Quality Payment
PROGRAM

# 2023 Quality Payment Program Experience Report

JUNE 2025

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# List of Acronyms

| | |
|---|---|
| **ACO** | Accountable Care Organization |
| **API** | Application Programming Interface |
| **APM** | Alternative Payment Model |
| **APP** | APM Performance Pathway |
| **CAHPS** | Consumer Assessment of Healthcare Providers and Systems |
| **CEHRT** | Certified Electronic Health Record Technology |
| **CMS** | Centers for Medicare & Medicaid Services |
| **COVID-19** | Coronavirus Disease 2019 |
| **CQM** | Clinical Quality Measure |
| **eCQM** | Electronic Clinical Quality Measure |
| **EHR** | Electronic Health Record |
| **EUC** | Extreme and Uncontrollable Circumstances |
| **HWR** | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups |
| **MCC** | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions |
| **MIPS** | Merit-based Incentive Payment System |
| **MSPB** | Medicare Spending Per Beneficiary |
| **MVP** | MIPS Value Pathway |
| **NPI** | National Provider Identifier |
| **PHE** | Public Health Emergency |
| **QCDR** | Qualified Clinical Data Registry |
| **QPP** | Quality Payment Program |
| **QP** | Qualifying APM Participant (in an Advanced APM) |
| **TIN** | Taxpayer Identification Number |
| **TPCC** | Total per Capita Cost |

# A. Background

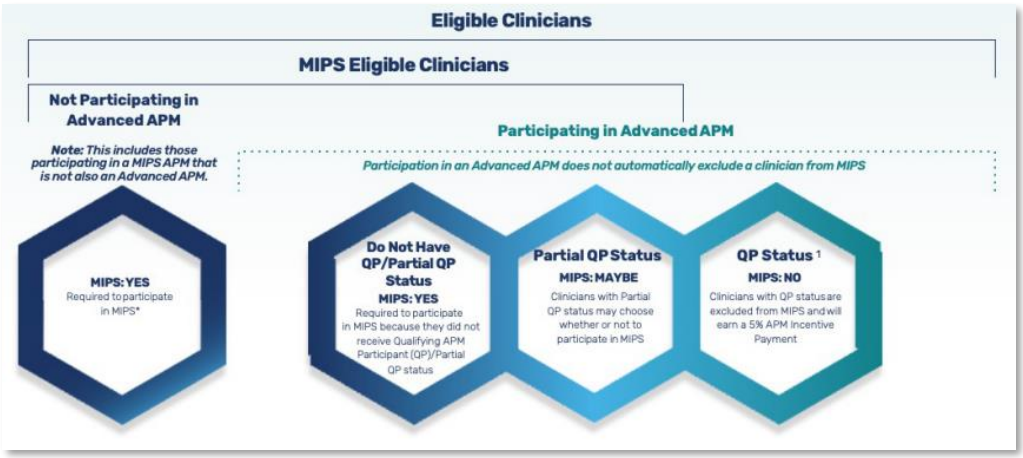
In 2017, the Centers for Medicare & Medicaid Services (CMS) launched the Quality Payment Program (QPP), which aims to reward improved patient outcomes and drive fundamental movement toward a value-based system of care. The program offers **2 payment tracks:** the Merit-based Incentive Payment System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

**The MIPS track** evaluates clinicians on their overall performance in up to 4 performance categories: quality, cost, improvement activities, and Promoting Interoperability. MIPS eligible clinicians will receive a MIPS payment adjustment – positive, negative, or neutral – 2 years after the performance year. For example, MIPS payment adjustments applied in 2025 (the payment year) are based on their performance in the 2023 performance year.

**The Advanced APM track** provides an opportunity to reward clinicians for taking on greater risk and accountability for patient outcomes. Eligible clinicians who participated in an Advanced APM and achieved Qualifying APM Participant (QP) status, based on the level of their participation in 2023 through the Medicare or the All-Payer Combination Option, will be eligible to receive a 3.5% APM Incentive Payment in 2025. Eligible clinicians with QP status are also excluded from MIPS. If an eligible clinician participating in an Advanced APM doesn't achieve QP status for the year, they'll need to participate in MIPS, unless they're otherwise excluded.

Review the Learning Resources for QP Status and APM Incentive Payment (ZIP) and the Advanced APM Participation section of this report for more information.

Although QPP has 2 payment tracks, these tracks can overlap for clinicians participating in an Advanced APM:



## 1. Purpose of This Report

From the start of QPP, CMS committed to being transparent with data and listening to feedback from interested parties. The primary goal of this report is to identify trends associated with the clinician experience during the 2023 performance year while identifying progress from the 2021 and 2022 performance years.

In this report, data and insights are provided in the following 5 sections:

- **Section 1. MIPS Eligibility and Participation:** Reviews the participation and engagement of MIPS eligible clinicians, with detailed breakouts by special status, practice size, participation option and reporting option.
- **Section 2. MVP Participation and Performance:** Reviews registration and performance data for clinicians who registered for, reported, and/or received a final score from a MIPS Value Pathway (MVP).
- **Section 3. MIPS Performance:** Reviews performance in the quality, cost, improvement activities, and Promoting Interoperability performance categories, with detailed breakouts in the quality performance category by frequency of reporting, scores, and specialty.
- **Section 4. 2023 MIPS Final Scores and Associated 2025 Payment Adjustments:** Reviews MIPS eligible clinicians' final scores and payment adjustments, with detailed breakouts by special status, practice size, participation option and reporting option.
- **Section 5. APM Participation:** Reviews the volume of eligible clinicians achieving QP status.

## 2. COVID-19 and 2023 Participation

The public health emergency (PHE) declaration for the Coronavirus Disease 2019 (COVID-19) officially ended May 11, 2023, though we allowed clinicians to submit a MIPS Extreme and Uncontrollable Circumstances (EUC) Exception Application due to the COVID-19 PHE for the entirety of the 2023 performance year. The 2023 performance year was the final year that clinicians could submit a MIPS EUC Exception Application due to COVID-19. Visit the QPP website to learn more about our COVID-19 response in the 2023 performance year and the MIPS EUC Exception Application.

## 3. Additional Information

For more information on the data included in this report, please see the 2023 QPP Data Use Guide (PDF). Along with this report, CMS released the 2023 QPP Public Use File (PUF). The 2023 QPP PUF is a large dataset that includes clinician-level, non-aggregated data on clinician experience in the 2023 performance year. It will enable you to get some of the details behind the data in tables and figures presented in this report.

- **Aggregating the clinician-level data in the PUF won't result in the same data presented in this report.**
- **Clinicians in the PUF are identified by National Provider Identifier (NPI) and clinicians who see a low volume of Medicare patients (10 or fewer) will be excluded from the PUF due to privacy and public reporting standards.**

The 2023 QPP Participation and Performance Results At-A-Glance (PDF) was released before this report; the At-A-Glance resource provides a snapshot of aggregated data from this report.

# B. Summary

The 2023 QPP Experience Report provides a glimpse into key program metrics, allowing interested parties to observe, identify trends in, and review changes to the experience of clinicians in the program. The Experience Report provides data that inspects clinician participation and performance overall, the results of those who **engaged**[1] with the program (or actively participated), as well as data for **non-reporting**[2] clinicians (those who didn't report data at all). The data also distinguishes many of the metrics by **practice size**, allowing for distinction in the participation and performance results between solo practitioners and "small practices" – a defined term within QPP policy for practices with fewer than 16 clinicians, but that also includes solo practitioners.

For example:

- MIPS eligible clinicians who engage[1] (actively participate) continue to be successful in the program, regardless of practice size:
    - **The mean final score for clinicians who engage was 85.54 points,** 10 points above the performance threshold of 75 points and almost twice the mean final score for non-reporting clinicians.
- Solo practitioners have the lowest mean and median scores overall (27.97 points and 15.34 points, respectively), primarily due to their high non-reporting rates. This changes significantly when we focus exclusively on solo practitioners who engaged:
    - **Engaged solo practitioners had a median final score of 85.51 points**, which was slightly higher than the median final score of clinicians in a practice with 16 – 99 clinicians (85.42 points).

The 2023 report continues to include **safety net provider**[3] designations, along with breakouts by MIPS eligible clinician types[4] and specialty[5].

We also continue to distinguish some metrics by reporting option and participation option. For the 2023 performance year, we added a **third reporting option** for clinicians to meet MIPS reporting requirements. In addition to traditional MIPS and the APM Performance Pathway (APP), clinicians had the option to report a **MIPS Value Pathway (MVP)**. MVPs offer clinicians more meaningful groupings of measures and activities that are

[1] **Engaged clinicians** are those who submitted at least one measure, attestation, or activity (or had this data submitted on their behalf), or who participated in a MIPS APM and received automatic credit in the improvement activities performance category because of their APM participation. Data could have been submitted at the individual, group, virtual group, or APM Entity level.

[2] **Non-reporting clinicians** were required to report (i.e., an individually eligible clinician, an opt-in eligible who submitted an election to opt-in to the program, or a clinician in a CMS-approved virtual group) but didn't actively submit any data for the quality, Promoting Interoperability, or improvement activities performance categories. Because they were required to report, they will receive a final score and MIPS payment adjustment even if no data was actively submitted. Their final score can include data calculated and scored automatically by CMS, such as administrative claims-based quality measures or cost measures, or quality and cost scores derived from the Hospital Value-based Purchasing Program (learn more in the 2023 Facility-Based Quick Start Guide (PDF)). Please note we refined our logic for identifying non-reporting clinicians with the publication of this report. As such, the non-reporting data in the 2023 report for PY 2021 and 2022 may not match data for these years in the 2022 report.

[3] **Safety net providers** are MIPS eligible clinicians who are in the top 20th percentile of all MIPS eligible clinicians in their percentage of patients who are enrolled in Medicare Part A and Part B and are also enrolled in full-benefit Medicaid.

[4] MIPS eligible clinician types are defined in regulation at 42 CFR 414.1305.

[5] This report uses specialties as defined for physicians by Medicare.

relevant to a specialty or medical condition. The MVP reporting option also introduced the subgroup **participation option**, where a subset of clinicians in a practice could decide to report an MVP together.

**MVP highlights include:**

- Almost 40,000 clinicians registered for an MVP this first year, and nearly half of them reported their selected MVP.
- The Patient Safety and Support of Positive Experiences with Anesthesia MVP was the most highly registered and reported MVP; almost half of the clinicians who registered for an MVP registered for this MVP.
- The median overall score[6] for clinicians who reported an MVP was 73.09 points.
- The median final score for clinicians who received a final score from MVP reporting was 87.86 points, 5 points higher than the median final score from traditional MIPS reporting.
    - **For small practices, the median final score** from MVP reporting increases to **95.24 points**.
    - **For safety net providers, the median final score** from MVP reporting increases even more to **99.13 points**.

While there was no change to the performance threshold of 75 points (the 2023 final score required to avoid a negative payment adjustment in the 2025 payment year), there was a significant change to associated payment adjustments available to clinicians with the highest final scores with the removal of the additional performance threshold. Specifically, Congressional funding for the additional payment adjustment for exceptional performance expired after the 2022 performance year/2024 payment year, which meant that the exceptional payment adjustment is no longer available beginning in the 2023 performance year/2025 payment year.

**Final score and payment adjustment highlights include:**

- The **mean final score** for all MIPS eligible clinicians was **83.18 points** and the **median final score** was **85.49 points**.
    - Both the mean and the median exceeded the performance threshold of 75 points, the final score needed to avoid a negative payment adjustment.
- **The mean payment adjustment amount was 0.59%, the median was 0.90%, and the maximum was 2.15%.**
    - The lower mean, median, and maximum payment adjustments that we observe reflect the removal of the exceptional adjustment.
    - However, when we exclude the exceptional adjustment, the maximum MIPS payment adjustment for the 2022 performance year/2024 MIPS payment year of 2.24% is in line with the maximum MIPS payment adjustment for the 2023 performance year/2025 MIPS payment year of 2.15%.

Finally, the report highlights clinician movement into Advanced APM participation, and their increasing levels of participation within their APM Entity as well.

**Advanced APM participation highlights include:**

- Between 2022 and 2023, there was a **20% increase in Advanced APM participation** and a **21% increase in** the number of clinicians who achieved **QP status**.

[6] The term "overall score" is used in this report to refer to the score calculated from data submitted for a MIPS reporting or participation option, but that wasn't necessarily the clinician's final score. (The overall score is between 0 and 100 points, based on all available performance categories and bonus points.) For example, a group that reported both traditional MIPS and an MVP has 2 overall scores – one calculated for traditional MIPS and the other for their MVP. The higher of these will be their final score, which determines the group's MIPS payment adjustment.

# C. Data Highlights and Detailed Tables

## 1. MIPS Eligibility and Participation

Clinicians were included and required to participate in MIPS for the 2023 performance year if they met all of the following requirements: (1) Were a MIPS eligible clinician type; (2) enrolled as a Medicare provider before January 1, 2023; (3) exceeded the low-volume threshold, and (4) weren't otherwise excluded (for example, by achieving QP status).

We evaluate a clinician's eligibility for MIPS based on their National Provider Identifier (NPI) and associated Taxpayer Identification Number (TIN).

- When a clinician reassigns their billing rights to a TIN, their NPI becomes associated with the TIN.
    - This association is referred to as the TIN/NPI combination.
- When a clinician reassigns their billing rights to multiple TINs, the clinician establishes multiple TIN/NPI combinations.
- We evaluate clinicians for MIPS eligibility under each unique TIN/NPI combination.
- **MIPS policy defines a MIPS eligible clinician by a unique TIN/NPI combination, which is reflected in this report**.
    - An individual clinician who has multiple TIN/NPI combinations are counted multiple times in this report.

**Clinicians who are individually eligible for MIPS are required to participate, as are clinicians in a CMS-approved virtual group, and those who make an opt-in election to receive a MIPS payment adjustment.**

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 clinician types in the 2023 performance year are listed here.

In 2023, MIPS eligible clinicians could participate in MIPS as an individual, a group, a virtual group, or an APM Entity. New for 2023, they could also register to participate as a subgroup to report a MIPS Value Pathway (MVP).

For detailed resources about MIPS eligibility and participation in the 2023 performance year, please refer to the Appendix.

## Data Highlights

### 1.1 Overall MIPS Participation

- There was an approximately 13% drop in the number of MIPS eligible clinicians between 2022 and 2023 (Table 1 and Table 2). This decrease is likely due to an increase in clinicians achieving QP status in 2023 (Table 41), just as we saw in 2022.
- There was an approximately 11% decrease in the count of non-reporting clinicians, though we do observe a slight increase in non-reporting MIPS eligible clinicians as a percentage of all MIPS eligible clinicians.

**Table 1. Overall MIPS Participation**

| | 2021 | 2022 | 2023 |
|---|---|---|---|
| Number of MIPS Eligible Clinicians (All) | 698,883 | 624,209 | 541,421 |
| Number of MIPS Eligible Clinicians (Non-Reporting[7]) | 41,082 | 36,554 | 32,631 |
| Percent of MIPS Eligible Clinicians (Non-Reporting) | 5.88% | 5.86% | 6.03% |

**Table 2. Changes in MIPS Participation**

| | Change from 2021 to 2022 (Number) | Change from 2021 to 2022 (Percentage) | Change from 2022 to 2023 (Number) | Change from 2022 to 2023 (Percentage) |
|---|---|---|---|---|
| MIPS Eligible Clinicians (All) | -74,674 | -10.68% | -82,788 | -13.26% |
| MIPS Eligible Clinicians (Non-Reporting[7]) | -4,528 | -11.02% | -3,923 | -10.73 |

[7] **Non-reporting MIPS eligible clinicians** were required to report (i.e., an individually eligible clinician, an opt-in eligible clinician or group who submitted an election to opt-in to the program, or a clinician in a CMS-approved virtual group) but didn't actively submit any data for the quality, Promoting Interoperability, or improvement activities performance category. Review the **2023 QPP Data Use Guide (PDF)** for more information on this definition.

## 1.2 MIPS Participation by Practice Size and Special Status/Designation

- Solo practitioners continue to have the highest rate of non-reporting clinicians (over 50%) in 2023 (Table 3a).
- Practices with 16 – 99 clinicians had the greatest decrease in participation, almost 21% from 2022 to 2023 (Table 3b).
- The rate of non-reporting has remained low (around 5%) for rural clinicians as well as those designated as safety net providers[8] (Table 4a).

**Table 3a. MIPS Participation by Practice Size**

| | 2021 | | | | 2022 | | | | 2023 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Practice Size[9] | Number of MIPS Eligible Clinicians (All) | Number of MIPS Eligible Clinicians (Engaged[10]) | Number of MIPS Eligible Clinicians (Non-Reporting[11]) | Rate of Non-Reporting Clinicians | Number of MIPS Eligible Clinicians (All) | Number of MIPS Eligible Clinicians (Engaged) | Number of MIPS Eligible Clinicians (Non-Reporting) | Rate of Non-Reporting Clinicians | Number of MIPS Eligible Clinicians (All) | Number of MIPS Eligible Clinicians (Engaged | Number of MIPS Eligible Clinicians (Non-Reporting) | Rate of Non-Reporting Clinicians |
| 1 Clinician (Solo Practitioner) | 20,305 | 9,589 | 10,716 | 52.78% | 17,937 | 8,811 | 9,126 | 50.88% | 16,731 | 8,304 | 8,427 | 50.37% |
| 2 – 15 Clinicians | 89,364 | 74,155 | 15,209 | 17.02% | 66,584 | 53,492 | 13,092 | 19.66% | 63,668 | 51,865 | 11,803 | 18.54% |
| 16 – 99 Clinicians | 145,299 | 135,324 | 9,975 | 6.87% | 125,174 | 115,576 | 9,598 | 7.67% | 99,240 | 90,516 | 8,724 | 8.79% |
| 100+ Clinicians | 443,915 | 438,733 | 5,182 | 1.17% | 414,514 | 409,776 | 4,738 | 1.14% | 361,782 | 358,105 | 3,677 | 1.02% |

[8] **Safety net providers** are MIPS eligible clinicians who are in the top 20th percentile of all MIPS eligible clinicians in their percentage of patients who are enrolled in Medicare Part A and Part B and are also enrolled in full-benefit Medicaid.

[9] Practice size in Tables 3a and 3b is determined by the number of clinicians billing under the practice's TIN in the second 12-month segment of the MIPS determination period (October 1, 2022 – September 30, 2023, for 2023).

