Scores for Improvement Activities in MIPS APMs in the 2021 Performance Period

Certain Alternative Payment Models (APMs) include MIPS eligible clinicians as participants and hold their participants accountable for the cost and quality of care provided to Medicare beneficiaries. This type of APM is called a "MIPS APM." Most Advanced APMs are also MIPS APMs so that if an eligible clinician participating in the Advanced APM does not meet the threshold of having sufficient payments or patients through an Advanced APM in order to become a Qualifying APM Participant (QP), the eligible clinician will be scored under MIPS. As finalized in the Quality Payment Program rule, under the Merit-Based Incentive Payment System (MIPS), CMS will assign scores to MIPS eligible clinicians in the improvement activities performance category for participating in MIPS APMs. For the 2021 performance period, the list of MIPS APMs include:

- Bundled Payments for Care Improvement (BPCI) Advanced [all Tracks]
- Comprehensive End-Stage Renal Disease Care (CEC) Model [all Tracks]
- Comprehensive Care for Joint Replacement Model (CJR)
- Comprehensive Primary Care Plus (CPC+) Model [all Tracks]
- Direct Contracting (DC)
- Kidney Care Choices (KCC) Model [Comprehensive Kidney Care Contracting (CKCC) Options and CMS Kidney Care First (KCF)]
- Maryland Total Cost of Care (MD TCOC) [Care Redesign Program (CRP) and Maryland Primary Care Program (MDPCP)]
- Medicare Shared Savings Program [all Tracks]
- Next Generation Accountable Care Organization (NGACO) Model
- Oncology Care Model (OCM) [all Tracks]
- Primary Care First (PCF)
- Radiation Oncology (RO)
- Vermont All-Payer ACO (VT ACO) Model

Table 2 shows the improvement activities performance category score CMS will assign participants in each MIPS APM for the 2021 performance year. MIPS eligible clinicians must earn 40 points in the improvement activities performance category to receive full credit in that performance category, and this category is weighted at 15 percent of the final MIPS score for the 2021 performance year. Note that all APM Entity groups in a MIPS APM will automatically receive at least 50 percent (20 points) in the improvement activities performance category score. As shown below, all APM Entities participating in the list of MIPS APMs above will receive a full score for the improvement activities performance category in performance period 2021, and therefore will not need to submit additional improvement activity information under MIPS.

CMS derived the assigned points for each MIPS APM by reviewing the MIPS APM's participation agreement and/or relevant regulations to determine the improvement activities required as a function of participation in the MIPS APM. The list of required activities for each MIPS APM was compared to the MIPS list of improvement activities for the 2021 performance period. Consistent with MIPS scoring, each improvement activity conveys either 10 points for a medium activity or 20 points for a high activity, and the points for required improvement activities within each MIPS APM were summed to derive the total improvement activities performance category score for each MIPS APM.

We understand that many MIPS eligible clinicians in a MIPS APM may, in the course of their participation, perform improvement activities other than those explicitly required by the MIPS APM's terms and conditions. However, because all MIPS APMs require sufficient improvement activities for us to assign them a full score in 2021, MIPS APM participants will not have any need to independently attest to additional activities. In the event that CMS amends the improvement activities scoring or assessment required to reach the maximum score through future rulemaking or if new MIPS APMs are created such that CMS does not assign participants in a MIPS APM full credit in this category, APM Entities may choose to submit additional improvement activities to reach the maximum score.

