Quality Payment
PROGRAM

2018 Quality Performance Category Scoring for Alternative Payment Models

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Section 1: Introduction

The Quality Payment Program (QPP), established by the Centers for Medicare & Medicare Services (CMS) in accordance with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is a quality payment incentive program for physicians and other eligible clinicians, which rewards value and outcomes in one of two ways: through the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).[1]

Advanced APMs are a subset of APMs that provide added incentives for high-quality and cost-efficient care and require participants to use certified EHR technology and hold a financial stake in quality and cost outcomes of their beneficiaries. APMs may attempt to improve the quality or cost of a specific clinical condition, care episode, or population.[2]

As prescribed by MACRA, MIPS has four performance categories: (1) ***Quality***—including a set of evidence-based, specialty-specific standards; (2) ***Cost***; (3) practice-based ***Improvement Activities***; and (4) ***Promoting Interoperability (formerly Advancing Care Information) —***use of certified electronic health record (EHR) technology (CEHRT) to support interoperability and advanced quality objectives in a single, cohesive program that avoids redundancies.[3] Performance in these categories is scored and weighted, and a MIPS final score is calculated for determining payment adjustments 2 years later.[4] Eligible clinicians can be assessed and scored for MIPS as individuals, part of a MIPS group, part of a MIPS virtual group, or as part of an APM Entity group. The scoring procedures for MIPS individuals, groups, and virtual groups are described elsewhere.[5] This document describes how eligible clinicians who are part of an APM Entity group will be assessed under the quality performance category in MIPS.

Certain APMs include MIPS eligible clinicians as participants and reward their participants for improving the cost and quality of care provided to Medicare beneficiaries. This type of APM is called a "MIPS APM," and participants in MIPS APMs have MIPS-specific reporting requirements and receive special MIPS scoring under the "APM scoring standard."

MIPS APMs are those in which:

1. APM Entities participate in the APM under an agreement with CMS or through a law or regulation;
2. The APM is designed such that APM Entities participating in the APM include at least one MIPS eligible clinician on a Participation List;
3. The APM bases payment on quality measures and cost/utilization; and
4. The APM is not either of the following:
    a. New APM: An APM for which the first performance year begins after the first day of the MIPS performance period for the year.

[1] https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf
[2] https://qpp.cms.gov/apms/overview
[3] https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-Year-2-Executive-Summary.pdf
[4] https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2017-MIPS-101-Guide.pdf
[5] https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/MIPS-Scoring-101-Guide.pdf

b. APM in final year of operation for which the APM scoring standard is impracticable: An APM in the final year of operation for which CMS determines, within 60 days after the beginning of the MIPS performance period for the year, that it is impracticable for APM Entity groups to report to MIPS using the APM scoring standard.[6]

Most Advanced APMs are also MIPS APMs; if an eligible clinician participating in the Advanced APM that is also a MIPS APM does not meet the threshold level of payments or patients through an Advanced APM to become a Qualifying APM Participant (QP), the eligible clinician will be scored under MIPS according to the APM scoring standard.[7] However, these participants will not be burdened with double-reporting quality to both the APM and MIPS. If they already report quality data for payment purposes within their respective model, they will not have to separately report quality data under MIPS.

The APM scoring standard does not apply to an APM that includes only facilities as participants. The standard also does not apply to a QP in an Advanced APM for the year, because that eligible clinician is excluded from the MIPS reporting requirements and payment adjustment for the year. Eligible clinicians that are Partial QPs for the year can choose as an APM Entity whether to participate in MIPS.[8]

1.1 MIPS APMs

There are six MIPS APMs in 2018: (1) Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model, (2) Comprehensive Primary Care Plus (CPC+) Model, (3) Medicare Shared Savings Program, (4) Next Generation ACO Model, and (5) Oncology Care Model (OCM), (6) Medicare ACOs Track 1+ Model **Table 1.1** shows the list of MIPS APMs in 2018, categorized by their track or arrangement, along with their Advanced APM status and whether they are a medical home model.[9]

Table 1.1 MIPS APM in 2018

APM	MIPS APM Under the APM Scoring Standard	Medical Home Model	Advanced APM
Comprehensive ESRD Care (CEC) Model (Large Dialysis Organization [LDO] arrangement)	Yes	No	Yes
Comprehensive ESRD Care (CEC) Model (non-LDO two-sided risk arrangement)	Yes	No	Yes

[6] 42 C.F.R. § 414.1370(b) 2017.
[7] https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Comprehensive-List-of-APMs.pdf
[8] https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/MIPS-APMs-in-the-Quality-Payment-Program.pdf
[9] https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Comprehensive-List-of-APMs.pdf

APM	MIPS APM Under the APM Scoring Standard	Medical Home Model	Advanced APM
Comprehensive ESRD Care (CEC) Model (non-LDO one-sided risk arrangement)	Yes	No	No
Comprehensive Primary Care Plus (CPC+) Model	Yes	Yes	Yes
Medicare Accountable Care Organization (ACO) Track 1+ Model[10]	Yes	No	Yes
Medicare Shared Savings Program — Track 1	Yes	No	No
Medicare Shared Savings Program — Track 2	Yes	No	Yes
Medicare Shared Savings Program— Track 3	Yes	No	Yes
Next Generation ACO Model	Yes	No	Yes
Oncology Care Model (OCM) (one-sided Risk Arrangement)	Yes	No	No
Oncology Care Model (OCM) (two-sided Risk Arrangement)	Yes	No	Yes

1.2 Purpose of this Document

The purpose of this document is to describe the APM scoring standard for the ***quality category*** for MIPS APMs. The quality performance category is one of four categories used for the MIPS performance assessment. Here, we aim to (1) summarize the regulatory requirements for 2018 APM scoring; (2) describe the quality measures from APMs that are MIPS APMs in the 2018 performance period; and (3) describe the standardized APM scoring methodology for these MIPS APMs that accommodates differences in their quality reporting requirements. The scoring standards for the other APM categories can be found in the 2018 Quality Payment Program Final Rule.[11]

1.3 Organization of this Document

Section 2 describes the overall APM scoring standard under regulations. Section 3 describes the 2018 Advanced APMs in terms of their data sources and availability of their quality results and benchmarks. Section 4 describes the 2018 scoring methodology for the quality category specifically for MIPS APM "Web Interface" submitters, as well as the participants in "Other MIPS APMs."

[10] ACOs participating in the ACO Track 1+ Model must maintain participation in Track 1 of the Shared Savings Program and remain subject to the Shared Savings Program quality performance standards and reporting requirements at 42 CFR Part 425 Subpart F which are relevant to the APM scoring standard under MIPS. As such, for purposes of the APM scoring standard, MIPS eligible clinicians in the ACO Track 1+ Model are considered to be participating in Track 1 of the Shared Savings Program.

[11] https://www.gpo.gov/fdsys/pkg/FR-2017-11-16/pdf/2017-24067.pdf

Section 2: Overall APM Scoring Standard

The 2017 Quality Payment Program Final Rule,[12] together with the updates specified in the 2018 Quality Payment Program Final Rule,[13] established the regulations for MIPS scoring. The APM scoring standard is the MIPS scoring methodology applicable to MIPS eligible clinicians identified on the Participation List for the performance period of an APM entity participating in a MIPS APM.[14]

2.1 Performance Period for APM Scoring

The MIPS performance period applies for the APM scoring standard. For the 2018 performance year, which corresponds to the 2020 payment year, the APM scoring standard performance period for the quality performance category is calendar year (CY) 2018 (January 1, 2018, through December 31, 2018). For the PI and improvement activities performance categories, the 2018 performance period is a minimum of a continuous 90-day period within CY 2018, up to and including the full CY 2018.[15]

2.2 APM Participant Identifier and APM Entity Group Determination

The APM participant identifier for an eligible clinician is the combination of four identifiers: (1) APM identifier (established for the APM by CMS); (2) APM Entity identifier (established for the APM Entity by CMS); (3) Medicare-enrolled billing tax identification number (TIN); and (4) eligible clinician national provider identifier (NPI).

