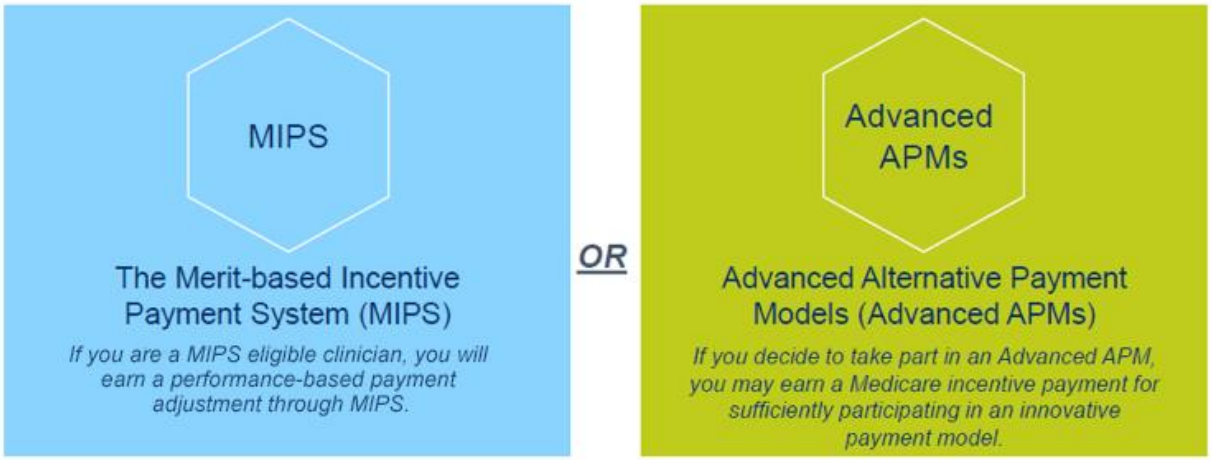
Quality Payment
PROGRAM

2018 MIPS Advancing Care Information Performance Category Fact Sheet

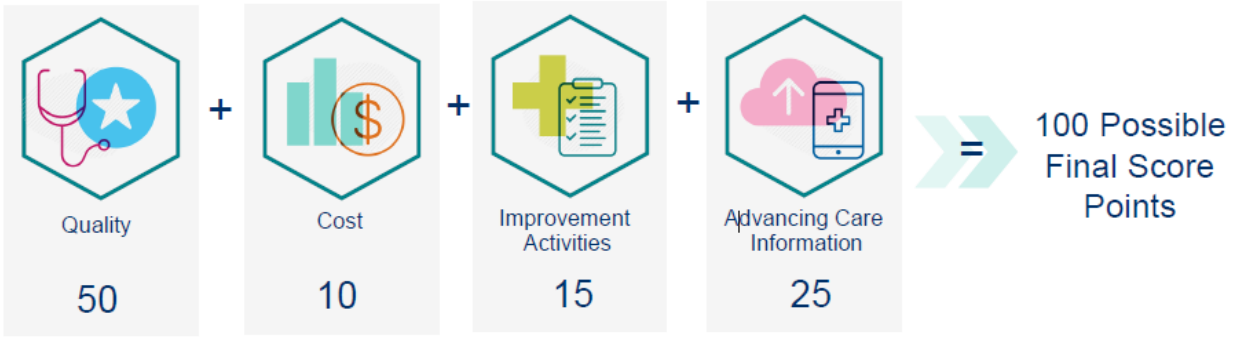
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have made major cuts to Medicare payment rates for clinicians. The law requires us to implement the Quality Payment Program and gives you 2 ways to participate:



Please note that this guide focuses on MIPS. For more information on how to participate in APMs, visit the QPP page of the CMS.gov. Additionally, clinicians participating in a MIPS APM should refer to the MIPS APMs fact sheet for more information.

Under MIPS, there are 4 performance categories that affect your future Medicare payments. Each performance category is scored by itself and has a specific weight that's part of the MIPS Final Score. The MIPS payment adjustment assessed for MIPS eligible clinicians is based on the Final Score. These are the performance category for the 2018 performance period:

MIPS Performance Categories for Year 2 (2018)



Starting in 2018, MIPS eligible clinicians may participate in MIPS individually, as a group, or as a Virtual Group.