[10] **Engaged clinicians** are those who submitted at least one measure, attestation, or activity (or had this data submitted on their behalf), or who participated in a MIPS APM and received automatic credit in the improvement activities performance category because of their APM participation. Data could have been submitted at the individual, group, virtual group, or APM Entity level.

[11] **Non-reporting MIPS eligible clinicians were** required to report (i.e., an individually eligible clinician, an opt-in eligible clinician or group who submitted an election to opt-in to the program, or a clinician in a CMS-approved virtual group) but didn't actively submit any data for the quality, Promoting Interoperability, or improvement activities performance category. Review the 2023 QPP Data Use Guide (PDF) for more information on this definition.

### Table 3b. Changes in MIPS Participation by Practice Size

| Practice Size[3] | Change from 2021 to 2022 (Count) | Change from 2021 to 2022 (Percentage) | Change from 2022 to 2023 (Count) | Change from 2022 to 2023 (Percentage) |
|---|---|---|---|---|
| 1 Clinician (Solo Practitioner) | -2,368 | -11.66% | -1,206 | -6.72% |
| 2 – 15 Clinicians | -22,780 | -25.49% | -2,916 | -4.38% |
| 16 – 99 Clinicians | -20,125 | -13.85% | -25,934 | -20.72% |
| 100+ Clinicians | -29,401 | -6.62% | -52,732 | -12.72% |

### Table 4a. MIPS Participation by Special Status Designation

| | 2021 | | | 2022 | | | 2023 | | |
|---|---|---|---|---|---|---|---|---|---|
| Special Status / Designation | Number of MIPS Eligible Clinicians (All) | Number of MIPS Eligible Clinicians (Non-Reporting[12]) | Rate of Non-Reporting Clinicians | Number of MIPS Eligible Clinicians (All) | Number of MIPS Eligible Clinicians (Non-Reporting) | Rate of Non-Reporting Clinicians | Number of MIPS Eligible Clinicians (All) | Number of MIPS Eligible Clinicians (Non-Reporting) | Rate of Non-Reporting Clinicians |
| Small Practice[13] | 108,377 | 26,297 | 24.26% | 84,713 | 22,579 | 26.65% | 78,108 | 20,419 | 26.14% |
| Rural | 89,107 | 5,176 | 5.81% | 80,950 | 4,128 | 5.10% | 60,680 | 3,307 | 5.45% |
| Safety Net Provider | 143,120 | 11,270 | 7.87% | 125,273 | 7,840 | 6.26% | 109,375 | 7,448 | 6.81% |

[12] **Non-reporting MIPS eligible clinicians were** required to report (i.e., an individually eligible clinician, an opt-in eligible clinician or group who submitted an election to opt-in to the program, or a clinician in a CMS-approved virtual group) but didn't actively submit any data for the quality, Promoting Interoperability, or improvement activities performance category. Review the **2023 QPP Data Use Guide (PDF)** for more information on this definition.

[13] The **small practice** special status in Tables 4a and 4b identifies clinicians in a practice with 15 or fewer clinicians who bill under the practice's TIN in either segment of the MIPS determination period. This means that a practice could have had 16 or more clinicians in 1 segment if there were 15 or fewer in the other segment. The small practice special status includes solo practitioners.

**Table 4b. Changes in MIPS Participation by Special Status/Designation**

| Special Status/Designation | Change from 2021 to 2022 (Count) | Change from 20121 to 2022 (Percentage) | Change from 2022 to 2023 (Count) | Change from 2022 to 2023 (Percentage) |
|---|---|---|---|---|
| Small Practice | -23,664 | -21.83% | -6,605 | -7.80% |
| Rural | -8,157 | -9.15% | -20,270 | -25.04% |
| Safety Net Provider | -17,847 | -12.47% | -15,898 | -12.69% |

## 1.3 MIPS Participation by MIPS Eligible Clinician Type

- The most common MIPS eligible clinician type each year is Doctor of Medicine, followed by Nurse Practitioners (Table 5).
- There's a consistent non-reporting rate for Doctors of Medicine (about 8%) and Nurse Practitioners (about 2%) between 2021 and 2023 (Table 6).

**Table 5. MIPS Participation and Non-Reporting by MIPS Eligible Clinician Type**

| | 2021 | | | 2022 | | | 2023 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Number of MIPS Eligible Clinicians (All) | Number of MIPS Eligible Clinicians (Non-Reporting[14]) | Rate of Non-Reporting Clinicians | Number of MIPS Eligible Clinicians (All) | Number of Non-Reporting[13] MIPS Eligible Clinicians | Rate of Non-Reporting Clinicians | Number of MIPS Eligible Clinicians (All) | Number of Non-Reporting[13] MIPS Eligible Clinicians | Rate of Non-Reporting Clinicians |
| Overall | 698,883 | 41,646 | 5.96% | 624,209 | 37,038 | 5.93% | 541,421 | 32,631 | 6.03% |
| Anesthesiologist Assistant[15] | 1,627 | 0 | 0.00% | 1,729 | 0 | 0.00% | 1,571 | 0 | 0.00% |
| Certified Nurse-Midwife[16] | N/A | N/A | N/A | 2,004 | 3 | 0.15% | 1,714 | 0 | 0.00% |
| Certified Registered Nurse Anesthetist | 27,017 | 281 | 1.04% | 26,805 | 178 | 0.66% | 22,059 | 165 | 0.75% |

[14] **Non-reporting MIPS eligible clinicians** were required to report (i.e., were an individually eligible clinician, an opt-in eligible clinician or group who submitted an election to opt-in to the program, or a clinician in a CMS-approved virtual group) but didn't actively submit any data for the quality, Promoting Interoperability, or improvement activities performance category. Review the 2023 QPP Data Use Guide (PDF) for more information on this definition.

[15] Included in the definition of a Certified Registered Nurse Anesthetist (a MIPS eligible clinician type) in section 1861(bb)(2) of the Social Security Act.

[16] Certified Nurse Midwives and Clinical Social Workers became a MIPS eligible clinician type in the 2022 performance year.

| | 2021 | | | 2022 | | | 2023 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Number of MIPS Eligible Clinicians (All) | Number of MIPS Eligible Clinicians (Non-Reporting[14]) | Rate of Non-Reporting Clinicians | Number of MIPS Eligible Clinicians (All) | Number of Non-Reporting[13] MIPS Eligible Clinicians | Rate of Non-Reporting Clinicians | Number of MIPS Eligible Clinicians (All) | Number of Non-Reporting[13] MIPS Eligible Clinicians | Rate of Non-Reporting Clinicians |
| **Clinical Nurse Specialist** | 853 | 30 | 3.52% | 680 | 13 | 1.91% | 605 | 11 | 1.82% |
| **Clinical Psychologist** | 4,699 | 163 | 3.47% | 4,054 | 141 | 3.48% | 3,883 | 145 | 3.73% |
| **Clinical Social Worker[15]** | N/A | N/A | N/A | 4,335 | 36 | 0.83% | 4,316 | 27 | 0.63% |
| **Doctor of Chiropractic (Chiropractor)** | 946 | 80 | 8.46% | 370 | 83 | 22.43% | 363 | 77 | 21.21% |
| **Doctor of Dental Medicine/Doctor of Dental Surgery (Dentist)** | 622 | 23 | 3.70% | 539 | 14 | 2.60% | 520 | 14 | 2.69% |
| **Doctor of Medicine[17]** | 462,518 | 36,737 | 7.94% | 403,943 | 31,935 | 7.91% | 343,713 | 28,171 | 8.20% |
| **Doctor of Optometry** | 9,461 | 626 | 6.62% | 7,456 | 589 | 7.90% | 7,561 | 688 | 9.10% |
| **Doctor of Osteopathy** | 325 | 13 | 4.00% | 267 | 16 | 5.99% | 223 | 21 | 9.42% |
| **Nurse Practitioner** | 95,516 | 1,862 | 1.95% | 87,816 | 1,893 | 2.16% | 77,183 | 1,832 | 2.37% |
| **Occupational Therapist** | 3,224 | 12 | 0.37% | 2,405 | 37 | 1.54% | 2,392 | 11 | 0.46% |
| **Physical Therapist** | 23,509 | 350 | 1.49% | 19,942 | 519 | 2.60% | 20,682 | 564 | 2.73% |
| **Physician Assistant** | 63,100 | 874 | 1.39% | 57,536 | 1,091 | 1.90% | 50,485 | 896 | 1.77% |
| **Qualified Audiologist** | 2,635 | 15 | 0.57% | 2,309 | 4 | 0.17% | 2,347 | 3 | 0.13% |
| **Qualified Speech-Language Pathologist** | 800 | 1 | 0.13% | 583 | 0 | 0.00% | 582 | 0 | 0.00% |

[17] Doctor of Medicine includes Doctors of Podiatry.

| | 2021 | | | 2022 | | | 2023 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Number of MIPS Eligible Clinicians (All) | Number of MIPS Eligible Clinicians (Non-Reporting[14]) | Rate of Non-Reporting Clinicians | Number of MIPS Eligible Clinicians (All) | Number of Non-Reporting[13] MIPS Eligible Clinicians | Rate of Non-Reporting Clinicians | Number of MIPS Eligible Clinicians (All) | Number of Non-Reporting[13] MIPS Eligible Clinicians | Rate of Non-Reporting Clinicians |
| Registered Dietician/ Nutrition Professional | 2,007 | 16 | 0.80% | 1,436 | 2 | 0.14% | 1,222 | 6 | 0.49% |

**Table 6. Changes in MIPS Participation by MIPS Eligible Clinician Type**

| | Change from 2021 to 2022 (Count) | Change from 2021 to 2022 (Percentage) | Change from 2022 to 2023 (Count) | Change from 2022 to 2023 (Percentage) |
|---|---|---|---|---|
| Anesthesiologist Assistant[18] | 102 | 6.27% | -158 | -9.14% |
| Certified Nurse-Midwife | N/A | N/A | -290 | -14.47% |
| Certified Registered Nurse Anesthetist | -212 | -0.78% | -4,746 | -17.71% |
| Clinical Nurse Specialist | -173 | -20.28% | -75 | -11.03% |
| Clinical Psychologist | -645 | -13.73% | -171 | -4.22% |
| Clinical Social Worker | N/A | N/A | -19 | -0.44% |
| Doctor of Chiropractic (Chiropractor) | -576 | -60.89% | -7 | -1.89% |
| Doctor of Dental Medicine/Doctor of Dental Surgery (Dentist) | -83 | -13.34% | -19 | -3.53% |
| Doctor of Medicine | -58,575 | -12.66% | -60,230 | -14.91% |
| Doctor of Optometry | -2,005 | -21.19% | 105 | 1.41% |

[18] Included in the definition of a Certified Registered Nurse Anesthetist in section 1861(bb)(2) of the Social Security Act.

| | Change from 2021 to 2022 (Count) | Change from 2021 to 2022 (Percentage) | Change from 2022 to 2023 (Count) | Change from 2022 to 2023 (Percentage) |
|---|---|---|---|---|
| **Doctor of Osteopathy** | -58 | -17.85% | -44 | -16.48% |
| **Nurse Practitioner** | -7,700 | -8.06% | -10,633 | -12.11% |
| **Occupational Therapist** | -819 | -25.40% | -13 | -0.54% |
| **Physical Therapist** | -3,567 | -15.17% | 740 | 3.71% |
| **Physician Assistant** | -5,564 | -8.82% | -7,051 | -12.25% |
| **Qualified Audiologist** | -326 | -12.37% | 38 | 1.65% |
| **Qualified Speech-Language Pathologist** | -217 | -27.13% | -1 | -0.17% |
| **Registered Dietician/ Nutrition Professional** | -571 | -28.45% | -214 | -14.90% |

## 1.4 MIPS Participation by Participation Option

- MIPS participation option levels have remained stable between 2021 and 2023, with approximately two-thirds of clinicians participating as a group, one-quarter participating as an APM Entity, and the majority of the remaining clinicians participating as individuals (Table 7).
- There was a significant increase in the percentage of clinicians participating as a virtual group, but the impact is small due to the low number of clinicians who elect this participation option.

### Table 7. MIPS Participation by Participation Option

| | 2021 | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|
| Participation Option[19] | Number of MIPS Eligible Clinicians | Percent of All MIPS Eligible Clinicians | Number of MIPS Eligible Clinicians | Percent of All MIPS Eligible Clinicians | Number of MIPS Eligible Clinicians | Percent of All MIPS Eligible Clinicians |
| Overall | 698,883 | 100.00% | 624,209 | 100.00% | 541,421 | 100.00% |
| Participate as Individual | 55,355 | 7.92% | 46,242 | 7.41% | 45,044 | 8.32% |
| Participate as Group | 473,631 | 67.77% | 427,425 | 68.47% | 375,400 | 69.34% |
| Participate as Subgroup | N/A[20] | N/A | N/A | N/A | 101 | 0.02% |
| Participate as Virtual Group | 110 | 0.02% | 94 | 0.02% | 300 | 0.06% |
| Participate as APM Entity | 169,787 | 24.29% | 150,448 | 24.10% | 120,576 | 22.27% |

### Table 8. Changes in MIPS Participation Options

| | 2022 | | 2023 | |
|---|---|---|---|---|
| | Change from 2021 to 2022 (Count) | Change from 2021 to 2022 (Percentage) | Change from 2022 to 2023 (Count) | Change from 2022 to 2023 (Percentage) |
| Participate as Individual | -9,113 | -16.46% | -1,198 | -2.59% |
| Participate as Group | -46,206 | -9.76% | -52,025 | -12.17% |
| Participate as Subgroup | N/A | N/A | N/A | N/A |

[19] This data reflects the participation option that resulted in the MIPS eligible clinician's final score. For example, if a clinician (under a single TIN/NPI combination) participated both as an individual and as part of a group, CMS would assign the higher final score – either from individual or group participation. If the individual score was higher, the clinician would be represented in the "individual" data; if the group score was higher, the clinician would be represented in the "group" data.

[20] The subgroup participation option wasn't available until the 2023 performance year when we introduced the MIPS Value Pathway (MVP) reporting option.

| | 2022 | | 2023 | |
|---|---|---|---|---|
| | Change from 2021 to 2022 (Count) | Change from 2021 to 2022 (Percentage) | Change from 2022 to 2023 (Count) | Change from 2022 to 2023 (Percentage) |
| Participate as Virtual Group | -16 | -14.55% | 206 | 219.15% |
| Participate as APM Entity | -19,339 | -11.39% | -29,872 | -19.86% |

## 1.5 MIPS Participation by Reporting Option

- The number and percentage of clinicians receiving a final score from MVP reporting (Table 9) represent approximately one-third of the clinicians who submitted MVP data (Table 11). More than 98% of clinicians who submitted MVP data also reported traditional MIPS (Table 11).
- The number of MIPS eligible clinicians who received a final score from APM Performance Pathway (APP) reporting generally aligns with the number of clinicians who participated as an APM Entity (Table 7), though the APP can also be reported by individuals and groups participating in a MIPS APM.

### Table 9. MIPS Participation by Reporting Option

| | 2021 | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|
| MIPS Reporting Option | Number of MIPS Eligible Clinicians | Percent of All MIPS Eligible Clinicians | Number of MIPS Eligible Clinicians | Percent of All MIPS Eligible Clinicians | Number of MIPS Eligible Clinicians | Percent of All MIPS Eligible Clinicians |
| Traditional MIPS | 529,754 | 75.80% | 473,663 | 75.88% | 415,000 | 76.65% |
| APM Performance Pathway (APP) | 169,129 | 24.20% | 150,546 | 24.12% | 119,631 | 22.10% |
| MIPS Value Pathways (MVPs)[21] | N/A[22] | N/A | N/A | N/A | 6,790 | 1.25% |

### Table 10. Changes in MIPS Participation by Reporting Option

| MIPS Reporting Option | Change from 2021 to 2022 (Count) | Change from 2021 to 2022 (Percentage) | Change from 2022 to 2023 (Count) | Change from 2022 to 2023 (Percentage) |
|---|---|---|---|---|
| Traditional MIPS | -56,091 | -10.59% | -58,663 | -12.38% |
| APM Performance Pathway (APP) | -18,583 | -10.99% | -30,915 | -20.54% |
| MIPS Value Pathways (MVPs)[21] | N/A | N/A | N/A | N/A |

[21] The MIPS Value Pathways reporting option wasn't available until the 2023 performance year.

## 2. MVP Participation and Performance

MIPS Value Pathways (MVPs) were the newest way for clinicians to meet their MIPS reporting requirements in the 2023 performance year. Clinicians could choose from 12 MVPs, each of which offered clinicians a subset of measures and activities relevant to a specialty or medical condition.

Unlike the other reporting options (traditional MIPS or the APM Performance Pathway [APP]), clinicians were required to register in advance to report an MVP. However, clinicians could register for an MVP and choose to report traditional MIPS and/or the APP in addition to – or instead of – the MVP they registered to report. Under MIPS scoring rules, clinicians (defined by a unique TIN/NPI combination) who reported in multiple ways would receive the highest final score available to them from any of these reporting options.

- In performance year 2023, almost all clinicians who reported an MVP also reported traditional MIPS, explaining the decrease from the number of clinicians who reported an MVP to the number receiving their final score from MVP reporting.

- **For clinicians who received their final score from MVP reporting, their median final score was 5 points higher than the median final score from traditional MIPS reporting.**

We expect to see this trend continue for the next few years. Dual reporting offers an opportunity for clinicians and groups to gain experience with the measures and activities available in their selected MVP, while still being eligible to receive the highest final score available to them.

For more detailed information about MVP participation and performance, you can review the 2023 MVP Reporting Supplement (XLS) which was released as a companion to the 2023 QPP Experience Report.

For resources about the MVP reporting option in the 2023 performance year, please refer to the Appendix.

## Data Highlights

### 2.1 MVP Registration and Reporting Information

- Almost 42,000 clinicians were represented in MVP registrations, and more than half of them submitted MVP data (Table 12a).
- The Patient Safety and Support of Positive Experiences with Anesthesia MVP was the most highly registered and reported MVP; 45% of the clinicians who registered for an MVP registered for this MVP (Table 13).
- The Advancing Cancer Care MVP resulted in the most final scores; 37% of clinicians who reported this MVP received their final score from this MVP.
- The Optimal Care for Patients with Episodic Neurological Conditions MVP was the least registered and reported MVP, with just 5 clinicians registered and 1 clinician who ultimately reported and received their final score from this MVP (Table 13).
- Clinicians registered for and reported every MVP available in the 2023 performance year (Table 13).