For the APM scoring standard, eligible clinicians are grouped and assessed through their collective participation in an APM Entity that is in a MIPS APM. To be included in the APM Entity group for purposes of the APM scoring standard, an eligible clinician's APM participant identifier must be present on a Participation List of a MIPS APM on one of the following dates: March 31, June 30, or August 31 of the Performance Period. An eligible clinician included on a Participation List on any one of these dates is included in the APM Entity group even if that eligible clinician is not included on that Participation List at one of the prior or later listed dates.[16] In addition to the dates set forth above, in 2018, an eligible clinician who is on a Participation List in a Full TIN APM on December 31 of the MIPS performance period will be included in the APM Entity group.[17]

The MIPS final score calculated for the APM Entity group is applied to each MIPS eligible clinician in the APM Entity group. The MIPS payment adjustment is applied at the TIN/NPI level for each of the MIPS eligible clinicians in the APM Entity group. For a Shared Savings Program ACO that does not report data on quality measures as required by the Shared Savings Program, each ACO participant TIN will be treated as a unique APM Entity for purposes of the

[12] https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf
[13] https://www.gpo.gov/fdsys/pkg/FR-2017-11-16/pdf/2017-24067.pdf
[14] 42 C.F.R. § 414.1370(a) 2017
[15] 42 C.F.R. § 414.1370(c); *see id.* § 414.1320(b) 2017
[16] 42 C.F.R. § 414.1425(b)(1) 2017
[17] 42 C.F.R. § 414.1370(e)(1) 2017

APM scoring standard, and the ACO participant TINs may report data for the MIPS quality performance category according to the MIPS group submission and reporting requirements. MIPS eligible clinicians who have elected to participate in a virtual group and who are also on a MIPS APM Participation List will be included in the assessment under MIPS for purposes of producing a virtual group score and under the APM scoring standard for purposes of producing an APM Entity score. The MIPS payment adjustment for these MIPS eligible clinicians is based solely on their APM Entity score.

2.3 APM Performance Categories and Weights

The performance category weights used to calculate the MIPS final score under the APM scoring standard for an APM Entity group for the 2018 performance period are as follows:

1. Quality: 50 percent;
2. Cost: 0 percent;
3. Improvement Activities: 20 percent; and
4. Promoting interoperability: 30 percent.

However, if CMS determines there are not sufficient measures applicable and available to MIPS eligible clinicians in the quality performance category, the performance categories will be weighted as follows:

1. Quality performance category is reweighted to 0 percent;
2. Improvement Activities performance category is reweighted to 25 percent; and
3. Promoting interoperability performance category is reweighted to 75 percent.

On the other hand, if the MIPS eligible clinicians in an APM Entity group qualify for a zero percent weighting for the promoting interoperability performance category, then the performance categories will be weighted as follows:

1. Quality performance category is reweighted to 80 percent; and
2. Improvement Activities performance category will remain at 20 percent.

2.4 Total APM Entity Score

CMS scores each performance category and then multiplies each performance category score by the applicable performance category weight. CMS then calculates the sum of each weighted performance category score and then adds all applicable bonuses. Each MIPS eligible clinician receives a final score of zero to 100 points for a performance period for a MIPS payment year. If an APM Entity group is scored on fewer than two performance categories, they receive a final score equal to the performance threshold.

APM Entity groups will receive MIPS bonuses applied to the final score, just as eligible clinicians who are scored as individuals or as part of a MIPS group or virtual group. There are two bonuses available for the 2018 performance period[18]:

(1) *Complex patient bonus*. If the APM Entity submits data for at least one MIPS performance category during the 2018 MIPS performance period, a complex patient bonus will be added to APM Entity's final score for the 2020 MIPS payment year based on the beneficiary weighted average Hierarchical Condition Category (HCC) risk score for all MIPS eligible clinicians, and the average dual-eligible ratio for all MIPS eligible clinicians, not to exceed 5.0; and

(2) *Small practice bonus*. A small practice bonus of 5 points will be added to the final score for the 2020 MIPS payment year for APM Entities that meet the definition of a small practice[19] and participate in MIPS by submitting data on at least one performance category in the 2018 MIPS performance period.

Thus, the MIPS final score is calculated as the sum of each performance category percent score multiplied by its weight, multiplied by 100, and including the two bonuses if applicable, all not to exceed 100 points:

Final Score = {[(quality performance category percent score x its weight)
+ (cost performance category percent score x its weight)
+ (improvement activities performance category score x its weight)
+ (PI performance category score x its weight)] x 100}
+ [the complex patient bonus + the small practice bonus]

2.5 Flow of Data

The APM Program Analysis Contractor will calculate the quality performance category percent score, using the quality measure information submitted by each APM Entity as required for participation in their respective APM. This quality performance category percent score, calculated from the performance results across the measures and including bonus points, will be sent to the MIPS system. Note that submissions for MIPS APMs that are Web Interface Reporters will be automatically calculated and scored for achievement points and bonus points for MIPS with other MIPS eligible clinicians reporting through the Web Interface, and according to Web Interface quality measure scoring procedures.

The MIPS team, rather than the APM Program Analysis Contractor, will then be responsible to aggregate the results from the quality performance category, as well as the improvement activities performance category and the PI performance category, apply appropriate category weights for each performance category, and generate a weighted MIPS final score with any applicable bonus points as specified above for each MIPS eligible clinician in a MIPS APM Entity.

[18] 42 C.F.R. §414.1380 (b) 2017
[19] 42 C.F.R.§ 414.1305 2017

Section 3: MIPS APMs in 2018

In 2017, MIPS eligible clinicians participating in Shared Savings Program ACOs and Next Generation ACOs were the only APM participants under the APM scoring standard whose MIPS final score was calculated based on quality measures submitted via the CMS Web Interface and included the quality performance category under MIPS. The quality performance category had a weight of 50 percent on the MIPS final score for these ACOs. APM Entity groups in all other MIPS APMs had a weight of zero for the quality performance category for the 2017 performance period.

Beginning in 2018, MIPS eligible clinicians participating in other MIPS APMs will be scored for the quality performance category under the APM scoring methodology. Unlike APMs that require reporting via the CMS Web Interface (Web Interface Reporters), these MIPS APMs, referred to as "Other MIPS APMs," do not require reporting through the CMS Web Interface and include participants in OCM, CPC+, and CEC Model.

The following sections describe each 2018 MIPS APM and the expected quality measures that will be used for APM scoring standard purposes.