Participate as an individual	***Participate as a group***	***Participate as a Virtual Group***
MIPS eligible clinicians participating as individuals, will have their **payment adjustment based on their individual performance.** An individual is a single clinician, identified by a single National Provider Identifier (NPI) number tied to a Taxpayer Identification Number (TIN).	MIPS eligible clinicians participating in MIPS with a group will receive a **payment adjustment based on the group's performance**. Under MIPS, a group is a single Taxpayer Identification Number (TIN) with 2 or more eligible clinicians (including at least 1 MIPS eligible clinician) as identified by their National Provider Identifiers (NPI), who have reassigned their Medicare billing rights to the TIN.	MIPS eligible clinicians participating in MIPS with a Virtual Group will receive a **payment adjustment based on the Virtual Group's performance**. A Virtual Group can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period for a year

What is the Advancing Care Information Performance Category?

The Advancing Care Information performance category promotes:

- Patient engagement
- The electronic exchange of health information using certified electronic health record technology (CEHRT).

The Advancing Care Information performance category replaced the Medicare EHR Incentive Program for eligible professionals, also known as Meaningful Use. It gives you more flexibility when you pick measures than the Medicare EHR Incentive Program did. In 2018, this performance category is worth 25% of your MIPS Final Score.

How Can I Use Certified EHR Technology to Report Advancing Care Information?

In 2018, there will still be 2 measure set options to report:

- Advancing Care Information Objectives and Measures
- 2018 Advancing Care Information Transition Objectives and Measures

The option you'll use to send in data is based on your CEHRT edition.

You can report the **Advancing Care Information Objectives and Measures** if you have:

- Technology certified to the 2015 Edition; or
- A combination of technologies certified to the 2014 and 2015 Editions that support these measures.

You can report the **2018 Advancing Care Information Transition Objectives and Measures** if you have:

- Technology certified to the 2015 Edition; or
- Technology certified to the 2014 Edition; or
- A combination of technologies certified to the 2014 and 2015 Editions

In the 2018 performance period, clinicians and groups that exclusively report the Advancing Care Information Objectives and Measures will earn a 10% bonus for using only 2015 Edition CEHRT.

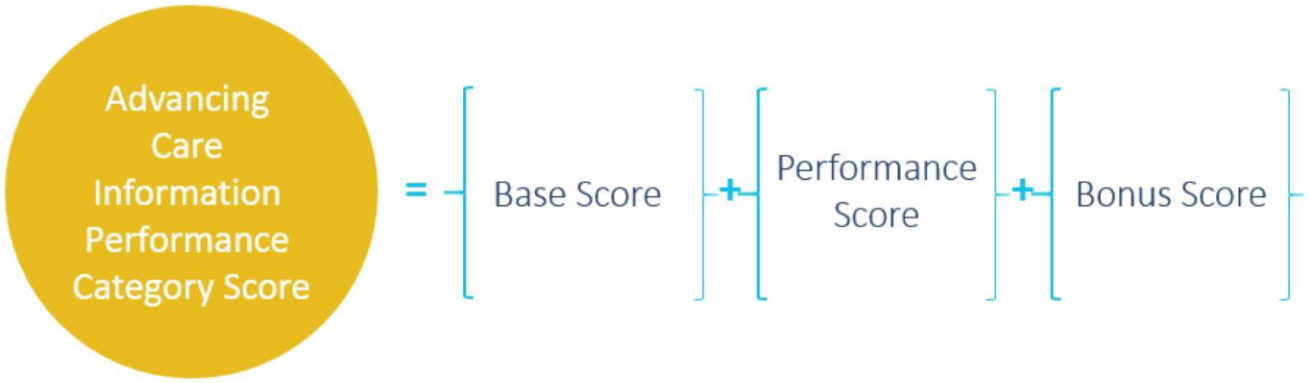
Appendix A has the full list of Advancing Care Information measures and **2018** Advancing Care Information transition measures. You can also find more details outlining each element of the Advancing Care Information measures and 2018 Advancing Care Information transition measures in the Advancing Care Information Measure Specification Fact Sheets.