**Table 11. MVP Participation Phases**

| Participation Stage | Count of Clinicians |
|---|---|
| Registered for an MVP | 41,765 |
| Submitted MVP Data | 20,484 |
| Submitted MVP Data and for Another Reporting Option | 20,137 |
| Received a Final Score from MVP Reporting | 6,790 |

**Table 12a. MVP Registration and Participation Numbers (MVPs Overall)**

| Clinician Type | Count of Clinicians Registered for an MVP | Percentage of Clinicians Who Registered for any MVP | Count of MIPS Eligible Clinicians Who Reported an MVP | Percentage of MIPS Eligible Clinicians Who Reported an MVP (Out of All Clinicians Who Registered for an MVP) | Count of MIPS Eligible Clinicians Who Received a Final Score from an MVP | Percentage of MIPS Eligible Clinicians Who Received a Final Score from an MVP (Out of All Clinicians Who Registered for an MVP) |
|---|---|---|---|---|---|---|
| All MIPS Eligible Clinicians | 41,765 | 100.00% | 20,484 | 49.05% | 6,790 | 16.26% |

**Table 12b. MVP Registration and Participation Numbers (Solo, Small, Rural, and Safety Net Providers – MVPs Overall)**

| Clinician Type | Count of Clinicians Registered for an MVP | Percentage of Clinicians Who Registered for an MVP (Out of all Clinicians Who Registered for Any MVP) | Count of MIPS Eligible Clinicians Who Reported an MVP | Percentage of MIPS Eligible Clinicians Who Reported an MVP (Out of the Clinician Type Who Registered for an MVP)[23] | Count of MIPS Eligible Clinicians Who Received a Final Score from an MVP | Percentage of MIPS Eligible Clinicians Who Received a Final Score from an MVP (Out of the Clinician Type Who Registered for an MVP)[22] |
|---|---|---|---|---|---|---|
| Solo Practitioner | 81 | 0.19% | 27 | 33.33% | 18 | 22.22% |
| Small Practice | 1,086 | 2.60% | 578 | 53.22% | 270 | 24.86% |
| Rural | 3,215 | 7.70% | 921 | 28.65% | 294 | 9.14% |
| Safety Net Provider | 1,912 | 4.58% | 1,696 | 88.70% | 1,131 | 59.15% |

**Table 13. MVP Registration and Participation Numbers by MVP**

| MVP Name | Count of Clinicians Registered | Percentage of Clinicians Who Registered for any MVP | Count of Clinicians Who Reported the MVP | Percentage of Clinicians Who Reported the MVP (Out of All Clinicians Who Registered for the MVP) | Count of Clinicians Who Received a Final Score from This MVP | Percentage of Clinicians Who Received a Final Score from This MVP (Out of All Clinicians Who Registered for the MVP) |
|---|---|---|---|---|---|---|
| Patient Safety and Support of Positive Experiences with Anesthesia | 19,063 | 45.64% | 7,437 | 39.01% | 1,681 | 8.82% |
| Advancing Cancer Care | 7,469 | 17.88% | 6,038 | 80.84% | 2,836 | 37.97% |
| Promoting Wellness | 6,402 | 15.33% | 2,160 | 33.74% | 978 | 15.28% |
| Optimal Care for Kidney Health | 2,318 | 5.55% | 1,821 | 78.56% | 14 | 0.60% |

[23] The denominator for this percentage is the "Count of Clinicians Registered for an MVP". For example, 53% of the small practices who registered for an MVP reported data for that MVP; and 24.86% of the small practices who registered for an MVP received their final score from MVP reporting.

| MVP Name | Count of Clinicians Registered | Percentage of Clinicians Who Registered for any MVP | Count of Clinicians Who Reported the MVP | Percentage of Clinicians Who Reported the MVP (Out of All Clinicians Who Registered for the MVP) | Count of Clinicians Who Received a Final Score from This MVP | Percentage of Clinicians Who Received a Final Score from This MVP (Out of All Clinicians Who Registered for the MVP) |
|---|---|---|---|---|---|---|
| Adopting Best Practices and Promoting Patient Safety within Emergency Medicine | 2,912 | 6.97% | 1,112 | 38.19% | 45 | 1.55% |
| Improving Care for Lower Extremity Joint Repair | 1,534 | 3.67% | 720 | 46.94% | 794 | 51.76% |
| Advancing Care for Heart Disease | 731 | 1.75% | 534 | 73.05% | 49 | 6.70% |
| Supportive Care for Neurodegenerative Conditions | 1,030 | 2.47% | 405 | 39.32% | 312 | 30.29% |
| Advancing Rheumatology Patient Care | 237 | 0.57% | 210 | 88.61% | 47 | 19.83% |
| Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes | 184 | 0.44% | 160 | 86.96% | 3 | 1.63% |
| Optimizing Chronic Disease Management | 58 | 0.14% | 42 | 72.41% | 30 | 51.72% |
| Optimal Care for Patients with Episodic Neurological Conditions | 5 | 0.01% | 1 | 20.00% | 1 | 20.00% |

## 2.2 MVP Final Score Information

- The mean and median overall scores[22] for clinicians who reported an MVP were 61.93 and 73.09 points respectively, regardless of whether their MVP data was their final score (Table 14).
- When MVP reporting counted as a clinician's final score (and determined their MIPS payment adjustment), mean and median scores increased to 82.87 and 87.86 points, respectively (Table 14).
- Clinicians who reported both an MVP and traditional MIPS generally had a higher mean overall score from traditional MIPS (solo and safety-net practitioners were the exception) (Table 15).
- For more detailed information about MVP participation and performance, review the **2023 MVP Reporting Supplement (XLS)**.

### Table 14. MVP Final Scores (MVPs Overall)

| Clinician Type | Mean Overall Score[24] – All Clinicians Who Reported an MVP | Median Overall Score – All Clinicians Who Reported an MVP | Mean Final Score – Clinicians Who Received a Final Score from MVP Reporting | Median Final Score – Clinicians Who Received a Final Score from MVP Reporting |
|---|---|---|---|---|
| All MIPS Eligible Clinicians | 61.93 | 73.09 | 82.87 | 87.86 |
| Solo Practitioner | 69.49 | 75.00 | 81.21 | 81.69 |
| Small Practice | 64.33 | 82.55 | 90.67 | 95.24 |
| Rural | 63.22 | 74.45 | 66.52 | 76.85 |
| Safety Net Provider | 84.84 | 98.66 | 96.07 | 99.13 |

### Table 15. Comparative Overall Scores

| | MVP SCORE | TRADTIONAL MIPS SCORE |
|---|---|---|
| Clinician Type | Mean Overall Score[23] (MVP) for Clinicians Who Reported an MVP and Traditional MIPS | Mean Overall Score[23] (Traditional MIPS) for Clinicians Who Reported an MVP and Traditional MIPS |
| All MIPS Eligible Clinicians | 61.80 | 73.39 |
| Solo Practitioner | 70.11 | 49.58 |
| Small Practice | 62.78 | 72.96 |
| Rural | 62.89 | 78.53 |
| Safety Net Provider | 85.04 | 81.67 |

[24] The term "overall score" is used in this report to refer to the score calculated from data submitted for a MIPS reporting or participation option, but that wasn't necessarily the clinician's final score. (The overall score is between 0 and 100 points, based on all available performance categories and bonus points.) For example, a group that reported both traditional MIPS and an MVP has 2 overall scores – one calculated for traditional MIPS and the other for their MVP. The higher of these will be their final score, which determines the group's MIPS payment adjustment.

## 3. MIPS Performance

CMS evaluates clinician performance based on the measures and activities reported or calculated for the MIPS quality, cost, improvement activities and Promoting Interoperability performance categories.

- **The quality performance category** measures performance on clinical practices and patient outcomes. Quality measures are tools used to assess healthcare processes, outcomes, and patient experiences to ensure that they align with CMS quality goals for healthcare. Quality measure reporting requirements and options change based on your reporting option. More information about the quality measures available for traditional MIPS, APM Performance Pathway (APP), and MIPS Value Pathway (MVP) reporting are available on the QPP website.
- **The cost performance category** measures a clinician's costs compared to other MIPS eligible clinicians. Although clinicians don't personally determine the price of individual services provided to Medicare patients, they can affect the amount and types of services provided. By better coordinating care and seeking to improve health outcomes by ensuring that their patients receive the right services, clinicians play a meaningful role in delivering high-quality care at a reasonable cost. Your reporting option determines which cost measures you'll be evaluated on. More information about the cost measures available in traditional MIPS and MVP reporting are available on the QPP website. Cost isn't evaluated under the APP.
- **The improvement activities performance category** assesses participation in clinical activities that support the improvement of clinical practice, care delivery, and outcomes. Improvement activity reporting requirements and options change based on your reporting option. More information about the quality measures available for traditional MIPS and MVP reporting are available on the QPP website. Clinicians reporting the APP receive full credit in this performance category.
- **The Promoting Interoperability performance category** measures the use of technology to exchange health information while improving outcomes and making the communication of patient information less burdensome. The MIPS Promoting Interoperability performance category emphasizes the electronic exchange of health information using Certified Electronic Health Record Technology (CEHRT) to improve patient access to their health information; the exchange of information between clinicians and pharmacies; and the systematic collection, analysis, and interpretation of healthcare data. Regardless of their MIPS reporting option, clinicians report a defined set of measures, many of which have one or more exclusions available

For more information about the 4 MIPS performance categories, review the additional resources in the Appendix.

## Data Highlights

### 3.1 Quality Performance Category[25]

**Table 16. 20 Most Frequently Used Quality Measures in 2023 (Excluding Qualified Clinical Data Registry [QCDR] Measures)**

- The top 3 quality measures attributed to clinicians' final scores are administrative claims measures, which are automatically attributed to clinicians and calculated by CMS. (These measures aren't submitted by clinicians.)
- Of the measures submitted by clinicians, the measures most likely to be attributed to their final score are the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey measure, CMS Web Interface measures, and electronic Clinical Quality Measures (eCQMs).
- The frequency with which CMS Web Interface measures and the CAHPS for MIPS Survey measure are attributed to clinicians' final score is likely due to their inclusion in the APM Performance Pathway (APP) quality measure set, which Shared Savings Program Accountable Care Organizations (ACOs) are required to report.

| Quality ID | Collection Type[26] | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality) | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|---|
| 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | 2022 | 318,392 | 65.51% | 5.18 | 2.30 | 4.68 | 9.01 |
| 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | 2021 | 318,193 | 65.47% | 5.98 | 2.78 | 5.87 | 9.52 |
| 492 | Administrative Claims Measure | Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System | 2023 | 138,642 | 28.53% | 5.65 | 1.87 | 5.23 | 10.00 |
| 321 | CAHPS Measure | CAHPS for MIPS Clinician/Group Survey | 2017 | 131,396 | 27.04% | 6.18 | 3.73 | 6.54 | 8.31 |

[25] This data reflects the quality measures that contributed to a MIPS eligible clinician's final score. A quality measure that was submitted but not used in final scoring wouldn't be eligible to contribute to the data in these tables. Measure data is broken out by collection type, which means that the same measure (as identified by ID) can appear in the same table under different collection types. (For example, measures 001 and 112 appear in Table 11 twice; once as a CMS Web Interface measure, and separately as an eCQM.)

[26] **Collection type** refers to the way you collect data for a MIPS quality measure. While an individual MIPS quality measure may be collected in multiple ways, each collection type has its own specification (instructions) for reporting that measure. More information about collection types is available beginning on p. 18 of the 2023 MIPS Quality User Guide (PDF, 1MB).

| Quality ID | Collection Type[26] | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality) | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|---|
| 001 | eCQM | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | 2017 | 122,678 | 25.24% | 7.56 | 5.42 | 7.92 | 9.82 |
| 134 | CMS Web Interface Measure | Preventive Care and Screening: Screening for Depression and Follow-Up Plan | 2017 | 117,895 | 24.26% | 8.95 | 7.28 | 9.16 | 10.00 |
| 236 | CMS Web Interface Measure | Controlling High Blood Pressure | 2017 | 117,895 | 24.26% | 8.47 | 7.88 | 8.51 | 9.04 |
| 112 | CMS Web Interface Measure | Breast Cancer Screening | 2017 | 117,895 | 24.26% | 9.21 | 8.51 | 9.37 | 9.84 |
| 113 | CMS Web Interface Measure | Colorectal Cancer Screening | 2017 | 117,895 | 24.26% | 8.79 | 7.94 | 8.89 | 9.49 |
| 001 | CMS Web Interface Measure | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | 2017 | 117,895 | 24.26% | 9.89 | 9.65 | 10.00 | 10.00 |
| 226 | CMS Web Interface Measure | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | 2017 | 117,895 | 24.26% | 8.83 | 7.00 | 9.07 | 10.00 |
| 110 | CMS Web Interface Measure | Preventive Care and Screening: Influenza Immunization | 2017 | 117,895 | 24.26% | 8.11 | 7.02 | 8.06 | 9.22 |
| 318 | CMS Web Interface Measure | Falls: Screening for Future Fall Risk | 2017 | 117,895 | 24.26% | 9.83 | 9.66 | 10.00 | 10.00 |
| 236 | eCQM | Controlling High Blood Pressure | 2017 | 112,580 | 23.16% | 7.38 | 4.75 | 7.92 | 9.59 |

| Quality ID | Collection Type[26] | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality) | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|---|
| 480 | Administrative Claims Measure | Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) | 2021 | 107,618 | 22.14% | 5.67 | 2.26 | 5.72 | 9.31 |
| 309 | eCQM | Cervical Cancer Screening | 2017 | 87,742 | 18.05% | 8.78 | 7.21 | 9.14 | 10.00 |
| 438 | eCQM | Statin Therapy for the Prevention and Treatment of Cardiovascular Disease | 2017 | 75,784 | 15.59% | 8.08 | 6.41 | 8.27 | 9.78 |
| 112 | eCQM | Breast Cancer Screening | 2017 | 72,820 | 14.98% | 8.18 | 6.14 | 8.63 | 9.66 |
| 475 | eCQM | HIV Screening | 2019 | 66,798 | 13.74% | 9.20 | 7.62 | 9.39 | 10.00 |
| 066 | eCQM | Appropriate Testing for Pharyngitis | 2017 | 63,908 | 13.15% | 9.15 | 7.71 | 9.92 | 10.00 |

**Table 17. 20 Most Frequently Used QCDR (Quality) Measures in 2023**

- No QCDR measures (including the 20 most frequently scored) were included in the final score of more than 1.8% of MIPS eligible clinicians.

| Quality ID | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality) | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|
| **AQI69** | Intraoperative Antibiotic Redosing | 2021 | 8,692 | 1.79% | 7.07 | 4.49 | 6.03 | 10.00 |
| **IRIS2** | Glaucoma – Intraocular Pressure Reduction | 2015 | 8,537 | 1.76% | 9.82 | 9.41 | 10.00 | 10.00 |
| **AQI68** | Obstructive Sleep Apnea: Mitigation Strategies | 2020 | 6,871 | 1.41% | 6.37 | 4.52 | 7.00 | 7.00 |

| Quality ID | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality) | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|
| **AQI56** | Use of Neuraxial Techniques and/or Peripheral Nerve Blocks for Total Knee Arthroplasty (TKA) | 2018 | 6,364 | 1.31% | 4.42 | 3.43 | 3.98 | 6.79 |
| **ABG41** | Upper Extremity Nerve Blockade in Shoulder Surgery | 2021 | 6,097 | 1.25% | 6.02 | 3.49 | 4.57 | 10.00 |
| **IRIS13** | Diabetic Macular Edema - Loss of Visual Acuity | 2015 | 5,437 | 1.12% | 9.98 | 10.00 | 10.00 | 10.00 |
| **MSN15** | Use of Thyroid Imaging Reporting & Data System (TI-RADS) in Final Report to Stratify Thyroid Nodule Risk | 2020 | 5,398 | 1.11% | 9.42 | 5.85 | 10.00 | 10.00 |
| **IROMS11** | Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) to indicate functional improvement in knee rehabilitation of patients with knee injury measured via their validated Knee Outcome Survey (KOS) score, or equivalent instrument which has undergone peer reviewed published validation and demonstrates a peer reviewed published MCID. | 2019 | 5,229 | 1.08% | 8.71 | 7.35 | 9.07 | 10.00 |
| **AQI73** | Prevention of Arterial Line-Related Bloodstream Infections | 2022 | 4,776 | 0.98% | 9.80 | 10.00 | 10.00 | 10.00 |

| Quality ID | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality) | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|
| ECPR39 | Avoid Head CT for Patients with Uncomplicated Syncope | 2016 | 4,159 | 0.86% | 7.16 | 6.01 | 7.83 | 8.21 |
| AQI72 | Perioperative Anemia Management | 2021 | 4,009 | 0.82% | 9.41 | 10.00 | 10.00 | 10.00 |
| IROMS18 | Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) in improvement in pain score, measured via the Numeric Pain Rating Scale (NPRS), in rehabilitation patients with low back pain. | 2019 | 3,794 | 0.78% | 8.25 | 6.17 | 8.93 | 9.97 |
| ACRAD40 | Use of Structured Reporting in Prostate MRI | 2020 | 3,692 | 0.76% | 9.78 | 10.00 | 10.00 | 10.00 |
| KEET01 | Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) to indicate functional improvement in rehabilitation of patients with neck pain/injury measured via the validated Neck Disability Index (NDI). | 2022 | 3,530 | 0.73% | 8.64 | 5.00 | 9.72 | 10.00 |
| IROMS17 | Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) to indicate functional improvement | 2019 | 3,467 | 0.71% | 8.67 | 5.54 | 9.53 | 10.00 |

| Quality ID | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality) | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|
| | in rehabilitation patients with low back pain measured via the validated Modified Low Back Pain Disability Questionnaire (MDQ) score. | | | | | | | |
| **IROMS16** | Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) in improvement in pain score, measured via the Numeric Pain Rating Scale (NPRS), in rehabilitation patients with neck pain/injury. | 2019 | 3,447 | 0.71% | 8.25 | 6.79 | 8.23 | 10.00 |
| **IROMS12** | Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) in improvement in pain score, measured via the Numeric Pain Rating Scale (NPRS), in rehabilitation patients with knee injury pain. | 2019 | 3,413 | 0.70% | 9.27 | 8.12 | 9.80 | 10.00 |
| **IROMS13** | Failure to Progress (FTP): Proportion of patients not achieving a Minimal Clinically Important Difference (MCID) to indicate functional improvement in rehabilitation of patients with hip, leg or ankle injuries using the validated Lower Extremity Function Scale (LEFS) score, or | 2019 | 3,320 | 0.68% | 8.96 | 6.81 | 10.00 | 10.00 |

| Quality ID | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality) | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|
| | equivalent instrument which has undergone peer reviewed published validation and demonstrates a peer reviewed published MCID. | | | | | | | |
| **ECPR58** | Patient-Reported Understanding of Discharge Diagnosis and Plan of Care after Emergency Department Visit | 2023 | 3,236 | 0.67% | 7.00 | 7.00 | 7.00 | 7.00 |
| **IROMS14** | Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) in improvement in pain score, measured via the Numeric Pain Rating Scale (NPRS), in rehabilitation patients with hip, leg or ankle (lower extremity except knee) injury. | 2019 | 3,196 | 0.66% | 8.40 | 5.59 | 9.32 | 10.00 |

