Scores for Improvement Activities in MIPS APMs in the 2017 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." 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. 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.

MIPS APMs for the 2017 Performance Period:

- Medicare Shared Savings Program Accountable Care Organizations - Tracks 1, 2 and 3
- Next Generation ACO Model
- Comprehensive ESRD Care (CEC) Model (LDO arrangement)
- Comprehensive ESRD Care (CEC) Model (non- LDO arrangement one-sided risk arrangement)
- Comprehensive ESRD Care (CEC) Model (non- LDO two-sided risk arrangement)
- Oncology Care Model (OCM) (one-sided risk arrangement)
- Oncology Care Model (OCM) (two-sided risk arrangement)
- Comprehensive Primary Care Plus (CPC+) Model

The table below shows the improvement activities performance category score CMS will assign participants in each MIPS APMs for the 2017 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 2017 performance year. As shown below, APM Entities participating in the MIPS APMs will receive a full score for the improvement activities performance category in 2017 and therefore will not need to submit additional improvement activity information for MIPS. All APM Entity groups in a MIPS APM will receive the same baseline improvement activities score that we assign for the MIPS APM in which they participate.

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 2017 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 2017, MIPS APM participants will not have any need to independently attest to additional activities. In the event that CMS amends through future rulemaking the improvement activities scoring or assessment required to reach the maximum score 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.

CMS determined that the Comprehensive Primary Care Plus (CPC+) Model meets the criteria to be a Medical Home Model; therefore, its participants will receive full credit under the improvement activities performance category without the need for CMS to assess its required improvement activities.

The weights applied to the improvement activities performance category under the APM scoring standard in the 2017 performance year are as follows:

- The Shared Savings Program and the Next Generation ACO Model improvement activities performance category weight is 20 percent.
- MIPS APMs other than the Shared Savings Program and the Next Generation ACO Model (which includes the CPC+ Model, the CEC Model, and the OCM) improvement activities performance category weight is 25 percent.

Improvement Activity ID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program Tracks 1, 2 and 3	Next Gener-ation ACO Model	Compre-hensive ESRD Care Model	Oncology Care Model
IA_EPA_1	Expanded Practice Access	Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: • Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care); • Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or • Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management	High				√
IA_EPA_2	Expanded Practice Access	Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or teleaudiology pilots that assess ability to still deliver quality care to patients.	Medium	√	√		
IA_EPA_3	Expanded Practice Access	Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs.	Medium	√	√		√
IA_PM_5	Population Management	Take steps to improve health status of communities, such as collaborating with key partners and stakeholders to implement evidenced-based practices to improve a specific chronic condition. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist MIPS eligible clinicians and groups	Medium	√			

		with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.					
IA_PM_7	Population Management	Use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.	High				√
IA_PM_8	Population Management	Participation in CMMI models such as the Million Hearts Cardiovascular Risk Reduction Model.	Medium		√	√	√
IA_PM_9	Population Management	Participation in research that identifies interventions, tools or processes that can improve a targeted patient population.	Medium		√	√	
IA_PM_10	Population Management	Participation in a QCDR, clinical data registries, or other registries run by other government agencies such as FDA, or private entities such as a hospital or medical or surgical society. Activity must include use of QCDR data for quality improvement (e.g., comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcome).	Medium				√
IA_PM_11	Population Management	Implementation of regular reviews of targeted patient population needs which includes access to reports that show unique characteristics of eligible professional's patient population, identification of vulnerable patients, and how clinical treatment needs are being tailored, if necessary, to address unique needs and what resources in the community have been identified as additional resources.	Medium				√
IA_PM_12	Population Management	Empanel (assign responsibility for) the total population, linking each patient to a MIPS eligible clinician or group or care team. Empanelment is a series of processes that assign each active patient to a MIPS eligible clinician or group and/or care team, confirm assignment with patients and clinicians, and use the resultant patient panels as a foundation for individual patient and population health management.	Medium	√	√	√	√