How is the Advancing Care Information Performance Category Score Calculated?

For scoring in the Advancing Care Information performance category (weighted at 25% of the MIPS Final Score), you may earn a maximum score of up to **165%**, but any score above 100% will be capped at **100%**. We designed scoring this way on purpose to make sure you have the flexibility to focus on measures that are the most relevant to you and your practice.

The Advancing Care Information score is the sum of these 3 scores:

The performance score and bonus score are added to the base score to get the total Advancing Care Information performance category score:



The total Advancing Care Information performance category score will then be multiplied by the 25% Advancing Care Information category weight. This product is then added to the overall MIPS final score.

For example, if a MIPS eligible clinician receives the base score (50%) and a 40% performance score and no bonus score, they would earn a 90% Advancing Care Information performance category score. When weighted by 25%, this would add 22.5 points to the overall MIPS final score. (90 X .25 = 22.5).

When is the Advancing Care Information Score Reweighted?

You have to use CEHRT to report on the Advancing Care Information performance category measures. You have to meet certain criteria in order to qualify for a reweighting of this performance category to 0%. Not having CEHRT is not sufficient by itself to qualify for a reweighting. The reweighting to 0% means that the Advancing Care Information performance category isn't included in your MIPS final score.

Here are the 2 reasons your Advancing Care Information performance category may be reweighted:

1. **You're one of the following types of MIPS eligible clinicians who qualify for automatic reweighting:**
    - Ambulatory Surgical Center (ASC) - based MIPS eligible clinicians (begins with the 2017 performance period)
    - Hospital-based MIPS eligible clinicians (definition updated to include off-campus outpatient hospital (Place of Service Code 19))
    - Physician assistants
    - Nurse practitioners
    - Clinical nurse specialists
    - Certified registered nurse anesthetists
    - Clinicians who lack face-to-face interactions with patients

You can still choose to report if you'd like. If you do submit data, we'll score your performance and weight your Advancing Care Information performance at 25% of your MIPS final score.

To qualify as a hospital-based MIPS eligible clinician:

- If you report for MIPS as an individual clinician, you have to furnish 75% or more of your covered professional services in the inpatient hospital, on-campus outpatient hospital , off-campus outpatient hospital or emergency room settings (based on place of service codes) during the applicable determination period.
- If you report for MIPS as part of a group or virtual group, all of the MIPS eligible clinicians in the group must furnish 75% or more of their covered professional services in the inpatient hospital, on-campus outpatient hospital, or, off-campus outpatient hospital emergency room settings (based on place of service codes) during the determination period prior to the performance period as specified by CMS.

If reporting for MIPS as a group, all MIPS eligible clinicians in the group must qualify for reweighting in order for the Advancing Care Information performance category score to be reweighted.

However, if you're one of these types of clinicians, you can still choose to report if you'd like. If you do submit data, we'll score your performance and weight your Advancing Care Information performance.

2. **You're a MIPS eligible clinician who has applied for reweighting, using one of these reasons:**
    - You're in a small practice
    - You're using decertified EHR technology
    - You have insufficient internet connectivity
    - You have extreme and uncontrollable circumstances
    - You don't have any control over whether CEHRT is available

You'll have to submit your application by December 31, 2018 for us to reweight the Advancing Care Information performance category to 0%. We'll be giving detailed information about the 2018 application and when the application will be available for submission in upcoming sub-regulatory guidance. We'll also be giving guidance on how to submit a 2018 hardship application.

What are the Minimum Advancing Care Information Requirements?

For you to earn a score for the Advancing Care Information performance category, here are the minimum requirements:

- Use Certified EHR Technology (CEHRT)
- Submit the performance period (a minimum of 90 consecutive days period in 2018
- Submit a "yes" to the Prevention of Information Blocking Attestation
- Submit a "yes" to the ONC Direct Review Attestation
- Submit a "yes" for the security risk analysis measure, and at least a 1 in the numerator for the remaining base score measures or submit an exclusion for the base score measures

How is the Base Score Calculated?

