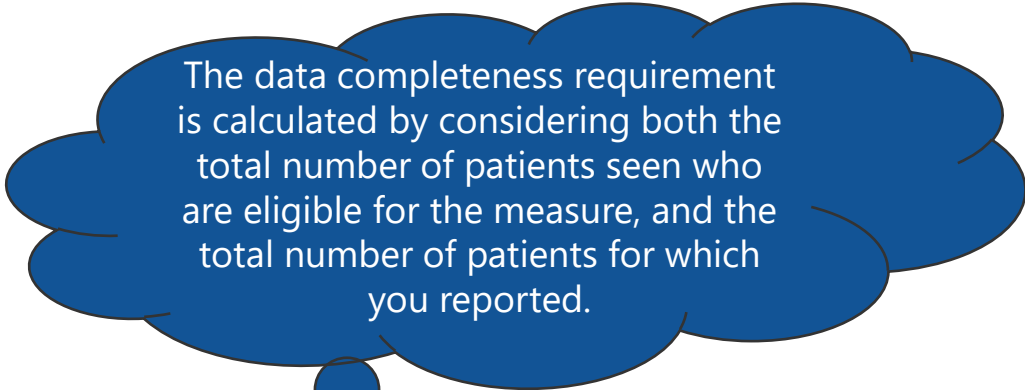




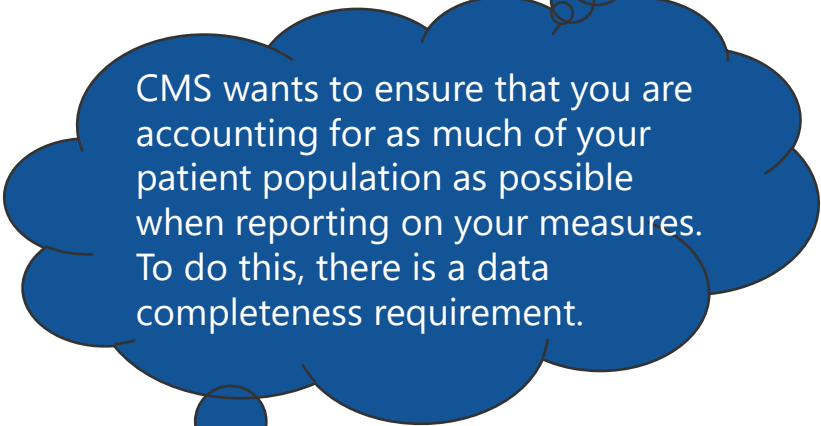
Merit-based Incentive Payment System (MIPS)

2023 MIPS Quality Data
Completeness Quick Guide

Quality Payment
PROGRAM



The data completeness requirement is calculated by considering both the total number of patients seen who are eligible for the measure, and the total number of patients for which you reported.



CMS wants to ensure that you are accounting for as much of your patient population as possible when reporting on your measures. To do this, there is a data completeness requirement.



Data Completeness Requirement for the 2023 Performance Period:

Numerator: The number of patients for which you report performance data (*performance met, not met, denominator exceptions*)

> = 70%

Denominator: The total number of patients eligible for the measure

Let's look at an example of how to calculate data completeness. **Step 1** is to aggregate data for the total patient population per measure at the level of reporting - individual MIPS eligible clinician, group, virtual group, subgroup, or APM Entity level.

Now that we know the total patient population, we can calculate the denominator.

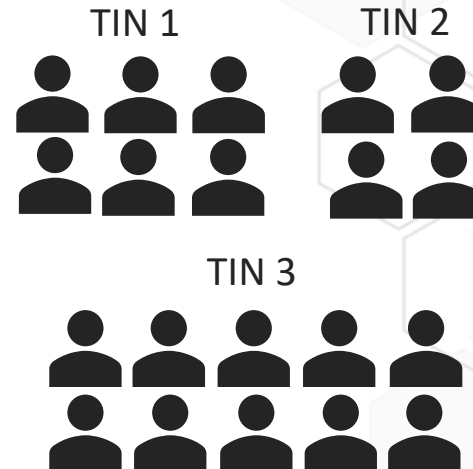
Example: An APM Entity, such as a Medicare Shared Savings Program Accountable Care Organization (ACO), has 3 Tax Identification Numbers (TINs), and each TIN saw a different number of **unique** patients during the performance year:

TIN 1 = 6 **unique** patients seen

TIN 2 = 4 **unique** patients seen

TIN 3 = 10 **unique** patients seen

Total across all TINs = **20 unique patients seen**



2023 MIPS Quality Data Completeness Quick Guide

Example Continued: For the APM Entity with 3 TINs, each TIN needs to calculate the measure's **eligible population**, which is always defined in the measure's specification document.

TIN 1 = 2 patients in the eligible population

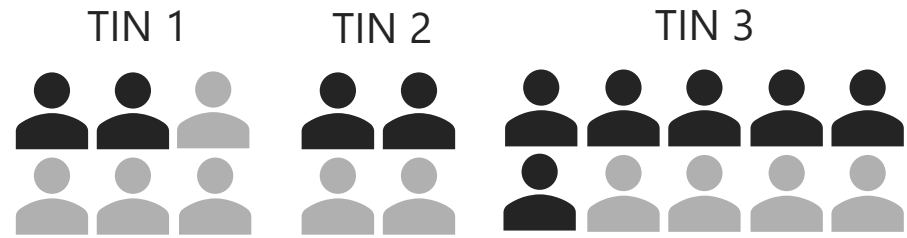
TIN 2 = 2 patients in the eligible population

TIN 3 = 6 patients in the eligible population

Total across all TINs = **10 patients in the eligible population**

Since the **denominator** must represent **100% of the eligible population**:

Denominator = 10



Step 2 is to calculate the denominator. In this example, since the denominator represents 100% of the eligible population, those 10 patients represent the denominator.

$$\frac{?}{10} = ?$$

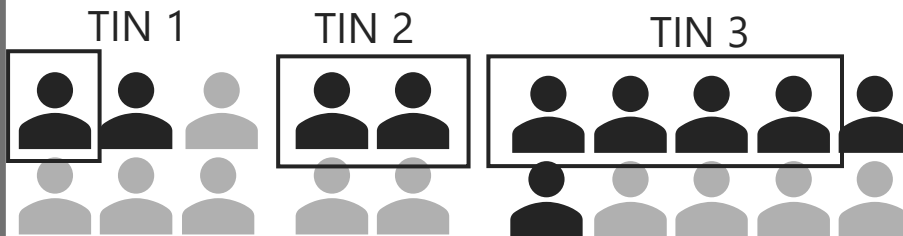


MIPS CQMs (All-Payer Data) - Calculating the Numerator

Example Continued: To meet or exceed the 70% data completeness requirement, the APM Entity **must report** performance data (performance met or not met, numerator exclusions, or denominator exceptions) for **at least 70%** of the total **eligible population** as shown in the denominator.

70% (data completeness threshold) **of 10** (total eligible population) = **7**

Numerator ≥ 7



Now that we know the denominator, we can calculate the numerator. Let's first look at how we would calculate the numerator for a MIPS Clinical Quality Measure (CQM).

$$\frac{7}{10} = 70\%$$

Data Completeness Requirement Met!

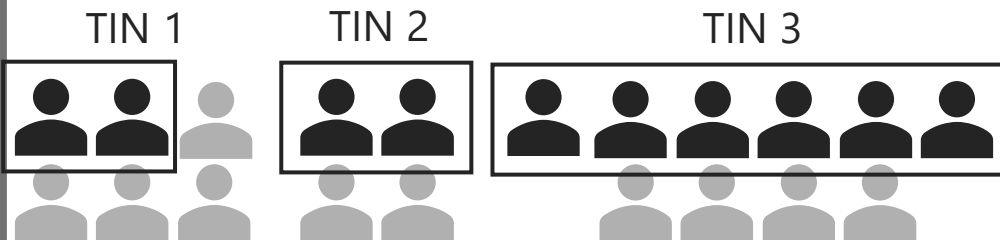
eQMs (All-Payer Data) - Calculating the Numerator

Example Continued: To meet or exceed the 70% data completeness requirement, the APM Entity **must report** performance data (performance met or not met, numerator exclusions, or denominator exceptions) for **at least 70%** of the total **eligible population** as shown in the denominator.

However, since eQMs are submitted electronically without any manual manipulation, **an APM Entity that submits an eQm via CEHRT automatically achieves 100% data completeness.**

100% (data submitted via CEHRT) **of 10** (total eligible and matched population) = **10**

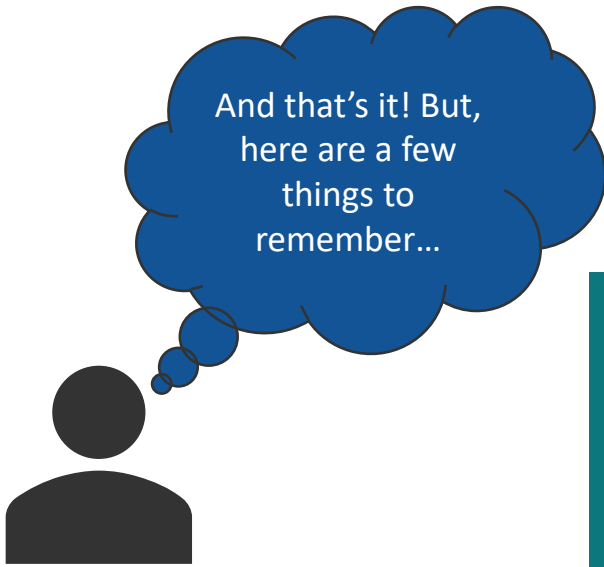
Numerator = 10



In this example, we will look at how the numerator is calculated for an electronic Clinical Quality Measure (eCQM) that is submitted using Certified Electronic Health Record Technology (CEHRT).

$$\frac{10}{10} = 100\%$$

Data Completeness Requirement Met!



And that's it! But,
here are a few
things to
remember...

2024 Performance Period Change

The data completeness threshold will **increase from 70% to 75%** for the 2024 performance period.

True, Accurate, and Complete Reporting

Selectively reporting favorable data that misrepresents your actual performance is called "**cherry-picking**". Part 42 sections 414.1390(b) and 414.1400(a)(5) provide that all MIPS data submitted must be certified as true, accurate, and complete. Incomplete reporting of a measure's eligible population, or otherwise misrepresenting a clinician or group's performance (e.g., only submitting favorable performance data), would not be considered true, accurate, or complete.

Avoid a Zero Score

Keep in mind there are no gradations of data completeness. **Data Completeness is met or not met.**

Using the example from p. 5, if the APM Entity reports on 6 patients instead of 7, **it would not meet data completeness** and would receive **zero points** for the measure.

Data Aggregation

Remember, data completeness is aggregated and calculated for each measure at the level of reporting - individual MIPS eligible clinician, group, virtual group, subgroup, or APM Entity level. When reporting eQMs and MIPS CQMs, your denominator eligible encounters include your entire patient population across the TIN, all sites associated with the TIN, all TINs part of the virtual group, or all TINs participating in the APM Entity (such as a Medicare Shared Savings Program ACO).