3.1 Medicare Shared Savings Program

The Shared Savings Program is a voluntary program that encourages groups of doctors, hospitals, and other health care providers to come together as an APM Entity, known as the Accountable Care Organization (ACO) to provide coordinated, high-quality care to their Medicare patients. An ACO agrees to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population. The Shared Savings Program offers different participation options (tracks) that allow ACOs to assume various levels of risk. The Medicare ACO Track 1+ Model (Track 1+ Model) is a time-limited CMS Innovation Center Model. An ACO must concurrently participate in Track 1 of the Shared Savings Program in order to be eligible to participate in the Track 1+ Model. An ACO participating in the Track 1+ Model remains subject to the Shared Savings Program quality performance standards and reporting requirements at 42 CFR Part 425 Subpart F which are relevant to the APM scoring standard under MIPS. As such, for purposes of the APM scoring standard, MIPS eligible clinicians in the ACO Track 1+ Model are considered to be participating in Track 1 of the Shared Savings Program. (**Table 3.1**)[20]

[20] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about.html

Table 3.1 Description of each track of the Shared Savings Program and the Track 1+ Model

Track	Financial Risk Arrangement	Description
1	One-sided	Track 1 ACOs do not assume shared losses if they do not lower growth in Medicare expenditures.
Track 1+ Model	Two-sided	Track 1+ Model ACOs assume limited downside risk (less than Track 2 or Track 3).
2	Two-sided	Track 2 ACOs may share in savings or repay Medicare losses depending on performance. Track 2 ACOs may share in a greater portion of savings than Track 1 ACOs.
3	Two-sided	Track 3 ACOs may share in savings or repay Medicare losses depending on performance. Track 3 ACOs take on the greatest amount of risk, but may share in the greatest portion of savings if successful.

Participating ACOs must report quality data to CMS after the close of every performance year to be eligible to share in any earned shared savings. Quality measures span four domains: patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk populations.[21] Although claims-based and administrative-data measures are required by the Shared Savings Program, only the ACO quality measures submitted via the CMS Web Interface and the CAHPS survey will be used for APM scoring standard purposes in 2018.

In 2018, there are 14 ACO quality measures that are submitted via the CMS Web Interface (including one two-component diabetes measure) and one collected by patient survey (**Table 3.2**). Note that measures may be removed from this list, but new measures will not be added for the 2018 performance year.

Table 3.2 Shared Savings Program and Next Generation ACO Model 2018 MIPS APM Measure List

	Measure Title	Measure Description	Submission Mechanism
ACO-12 (CARE-1)	Medical Reconciliation Post-Discharge	**Medication Reconciliation Post-Discharge:** The percentage of discharges from any inpatient facility (e.g., hospital, skilled	CMS Web Interface

[21] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-guidance-and-specifications.html

	Measure Title	Measure Description	Submission Mechanism
		nursing facility, or rehabilitation facility) for patients 18 years and older of age seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing ongoing care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is reported as three rates stratified by age group: Reporting Criteria 1: 18–64 years of age Reporting Criteria 2: 65 years of age and older Total Rate: All patients 18 years of age and older	
ACO-13 (CARE-2)	Falls: Screening for Future Fall Risk	**Falls: Screening for Future Fall Risk:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	CMS Web Interface
ACO-14 (PREV-7)	Preventive Care and Screening: Influenza Immunization	**Preventive Care and Screening:** **Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	CMS Web Interface
ACO-15 (PREV-8)	Pneumonia Vaccination Status for Older Adults	**Pneumococcal Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	CMS Web Interface

	Measure Title	Measure Description	Submission Mechanism
ACO-16 (PREV-9)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous 12 months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous 12 months of the current encounter. Normal Parameters: Age 18 years and older BMI ≥18.5 and <25 kg/m^2.	CMS Web Interface
ACO-17 (PREV-10)	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	CMS Web Interface
ACO-18 (PREV-12)	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	**Preventive Care and Screening: Screening for Depression and Follow-Up** **Plan:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age-	CMS Web Interface

	Measure Title	Measure Description	Submission Mechanism
		appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	
ACO-19 (PREV-6)	Colorectal Cancer Screening	**Colorectal Cancer Screening:** Percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.	CMS Web Interface
ACO-20 (PREV-5)	Breast Cancer Screening	**Breast Cancer Screening:** Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	CMS Web Interface
ACO-42 (PREV-13)	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease:** Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period: ▪ Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR ▪ Adults aged ≥21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥190 mg/dL; OR ▪ Adults aged 40–75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70–189 mg/dL	CMS Web Interface
ACO-40 (MH-1)	Depression Remission at Twelve Months	**Depression Remission at Twelve Months:** Patients aged 18 and older with major depression or dysthymia and an initial Patient Health Questionnaire (PHQ-9)	CMS Web Interface

	Measure Title	Measure Description	Submission Mechanism
		score greater than nine who demonstrate remission at twelve months (+/− 30 days after an index visit) defined as a PHQ-9 score lower than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.	
Diabetes Composite ACO-27 (DM-2)	Diabetes: Hemoglobin A1c Poor Control	**Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%):** Percentage of patients 18–75 years of age with diabetes who had HbA1c >9.0% during the measurement period.	CMS Web Interface
Diabetes Composite ACO-41 (DM-7)	Diabetes: Eye Exam	**Diabetes: Eye Exam**: Percentage of patients 18–75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	CMS Web Interface
ACO-28 (HTN-2)	Hypertension (HTN): Controlling High Blood Pressure	**Controlling High Blood Pressure:** Percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement period.	CMS Web Interface
ACO-30 (IVD-2)	Ischemic Vascular Disease: Use of Aspirin of Another Antithrombotic	**Ischemic Vascular Disease (IVD):** **Use of Aspirin or Another Antiplatelet:** Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement	CMS Web Interface

	Measure Title	Measure Description	Submission Mechanism
		period, and who had documentation of use of aspirin or another antiplatelet during the measurement period.	
ACO-1 through ACO-7; ACO-34	Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs Clinician/Group	**CAHPS for MIPS Clinician/Group Survey:** Summary Survey Measures may include ▪ Getting timely care, appointments, and information; ▪ How well providers communicate; ▪ Patient's rating of provider; ▪ Access to specialists; ▪ Health promotion and education; ▪ Shared decision making; ▪ Health status and functional status; ▪ Courteous and helpful office staff; ▪ Care coordination; and ▪ Stewardship of patient resources.	Patient Survey

3.2 Next Generation ACO

Building upon experience from the Pioneer ACO Model and the Medicare Shared Savings Program, the Next Generation ACO (NGACO) Model is an opportunity in accountable care—one that sets predictable financial targets, enables health care providers greater opportunities to coordinate care, and aims to attain the highest quality standards of care. The NGACO Model is an initiative for ACOs that are experienced in coordinating care for populations of patients that will allow participating ACOs to assume higher levels of financial risk and reward than are available under the Shared Savings Program. The goal of the NGACO Model is to test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can lower Medicare expenditures and improve health outcomes for Original Medicare FFS beneficiaries.[22]

In the 2018 QPP performance period, the APM scoring methodology in the quality performance category for NGACO will follow the same measures and methodology used for the Shared Savings Program (**Table 3.2**). However, should a Next Generation ACO fail to report any Web Interface quality measure, the MIPS eligible clinicians participating in the ACO will receive a zero for the entire quality performance category.

3.3 Comprehensive Primary Care Plus Model

[22] https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/

CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through regionally based multipayer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States. This model seeks to improve quality, access, and efficiency of primary care. Practices in both tracks will make changes in the way they deliver care, centered on key Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health.[23]

For the 2017 performance period, the CPC+ Model included 17 quality and utilization measures for performance-based incentive payment purposes. These 17 measures included 14 electronic Clinical Quality Measures (eCQMs), a subset of the Consumer Assessment of Healthcare Providers and Systems Clinician and Group Survey (CG CAHPS Survey), one inpatient hospital utilization measure, and one emergency department utilization measure. CPC+ Practices were required to report data on 9 of the 14 eCQMs from the eCQM measure set. For scoring under the APM scoring standard in 2018, the updated quality and utilization measures are listed in **Table 3.3**. Note that measures may be removed from this list, but new measures will not be added for the 2018 performance period.