You'll need to meet the requirements of all the base score measures in order to receive the 50% base score. If these requirements are not met, you will get a **0** for the overall Advancing Care Information performance category score.

In order to receive the 50% base score, you have to submit a "yes" for the security risk analysis measure, and **at least a 1** in the numerator for the numerator/denominator of the remaining measures.

The 5 base score Advancing Care Information measures are:

1. Security Risk Analysis
2. e-Prescribing*
3. Provide Patient Access
4. Send a Summary of Care*
5. Request/Accept Summary of Care*

The 4 base score 2018 Advancing Care Information **transition** measures are:

1. Security Risk Analysis
2. e-Prescribing*
3. Provide Patient Access
4. Health Information Exchange*

*The 2018 Quality Payment Program final rule with comment period added exclusions for the e-Prescribing and Health Information Exchange measures beginning with the 2017 performance period. If you qualify for these exclusions, you can still receive the base score if you:

- Report a 0 in the numerator/denominator for the applicable measure(s) AND
- Claim the exclusion through attestation or EHR reporting.

If you claim these exclusions, you'll meet the base score but will receive a 0% performance score for the measure(s). If you report a 0 in the numerator/denominator for these measures **without** claiming the exclusion, you wouldn't meet the base score and would receive a **0** for the overall Advancing Care Information performance category score.

- **e-Prescribing Exclusion (both measure sets):** Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period

- **Send a Summary of Care Exclusion (Advancing Care Information measure):** Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.

- **Request/Accept a Summary of Care Exclusion (Advancing Care Information measure):** Any MIPS eligible clinician who receives transitions of care or referrals fewer than 100 times during the performance period OR has patient encounters where the MIPS eligible clinician hasn't ever before encountered the patient fewer than 100 times during the performance period

- **Health Information Exchange Exclusion (2018 Advancing Care Information *transition* measure):** Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.

How is the Performance Score Calculated?

We calculate the performance score using the numerators and denominators you submitted for measures included in the performance score. There's one measure that we use the "yes" or "no" as the answer submitted.

The potential total performance score is 90%. For each measure with a numerator/denominator, the percentage score is determined by the performance rate. Most measures are worth a maximum of 10 percentage points, except for two measures included in the 2018 Transition measures, which are worth up to 20 percentage points.

Performance rates for each measure worth up to 10%	
Performance Rate >0-10 = 1% Performance Rate 11-20 = 2% Performance Rate 21-30 = 3% Performance Rate 31-40 = 4% Performance Rate 41-50 = 5%	Performance Rate 51-60 = 6% Performance Rate 61-70 = 7% Performance Rate 71-80 = 8% Performance Rate 81-90 = 9% Performance Rate 91-100 = 10%

For example, if a MIPS eligible clinician submits a numerator and denominator of 85/100 for the Patient-Specific Education measure, their performance rate would be 85%, and they would earn 9 out of 10 % points for that measure.

Performance rates for each measure worth up to 20%	
Performance Rate >0-10 = 2% Performance Rate 11-20 = 4% Performance Rate 21-30 = 6% Performance Rate 31-40 = 8% Performance Rate 41-50 = 10%	Performance Rate 51-60 = 12% Performance Rate 61-70 = 14% Performance Rate 71-80 = 16% Performance Rate 81-90 = 18% Performance Rate 91-100 = 20%

The only performance score measures that have yes/no responses are the Public Health and Clinical Data Registry (CDR) Reporting measures and the Public Health Reporting measures. MIPS eligible clinicians who are actively working with a public health agency or clinical data registry who submit a "yes" for one of these measures would receive the full 10%. When reporting as a group, the group can submit a "yes" for one of these measures as long as 1 clinician in the group is actively working with one of these entities.

How is the Bonus Score Calculated?

You can earn bonus percentage points:

- Reporting “yes” for 1 or more additional public health agencies or clinical data registries beyond the one identified for the performance score measure results in a 5% bonus. Like the performance score measure, groups can claim this as long as 1 clinician in the group is actively working with an entity that’s different from what’s reported for the performance score.

