Scores for Improvement Activities in MIPS APMs in the 2020 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," and participants in MIPS APMs receive special MIPS scoring under the "APM scoring standard." 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 according to the APM scoring standard. 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 activity performance category for participating in MIPS APMs. For the 2020 performance period, the list of MIPS APMs include:

- Maryland Primary Care Program (MD PCP)
- Oncology Care Model (OCM; all Tracks)
- Next Generation Accountable Care Organization (NGACO) Model
- Comprehensive End-Stage Renal Disease Care (CEC) Model (all Tracks)
- Bundled Payments for Care Improvement (BPCI) Advanced
- Independence at Home (IAH) Demonstration
- Comprehensive Primary Care Plus (CPC+) Model (all Tracks)
- Vermont All-Payer ACO (VT ACO) Model
- Medicare Shared Savings Program (MSSP) (all Tracks, including the Medicare ACO Track 1+ Model)

The table beginning on page 3 shows the Improvement Activities performance category score CMS will assign participants in each MIPS APMs for the 2020 performance year. MIPS eligible clinicians must earn 40 points in the Improvement Activities performance category in order to receive full credit in that performance category for the 2020 performance year. Note that all APM Entity groups in a MIPS APM will 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 2020, 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 2020 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 2020, 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.

In the 2020 performance year, the Improvement Activities performance category for all MIPS APMs is weighted at 20 percent under the APM Scoring Standard.

Improvement Activity ID	Strategy/ Activity Name	MD Total Cost of Care (MD Primary Care Program)	Oncology Care Model (One-sided and Two-sided)	NGACO	CEC	BPCI-Advanced	IAH	CPC+ Track 1 and Track 2	VT ACO	Medicare Shared Savings Program
IA_EPA_1 (High)	Expanded Practice Access: Provide 24/7 access to MIPS eligible clinicians or groups who have real-time access to patient's medical record		[2] 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				The goal of the IAH demonstration is to provide care in the home	[7] Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR.		
IA_EPA_3 (Medium)	Expanded Practice Access: Collection and use of patient experience and satisfaction data on access	[1] Patient experience of care: The State will measure patient satisfaction	[2] Mandated quality measure assessing person and caregiver experience and outcomes	[3] The ACO must completely, timely, and accurately report quality measure data using CAHPS or other patient experience surveys	[4] The Kidney Disease Quality of Life (KDQOL) survey and the In-Center Hemodialysis (ICH) CAHPS	[5] CMS will administer and analyze a BPCI Advanced Beneficiary experience survey for purposes of conducting the Model Evaluation.		[7] CMS will administer a subset of CAHPS survey to a sample of the CPC+ Practice's entire patient population		ACO-1 (CAHPS: Getting Timely care, Appointments, and Information) and ACO-4 (CAHPS: Access to Specialists)

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IA_PM_14 (Medium)	Population Management: Implementation of methodologies for improvements in longitudinal care management for high risk patients		[2] The Practice shall document comprehensive Cancer care plans for all Medicare beneficiaries that meet the OCM Beneficiary Criteria in section IX.A	[3] Measures relate to multiple aspects of population management, including Risk Standardized, All Condition Readmission and other preventative health and care coordination measures			[6] Patient preferences documented in the medical record	[7] Ensure all empaneled patients are risk stratified		Quality reporting requirements for ACO
IA_CC_9 (Medium)	Care Coordination: Implementation of practices/ processes for developing regular individual care plans		[2] 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	[3] The ACO shall implement processes and protocols ensuring individualized care for Beneficiaries, such as through personalized care plans		[5] Advance Care Plan quality measure	[6] Patient preferences documented in the medical record			[9] 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

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			care plan for each Medicare beneficiary that meets the OCM Beneficiary Criteria in section IX.A							care plans; also measured by CAHPS for ACO items
IA_CC_10 (Medium)	Care Coordination: Care transition documentation practice improvements			[3] Benefit enhancement -Post-discharge home visits		[5] AMI Excess Days quality measure: Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (CMS 2706; NQF #2881)	[6] Contact with beneficiaries within 48 hours upon admission to the hospital, and discharge from the hospital and/or ED; Patient preferences documented in medical record	[7] Ensure all patients receive timely follow-up contact from practice after ED visits and hospitalizations, as clinically indicated	[8] 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	[9] 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