**Table 18. 20 Least Frequently Used Quality Measures in 2023 (Excluding QCDR Measures)[27]**

- The least frequently reported measures generally have a mean measure score of 3 points, which is the scoring floor in the 2023 performance year for small practices reporting a quality measure that doesn't meet case minimum or have a benchmark.

| Quality ID | Collection Type | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality) | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|---|
| **110** | Medicare Part B Claims Measure | Preventive Care and Screening: Influenza Immunization | 2017 | 1 | 0.00% | 10.00 | 10.00 | 10.00 | 10.00 |
| **465** | MIPS CQM | Uterine Artery Embolization Technique: Documentation of Angiographic Endpoints and Interrogation of Ovarian Arteries | 2018 | 1 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| **102** | eCQM | Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients | 2017 | 3 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| **392** | MIPS CQM | Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation | 2017 | 3 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| **111** | Medicare Part B Claims Measure | Pneumococcal Vaccination Status for Older Adults | 2017 | 4 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| **304** | MIPS CQM | Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery | 2017 | 4 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| **422** | MIPS CQM | Performing Cystoscopy at the Time of Hysterectomy for Pelvic Organ Prolapse to Detect Lower Urinary Tract Injury | 2017 | 4 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |

[27] This data was sorted by Percentage of Clinicians Scored on the Measure (smallest to largest) and then by Quality ID (smallest to largest).

| Quality ID | Collection Type | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality) | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|---|
| **476** | eCQM | Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia | 2020 | 4 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| **433** | MIPS CQM | Proportion of Patients Sustaining a Bowel Injury at the time of any Pelvic Organ Prolapse Repair | 2017 | 5 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| **451** | MIPS CQM | RAS (KRAS and NRAS) Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer who receive Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibody Therapy | 2017 | 5 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| **111** | eCQM | Pneumococcal Vaccination Status for Older Adults | 2017 | 6 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| **393** | MIPS CQM | Infection within 180 Days of Cardiac Implantable Electronic Device (CIED) Implantation, Replacement, or Revision | 2017 | 6 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| **422** | Medicare Part B Claims Measure | Performing Cystoscopy at the Time of Hysterectomy for Pelvic Organ Prolapse to Detect Lower Urinary Tract Injury | 2017 | 6 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| **452** | MIPS CQM | Patients with Metastatic Colorectal Cancer and RAS (KRAS or NRAS) Gene Mutation Spared Treatment with Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibodies | 2017 | 7 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| **468** | MIPS CQM | Continuity of Pharmacotherapy for Opioid Use Disorder (OUD) | 2019 | 8 | 0.00% | 2.63 | 2.10 | 3.00 | 3.00 |

| Quality ID | Collection Type | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality) | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|---|
| **482** | MIPS CQM | Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate | 2022 | 8 | 0.00% | 5.00 | 5.00 | 5.00 | 5.00 |
| **387** | MIPS CQM | Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users | 2017 | 9 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| **461** | MIPS CQM | Leg Pain After Lumbar Surgery | 2018 | 9 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |

**Table 19. 20 Least Frequently Used QCDR (Quality) Measures in 2023[28]**

- The mean performance score for the least frequently reported QCDR measures was generally the scoring floor for measures without a benchmark: 7 points for measures in their first year in the program (added in 2023), 5 points for measures in their second year in the program (added in 2022) and 0 points (3 points for small practices) for measures in their third year in the program or later.

| Quality ID | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality) | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|
| **AAN30** | Migraine Preventive Therapy Management | 2021 | 1 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| **AAN31** | Acute Treatment Prescribed for Cluster Headache | 2021 | 1 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| **IRIS1** | Endothelial Keratoplasty - Post-operative improvement in best corrected visual acuity to 20/40 or better | 2015 | 1 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| **IRIS56** | Adult Diplopia: Improvement of ocular deviation or absence of diplopia or functional improvement | 2020 | 1 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |

[28] This data was sorted by Percentage of Clinicians Scored on the Measure (smallest to largest) and then by Quality ID (A to Z).

| Quality ID | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality) | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|
| OEIS7 | Structured Walking Program Prior to Intervention for Claudication | 2019 | 1 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| AAD8 | Chronic Skin Conditions: Patient Reported Quality-of-Life | 2020 | 2 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| AJRR8 | Physical Health Outcomes in Total Hip and Knee Arthroplasty | 2023 | 2 | 0.00% | 7.00 | 7.00 | 7.00 | 7.00 |
| AJRR9 | Risk-Standardized Routine Discharge Rate Following Elective Primary Hip and Knee Arthroplasty | 2023 | 2 | 0.00% | 7.00 | 7.00 | 7.00 | 7.00 |
| CDR6 | Venous Leg Ulcer (VLU) Healing or Closure | 2014 | 2 | 0.00% | 10.00 | 10.00 | 10.00 | 10.00 |
| CDR8 | Appropriate Use of hyperbaric oxygen therapy for patients with diabetic foot ulcers | 2014 | 2 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| USWR29 | Adequate Off-loading of Diabetic Foot Ulcers performed at each visit, appropriate to location of ulcer | 2022 | 2 | 0.00% | 5.00 | 5.00 | 5.00 | 5.00 |
| USWR32 | Adequate Compression at each visit for Patients with Venous Leg Ulcers (VLUs) appropriate to arterial supply | 2022 | 2 | 0.00% | 5.00 | 5.00 | 5.00 | 5.00 |
| AAD14 | Melanoma: Tracking and Evaluation of Recurrence | 2022 | 3 | 0.00% | 5.00 | 5.00 | 5.00 | 5.00 |
| MUSIC4 | Prostate Cancer: Active Surveillance/Watchful Waiting for Newly-Diagnosed Low Risk Prostate Cancer Patients | 2014 | 3 | 0.00% | 2.00 | 0.60 | 3.00 | 3.00 |
| USWR30 | Non-Invasive Arterial Assessment of patients with lower extremity wounds or ulcers for determination of healing potential at the initial visit | 2022 | 3 | 0.00% | 5.00 | 5.00 | 5.00 | 5.00 |
| AAN32 | Preventive Treatment Prescribed for Cluster Headache | 2021 | 4 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |

| Quality ID | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality) | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|
| ABG40 | Hypotension Prevention After Spinal Placement for Elective Cesarean Section | 2021 | 4 | 0.00% | - | - | - | - |
| MSN16 | Screening Abdominal Aortic Aneurysm Reporting with Recommendations | 2021 | 4 | 0.00% | 3.00 | 3.00 | 3.00 | 3.00 |
| USWR31 | Pressure Ulcer* (PU) Healing or Closure (not on the lower extremity) | 2022 | 4 | 0.00% | 5.00 | 5.00 | 5.00 | 5.00 |
| CDR2 | Diabetic Foot Ulcer (DFU) Healing or Closure | 2014 | 5 | 0.00% | 7.20 | 3.00 | 10.00 | 10.00 |

**Table 20. 20 Highest Scoring Quality Measures in 2023 (Excluding QCDR Measures)**

| Quality ID | Collection Type | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)[29] | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|---|
| 379 | eCQM | Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists | 2017 | 13,726 | 2.82% | 10.00 | 10.00 | 10.00 | 10.00 |
| 001 | CMS Web Interface Measure | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | 2017 | 117,895 | 24.26% | 9.89 | 9.65 | 10.00 | 10.00 |
| 318 | CMS Web Interface Measure | Falls: Screening for Future Fall Risk | 2017 | 117,895 | 24.26% | 9.83 | 9.66 | 10.00 | 10.00 |

[29] A 2% minimum reporting threshold was applied to this table; data is limited to measures that contributed to the final score of at least 2% of clinicians.

| Quality ID | Collection Type | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)[29] | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|---|
| **238** | MIPS CQM | Use of High-Risk Medications in Older Adults | 2017 | 11,512 | 2.37% | 9.71 | 10.00 | 10.00 | 10.00 |
| **305** | eCQM | Initiation and Engagement of Substance Use Disorder Treatment | 2017 | 40,278 | 8.29% | 9.35 | 8.42 | 9.68 | 10.00 |
| **112** | CMS Web Interface Measure | Breast Cancer Screening | 2017 | 117,895 | 24.26% | 9.21 | 8.51 | 9.37 | 9.84 |
| **475** | eCQM | HIV Screening | 2019 | 66,798 | 13.74% | 9.20 | 7.62 | 9.39 | 10.00 |
| **066** | eCQM | Appropriate Testing for Pharyngitis | 2017 | 63,908 | 13.15% | 9.15 | 7.71 | 9.92 | 10.00 |
| **134** | CMS Web Interface Measure | Preventive Care and Screening: Screening for Depression and Follow-Up Plan | 2017 | 117,895 | 24.26% | 8.95 | 7.28 | 9.16 | 10.00 |
| **370** | eCQM | Depression Remission at Twelve Months | 2017 | 37,344 | 7.68% | 8.92 | 7.11 | 9.31 | 10.00 |
| **226** | CMS Web Interface Measure | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | 2017 | 117,895 | 24.26% | 8.83 | 7.00 | 9.07 | 10.00 |
| **239** | eCQM | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents | 2017 | 59,518 | 12.25% | 8.82 | 7.32 | 9.17 | 10.00 |
| **113** | CMS Web Interface Measure | Colorectal Cancer Screening | 2017 | 117,895 | 24.26% | 8.79 | 7.94 | 8.89 | 9.49 |
| **309** | eCQM | Cervical Cancer Screening | 2017 | 87,742 | 18.05% | 8.78 | 7.21 | 9.14 | 10.00 |

| Quality ID | Collection Type | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)[29] | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|---|
| **310** | eCQM | Chlamydia Screening for Women | 2017 | 36,439 | 7.50% | 8.64 | 6.81 | 8.72 | 10.00 |
| **281** | eCQM | Dementia: Cognitive Assessment | 2017 | 10,760 | 2.21% | 8.55 | 6.50 | 8.80 | 10.00 |
| **236** | CMS Web Interface Measure | Controlling High Blood Pressure | 2017 | 117,895 | 24.26% | 8.47 | 7.88 | 8.51 | 9.04 |
| **117** | eCQM | Diabetes: Eye Exam | 2017 | 13,523 | 2.78% | 8.46 | 5.29 | 9.35 | 10.00 |
| **107** | eCQM | Adult Major Depressive Disorder (MDD): Suicide Risk Assessment | 2017 | 12,174 | 2.50% | 8.45 | 7.77 | 8.08 | 10.00 |
| **008** | eCQM | Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) | 2017 | 13,168 | 2.71% | 8.41 | 7.59 | 8.42 | 9.43 |

**Table 21. 20 Highest Scoring QCDR (Quality) Measures in 2023**

There are no QCDR measures that met the 2% reporting threshold for inclusion in this table. Refer to Table 17 for the most frequently reported QCDR measures, including measure score information.

**Table 22. 20 Lowest Scoring Quality Measures in 2023 (Excluding QCDR Measures)[30]**

| Quality ID | Collection Type | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)[31] | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|---|
| 424 | MIPS CQM | Perioperative Temperature Management | 2017 | 9,819 | 2.02% | 5.12 | 3.31 | 4.88 | 7.00 |
| 130 | eCQM | Documentation of Current Medications in the Medical Record | 2017 | 30,851 | 6.35% | 5.14 | 1.95 | 5.76 | 7.00 |
| 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | 2022 | 318,392 | 65.51% | 5.18 | 2.30 | 4.68 | 9.01 |
| 492 | Administrative Claims Measure | Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System | 2023 | 138,642 | 28.53% | 5.65 | 1.87 | 5.23 | 10.00 |
| 480 | Administrative Claims Measure | Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) | 2021 | 107,618 | 22.14% | 5.67 | 2.26 | 5.72 | 9.31 |
| 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | 2021 | 318,193 | 65.47% | 5.98 | 2.78 | 5.87 | 9.52 |

[30] Table 22 includes the 20 lowest scoring quality measures from 2022, as determined by the mean score. Measures with the same mean score were further sorted in descending order by the percentage of clinicians measured. QCDR measures are excluded from Table 17 and can be found in Table 18.

[31] A 2% minimum reporting threshold was applied to this table; data is limited to measures that contributed to the final score of at least 2% of clinicians.

| Quality ID | Collection Type | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)[31] | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|---|
| 321 | CAHPS Measure | CAHPS for MIPS Clinician/Group Survey | 2017 | 131,396 | 27.04% | 6.18 | 3.73 | 6.54 | 8.31 |
| 130 | MIPS CQM | Documentation of Current Medications in the Medical Record | 2017 | 20,030 | 4.12% | 6.32 | 3.93 | 7.00 | 7.00 |
| 147 | MIPS CQM | Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy | 2017 | 10,268 | 2.11% | 6.84 | 7.00 | 7.00 | 7.00 |
| 065 | eCQM | Appropriate Treatment for Upper Respiratory Infection (URI) | 2017 | 18,677 | 3.84% | 7.23 | 3.79 | 7.83 | 10.00 |
| 113 | eCQM | Colorectal Cancer Screening | 2017 | 26,045 | 5.36% | 7.27 | 4.66 | 7.63 | 9.74 |
| 128 | eCQM | Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan | 2017 | 26,585 | 5.47% | 7.35 | 3.43 | 8.10 | 10.00 |
| 236 | eCQM | Controlling High Blood Pressure | 2017 | 112,580 | 23.16% | 7.38 | 4.75 | 7.92 | 9.59 |
| 404 | MIPS CQM | Anesthesiology Smoking Abstinence | 2017 | 11,171 | 2.30% | 7.45 | 5.07 | 7.62 | 9.49 |
| 226 | MIPS CQM | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | 2017 | 11,189 | 2.30% | 7.51 | 3.43 | 7.77 | 10.00 |
| 001 | eCQM | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | 2017 | 122,678 | 25.24% | 7.56 | 5.42 | 7.92 | 9.82 |
| 128 | MIPS CQM | Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan | 2017 | 13,073 | 2.69% | 7.70 | 3.65 | 7.89 | 10.00 |
| 226 | eCQM | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | 2017 | 53,195 | 10.95% | 7.72 | 4.89 | 8.27 | 10.00 |
| 238 | eCQM | Use of High-Risk Medications in Older Adults | 2017 | 35,712 | 7.35% | 7.76 | 4.67 | 7.69 | 10.00 |

| Quality ID | Collection Type | Measure Name | Measure's First Year in Program | Number of Clinicians Scored on the Measure | Percentage of Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Quality)[31] | Mean Measure Score | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|---|---|
| 134 | eCQM | Preventive Care and Screening: Screening for Depression and Follow-Up Plan | 2017 | 56,985 | 11.72% | 7.82 | 5.37 | 8.17 | 9.89 |

**Table 23. 20 Lowest Scoring QCDR (Quality) Measures in 2023**

There are no QCDR measures that met the 2% threshold for inclusion in this table. Refer to **Table 19** for the least frequently reported QCDR measures, including measure score information.

