

2017 Quality Payment Program Reporting Experience



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List of Acronyms

ACI	Advancing Care Information
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 and Medicaid Services
EHR	Electronic Health Record
ERSD	End-Stage Renal Disease
HPSA	Health Professional Shortage Area
IA	Improvement Activities
IVD	Ischemic Vascular Disease
MIPS	Merit-based Incentive Payment System
MSPB	Medicare Spending per Beneficiary
MSSP	Medicare Shared Savings Program
NPI	National Provider Identifier
PQRS	Physician Quality Reporting System
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 & Medicare Services (CMS) launched the Quality Payment Program, a brand new program that rewards innovation in improving patient outcomes and drives a fundamental movement toward a value-based system of care. The program consists of two participation tracks from which eligible clinicians may choose: The Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

Clinicians participating in MIPS will receive a payment adjustment during the 2019 payment year, either positive, neutral, or negative, based on their performance in 2017. Alternatively, clinicians who participate in an Advanced APM and achieve Qualifying APM Participant (QP) status based on their performance in 2017 will receive an APM Incentive Payment in 2019. Regardless of the pathway that an eligible clinician may choose, both tracks of the Quality Payment Program incentivize meaningful participation, enhancements in clinical practice, and, most importantly, improved beneficiary outcomes.

The primary goal of this report is to create a comprehensive representation of the overall clinician experience during the inaugural year of the Quality Payment Program. Based on feedback that we have received from clinicians, stakeholders, researchers, and others, we have drafted a concise report in an effort to highlight the data elements that you have indicated are important in understanding the entirety of the program. This report summarizes the journey of eligible clinicians in both MIPS and Advanced APMs during the 2017 performance year by analyzing several major aspects of the program:

- **Background**: Details the historical CMS programs prior to the Quality Payment Program and outlines the program's strategic objectives.
- **Participation**: Identifies who was eligible to participate in the Quality Payment Program and provides a breakout of participation rates across both MIPS and Advanced APMs.
- **Reporting Options**: Highlights the various ways clinicians could submit performance data, specifically for MIPS, to CMS.
- **Performance Categories**: Discusses the MIPS performance category requirements and provides data on the performance periods as well as measure/activity selection.
- **Final Score and Payment Adjustments**: Examines the MIPS final scores and payment adjustments across clinicians reporting as individuals, clinicians reporting as a group, and clinicians participating through a MIPS APM.

From the start of the Quality Payment Program, we committed to being fully transparent with our data. We anticipate that this report, complete with an accompanying appendix, provides the data needed to illustrate the successes and challenges in 2017, and opportunities for future program years.

We have made significant strides under the Quality Payment Program in 2017, from 95 percent of clinicians avoiding a negative payment adjustment under MIPS to having approximately 99,000 clinicians earning Qualifying APM Participant (QP) status and the associated incentive payment under the Advanced APM track. We look forward to continuing to listen and identify ways to improve the Quality Payment Program to help drive value, reduce burden, and improve outcomes for our beneficiaries.

Background

The Quality Payment Program, which consists of the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (APM) tracks, started on January 1, 2017. At its core, the Quality Payment Program is about improving the quality of patient care and outcomes.

The MIPS track streamlined the three existing CMS legacy 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 where clinicians are evaluated and receive payment adjustments based on their overall performance on four performance categories: Quality, Cost, Improvement Activities, and Advancing Care Information (ACI).¹

Conversely, the Advanced APM track offers a five percent incentive for significant participation in an Advanced APM and rewards clinicians for taking on greater risk and accountability for patient outcomes. While both tracks are structured to complement each other, one of CMS's foremost goals under the Quality Payment Program is to encourage the movement of clinicians and practices into APMs or Advanced APMs and ultimately toward a value-based system.

The Quality Payment Program had numerous strategic objectives that helped guide policy and product development in 2017.² At a high-level, these include:

- Improve beneficiary outcomes and engage patients through patient-centered Advanced APM and MIPS policies.
- Enhance clinician experience and reduce burden through flexible and transparent program design and interactions with easy-to-use program tools.
- Increase the availability and adoption of robust Advanced APMs.
- Promote program understanding and maximize participation through customized communication, education, outreach, and support that meet the needs of the diversity of clinician practices and patients, especially the unique needs of small practices.
- Improve data and information sharing on program performance to provide accurate, timely, and actionable feedback to clinicians and other stakeholders.
- Promote Information Technology systems capabilities that meet the needs of users for data submission, reporting, and improvement, and are seamless, efficient, and valuable on the front- and back-end.
- Ensure operational excellence in program implementation and ongoing development, and to design the program in a manner that allows smaller, independent and rural practices to be successful.

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

¹ Note the Advancing Care Information performance category was renamed Promoting Interoperability (PI) in the 2018 performance year.

² Additional details on the program's [Strategic Objectives](#) are found on the Quality Payment Program [website](#).

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 mentioned in the background section, the Quality Payment Program has two participation tracks – the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

As a part of the Advanced APM track, eligible clinicians have an opportunity to become Qualifying APM Participants (QPs) and earn a five percent APM incentive payment if they sufficiently participate in an Advanced APM during a given performance year. Eligible clinicians who become QPs are also excluded from MIPS reporting requirements to account for the work they are doing within an Advanced APM. Sufficient participation in an Advanced APM means that eligible clinicians must meet or exceed a specific percentage of payments for covered professional services or percentage of patients delivered covered professional services through an Advanced APM at one of the determination periods (which are also referred to as “snapshots”) to become a QP for a year. These “snapshot” dates are March 31, June 30, and August 31 of the QP Performance Period.

In 2017, if an eligible clinician participated in an Advanced APM and at least 25 percent of their payments or 20 percent 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 meet the QP payment amount or patient count thresholds. In this instance, the eligible clinician could also become a Partial QP if the Partial QP payment amount threshold or patient count threshold are met. Partial QPs would not receive the five percent incentive payment, but have the option to elect to participate in MIPS and receive a MIPS payment adjustment. Tables 5, 6, and 7 summarize APM and Advanced APM participation in 2017.