- Reporting “yes” to the completion of at least 1 of the specified Improvement Activities using CEHRT will result in a 10% bonus and submitting that activity for the Improvement Activity performance category. *See Appendix B for the list of Improvement Activities that may be completed using CEHRT to qualify for the bonus.*

- Reporting only from the Advancing Care Information Objectives and Measures set (and only using 2015 edition CEHRT) will result in a 10% bonus.

How is the Advancing Care Information Performance Score Calculated for Group Reporting?

When reporting as a group to the Advancing Care Information performance category, the group should combine all of their MIPS eligible clinicians’ data under one Taxpayer Identification Number (TIN).

This includes the data of MIPS eligible clinicians who may qualify for a reweighting of the advancing care information performance category, such as a significant hardship or other type of exception, hospital-based or ASC-based status, and certain types of non-physician practitioners (NPs, PAs, CNSs, and CRNAs). If these MIPS eligible clinicians report as part of a group or virtual group, and have data in CEHRT, their data should be included and they will be scored on the advancing care information performance category like all other MIPS eligible clinicians.

Appendix A: Advancing Care Information Performance Category Measures & Scores

This is a chart of all the Advancing Care Information measures and 2018 Advancing Care Information transition measures. You can find more details about each Advancing Care Information measure and **2018** Advancing Care Information **transition** measure in the Advancing Care Information Specification Sheets.

Advancing Care Information Measures & Scores

Required Measures for 50% Base Score
Security Risk Analysis
e-Prescribing
Provide Patient Access*
Send a Summary of Care*
Request/Accept Summary Care*

2018 Advancing Care Information Transition Measures & Scores

Required Measures for 50% Base Score
Security Risk Analysis
e-Prescribing
Provide Patient Access*
Health Information Exchange*

*Note that these measures are also included as performance score measures and will allow a clinician to earn a score that contributes to the performance score (see the list below).

Measures for Performance Score	% Points
Provide Patient Access*	Up to 10%
Send a Summary of Care*	Up to 10%
Request/Accept Summary Care*	Up to 10%
Patient Specific Education	Up to 10%
View, Download or Transmit (VDT)	Up to 10%
Secure Messaging	Up to 10%
Patient-Generated Health Data	Up to 10%
Clinical Information Reconciliation	Up to 10%
One of the Public Health and Clinical Data Registry Reporting Measures	0 or 10%

Measures for Performance Score	% Points
Provide Patient Access*	Up to 20%
Health Information Exchange*	Up to 20%
View, Download, or Transmit (VDT)	Up to 10%
Patient-Specific Education	Up to 10%
Secure Messaging	Up to 10%
Secure Messaging	Up to 10%
One of the Public Health Reporting Measures	0 or 10%

Requirements for Bonus Score	% Points
*Report to 1 or more of the following public health agencies or clinical data registries not reported for the performance score: • Immunization Registry Reporting • Syndromic Surveillance Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting	5%
Report certain Improvement Activities using CEHRT	10%
Report exclusively from this measure set (2015 edition CEHRT)	10%

Requirements for Bonus Score	% Points
*Report to 1 or more of the following public health reporting registries not reported for the performance score: • Immunization Registry Reporting • Syndromic Surveillance Reporting • Specialized Registry Reporting	5%
Report certain Improvement Activities using CEHRT	10%

Appendix B: Improvement Activities Eligible for the Advancing Care Information Performance Category Bonus

This chart shows you the subset of Improvement Activities from the complete list of Improvement Activities performance category that can be tied to the objectives, measures, and CEHRT functions of the Advancing Care Information performance category beginning with the 2018 performance period. These would qualify for the bonus in the Advancing Care Information performance category if you complete them using CEHRT and report them when you submit to the Improvement Activities performance category. While these activities can be made much better by using CEHRT, you don't need to use CEHRT to complete these activities for the Improvement Activities performance category.