Table 1. Example of How MIPS APMs Met Specific Improvement Activities in PY 2021

Improvement Activity ID	BPCI Advanced	CEC	CJR	CPC+	DC	KCC (CKCC)	KCC (KCF)	MD TCOC (CRP)	MD TCOC (MDPCP)	Medicare Shared Savings Program	NGACO	OCM	PCF	RO	VT ACO
IA_EPA_1 (High)				✓								✓	✓		
IA_EPA_3 (Medium)	✓	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓
IA_PM_12 (Medium)		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
IA_PM_13 (Medium)				✓		✓	✓		✓	✓	✓	✓	✓		✓
IA_PM_14 (Medium)				✓	✓	✓		✓		✓	✓	✓	✓		✓
IA_PM_15 (Medium)				✓	✓			✓	✓	✓	✓	✓	✓	✓	✓
IA_CC_9 (Medium)	✓	✓			✓	✓		✓		✓	✓	✓	✓	✓	
IA_CC_10 (Medium)				✓	✓			✓		✓	✓		✓	✓	✓
IA_CC_17 (High)								✓				✓			
IA_BE_6 (High)	✓	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓
IA_BE_13 (Medium)		✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓
IA_BE_15 (Medium)					✓			✓		✓	✓	✓		✓	

Improvement Activity ID	BPCI Advanced	CEC	CJR	CPC+	DC	KCC (CKCC)	KCC (KCF)	MD TCOC (CRP)	MD TCOC (MDPCP)	Medicare Shared Savings Program	NGACO	OCM	PCF	RO	VT ACO
IA_PSPA_11 (High)		✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓
IA_PSPA_17 (Medium)	✓		✓	✓		✓	✓	✓	✓	✓		✓			
IA_PSPA_18 (Medium)	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓
IA_BMH_2 (Medium)						✓	✓			✓		✓			✓

Table 2. Improvement Activity Category Scoring for MIPS APM Models in PY 2021

	BPCI Advanced	CEC	CJR	CPC+	DC	KCC (CKCC)	KCC (KCF)	MD TCOC (CRP)	MD TCOC (MDPCP)	Medicare Shared Savings Program	NGACO	OCM	PCF	RO	VT ACO
Number of 'Medium' Weighted Improvement Activities	7	12	7	16	15	14	13	25	11	24	18	28	15	11	15
Number of 'High' Weighted Improvement Activities	1	2	3	15	0	1	1	3	2	5	4	8	6	2	7
Total Number of Improvement Activities	8	14	10	21	15	15	14	28	13	29	22	36	21	13	22
Subtotal Score from Improvement Activities	90	160	130	260	150	160	140	310	150	340	260	440	270	160	290
Base Score for Being an APM	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
(a) Total Number of Points Earned by the APM	110	180	150	280	170	180	160	330	170	360	280	460	290	180	310
(b) Total Possible Points Earned	40	40	40	40	40	40	40	40	40	40	40	40	40	40	40
Improvement Activities Category Score [(a)/(b)] x 100%[19]	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Improvement Activity Evidence

Improvement Activity ID: IA_EPA_1 (High)
Strategy/Activity Name: Expanded Practice Access: Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record

MIPS APM	Improvement Activity Evidence
CPC+	Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR.[5]
OCM	The Practice is required to provide Medicare beneficiaries that meet the OCM Beneficiary Criteria with 24 hours per day / 7 days per week access to a clinician who has real-time access to patients' medical records.[15]
PCF	The PCF Practice must provide 24/7 access to a Care Team Practitioner with real-time access to the EHR.[16]

Improvement Activity ID: IA_EPA_3 (Medium)
Strategy/Activity Name: Expanded Practice Access: Collection and Use of Patient Experience and Satisfaction Data on Access

MIPS APM	Improvement Activity Evidence
BPCI Advanced	CMS will administer and analyze a BPCI Advanced Beneficiary experience survey for purposes of conducting the Model Evaluation.[1]
CEC	In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS)[2]
CJR	Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) is used for public reporting[3]
CPC+	CMS will administer a subset of CAHPS survey to a sample of the CPC+ Practice's entire patient population.[5]
MD TCOC (CRP)	Patient experience of care: The State will measure patient satisfaction, the effectiveness of care transitions, physician participation in public programs, hospital process of care measures, and measures of hospital care (e.g., readmissions and complications).[8]
MD TCOC (MDPCP)	Patient experience of care: The State will measure patient satisfaction.[8]
Medicare Shared Savings Program	CAHPS for MIPS
NGACO	The ACO must completely, timely, and accurately report quality measure data using CAHPS or other patient experience surveys.[14]
OCM	Mandated quality measure assessing person and caregiver experience and outcomes.[15]
PCF	The PCF Practice shall procure a CMS-approved vendor to conduct the Consumer Assessment of Healthcare Providers & Systems (CAHPS®), also known as the Patient Experience of Care Surveys (PECS)[16]
RO	We are adopting four quality measures and will collect the CAHPS® Cancer Care Radiation Therapy Survey for the RO Model.[17]
VT ACO	CAHPS measures