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. MIPS eligible clinicians are both physicians and non-physician clinicians who are eligible to participate in MIPS. CMS, through rulemaking, defines the MIPS eligible clinician types for a specific performance year.



Physicians include doctors of medicine, doctors of osteopathy, doctors of dental surgery, doctors of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors.

The low-volume threshold is the second step in determining whether a clinician is included in MIPS for a specific performance period. It helps CMS determine if a MIPS eligible clinician has an adequate amount of volume to be included in MIPS and meaningfully participate. In 2017, the low-volume threshold was based on the amount of Medicare Part B allowed charges billed and the number of Medicare Part B beneficiaries who received care during two distinct determination periods: September 1, 2015 – August 31, 2016 (initial determination period based on historic claims) and September 1, 2016 – August 31, 2017 (second determination based on performance

period claims).³ In order for MIPS eligible clinicians to be required to participate in MIPS in 2017, they had to bill more than \$30,000 in Medicare Part B allowed charges and see more than 100 Medicare Part B beneficiaries in both determination periods.

There are a number of exclusions available to MIPS eligible clinicians. In 2017, clinicians were excluded from MIPS if they met any one of the following:

- Not a MIPS eligible clinician type
- Enrolled in Medicare for the first time in 2017
- Did not exceed the low-volume threshold
- Significantly participated in an Advanced APM and were either a Qualifying APM Participant (QP) or Partial QP (and did not elect to participate in MIPS)

Clinicians had the opportunity to determine their eligibility for the 2017 performance period by searching their National Provider Identifier (NPI) using the [Quality Payment Program Participation Status Look-up Tool](https://qpp.cms.gov/status-look-up) on qpp.cms.gov.

In 2017, MIPS eligible clinicians required to participate in MIPS could either report as an individual,⁴ a group, or through an APM. It's important to understand that 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 beneficiaries. MIPS eligible clinicians participating in a MIPS APM receive special MIPS scoring to help account for the activities already required by the model.

Aside from eligibility and reporting, it is beneficial to review the basic participation options available to MIPS eligible clinicians. In 2017, MIPS eligible clinicians had flexible participation options under the “pick your pace” approach to help ease their transition into the program and encourage robust participation. “Pick your pace” also allowed for MIPS eligible clinicians to reach the MIPS performance threshold (i.e., the minimum number of points needed to avoid a negative payment adjustment, which, in 2017, was 3 points) in various ways. This meant that MIPS eligible clinicians could:

- Submit a small amount of data, including one quality measure, one Improvement Activity, or the base measures for the Advancing Care Information performance category
- Submit data for a 90-day period
- Submit a full year of data

As a part of participation, we also implemented “special status” designations for certain MIPS eligible clinicians. These designations are determined to indicate a circumstance of a MIPS eligible clinician’s practice for which special rules will affect the number of total measures, activities, or entire performance categories that an individual clinician or group must report. In 2017, “special status” designations included: small practice, rural practice, non-patient facing, health professional shortage area (HPSA), hospital-based, and ambulatory surgical center-based (ASC).

³ The passage of the Bipartisan Budget Act of 2018 on February 9, 2018, included several changes to the Merit-based Incentive Payment System for the 2018 performance year and subsequent performance years. One adjustment included basing the low volume threshold calculations on allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS) and the number of Medicare Part B beneficiaries who are furnished covered professional services under the Medicare PFS. This change did not apply to the 2017 performance year.

⁴ 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 two or more clinicians as identified by their NPI who have assigned their Medicare billing rights to a single TIN (at least one clinician within the group must be MIPS eligible in order for the group to be MIPS eligible).

The following participation results highlight the measured approach taken during the 2017 performance year.

TABLE



Overall Participation Rate of MIPS Eligible Clinicians

Total MIPS Eligible Clinicians in 2017	1,057,824
Number of MIPS Eligible Clinicians that Participated in 2017	1,006,319
Participation Rate	95%

NOTE

Table 1 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS. Additionally, "participated" is defined as the total number of MIPS eligible clinicians who received at least 3 points (which was the MIPS performance threshold in 2017) and avoided a negative payment adjustment.

Key Insights on Table 1:

A total of 1,057,824 clinicians were eligible for MIPS in 2017. Of these, 1,006,319, or 95 percent, participated in the program and avoided a negative payment adjustment by receiving at least 3 points as their MIPS final score. This exceeded the CMS established goal of having 90 percent of MIPS eligible clinicians participate during the 2017 performance year. These numbers are exciting because they illustrate the concerted efforts by CMS, clinicians, clinician support staff, professional associations, and many others to support successful participation, especially with 2017 being the inaugural year of the Quality Payment Program.

TABLE



Overall Participation Count by Reporting Entity

Total MIPS Eligible Clinicians in 2017	1,057,824
Individual Participation	122,897
Group Participation	542,202
MIPS APM Participation	341,220

NOTE

Table 2 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as 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.

Key Insights on Table 2:

Of the 1,006,319 eligible clinicians that participated in MIPS, 54 percent of clinicians (542,202) received their final score based on participation as part of a group; 12 percent of clinicians (122,897) received their final score based on individual participation; and 34 percent of clinicians (341,220) received final scores based on participating in MIPS through an APM. These data indicate that group reporting seems to be the preferred option for participating in the Quality Payment Program. Additionally, the significant participation in MIPS through APMs and the total number of Qualifying APM Participants (QPs) highlighted in Table 6 indicates that clinicians and practices are interested in and moving toward value-based arrangements and taking on additional risk for the outcomes of their patients.

TABLE 3 Participation Rates by Clinician Type

Clinician Type	Total MIPS Eligible Clinicians in 2017	Number of MIPS Eligible Clinicians that Participated in 2017	Participation Rate %
Physicians	777,283	732,073	94.18%
Non-Physician Clinicians	254,552	248,306	97.55%
Unknown	25,989	25,940	99.81%

NOTE Table 3 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS. Non-physician clinicians include Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists.