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
Expanded Practice Access	Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record	Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (for example, 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 (for example, 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 alternative locations (for example, 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.	Medium	Provide Patient Access Secure Messaging Send a Summary of Care Request/Accept Summary of Care
Patient Safety and Practice Assessment	Communication of Unscheduled Visit for Adverse Drug Event and	A MIPS eligible clinician providing unscheduled care (such as an emergency room, urgent care, or other unplanned encounter) attests that, for greater than 75 percent of case visits that result from a clinically significant adverse drug event, the MIPS eligible	Medium	Secure Messaging Send A Summary of Care Request/Accept

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
	Nature of Event	clinician transmits information, including through the use of CEHRT to the patient's primary care clinician regarding both the unscheduled visit and the nature of the adverse drug event within 48 hours. A clinically significant adverse event is defined as a medication-related harm or injury such as side-effects, supratherapeutic effects, allergic reactions, laboratory abnormalities, or medication errors requiring urgent/emergent evaluation, treatment, or hospitalization.		Summary of Care
Patient Safety and Practice Assessment	Consulting AUC using clinical decision support when ordering advanced diagnostic imaging	Clinicians attest that they are consulting specified applicable AUC through a qualified clinical decision support mechanism for all applicable imaging services furnished in an applicable setting, paid for under an applicable payment system, and ordered on or after January 1, 2018. This activity is for clinicians that are early adopters of the Medicare AUC program (2018 performance year) and for clinicians that begin the Medicare AUC program in future years as specified in our regulation at §414.94. The AUC program is required under section 218 of the Protecting Access to Medicare Act of 2014. Qualified mechanisms will be able to provide a report to the ordering clinician that can be used to assess patterns of image-ordering and improve upon those patterns to ensure that patients are receiving the most appropriate imaging for their individual condition.	High	Clinical Decision Support (CEHRT function only)
Patient Safety and Practice Assessment	Cost Display for Laboratory and Radiographic Orders	Implementation of a cost display for laboratory and radiographic orders, such as costs that can be obtained through the Medicare clinical laboratory fee schedule.	Medium	Clinical Decision Support (CEHRT function only)
Population Management	Glycemic screening services	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the 2018 performance period and 75 percent in future years, of CEHRT with documentation of screening patients	Medium	Patient-Specific Education Patient Generated Health Data or Data from Nonclinical Settings

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
		for abnormal blood glucose according to current US Preventive Services Task Force (USPSTF) and/or American Diabetes Association (ADA) guidelines.		
Population Management	Glycemic management services	For outpatient Medicare beneficiaries with diabetes and who are prescribed antidiabetic agents (for example, insulin, sulfonylureas), MIPS eligible clinicians and groups must attest to having: For the first performance period, at least 60 percent of medical records with documentation of an individualized glycemic treatment goal that: a) Takes into account patient-specific factors, including, at least 1) age, 2) comorbidities, and 3) risk for hypoglycemia, and b) Is reassessed at least annually. The performance threshold will increase to 75 percent for the second performance period and onward. Clinicians would attest that, 60 percent for first year, or 75 percent for the second year, of their medical records that document individualized glycemic treatment represent patients who are being treated for at least 90 days during the performance period.	High	Patient Generated Health Data Clinical Information Reconciliation Clinical Decision Support, CCDS, Family Health History (CEHRT functions only)
Population Management	Glycemic referring services	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the CY 2018 performance period and 75 percent in future years, of CEHRT with documentation of referring eligible patients with prediabetes to a CDC-recognized diabetes prevention program operating under the framework of the National Diabetes Prevention Program.	Medium	Patient-Specific Education Patient Generated Health Data or Data from Nonclinical Settings

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
Population Management	Anticoagulant management improvements	Individual MIPS eligible clinicians and groups who prescribe oral Vitamin K antagonist therapy (warfarin) must attest that, for 60 percent of practice patients in the transition year and 75 percent of practice patients in Quality Payment Program Year 2 and future years, their ambulatory care patients receiving warfarin are being managed by one or more of the following improvement activities: - Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-INR) testing, tracking, follow-up, and patient communication of results and dosing decisions; - Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; - For rural or remote patients, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; and/or - For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self management (PSM) program.	High	Provide Patient Access Patient-Specific Education View, Download, Transmit Secure Messaging Patient Generated Health Data or Data from Non- Clinical Setting Send a Summary of Care Request/ Accept Summary of Care Clinical Information Reconciliation Exchange Clinical Decision Support (CEHRT Function Only)
Population Management	Provide Clinical-Community Linkages	Engaging community health workers to provide a comprehensive link to community resources through family-based services focusing on success in health, education, and self-sufficiency.	Medium	Provide Patient Access