For eCQMs, there are several reporting options, including attestation through the secure CPC+ Practice Portal, or submission of a Quality Reporting Document Architecture (QRDA) Category III file to CMS electronically either via direct EHR or through a third-party data submission vendor. The CG CAHPS Survey will be conducted by CMS. The utilization measures are calculated by CMS based on claims data.

Table 3.3 Comprehensive Primary Care Plus Model 2018 MIPS APM Measure List

Measure Name	NQF[a]/Quality Number (if applicable)	Measure Description	Submission Mechanism
Controlling High Blood Pressure	0018 / 236	Percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement period	QRDA III
Diabetes: Eye Exam	0055 / 117	Percentage of patients 18–75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12	QRDA III

[23] https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

Measure Name	NQF[a]/Quality Number (if applicable)	Measure Description	Submission Mechanism
		months prior to the measurement period	
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	0059 / 001	Percentage of patients 18–75 years of age with diabetes who had HbA1c >9.0% during the measurement period	QRDA III
Dementia: Cognitive Assessment	2872 / 281	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period	QRDA III
Falls: Screening for Future Fall Risk	0101 / 318	A) Screening for Future Fall Risk: Patients who were screened for future fall risk at last once within 12 months B) Multifactorial Falls Risk Assessment: Patients at risk of future fall who had a multifactorial risk assessment for falls completed within 12 months C) Plan of Care to Prevent Future Falls: Patients at risk of future fall with a plan of care for falls prevention documented within 12 months.	QRDA III
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004 / 305	Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported: a. Percentage of patients who initiated treatment within 14 days of the diagnosis. b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	QRDA III
Closing the Referral Loop: Receipt of Specialist Report	N/A / 374	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report	QRDA III

Measure Name	NQF[a]/Quality Number (if applicable)	Measure Description	Submission Mechanism
		from the provider to whom the patient was referred	
Cervical Cancer Screening	0032 / 309	Percentage of women 21–64 years of age, who were screened for cervical cancer using either of the following criteria. ▪ Women aged 21–64 who had cervical cytology performed every 3 years ▪ Women aged 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years	QRDA III
Colorectal Cancer Screening	0034 / 113	Percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer	QRDA III
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	0028 / 226	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received cessation counseling intervention if identified as a tobacco user	QRDA III
Breast Cancer Screening	2372 / 112	Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer	QRDA III
Preventive Care and Screening: Influenza Immunization	0041 / 110	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	QRDA III
Pneumonia Vaccination Status for Older Adults	0043 / 111	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine	QRDA III
Diabetes: Medical Attention for Nephropathy	0062 / 119	Percentage of patients 18–75 years of age with diabetes who had a nephropathy screening test or	QRDA III

Measure Name	NQF[a]/Quality Number (if applicable)	Measure Description	Submission Mechanism
		evidence of nephropathy during the measurement period	
Ischemic Vascular Disease (IVD): Use of Aspirin or Another	0068 / 204	Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period	QRDA III
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	0418 / 134	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	QRDA III
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	N/A / 438	Percentage of the following patients—all considered at high risk of cardiovascular events— who were prescribed or were on statin therapy during the measurement period: ▪ Adults aged ≥21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR ▪ Adults aged ≥21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥190 mg/dL or were previously diagnosed with or	QRDA III

Measure Name	NQF[a]/Quality Number (if applicable)	Measure Description	Submission Mechanism
		currently have an active diagnosis of familial or pure hypercholesterolemia; OR ▪ Adults aged 40–75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70–189 mg/dL	
Inpatient Hospital Utilization (IHU)	N/A	For members 18 years of age and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year reported by Surgery, Medicine, and Total	N/A: Claims-based measure
Emergency Department Utilization (EDU)	N/A	For members 18 years of age and older, the risk-adjusted ratio of observed to expected emergency department (ED) visits during the measurement year	N/A: Claims-based measure
CAHPS	CPC+-specific; different than CAHPS for MIPS	CG-CAHPS Survey 3.0	Patient Survey

[a] NQF = National Quality Forum
N/A = not applicable.

CPC+ Practices are required to submit data on only 9 measures out of the list of eCQMs. CMS will only use the best performing 9 measures for purposes of the APM scoring standard, provided the measure set meets minimum case size and has a benchmark available, should Practices submit beyond the required 9 measures.

The CPC+ Practices' performance on eCQMs are assessed against absolute performance thresholds.. All eCQMs will have benchmarks; the benchmarks for 2018 will be available to CPC+ Practices prior to the performance period. The CAHPS benchmarks are calculated from the Agency for Healthcare Research and Quality (AHRQ) CAHPS database using the CAHPS Analysis Program.

3.4 Oncology Care Model

The OCM aims to provide higher-quality, more coordinated oncology care at the same or lower cost to Medicare. Under OCM, physician group practices may receive performance-based

payments for episodes of care surrounding chemotherapy administration to cancer patients. One-sided risk and two-sided risk arrangements are available in the Model. The practices participating in OCM have committed to providing enhanced services to Medicare beneficiaries such as documenting a care plan, providing the core functions of patient navigation, and using therapies consistent with nationally recognized treatment guidelines for care.[24]

The OCM collects results from 12 quality measures that are tied to payment, including one composite measure. These include both process and outcome measures, which are collected via three data sources: claims, reported by the practice, and a survey measure (Patient Reported Experience).

OCM practices submit the majority of the measures using a registry. However, for the 2018 MIPS performance year, CMS will use the three claims-based measures and the one patient survey measure available from "Performance Period 3"[25] of OCM for APM scoring standard purposes (see **Table 3.4** for details). Note that measures may be removed from this list, but new measures will not be added for the 2018 MIPS performance year.

Table 3.4 Oncology Care Model 2018 MIPS APM Measure List

Measure Number in OCM	Measure Name	NQF/ Quality Number (if applicable)	Measure Description	Submission Mechanism
OCM-1	All-cause admissions	N/A	Risk-adjusted proportion of patients with all-cause hospital admissions within the 6-month episode	N/A: Claims-based measure
OCM-2	All-cause emergency department visits or observation stays	N/A	Risk-adjusted proportion of patients with all-cause emergency department visits or observation stays that did not result in a hospital admission within the 6-month episode	N/A: Claims-based measure
OCM-3	Patients admitted to hospice	N/A	Proportion of patients who died who were admitted to hospice for 3 days or more	N/A: Claims-based measure

[24] https://innovation.cms.gov/initiatives/oncology-care/
[25] Performance Period 3 covers the 6-month oncology care episodes that ends January 1, 2018, through June 30, 2018.

Measure Number in OCM	Measure Name	NQF/ Quality Number (if applicable)	Measure Description	Submission Mechanism
OCM-6	Patient-Reported Experience of Care	N/A	Patient-Reported Experience of Care	Patient Survey

N/A = not applicable

3.5 Comprehensive End-Stage Renal Disease Care Model

The CEC Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with ESRD. The Model aims to test accountable care concepts for ESRD beneficiaries. In the CEC Model, dialysis clinics, nephrologists, and other providers join together to create an APM Entity, known as an ESRD Seamless Care Organization (ESCO) to coordinate care for matched beneficiaries. ESCOs are accountable for clinical quality outcomes and financial outcomes.[26]

The CEC Model includes separate financial arrangements for large and small dialysis organizations. Large Dialysis Organizations (LDOs), which have 200 or more dialysis facilities, will be eligible to receive shared savings payments. These LDOs will also be liable for shared losses and will have higher overall levels of risk compared with their smaller counterparts. Non-LDOs include chains with fewer than 200 dialysis facilities, independent dialysis facilities, and hospital-based dialysis facilities. Non-LDOs will have the option of participating in a one-sided risk track where they will be able to receive shared savings payments but will not be liable for payment of shared losses, or participating in a track with the opportunity for greater shared savings and the potential for shared losses. The one-sided risk track is offered in recognition of non-LDOs more-limited resources.[27]

The CEC Model has 21 quality measures that are tied to payment, however only 16 are eligible for scoring under the APM scoring standard in 2018. Measures are either process or outcome measures and there are 4 data sources for the measures collected in the CEC measures set—CMS ESRD Quality Incentive Program (QIP) results, claims measures, hybrid measures, and a survey measure (the Kidney Disease Quality of Life Survey). The ESCO receives credit under the APM for complete reporting on all measures (see below).

