Quality Payment
PROGRAM

2018 Quality Payment Program Experience Report

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List of Acronyms

ACO	Accountable Care Organization
API	Application Programming Interface
APM	Alternative Payment Model
ASC	Ambulatory Surgical Center
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CEHRT	Certified EHR Technology
CJR	Comprehensive Care for Joint Replacement
CMS	Centers for Medicare & Medicaid Services
EHR	Electronic Health Record
ESRD	End-Stage Renal Disease
IA	Improvement Activities
IVD	Ischemic Vascular Disease
MAQI	Medicare Advantage Qualifying Payment Arrangement Incentive
MIPS	Merit-based Incentive Payment System
MSPB	Medicare Spending per Beneficiary
MSSP	Medicare Shared Savings Program
NPI	National Provider Identifier
QCDR	Qualified Clinical Data Registry
QPP	Quality Payment Program
QPs	Qualifying APM Participant (in an Advanced APM)
TIN	Taxpayer Identification Number
TPCC	Total per Capita Costs

Introduction

In 2017, the Centers for Medicare & Medicaid Services (CMS) launched the Quality Payment Program (QPP), a new program that aims to reward innovation in improving patient outcomes and drive fundamental movement toward a value-based system of care. The program offers 2 participation tracks: The Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

The MIPS track streamlined 3 CMS programs (Physician Quality Reporting System (PQRS), Value-Based Payment Modifier, and the Medicare Electronic Health Record (EHR) Incentive (or Meaningful Use) Program) into a single system. Clinicians are evaluated and receive payment adjustments based on their overall performance in 4 performance categories:

- Quality;
- Cost;
- Improvement Activities; and
- Promoting Interoperability (formerly known as Advancing Care Information).

Clinicians who were eligible for MIPS in the 2018 performance period will receive a payment adjustment during the 2020 payment year—either positive, neutral, or negative—based on their performance in 2018.

The Advanced APM track provides an opportunity to reward clinicians for significant participation in taking on greater risk and accountability for patient outcomes. Eligible clinicians who participated in an Advanced APM and achieve Qualifying APM Participant (QP) status based on the level of their participation in 2018 will be eligible to receive a 5% APM Incentive Payment in 2020.

While these tracks are structured to complement each other, one of CMS's foremost goals under the Quality Payment Program is to encourage movement of clinicians and practices into APMs and Advanced APMs and ultimately toward a value-based system of care.

Purpose

From the start of the Quality Payment Program, we committed to being transparent with our data and listening to your feedback. The primary goal of this report is to identify trends associated with the clinician experience in the second year of the Quality Payment Program, while noting progress from program year 2017.

Based on stakeholder feedback, we have drafted a concise report highlighting the data elements that you have indicated are important. This report is divided into 4 sections:

- Eligibility and **Participation**: Reviews eligibility requirements, identifies the number of clinicians eligible to participate in the Quality Payment Program and provides a breakout of participation rates across both MIPS and Advanced APMs.
- **Reporting Options**: Highlights various ways clinicians could and did submit performance data, specifically for MIPS, to CMS.
- **Performance Categories**: Reviews MIPS performance category requirements and performance periods and provides trends in measure/activity selection.
- **Final Score and Payment Adjustments**: Examines MIPS final scores and payment adjustments across clinicians reporting as individuals, clinicians reporting as a group, and clinicians participating through a MIPS APM.

Looking for More Information?

We will also release a Public Use File (PUF) in the summer of 2020 that will allow you to drill down into details behind the data in the tables presented in this report. Once released, it will be available at https://www.data.gov.

We believe that this report, along with the Public Use File, will provide the data needed to illustrate the successes and challenges in 2018, and opportunities for future program years.

QPP follows numerous strategic objectives that helped guide policy and product development in 2018.[1] At a high level, these include:

- Improve patient population health
- Improve care received by Medicare patients
- Lower costs to the Medicare program through improvement of care and health
- Advance use of healthcare information between allied providers and patients
- Educate, engage, and empower patients as members of their care team
- Maximize QPP participation through a flexible and transparent design, and easy-to-use program tools
- Maximize QPP participation through education, outreach and support tailored to the needs of practices, especially those that are small, rural, and in underserved areas
- Expand Alternative Payment Model participation
- Provide accurate, timely, and actionable performance data to clinicians, patients, and other stakeholders
- Continuously improve QPP based on participant feedback and collaboration

We believe these strategic objectives are dynamic and should reflect current needs and values of participating clinicians. Therefore, we anticipate the continual refinement of these strategic objectives as we work closely with clinician and stakeholder communities to improve and evolve the Quality Payment Program.