Key Insights on Table 3: A further breakdown of the total MIPS eligible clinician population in 2017 by specialty category showed that approximately 73 percent of clinicians were physicians, 25 percent were non-physician clinicians (that is, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists), and the remaining two percent fell into the “unknown” category. The “unknown” category contains those clinicians who may have fallen under multiple specialties during the MIPS eligibility determination periods discussed in the introduction section of participation. Regardless of classification, all specialty groups participated in MIPS in 2017 at an incredibly high level, with rates exceeding 94 percent across the board. Additional participation rates by specialty are available in the appendix.

TABLE 4 Participation Rates for Small and Rural Eligible Clinicians

Small or Rural	Total MIPS Eligible Clinicians	MIPS Eligible Clinicians that Participated	Participation Rate
Small	229,106	186,428	81%
Rural	164,598	155,309	94%

NOTE Table 4 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in 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.

Key Insights on Table 4: MIPS eligible clinicians in rural practices had a participation rate of 94 percent, which was virtually equal to the overall average and a remarkable accomplishment in 2017. Similarly, the 81 percent participation rate among MIPS eligible clinicians in small practices demonstrated that, even with unique challenges, these clinicians want to meaningfully engage and participate in the program. It is worth noting that the participation rate for clinicians in small practices was higher in MIPS than under the previous legacy programs, which may indicate a strong desire from these clinicians to be at the forefront of driving value in healthcare. Our goal is to continue offering as much no-cost technical assistance as possible to MIPS eligible clinicians in small and rural practices through the Small, Underserved, and Rural Support initiative as well as other networks to help these clinicians sustain successful participation and achieve the outcomes and results that they seek.

TABLE 5 MIPS Eligible Clinicians Who Participated in MIPS through an APM by Model

APM Model	Number of MIPS Eligible Clinicians
Comprehensive ESRD Care Model	32
Comprehensive Primary Care Plus Model	99
Medicare Shared Savings Program	320,945
Next Generation Accountable Care Organization (ACO) Model	17,398
Oncology Care Model	6,188

NOTE Table 5 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS. A clinician can participate in more than one APM.

Key Insights on Table 5: In 2017, the majority of MIPS eligible clinicians participated in Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program, followed by the Next Generation ACO model. We’re encouraged by the number of clinicians and practices who have made the transition to and participated in either an APM or Advanced APM (as seen in Table 6) during the 2017 performance year. One of CMS’s strategic objectives under the Quality Payment Program is to encourage more clinicians to participate in APMs and Advanced APMs, so we will continue to identify ways to help ease the transition and encourage more robust participation in future performance years along with developing new models for a wide variety of clinicians and specialties.

TABLE 6 Advanced APM Qualifying APM Participant (QP) Status

Total number of Qualifying APM Participants (QPs)	99,076
Total number of Partial QPs	52

NOTE The total number of Partial QPs includes clinicians who both elected to participate in MIPS and those who remained excluded for the performance year.

Key Insights on Table 6: As noted in Table 6, we're pleased that over 99,000 eligible clinicians became Qualifying APM Participants in 2017, with an additional 52 reaching Partial QP status. This exceeded our preliminary and conservative estimates for the 2017 performance year of having approximately 70,000 eligible clinicians reach QP status. We're eager to continue working with clinicians to help them make the successful transition into an Advanced APM, especially as we look to continue creating new models.

TABLE 7 Advanced APM Participation by Model and Average Qualifying APM Participant (QP) Threshold Scores			
Advanced APM	Number of Eligible Clinicians	Average Payment Threshold Score	Average Patient Threshold Score
Comprehensive ESRD Care Model - Two-Sided Risk	1,102	64	62
Comprehensive Care for Joint Replacement Payment Model (Track 1 - CEHRT)	1,115	13	5
Comprehensive Primary Care Plus Model	8,891	81	72
Medicare Shared Savings Program - Tracks 2 and 3	59,032	44	44
Next Generation ACO Model	73,638	50	52

NOTE The Oncology Care Model (OCM) - Two-Sided Risk was an Advanced APM for 2017. However, for the 2017 performance period, there were no participants in the two-sided risk track of the model. Additionally, the data within this table reflects overall participation in each model, not just those eligible clinicians with QP status.

Key Insights on Table 7: Both the Next Generation ACO Model and the Medicare Shared Savings Program (also supporting participation in Accountable Care Organizations) had the highest rates of Advanced APM participation among eligible clinicians. With the exception of the Comprehensive Care for Joint Replacement (CJR) Payment Model, we note that the average payment and patient threshold scores for eligible clinicians within the remaining Advanced APMs listed in Table 7 exceeded the required threshold scores for 2017 (which were 25 percent of payments and 20 percent of patients). In fact, if these eligible clinicians received the same scores in 2018, they would once again earn QP status for that performance period.

Reporting Options and Performance Categories

The following section of the 2017 Quality Payment Program Experience Report pulls together two very important aspects of the clinician journey through MIPS: measure/activity selection and submitting the 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 report (as an individual, as a part of a group, or through an APM), the next fundamental step is identifying an appropriate submission method based on measure/activity selection and available resources within the practice.

In 2017, there were six different methods⁵ based on the MIPS performance categories by which MIPS eligible clinicians reporting either individually or as a part of a group could submit data to CMS:

- Claims (only available to individual reporters under the Quality performance category)
- Qualified Registry
- Qualified Clinical Data Registry (QCDR)
- Electronic Health Record (EHR)
- CMS Web Interface (only available to registered groups of 25 or more clinicians)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey (available for registered groups with two or more clinicians)

In addition to the methods listed above, individual and group reporters also had the option of “attesting” for the Improvement Activities and Advancing Care Information performance categories through the Quality Payment Program website (qpp.cms.gov). This meant that a MIPS eligible clinician, authorized support staff, or third-party vendor could sign-in to the Quality Payment Program website and manually select and report Improvement Activities and measures under the Advancing Care Information performance category. This new form of data submission received favorable feedback from the clinician and stakeholder communities for its streamlined and user-friendly approach.