ESCOs submit some measures to CEC through the Quality Measures Assessment Tool (QMAT), and other measures (e.g., CAHPS) come from Center for Clinical Standards and Quality measure results (see **Table 3.5**). Note that measures may be removed from this list, but new measures will not be added for the 2018 performance year.

[26] https://innovation.cms.gov/initiatives/comprehensive-esrd-care/
[27] https://innovation.cms.gov/initiatives/comprehensive-esrd-care/

Benchmarks will be used for all measures. Given the CEC timeline, it may be likely that the CEC Model will not have participants' quality information collected in time for APM scoring in 2019 for the 2018 performance period. In this case, eligible clinicians in these CEC APM entities will have their quality performance category reweighted to zero percent.

Table 3.5 Comprehensive ESRD Care Model 2018 MIPS APM measure list

Measure Name	NQF/ Quality Number (if applicable)	Measure Description	Submission Mechanism
ESCO Standardized Mortality Ratio	0369/154	This measure is calculated as a ratio but can also be expressed as a rate.	N/A: Claims-based measure
Falls: Screening, Risk Assessment and Plan of Care to Prevent Future Falls	0101/154	A) Screening for Future Fall Risk: Patients who were screened for future fall risk at last once within 12 months B) Multifactorial Falls Risk Assessment: Patients at risk of future fall who had a multifactorial risk assessment for falls completed within 12 months C) Plan of Care to Prevent Future Falls: Patients at risk of future fall with a plan of care for falls prevention documented within 12 months.	QMAT
Advance Care Plan	0326/47	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	QMAT
In-Center Hemodialysis (ICH)-CAHPS: Nephrologists'	0258	• Summary/Survey Measures may include: • Getting timely care, appointments, and information;	Patient Survey

Measure Name	NQF/ Quality Number (if applicable)	Measure Description	Submission Mechanism
Communication and Caring		• How well providers communicate; • Patients' rating of provider; • Access to specialists; • Health promotion and education; • Shared decision making; • Health status and functional status; • Courteous and helpful office staff; • Care coordination; • Between visit communication; • Helping you to take medications as directed; and • Stewardship of patient resources.	
ICH-CAHPS: Rating of Dialysis Center	0258	Comparison of services and quality of care that dialysis facilities provide from the perspective of ESRD patients receiving in-center hemodialysis care. Patients will assess their dialysis providers, including nephrologists and medical and non-medical staff, the quality of dialysis care they receive, and information sharing about their disease.	Patient Survey
ICH-CAHPS: Quality of Dialysis Center Care and Operations	0258	Comparison of services and quality of care that dialysis facilities provide from the perspective of ESRD patients receiving in-center hemodialysis care. Patients will assess their dialysis providers, including nephrologists and medical and non-medical staff, the quality of dialysis care they receive, and	Patient Survey

Measure Name	NQF/ Quality Number (if applicable)	Measure Description	Submission Mechanism
		information sharing about their disease.	
ICH-CAHPS: Providing Information to Patients	0258	Comparison of services and quality of care that dialysis facilities provide from the perspective of ESRD patients receiving in-center hemodialysis care. Patients will assess their dialysis providers, including nephrologists and medical and non-medical staff, the quality of dialysis care they receive, and information sharing about their disease.	Patient Survey
ICH-CAHPS: Rating of Kidney Doctors	0258	Comparison of services and quality of care that dialysis facilities provide from the perspective of ESRD patients receiving in-center hemodialysis care. Patients will assess their dialysis providers, including nephrologists and medical and non-medical staff, the quality of dialysis care they receive, and information sharing about their disease.	Patient Survey
ICH-CAHPS: Rating of Dialysis Center Staff ICH-CAHPS: Rating of Dialysis Center	0258	Comparison of services and quality of care that dialysis facilities provide from the perspective of ESRD patients receiving in-center hemodialysis care. Patients will assess their dialysis providers, including nephrologists and medical and non-medical staff, the quality of dialysis care they receive, and information sharing about their disease.	Patient Survey
Medication Reconciliation Post Discharge	0554	The percentage of discharges from any inpatient facility (e.g., hospital, skilled nursing facility, or	QMAT

Measure Name	NQF/ Quality Number (if applicable)	Measure Description	Submission Mechanism
		rehabilitation facility) for patients 18 years of age and older seen within 30 days following the discharge in the office by the physicians, prescribing practitioner, registered nurse, or clinical pharmacist providing ongoing care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is reported as three rates stratified by age group: ▪ Reporting Criteria 1: 18–64 years of age ▪ Reporting Criteria 2: 65 years and older ▪ Total Rate: All patients 18 years of age and older	
Diabetes Care: Eye Exam	0055/117	Percentage of patients 18–75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period	QMAT
Diabetes Care: Foot Exam	0056/163	Percentage of patients 18–75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the previous measurement year	QMAT
Influenza Immunization for the ESRD Population	0041/110, 0226	Percentage of patients aged 6 months and older seen for a visit between July 1 and March 31 who received an influenza immunization	QMAT

Measure Name	NQF/ Quality Number (if applicable)	Measure Description	Submission Mechanism
		OR who reported previous receipt of an influenza immunization	
Pneumococcal Vaccination Status	0043/111	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine	QMAT
Screening for Clinical Depression and Follow-Up Plan	0418/134	Percentage of patients aged 12 and older screened for depression on the date of the encounter and using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	QMAT
Tobacco Use: Screening and Cessation Intervention	0028/226	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	QMAT

N/A = not applicable.

Section 4: APM Scoring Standard for the Quality Performance Category

In the 2018 Quality Payment Program Final Rule, the APM scoring standard for the quality performance category is broken out separately for (1) APM Entities that submit quality data using the CMS Web Interface; and (2) Other MIPS APM Entities that do not use the CMS Web Interface.[28] Regardless of this distinction, the APM scoring standard in this category for MIPS APMs comprises three scoring concepts: (1) quality measures achievement points, scored according to performance against a benchmark; (2) quality measures bonus points; and (3) quality improvement score if applicable.

4.1 Quality Measures Achievement Points

4.1.1 CMS Web Interface Reporters

The quality performance category score for a MIPS performance period is calculated for the MIPS eligible clinicians identified on a Participation List for the MIPS APM using the data

[28] 42 C.F.R. §414.1370 2017

submitted by the APM Entity according to the terms of the MIPS APM, including data on measures submitted through the CMS Web Interface and other measures specified by CMS through notice and comment rulemaking for the APM scoring standard.

4.1.2 Other MIPS APMs

The MIPS quality performance category score for a MIPS performance period is calculated for the MIPS eligible clinicians identified as participating in the MIPS APM using the data submitted by the APM Entity based on measures specified by CMS through notice and comment rulemaking for each Other MIPS APM from among those used under the terms of the MIPS APM.

4.1.3 Achievement Points

For a quality measure to be scored under the APM scoring standard, it must meet all the following criteria:

(1) Be tied to payment[29];

(2) Be available for scoring[30];

(3) Have a minimum of 20 cases available for reporting; and

(4) Have an available benchmark.