Improvement Activity ID: IA_PM_12 (Medium)
Strategy/Activity Name: Population Management: Population Empanelment

MIPS APM	Improvement Activity Evidence
CEC	CMS will align Medicare beneficiaries to an ESCO for the purposes of the CEC initiative [2]
CPC+	Optimize continuity of care for empaneled patients while preserving access. [5]
DC	Beneficiaries that received a plurality of qualifying E&M services from participants in the DCE during a historical period will be aligned to the DCE. There will also be a process for beneficiaries to voluntarily align to the DCE by selecting a participant as their primary care provider.[6]
KCC (CKCC)	CKD and ESRD beneficiaries are eligible for alignment and may remain aligned to a KCE or KCF Practice for a performance year if they meet the certain criteria. [7]
KCC (KCF)	CKD and ESRD beneficiaries are eligible for alignment and may remain aligned to a KCE or KCF Practice for a performance year if they meet the certain criteria. [7]
MD TCOC (CRP)	There is empanelment since payment is on a PMPM-type basis.
MD TCOC (MDPCP)	Each Participant Practice will be responsible for the care management of the beneficiaries on its attribution list. CMS will make the attribution lists available to the Participant Practices at the start of each Performance Year.[12]
Medicare Shared Savings Program	Beneficiaries are assigned prospectively and retrospectively. Assignment is shared with the ACOs on a quarterly basis.
NGACO	A Medicare ACO is an entity formed by certain health care providers that accepts financial accountability for the overall quality and cost of medical care furnished to Medicare fee-for-service beneficiaries assigned to the entity.[14]
OCM	The Parties acknowledge that the Practice submitted to CMS a preliminary OCM Practitioner List that included the NPI of each physician and NPP who would be an OCM Practitioner effective on the Start Date. The Practice certified that such list was true, accurate, and complete.[15]
PCF	Provide risk-stratified care management for all empaneled patients.[16]
RO	We are including beneficiaries that meet certain criteria under the RO Model. For example, these criteria will require that a beneficiary have a diagnosis of at least one of the cancer types included in the RO Model and that the beneficiary receive RT services from a participating provider or supplier in one of the selected CBSAs. Beneficiaries who meet these criteria will be included in RO episodes.[17]
VT ACO	This model has a quality metric that assesses the number of Medicaid beneficiaries that are attributed to the ACO.

Improvement Activity ID: IA_PM_13 (Medium)
Strategy/Activity Name: Population Management: Chronic Care and Preventative Care Management for Empaneled Patients

MIPS APM	Improvement Activity Evidence
CPC+	Ensure patients with complex needs and likely to benefit receive proactive, relationship-based care management. [5]
KCC (CKCC)	Complex Chronic Care Coordination Services; Chronic Care Management Services [7]
KCC (KCF)	Complex Chronic Care Coordination Services; Chronic Care Management Services [7]
MD TCOC (MDPCP)	Measures: Controlling High Blood Pressure; Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
Medicare Shared Savings Program	Quality Measure: ACO-38 All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
NGACO	Quality Measure: ACO-38 All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions

MIPS APM	Improvement Activity Evidence
OCM	Document a care plan that contains the 13 components in the Institute of Medicine Care Management Plan.[15]
PCF	Provide risk-stratified care management for all empaneled patients. Ensure all PCF Beneficiaries receive timely follow-up contact from the PCF Practice after ED visits and hospitalizations.[16]
VT ACO	Quality Measures: • Hypertension (HTN): Controlling High Blood Pressure • Prevalence of chronic disease for COPD, hypertension and diabetes