Eligibility and Participation

The primary starting point for clinicians within the Quality Payment Program is determining their eligibility and how they intend to report, if required to participate. As previously mentioned, the Quality Payment Program has 2 participation tracks – the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

Advanced APMs

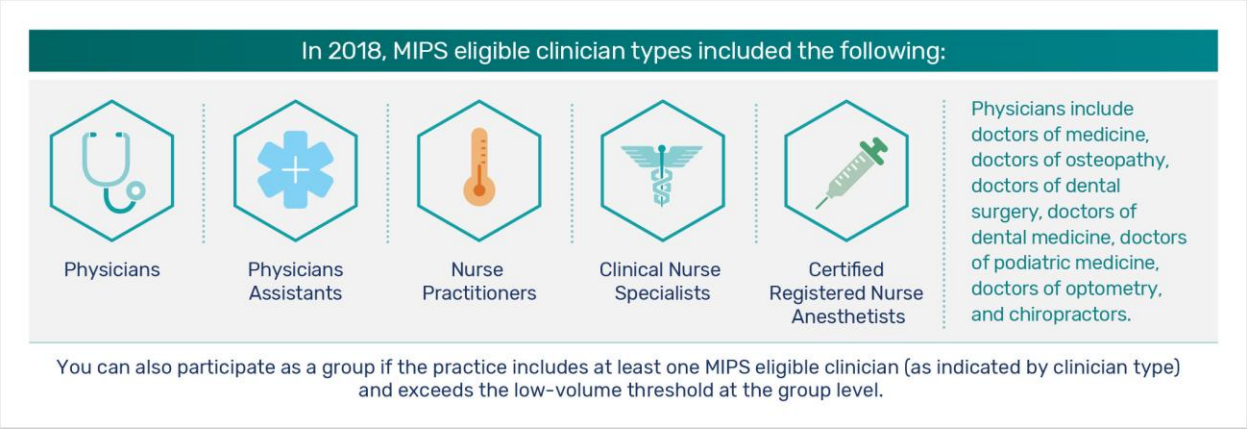
Eligible clinicians have an opportunity to become QPs and earn a 5% APM incentive payment by sufficiently participating in an Advanced APM during a given performance year. Eligible clinicians who become QPs also are excluded from MIPS reporting, scoring, and payment adjustments. To become a QP, eligible clinicians must meet or exceed specific thresholds for payment amount or patient count based on their participation in the Advanced APM. QP determinations are made at 3 specific dates—March 31, June 30, and August 31 (also referred to as “Snapshots”).

[1] Additional details on the program’s Strategic Objectives are found on the Quality Payment Program website.

In 2018, if an eligible clinician participated in an Advanced APM and at least 25% of their payments or 20% of their patients were through an Advanced APM, they became a QP. There are instances where a clinician who participated in an Advanced APM may not have met the QP payment amount or patient count thresholds. In such cases, an eligible clinician could become a Partial QP if the Partial QP payment amount threshold (20% of their payments) or patient count threshold (10% of their patients) were met. Partial QPs do not receive the 5% APM incentive payment, but within the performance year they had the option to elect to participate in MIPS and receive a MIPS payment adjustment. Tables 5, 6, and 7 summarize 2018 APM and Advanced APM participation.

MIPS

Under the MIPS track, clinicians are included and required to participate if they: (1) are a MIPS eligible clinician type; (2) exceed the low volume threshold; and (3) are not otherwise excluded (for example, by becoming QPs). MIPS eligible clinicians are both physicians and non-physician clinicians who are eligible to participate in MIPS. Through rulemaking, CMS defines the MIPS eligible clinician types for a specific performance year. MIPS eligible clinicians in 2018 include certain physicians and non-physician clinicians as described in the graphic below.



The low-volume threshold is the second step in determining whether a clinician is included in MIPS for a specific performance period. It's used to determine if a MIPS eligible clinician saw enough patients and provided enough services to meaningfully participate in MIPS. In 2018, the low-volume threshold was based on the amount of allowed charges for covered professional services under Medicare Physician Fee Schedule (PFS) and the number of Medicare Part B patients who were furnished covered professional services under the PFS during 2 distinct determination periods: September 1, 2016 – August 31, 2017 (initial determination period based on historic claims) and September 1, 2017 – August 31, 2018 (second determination based on performance period claims). MIPS eligible clinicians were required to participate in MIPS in 2018 if they billed more than $90,000 in Medicare Part B covered professional services and saw more than 200 Medicare Part B beneficiaries in both determination periods. Note that these thresholds have increased from 2017 levels of $30,000 in Part B charges and 100 Part B patients.

There are several exclusions available to MIPS eligible clinicians. In 2018, clinicians were excluded from MIPS if they met any 1 of the following conditions:

- Not a MIPS eligible clinician type
- Enrolled in Medicare for the first time in 2018
- Participated in the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI)
- Did not exceed the low-volume threshold in at least 1 determination period.
- Participated in an Advanced APM sufficiently to either become a QP or become a Partial QP and then elected not to participate in MIPS

In 2018, MIPS eligible clinicians required to participate in MIPS either could report data as an individual,[2] a group, a virtual group, or through an APM. Certain APMs, called MIPS APMs, include MIPS eligible clinicians as participants and hold them accountable for the cost and quality of care provided to Medicare patients. MIPS eligible clinicians participating in a MIPS APM receive special MIPS scoring to help account for the activities already required by the model.

