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To What Extent Are the Centers for Medicare & Medicaid Services 2019 MIPS Quality Measures Inclusive of Home-Based Medical Care?

Bruce Leff, MD,

Johns Hopkins University School of Medicine, Center for Transformative Geriatric Research, Johns Hopkins University Bloomberg School of Public Health, and Johns Hopkins School of Nursing; Baltimore, Maryland

Orla Sheehan, MD, PhD,

Johns Hopkins University School of Medicine, Center for Transformative Geriatric Research, and Johns Hopkins University; Baltimore, Maryland

Shivani Bhatnagar, BS,

Texas College of Osteopathic Medicine and University of North Texas Health Science Center; Fort Worth, Texas

Krista L. Harrison, PhD,

University of California San Francisco; San Francisco, California

Randolph C. Barrows, MS, MD,

Elimu Informatics; Richmond, California

Christine S. Ritchie, MD, MSPH

Massachusetts General Hospital, Harvard Medical School; Boston, Massachusetts

Background:

Two million older adults are completely or mostly homebound, and another 5.3 million have difficulty or need help getting out of their homes (1). Several studies, including the Centers for Medicare & Medicaid Services (CMS) Independence at Home Demonstration, have proven that home-based primary care is effective in providing cost-saving, high-quality care to high-need, high-cost homebound older adults (2).

Making home-based primary care available to frail older adults will require better financial incentives to encourage provision of this type of care. A potentially important opportunity for home-based primary care practices to enter into value-based care is to leverage performance payments available through the CMS Merit-based Incentive Payment System

Corresponding Author: Bruce Leff, MD, Division of Geriatric Medicine and Gerontology, Department of Medicine, Johns Hopkins University School of Medicine, Center for Transformative Geriatric Research, 5200 Eastern Avenue, Baltimore, MD 21224; bleff@jhmi.edu.

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(MIPS) (3). Performance payments through MIPS are predicated on eligible providers participating in quality reporting using CMS-specified quality measures. A quality measure numerator specifies whether a certain process of care or outcome has been achieved; the denominator defines whether a quality measure can be applied to a certain patient population. Some CMS measures lack home visit evaluation and management codes in their denominators, rendering them completely unusable by home-based medical care providers and leaving a vulnerable patient population outside the realm of value-based care.

Objective:

To determine the proportion of CMS 2019 MIPS quality measures that were potentially appropriate for patients receiving home-based medical care, which included denominator codes for home-based care.

Methods:

Two investigators (O.S. and B.L.) reviewed all 257 CMS 2019 MIPS quality measures for inclusion in the analysis on the basis of their applicability to homebound older adults cared for by home-based primary care providers. Disputes were adjudicated in discussion with a third investigator (C.S.R.). Measures were excluded if they focused on care provided by specialist physicians (except geriatric or palliative medicine specialists), issues of low prevalence among homebound older adults, lack of applicability of the measure due to limited time to benefit the patient, pediatric patients, or maternity and pregnant patients.

Using publically available documents from 5 CMS Web sites spanning 2017 to 2019, we assessed the denominator criteria of the quality measure for the presence of Healthcare Common Procedure Coding System codes to identify medical visits to private residences (99341 to 99345, 99347 and 99350) and domiciliary visits (99324 to 99328, 99334 to 99337). For measures specified in Clinical Quality Language, we examined the denominator for home medical visits to private residences by using the value set “home healthcare services” object identifier definition 2.16.840.1.113883.3.464.1003.101.12.1016 and for domiciliary visits by using the value set “Care Services in Long-Term Residential Facility” object identifier 2.16.840.1.113883.3.464.1003.101.12.1014. We required denominators to have both home and domiciliary visit codes, because approximately half of all medical home visits are domiciliary (4). This research was approved by the institutional review board of Johns Hopkins University School of Medicine.

Findings:

Of 257 quality measures on the CMS 2019 MIPS Quality Measures list (Figure), 179 (70%) were excluded; a focus on specialist physician care was the most common reason for exclusion. Of the 78 potentially appropriate quality measures for home-based medical care, only 39 (50%) had appropriate codes in the measure denominator. The Table provides examples of particularly relevant measures without appropriate denominator codes for home-based medical care.

Discussion:

Fully half of the MIPS quality measures potentially appropriate for the care of homebound older adults receiving home-based medical care are unusable by home-based medical care providers because they lack appropriate denominator codes. The homebound remain an invisible population to key stakeholders, including quality measure developers and CMS (5). This is unfortunate, because strong evidence exists that improving care for frail older adults, particularly those who are homebound, can reduce preventable health care costs. Currently, only 12% of homebound patients receive medical care at home.

Properly structured, value-based care has the potential to provide incentives to foster workforce growth and scaling of home-based medical care. The CMS should work to add home visit codes to all MIPS quality measures relevant to the practice of home-based medical care. The National Quality Forum should require measure developers to include appropriate codes in the denominators of all measures applicable to this population. Systematically including appropriate measure denominator codes would enable value-based care for a consequential patient population and serve CMS's goal of harmonizing measures across care settings.

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Figure:
Eligibility Status of 2019 Center for Medicare and Medicaid Services Merit Incentive Payment System (MIPS) Quality Measures for Use in Home-Based Medical Care

Table.

Examples of Quality Measures From the 2019 MIPS Quality Measure List Lacking Denominator Codes for Home-Based Medical Care

Measure Title	Measure Description	CMS Quality Number
Osteoarthritis (OA): Function and Pain Assessment	Percentage of patient visits for patients aged ≥ 21 years with a diagnosis of osteoarthritis with assessment for function and pain	109
Pneumococcal Vaccination Status for Older Adults	Percentage of patients aged ≥ 65 years who have ever received a pneumococcal vaccination	111
Functional Outcome Assessment	Percentage of visits for patients aged ≥ 18 years with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies	182
Use of High-Risk Medications in the Elderly	Percentage of patients aged ≥ 65 years who were ordered high-risk medications. Two rates are submitted: 1. Percentage of patients who were ordered at least 1 high-risk medication 2. Percentage of patients who were ordered at least 2 of the same high-risk medications	238
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Percentage of patients aged ≥ 12 years screened for depression on the date of the encounter with an age-appropriate standardized depression screening tool AND, if the results were positive, had a follow-up plan documented on the date of the screening	134

CMS = Centers for Medicare & Medicaid Services; MIPS = Merit-based Incentive Payment System.