		Empanelment identifies the patients and population for whom the MIPS eligible clinician or group and/or care team is responsible and is the foundation for the relationship continuity between patient and MIPS eligible clinician or group /care team that is at the heart of comprehensive primary care. Effective empanelment requires identification of the "active population" of the practice: those patients who identify and use your practice as a source for primary care. There are many ways to define "active patients" operationally, but generally, the definition of "active patients" includes patients who have sought care within the last 24 to 36 months, allowing inclusion of younger patients who have minimal acute or preventive health care.					
IA_PM_13	Population Management	Proactively manage chronic and preventive care for empaneled patients that could include one or more of the following: • Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning; • Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target; • Use pre-visit planning to optimize preventive care and team management of patients with chronic conditions; • Use panel support tools (registry functionality) to identify services due; • Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due; and/or • Routine medication reconciliation.	Medium	√	√	√	√

IA_PM_14	Population Management	Provide longitudinal care management to patients at high risk for adverse health outcome or harm that could include one or more of the following: • Use a consistent method to assign and adjust global risk status for all empaneled patients to allow risk stratification into actionable risk cohorts. Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification; • Use a personalized plan of care for patients at high risk for adverse health outcome or harm, integrating patient goals, values and priorities; and/or • Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients.	Medium	√	√		√
IA_PM_15	Population Management	Provide episodic care management, including management across transitions and referrals that could include one or more of the following: • Routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings, including symptom and disease management, and medication reconciliation and management; and/or • Managing care intensively through new diagnoses, injuries and exacerbations of illness.	Medium				√
IA_PM_16	Population Management	Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following: • Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups; • Integrate a pharmacist into the care team; and/or • Conduct periodic, structured medication reviews.	Medium	√	√	√	√
IA_CC_1	Care Coordination	Performance of regular practices that include providing specialist reports back to the referring MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the certified EHR technology.	Medium	√			√

IA_CC_2	Care Coordination	Timely communication of test results defined as timely identification of abnormal test results with timely follow-up.	Medium	√	√		
IA_CC_6	Care Coordination	Participation in a Qualified Clinical Data Registry, demonstrating performance of activities that promote use of standard practices, tools and processes for quality improvement (e.g., documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups).	Medium				√
IA_CC_8	Care Coordination	Implementation of practices/processes that document care coordination activities (e.g., a documented care coordination encounter that tracks all clinical staff involved and communications from date patient is scheduled for outpatient procedure through day of procedure).	Medium	√		√	
IA_CC_9	Care Coordination	Implementation of practices/processes to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s).	Medium	√	√		√
IA_CC_10	Care Coordination	Implementation of practices/processes for care transition that include documentation of how a MIPS eligible clinician or group carried out a patient-centered action plan for first 30 days following a discharge (e.g., staff involved, phone calls conducted in support of transition, accompaniments, navigation actions, home visits, patient information access, etc.).	Medium	√	√		
IA_CC_11	Care Coordination	Establish standard operations to manage transitions of care that could include one or more of the following: • Establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information and seamless transitions in care; and/or • Partner with community or hospital-based transitional care services.	Medium				√
IA_CC_12	Care Coordination	Establish effective care coordination and active referral management that could include one or more of the following: • Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and MIPS eligible clinician or MIPS eligible clinician group expectations between settings.	Medium				√

		Provide patients with information that sets their expectations consistently with the care coordination agreements; • Track patients referred to specialist through the entire process; and/or • Systematically integrate information from referrals into the plan of care.					
IA_CC_13	Care Coordination	Ensure that there is bilateral exchange of necessary patient information to guide patient care that could include one or more of the following: • Participate in a Health Information Exchange if available; and/or • Use structured referral notes.	Medium	√			√
IA_CC_14	Care Coordination	Develop pathways to neighborhood/community-based resources to support patient health goals that could include one or more of the following: • Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information; and/or • Provide a guide to available community resources.	Medium	√			√
IA_BE_1	Beneficiary Engagement	In support of improving patient access, performing additional activities that enable capture of patient reported outcomes (e.g., home blood pressure, blood glucose logs, food diaries, at-risk health factors such as tobacco or alcohol use, etc.) or patient activation measures through use of certified EHR technology, containing this data in a separate queue for clinician recognition and review.	Medium				√
IA_BE_6	Beneficiary Engagement	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.	High	√	√	√	√
IA_BE_9	Beneficiary Engagement	Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.	Medium				√
IA_BE_12	Beneficiary Engagement	Use evidence-based decision aids to support shared decision-making.	Medium	√			
IA_BE_13	Beneficiary Engagement	Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.	Medium	√	√	√	√