We also employ "special status" designations for certain MIPS eligible clinicians. These designations determine whether special rules will affect the number of total measures, activities, or entire performance categories that an individual clinician, group, or virtual group must report. In 2018, "special status" designations included: small practice, rural practice, non-patient facing, health professional shortage area (HPSA), hospital-based, and ambulatory surgical center-based (ASC). Note that the data in this report focuses on small and rural practices. The Public Use File will include breakouts for clinicians with other special statuses.

Data Tables

Tables 1 – 7 provide high-level eligibility and participation information for the 2018 performance period. Note that we generally define participation in terms of data submission. "Eligible participants" are MIPS eligible clinicians who submitted any amount of MIPS data as an individual or group or who were excepted from data submission in 2018 under the automatic extreme and uncontrollable circumstances policy.

[2] An individual is defined as a single clinician, identified by their Individual National Provider Identifier (NPI) tied to a single Taxpayer Identification Number (TIN). A group is defined as a single TIN with 2 or more clinicians as identified by their NPI who have assigned their Medicare billing rights to the TIN (at least 1 clinician within the group must be MIPS eligible in order for the group to be MIPS eligible).

TABLE 1 Overall MIPS Participation

Eligible Clinicians	889,995
Eligible Clinicians Who Participated	874,515
Participation Rate	98.26%

NOTE Table 1 excludes clinicians who were QPs and Partial QPs who did not elect to participate in MIPS.

Key Insights for Table 1

A total of 889,995 clinicians were eligible for MIPS in 2018. Of these, 874,515, or 98%, participated in the program. Due to changes in the low volume thresholds, fewer clinicians were eligible for the program in 2018 than in 2017.

Key Insights for Table 2

Of the 874,515 clinicians who participated in MIPS in 2018,

- 53% (466,942) received their final score based on participation as part of a group (this is virtually the same percentage of 2017 participants who received their final score based on group participation);
- 41% (356,353) received their final score for participation as part of a MIPS APM (up from 34% of 2017 participants); and
- 6% (51,220) received their final score based on participation as an individual (down from % of 2017 participants).

TABLE 2 Type of MIPS Participation

	Count (TIN/NPI)	Percentage of Eligible Participants
Group Participants	466,942	53%
MIPS APM Participants	356,353	41%
Individual Participants	51,220	6%
Total Eligible Participants (MIPS Eligible Clinicians Who Participated)	**874,515**	**100%**

NOTE Table 2 excludes QPs and Partial QPs who did not elect to participate in MIPS. Participants are counted once based on the submission method used for the clinician's final score.

In addition to a higher percentage of final scores coming from MIPS APM participation, there also was a large increase in QPs which is highlighted in Table 6. No clinicians received their final score based on participation as part of a virtual group. Although there were 2 virtual groups in 2018, 1 of them did not participate; all MIPS eligible clinicians in the other virtual group received their final score through participation in a MIPS APM.

TABLE 3 MIPS Participation by Clinician Type

Clinician Type	MIPS Eligible Clinicians (TIN/NPI Count)	Eligible Clinicians who Participated (TIN/NPI Count)	Participation Rate
Physicians	619,465	604,865	97.64%
Non-Physician Clinicians	230,009	229,146	99.62%
Unknown	40,506	40,489	99.96%
Therapists	15	15	100.00%
Totals	**889,995**	**874,515**	**98.26%**

NOTE Table 3 excludes QPs and Partial QPs who did not elect to participate in MIPS.

Key Insights for Table 3

An examination of MIPS eligible clinicians shows that 70% were physicians, 26 percent were non-physician clinicians, and 5% are unknown. The “unknown” category contains those clinicians who may have fallen under multiple specialties during the MIPS eligibility determination period. Participation rates were 97.6% or better for all provider categories. Further breakouts by specialty will be available in the Public Use File.

TABLE 4 MIPS Participation by Clinicians in a Small Practice or Rural Area

Special Status	MIPS Eligible Clinicians	Eligible Participants	Participation Rate
Rural	116,222	114,205	98.26%
Small	115,071	100,748	87.55%

NOTE Table 4 excludes QPs as well as Partial QPs who did not elect to participatein MIPS. Small practices are defined as having 15 or fewer clinicians (NPIs billing under the same TIN). A rural practice is one where the TIN has at least one practice site in a zip code designated as a rural area. The "small" and "rural" designations are not mutually exclusive.

Key Insights for Table 4

Over 98% of MIPS eligible clinicians in rural practices participated in the program which is in line with the overall participation rate for all MIPS eligible clinicians. The participation rate for clinicians in small practices increased from 81% in 2017 to almost 88% in 2018; part of this increase could be due to the increase in low-volume thresholds in 2018 (from $30,000 to $90,000 in charges and patient volume from 100 to 200).