**Table 24a. Top 2 Most Frequently Reported Quality Measures per Specialty**

- The Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups measure and the Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure (both of which are automatically calculated) were those most frequently contributing to the quality score of almost all specialties listed below.
- Dermatologists' most frequently reported measure was the Melanoma: Continuity of Care - Recall System measure (MIPS CQM), but the 2nd most common measure was the Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure (administrative claims).
- Optometrists and Ophthalmologists were the exception; neither of their 2 most commonly scored measures were administrative claims measures.
    - The 2 most commonly scored measures for these specialties were the Use of High-Risk Medications in Older Adults measure and Diabetes: Eye Exam measure, both reported as eCQMs.

| | Most Frequently Reported Quality Measure | | | | | Second Most Frequently Reported Quality Measure | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Specialty[32] | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure |
| Internal Medicine | 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned | 25,175 | 79.29% | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk- | 23,507 | 74.04% |

[32] This table is limited to the 20 specialties with the greatest number of MIPS eligible clinicians in the 2023 performance year.

| | Most Frequently Reported Quality Measure | | | | | Second Most Frequently Reported Quality Measure | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Specialty[32] | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure |
| | | | Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | | | | | standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | | |
| **Family Medicine** | 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | 18,516 | 77.21% | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | 18,419 | 76.81% |
| **Emergency Medicine** | 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | 15,281 | 74.92% | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | 10,776 | 52.83% |
| **Diagnostic Radiology** | 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | 9,543 | 37.06% | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | 8,864 | 34.42% |
| **Anesthesiology** | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk- | 9,054 | 51.96% | 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned | 8,932 | 51.26% |

| | Most Frequently Reported Quality Measure | | | | | Second Most Frequently Reported Quality Measure | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Specialty[32] | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure |
| | | | standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | | | | | Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | | |
| **Orthopedic Surgery** | 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | 7,693 | 68.50% | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | 7,527 | 67.03% |
| **Cardiology** | 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | 7,672 | 71.51% | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | 7,629 | 71.11% |
| **Ophthalmology** | 238 | eCQM | Use of High-Risk Medications in Older Adults | 6,567 | 53.17% | 117 | eCQM | Diabetes: Eye Exam | 6,428 | 52.04% |
| **Obstetrics/Gynecology** | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | 9,520 | 83.83% | 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive | 8,816 | 77.63% |

| | Most Frequently Reported Quality Measure | | | | | Second Most Frequently Reported Quality Measure | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Specialty[32] | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure |
| | | | | | | | | Payment System (MIPS) Groups | | |
| **General Surgery** | 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | 8,251 | 82.54% | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | 8,090 | 80.93% |
| **Hospitalist** | 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | 9,406 | 94.07% | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | 8,242 | 82.43% |
| **Neurology** | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | 6,712 | 78.59% | 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | 6,611 | 77.41% |
| **Gastroenterology** | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for | 5,719 | 75.93% | 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive | 5,557 | 73.78% |

| | Most Frequently Reported Quality Measure | | | | | Second Most Frequently Reported Quality Measure | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Specialty[32] | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure |
| | | | Patients with Multiple Chronic Conditions | | | | | Payment System (MIPS) Groups | | |
| **Dermatology** | 137 | MIPS CQM | Melanoma: Continuity of Care - Recall System | 3,162 | 45.25% | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | 2,910 | 41.64% |
| **Podiatry** | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | 1,779 | 28.25% | 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | 1,557 | 24.73% |
| **Psychiatry** | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | 5,761 | 80.34% | 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | 5,398 | 75.28% |
| **Pathology** | 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive | 3,933 | 51.75% | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | 3,928 | 51.68% |

| | Most Frequently Reported Quality Measure | | | | | Second Most Frequently Reported Quality Measure | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Specialty[32] | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure |
| | | | Payment System (MIPS) Groups | | | | | | | |
| **Optometry** | 117 | eCQM | Diabetes: Eye Exam | 3,891 | 55.29% | 238 | eCQM | Use of High-Risk Medications in Older Adults | 3,860 | 54.85% |
| **Pulmonary Disease** | 479 | Administrative Claims Measure | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | 4,247 | 76.80% | 484 | Administrative Claims Measure | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | 4,197 | 75.90% |
| **Urology** | 484 | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | Administrative Claims | 3,434 | 72.54% | 479 | Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups | Administrative Claims | 3,286 | 69.41% |

**Table 24b. Top 2 Most Frequently Reported Quality Measures by Specialty – Excluding Administrative Claims[33]**

| | Most Frequently Reported Quality Measure | | | | | Second Most Frequently Reported Quality Measure | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Specialty[34] | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure |
| Internal Medicine | 321 | CAHPS Measure | CAHPS for MIPS Clinician/Group Survey | 10,221 | 32.19% | 001 | eCQM | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | 10,064 | 31.70% |
| Family Medicine | 321 | CAHPS Measure | CAHPS for MIPS Clinician/Group Survey | 8,684 | 36.21% | 001 | eCQM | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | 8,558 | 35.69% |
| Emergency Medicine | 001 | eCQM | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | 5,013 | 24.58% | 321 | CAHPS Measure | CAHPS for MIPS Clinician/Group Survey | 4,848 | 23.77% |
| Diagnostic Radiology | 147 | MIPS CQM | Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy | 8,817 | 34.24% | 364 | MIPS CQM | Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines | 6,475 | 25.14% |
| Anesthesiology | 404 | MIPS CQM | Anesthesiology Smoking Abstinence | 4,457 | 25.58% | 424 | MIPS CQM | Perioperative Temperature Management | 4,366 | 25.06% |
| Orthopedic Surgery | 001 | eCQM | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | 3,210 | 28.58% | 236 | eCQM | Controlling High Blood Pressure | 2,748 | 24.47% |
| Cardiology | 236 | eCQM | Controlling High Blood Pressure | 3,518 | 32.79% | 321 | CAHPS Measure | CAHPS for MIPS Clinician/Group Survey | 3,479 | 32.43% |

[33] Table 24b provides the top 2 measures attributed to clinicians in each specialty, based on the measures selected and submitted by the practice.
[34] This table is limited to the 20 specialties with the greatest number of MIPS eligible clinicians in the 2023 performance year.

| | Most Frequently Reported Quality Measure | | | | | Second Most Frequently Reported Quality Measure | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Specialty[34] | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure |
| **Ophthalmology** | 238 | eCQM | Use of High-Risk Medications in Older Adults | 6,567 | 53.17% | 117 | eCQM | Diabetes: Eye Exam | 6,428 | 52.04% |
| **Obstetrics/Gynecology** | 309 | eCQM | Cervical Cancer Screening | 4,724 | 41.60% | 236 | eCQM | Controlling High Blood Pressure | 4,315 | 37.99% |
| **General Surgery** | 321 | CAHPS Measure | CAHPS for MIPS Clinician/Group Survey | 3,542 | 35.43% | 001 | CMS Web Interface Measure | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | 3,247 | 32.48% |
| **Hospitalist** | 321 | CAHPS Measure | CAHPS for MIPS Clinician/Group Survey | 4,636 | 46.36% | 001 | CMS Web Interface Measure | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | 4,285 | 42.85% |
| **Neurology** | 321 | CAHPS Measure | CAHPS for MIPS Clinician/Group Survey | 2,734 | 32.01% | 001 | CMS Web Interface Measure | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | 2,486 | 29.11% |
| **Gastroenterology** | 236 | eCQM | Controlling High Blood Pressure | 2,590 | 34.39% | 321 | CAHPS Measure | CAHPS for MIPS Clinician/Group Survey | 2,550 | 33.86% |
| **Dermatology** | 137 | MIPS CQM | Melanoma: Continuity of Care - Recall System | 3,162 | 45.25% | 238 | MIPS CQM | Use of High-Risk Medications in Older Adults | 2,625 | 37.56% |
| **Podiatry** | 001 | eCQM | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | 1,285 | 20.41% | 236 | eCQM | Controlling High Blood Pressure | 1,103 | 17.52% |
| **Psychiatry** | 001 | eCQM | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | 2,690 | 37.51% | 321 | CAHPS Measure | CAHPS for MIPS Clinician/Group Survey | 2,161 | 30.14% |

| | Most Frequently Reported Quality Measure | | | | | Second Most Frequently Reported Quality Measure | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Specialty[34] | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure | Quality ID | Measure Name | Collection Type | Number of Clinicians Scored on the Measure | Percentage of Clinicians within the Specialty Who Reported the Measure |
| **Pathology** | 396 | MIPS CQM | Lung Cancer Reporting (Resection Specimens) | 2,242 | 29.50% | 395 | MIPS CQM | Lung Cancer Reporting (Biopsy/Cytology Specimens) | 2,068 | 27.21% |
| **Optometry** | 117 | eCQM | Diabetes: Eye Exam | 3,891 | 55.29% | 238 | eCQM | Use of High-Risk Medications in Older Adults | 3,860 | 54.85% |
| **Pulmonary Disease** | 321 | CAHPS Measure | CAHPS for MIPS Clinician/Group Survey | 1,935 | 34.99% | 001 | CMS Web Interface Measure | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | 1,782 | 32.22% |
| **Urology** | 321 | CAHPS for MIPS Clinician/Group Survey | CAHPS | 1,475 | 31.16% | 112 | Breast Cancer Screening | CMS Web Interface | 1,316 | 27.80% |

## 3.2 Cost Performance Category

**Table 25. Cost Measure Performance in 2023 (All Measures)**

- It's not surprising that the 2 population-based cost measures – Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) Clinician measures – were applicable to the greatest percentage of MIPS eligible clinicians who received a score in the cost performance category.
- Almost 87% of these clinicians were scored on the TPCC measure, whereas approximately 70% of these clinicians received a score on the MSPB Clinician measure.

| Measure ID | Measure Name | Number of MIPS Eligible Clinicians Scored on the Measure | Percentage of MIPS Eligible Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Cost) | Mean Measure Score[35] | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|
| TPCC_1 | Total Per Capita Cost (TPCC) | 238,420 | 86.74% | 5.21 | 1.96 | 5.06 | 8.78 |
| MSPB_1 | Medicare Spending Per Beneficiary (MSPB) Clinician | 194,895 | 70.91% | 7.56 | 4.77 | 7.76 | 10.00 |
| COST_D_1 | Diabetes | 178,525 | 64.95% | 5.08 | 2.73 | 5.10 | 7.24 |
| COST_ACOPD_1 | Asthma/Chronic Obstructive Pulmonary Disease (COPD) | 167,820 | 61.06% | 4.14 | 2.12 | 3.98 | 6.32 |
| COST_S_1 | Sepsis | 154,801 | 56.32% | 8.85 | 7.15 | 9.35 | 10.00 |
| COST_SSC_1 | Screening/Surveillance Colonoscopy | 138,376 | 50.34% | 5.13 | 2.39 | 4.76 | 9.09 |
| COST_COPDE_1 | Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation | 128,196 | 46.64% | 6.85 | 3.73 | 6.78 | 10.00 |
| COST_KA_1 | Knee Arthroplasty | 126,021 | 45.85% | 5.28 | 2.49 | 5.03 | 8.24 |
| COST_IHCI_1 | Intracranial Hemorrhage or Cerebral Infarction | 124,220 | 45.19% | 5.89 | 2.79 | 5.65 | 9.51 |
| COST_FIHR_1 | Femoral or Inguinal Hernia Repair | 121,999 | 44.39% | 5.29 | 2.78 | 4.89 | 8.18 |

[35] In the CY 2025 Physician Fee Schedule Final Rule, CMS finalized a change to the cost measure scoring methodology which will begin with the 2024 performance year. This change wasn't in effect with the data in this report.

| Measure ID | Measure Name | Number of MIPS Eligible Clinicians Scored on the Measure | Percentage of MIPS Eligible Clinicians Scored on the Measure (Out of All MIPS Eligible Clinicians Scored on Cost) | Mean Measure Score[35] | 10th Percentile Measure Score | 50th Percentile Measure Score (Median) | 90th Percentile Measure Score |
|---|---|---|---|---|---|---|---|
| COST_PHA_1 | Elective Primary Hip Arthroplasty | 114,838 | 41.78% | 5.15 | 1.93 | 4.72 | 8.79 |
| COST_RUSST_1 | Renal or Ureteral Stone Surgical Treatment | 108,972 | 39.65% | 5.95 | 2.27 | 5.97 | 9.86 |
| COST_LPMSM_1 | Lumpectomy, Partial Mastectomy, Simple Mastectomy | 108,143 | 39.34% | 5.93 | 2.66 | 5.91 | 9.20 |
| COST_EOPCI_1 | Elective Outpatient Percutaneous Coronary Intervention (PCI) | 106,315 | 38.68% | 5.18 | 2.22 | 4.69 | 9.21 |
| COST_CCLI_1 | Revascularization for Lower Extremity Chronic Critical Limb Ischemia | 101,415 | 36.90% | 6.35 | 3.29 | 5.99 | 9.62 |
| COST_LGH_1 | Lower Gastrointestinal Hemorrhage (groups only) | 97,699 | 35.54% | 6.51 | 2.55 | 6.95 | 10.00 |
| COST_LSFDD_1 | Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels | 97,364 | 35.42% | 6.03 | 2.48 | 6.19 | 9.44 |
| COST_MR_1 | Melanoma Resection | 97,067 | 35.31% | 5.43 | 2.80 | 5.43 | 7.87 |
| COST_CRR_1 | Colon and Rectal Resection | 89,944 | 32.72% | 5.89 | 1.86 | 6.09 | 9.25 |
| COST_HAC_1 | Hemodialysis Access Creation | 89,513 | 32.57% | 5.33 | 2.41 | 4.83 | 8.72 |
| COST_NECABG_1 | Non-Emergent Coronary Artery Bypass Graft (CABG) | 87,751 | 31.93% | 6.36 | 2.50 | 6.73 | 10.00 |
| COST_IOL_1 | Routine Cataract Removal with Intraocular Lens (IOL) Implantation | 85,860 | 31.24% | 5.66 | 2.57 | 4.75 | 10.00 |
| COST_AKID_1 | Acute Kidney Injury Requiring New Inpatient Dialysis | 63,540 | 23.12% | 5.71 | 2.12 | 5.68 | 9.58 |
| COST_STEMI_1 | ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) | 37,110 | 13.50% | 5.83 | 2.33 | 5.99 | 10.00 |

### 3.3 Improvement Activities Performance Category

- "Engagement of patients through implementation of improvements in patient portal" was the most reported improvement activity.
- The 20 most frequently reported improvement activities were evenly distributed across the different subcategories.

**Table 26. 20 Most Frequently Reported Improvement Activities in 2023**

| Activity ID | Activity Name | Number of Clinicians Who Reported the Activity | Percentage of Clinicians Who Reported the Activity (Out of All MIPS Eligible Clinicians Scored on Improvement Activities) |
|---|---|---|---|
| IA_BE_4 | Engagement of patients through implementation of improvements in patient portal | 113,471 | 22.02% |
| IA_EPA_1 | Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record | 101,361 | 19.67% |
| IA_BE_6 | Regularly Assess Patient Experience of Care and Follow Up on Findings | 94,742 | 18.38% |
| IA_CC_13 | Practice Improvements to Align with OpenNotes Principles | 52,387 | 10.16% |
| IA_PSPA_16 | Use of decision support and standardized treatment protocols | 37,442 | 7.26% |
| IA_EPA_2 | Use of telehealth services that expand practice access | 33,885 | 6.57% |
| IA_CC_2 | Implementation of improvements that contribute to more timely communication of test results | 31,262 | 6.07% |
| IA_PM_16 | Implementation of medication management practice improvements | 23,824 | 4.62% |
| IA_AHE_3 | Promote Use of Patient-Reported Outcome Tools | 23,313 | 4.52% |
| IA_BMH_2 | Tobacco use | 22,838 | 4.43% |
| IA_BMH_4 | Depression screening | 19,825 | 3.85% |
| IA_CC_1 | Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop | 16,885 | 3.28% |
| IA_EPA_3 | Collection and use of patient experience and satisfaction data on access | 15,114 | 2.93% |

| Activity ID | Activity Name | Number of Clinicians Who Reported the Activity | Percentage of Clinicians Who Reported the Activity (Out of All MIPS Eligible Clinicians Scored on Improvement Activities) |
|---|---|---|---|
| IA_AHE_6 | Provide Education Opportunities for New Clinicians | 13,107 | 2.54% |
| IA_BE_1 | Use of certified EHR to capture patient reported outcomes | 11,793 | 2.29% |
| IA_PCMH | Electronic submission of Patient Centered Medical Home accreditation | 11,070 | 2.15% |
| IA_CC_19 | Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes. | 10,331 | 2.00% |
| IA_PM_13 | Chronic Care and Preventative Care Management for Empaneled Patients | 10,126 | 1.96% |
| IA_BMH_12 | Promoting Clinician Well-Being | 10,091 | 1.96% |
| IA_BE_12 | Use evidence-based decision aids to support shared decision-making. | 9,472 | 1.84% |

## 3.4 Promoting Interoperability Performance Category

- More than 92% of clinicians reported the now-required Query of the Prescription Drug Monitoring Program (PDMP) measure.
- Approximately 77% of clinicians fulfilled their Health Information Exchange (HIE) objective by reporting the Bi-Directional Exchange measure.
- Almost 95% of clinicians reporting the Immunization Registry Reporting measure were in the validated data production level (completed testing and validation of the electronic submission; electronically submitting production data to the Public Health Agency or Clinical Data Registry), whereas 58% of those reporting the Electronic Case Reporting measure were in the validated data production level.
- Almost one-third of clinicians reported the optional/bonus Syndromic Surveillance Reporting measure.

**Table 27. Frequency of Promoting Interoperability Measures Reported in 2023**

| Objective | Measure ID | Measure Name[36] | Measure Type[37] | Number of Clinicians Who Reported the Measure | Percentage of Clinicians Who Reported the Measure (Out of All MIPS Eligible Clinicians Scored on Promoting Interoperability) |
|---|---|---|---|---|---|
| Attestation | PI_ONCDIR_1 | ONC Direct Review Attestation | Required | 371,090 | 96.31% |
| | PI_INFBLO_1 | Actions to Limit or Restrict the Compatibility of CEHRT | Required | 370,960 | 96.27% |
| | PI_ONCACB_1 | ONC-ACB Surveillance Attestation | Optional | 302,792 | 78.58% |
| Protect Patient Health Information | PI_PPHI_1 | Security Risk Analysis | **Required** | 370,908 | 96.26% |
| | PI_PPHI_2 | High Priority Practices Guide of the Safety Assurance Factors for EHR Resilience (SAFER) Guides | **Required** | 370,819 | 96.24% |
| e-Prescribing | PI_EP_1 | e-Prescribing | Required | 367,168 | 95.29% |
| | PI_LVPP_1 | e-Prescribing Exclusion | Exclusion | 3,707 | 0.96% |
| | PI_EP_2 | Query of the Prescription Drug Monitoring Program (PDMP) | Required | 352,489 | 91.48% |
| | PI_EP_2_EX_1 | Query of the Prescription Drug Monitoring Program (PDMP) Exclusion | Exclusion | 2,028 | 0.53% |
| | PI_EP_2_EX_2 | Query of the Prescription Drug Monitoring Program (PDMP) Exclusion | Exclusion | 7,030 | 1.82% |
| | PI_EP_2_EX_3 | Query of the Prescription Drug Monitoring Program (PDMP) Exclusion | Exclusion | 9,348 | 2.43% |

[36] For more information about the 2023 Promoting Interoperability measures and exclusions, review the 2023 MIPS Promoting Interoperability Measure Specifications (ZIP, 3MB).
[37] This performance category includes both required and optional/bonus measures; most required measures have one or more exclusions available for clinicians who qualify. For example, there are 3 exclusions available for the Immunization Registry Reporting.