Another exciting and award winning ⁶ enhancement to the reporting process was a new submission method called an Application Programming Interface (API). We heard feedback at the onset of the program from various stakeholders encouraging us to develop new and innovative ways to allow CMS systems to interact directly with other software applications. We partnered with the developer community to create a submissions API that allowed Registries, QCDRs, and EHR vendors to submit data directly to CMS for the Quality, Improvement Activities, and Advancing Care Information performance categories. When data is sent via the submissions API, we provide immediate, clear, and actionable feedback to the user, which enhances confidence that the data was reported successfully and provides a preliminary score for the submission. The API was launched in 2017 to coincide with the first year of the Quality Payment Program and we are thrilled to highlight that there were 56,531 submissions accounting for over 288,000 clinicians,

⁵ For 2019, we have revised these existing terms and defined additional terminology to help clarify the process of submitting data, which includes collection types, submission types, and submitter types. Several of the terms listed are considered collection types. Submitter type refers to the MIPS eligible clinician, group, virtual group, or third party intermediary acting on behalf of a MIPS eligible clinician, group, or virtual group, as applicable, that submits data on measures and activities. Submission type is the mechanism by which a submitter type submits data to CMS, including, but not limited to: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface. The Application Programming Interface (API) referenced later in the report is an example of a direct submission type.

⁶ Received the 2018 API Award for Best in Health APIs presented by API World as well as the FedHealthIT Innovation Award.

or 30 percent of all participants. Additional details for all submission methods used to report data to CMS are available in the appendix.

The main component of MIPS is selecting and reporting on various measures and activities within the MIPS performance categories. In 2017, we assessed clinicians on three of the four performance categories: Quality, Improvement Activities, and Advancing Care Information. The Cost performance category was not scored in 2017 to allow clinicians time to familiarize themselves with the measures. Additional details on each performance category are available below along with direct links to the respective pages on the Quality Payment Program website. We also launched the [Explore Measures](#) tool on the Quality Payment Program website during 2017 in response to feedback that we received from clinicians that it was often difficult and time-consuming to find measure details and identify those that were applicable to their practice. This feature allowed 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

[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 six measures (in 2017, there were 271 QPP measures available and an additional 610 QCDR measures), one of which must be an outcome or high-priority measure (if an outcome is not available). It's important to note that 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 instead of reporting on individual measures.



Cost

[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 beneficiaries. In 2017, two measures were included in this category: Medicare Spending per Beneficiary (MSPB) and Total Per Capita Costs (TPCC).⁷ It is important to note that, in 2017, the Cost measures did not count toward a MIPS eligible clinician's final score. Instead, clinicians received feedback to prepare for future performance periods, such as 2018, when the performance category counts as a part of the MIPS final score.



Improvement Activities

[Improvement Activities](#) – the Improvement Activities performance category within MIPS 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 2017, there were a total of 93 Improvement Activities available.

⁷ For the 2017 MIPS performance period, CMS also adopted 10 episode-based measures that had previously been included in the Supplemental Quality and Resource Use Reports (QRURs), but assigned a weight of zero to each measure. Episode-based measures differ from the TPCC and MSPB measures because their specifications only include items and services that are related to the episode of care for a clinical condition or procedure (defined by procedure and diagnosis codes), as opposed to including all items and services that are provided to a patient over a given period of time.



Advancing Care Information

[Advancing Care Information](#) (ACI – which for the 2018 performance period and beyond is known as Promoting Interoperability (PI)) – this performance category promotes patient engagement and electronic exchange of health information using certified EHR technology (CEHRT). During the 2017 performance period, MIPS eligible clinicians had the option of reporting measures from the Advancing Care Information Objectives and Measures set or from the Advancing Care Information Transition Objectives and Measures set depending on their edition of CEHRT. For example, MIPS eligible clinicians could report from the ACI Objectives and Measures set if they had EHR technology certified to the 2015 Edition. Alternatively, MIPS eligible clinicians could report from the ACI Transition Objectives and Measures set if they had EHR technology certified to the 2015 Edition, or the 2014 Edition, or a

combination of both. An illustrative breakout of these measure sets is available within Tables 15 and 16. The total score for this performance category was comprised of a base, performance, and bonus score. To receive a score in ACI, MIPS eligible clinicians were required to submit the base score measures at a minimum. Additionally, there were several types of hardship exceptions available to MIPS eligible clinicians who were not able to report ACI due to: 1) insufficient internet connectivity; 2) extreme and uncontrollable circumstances, and 3) lack of control over the availability of CEHRT.

Aside from the basic requirements, each category has a specific weight and period of performance. A weight is the total value that a performance category contributes to a MIPS eligible clinician's final score. In 2017, the following weights were applied to the MIPS performance categories:

- Quality – 60%
- Cost – 0%
- Improvement Activities – 15%
- Advancing Care Information – 25%

A period of performance is the minimum duration (i.e., the timeframe) that a MIPS eligible clinician must capture and report data for the performance category. In 2017, the following reporting periods were applied to the MIPS performance categories:

- Quality – Minimum of 90-days (12-month reporting was an option)⁸
- Cost – No requirement (12-months of feedback only)
- Improvement Activities – Minimum of 90-days
- Advancing Care Information – Minimum of 90-days

The following tables highlight important reporting and performance category data.

⁸ Please note that while the “pick your pace” approach maintained many of the period of performance requirements, MIPS eligible clinicians could submit one quality measure for a minimum of one day and receive 3 points.

TABLE

8

MIPS Eligible Clinician Reporting Timeframe by Performance Category

Performance Period Reported	Quality#	Quality%	ACI#	ACI%	IA#	IA%
Number of clinicians reporting data for less than 90-days	7,402	0.80%	301	0.10%	2,369	0.40%
Number of clinicians reporting data for 90-days or greater but less than 12-months	225,662	24.90%	198,783	51.20%	223,703	38.90%
Number of clinicians reporting data for a full 12-months	673,029	74.30%	188,873	48.70%	348,602	60.70%



NOTE Table 8 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS.