Improvement Activity ID: IA_PM_14 (Medium)
Strategy/Activity Name: Population Management: Implementation of Methodologies for Improvements in Longitudinal Care Management for High Risk Patients

MIPS APM	Improvement Activity Evidence
CPC+	Ensure all empaneled patients are risk stratified. [5]
DC	CMS will make available to qualified DCEs a conditional waiver of the requirement for direct supervision to allow for payment for certain home visits that are furnished to eligible beneficiaries proactively and in advance of potential hospitalization.[6]
KCC (CKCC)	KCEs must explain their process for how they will ensure working with partner hospices and other non-hospice providers that an appropriate plan of care will be developed for beneficiaries receiving concurrent care and ensure that the beneficiary is fully informed of what care or services are included in the care plan, what is not, what clinician or organization will be providing which services, how care coordination will be achieved, and whether there are any limitations, including services provided for transitional purposes only. [7]
MD TCOC (CRP)	Care Coordination Allowable CRP Interventions: •Care alert or care plans completed for high risk patients per protocol • Patients with a high risk of readmission are identified, per protocols, and subsequently connected with transitions of care services[10]
Medicare Shared Savings Program	Quality Measure: ACO-08: Risk-Standardized, All condition Readmission
NGACO	Measures relate to multiple aspects of population management, including ACO-8 Risk-Standardized, All Condition Readmission
OCM	The Practice shall document comprehensive Cancer care plans for all Medicare beneficiaries that meet the OCM Beneficiary Criteria in section IX.A.[15]
PCF	Provide risk-stratified care management for all empaneled patients.[16]
VT ACO	Quality Measures: • All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions • Follow-up after discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence • Death rate due to suicide • Prevalence of chronic disease for COPD, hypertension and diabetes • Percentage of patients that receive appropriate asthma medication management • Risk-Standardized, All Condition Readmission

Improvement Activity ID: IA_PM_15 (Medium)
Strategy/Activity Name: Population Management: Implementation of Episodic Care Management Practice Improvements

MIPS APM	Improvement Activity Evidence
CPC+	Ensure all patients receive timely follow-up contact from your practice after ED visits and hospitalizations, as clinically indicated. [5]
DC	CMS will make available to qualified DCEs a conditional waiver of the requirement for direct supervision to allow for payment for certain home visits that are furnished to eligible beneficiaries proactively and in advance of potential hospitalization.[6]

MIPS APM	Improvement Activity Evidence
MD TCOC (CRP)	The Hospital is expected to use the requested data in its efforts to deliver seamless, coordinated care for CRP Beneficiaries with whom the Hospital has a treatment relationship.[11]
MD TCOC (MDPCP)	To successfully prevent avoidable hospitalizations, Participant Practices may leverage disease registries, staff such as health coaches and educators (including CHWs), and partnerships with the non-clinical community—all of which can help identify and address gaps in care for at-risk beneficiaries. Participant Practices must address opportunities to improve transitions of care for attributed beneficiaries, focusing on hospital and ED discharges, as well as post-acute care facility usage and interactions with specialists.[12]
Medicare Shared Savings Program	Quality Measure: • ACO-08: Risk-Standardized, All condition Readmission • ACO-38 All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
NGACO	ACO-8 Risk-Standardized, All Condition Readmission and ACO-38 All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
OCM	The Practice must provide functions of patient navigation to all Medicare beneficiaries that meet the OCM Beneficiary Criteria in section IX.A.[15]
PCF	Provide risk-stratified care management for all empaneled patients. Ensure all PCF Beneficiaries receive timely follow-up contact from the PCF Practice after ED visits and hospitalizations.[16]
RO	The Treatment Summary Communication measure is a process measure that assesses the ‘‘percentage of patients, regardless of age, with a diagnosis of cancer that have undergone brachytherapy or external beam RT who have a treatment summary report in the chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment.[17]
VT ACO	Quality Measures: • All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions • Follow-up after discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence • Percentage of patients that receive appropriate asthma medication management • Risk-Standardized, All Condition Readmission