If any of the above conditions are not met for a given measure, the APM Entity group that reported the measure will receive a null score for that measure's achievement points, and the measure will be removed from both the numerator and the denominator of the quality performance category percentage.

The minimum number of required measures to be reported will be the minimum number of quality measures available for scoring up to the number of quality measures that are required to be reported under the terms of the APM. If an APM Entity reports fewer quality measures than the minimum number required by the corresponding MIPS APM, then that APM Entity will receive a zero for those unreported measures.

[29] Only pay-for-performance measures from the APM entity would be eligible for APM scoring; pay-for-reporting measures will not be scored.
[30] Measures that are available for scoring are those that have been submitted by the close of the MIPS submission period and have been processed and made available to MIPS for scoring in time to calculate a MIPS quality performance category score.

On the other hand, if an APM Entity reports more than the minimum, and those additional measures meet the criteria for scoring, only the measures with the highest scores will be scored, up to the number of measures required to be reported under the MIPS APM.

Measure achievement points will be calculated for a given measure that meet the data completeness requirement by comparing an APM Entity's measure performance against the corresponding set of benchmarks. Whole-number points, between 1 and 10, will be awarded based on the decile within which an APM Entity's measure performance falls. In addition, tenths of a point will be awarded based on the APM Entity's measure performance according to the following formula:

$$p = (q-D_n)/(D_{n+1} - D_n)$$

where p is the quantity of partial points,
q is an APM entity's performance rating for a given measure,
D is the score associated with the lower-bound of a given decile, and
n is the decile within which the performance rating (q) falls.
Note: Partial points are truncated to the tenths place.

For example, if an APM Entity's measure performance is 84% of the way to the next decile, then it will score 0.8 points in addition to the whole-number quantity corresponding to the decile within which its measure performance falls. Measures that fall within the 10th decile earn the maximum 10.0 points with no partial points. CMS Web Interface measures that do not meet the data completeness requirement will receive a score of zero.[31] Required measures that are eligible for scoring but are not submitted will earn zero points.

4.1.4 Benchmarks

Under the APM scoring standard, CMS will use the benchmarks for each measure based on the MIPS APM's own established benchmarks. For example, for all CMS Web Interface reporters, benchmarks from the corresponding reporting year of the Shared Savings Program will be used. Similarly, benchmarks calculated by the OCM for "Period 3" will be used for its APM Entities' scoring. If the APM does not produce a set of benchmark scores for a reportable measure, CMS will use the MIPS benchmarks, provided the measure specifications are the same under both the MIPS final list and the APM measures list. If neither the APM nor MIPS has a set of benchmarks scores available for a reported measure, then the measure would be "disqualified" and removed from both the numerator and the denominator of the quality performance category percentage.

Quality measure benchmarks are defined as decile breakpoints in the performance rating distribution for a given measure, MIPS APM, performance year, and even by submission

[31] 42 C.F.R §414.1380(b)(1)(viii) 2017

mechanism. Thus, a given set of benchmarks will be distinct to the combination of measure, MIPS APM, performance year, and submission mechanism.

4.2 Bonus Points in the Quality Performance Category

For both CMS Web Interface submitters and Other MIPS APMs, quality measure bonus points are available in the quality performance category in two ways:

1. High-priority measures. High-priority measures are defined as outcome, appropriate use, patient safety, efficiency, patient experience, and care coordination measures. Measure bonus points are not available for the first reported outcome measure, which is required to be reported. Outcome and patient experience measures receive two measure bonus points. Other high-priority measures receive one measure bonus point. Note that if no outcome measures are available, then one high-priority measure is required, and thus one bonus point will be awarded for each additional high-priority measure reported beyond the first required high-priority measure.

   To qualify for measure bonus points, each measure must
   be reported with sufficient case volume to meet the required case minimum,
   meet the required data completeness criteria, and
   not have a zero percent performance rate.[32]

   Measure bonus points may be included in the calculation of the quality performance category percent score regardless of whether the measure is included in the calculation of the total measure achievement point. However, measure bonus points for high-priority measures cannot exceed 10 percent of the total available measure achievement points for the 2019 and 2020 MIPS payment years.

2. CEHRT bonus points. One measure bonus point is also available for each measure submitted with end-to-end electronic reporting for a quality measure under certain criteria determined by the Secretary. Bonus points cannot exceed 10 percent of the total available measure achievement points for the 2019 and 2020 MIPS payment years (2017 and 2018 performance years, respectively). If the same measure is submitted via two or more submission mechanisms, the measure will receive measure bonus points only once for the measure beginning in the 2021 MIPS payment year.

Any bonus points earned by an APM Entity reporting on measures beyond the minimum number of measures required by the model will still be awarded, subject to the limitations discussed above, even if the measure may not be scored for achievement points.

[32] For any high-priority measures that are inverse measures, the requirement becomes “not have a 100 percent performance rate.”

4.3 Quality Improvement Score

CMS will calculate a quality improvement score for the MIPS eligible clinicians in the APM Entity group beginning in 2018.[33] The improvement percent score is assessed at the performance category level for the quality performance category.[34] To be eligible for the quality improvement score, data must be comparable to meet the requirement of data sufficiency, which means the following:

- The quality performance category achievement percent score is available for the current performance period and the previous performance period and quality performance category achievement percent scores can be compared.
- The quality performance category achievement percent scores are comparable when submissions are received from the same identifier for two consecutive performance periods.[35]

The improvement score is awarded based on the rate of increase in the quality performance category achievement percent score of MIPS eligible clinicians from the previous performance period to the current performance period. In particular, this score is calculated by dividing the increase in the quality performance category achievement percent score from the prior performance period to the current performance period by the prior performance period quality performance category achievement percent score multiplied by 10 percent, without consideration of measure bonus points or improvement percent score. The improvement percent score may not total more than 10 percentage points and cannot be lower than zero percentage points.

For the 2020 MIPS payment year (i.e., 2018 performance year), if an APM Entity or MIPS eligible clinician has a previous year quality performance category achievement percent score less than or equal to 30 percent, then the 2018 performance will be compared to an assumed 2017 quality performance category achievement percent score of 30 percent. But the improvement percent score will be zero if the MIPS eligible clinician did not fully participate in the quality performance category for the current performance period.

4.4 Total Quality Performance Category Score.

The total quality performance category percent score is generated by first summing achievement points and any applicable bonus points. This sum is then divided by the total number of available achievement points, multiplied by 100 percent. This percentage score is

[33] 42 C.F.R. §414.1370(g)(1)(i)(B) 2017
[34] 42 C.F.R. §414.1380(b)(1)(xvi) 2017
[35] If the identifier is not the same for two consecutive performance periods from an APM Entity, the comparable quality performance category achievement percent score is the average of the quality performance category achievement percent score associated with the final score from the prior performance period that will be used for payment for each of the individuals in the group.

then combined with the quality improvement score for the total quality performance category score, which may not exceed 100 percent.

*Quality performance category percent score = ([total measure achievement points + measure bonus points]/total available measure achievement points * 100%) + quality improvement percent score*

Note that the number of available achievement points is the number of measures required under the terms of the APM, which meet the criteria for scoring multiplied by 10. Bonus points for CEHRT reporting and bonus points for reporting high-priority measures are each capped at 10 percent of the total available measure achievement points; the quality improvement score is capped at 10 percent of the total quality performance category percent score

4.5 2018 APM Scoring Standard for CMS Web Interface Reporters

The following section explains the 2018 APM scoring standard for CMS Web Interface submitters, which covers MIPS eligible clinicians participating in both Shared Savings Program APM entities (all tracks), Track 1+ ACOs, and the NGACO APM entities. This section ends with a table that displays both the maximum points possible and a more realistic "real-world" performance scoring scenario for illustration purposes.