Key Insights on Table 8: Across all MIPS performance categories, MIPS eligible clinicians who participated generally opted to report data for 90-days or longer. This trend was especially prominent in the Quality performance category, where approximately three-quarters of all participants elected to report a full year of data while just under one-quarter of participants reported for a period of 90-days to less than a year. Less than one percent elected to submit the minimum amount of data and report for performance periods of less than 90-days. While clinicians had the opportunity to submit minimal amounts of data in 2017 through the “pick your pace” approach to avoid a negative adjustment, these data suggest that the majority of clinicians opted to meaningfully participate by reporting more data and for longer periods of time.

TABLE

9

Overall Reporting Timeframe for MIPS Eligible Clinicians
in Small and Rural Practices

Small or Rural by Performance Period	Quality#	Quality%	ACI#	ACI%	IA#	IA%
Number of MIPS Eligible Clinicians in Small Practices reporting data for less than 90-days	2,008	1.60%	79	0.10%	599	0.60%
Number of MIPS Eligible Clinicians in Small Practices reporting data for 90-days or greater but less than 12-months	68,710	53.90%	32,865	48.80%	46,586	45.80%
Number of MIPS Eligible Clinicians in Small Practices reporting data for a full 12-months	56,660	44.50%	34,348	51.00%	54,494	53.60%
Number of MIPS Eligible Clinicians in Rural Practices reporting data for less than 90-days	982	0.50%	83	0.10%	788	0.40%
Number of MIPS Eligible Clinicians in Rural Practices reporting data for 90-days or greater but less than 12-months	58,835	32.00%	78,118	54.50%	65,640	34.20%
Number of MIPS Eligible Clinicians in Rural Practices reporting data for a full 12-months	123,782	67.40%	65,233	45.50%	125,479	65.40%

NOTE

Table 9 excludes clinicians who were Qualifying APM Participants (QPs) as well as Partial QPs who chose not to participate in MIPS.

Key Insights on Table 9: MIPS eligible clinicians in small and rural practices also opted to submit more than the minimum amount of required data in 2017. This highlights that these clinicians were committed to meaningfully participating in MIPS to continue driving value and innovating to improve patient outcomes.

TABLE

10

Percentage of MIPS Eligible Clinicians Reporting by Submission Method and Performance Category

Submission Method	Quality	ACI	IA
Percentage of MIPS Eligible Clinicians Submitting Claims	4.70%	N/A	N/A
Percentage of MIPS Eligible Clinicians Submitting CMS Web Interface	41.74%	N/A	N/A
Percentage of MIPS Eligible Clinicians Submitting EHR	21.99%	25.20%	15.76%
Percentage of MIPS Eligible Clinicians Submitting Registry/QCDR	31.57%	19.32%	35.33%
Percentage of MIPS Eligible Clinicians Attesting via Quality Payment Program Website	N/A	55.48%	48.91%
Totals	100.00%	100.00%	100.00%



Table 10 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS. Additionally, these are the submission methods that were used for final scoring.

Key Insights on Table 10: For the MIPS Quality performance category, the CMS Web Interface was the most selected submission method for reporting quality measure data, which is in part due to larger groups and APM participants leveraging this option. Aside from the CMS Web Interface, submission via a Qualified Registry or Qualified Clinical Data Registry was the second most selected option. Interestingly, less than five percent of submissions for the Quality performance category came from claims. Aside from the Quality performance category, many MIPS eligible clinicians took advantage of the attestation (or manual) submission method available on the Quality Payment Program website for both the Advancing Care Information and Improvement Activities performance categories. Based on feedback we received during the 2017 submission period, clinicians, clinician support staff, and third-party vendors indicated that the attestation method was streamlined, user-friendly, and allowed for the quick reporting of ACI measures and Improvement Activities.

TABLE 11

Participation Option Percentages for each Submission Method and Performance Category

Performance Category	Quality				ACI			IA		
	Claims	CMS Web Interface	Electronic Health Record	Registry	Electronic Health Record	Registry	Web Attestation	Electronic Health Record	Registry	Web Attestation
Individual Participants %	99%	0%	12%	13%	11%	19%	10%	13%	12%	11%
Group Participants %	0%	15%	85%	86%	87%	78%	85%	85%	86%	86%
MIPS APM Participants %	1%	85%	3%	1%	2%	3%	5%	2%	2%	4%

NOTE Table 11 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS.

Key Insights for Table 11: This table provides an additional breakdown of Table 10 and examines the percentages of MIPS eligible clinicians who submitted data as individuals, as a part of a group, or through an APM based on performance category. As an example, Table 10 shows that 25.2 percent of ACI measures were submitted through an EHR. Of that population, based on Table 11, 87 percent submitted as a group, 11 percent as individuals, and the remaining 2 percent through an APM. Please note that this report is purely based on submissions, which means that although we did not score clinicians on the other submission methods, they may have been used.

TABLE

12

Top 10 Quality Measures Selected and Reported by MIPS Eligible Clinicians (Includes CMS Web Interface Measures)

Measure Name	Quality Measure ID	Participants #	Average Eligible Patients #	Average Reporting Rate %	Average Performance Rate %	Average Measure Score #
Controlling High Blood Pressure	236	510,723	4,035.81	99.45%	69.04%	7.6
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	492,357	3,456.87	97.83%	91.57%	9.12
Breast Cancer Screening	112	473,819	4,294.47	99.60%	68.65%	8.09
Pneumococcal Vaccination Status for Older Adults	111	469,714	3,760.34	99.03%	74.10%	8.42
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	204	467,699	2,364.46	99.59%	88.66%	9.49
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	128	463,231	9,235.11	99.00%	66.39%	7.73
Preventive Care and Screening: Influenza Immunization	110	444,223	3,484.71	98.48%	70.66%	8.14
Colorectal Cancer Screening	113	436,139	3,536.86	99.60%	63.63%	7.48
Falls: Screening for Future Fall Risk	318	419,862	1,894.93	99.89%	76.17%	9.07
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	134	415,194	5,600.43	99.73%	58.24%	7.02

NOTE

Table 12 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS. This table only includes performance results for clinicians who selected and submitted these measures and further consolidates the performance across all submission methods combined (i.e. EHR, QCDRs, Qualified Registries, and CMS Web Interface).