Improvement Activity ID: IA_CC_9 (Medium)
Strategy/Activity Name: Care Coordination: Implementation of Practices/Processes for Developing Regular Individual Care Plans

MIPS APM	Improvement Activity Evidence
BPCI Advanced	Quality Measure: Advance Care Plan
CEC	Quality Measure: Advance Care Plan
DC	Document and communicate clinical care to their patients or other health care providers.[6]
KCC (CKCC)	Measures: • ESRD Optimal Starts • Gains in Patient Activation (PAM) Scores at 12 Months
MD TCOC (CRP)	ECIP: Patient and Caregiver Engagement: Increase the likelihood of better health at lower cost through patient education and ongoing communication throughout the clinical episode.[10] HCIP: Advanced directives obtained per protocol.[10]
Medicare Shared Savings Program	To be eligible for participation, the ACO must submit a description of its individualized care program, along with a sample individualized care plan and describe additional populations that would benefit from individualized care plans.[13]
NGACO	The ACO shall implement processes and protocols ensuring individualized care for Beneficiaries, such as through personalized care plans. [14]
OCM	Document a care plan that contains the 13 components in the Institute of Medicine Care Management Plan. The Practice must provide practice-level certification at intervals no more frequent than quarterly that it completes and documents a care plan for each Medicare beneficiary that meets the OCM Beneficiary Criteria in section IX.A.[15]
PCF	Collaborate with all high-risk PCF Beneficiaries to develop and maintain documented personalized care plans addressing their goals, preferences, and values.[16]

MIPS APM	Improvement Activity Evidence
RO	Advance Care Plan (NQF #0326; CMS Quality ID #047

Improvement Activity ID: IA_CC_10 (Medium)
Strategy/Activity Name: Care Coordination: Care Transition Documentation Practice Improvements

MIPS APM	Improvement Activity Evidence
BPCI Advanced	AMI Excess Days quality measure: Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (CMS 2706; NQF #2881) [1]
CPC+	Ensure all patients receive timely follow-up contact from practice after ED visits and hospitalizations, as clinically indicated. [5]
DC	Seeking benefit and other design enhancements, that provide flexibility in FFS payment rules and encourage beneficiaries to seek high value services and providers and engage in self-care, which include: • Post-discharge home visits • Care management home visits[6]
MD TCOC (CRP)	The Hospital is expected to use the requested data in its efforts to deliver seamless, coordinated care for CRP Beneficiaries with whom the Hospital has a treatment relationship.[11]
Medicare Shared Savings Program	The ACO must have a written plan to encourage and promote use of enabling technologies for improving care coordination for beneficiaries and partner with long-term and post-acute care providers, both inside and outside the ACO, to improve care coordination for its assigned beneficiaries. [13]
NGACO	Benefit enhancement -Post-discharge home visits[14]
PCF	Ensure all PCF Beneficiaries receive timely follow-up contact from the PCF Practice after ED visits and hospitalizations. [16]
RO	Treatment Summary Communication measure
VT ACO	Suicide and substance abuse disorder target-follow up after discharge from the emergency department for mental health. Suicide and substance abuse disorder target-follow up after discharge from the ED for alcohol or other drug dependencies[18]

Improvement Activity ID: IA_CC_17 (High)
Strategy/Activity Name: Care Coordination: Patient Navigator Program

MIPS APM	Improvement Activity Evidence
MD TCOC (CRP)	Care Coordination and Care Transition Allowable ECIP Interventions: • Patient risk assessment/stratification is used to target services. • Assignment of a care manager/ coordinator/ navigator to follow patient across care settings (e.g., to help coordinate follow-up appointments and to connect patient to needed community resources). • Performance of medication reconciliation. • Remote patient consultation monitoring. [9]
OCM	The Practice must provide functions of patient navigation to all Medicare beneficiaries that meet the OCM Beneficiary Criteria in section IX.A[15]