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
		This activity supports individual MIPS eligible clinicians or groups that coordinate with primary care and other clinicians, engage and support patients, use of CEHRT, and employ quality measurement and improvement processes. An example of this community based program is the NCQA Patient-Centered Connected Care (PCCC) Recognition Program or other such programs that meet these criteria		Patient-Specific Education Patient-Generated Health Data
Population Management	Advance Care Planning	Implementation of practices/processes to develop advance care planning that includes: documenting the advance care plan or living will within CEHRT, educating clinicians about advance care planning, motivating them to address advance care planning needs of their patients, and how these needs can translate into quality improvement, educating clinicians on approaches and barriers to talking to patients about end-of-life and palliative care needs and ways to manage its documentation, as well as informing clinicians of the healthcare policy side of advance care planning.	Medium	Patient-Specific Education Patient-Generated Health Data
Population Management	Chronic care and preventative care management for empaneled patients	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 (for example, 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;	Medium	Provide Patient Access Patient-Specific Education View, Download, Transmit Secure Messaging Patient Generated health Data or Data from Non-Clinical Setting

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
		- Use panel support tools (registry functionality) to identify services due; - Use reminders and outreach (for example, 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.		Send A Summary of Care Request/Accept Summary of care Clinical Information Reconciliation Clinical Decision Support, Family Health History (CEHRT functions only)
Population Management	Implementation of methodologies for improvements in longitudinal care management for high risk patients	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	Provide Patient Access Patient-Specific Education Patient Generated Health Data or Data from Nonclinical Settings Send A Summary of Care Request/Accept Summary of Care Clinical information reconciliation Clinical Decision Support, CCDS,

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
				Family Health History, Patient List (CEHRT functions only)
Population Management	Implementation of episodic care management practice improvements	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	Send A Summary of Care Request/ Accept Summary of Care Clinical Information Reconciliation
Population Management	Implementation of medication management practice improvements	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	Clinical Information Reconciliation Clinical Decision Support, Computerized Physician Order Entry Electronic Prescribing (CEHRT functions only)
Achieving Health Equity	Promote use of patient-reported outcome tools	Demonstrate performance of activities for employing patient-reported outcome (PRO) tools and corresponding collection of PRO data (e.g., use of PQH-2 or PHQ-9 and PROMIS instruments) such as patient reported Wound Quality of Life (QoL), patient reported Wound Outcome, and patient reported Nutritional Screening.	High	Public Health Registry Reporting Clinical Data Registry Reporting Patient-Generated Health Data
Care Coordination	Practice Improvements that Engage Community Resources to Support	Develop pathways to neighborhood/community-based resources to support patient health goals that could include one or more of the following:	Medium	Send a Summary of Care

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
	Patient Health Goals	- 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 provide a guide to available community resources. - Including through the use of tools that facilitate electronic communication between settings; - Screen patients for health-harming legal needs; - Screen and assess patients for social needs using tools that are CEHRT enabled and that include to any extent standards-based, coded question/field for the capture of data as is feasible and available as part of such tool; and/or - Provide a guide to available community resources.		Request/Accept Summary of Care Patient-Generated Health Data
Care Coordination	Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients	The primary care and behavioral health practices use the same CEHRT system for shared patients or have an established bidirectional flow of primary care and behavioral health records.	Medium	Send a Summary of Care Request/Accept Summary of Care
Care Coordination	PSH Care Coordination	Participation in a Perioperative Surgical Home (PSH) that provides a patient-centered, physician-led, interdisciplinary, and team-based system of coordinated patient care, which coordinates care from pre-procedure assessment through the acute care episode, recovery, and post-acute care. This activity allows for reporting of strategies and processes related to care coordination of patients receiving surgical or procedural care within a PSH. The clinician must perform one or more of the following care coordination activities: - Coordinate with care managers/navigators in preoperative clinic to plan and implementation comprehensive post discharge plan of care;	Medium	Send a Summary of Care Request/Accept Summary of Care Clinical Information Reconciliation Health Information Exchange