Key Insights on Table 12: Each MIPS Quality performance category measure listed within this table was selected and reported on by more than 400,000 MIPS eligible clinicians and had an average measure score of seven points or greater. It is important to note that this table includes the CMS Web Interface measures. The most commonly selected and reported Quality performance category measure was #236: Controlling High Blood Pressure, which was an intermediate outcome measure. The remaining nine most selected and reported measures were process measures.

TABLE 13 Top 10 Quality Measures Selected and Reported on by MIPS Eligible Clinicians (Excludes CMS Web Interface Measures)						
Measure Name	Quality Measure ID	Participants #	Average Eligible Patients #	Average Reporting Rate %	Average Performance Rate %	Average Measure Score #
Documentation of Current Medications in the Medical Record	130	153,511	35,430	91%	91%	6.98
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	317	97,635	49,076	92%	48%	7.29
Hypertension: Improvement in Blood Pressure	373	88,299	7,888	100%	38%	9.35
Use of High-Risk Medications in the Elderly	238	77,155	8,018	99%	4%	7.8
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	239	52,904	53,072	100%	49%	9.57
Prevention of Central Venous Catheter (CVC) – Related Bloodstream Infections	076	49,715	591	78%	85%	6.3
Care Plan	047	48,954	3,408	79%	75%	6.5
Cervical Cancer Screening	309	45,174	45,445	100%	55%	8.76
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	008	42,788	704	99%	94%	8.98
Childhood Immunization Status	240	41,785	1,914	100%	38%	9.39

NOTE Table 13 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS. This table only includes performance results for clinicians who selected and submitted these measures and further consolidates the performance across all submission methods combined (i.e. EHR, QCDRs, and Qualified Registries).

Key Insights on Table 13: There are stark contrasts in the Quality measure selection between Table 12 and Table 13 when removing the CMS Web Interface measures. The average performance measure scores are all still relatively high, averaging over 6 points per listed measure. Similar to Table 12, the majority of the measures selected and reported on were process measures with the exception of #373: Hypertension Improvement in Blood Pressure, which was an intermediate outcome measure. We anticipate that quality measure selection and reporting will continue to evolve as we move into future programs years. We will continue to leverage the Meaningful Measures framework to identify the highest priority areas for quality measurement and improvement in order to advance high-priority and outcome oriented measures and remove those that are process, duplicative, and/or topped out. We've also recently partnered with several external organizations to help us develop, improve, update, and expanding the quality measures for the Quality Payment Program. We'll leverage this new collaborative effort to develop and implement measures that offer the most promise for improving patient care.

TABLE 14 Top Five Improvement Activities Reported

Activity ID	Activity Name	Number of MIPS Eligible Clinicians Reporting this Activity
IA_EPA_1	Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record	190,510
IA_PSPA_16	Use of decision support and standardized treatment protocols	118,450
IA_PCMH	Patient Centered Medical Home Attestation	111,057
IA_BE_4	Engagement of patients through implementation of improvements in patient portal	106,028
IA_BE_6	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement	105,072

Key Insights on Table 14: Providing 24/7 access to a patient's medical record was by far the most reported Improvement Activity by MIPS eligible clinicians in 2017, which is a considerable step forward in ensuring coordinated and timely care for patients for emergent issues, transition management, etc. The selection of this specific Improvement Activity reflects the movement toward integrating expanded hours, virtual care, home visits and other innovative techniques into clinical practice. We also noticed the desire to enhance access for patients through the widely selected "Engagement of Patients through Implementation of Improvement in Patient Portal" Improvement Activity. The goal for this activity was to encourage the creation of patient portals that provide up-to-date health information and allow for a bi-directional communication between patients and clinicians, which ultimately enhances access to care, promotes communication, and puts patients in control of their health information.

TABLE 15 Reporting Percentages for the Advancing Care Information Measure Sets

Number of MIPS Eligible Clinicians Reporting ACI	387,957
Percentage of MIPS Eligible Clinicians Reporting Measures from the ACI Objectives and Measures Set*	40%
Percentage of MIPS Eligible Clinicians Reporting Measures from the ACI Transition Objectives and Measures Set**	60%

NOTE Table 15 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS.

*For MIPS eligible clinicians with EHR technology certified to the 2015 Edition.

**For MIPS eligible clinicians with EHR technology certified to the 2015 Edition, or 2014 Edition, or a combination of both.

Key Insights on Table 15: In 2017, approximately 40 percent (387,957 out of 1,006,319 MIPS eligible clinicians) reported data for the Advancing Care Information performance category. Of those MIPS eligible clinicians, 40 percent (or approximately 155,182 MIPS eligible clinicians) reported measures from the Advancing Care Information Objectives and Measures set. The remaining 60 percent (or approximately 232,774 MIPS eligible clinicians) reported measures from the Advancing Care Information Transition Objectives and Measures set. Please note that a MIPS eligible clinician or group selected a measure set based on their edition of certified EHR technology.