| | | | | | |
|---|---|---|---|---|---|
| **Health Information Exchange (HIE) – Option 1** | PI_HIE_1 | Support Electronic Referral Loops By Sending Health Information | Required | 53,670 | 13.93% |
| | PI_LVOTC_1 | Support Electronic Referral Loops By Sending Health Information Exclusion | Exclusion | 15,987 | 4.15% |
| | PI_HIE_4 | Support Electronic Referral Loops By Receiving and Reconciling Health Information | Required | 56,813 | 14.74% |
| | PI_LVITC_2 | Support Electronic Referral Loops By Receiving and Reconciling Health Information Exclusion | Exclusion | 12,572 | 3.26% |
| **Health Information Exchange (HIE) – Option 2** | PI_HIE_5 | Health Information Exchange | Required | 295,514 | 76.69% |
| **Health Information Exchange (HIE) – Option 3** | PI_HIE_6 | Enabling Exchange Under TEFCA | Required | 5,611 | 1.46% |
| **Provider to Patient Exchange** | PI_PEA_1 | Provide Patients Electronic Access to Their Health Information | Required | 370,695 | 96.20% |
| **Public Health and Clinical Data Exchange** | PI_PHCDRR_1 | Immunization Registry Reporting | **Required** | 327,195 | 84.91% |
| | PI_PHCDRR_1_PRE | Immunization Registry Reporting Active Engagement Level 1 | **Required** | 17,422 | 4.52% |
| | PI_PHCDRR_1_PROD | Immunization Registry Reporting Active Engagement Level 2 | **Required** | 309,606 | 80.35% |
| | PI_PHCDRR_1_EX_1 | Immunization Registry Reporting Exclusion (1) | Exclusion | 42,655 | 11.07% |
| | PI_PHCDRR_1_EX_2 | Immunization Registry Reporting Exclusion (2) | Exclusion | 610 | 0.16% |
| | PI_PHCDRR_1_EX_3 | Immunization Registry Reporting Exclusion (3) | Exclusion | 338 | 0.09% |

| | | | | | |
|---|---|---|---|---|---|
| **Public Health and Clinical Data Exchange (Continued)** | PI_PHCDRR_3 | Electronic Case Reporting | Required | 326,047 | 84.62% |
| | PI_PHCDRR_3_PRE | Electronic Case Reporting Active Engagement Level 1 | Required | 136,353 | 35.39% |
| | PI_PHCDRR_3_PROD | Electronic Case Reporting Active Engagement Level 2 | Required | 189,335 | 49.14% |
| | PI_PHCDRR_3_EX_1 | Electronic Case Reporting Exclusion (1) | Exclusion | 25,418 | 6.60% |
| | PI_PHCDRR_3_EX_2 | Electronic Case Reporting Exclusion (2) | Exclusion | 7,780 | 2.02% |
| | PI_PHCDRR_3_EX_3 | Electronic Case Reporting Exclusion (3) | Exclusion | 11,524 | 2.99% |
| | PI_PHCDRR_2 | Syndromic Surveillance Reporting | Optional/Bonus | 215,283 | 55.87% |
| | PI_PHCDRR_2_PRE | Syndromic Surveillance Reporting Active Engagement Level 1 | Optional/Bonus | 9,133 | 2.37% |
| | PI_PHCDRR_2_PROD | Syndromic Surveillance Reporting Active Engagement Level 2 | Optional/Bonus | 116,174 | 30.15% |
| | PI_PHCDRR_4 | Public Health Registry Reporting | Optional/Bonus | 246,952 | 64.09% |
| | PI_PHCDRR_4_PRE | Public Health Registry Reporting Active Engagement Level 1 | Optional/Bonus | 57,993 | 15.05% |
| | PI_PHCDRR_4_PROD | Public Health Registry Reporting Active Engagement Level 2 | Optional/Bonus | 82,937 | 21.52% |
| | PI_PHCDRR_5 | Clinical Data Registry Reporting | Optional/Bonus | 235,016 | 60.99% |
| | PI_PHCDRR_5_PRE | Clinical Data Registry Reporting Active Engagement Level 1 | Optional/Bonus | 13,706 | 3.56% |
| | PI_PHCDRR_5_PROD | Clinical Data Registry Reporting Active Engagement Level 2 | Optional/Bonus | 79,714 | 20.69% |

## 3.5 Unweighted Performance Category Scores[38]

- The improvement activities performance category had the highest mean and median scores (more than 95%) and contributed to the final score of the most clinicians (more than 95%).
- Only 43% of MIPS eligible clinicians received a cost performance category, which had the lowest mean and median scores of any performance category.
    - Approximately 51% of MIPS eligible clinicians didn't receive a cost performance score because **(1)** they didn't meet the requirements for any cost measure, **(2)** they were approved for reweighting due to extreme and uncontrollable circumstances, **or (3)** they reported through the APM Performance Pathway (APP) (cost isn't scored under this MIPS reporting option).

**Table 28. Unweighted Performance Category Scores**

| Performance Category | Overall Unweighted Mean Score | Overall Unweighted Median Score | Number of MIPS Eligible Clinicians Who Received a Score for the Performance Category | Percentage of All MIPS Eligible Clinicians |
|---|---|---|---|---|
| Quality | 75.33 | 78.84 | 486,018 | 89.77% |
| Cost | 60.94 | 59.51 | 274,865 | 50.77% |
| Improvement Activities | 95.43 | 100 | 515,384 | 95.19% |
| Promoting Interoperability | 95.57 | 100 | 385,324 | 71.17% |

[38] The unweighted score (0% – 100%) is generally determined by dividing *the points earned* by *the points available* in a performance category. (**For example:** Earning 20 out of 40 points for the improvement activities would result in an unweighted score of 50%.) The unweighted score is the measure of performance before it's multiplied by the category's weight to determine how many points will contribute to the final score. The unweighted score also allows for comparison between clinicians with different performance category weighting. (**For example:** An unweighted quality score of 100% contributes 30 points towards the final score when the category is weighted at 30% of the final score; alternatively, the same 100% performance contributes 50 points when the category is weighted at 50% of the final score.)

## 4. 2023 MIPS Final Scores and Associated 2025 Payment Adjustments

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.

When MIPS eligible clinicians were scored on all 4 performance categories, the categories had the following weights:

- Quality: 30%
- Cost: 30%
- Improvement Activities: 15%
- Promoting Interoperability: 25%

The Medicare Access and CHIP Reauthorization Act (MACRA) requires MIPS to be a budget-neutral program. Generally, this means the projected negative adjustments must be balanced by the projected positive adjustments. When more clinicians receive a negative payment adjustment, clinicians with a positive payment adjustment see a larger payment adjustment amount.

As a reminder, congressional funding for the MIPS exceptional payment adjustment expired after the 2022 performance year. The 2022 performance year was the final year for the exceptional performance adjustment, which was paid in the 2024 payment year.

For more information about final scores and MIPS payment adjustments, review the additional resources found in the Appendix.

## Data Highlights

### 4.1 Final Scores and Payment Adjustments

- As communicated in the 2025 MIPS Payment Year Payment Adjustment User Guide (PDF, 1MB) and the 2023 QPP Participation and Performance Results At-A-Glance (PDF, 411KB), the maximum positive payment adjustment was 2.15%, for a final score of 100 points.
- MIPS eligible clinicians who engaged[39] in the program had a mean final score over 85 points and mean payment adjustment of 0.86%, whereas non-reporting clinicians[37] had a mean score below 47 points (well below the 75-point performance threshold) and a mean payment adjustment of -3.59%.

**Table 29. 2023 Final Scores and 2025 Payment Adjustments**

| | Final Score | | Payment Adjustment | |
|---|---|---|---|---|
| **Status** | **Mean** | **Median** | **Mean** | **Median** |
| **MIPS Eligible Clinicians (All)** | 83.18 | 85.49 | 0.59% | 0.90% |
| MIPS Eligible Clinicians (**Engaged**[36]) | 85.54 | 86.59 | 0.86% | 1.00% |
| MIPS Eligible Clinicians **(Non-Reporting**[40]**)** | 46.35 | 75.00 | -3.59% | 0.00% |

### 4.2 Final Scores and Payment Adjustments by Practice Size, Special Status, Reporting Option, and Participation Option

- Clear differences in mean final scores remain between engaged and non-reporting clinicians, regardless of practice size:
  - The mean final score for engaged clinicians in every practice size was above the 75-point performance threshold (positive payment adjustment), whereas non-reporting clinicians in every practice size had a mean score below the 75-point performance threshold (negative payment adjustment) (Table 30a).

[39] **Engaged clinicians** are those who submitted at least one measure, attestation or activity (or had this data submitted on their behalf), or who participated in a MIPS APM and received automatic credit in the improvement activities performance category because of their APM participation. Data could have been submitted at the individual, group, virtual group, or APM Entity level.

[40] **Non-reporting MIPS eligible clinicians** were required to report (i.e., an individually eligible clinician, an opt-in eligible clinician or group who submitted an election to opt-in to the program, or a clinician in a CMS-approved virtual group) but didn't actively submit any data for the quality, Promoting Interoperability, or improvement activities performance category. Review the 2023 QPP Data Use Guide (PDF) for more information on this definition.

- While solo practitioners had the lowest mean final score overall (below the 75-point performance threshold), **engaged solo practitioners had a mean final score over 79 points and a median final score of almost 86 points**. By contrast, non-reporting solo practitioners had a mean final score below 29 points and a median final score just above 15 points (Table 30a).

- Clinicians participating in MIPS through the APM Performance Pathway (APP), and as an APM Entity, continue to have the highest mean and median final scores and payment adjustments (Table 31a and Table 31b).

**Table 30a: 2023 Final Scores and 2025 Payment Adjustments by Practice Size**

| | Final Score | | Payment Adjustment | |
|---|---|---|---|---|
| Practice Size[41] | Mean | Median | Mean | Median |
| 1 Clinician (Solo Practitioner: All) | 53.64 | 75.00 | −2.89% | 0.00% |
| 1 Clinician (Solo Practitioner: Engaged[42]) | 79.68 | 85.51 | 0.15% | 0.91% |
| 1 Clinician (Solo Practitioner: Non-Reporting[43]) | 27.97 | 15.34 | -5.88% | -9.00% |
| 2 – 15 Clinicians (All) | 76.92 | 84.49 | -0.17% | 0.82% |
| 2 – 15 Clinicians (Engaged) | 85.05 | 89.13 | 0.76% | 1.22% |
| 2 – 15 Clinicians (Non-Reporting) | 41.16 | 38.72 | −4.24% | −4.35% |
| 16 – 99 Clinicians (All) | 81.81 | 84.18 | 0.46% | 0.79% |
| 16 – 99 Clinicians (Engaged) | 83.74 | 85.42 | 0.67% | 0.90% |
| 16 – 99 Clinicians (Non-Reporting) | 61.73 | 75.00 | -1.68% | 0.00% |

[41] The **practice size** is determined by the number of clinicians billing under the practice's TIN in the second 12-month segment of the MIPS determination period (October 1, 2021 – September 30, 2022 for 2022).

[42] **Engaged clinicians** are those who submitted at least one measure, attestation or activity (or had this data submitted on their behalf), or who participated in a MIPS APM and received automatic credit in the improvement activities performance category because of their APM participation. Data could have been submitted at the individual, group, virtual group, or APM Entity level.

[43] **Non-reporting MIPS eligible clinicians** were required to report (i.e., were an individually eligible clinician, an opt-in eligible clinician or group who submitted an election to opt-in to the program, or a clinician in a CMS-approved virtual group) but didn't actively submit any data for the quality, Promoting Interoperability, or improvement activities performance category. Review the **2023 QPP Data Use Guide (PDF)** for more information on this definition.

| | Final Score | | Payment Adjustment | |
|---|---|---|---|---|
| Practice Size[41] | Mean | Median | Mean | Median |
| 100+ Clinicians (All) | 86.02 | 86.41 | 0.92% | 0.98% |
| 100+ Clinicians (Engaged) | 86.20 | 86.64 | 0.94% | 1.00% |
| 100+ Clinicians (Non-Reporting) | 68.63 | 75.00 | -0.80% | 0.00% |

**Table 30b: 2023 Final Scores and 2025 Payment Adjustments by Special Status/Designation**

| | Final Score | | Payment Adjustment | |
|---|---|---|---|---|
| **Special Status/ Designation** | **Mean** | **Median** | **Mean** | **Median** |
| **Small Practice[44] (All)** | 71.40 | 80.33 | 0.81% | 0.46% |
| **Small Practice (Engaged[45])** | 84.11 | 88.36 | 0.65% | 1.15% |
| **Small Practice (Non-Reporting[46])** | 35.49 | 22.24 | -4.95% | -6.33% |
| **Rural (All)** | 81.45 | 83.80 | 0.42% | 0.76% |
| **Rural (Engaged)** | 83.80 | 84.56 | 0.69% | 0.82% |
| **Rural (Non-Reporting)** | 40.58 | 30.00 | -4.33% | -5.40% |
| **Safety Net Provider (All)** | 86.50 | 91.25 | 0.86% | 1.40% |

[44] The **small practice special status** identifies clinicians in a practice with 15 or fewer clinicians bill under the practice's TIN in either segment of the MIPS determination period. This means that a practice could have had 16 or more clinicians in 1 segment if there were 15 or fewer in the other segment. The small practice special status includes solo practitioners.
[45] **Engaged clinicians** are those who submitted at least one measure, attestation or activity (or had this data submitted on their behalf), or who participated in a MIPS APM and received automatic credit in the improvement activities performance category because of their APM participation. Data could have been submitted at the individual, group, virtual group, or APM Entity level.
[46] **Non-reporting MIPS eligible clinicians** were required to report (i.e., were an individually eligible clinician, an opt-in eligible clinician or group who submitted an election to opt-in to the program, or a clinician in a CMS-approved virtual group) but didn't actively submit any data for the quality, Promoting Interoperability, or improvement activities performance category. Review the **2023 QPP Data Use Guide (PDF)** for more information on this definition.

| | Final Score | | Payment Adjustment | |
|---|---|---|---|---|
| Special Status/ Designation | Mean | Median | Mean | Median |
| Safety Net Provider (Engaged) | 89.87 | 91.60 | 1.24% | 1.43% |
| Safety Net Provider (Non-Reporting) | 40.39 | 30.00 | -4.38% | -5.40% |

**Table 31a. 2023 Final Scores and 2025 Payment Adjustments by MIPS Reporting Option**

| | Final Score | | Payment Adjustment | |
|---|---|---|---|---|
| Reporting Option | Mean | Median | Mean | Median |
| Traditional MIPS | 79.96 | 82.11 | 0.28% | 0.61% |
| APM Performance Pathway (APP) | 94.35 | 94.62 | 1.67% | 1.69% |
| MIPS Value Pathways (MVPs) | 82.87 | 87.86 | 0.57% | 1.11% |

**Table 31b. 2023 Final Scores and 2025 Payment Adjustments by Participation Option**

| | Final Score | | Payment Adjustment | |
|---|---|---|---|---|
| Participation Option | Mean | Median | Mean | Median |
| Individual | 56.16 | 75 | -2.58% | 0.00% |
| Group | 82.87 | 82.91 | 0.63% | 0.68% |
| Virtual Group | 74.88 | 75 | -0.01% | 0.00% |
| APM Entity | 94.24 | 94.31 | 1.66% | 1.66% |
| Subgroup | 89.98 | 93.62 | 1.25% | 1.60% |

## 4.3 Mean and Median Final Score Trends

- The overall mean and median final scores remained above the performance threshold in 2023 and were consistent with those from 2022.
  - In 2023, the mean and median final scores across all MIPS eligible clinicians were 83.18 and 85.49 points, respectively (Table 32a).
  - In 2022, the mean and median final scores across all MIPS eligible clinicians were 82.90 and 85.29 points, respectively (Table 32a).
- There were significant decreases from 2022 to 2023 in the mean and median final scores for non-reporting clinicians in the following categories:
  - The median score for non-reporting clinicians in a practice with 2 – 15 clinicians (small practices excluding solo practitioners) in 2023 was half of what it was in 2022 (Table 32a).
  - The median score for non-reporting rural clinicians in 2023 was 45 points lower than it was in 2022 (Table 32a).

**Table 32a. Final Score Trends by Practice Size**

| | Mean Final Scores | | | Median Final Scores | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2021 | 2022 | 2023 |
| MIPS Eligible Clinicians (All) | 89.22 | 82.90 | 83.18 | 97.22 | 85.29 | 85.49 |
| MIPS Eligible Clinicians (Engaged[47]) | 91.13 | 85.1 | 85.54 | 98 | 86.67 | 86.59 |
| MIPS Eligible Clinicians (Non-Reporting[48]) | 58.63 | 47.85 | 46.35 | 60.00 | 75.00 | 75.00 |
| 1 Clinician/Solo Practitioner (All) | 71.08 | 54.33 | 53.64 | 60.00 | 75.00 | 75.00 |
| 1 Clinician/Solo Practitioner (Engaged) | 83.48 | 78.68 | 79.68 | 93.22 | 86.37 | 85.51 |
| 1 Clinician/Solo Practitioner (Non-Reporting) | 59.99 | 30.81 | 27.97 | 60.00 | 18.15 | 15.34 |

[47] **Engaged clinicians** are those who submitted at least one measure, attestation, or activity (or had this data submitted on their behalf), or who participated in a MIPS APM and received automatic credit in the improvement activities performance category because of their APM participation. Data could have been submitted at the individual, group, virtual group, or APM Entity level.

[48] **Non-reporting MIPS eligible clinicians** were required to report (i.e., were an individually eligible clinician, an opt-in eligible clinician or group who submitted an election to opt-in to the program, or a clinician in a CMS-approved virtual group) but didn't actively submit any data for the quality, Promoting Interoperability, or improvement activities performance category. Review the **2023 QPP Data Use Guide (PDF)** for more information on this definition.

| | | | | | | |
|---|---|---|---|---|---|---|
| 2 – 15 Clinicians (All) | 76.10 | 76.59 | 76.92 | 85.54 | 84.61 | 84.49 |
| 2 – 15 Clinicians (Engaged) | 79.43 | 84.8 | 85.05 | 93.14 | 89.17 | 89.13 |
| 2 – 15 Clinicians (Non-Reporting) | 59.91 | 43.11 | 41.16 | 60.00 | 75.00 | 38.72 |
| 16 – 99 Clinicians (All) | 87.47 | 81.55 | 81.81 | 94.43 | 83.58 | 84.18 |
| 16 – 99 Clinicians (Engaged) | 89.59 | 83.35 | 83.74 | 95.44 | 85.19 | 85.42 |
| 16 – 99 Clinicians (Non-Reporting) | 58.70 | 60.03 | 61.73 | 60.00 | 75.00 | 75.00 |
| 100+ Clinicians (All) | 93.27 | 85.55 | 86.02 | 99.14 | 86.50 | 86.41 |
| 100+ Clinicians (Engaged) | 93.76 | 85.77 | 86.2 | 99.24 | 86.78 | 86.64 |
| 100+ Clinicians (Non-Reporting) | 52.33 | 67.33 | 68.63 | 60.00 | 75.00 | 75.00 |

**Table 32b. Final Score Trends by Special Status/Designation**

| | Mean Final Scores | | | Median Final Scores | | |
|---|---|---|---|---|---|---|
| Special Status/Designation | 2021 | 2022 | 2023 | 2021 | 2022 | 2023 |
| Small Practice[49] (All) | 73.71 | 71.52 | 71.40 | 66.36 | 80.18 | 80.33 |
| Small Practice (Engaged[50]) | 78.14 | 83.6 | 84.11 | 91.15 | 88.06 | 88.36 |
| Small Practice (Non-Reporting[51]) | 59.90 | 38.34 | 35.49 | 60.00 | 25.77 | 22.24 |

[49] The **small practice special status** identifies clinicians in a practice with 15 or fewer clinicians bill under the practice's TIN in either segment of the MIPS determination period. This means that a practice could have had 16 or more clinicians in 1 segment if there were 15 or fewer in the other segment. The small practice special status includes solo practitioners.