- In 2018, Shared Savings Program ACOs, Track 1+ ACOs, and NGACOs must report on all 14 Web Interface measures (including one two-component diabetes measure), and the CAHPS for ACO survey;
    - If NGACOs do not completely report on all Web Interface measures, then they get zero points for the quality performance category.
    - If Shared Savings Program ACOs (in any track) do not completely report on all 15 measures, their quality performance category scoring will revert to each ACO participant TIN. These participant TINs will have to separately submit quality measures under the MIPS standards (e.g., via claims, qualified registry, EHR, QCDR, or Web Interface) to be successful under this category.
- Only measures that are designated as pay for performance are eligible for scoring. Measures that have a measure benchmark but are redesignated as pay for reporting for all Shared Savings Program ACOs by the Shared Savings Program will not be scored, as long as the data completeness requirement is met.[36] Note that quality points are earned regardless of whether the Shared Savings Program ACO or the NGACO is in its first performance year (thus under pay-for-reporting only), as long as the measure itself has phased into pay for performance.
- The maximum number of points for each Web Interface measure submitted, assuming complete reporting, is 10 points. However, because only 14 out of the 15 measures have a benchmark that allows the measure to be scored in 2018, the total number of possible points for Shared Savings Program and NGACOs under MIPS APM is 140

[36] 42 C.F.R. §414.1380(b)(1)(viii) 2017

points for this category (i.e., this is the "denominator" by which the 10% capped bonus points are calculated). The minimum number of points for each Web Interface measure submitted is zero points, assuming the measure meets data completeness, has a benchmark, and meets the case minimum requirements.

- CAHPS reporting will count toward the Quality Performance Category for Shared Savings Program ACOs and NGACOs beginning in performance year 2018.
- High-priority measures bonus points:
    - CAHPS for ACOs survey will be included in the MIPS APM quality performance category score starting in performance year 2018, and CMS Web Interface reporters will be eligible to receive two bonus points for reporting the CAHPS for ACOs, which is a high-priority patient experience measure.
    - There are six high-priority measures for Shared Savings Program and NGACO Web Interface submitters, including three that are outcomes measures and one patient experience CAHPS measure. Note that the first outcomes measure is required and does not earn any bonus points. Accordingly, the maximum number of high priority bonus points that ACOs can earn is 8 points, which is below the cap of 14 points (10% of denominator).
- CEHRT bonus points:
    - ACOs will need to demonstrate end-to-end reporting via CEHRT to earn 1 bonus point for each measure; note that the number of possible bonus points under CEHRT is capped at 14 (10% of denominator).
    - ACOs will not be eligible to receive the CEHRT bonus points under the following scenarios because the data was manually entered, and there was interrupted data flow:
        - ACOs use certified health information technology (IT), including but not limited to, technology needed to satisfy the definition of CEHRT at §414.1305, to capture demographic and clinical data and transmit it to the third-party intermediary using appropriate standard or method (Quality Reporting Document Architecture [QRDA], Consolidated-Clinical Document. Architecture [C-CDA], application programming interface [API]). For example: the eligible clinician or group, or a third-party intermediary, uses automated, verifiable software to process data, calculate, and report MIPS-approved measures through manual entry, or manual manipulation of an uploaded file, into a CMS web portal.[37]

[37] As stated in the CY 2017 Quality Payment Program final rule with comment period at 81 FR 77299: "The group, or a third party submitting data on their behalf, may use the CMS Web Interface to submit electronic data for quality measure submissions. However, such a submission would only be awarded the bonus for end-to-end reporting if the submission included uploading an electronic file without modification. This is to preserve the electronic flow of data end-to-end and provide a verifiable method to ensure that manual abstraction, manual calculation, or subsequent manual correction or manipulation of the measures using abstraction did not occur."

- Uses certified health IT to support patient care and capture data but abstracts it manually into a web portal or abstraction-input app. For example, the third-party intermediary uses automated, verifiable software to process data, calculate, and report the measure.[38]

Table 4.1 provides detailed examples of the APM scoring standard for CMS Web Interface submitters under the quality performance category.

[38] As stated in the CY 2018 Quality Payment Program final rule with comment period at 81 FR 77299: "The MIPS eligible clinician initially captures data electronically, but manually abstracts the data for analysis and keys it into a web portal used by a registry. The registry then calculates and submits the measure results to CMS electronically. In this case, no bonus point would be given as the manual abstraction process interrupted the complete end-to-end electronic data flow."

Table 4.1 Quality performance scenario under APM scoring standards for CMS Web Interface submitters

ACO measure number	Measure title	High-priority measure? (# bonus points)	Benchmark available?	Shared Savings Program and NGACO (if ACO successfully reports) max. points scenario		Shared Savings Program and NGACO (if ACO successfully reports) hypothetical scenario[a]	
				Scored?	Achievement points earned	Scored?	Achievement points earned
ACO-12	Medication Reconciliation Post-Discharge	Yes (1 point)	Yes	Yes	10.0	Yes	5.4
ACO-13	Falls: Screening for Future Fall Risk	Yes (1 point)	Yes	Yes	10.0	Yes	5.4
ACO-14	Preventive Care and Screening: Influenza Immunization	No	Yes	Yes	10.0	Yes	5.4
ACO-15	Pneumonia Vaccination Status for Older Adults	No	Yes	Yes	10.0	Yes	5.4
ACO-16	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up	No	Yes	Yes	10.0	Yes	5.4
ACO-17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	No	Yes	Yes	10.0	Yes	5.4

ACO measure number	Measure title	High-priority measure? (# bonus points)	Benchmark available?	Shared Savings Program and NGACO (if ACO successfully reports) max. points scenario		Shared Savings Program and NGACO (if ACO successfully reports) hypothetical scenario[a]	
				Scored?	Achievement points earned	Scored?	Achievement points earned
ACO-18	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	No	Yes	Yes	10.0	Yes	5.4
ACO-19	Colorectal Cancer Screening	No	Yes	Yes	10.0	Yes	5.4
ACO-20	Breast Cancer Screening	No	Yes	Yes	10.0	Yes	5.4
ACO-42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	No	Yes	Yes	10.0	Yes	5.4
ACO-40	***Depression Remission at Twelve Months***	Yes (0 points; first required outcome)	No	No	-	No	-

ACO measure number	Measure title	High-priority measure? (# bonus points)	Benchmark available?	Shared Savings Program and NGACO (if ACO successfully reports) max. points scenario		Shared Savings Program and NGACO (if ACO successfully reports) hypothetical scenario[a]	
				Scored?	Achievement points earned	Scored?	Achievement points earned
Diabetes Composite	***ACO-27: Hemoglobin A1c Poor Control*** ACO-41: Diabetes—Eye Exam	Yes (2 points)	Yes	Yes	10.0	Yes	5.4
ACO-28	***Hypertension (HTN): Controlling High Blood Pressure***	Yes (2 points)	Yes	Yes	10.0	Yes	5.4
ACO-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	No	Yes	Yes	10.0	Yes	5.4
Composite of ACO 1-7 and ACO-34	CAHPS measure	Yes (2 points)	Yes	Yes	10.0	Yes	5.4
(A) Subtotal quality performance category regular points =					**140.0**		**75.6**
(B) Total possible Quality Performance Category points ("Denominator")[b]=					*140*		*140*
i. Bonus points for reporting high priority in Web Interface, including outcomes measures =					6		6
ii. Bonus points for reporting high-priority measures via patient experience CAHPS =					2		2