TABLE 5 Clinicians Participating in MIPS APMs Scored under the APM Scoring Standard

MIPS APM	# of MIPS Eligible Clinicians Participating in Model
Medicare Shared Savings Program	351,686
Oncology Care Model	6,206
Comprehensive Primary Care Plus Model	496
Next Generation ACO Model	42
Comprehensive ESRD Care Model	28

NOTE Table 5 excludes QPs and Partial QPs who did not elect to participate in MIPS. A clinician can participate in more than one APM.

Key Insights for Table 5

Most clinicians who participated in MIPS through an APM did so under the Medicare Shared Savings Program.

TABLE 6 Total Count of QPs and Partial QPs

	QPs	Partial QPs
Total	183,306	47

NOTE The total number of Partial QPs includes all clinicians who achieved Partial QP status, whether or not they chose to participate in MIPS.

Key Insights for Table 6

The number of clinicians achieving QP status has nearly doubled from the 2017 total of 99,076 to 183,306. The number of Partial QPs decreased slightly from 52 to 47. Please note that this table reflects data at the individual clinician level and counts distinct NPIs rather than TIN/NPIs.

TABLE 7 QP Threshold Scores by Advanced APM

Advanced APM	Average Payment Threshold Score	Average Patient Threshold Score
Medicare Shared Savings Program	44%	45%
Next Generation ACO Model	49%	51%
Comprehensive Primary Care Plus Model	83%	75%
Maryland All Payer Hospital Model	38%	39%
Comprehensive ESRD Care Model	68%	65%
Comprehensive Care for Joint Replacement Payment Model	12%	5%

NOTE The data within this table reflect overall participation in each Advanced APM, not just those eligible clinicians with QP status. Out of all Advanced APMs, the Medicare Shared Savings Program accounts for the majority of participation.

Key Insights for Table 7

For almost all Advanced APMs, the average Payment Threshold Scores are well above the 25% needed to become a QP and the patient threshold scores are well above the 20% needed.

Reporting Options and Performance Categories

The following section of the 2018 Quality Payment Program Experience Report pulls together two important aspects of clinician participation in MIPS: measure/activity selection and submission of data to CMS. These two components are complementary, and it is beneficial to review the data elements listed below within this context.

Once clinicians determine their eligibility in MIPS and identify how they intend to participate (as an individual, as a part of a group, a virtual group, or through a MIPS APM), the next step is identifying an appropriate submission method based on measure/activity selection and available resources within the practice.

Reporting Options

In 2018, there were various methods by which MIPS eligible clinicians (participating either individually or as a part of a group or virtual group) could submit data to CMS:

- Adding quality data codes to Medicare Part B Claims (only available to individual MIPS eligible clinicians for the Quality performance category)
- Working with a Qualified Registry to submit data on their behalf
- Working with a Qualified Clinical Data Registry (QCDR) to submit data on their behalf
- Extracting data from their Electronic Health Record (EHR)
- Reporting beneficiary level quality data through CMS Web Interface (only available to registered groups and virtual groups of 25 or more clinicians for the Quality performance category)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey (available for registered groups and virtual groups with 2 or more clinicians)

In addition to the methods listed above, individual clinicians, groups and virtual groups also had the option of “attesting” for the Improvement Activities and Promoting Interoperability performance categories through the QPP website (https://qpp.cms.gov). This meant that a MIPS eligible clinician or their authorized support staff could sign-in to the QPP website and manually select and report activities and measure data for the Improvement Activities and Promoting Interoperability performance categories. This form of data submission received favorable feedback from the clinician and stakeholder communities for its streamlined and user-friendly approach.

Performance Categories

We assess clinician performance based on the various measures and activities reported or calculated for the MIPS Quality, Cost, Improvement Activities, and Promoting Interoperability performance categories. Additional details on each performance category are available below along with direct links to the respective pages on the QPP website.

In 2017 we launched the Explore Measures & Activities tool on the QPP website, responding to feedback that it was often difficult and time-consuming to find measure details and identify those that were applicable to their practice. This feature continues to be available to allow clinicians to easily search (via type, specialty set, submission method, etc.) and review both measures and activities in a centralized location. Overall, we’ve received positive feedback on this tool since its launch in spring 2017, and we’ll keep working with clinicians and stakeholders to continue enhancing the functionality.

Quality – this performance category measures healthcare processes, outcomes, and patient experiences of their care. The general requirements of the performance category stipulate that clinicians must select 6 measures (in 2018, there were 284 QPP measures available and an additional 701 QCDR measures), 1 of which must be an outcome or high-priority measure (if an outcome measure is not available). High-priority measures fall within these categories: Outcome, Patient Experience, Patient Safety, Efficiency, Appropriate Use, and Care Coordination. Clinicians also have the opportunity to select a specialty-specific set of measures.

Cost – this performance category is an important part of MIPS because it measures resources clinicians use to care for patients and Medicare payments made for care provided to patients. In 2018, 2 measures were included in this category: Medicare Spending per Beneficiary (MSPB) and Total Per Capita Costs (TPCC). Clinicians who met case minimums were automatically evaluated on these measures using the claims submitted to Medicare for reimbursement (also referred to as “administrative claims”).