[50] **Engaged clinician**s are those who submitted at least one measure, attestation, or activity (or had this data submitted on their behalf), or who participated in a MIPS APM and received automatic credit in the improvement activities performance category because of their APM participation. Data could have been submitted at the individual, group, virtual group, or APM Entity level.

[51] **Non-reporting MIPS eligible clinicians** were required to report (i.e., were an individually eligible clinician, an opt-in eligible clinician or group who submitted an election to opt-in to the program, or a clinician in a CMS-approved virtual group) but didn't actively submit any data for the quality, Promoting Interoperability, or improvement activities performance category. Review the **2023 QPP Data Use Guide (PDF)** for more information on this definition.

| | Mean Final Scores | | | Median Final Scores | | |
|---|---|---|---|---|---|---|
| Special Status/Designation | 2021 | 2022 | 2023 | 2021 | 2022 | 2023 |
| Rural Practitioner (All) | 88.44 | 81.71 | 81.45 | 97.18 | 84.10 | 83.80 |
| Rural Practitioner (Engaged) | 90.36 | 83.8 | 83.8 | 97.61 | 85.05 | 84.56 |
| Rural Practitioner (Non-Reporting) | 57.32 | 45.05 | 40.58 | 60.00 | 75.00 | 30.00 |
| Safety Net Provider (All) | 87.20 | 86.38 | 86.50 | 96.23 | 91.57 | 91.25 |
| Safety Net Provider (Engaged) | 89.59 | 89.51 | 89.87 | 97.44 | 93.21 | 91.6 |
| Safety Net Provider (Non-Reporting) | 59.26 | 39.48 | 40.39 | 60.00 | 27.84 | 30.00 |

## 4.4 Overall Payment Adjustments

- Approximately 80% of MIPS eligible clinicians earned a positive payment adjustment for the 2023 performance year (payment will be adjusted in the 2025 payment year) (Table 33).
- Less than 15% of MIPS eligible clinicians earned a positive payment adjustment for the 2023 performance year, with just over 2% of clinicians receiving the maximum negative payment adjustment of -9% (Table 33).

**Table 33. 2025 Payment Adjustments Overall**

| Payment Adjustment Type | Max Negative | Negative | Neutral | Positive | |
|---|---|---|---|---|---|
| **Payment Adjustment Range** | -9% | -6.75% – 0% | 0% | 0% – 1.28% | 1.28% – 2.15% |
| **Associated Final Score Range** | 0 – 18.75 points | 18.76 – 74.99 points | 75 points | 75.01 – 88.99 points | 89 – 100 points |
| **Percentage of MIPS Eligible Clinicians in Payment Adjustment/Final Score Range (All)** | 2.26% | 12.13% | 4.75% | 38.86% | 42.00% |
| **Percentage of MIPS Eligible Clinicians in Payment Adjustment/Final Score Range (Non-Reporting[52])** | 33.44% | 11.00% | 54.04% | 1.39% | 0.13% |

## 4.5 Payment Adjustment by Practice Size, Special Status, Reporting Option, and Participation Option

- More than 20% of solo practitioners received final scores between 89 and 100 points, though they also have the highest instance of clinicians receiving the maximum negative payment adjustment of -9% (Table 34a).
- Almost 42% of clinicians in a practice with 2 – 15 clinicians received final scores between 89 and 100 points, which is consistent with the rate of MIPS eligible clinicians overall.
- In the first year of the MVP reporting option, more than 43% of clinicians who received their final score from MVP reporting also earned final scores between 89 and 100 points (Table 35b).
- Over 99% of MIPS eligible clinicians who participated in MIPS through their APM Entity received a positive payment adjustment (Table 35a).

[52] **Non-reporting clinicians** were required to report (i.e., were an individually eligible clinician, an opt-in eligible clinician or group who submitted an election to opt-in to the program, or a clinician in a CMS-approved virtual group) but didn't actively submit any data for the quality, Promoting Interoperability, or improvement activities performance categories. Because they were required to report, they will receive a final score and MIPS payment adjustment even if no data was actively submitted. Their final score can include data calculated and scored automatically by CMS, such as administrative claims-based quality measures or cost measures, or quality and cost scores derived from the Hospital Value-based Purchasing Program (learn more in the 2023 Facility-Based Quick Start Guide (PDF)).

**Table 34a. 2025 Payment Adjustment Types by Practice Size**

| Payment Adjustment Type | Max Negative Number AND Percentage | | Negative Number AND Percentage | | Neutral Number AND Percentage | | Positive Number AND Percentage | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Payment Adjustment Range | (-9%) | | (-6.75% - 0%) | | (0%) | | (0% – 1.28%) | | (1.28% – 2.15%) | |
| Associated Final Score Range | 0 – 18.75 points | | 18.76 – 74.99 points | | 75 points | | 75.01 – 88.99 points | | 89 – 100 points | |
| 1 Clinician/ Solo Practitioner (All) | 4,814 | 28.77% | 3,305 | 19.75% | 3,072 | 18.36% | 1,949 | 11.65% | 3,591 | 21.46% |
| 1 Clinician/Solo Practitioner (Engaged[53]) | 209 | 2.52% | 1,838 | 22.13% | 730 | 8.79% | 1,936 | 23.31% | 3,591 | 43.24% |
| 1 Clinician/ Solo Practitioner (Non-Reporting[54]) | 4,605 | 54.65% | 1,467 | 17.41% | 2,342 | 27.79% | 13 | 0.15% | 0 | 0.00% |
| 2 – 15 Clinicians (All) | 5,266 | 8.27% | 8,811 | 13.84% | 8,331 | 13.09% | 15,128 | 23.76% | 26,132 | 41.04% |
| 2 – 15 Clinicians (Engaged) | 526 | 1.01% | 7,459 | 14.38% | 2,635 | 5.08% | 15,113 | 29.14% | 26,132 | 50.38% |
| 2 – 15 Clinicians (Non-Reporting) | 4,740 | 40.16% | 1,352 | 11.45% | 5,696 | 48.26% | 15 | 0.13% | 2 | 0.02% |
| 16 – 99 Clinicians (All) | 1,542 | 1.55% | 16,467 | 16.59% | 8,052 | 8.11% | 37,142 | 37.43% | 36,037 | 36.31% |
| 16 – 99 Clinicians (Engaged) | 227 | 0.25% | 15,852 | 17.51% | 1,614 | 1.78% | 36,823 | 40.68% | 36,000 | 39.77% |
| 16 – 99 Clinicians (Non-Reporting) | 1,315 | 15.07% | 615 | 7.05% | 6,438 | 73.80% | 319 | 3.66% | 37 | 0.42% |

[53] Engaged clinicians are those who submitted at least one measure, attestation or activity (or had this data submitted on their behalf), or who participated in a MIPS APM and received automatic credit in the improvement activities performance category because of their APM participation. Data could have been submitted at the individual, group, virtual group, or APM Entity level.

[54] **Non-reporting MIPS eligible clinicians** were required to report (i.e., were an individually eligible clinician, an opt-in eligible clinician or group who submitted an election to opt-in to the program, or a clinician in a CMS-approved virtual group) but didn't actively submit any data for the quality, Promoting Interoperability, or improvement activities performance category. Review the **2023 QPP Data Use Guide (PDF)** for more information on this definition.

| Payment Adjustment Type | Max Negative Number AND Percentage | | Negative Number AND Percentage | | Neutral Number AND Percentage | | Positive Number AND Percentage | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Payment Adjustment Range | (-9%) | | (-6.75% - 0%) | | (0%) | | (0% – 1.28%) | | (1.28% – 2.15%) | |
| Associated Final Score Range | 0 – 18.75 points | | 18.76 – 74.99 points | | 75 points | | 75.01 – 88.99 points | | 89 – 100 points | |
| 100+ Clinicians (All) | 631 | 0.17% | 37,104 | 10.26% | 6,241 | 1.73% | 156,179 | 43.17% | 161,627 | 44.68% |
| 100+ Clinicians (Engaged) | 378 | 0.11% | 36,950 | 10.32% | 3,082 | 0.86% | 156,074 | 43.58% | 161,621 | 45.13% |
| 100+ Clinicians (Non-Reporting) | 253 | 6.88% | 154 | 4.19% | 3,159 | 85.91% | 105 | 2.86% | 6 | 0.16% |

**Table 34b. 2025 Payment Adjustment Types by Special Status**

| Payment Adjustment Type | Max Negative Number AND Percentage | | Negative Number AND Percentage | | Neutral Number AND Percentage | | Positive Number AND Percentage | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Payment Adjustment Range | (-9%) | | (-6.75% - 0%) | | (0%) | | (0% - 1.25%) | | (1.55%-8.26%) | |
| Associated Final Score Range | 0 – 18.75 points | | 18.76 – 74.99 points | | 75 points | | 75.01 – 88.99 points | | 89 – 100 points | |
| Small Practice[55] (All) | 10,211 | 13.07% | 12,135 | 15.54% | 11,474 | 14.69% | 16,396 | 20.99% | 27,892 | 35.71% |
| Small Practice (Engaged[56]) | 736 | 1.28% | 9,275 | 16.08% | 3,419 | 5.93% | 16,367 | 28.37% | 27,892 | 48.35% |
| Small Practice (Non-Reporting[57]) | 9,475 | 46.40% | 2,860 | 14.01% | 8,055 | 39.45% | 29 | 0.14% | 0 | 0.00% |

[55] The **small practice special status** identifies clinicians in a practice with 15 or fewer clinicians bill under the practice's TIN in either segment of the MIPS determination period. This means that a practice could have had 16 or more clinicians in 1 segment if there were 15 or fewer in the other segment. The small practice special status includes solo practitioners.

[56] **Engaged clinicians** are those who submitted at least one measure, attestation or activity (or had this data submitted on their behalf), or who participated in a MIPS APM and received automatic credit in the improvement activities performance category because of their APM participation. Data could have been submitted at the individual, group, virtual group, or APM Entity level.

[57] **Non-reporting MIPS eligible clinicians** were required to report (i.e., were an individually eligible clinician, an opt-in eligible clinician or group who submitted an election to opt-in to the program, or a clinician in a CMS-approved virtual group) but didn't actively submit any data for the quality, Promoting Interoperability, or improvement activities performance category. Review the **2023 QPP Data Use Guide (PDF)** for more information on this definition.

| Payment Adjustment Type | Max Negative Number AND Percentage | | Negative Number AND Percentage | | Neutral Number AND Percentage | | Positive Number AND Percentage | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Payment Adjustment Range | (-9%) | | (-6.75% - 0%) | | (0%) | | (0% - 1.25%) | | (1.55%-8.26%) | |
| Associated Final Score Range | 0 – 18.75 points | | 18.76 – 74.99 points | | 75 points | | 75.01 – 88.99 points | | 89 – 100 points | |
| Rural Practitioner (All) | 1,552 | 2.56% | 9,234 | 15.22% | 2,315 | 3.82% | 26,469 | 43.62% | 21,110 | 34.79% |
| Rural Practitioner (Engaged) | 227 | 0.40% | 8,800 | 15.34% | 806 | 1.40% | 26,436 | 46.08% | 21,104 | 36.78% |
| Rural Practitioner (Non-Reporting) | 1,325 | 40.07% | 434 | 13.12% | 1,509 | 45.63% | 33 | 1.00% | 6 | 0.18% |
| Safety Net Practitioner (All) | 3,079 | 2.82% | 8,627 | 7.89% | 3,989 | 3.65% | 27,502 | 25.14% | 66,178 | 60.51% |
| Safety Net Practitioner (Engaged) | 151 | 0.15% | 7,411 | 7.27% | 891 | 0.87% | 27,324 | 26.81% | 66,150 | 64.90% |
| Safety Net Practitioner (Non-Reporting) | 2,928 | 39.31% | 1,216 | 16.33% | 3,098 | 41.60% | 178 | 2.39% | 28 | 0.38% |

**Table 35a. 2025 Payment Adjustment Types by Reporting Option**

| Payment Adjustment Type | Max Negative Number AND Percentage | | Negative Number AND Percentage | | Neutral Number AND Percentage | | Positive Number AND Percentage | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Payment Adjustment Range | (-9%) | | (-6.75% - 0%) | | (0%) | | (0% - 1.25%) | | (1.55%-8.26%) | |
| Associated Final Score Range | 0 – 18.75 points | | 18.76 – 74.99 points | | 75 points | | 75.01 – 88.99 points | | 89 – 100 points | |
| Traditional MIPS | 12,225 | 2.95% | 63,626 | 15.33% | 25,404 | 6.12% | 203,216 | 48.97% | 110,529 | 26.63% |
| APM Performance Pathway | 0 | 0.00% | 535 | 0.45% | 41 | 0.03% | 5,138 | 4.29% | 113,917 | 95.22% |
| MIPS Value Pathways | 28 | 0.41% | 1,526 | 22.47% | 251 | 3.70% | 2,044 | 30.10% | 2,941 | 43.31% |

**Table 35b. 2025 Payment Adjustment Types by Participation Option**

| Payment Adjustment Type | Max Negative Number AND Percentage | | Negative Number AND Percentage | | Neutral Number AND Percentage | | Positive Number AND Percentage | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Payment Adjustment Range** | **(-9%)** | | **(-6.75% - 0%)** | | **(0%)** | | **(0% - 1.25%)** | | **(1.55%-8.26%)** | |
| **Associated Final Score Range** | **0 – 18.75 points** | | **18.76 – 74.99 points** | | **75 points** | | **75.01 – 88.99 points** | | **89 – 100 points** | |
| **Individual** | 11,607 | 25.77% | 9,073 | 20.14% | 8,327 | 18.49% | 6,932 | 15.39% | 9,105 | 20.21% |
| **Group** | 646 | 0.17% | 56,043 | 14.93% | 16,776 | 4.47% | 198,199 | 52.80% | 103,736 | 27.63% |
| **Subgroup** | 0 | 0.00% | 12 | 11.88% | 0 | 0.00% | 0 | 0.00% | 89 | 88.12% |
| **Virtual Group** | 0 | 0.00% | 9 | 3.00% | 291 | 97.00% | 0 | 0.00% | 0 | 0.00% |
| **APM Entity** | 0 | 0.00% | 550 | 0.46% | 302 | 0.25% | 5,267 | 4.37% | 114,457 | 94.93% |

## 4.6 Payment Adjustments by Clinician Type and Specialty

- Out of all clinician types, Clinical Social Workers had the highest percentage of clinicians receiving a final score of 89 – 100 points (almost 55%) (Table 36).
- Not surprisingly, the payment adjustments for Doctors of Medicine (the most numerous clinician type) were consistent with MIPS eligible clinicians overall (Table 36).
- The specialties with the highest proportion of clinicians receiving negative payment adjustments are Podiatry, Orthopedic Surgery, Optometry, and Anesthesiology (Table 37).

**Table 36. 2025 Payment Adjustment Types by Clinician Type**

| Payment Adjustment Type | Max Negative Number AND Percentage | | Negative Number AND Percentage | | Neutral Number AND Percentage | | Positive Number AND Percentage | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Payment Adjustment Range** | **(-9%)** | | **(-6.75% - 0%)** | | **(0%)** | | **(0% - 1.25%)** | | **(1.55%-8.26%)** | |
| **Associated Final Score Range** | **0 – 18.75 points** | | **18.76 – 74.99 points** | | **75 points** | | **75.01 – 88.99 points** | | **89 – 100 points** | |
| **Anesthesiologist Assistant**[58] | 0 | 0.00% | 106 | 6.75% | 0 | 0.00% | 669 | 42.58% | 796 | 50.67% |
| **Certified Nurse-Midwife** | 0 | 0.00% | 154 | 8.98% | 0 | 0.00% | 724 | 42.24% | 836 | 48.77% |
| **Certified Registered Nurse Anesthetist** | 118 | 0.53% | 3,593 | 16.29% | 204 | 0.92% | 10,087 | 45.73% | 8,057 | 36.52% |
| **Clinical Nurse Specialist** | 2 | 0.33% | 98 | 16.20% | 5 | 0.83% | 260 | 42.98% | 240 | 39.67% |
| **Clinical Psychologist** | 75 | 1.93% | 325 | 8.37% | 80 | 2.06% | 1,665 | 42.88% | 1,738 | 44.76% |
| **Clinical Social Worker** | 7 | 0.16% | 289 | 6.70% | 22 | 0.51% | 1,647 | 38.16% | 2,351 | 54.47% |
| **Doctor of Chiropractic (Chiropractor)** | 66 | 18.18% | 79 | 21.76% | 13 | 3.58% | 130 | 35.81% | 75 | 20.66% |
| **Doctor of Dental Medicine/Doctor of Dental Surgery (Dentist)** | 8 | 1.54% | 48 | 9.23% | 7 | 1.35% | 209 | 40.19% | 248 | 47.69% |
| **Doctor of Medicine**[59] | 9,834 | 2.86% | 41,878 | 12.18% | 22,025 | 6.41% | 129,199 | 37.59% | 140,777 | 40.96% |
| **Doctor of Optometry** | 567 | 7.50% | 952 | 12.59% | 410 | 5.42% | 2,508 | 33.17% | 3,124 | 41.32% |
| **Doctor of Osteopathy** | 6 | 2.69% | 22 | 9.87% | 14 | 6.28% | 87 | 39.01% | 94 | 42.15% |
| **Nurse Practitioner** | 554 | 0.72% | 9,288 | 12.03% | 1,577 | 2.04% | 32,676 | 42.34% | 33,088 | 42.87% |
| **Occupational Therapist** | 43 | 1.80% | 364 | 15.22% | 32 | 1.34% | 946 | 39.55% | 1,007 | 42.10% |
| **Physical Therapist** | 723 | 3.50% | 2,018 | 9.76% | 342 | 1.65% | 6,721 | 32.50% | 10,878 | 52.60% |
| **Physician Assistant** | 245 | 0.49% | 5,919 | 11.72% | 951 | 1.88% | 20,977 | 41.55% | 22,393 | 44.36% |