TABLE

16

Number of MIPS Eligible Clinicians Submitting
Advancing Care Information by Measure

Participants Reporting Measure	ACI Measure ID	Measure Name	Objectives and Measures	Transition Objectives and Measures	
Base	ACI_HIE_1	Send a Summary of Care	14,582		
	ACI_HIE_2	Request/Accept Summary of Care	14,044		
	ACI_PEA_1	Provide Patient Access	17,134		
	ACI_TRANS_HIE_1	Health Information Exchange		328,098	
	ACI_TRANS_PEA_1	Provide Patient Access		370,522	
Performance	ACI_CCTPE_1	View, Download and Transmit (VDT)	15,710		
	ACI_CCTPE_2	Secure Messaging	15,233		
	ACI_CCTPE_3	Patient-Generated Health Data	11,697		
	ACI_HIE_3	Clinical Information Reconciliation	13,794		
	ACI_PEA_2	Patient-Specific Education	16,199		
	ACI_PHCDRR_1	Immunization Registry Reporting	14,130		
	ACI_TRANS_MR_1	Medication Reconciliation		355,172	
	ACI_TRANS_PEA_2	View, Download, or Transmit (VDT)		355,882	
	ACI_TRANS_PHCDRR_1	Immunization Registry Reporting		264,941	
	ACI_TRANS_PSE_1	Patient-Specific Education		360,707	
	ACI_TRANS_SM_1	Secure Messaging		343,757	
	Bonus	ACI_IACEHRT_1	CEHRT Used	240,548	
		ACI_PHCDRR_2	Syndromic Surveillance Reporting	3,291	
ACI_PHCDRR_3		Electronic Case Reporting	1,361		
ACI_PHCDRR_4		Public Health Registry Reporting	6,309		
ACI_PHCDRR_5		Clinical Data Registry Reporting	8,653		
ACI_TRANS_PHCDRR_2		Syndromic Surveillance Reporting		114,387	
ACI_TRANS_PHCDRR_3		Specialized Registry Reporting		239,202	

Key Insights on Table 16: We found that the majority of measures submitted under the Advancing Care Information performance category were from the Transition Objectives and Measures set. Please note that MIPS eligible clinicians could use either 2014 or 2015 Edition CEHRT to report the Transition Objectives and Measures set, which may indicate the higher measure selection and submission rates. The highest reported measure across both ACI measure sets was Provide Patient Access. When compared against the Improvement Activities table, we are encouraged that MIPS eligible clinicians are seeking innovative ways to ensure that patients have timely and unrestricted access to their health information.

Final Score and Payment Adjustment⁹

After MIPS eligible clinicians select and report on measures and activities, they receive a MIPS final score and associated payment adjustment based on their performance. In 2017, MIPS eligible clinicians had their performance scored across the MIPS Quality, Improvement Activities, and Advancing Care Information performance categories, as applicable. As noted in the Reporting and Performance Category section, all of the MIPS performance categories had an associated weight in 2017: for Quality it was 60% of the MIPS final score, for Improvement Activities it was 15%, and for Advancing Care Information it was 25%. The scores from each performance category were added together to give a clinician a MIPS final score. The MIPS final score is then compared to the MIPS performance threshold (which, for 2017, was 3 points) to determine if a clinician would receive a positive, negative, or neutral payment adjustment. It is important to note that the performance category weights could differ depending on the specific circumstances of a MIPS eligible clinician. For example, MIPS eligible clinicians in small and rural practices received double-weighting to their activities within the Improvement Activities performance category. Additional details for the scoring methodology in 2017 are available in the [2017 MIPS 101 Scoring Guide](#).

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

⁹ Note that all data regarding payment adjustment status do not reflect targeted reviews. Additional information on [targeted review](#) is available in the Quality Payment Program Resource Library.

TABLE

17

Payment Adjustment TIN/NPI Counts Prior to Targeted Reviews

Payment Adjustment Type	Count TIN/NPI	Percent of TIN/NPI	Min Final Score	Max Final Score	Minimum Payment Adjustment	Maximum Payment Adjustment
Negative Payment Adjustment Participants #	51,505	5%	0.00	1.42	-2.11%	-4.00%
Neutral Payment Adjustment Participants #	21,257	2%	3.00	3.00	0.00%	0.00%
Positive Payment Adjustment Participants #	230,084	22%	3.02	69.99	0.00%	0.20%
Positive with Additional Adjustment for Exceptional Performance Payment Adjustment Participants #	754,978	71%	70.00	100.00	0.28%	1.88%

NOTE

Table 17 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS. The table reflects payment adjustment status prior to any targeted reviews

Key Insights on Table 17: Remarkably, out of the 1,057,824 clinicians eligible for MIPS for the first performance year, 93 percent received a positive payment adjustment or better, whereas another two percent earned a neutral payment adjustment. Only five percent of MIPS eligible clinicians received a negative payment adjustment for their 2017 performance, and we will work with these clinicians through our [Quality Payment Program technical assistance initiative](#) to identify their needs, address potential barriers, and help them prepare to successfully participate in future years. These data suggest that the measured approach of providing flexible options to clinicians encouraged higher rates of participation in 2017. When analyzing the percentages, we found that the highest payment adjustment applied in the 2019 payment year (based on 2017 performance) is 1.88%. This 1.88% adjustment, earned by MIPS eligible clinicians with a maximum final score of 100 points, includes the additional adjustment for exceptional performance. Additionally, 0.20 percent is the highest positive payment adjustment that will be applied in 2019 to MIPS eligible clinicians who did not receive an additional adjustment for exceptional performance (i.e. had a final score of 3.01 to 69.99 points).

While we have heard concern that the MIPS positive payment adjustments are modest, it is important to remember that the funds available for positive payment adjustments are subject to the budget neutrality requirements in MIPS as established by law under MACRA. This means that the law allows for positive payment adjustments to be up to 4 percent for the 2017 performance year/2019 payment year; however, we must apply a scaling factor to the positive payment adjustments to ensure budget neutrality. Additionally, the performance threshold for MIPS was set relatively low at 3 points and the availability of “pick your pace” allowed for more clinicians to successfully participate and earn a positive adjustment and/or a positive adjustment with an additional adjustment for exceptional performance.