Improvement Activity ID: IA_BE_6 (High)
Strategy/Activity Name: Beneficiary Engagement: Collection and Follow-up on Patient Experience and Satisfaction Data on Beneficiary Engagement

MIPS APM	Improvement Activity Evidence
BPCI Advanced	CMS will administer and analyze a BPCI Advanced Beneficiary experience survey for purposes of conducting the Model Evaluation. [1]
CEC	In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) [2]
CJR	Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) is used for public reporting [3]
CPC+	CMS will administer a subset of CAHPS survey to a sample of the CPC+ Practice's entire patient population [5]
MD TCOC (CRP)	The State will measure patient satisfaction, the effectiveness of care transitions, physician participation in public programs, hospital process of care measures, and measures of hospital care (e.g., readmissions and complications).[8]
MD TCOC (MDPCP)	Quality Measure: CG-CAHPS Survey 3.0 - Modified for CPC+
Medicare Shared Savings Program	To be eligible for participation, the ACO must describe how it will encourage and promote use of enabling technologies for improving care coordination for beneficiaries.[13]
NGACO	CAHPS measures
OCM	Quality measures based on Patient-reported Experience of Care survey will be administered, analyzed, and reported by a third party that is directly contracted by CMS.[15]
PCF	The PCF Practice shall procure a CMS-approved vendor to conduct the Consumer Assessment of Healthcare Providers & Systems (CAHPS®), also known as the Patient Experience of Care Surveys (PECS)[16]
RO	CAHPS® Cancer Care Radiation Therapy Survey[17]
VT ACO	CAHPS measures

Improvement Activity ID: IA_BE_13 (Medium)
Strategy/Activity Name: Beneficiary Engagement: Regularly Assess the Patient Experience of Care Through Surveys, Advisory Councils and/or Other Mechanisms

MIPS APM	Improvement Activity Evidence
CEC	In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) [2]
CJR	Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) is used for public reporting [3]
CPC+	CAHPS surveys: • Convene a PFAC and integrate recommendations into care and practice improvement activities. [5]
MD TCOC (CRP)	The State will measure patient satisfaction, the effectiveness of care transitions, physician participation in public programs, hospital process of care measures, and measures of hospital care (e.g., readmissions and complications).[8]
MD TCOC (MDPCP)	Quality Measure: CG-CAHPS Survey 3.0 - Modified for CPC+
Medicare Shared Savings Program	CAHPS for MIPS
NGACO	CAHPS measures

MIPS APM	Improvement Activity Evidence
OCM	The Practice is required to report quality measures and clinical data to the Data Registry. Mandated quality measure includes patient-reported experience of care. [15]
PCF	The PCF Practice shall procure a CMS-approved vendor to conduct the Consumer Assessment of Healthcare Providers & Systems (CAHPS®), also known as the Patient Experience of Care Surveys (PECS)[16]
RO	CAHPS® Cancer Care Radiation Therapy Survey[17]
VT ACO	CAHPS measures

Improvement Activity ID: IA_BE_15 (Medium)
Strategy/Activity Name: Beneficiary Engagement: Engagement of Patients, Family and Caregivers in Developing a Plan of Care

