reported as an eCQM

Dr. Clark submits data for Measure 419 (MIPS CQM) - an inverse measure, where a lower rate indicates better performance - that results in a performance rate of 25.56% and 3.0 achievement

Why?

measures that can be scored against a benchmark.

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

Scoring Example 1.

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

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

$$\text{Achievement points} = 7 + \frac{(42.28-38.8)}{(45.88-38.8)}$$

$$\frac{(42.28-38.8)}{(45.88-38.8)} = 0.491525\ldots$$

Which is rounded to 0.5

$$\textit{Achievement points} = 7.5$$

X = decile #
q = performance rate
a = bottom of decile range
b = top of decile range

Note: Partial achievement points are rounded to the tenths digit for partial points between 0.01 to 0.89. Partial achievement points above 0.9 are truncated to 0.9.

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

If a quality measure or collection type doesn't have a historical benchmark, we'll attempt to calculate benchmarks based on data submitted for the 2022 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).

Performance period benchmarks will be established using data submitted by individual clinicians, groups, and virtual groups that are eligible for MIPS in the 2022 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.

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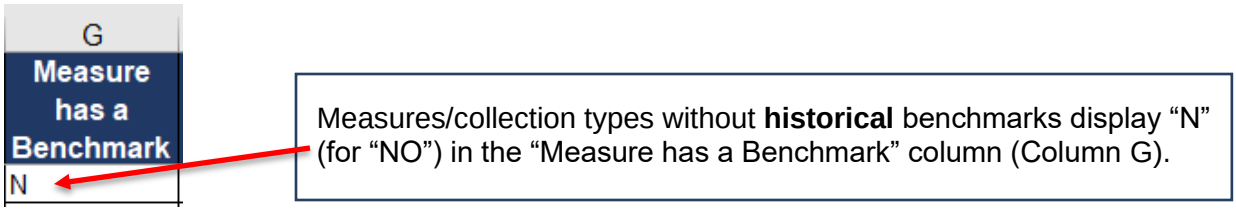

NEW: We've added a new column to the benchmark file indicating why there's no historical benchmark for a measure/collection type (Column R)

R
Reason for No Historical Benchmark
Substantive changes to specification in PY 2021; PY 2022 measure can't be compared to PY 2020 measure
Insufficient volume of data submitted in PY 2020 to establish historical benchmark
Substantive changes to specification in PY 2022; PY 2022 measure can't be compared to PY 2020 measure
Measure added in PY 2022; subject to 7-point scoring floor if data completeness is met

If no historical benchmark exists and no performance period benchmark can be calculated, then the measure will receive 3 points provided data completeness requirements are met.

- **EXCEPTION:** We've established a policy for new quality measures beginning with the 2022 performance period. (These policies don't apply to administrative claims-based measures)
    - New measures in their 1st year in the program are subject to a 7-point scoring floor provided data completeness requirements are met.
    - New measures in their 2nd year in the program are subject to a 5-point scoring floor provided data completeness requirements are met.

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 "Yes" in the **Seven Point Cap** column (column Q) of the benchmark file indicates the measure is capped at 7 points.

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Example 1. Measure ID 374, **Closing the Referral Loop: Receipt of Specialist Report** (MIPS CQM)

Topped Out	Seven Point Cap
Yes	No

Even though it's topped out, it's not capped at 7 points.

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

Example 2. Measure ID 130, **Documentation of Current Medications in the Medical Record** (all collection types)

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
Yes	Yes

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 are 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'll compare the "overall performance rate" of your submitted measure to the measure's benchmark which is also based on the "overall performance rate".

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The **2022 Multi-Performance Rate Measure file** identifies the method used to determine the "overall performance rate" for each multi-performance rate measure.

- It ISN'T 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'll publish 2022 performance period benchmarks on the QPP Resource Library once they're available in Summer 2023.

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.
- 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
12/30/2021	Original posting.

Original Posting: 12/30/2021