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IA_CC_17 (High)	Care Coordination: Patient Navigator Program		[2] The Practice must provide functions of patient navigation to all Medicare beneficiaries that meet the OCM Beneficiary Criteria in section IX.A				[6] Contact with beneficiaries within 48 hours upon admission to the hospital, and discharge from the hospital and/or ED			
IA_BE_6 (High)	Beneficiary Engagement: Collection and follow-up on patient experience and satisfaction data on beneficiary engagement	[1] Proposed quality measures: Increase Patient Satisfaction – Hospital Increase Patient Satisfaction – Home Health Increase Patient Satisfaction – Nursing Homes Increase Patient Satisfaction – Ambulatory Care	[2] 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	[3] 8 CAHPS measures	[4] ICH CAHPS	[5] CMS will administer and analyze a BPCI Advanced Beneficiary experience survey for purposes of conducting the Model Evaluation.		[7] CMS will administer a subset of CAHPS survey to a sample of the CPC+ Practice's entire patient population		[9] 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 And ACO-6 (CAHPS: Shared Decision Making)

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IA_BE_15 (Medium)	Beneficiary Engagement: Engagement of patients, family and caregivers in developing a plan of care		[2] The OCM Participant shall document comprehensive Cancer care plans for all OCM Beneficiaries. Treatment goals are a requirement for the care plans	[3] 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			[6] Patient preferences documented in the medical record			[9] 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 takes into account the beneficiaries' unique needs, preferences, values, and priorities. Also part of CAHPS for ACO
IA_PSPA_17 (Medium)	Patient Safety & practice Assessment: Implementation of analytic capabilities to manage total cost of care for	This model operates under a total cost of care concept (possibly with exceptions). Therefore	[2] Participants are responsible for total cost of care.			This model operates under a total cost of care concept (possibly with exceptions). Therefore	This demonstration awards annual shared savings bonuses if practices lower their patients'	[7] The payment redesign methodologies under the Model will facilitate investment in primary care by		[9] As a condition of participation in the Shared Savings Program, ACOs are expected to have processes in place to

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	practice population	participants will need to develop analytic capabilities				participants will need to develop analytic capabilities	total cost of care while meeting quality targets	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		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
IA_BMH_2 (Medium)	Behavioral and Mental Health: Tobacco use	[1] Payment for Alcohol and Substance Use Disorder. The State may submit to CMS a proposal to include payments for Medicare beneficiaries'	This is a mandated implementation activity	[3] ACO-17 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	[4] Tobacco Use: Screening and Cessation Intervention measure				[8] Chronic Condition Milestone: tobacco use assessment and cessation interventions.	ACO-17 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

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		alcohol, substance use disorder and wrap-around recovery services in a new or existing Model Program								
Number of 'medium' weighted Improvement Activities		9	29	23	12	10	4	16	7	25
Number of 'high' weighted Improvement Activities		2	7	3	2	1	2	5	4	4
Total number of Improvement Activities		11	36	26	14	11	6	21	12	29
Subtotal score from Improvement Activities		130	430	290	160	120	80	260	160	330
Base score for being an APM		20	20	20	20	20	20	20	20	20
(a) Total Number of Points Earned by the APM		150	450	310	180	140	100	280	180	350
(b) Total possible points earned		40	40	40	40	40	40	40	40	40
Improvement activities category score [(a)/(b)] x 100%[10]		100%	100%	100%	100%	100%	100%	100%	100%	100%

Sources

1. Centers for Medicare & Medicaid Services (CMS) and the State of Maryland. (2018). Maryland Total Cost of Care Model State Agreement.
2. Centers for Medicare & Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI). (N.d.). Oncology Care Model Participation Agreement. Baltimore, MD.
3. Centers for Medicare & Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI). (Modified June 23, 2016). Next Generation ACO Model Participation Agreement. Baltimore, MD.
4. Centers for Medicare and Medicaid Services (CMS). (January 1, 2018). First Amended and Restated Participation Agreement (LDO 2015 Starter - CEC Model).
5. Centers for Medicare & Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI). (Updated August 1, 2018). Bundled Payments for Care Improvement (BCPI) Advanced Participation Agreement. Baltimore, MD.
6. Centers for Medicare and Medicaid Services (CMS). (N.d.) Independence at Home Demonstration Participation Agreement.
7. Centers for Medicare and Medicaid Services (CMS). (Last Modified October 19, 2018). Comprehensive Primary Care Plus Model Practice Participation Agreement (Amended and Restated).
8. Centers for Medicare & Medicaid Services (CMS) and the State of Vermont. (2016). Vermont All-Payer Accountable Care Organization Model Agreement.
9. Current Shared Savings Program 42 CFR 425.112(b)(4) Document Date: June 9, 2015.
10. Since (a) is capped at (b), the IA category score cannot exceed 100%.