Improvement Activities – this performance category assesses how much a clinician or group participates in activities that improve clinical practice. Examples include ongoing care coordination, clinician and patient shared decision making, regular implementation of patient safety practices, and expanding practice access. In 2018, there were a total of 113 Improvement Activities available.

Promoting Interoperability – this performance category promotes patient engagement and electronic exchange of health information using certified EHR technology (CEHRT). During the 2018 performance period, MIPS eligible clinicians had the option of reporting measures from the Promoting Interoperability Objectives and Measures set or from the Promoting Interoperability Transition Objectives and Measures set depending on their edition of CEHRT (2014 Edition or 2015 Edition). In 2018, clinicians were required to report the base measures from their available measure set but could select from additional performance and bonus measures. An illustrative breakout of these measure sets is available within Table 13.

Aside from the basic requirements, each performance category has a specific weight and performance period.

- The weight is the value that a performance category contributes to a MIPS eligible clinician's final score.
- The performance period is the minimum duration (i.e. the timeframe) that a MIPS eligible clinician must collect and report data for the performance category.

In 2018, the following weights and performance periods were applied to the MIPS performance categories unless the clinician qualified for reweighting in 1 or more performance categories:

Performance Category	Quality	Cost	Improvement Activities	Promoting Interoperability
Weight	50%	10%	15%	25%
Performance Period	12 months	12 months (no data submission required)	Minimum of 90 continuous days per activity, or as specified in the activity description	Minimum of 90 continuous days

The following tables highlight important reporting and performance category data.

Data Tables

Note: Additional details for all submission methods used to report data to CMS will be available in the Public Use File.

TABLE 8 Submission Methods, by Performance Category, for Measures/Activities that Contributed to Final Scores

Submission Method	Quality	Promoting Interoperability	Improvement Activities
Medicare Part B Claims	2%	N/A	N/A
CMS Web Interface	47%	N/A	N/A
Electronic Health Record	19%	34%	21%
QCDR	8%	6%	11%
Registry	24%	19%	31%
Attestation	N/A	41%	36%

NOTE Table 8 excludes clinicians who were QPs as well as Partial QPs who did not elect to participate in MIPS.

Key Insights for Table 8

The percentages presented in this table reflect the submission methods that were used for measures and activities contributing to a MIPS eligible clinician's final score. If a clinician used 2 methods to submit data for a single performance category, we used whichever submission resulted in a higher score.

Quality: The CMS Web Interface (patient level reporting on a specified measure set through qpp.cms.gov) was the most common method for submitting MIPS quality measures, largely due to this method being used by many groups and MIPS APMs (primarily ACOs); the second most popular method of reporting Quality Measures was Registry, which accounted for 24% of clinicians and Electronic Health Records made up another 19%; QCDR accounts for 8% of the submissions and Claims accounted for less than 2% of Quality Measure submissions used in final scoring.

Improvement Activities: Attestation (manually selecting "yes" on qpp.cms.gov for each activity performed) was the most common form of submission for Improvement Activities and accounted for almost 36% of submissions for this performance category; Registry was the second most popular way of reporting measures in this performance category, accounting for 31% of the submissions; EHR was used for 21% and QCDR accounts for the remaining 11%.

Promoting Interoperability: Attestation (manually entering measure information, such as numerators and denominators, on qpp.cms.gov) was the most common submission method, accounting for 41% of submissions; after attestation, EHR was the second most common reporting method with almost 34% of submissions and Registry accounted for almost 25%.

TABLE 9 Submission Method and Participation Type for Each Performance Category

Performance Category	Submission Method	Participation Type		
		Individual	Group	MIPS APM
Quality	Claims	2%	N/A	N/A
	CMS Web Interface	N/A	5%	42%
	EHR	1%	18%	N/A
	QCDR	1%	7%	N/A
	Registry	2%	22%	N/A
Improvement Activities	EHR	1%	20%	N/A
	QCDR	1%	11%	N/A
	Registry	3%	29%	N/A
	Web Attestation	3%	33%	N/A
Promoting Interoperability	EHR	2%	32%	N/A
	QCDR	1%	5%	N/A
	Registry	3%	16%	N/A
	Web Attestation	2%	39%	N/A
Cost	Administrative Claims	6%	94%	N/A

NOTE Table 9 excludes clinicians who were QPs and Partial QPs who did not elect to participate in MIPS.

Key Insights for Table 9

This table provides a breakdown of how each performance category was reported in regard to how clinicians participated (individually, in a group, or in a MIPS APM) as well as which submission method they used. MIPS APMs report through the CMS Web Interface but groups are using Registry and EHR reporting much more than the CMS Web Interface. Attestation is the most popular choice for reporting activities and measures for the Improvement Activities and Promoting Interoperability performance categories.