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
		- Deploy perioperative clinic and care processes to reduce post-operative visits to emergency rooms; - Implement evidence-informed practices and standardize care across the entire spectrum of surgical patients; or - Implement processes to ensure effective communications and education of patients' post-discharge instructions.		
Care Coordination	Implementation or use of specialist reports back to referring clinician or group to close referral loop	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 CEHRT.	Medium	Send A Summary of Care Request/Accept Summary of Care Clinical Information Reconciliation
Care Coordination	Implementation of practices/ processes for developing regular individual care plans	Implementation of practices/processes to develop regularly updated individual care plans for at-risk patients that are shared what the beneficiary or caregiver(s). Individual care plans should include consideration of a patient's goals and priorities, as well as desired outcomes of care.	Medium	Provide Patient Access (formerly Patient Access) View, Download, Transmit Secure Messaging Patient Generated Health Data or Data from Non-Clinical Setting
Care Coordination	Practice improvements for bilateral exchange of patient information	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	Send A Summary of Care Request/ Accept Summary of Care

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
				Clinical Information Reconciliation
Beneficiary Engagement	Engage Patients and Families to Guide Improvement in the System of Care	Engage patients and families to guide improvement in the system of care by leveraging digital tools for ongoing guidance and assessments outside the encounter, including the collection and use of patient data for return-to-work and patient quality of life improvement. Platforms and devices that collect patient-generated health data (PGHD) must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient. Includes patient reported outcomes (PROs). Examples include patient engagement and outcomes tracking platforms, cellular or web-enabled bidirectional systems, and other devices that transmit clinically valid objective and subjective data back to care teams. Because many consumer-grade devices capture PGHD (for example, wellness devices), platforms or devices eligible for this improvement activity must be, at a minimum, endorsed and offered clinically by care teams to patients to automatically send ongoing guidance (one way). Platforms and devices that additionally collect PGHD must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient (e.g. automated patient-facing instructions based on glucometer readings). Therefore, unlike passive platforms or devices that may collect but do not transmit PGHD in real or near-real time to clinical care teams, active devices and platforms can inform the patient or the clinical care team in a timely manner of important parameters regarding a patient's	High	Patient-Generated Health Data Provide Patient Access View, Download, or Transmit

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
		status, adherence, comprehension, and indicators of clinical concern.		
Beneficiary Engagement	Use of CEHRT to capture patient reported outcomes	In support of improving patient access, performing additional activities that enable capture of patient reported outcomes (for example, 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 CEHRT, containing this date in a separate queue for clinician recognition and review.	Medium	Provide Patient Access Patient-specific Education Care Coordination through Patient Engagement
Beneficiary Engagement	Engagement of patients through implementation	Access to an enhanced patient portal that provides up to date information related to relevant chronic disease health or blood pressure control, and includes interactive features allowing patients to enter health information and/or enables bidirectional communication about medication changes and adherence.	Medium	Provide Patient Access Patient-specific Education
Beneficiary Engagement	Engagement of patients, family and caregivers in developing a plan of care	Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the CEHRT.	Medium	Provide Patient Access Patient-specific Education View, Download, Transmit (Patient Action) Secure Messaging
Patient Safety and Practice Assessment	Use of decision support and standardized treatment protocols	Use decision support and protocols to manage workflow in the team to meet patient needs.	Medium	Clinical Decision Support (CEHRT function only)
Behavioral and Mental Health	Implementation of integrated Patient Centered Behavioral	Offer integrated behavioral health services to support patients with behavioral health needs, dementia, and poorly controlled chronic	High	Provide Patient Access

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
	Health (PCBH) model	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; - 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.		Patient-Specific Education View, Download, Transmit Secure Messaging Patient Generated Health Data or
Behavioral and Mental Health	Electronic Health Record Enhancements for BH data capture	Enhancements to CEHRT to capture additional data on behavioral health (BH) populations and use that data for additional decision-making purposes (for example, capture of additional BH data results in additional depression screening for at-risk patient not previously identified).	Medium	Patient Generated Health Data or Data from Non-clinical Setting Send A Summary of Care Request/ Accept Summary of Care Clinical Information Reconciliation