MIPS APM	Improvement Activity Evidence
DC	DC Participant Providers, Preferred Providers, and other individuals or entities performing functions or services related to DCE activities will be permitted to provide in-kind items or services to beneficiaries, if the following conditions are satisfied: 1. There is a direct connection between the items or services and the medical care of the beneficiary; 2. The items or services are preventative care items and services or advance one or more goals of the Model, including adherence to a treatment regime, adherence to a drug regime, adherence to a follow-up care plan[6]
MD TCOC (CRP)	Comprehensive, individualized patient/family education (considering health literacy, preferred method of education, use of Teach Back) documented. [10]
Medicare Shared Savings Program	To be eligible for participation, as part of the ACO's process to promote beneficiary engagement, it must address beneficiary engagement and shared decision making that considers the beneficiaries' unique needs, preferences, values, and priorities. [13]
NGACO	The ACO shall implement processes and protocols that relate to process to ensure Beneficiary/caregiver engagement, and shared decision-making processes employed by Next Generation Participants that takes into account the Beneficiaries' unique needs, preferences, values, and priorities[14]
OCM	The OCM Participant shall document comprehensive Cancer care plans for all OCM Beneficiaries. Treatment goals are a requirement for the care plans. [15]
RO	The Advance Care Plan measure quantifies the number of patients who have an advance care plan or a surrogate decision-maker documented in the medical record, or documentation that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate. [17]

Improvement Activity ID: IA_PSPA_11 (High)
Strategy/Activity Name: Patient Safety & Practice Assessment: Participation in CAHPS or Other Supplemental Questionnaire

MIPS APM	Improvement Activity Evidence
CEC	CEC Quality Measure Set includes CAHPS measures [2]
CJR	Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) is used for public reporting [3]
CPC+	CMS will administer a subset of CAHPS survey to a sample of the CPC+ Practice's entire patient population [5]
MD TCOC (CRP)	The State will measure patient satisfaction, the effectiveness of care transitions, physician participation in public programs, hospital process of care measures, and measures of hospital care (e.g., readmissions and complications). [8]
MD TCOC (MDPCP)	Quality Measure: CG-CAHPS Survey 3.0 - Modified for CPC+
Medicare Shared Savings Program	CAHPS for MIPS

MIPS APM	Improvement Activity Evidence
NGACO	Pay for Reporting requires CAHPS measures[14]
OCM	Quality measures based on Patient-reported Experience of Care survey will be administered, analyzed, and reported by a third party that is directly contracted by CMS[15]
PCF	The PCF Practice shall procure a CMS-approved vendor to conduct the Consumer Assessment of Healthcare Providers & Systems (CAHPS®), also known as the Patient Experience of Care Surveys (PECS)[16]
RO	CAHPS® Cancer Care Radiation Therapy Survey[17]
VT ACO	CAHPS measures

Improvement Activity ID: IA_PSPA_17 (Medium)
Strategy/Activity Name: Patient Safety & Practice Assessment: Implementation of Analytic Capabilities to Manage Total Cost of Care for Practice Population

MIPS APM	Improvement Activity Evidence
BPCI Advanced	This model operates under a total cost of care concept (possibly with exceptions). Therefore, participants will need to develop analytic capabilities.
CJR	The CJR model holds participant hospitals financially accountable for the quality and cost of a CJR episode of care and incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers.[4]
CPC+	The payment redesign methodologies under the Model will facilitate investment in primary care by aligning payment incentives with the changes primary care practices need to make to provide high quality, whole-person, patient-centered care and to manage total costs of care[5]
KCC (CKCC)	• CKCC Graduated: Yes, via shared losses and savings. However, Graduated KCEs who select one-sided risk (Level 1) are not liable for shared losses in their first performance year. • CKCC Professional: Yes, via shared losses and savings. • CKCC Global: Yes, via shared losses and savings.[7]
KCC (KCF)	Episode-based cost measure that impacts the Performance Based Adjustment (PBA) applied to model payments.[7]
MD TCOC (CRP)	This model operates under a total cost of care concept (possibly with exceptions). Therefore, participants will need to develop analytic capabilities
MD TCOC (MDPCP)	This model operates under a total cost of care concept (possibly with exceptions). Therefore, participants will need to develop analytic capabilities.
Medicare Shared Savings Program	As a condition of participation in the Shared Savings Program, ACOs are expected to have processes in place to independently identify and produce the data they believe are necessary to best evaluate the health needs of their patient population, improve health outcomes, monitor provider/supplier quality of care and patient experience of care, and produce efficiencies in utilization of services… this ability to self-manage is a critical skill for each ACO to develop, leading to an understanding of the unique patient population that it serves." And later as a rationale for sharing claims data: "we believe that more complete beneficiary-identifiable information would enable practitioners in an ACO to better coordinate and target care strategies towards the individual beneficiaries who may ultimately be assigned to them.[13]
OCM	Participants are responsible for total cost of care.[15]