TABLE 10 Top 10 Quality Measures Contributing to a Clinician's Quality Performance Category Score Across All Submission Methods

Measure Name	Quality Measure ID	Eligible Participants	Average Reporting Rate %	Average Performance Rate %	Average Measure Score
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	204	477,249	99.72%	89.44%	9.58
Pneumococcal Vaccination Status for Older Adults	111	471,202	99.38%	75.99%	8.57
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	128	465,813	99.43%	73.44%	8.28
Controlling High Blood Pressure	236	464,759	99.06%	70.60%	7.86
Preventive Care and Screening: Influenza Immunization	110	434,372	99.16%	70.73%	8.08
Breast Cancer Screening	112	431,613	99.48%	71.03%	8.12
Falls: Screening for Future Fall Risk	318	430,776	99.80%	80.60%	8.61
Preventive Care Screening: Screening for Depression and Follow-Up Plan	134	420,973	99.76%	63.72%	7.36
Colorectal Cancer Screening	113	416,917	99.40%	67.06%	7.69
Diabetes Mellitus (DM) Composite (All or Nothing Scoring)	DMCOMPOSITE	388,886	99.82%	46.58%	7.05

NOTE Table 10 excludes clinicians who were QPs and Partial QPs who did not elect to participate in MIPS. In addition, data here represent submissions used in final scoring.

Key Insights for Table 10

Nine of the 10 most frequently reported quality measures were used to calculate the final score for 400,000 clinicians and contributed to the final scores of between 48 and 53% of eligible clinicians who participated. All of the top 10 reported measures were among the 15 CMS Web Interface measures which are required for groups and APMs who submitted via the CMS Web Interface; this is not surprising given the CMS Web Interface (beneficiary level reporting on a specified set of quality measures) was the most common submission method for quality measures (see Table 8); the performance rates on these measures earned average scores between 7 and 9.6. The measure used most frequently in final scoring was Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet.

TABLE 11 Top 10 Quality Measures Contributing to a Clinician's Quality Performance Category Score Excluding CMS Web Interface Submissions

Measure Name	Quality Measure ID	Eligible Participants	Average Reporting Rate %	Average Performance Rate %	Average Measure Score
All-cause Hospital Readmission	458	128,474	N/A	15.29%	5.1
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	1	109,208	96.84%	39.30%	6.44
Documentation of Current Medications in the Medical Record	130	106,385	92.05%	92.11%	6.85
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	204	88,381	99.21%	84.48%	8.65
Preventive Care & Screening: Screening for High Blood Pressure and Follow-Up Documented	317	83,817	97.38%	45.82%	8.07
Pneumococcal Vaccination Status for Older Adults	111	81,975	97.02%	66.94%	7.64
Preventive Care & Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	128	77,075	97.14%	68.22%	7.89
Controlling High Blood Pressure	236	75,542	97.27%	64.73%	6.27
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	239	60,823	99.97%	48.61%	9.45
Diabetes: Medical Attention for Nephropathy	119	59,308	98.73%	86.79%	7.85

NOTE Table 11 excludes clinicians who were QPs as well as Partial QPs who did not elect to participate in MIPS. In addition, data in this table represent the submissions used in final scoring.

Key Insights for Table 11

This table shows the same information as Table 10 with one exception: it excludes clinicians reporting as a group or MIPS APM through the CMS Web Interface. Three of these measures contributed to the final scores of more than 100,000 clinicians, which is 11% of all participating clinicians: All-Cause Hospital Readmission, Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%), and Documentation of Current Medications in the Medical Record. The performance rates on these scores earned clinicians average measure scores ranging from 5.1 (All-cause readmission) to 9.45 (Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents). Four of these measures were also among the top 10 including the web interface submissions (111, 128, 204, and 236).

TABLE 12 Top 5 Improvement Activities Reported

Activity ID	Activity Name	# of Times Activity was Reported	Subcategory Name	Activity Weighting
IA_EPA_1	Provide 24/7 access to MIPS eligible clinicians or groups who have real-time access to patient's medical record	162,476	Expanded Practice Access	High
IA_PSPA_16	Use of decision support and standardized treatment protocols	112,259	Patient Safety And Practice Assessment	Medium
IA_BE_4	Engagement of patients through implementation of improvements in patient portal	95,586	Beneficiary Engagement	Medium
IA_BE_6	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement	94,628	Beneficiary Engagement	High
IA_PSPA_18	Measurement and improvement at the practice and panel level	81,628	Patient Safety And Practice Assessment	Medium

NOTE Table 12 excludes clinicians who were QPs and Partial QPs who did not elect to participate in MIPS.

Key Insights for Table 12

Providing 24/7 access to a patient's medical record remains the most reported Improvement Activity by a large margin. The top 4 improvement activities in 2018 also were among the top 5 improvement activities in program year 2017.