IA_BE_14	Beneficiary Engagement	Engage patients and families to guide improvement in the system of care.	Medium	√	√		
IA_BE_15	Beneficiary Engagement	Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the certified EHR technology.	Medium	√	√		√
IA_BE_20	Beneficiary Engagement	Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community.	Medium				√
IA_PSPA_11	Patient Safety & Practice Assessment	Participation in the Consumer Assessment of Healthcare Providers and Systems Survey or other supplemental questionnaire items (e.g., Cultural Competence or Health Information Technology supplemental item sets).	High	√	√	√	√
IA_PSPA_17	Patient Safety & Practice Assessment	Build the analytic capability required to manage total cost of care for the practice population that could include one or more of the following: • Train appropriate staff on interpretation of cost and utilization information; and/or • Use available data regularly to analyze opportunities to reduce cost through improved care.	Medium	√			√
IA_PSPA_18	Patient Safety & Practice Assessment	Measure and improve quality at the practice and panel level that could include one or more of the following: • Regularly review measures of quality, utilization, patient satisfaction and other measures that may be useful at the practice level and at the level of the care team or MIPS eligible clinician or group (panel); and/or • Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.	Medium	√	√	√	√
IA_PSPA_20	Patient Safety & Practice Assessment	Ensure full engagement of clinical and administrative leadership in practice improvement that could include one or more of the following: • Make responsibility for guidance of practice change a component of clinical and administrative leadership roles; • Allocate time for clinical and administrative leadership for practice improvement efforts, including participation in regular team meetings; and/or	Medium	√			

		• Incorporate population health, quality and patient experience metrics in regular reviews of practice performance.					
IA_PSPA_21	Patient Safety & Practice Assessment	Implementation of fall screening and assessment programs to identify patients at risk for falls and address modifiable risk factors (e.g., Clinical decision support/prompts in the electronic health record that help manage the use of medications, such as benzodiazepines, that increase fall risk).	Medium	√	√	√	
IA_BMH_2	Behavioral and Mental Health	Tobacco use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including tobacco use screening and cessation interventions (refer to NQF #0028) for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence.	Medium	√	√	√	√
IA_BMH_4	Behavioral and Mental Health	Depression screening and follow-up plan: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including depression screening and follow-up plan (refer to NQF #0418) for patients with co-occurring conditions of behavioral or mental health conditions.	Medium	√	√	√	√
IA_BMH_5	Behavioral and Mental Health	Major depressive disorder: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including suicide risk assessment (refer to NQF #0104) for mental health patients with co-occurring conditions of behavioral or mental health conditions.	Medium	√	√	√	√
IA_BMH_7	Behavioral and Mental Health	Offer integrated behavioral health services to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions that could include one or more of the following: Use evidence-based treatment protocols and treatment to goal where appropriate; • Use evidence-based screening and case finding strategies to identify individuals at risk and in need of services; • Ensure regular communication and coordinated workflows between eligible clinicians in primary care and behavioral health; • Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment;	High			√	

		• Use of a registry or certified health information technology functionality to support active care management and outreach to patients in treatment; and/or • Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible.					

Number of 'medium' weighted Improvement Activities	25	19	12	26
Number of 'high' weighted Improvement Activities	2	2	3	4
Total number of Improvement Activities	**27**	**21**	**15**	**30**
Subtotal score from Improvement Activities	290	230	180	340
Base score for being an APM	20	20	20	20
Total Number of Points Earned	310	250	200	360
Total possible points earned	40	40	40	40
% of total possible points earned (capped at 100%)	**100%**	**100%**	**100%**	**100%**