Improvement Activity ID: IA_PSPA_18 (Medium)
Strategy/Activity Name: Patient Safety & Practice Assessment: Measurement and Improvement at the Practice and Panel Level

MIPS APM	Improvement Activity Evidence
BPCI Advanced	CMS will administer and analyze a BPCI Advanced Beneficiary experience survey [1]
CEC	CMS will calculate the End Stage Renal Disease (ESRD) Seamless Care Organization's (ESCO) Total Quality Score (TQS) for the Comprehensive ESRD Care Initiative (CEC Initiative) using a set of standardized quality measures. These measures align with the National Quality Strategy (NQS) priorities and will encourage the ESCO to meet high standards of clinical care, patient-centeredness, and care coordination across multiple care settings for ESRD Beneficiaries. [2]
CJR	Quality Measures used for reporting: • Hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty. • Hospital Consumer Assessment of Healthcare Providers and Systems Survey.[3]
CPC+	Use data to continuously improve your patients' health, experience, and quality of care, and decrease cost. [5]
DC	CMS will provide DCEs with operational reports on a regular basis. These reports may include, but will not be limited to: Quarterly and Annual Utilization; Monthly Expenditures; Beneficiary Data Sharing Preferences; Monthly Claims Lag; and Beneficiary Alignment reports[6]
KCC (CKCC)	The benchmarking methodology is common across risk options.[7]
KCC (KCF)	Establish reporting mechanisms and ensuring compliance with program Model requirements, including but not limited to reporting on quality measures.[7]
MD TCOC (CRP)	HIT will enable quality measurement, reporting and feedback, and use of electronic health records (EHRs) as a part of care redesign across treating health care providers.[9]
Medicare Shared Savings Program	To be eligible for participation, the ACO must develop an infrastructure to… internally report on quality and cost metrics that enables the ACO to monitor, provide feedback, and evaluate its [participants'] performance and to use these results to improve care over time. Quality reporting requirements in ACO.[13]
NGACO	ACO reporting of results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) or other patient experience surveys[14]
OCM	Mandated practice redesign activity of using data to continuously improve its performance and achieve the goals of OCM. [15]
PCF	The PCF Practice shall procure a CMS-approved vendor to conduct the Consumer Assessment of Healthcare Providers & Systems (CAHPS®), also known as the Patient Experience of Care Surveys (PECS)[16]
VT ACO	CAHPS measures as well as other preventative and utilization measures.

Improvement Activity ID: IA_BMH_2 (Medium)
Strategy/Activity Name: Tobacco Use

MIPS APM	Improvement Activity Evidence
KCC (CKCC)	Lifestyle interventions - Encourage health-promoting behaviors such as smoking cessation[7]
KCC (KCF)	Lifestyle interventions - Encourage health-promoting behaviors such as smoking cessation[7]
Medicare Shared Savings Program	Quality Measure: ACO-17 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
OCM	Survivorship plan, including a summary of treatment and information on recommended follow-up activities and surveillance, as well as risk reduction and health promotion activities[15]
VT ACO	Quality Measure: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

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9. Episode Care Improvement Program (ECIP) Track Implementation Protocol Performance Period Six (January 2021 - December 2021).
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17. Medicare Program; Specialty Care Models To Improve Quality of Care and Reduce Expenditures 85 FR 61114 Document Date: September 29, 2020
18. Centers for Medicare & Medicaid Services (CMS) and the State of Vermont. (2016). Vermont All-Payer Accountable Care Organization Model Agreement.
19. Since (a) is capped at (b), the IA category score cannot exceed 100%.

Version History

Date	Change Description
3/1/2021	Original version