[58] Included in the definition of a Certified Registered Nurse Anesthetist in section 1861(bb)(2) of the Social Security Act.
[59] Includes Doctors of Podiatric Medicine (podiatrists).

| Payment Adjustment Type | Max Negative Number AND Percentage | | Negative Number AND Percentage | | Neutral Number AND Percentage | | Positive Number AND Percentage | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Payment Adjustment Range | (-9%) | | (-6.75% - 0%) | | (0%) | | (0% - 1.25%) | | (1.55%-8.26%) | |
| Associated Final Score Range | 0 – 18.75 points | | 18.76 – 74.99 points | | 75 points | | 75.01 – 88.99 points | | 89 – 100 points | |
| Qualified Audiologist | 5 | 0.21% | 371 | 15.81% | 13 | 0.55% | 1,027 | 43.76% | 931 | 39.67% |
| Qualified Speech-Language Pathologist | 0 | 0.00% | 64 | 11.00% | 1 | 0.17% | 273 | 46.91% | 244 | 41.92% |
| Registered Dietician/Nutrition Professional | 0 | 0.00% | 119 | 9.74% | 0 | 0.00% | 593 | 48.53% | 510 | 41.73% |

**Table 37. 2025 Payment Adjustment Types by Specialty**

| Payment Adjustment Type | Max Negative Number AND Percentage | | Negative Number AND Percentage | | Neutral Number AND Percentage | | Positive Number AND Percentage | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Payment Adjustment Range | (-9%) | | (-6.75% - 0%) | | (0%) | | (0% - 1.25%) | | (1.55%-8.26%) | |
| Associated Final Score Range | 0 – 18.75 points | | 18.76 – 74.99 points | | 75 points | | 75.01 – 88.99 points | | 89 – 100 points | |
| Specialty[60] | | | | | | | | | | |
| Internal Medicine | 890 | 2.52% | 4,487 | 12.68% | 1,623 | 4.59% | 13,407 | 37.89% | 14,974 | 42.32% |
| Family Medicine | 546 | 2.08% | 3,527 | 13.45% | 898 | 3.43% | 9,861 | 37.62% | 11,383 | 43.42% |
| Emergency Medicine | 100 | 0.45% | 1,942 | 8.69% | 1,192 | 5.33% | 7,102 | 31.77% | 12,015 | 53.76% |
| Diagnostic Radiology | 448 | 1.53% | 3,816 | 12.99% | 3,003 | 10.23% | 12,305 | 41.90% | 9,796 | 33.36% |
| Anesthesiology | 245 | 1.34% | 3,232 | 17.62% | 306 | 1.67% | 7,917 | 43.17% | 6,640 | 36.21% |
| Orthopedic Surgery | 521 | 3.77% | 2,513 | 18.18% | 1,524 | 11.03% | 5,104 | 36.93% | 4,160 | 30.10% |
| Cardiology | 308 | 2.46% | 1,347 | 10.77% | 951 | 7.60% | 4,639 | 37.10% | 5,260 | 42.06% |

[60] This table is limited to the 20 specialties (as defined by Medicare for physicians) with the greatest number of MIPS eligible clinicians in the 2023 performance year.

| Payment Adjustment Type | Max Negative Number AND Percentage | | Negative Number AND Percentage | | Neutral Number AND Percentage | | Positive Number AND Percentage | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Payment Adjustment Range** | **(-9%)** | | **(-6.75% - 0%)** | | **(0%)** | | **(0% - 1.25%)** | | **(1.55%-8.26%)** | |
| **Associated Final Score Range** | **0 – 18.75 points** | | **18.76 – 74.99 points** | | **75 points** | | **75.01 – 88.99 points** | | **89 – 100 points** | |
| **Ophthalmology** | 542 | 3.88% | 1,440 | 10.30% | 1,394 | 9.97% | 3,926 | 28.09% | 6,674 | 47.75% |
| **Obstetrics/Gynecology** | 55 | 0.45% | 1,417 | 11.67% | 147 | 1.21% | 4,998 | 41.15% | 5,529 | 45.52% |
| **General Surgery** | 128 | 1.16% | 1,225 | 11.14% | 264 | 2.40% | 4,586 | 41.69% | 4,796 | 43.60% |
| **Hospitalist** | 31 | 0.30% | 801 | 7.66% | 125 | 1.19% | 4,295 | 41.06% | 5,209 | 49.79% |
| **Neurology** | 407 | 4.18% | 1,154 | 11.85% | 602 | 6.18% | 3,880 | 39.84% | 3,696 | 37.95% |
| **Gastroenterology** | 147 | 1.67% | 890 | 10.09% | 517 | 5.86% | 3,849 | 43.65% | 3,415 | 38.73% |
| **Dermatology** | 749 | 7.95% | 786 | 8.34% | 1,290 | 13.69% | 2,724 | 28.91% | 3,873 | 41.11% |
| **Podiatry** | 1,887 | 23.20% | 964 | 11.85% | 1,628 | 20.01% | 1,742 | 21.41% | 1,914 | 23.53% |
| **Psychiatry** | 292 | 3.75% | 793 | 10.20% | 166 | 2.13% | 3,197 | 41.11% | 3,329 | 42.81% |
| **Pathology** | 103 | 1.24% | 801 | 9.67% | 398 | 4.81% | 3,548 | 42.85% | 3,431 | 41.43% |
| **Optometry** | 567 | 7.50% | 952 | 12.59% | 410 | 5.42% | 2,508 | 33.17% | 3,124 | 41.32% |
| **Pulmonary Disease** | 124 | 1.98% | 814 | 12.98% | 392 | 6.25% | 2,303 | 36.72% | 2,639 | 42.08% |
| **Urology** | 177 | 2.82% | 640 | 10.20% | 642 | 10.23% | 2,120 | 33.80% | 2,694 | 42.95% |

## 4.7 Mean and Median Payment Adjustment Trends

- While the mean payment adjustment decreased to 0.59% in 2023 due to the removal of the exceptional adjustment after the 2022 performance year/2024 payment year, the median payment adjustment of 0.90% was consistent with last year (Table 38a).
- Non-reporting clinicians in practices with 2 – 15 clinicians and non-reporting rural clinicians saw the greatest decline in median payment adjustments from 2022 to 2023. (Table 38a and Table 38b).

**Table 38a. Payment Adjustment Trends by Practice Size**

| | Mean Payment Adjustments | | | Median Payment Adjustments | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2021 | 2022 | 2023 |
| MIPS Eligible Clinicians (All) | 1.32% | 2.06% | 0.59% | 1.94% | 0.92% | 0.90% |
| MIPS Eligible Clinicians (Engaged[61]) | 1.41% | 2.4% | 0.86% | 2.05% | 1.04% | 1.00% |
| MIPS Eligible Clinicians (Non-Reporting[62]) | -0.23% | -3.41% | -3.59% | 0.00% | 0.00% | 0.00% |
| 1 Clinician/Solo Practitioner (All) | 0.53% | -1.89% | -2.89% | 0.00% | 0.00% | 0.00% |
| 1 Clinician/Solo Practitioner (Engaged) | 1.13% | 1.89% | 0.15% | 1.36% | 1.02% | 0.91% |
| 1 Clinician/Solo Practitioner (Non-Reporting) | 0.00% | -5.54% | -5.88% | 0.00% | -9.00% | -9.00% |
| 2 – 15 Clinicians (All) | 0.34% | 1.40% | -0.17% | 0.26% | 0.86% | 0.82% |
| 2 – 15 Clinicians (Engaged) | 0.42% | 2.73% | 0.76% | 1.35% | 1.66% | 1.22% |
| 2 – 15 Clinicians (Non-Reporting) | -0.02% | -4.01% | -4.24% | 0.00% | 0.00% | -4.35% |
| 16 – 99 Clinicians (All) | 1.18% | 1.74% | 0.46% | 1.54% | 0.77% | 0.79% |
| 16 – 99 Clinicians (Engaged) | 1.28% | 2.04% | 0.67% | 1.68% | 0.91% | 0.90% |

[61] **Engaged clinicians** are those who submitted at least one measure, attestation or activity (or had this data submitted on their behalf), or who participated in a MIPS APM and received automatic credit in the improvement activities performance category because of their APM participation. Data could have been submitted at the individual, group, virtual group, or APM Entity level.

[62] **Non-reporting MIPS eligible clinicians** were required to report (i.e., were an individually eligible clinician, an opt-in eligible clinician or group who submitted an election to opt-in to the program, or a clinician in a CMS-approved virtual group) but didn't actively submit any data for the quality, Promoting Interoperability, or improvement activities performance category. Review the **2023 QPP Data Use Guide (PDF)** for more information on this definition.

| | Mean Payment Adjustments | | | Median Payment Adjustments | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2021 | 2022 | 2023 |
| 16 – 99 Clinicians (Non-Reporting) | -0.22% | -1.88% | -1.68% | 0.00% | 0.00% | 0.00% |
| 100+ Clinicians (All) | 1.59% | 2.43% | 0.92% | 2.22% | 1.03% | 0.98% |
| 100+ Clinicians (Engaged) | 1.63% | 2.47% | 0.94% | 2.23% | 1.05% | 1.00% |
| 100+ Clinicians (Non-Reporting) | -1.30% | -0.97% | -0.80% | 0.00% | 0.00% | 0.00% |

**Table 38b. Payment Adjustment Trends by Special Status**

| | Mean Payment Adjustments | | | Median Payment Adjustments | | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2021 | 2022 | 2023 |
| Small Practice[63] (All) | 0.26% | 0.67% | -0.81% | 0.02% | 0.46% | 0.46% |
| Small Practice (Engaged[64]) | 0.35% | 2.59% | 0.65% | 1.07% | 1.17% | 1.15% |
| Small Practice (Non-Reporting[65]) | -0.02% | -4.60% | -4.95% | 0.00% | -5.91% | -6.33% |
| Rural Practitioner (All) | 1.25% | 1.72% | 0.42% | 1.93% | 0.81% | 0.76% |
| Rural Practitioner (Engaged) | 1.35% | 2.03% | 0.69% | 2.00% | 0.9% | 0.82% |
| Rural Practitioner (Non-Reporting) | -0.46% | -3.78% | -4.33% | 0.00% | 0.00% | -5.40% |

[63] The **small practice special status** identifies clinicians in a practice with 15 or fewer clinicians bill under the practice's TIN in either segment of the MIPS determination period. This means that a practice could have had 16 or more clinicians in 1 segment if there were 15 or fewer in the other segment. The small practice special status includes solo practitioners.
[64] **Engaged clinicians** are those who submitted at least one measure, attestation or activity (or had this data submitted on their behalf), or who participated in a MIPS APM and received automatic credit in the improvement activities performance category because of their APM participation. Data could have been submitted at the individual, group, virtual group, or APM Entity level.
[65] **Non-reporting MIPS eligible clinicians** were required to report (i.e., were an individually eligible clinician, an opt-in eligible clinician or group who submitted an election to opt-in to the program, or a clinician in a CMS-approved virtual group) but didn't actively submit any data for the quality, Promoting Interoperability, or improvement activities performance category. Review the **2023 QPP Data Use Guide (PDF)** for more information on this definition.

| | | | | | | |
|---|---|---|---|---|---|---|
| **Safety Net Provider (All)** | 1.23% | 3.33% | 0.86% | 1.80% | 3.12% | 1.40% |
| **Safety Net Provider (Engaged)** | 1.35% | 3.86% | 1.24% | 1.97% | 4.12% | 1.43% |
| **Safety Net Provider (Non-Reporting)** | -0.13% | -4.50% | -4.38% | 0.00% | -5.66% | -5.40% |

## 5. APM Participation

An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to reward healthcare providers for delivering high-quality and coordinated care. APMs can apply to a specific clinical condition, a care episode, or a population.

MIPS APM: A MIPS APM is a type of APM that allows participants to receive MIPS scoring that reflects their participation in an APM.

Advanced APM: An Advanced APM is a type of APM that allows participants to seek Qualifying APM Participant (QP) status by achieving threshold levels of payments or patients through their Advanced APM Entity.

- For the 2023 performance year, QPs received at least 50% of payments **or** saw at least 35% of patients through an Advanced APM. They're exempt from MIPS. They aren't eligible to receive a MIPS payment adjustment but will receive a financial incentive for being a QP.

- Partial QPs received at least 40% of payments **or** saw at least 25% of patients through an Advanced APM Entity. They can choose whether to participate in MIPS. If they elect to participate, they'll receive a MIPS payment adjustment. incentives.

Clinicians in an Advanced APM who don't achieve QP or Partial QP status based on the thresholds above are evaluated for MIPS eligibility like any other clinician. A clinician can participate in an Advanced APM **and** be required to report for MIPS. Refer to the Appendix for additional resources.

### Table 39: MIPS Eligible Clinicians Who Received a MIPS Final Score and Payment Adjustment from APM Entity Participation

- In performance year 2021, 12 out of 475 Medicare Shared Savings Program Accountable Care Organizations (ACOs) reported eCQMs/MIPS CQMs under the APP, while 37 out of 482 ACOs reported eCQMs/MIPS CQMs in performance year 2022.
- Submission data for performance year 2023 indicate that 72 out of 456 ACOs reported eCQMs/MIPS CQMs under the APP.

| MIPS APM | Number of MIPS Eligible Clinicians | Percentage of MIPS Eligible Clinicians |
|---|---|---|
| Medicare Shared Savings Program | 119,467 | 99.08% |
| Enhancing Oncology Model | 1,109 | 0.92% |

### Table 40: QP Threshold Scores by Advanced APM[66]

| Advanced APM | Average Payment Threshold Score | Average Patient Threshold Score |
|---|---|---|
| Primary Care First Model | 92.84 | 88.7 |
| Maryland Total Cost of Care Model | 88.7 | 87.93 |
| Vermont ACO Model | 74.92 | 74.79 |
| Medicare Shared Savings Program | 64.59 | 65.72 |
| ACO REACH Model | 62.87 | 63.23 |
| Kidney Care Choices Model | 60.22 | 42.73 |
| Comprehensive Care for Joint Replacement Payment Model | 31.38 | 16.28 |
| Bundled Payment for Care Improvement Advanced Model | 23.45 | 21.07 |

[66] Threshold scores reflect eligible clinician scores that participated in the model listed and as such may reflect participation in more than one model.

## Key Insights

- From 2022 to 2023, there was a 20% increase in the percentage of clinicians participating in Advanced APMs (Table 41).
- From 2022 to 2023, there was a 41% increase in the percentage of clinicians who achieved QP status (Table 41).
- Almost 21% of clinicians who participated in an Advanced APM without achieving QP status in 2021 achieved QP status in 2022 (Table 42).

**Table 41: Participation and Qualifying APM Participant (QP) Status**

| Qualifying APM Participant (QP) Status | Number of Clinicians (Identified by NPI) in 2021 | Number of Clinicians (Identified by NPI) in 2022 | Number of Clinicians (Identified by NPI) in 2023 | Number Change from 2021 to 2022 | Number Change from 2022 to 2023 | Percentage Change from 2021 to 2022 | Percentage Change from 2022 to 2023 |
|---|---|---|---|---|---|---|---|
| Advanced APM Participants | 333,658 | 420,591 | 505,201 | 86,933 | 84,610 | 26.05% | 20.12% |
| QP | 271,231 | 384,105 | 463,669 | 112,874 | 79,564 | 41.62 % | 20.71% |
| Partial QP | 3,365 | 2,528 | 1,339 | -837 | -1,189 | -24.87% | -47.03% |

**Table 42. Participants in Advanced APMs Gain QP Status**

| | Number of Clinicians (Identified by NPI, and in an Advanced APM) Not QP in 2021 | Number of Clinicians (Identified by NPI) Not QP in 2021 Who Became QP in 2022 | Percentage of Clinicians (Identified by NPI) Not QP in 2021 Who Became QP in 2022 | Number of Clinicians (Identified by NPI, and in an Advanced APM) Not QP in 2022 | Number of Clinicians (Identified by NPI) Not QP in 2022 Who Became QP in 2023 | Percentage of Clinicians (Identified by NPI) Not QP in 2022 Who Became QP in 2023 |
|---|---|---|---|---|---|---|
| All Clinicians | 42,782 | 6,449 | 32.79% | 19,666 | 7,111 | 38.56% |
| Small Practice Clinicians | 3,554 | 523 | 27.95% | 1,871 | 473 | 34.48% |

## Appendix: Additional Resources

### Eligibility and Participation Resources

- How MIPS Eligibility Is Determined (QPP Website)
- 2023 MIPS Eligibility and Participation Quick Start Guide (PDF)
- 2023 MIPS Eligibility and Participation User Guide (PDF)

### MIPS Performance Category Resources

#### Quality

- 2023 Traditional MIPS Quality Requirements (QPP Website)
- 2023 Quality Quick Start Guide (PDF)
- 2023 Quality User Guide (PDF)
- 2023 MIPS Quality Measures

#### Cost

- 2023 Traditional MIPS Cost Requirements (QPP Website)
- 2023 Cost Quick Start Guide (PDF)
- 2023 Cost User Guide (PDF)
- 2023 MIPS Cost Measures

#### Improvement Activities

- 2023 Traditional MIPS Improvement Activities Requirements (QPP Website)
- 2023 Improvement Activities Quick Start Guide (PDF)
- 2023 Improvement Activities User Guide (PDF)
- 2023 MIPS Improvement Activities
- 2023 Improvement Activities Inventory

#### Promoting Interoperability

- 2023 Promoting Interoperability Requirements
- 2023 Promoting Interoperability Quick Start Guide
- 2022 Promoting Interoperability User Guide
- 2023 MIPS Promoting Interoperability Measures
- 2023 Promoting Interoperability Actions to Limit or Restricts Fact Sheet
- 2023 High Priority Practices SAFER Guide Fact Sheet

### Final Score and Payment Adjustment Resources

- 2023 Traditional MIPS Scoring Guide (PDF)
- **2023 APP Scoring Guide**, available in the 2023 APM Performance Pathway (APP) Toolkit (ZIP)
- 2025 MIPS Payment Year Payment Adjustment User Guide (PDF)

### Advanced APM Resources

- 2023 and 2024 Comprehensive List of APMs
- Learning Resources for QP Status and APM Incentive Payment

| Date | Comment |
| --- | --- |
| 6/25/2025 | Original Posting. |

## Version History