TABLE

18

Final Score by Payment Adjustment Type for Small and Rural Prior to Targeted Reviews

Payment Adjustment Type	Count TIN/NPI	Percent of TIN/NPI	Min Final Score	Max Final Score	Minimum Payment Adjustment	Maximum Payment Adjustment
Negative Payment Adjustment Small Participants #	42,678	19%	0.00	0.00	-4.00%	-4.00%
Neutral Payment Adjustment Small Participants #	17,850	8%	3.00	3.00	0.00%	0.00%
Positive Payment Adjustment Small Participants #	67,682	30%	3.02	69.99	0.00%	0.20%
Positive with Additional Adjustment for Exceptional Performance Payment Adjustment Small Participants #	100,896	44%	70.00	100.00	0.28%	1.88%
Negative Payment Adjustment Rural Participants #	9,289	6%	0.00	0.00	-4.00%	-4.00%
Neutral Payment Adjustment Rural Participants #	2,460	1%	3.00	3.00	0.00%	0.00%
Positive Payment Adjustment Rural Participants #	46,426	28%	3.52	69.99	0.00%	0.20%
Positive with Additional Adjustment for Exceptional Performance Payment Adjustment Rural Participants #	106,423	65%	70.00	100.00	0.28%	1.88%

NOTE

Table 18 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS. Additionally, Table 18 reflects payment adjustment status prior to any targeted reviews.

Key Insights on Table 18: In 2017, 74 percent of MIPS eligible clinicians in small practices received a positive payment adjustment compared to 93 percent of MIPS eligible clinicians in rural practices. The high percentages of clinicians in small and rural practices receiving a positive MIPS payment adjustment is encouraging. We also understand that clinicians in these settings still face challenges to full participation, which is why we will continue to provide direct technical assistance to these clinicians through the Small, Underserved, and Rural Support initiative to help alleviate barriers and create pathways for improvement and success.

TABLE 19

Mean and Median Scores by Participation Method

Participation Method	Mean Final Score	Median Final Score
Individuals	55.08	60.00
Groups	76.20	91.04
MIPS APM	87.64	91.76
National Total	74.01	88.97

NOTE Table 19 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS. The National Total row is the overall mean and median when considering all individual, group, and MIPS APM submissions.

Key Insights on Table 19: We experienced a range of average final scores across the various reporting options, i.e. individual, group, and through an APM. The mean final score was highest for MIPS eligible clinicians who participated in MIPS through an APM (87.64), followed by those reporting as a part of a group (76.20). We still believe that MIPS eligible clinicians reporting at the individual level can be very successful within the program. When comparing the 2017 average final score for MIPS eligible clinicians reporting as individuals against the performance thresholds for the 2018 (15 points) and 2019 (30 points) performance years, these clinicians would still receive a positive payment adjustment. Additionally, we want to emphasize the importance of highlighting the mean and median throughout this section of the report for two reasons: 1) to allow for comparison between clinicians (participating as individuals and groups) and 2) because by the 2022 performance period we are required to set the MIPS performance threshold at either the mean or median of the final scores for all MIPS eligible clinicians from a prior performance period.

TABLE 20 Mean and Median Final Scores for Small and Rural Clinicians

Small or Rural	Mean Final Score	Median Final Score
Small Eligible Clinicians	43.46	37.67
Rural Eligible Clinicians	63.08	75.29



Table 20 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS.

Key Insights on Table 20: In reviewing the mean and median final scores for MIPS eligible clinicians in small and rural practices, the analysis shows that MIPS eligible clinicians in rural practices earned a mean score of 63.08 points, while clinicians in small practices received a mean score of 43.46 points. While these averages are slightly lower than those mean final scores found in Tables 18 and 19, these results suggest that clinicians in small and rural practices can still successfully participate in the program and at a high level. Additionally, with these mean scores, clinicians in small and rural practices would still receive a neutral or positive payment adjustment for the 2017, 2018, and 2019 performance years due to the relatively modest performance thresholds that we have established. We'll also continue connecting clinicians in small (especially solo clinicians) and rural practices to our Small, Underserved, and Rural Support initiative both now and in future performance years to reduce participation barriers, identify areas for improvement, and drive success for all at absolutely no-cost.

Summary

The data found within this report as well as the accompanying appendix illustrates the significant strides made during the first year of the Quality Payment Program. A resounding 95 percent of MIPS eligible clinicians participated in 2017 and avoided a negative payment adjustment, of which 93 percent earned a positive payment adjustment. These results exceeded our goal of having 90 percent of MIPS eligible clinicians participate in 2017. We're also encouraged by the participation and performance rates of clinicians in small practices, and we will continue to work with these clinicians to ensure success in future performance years. Aside from MIPS, the data showed that more clinicians are beginning to transition to APMs and Advanced APMs, as over 340,000 clinicians participated in MIPS through an APM and over 99,000 clinicians earned Qualifying APM Participant status in an Advanced APM. Overall, the participation and performance in the Quality Payment Program during 2017 highlighted the general interest of clinicians to begin transitioning away from a fee-for-service model and toward a value-based system.

While we've made significant process, we know additional work remains. We're making a strong commitment to further reduce burdensome requirements and will work with clinicians and practices to make that a reality. Our obligation is to make this a practical program for every clinician, in both small and large practices. We take this responsibility very seriously. We're committed to continue leveraging our Patients over Paperwork framework to review many of the MIPS requirements to reduce burden and add additional flexibilities so clinicians can successfully participate without sacrificing the time they spend with patients.

We're still listening and looking for ways to improve the Quality Payment Program to help drive value, reduce burden, promote meaningful participation by clinicians, and improve outcomes for beneficiaries. We encourage clinicians, stakeholders, and others to thoroughly review this report and accompanying appendix and send us their feedback to help identify areas of immediate need as well as shape the program for future performance years. There are also numerous resources available to clinicians and stakeholders who wish to learn more about the Quality Payment Program and ways to work with CMS in order to continue to improve the program and achieve stronger results. We encourage you to visit the [Quality Payment Program website](#) and sign-up for our listserv or contact us directly at QPP@cms.hhs.gov or via phone at 1-866-288-8292 (TTY: 1-877-715-6222).