TABLE 13 Promoting Interoperability Base Measure Reporting

Promoting Interoperability Transition Objectives and Measures
(2014 CEHRT, or combination of 2014 and 2015 CEHRT)
All Measures Required (unless an exclusion can be claimed)

Objective	Measure Title	CMS Measure ID	Count of TIN/NPIs Reporting Each Measure
Protect Patient Health Information	Security Risk Analysis	PI_TRANS_PPHI_1	416,812
Patient Electronic Access	Provide Patient Access	PI_TRANS_PEA_1	416,578
Electronic Prescribing	e-Prescribing	PI_TRANS_EP_1	411,080
Health Information Exchange	Health Information Exchange	PI_TRANS_HIE_1	366,147

Promoting Interoperability Objectives and Measures
(2015 CEHRT) All Measures Required (unless an exclusion can be claimed)

Objective	Measure Title	CMS Measure ID	Count of TIN/NPIs Reporting Each Measure
Protect Patient Health Information	Security Risk Analysis	PI_PPHI_1	75,936
Patient Electronic Access	Provide Patient Access	PI_PEA_1	74,748
Electronic Prescribing	e-Prescribing	PI_EP_1	74,671
Health Information Exchange	Send a Summary of Care	PI_HIE_1	69,876
	Request/Accept Summary of Care	PI_HIE_2	71,184

NOTE Table 13 excludes clinicians who were QPs and Partial QPs who did not elect to participate in MIPS.

Key Insights for Table 13

The table provides reporting counts for the base measures (a subset of the measures, required to earn a score greater than 0 in the Promoting Interoperability performance category), highlighting the greater use of the Transition Objectives and Measures set.(Measure exclusions are not included in these counts.) Details on the Performance and Bonus measures will be available in the Public Use File at https://data.cms.gov.

Final Score and Payment Adjustment

After MIPS eligible clinicians select and report on measures and activities, they receive MIPS final scores and associated payment adjustments based on their performance. In 2018, MIPS eligible clinicians had their performance scored across the MIPS Quality, Improvement Activities, Promoting Interoperability, and Cost performance categories, as applicable. As noted in the Reporting and Performance Category section, all of the MIPS performance categories had an associated weight in 2018, in general: Quality was 50% of the MIPS final score, Improvement Activities was 15%, Promoting Interoperability was 25%, and Cost was 10%. The scores from each performance category were added together to give a clinician a MIPS final score. The MIPS final score was then compared to the MIPS performance threshold (which, for 2018, was 15 points) to determine if a clinician would receive a positive, negative, or neutral payment adjustment in payment year 2020. It is important to note that the performance category weights could differ depending on the specific circumstances of a MIPS eligible clinician. For example, the Cost performance category is weighted at 0% for MIPS eligible clinicians in a MIPS APM, and the other categories are reweighted as a result.

Additional details for the scoring methodology in 2018 are available in the 2018 MIPS 101 Scoring Guide.

The following tables reflect data related to MIPS final scores and payment adjustments.

TABLE 14 Payment Adjustment and Final Scores Attributed to MIPS Eligible Clinicians (Identified by TIN/NPI)

Payment Adjustment Type (Final Score Ranges)	Count TIN/NPI	Percent of TIN/NPI	Min Final Score (Earned)	Max Final Score (Earned)	Min Adjustment (Earned)	Max Adjustment (Earned)
Exceptional Performance (70.00-100)	749,016	84.16%	70.00	100.00	0.20%	1.68%
Positive (15.01-69.99)	119,141	13.39%	15.01	69.99	0.00%	0.20%
Neutral (15.00)	3,991	0.45%	15.00	15.00	0.00%	0.00%
Negative (0 – 14.99)	17,847	2.01%	0.00	14.97	-5.00%	-0.01%

NOTE Table 14 excludes clinicians who were QPs and Partial QPs who did not elect to participate in MIPS. Minimum and maximum adjustments have been rounded to two decimal places.

Key Insights for Table 14

Of the 889,995 MIPS eligible clinicians in 2018, 98% (872,148) avoided a negative payment adjustment; almost all of these clinicians earned a positive adjustment. By contrast, in 2017, 5% of all MIPS eligible clinicians received a negative payment adjustment. Payment adjustments based on final scores from the 2018 performance year will be applied in payment year 2020. Only 2% of MIPS eligible clinicians (17,847) who received a negative payment adjustment this year; the negative adjustments ranged from -5.0% to -0.01%. There were 3,991 MIPS eligible clinicians who scored the performance threshold of 15 points and therefore received a neutral adjustment. About 13.4% of all MIPS eligible clinicians scored between 15.01 and 69.99 points; the payment adjustments for these clinicians ranged from 0% to 0.20%. Over 84% of MIPS eligible clinicians achieved exceptional performance by earning 70 points or more, resulting in positive payment adjustments ranging from 0.20% to 1.68%.

It is important to remember that the funds available for positive payment adjustments are subject to budget neutrality requirements in MIPS as established by law under MACRA. This means the law allows for positive payment adjustment up to 5% for the 2018 performance year to apply to payment year 2020; however, we must apply a scaling factor to the positive adjustments to ensure budget neutrality.

TABLE 15 Final Score and Payment Adjustment for Small Practices and Rural Practices

	Count of MIPS Eligible Clinicians (TIN/NPI)	Minimum Final Score Earned	Maximum Final Score Earned	Minimum Payment Adjustment Earned	Maximum Payment Adjustment Earned
Rural	**116,222 Total**				
Positive Payment Adjustment with Additional Adjustment for Exceptional Performance	96,364	70	100	0.20%	1.68%
Positive Payment Adjustment	16,761	15.02	69.98	0.00%	0.20%
Neutral Payment Adjustment	712	15	15	0.00%	0.00%
Negative Payment Adjustment	2,385	0	14.93	-5.00%	-0.02%
Small Practices	**115,047 Total**				
Positive Payment Adjustment with Additional Adjustment for Exceptional Performance	66,638	70	100	0.20%	1.68%
Positive Payment Adjustment	29,919	15.01	69.99	0.00%	0.20%
Neutral Payment Adjustment	3,302	15	15	0.00%	0.00%
Negative Payment Adjustment	15,188	0	14.97	-5.00%	-0.01%

NOTE Table 15 excludes clinicians who were QPs as well as Partial QPs who did not elect to participate in MIPS. Minimum and maximum adjustments have been rounded to two decimal places. Note that Small and Rural designations are not mutually exclusive. Data in this table reflect payment adjustment status as of November 7, 2019.

Key Insights for Table 15

In 2018, 84% of small practices and 97% of rural practices earned a positive payment adjustment; this shows an improvement from the 2017 results of 74% of small practices and 93% of rural practices receiving positive adjustments. We understand that clinicians in these settings still face challenges to full participation, which is why we continue to provide direct technical assistance and flexibilities to these clinicians through the Small, Underserved, and Rural Support initiative to help alleviate barriers and create pathways to improvement and success.

TABLE 16 Final Scores by Participation Type

Participation Type	Mean Final Score	Median Final Score
Individual	52.44	57.67
Group	82.88	95.26
MIPS APM	98.77	100.00
All Participation Types	**86.96**	**99.63**

NOTE Table 16 excludes clinicians who were QPs as well as Partial QPs who did not elect to participate in MIPS.

Key Insights for Table 16

Mean scores by participation type show that MIPS APMs scored the highest (98.77), followed by Groups (82.88) and Individuals (52.44). The mean scores for MIPS APM and Group participation are higher than 2017, which were 87.64 and 76.20 respectively. Individual mean scores remain fairly consistent with the 2017 mean score of 55.08.

Key Insights for Table 17

MIPS eligible clinicians in rural practices earned a mean score of 85.99 while small practices earned a mean score of 65.69. The rural mean is quite close to the national mean of 86.96. These results suggest that clinicians in small and rural practices can still successfully participate in the program. We will continue to connect clinicians in small (especially solo clinicians) and rural practices to our Small, Underserved, and Rural Support initiative both now and in future years to reduce barriers, identify areas for improvement, and drive success in future program years.

TABLE 17 Final Scores for Clinicians in a Rural Area or Small Practice

Special Status	Mean Overall Score for MIPS Eligible Clinicians	Median Overall Score for MIPS Eligible Clinicians	Mean Overall Score for Eligible Participants	Median Overall Score for Eligible Participants
Rural	85.99	99.45	87.51	99.77
Small	65.69	81.16	75.03	87.48

NOTE Table 17 excludes clinicians who were QPs and Partial QPs who did not elect to participate in MIPS. Otherwise, the first two columns include all MIPS eligible clinicians, whether they participated in MIPS or not, and the last two columns include only eligible clinicians who participated in MIPS. Small and Rural designations are not mutually exclusive.

Summary

This report provides high-level summaries of results for the second year of the QPP; we are pleased to see numerous positive changes compared to 2017.

- Overall participation rates have increased from 95% to 98%.
- The percentage of eligible clinicians receiving a positive payment adjustment has increased from 93% to 97.5%, despite the increase in the performance threshold from 3 points in 2017 to 15 points in 2018.
- The number of clinicians receiving a negative payment adjustment has decreased significantly, from 51,505 to 17,847.
- The number of QPs in Advanced APMs has increased almost twofold from 99,076 to 183,306.
- The participation rate for Small practices increased from 81% to 94% and their average overall score has increased substantially, from 43.16 to 65.69.
- The rural practice participation rate increased from 94% to 98% and their average overall score has increased substantially, from 63.08 to 85.99.

For readers who are interested in examining these results in more detail, we will make a Public Use File available, rather than creating an appendix with additional tables. This will allow you to more easily explore the information that is important to you.

We are committed to continue working with clinicians to increase awareness of program requirements and help clinicians improve with each performance year.

The lessons learned from the first 2 years of the program, coupled with clinicians' experience and feedback, have helped us identify areas in need of improvement As we look to the future of MIPS, we envision a continued partnership with stakeholders to develop a more streamlined program with better alignment between the measures and activities available for the different performance categories.