ACO measure number	Measure title	High-priority measure? (# bonus points)	Benchmark available?	Shared Savings Program and NGACO (if ACO successfully reports) max. points scenario		Shared Savings Program and NGACO (if ACO successfully reports) hypothetical scenario[a]	
				Scored?	Achievement points earned	Scored?	Achievement points earned
Subtotal high-priority bonus points (i+ii)=					8		8
(1) Subtotal high-priority bonus points (no more than cap[c]) =					**8**		**8**
Bonus points for reporting measures via end-to-end CEHRT (1 points x 14 measures)[d] =					14		14
(2) Subtotal CEHRT bonus points (no more than cap) =					**14**		**14**
(C) Total Bonus points [(1) + (2)] =					**22**		**22**
Total possible Quality Performance Category points (A) + (C) =					162		97.6
(D) Quality Performance Category Achievement Score [(A)+(C)]/(B*100%) =					**115.7%**		**69.7%**
(E) Quality Performance Category Improvement Score (%)[e] =					10.0%		10.0%
(F) Total Quality Performance Category Percent Score [(D)+(E)][f]=					100.0%		79.7%
(G) Weight of quality performance Category =					0.5		0.5
(H) Quality Performance points toward the MIPS final score [(F) x (G)]					**50.0%**		**39.9%**

Bolded and *italicized* measures are considered outcomes measures (ACO-27, ACO-28, and ACO-40)

[a] For ease of illustration, we assume that this CMS Web Interface submitting APM entity receives 5.4 out of 10 achievement points for each eligible measure in this hypothetical but more realistic scenario.

[b] Case size minimum=20 for all Web interface measures 1 through 14

[c] High-priority and CEHRT bonuses: Cap on bonus points to 10 percent of the quality score denominator (i.e., 10% x 140 = 14 points); assuming full CEHRT bonus earned

[d] Assuming full CEHRT submission assumed on all 14 measures

[e] Assuming full improvement score earned

[f] Cannot exceed 100%

4.6 2018 APM Scoring Methodology for Other MIPS APM

The following section the 2018 APM scoring standard for Other MIPS APMs, which covers MIPS eligible clinicians participating in APM entities in the OCM, CPC+ Model, and CEC Model. This section ends with a table that displays both the maximum points possible and a more realistic "real-world" performance scoring scenario for illustration purposes.

- CMS expects that each of these Other MIPS APMs will have at least one eligible measure for 2018 APM scoring (i.e., meeting all the inclusion criteria listed in Section 4.1.3).

- In the event that an APM entity has no 2018 performance year data available for APM scoring, they will be given a weight of zero for the quality performance category.

- Similar to the CMS Web Interface submitters, bonus points will be awarded for (1) reporting high priority measures (outcome, appropriate use, patient safety, efficiency, patient experience, or care coordination quality measure) or (2) measures with end-to-end CEHRT reporting. Two bonus points will be awarded for reporting each outcome measure beyond the required first, two bonus points will be awarded for each patient experience measure reported, and one bonus point will be awarded for reporting each additional high priority measure. Each measure must have a performance rate that is greater than zero and meet the case minimum requirements in order to earn bonus points. The total number of bonus points awarded may not exceed 10 percent of the APM entity's total available achievement points for the MIPS quality performance category score; this cap is applied separately to bonus points from high priority measures and bonus points from CEHRT reporting.

Tables 4.2 through 4.4 provide detailed examples of the APM scoring standards for Other MIPS APMs (CEC, CPC+, OCM, respectively) under the quality performance category.

Table 4.2 Comprehensive ESRD Care Quality Performance Category Percentage Score Calculation

Measure title	High-priority measure? (# bonus points)	Eligible for CEHRT bonus (1 point ea.)	Benchmark available?	CEC Model max. points scenario		CEC Model hypothetical points scenario	
				Scored?	Achievement points earned	Scored?	Achievement points earned
ESCO Standardized Mortality Ratio	Yes (0 points; first required outcome)	0	Yes	Yes	10	Yes	5.4
ICH-CAHPS: Nephrologists' Communication and Caring	Yes (2 points; Patient Experience)	0	Yes	Yes	10	Yes	5.4
ICH-CAHPS: Quality of Dialysis Center Care and Operations	Yes (2 points; Patient Experience)	0	Yes	Yes	10	Yes	5.4
ICH-CAHPS: Providing Information to Patients	Yes (2 points; Patient Experience)	0	Yes	Yes	10	Yes	5.4
ICH-CAHPS: Rating of Kidney Doctors	Yes (2 points; Patient Experience)	0	Yes	Yes	10	Yes	5.4
ICH-CAHPS: Rating of Dialysis Center Staff	Yes (2 points; Patient Experience)	0	Yes	Yes	10	Yes	5.4
ICH-CAHPS: Rating of Dialysis Center	Yes (2 points; Patient Experience)	0	Yes	Yes	10	Yes	5.4

Measure title	High-priority measure? (# bonus points)	Eligible for CEHRT bonus (1 point ea.)	Benchmark available?	CEC Model max. points scenario		CEC Model hypothetical points scenario	
				Scored?	Achievement points earned	Scored?	Achievement points earned
Falls: Screening, Risk Assessment and Plan of Care to Prevent Future Falls	Yes (1 point; Patient Safety)	1	Yes	Yes	10	Yes	5.4
Advance Care Plan	Yes (1 point; Care Coordination)	1	Yes	Yes	10	Yes	5.4
Medication Reconciliation Post Discharge	No	1	Yes	Yes	10	Yes	5.4
Diabetes Care: Eye Exam	No	1	Yes	Yes	10	Yes	5.4
Diabetes Care: Foot Exam	No	1	Yes	Yes	10	Yes	5.4

(continued)

Measure title	High-priority measure? (# bonus points)	Eligible for CEHRT bonus (1 point ea.)	Benchmark available?	CEC Model max. points scenario		CEC Model hypothetical points scenario	
				Scored?	Achievement points earned	Scored?	Achievement points earned
Influenza Immunization for the ESRD Population	No	1	Yes	Yes	10	Yes	5.4
Pneumococcal Vaccination Status	No	1	Yes	Yes	10	Yes	5.4
Screening for Clinical Depression and Follow-Up Plan	No	1	Yes	Yes	10	Yes	5.4
Tobacco Use: Screening and Cessation Intervention	No	1	Yes	Yes	10	Yes	5.4
(A) Total Possible Measure Achievement Points[a]					160		160
(B) Maximum Earned Measure Achievement Points[b]					**160.0**		**86.4**
(C) Maximum Earned High Priority Bonus Points[c]					14		14
(D) Maximum Earned CEHRT Bonus Points[c,d]					9		9
(E) Total Bonus Points = [(C)+(D)]					**23**		**23**
Total possible Quality Performance Category points = [(B)+(E)]					183.0		109.4
(F) Quality Performance Category Achievement Score= [(B)+(E)]/(A)*100%]					114.4%		68.4%
(G) Quality Performance Category Improvement Percent Score[e]					10.0%		10.0%
(H) Total Quality Performance Category Percent Score[f]= [(F)+(G)]					**100.0%**		**78.4%**
(I) Weight of the Quality Performance Category					0.5		0.5
Total Quality Performance Category Points Toward Final Score = [(H)*(I)]					**50.0%**		**39.2%**

[a] Assumes measure performance data are available for scoring, the 20-case minimum has been met, and benchmarks are available.
[b] Assumes data completeness requirements have been met and a maximum score of 10 on all measures.
[c] Bonus points are capped at 10% of the Total Possible Measure Achievement Points (A). Any bonus points earned by an APM entity reporting on measures beyond the minimum number of measures required by the model will still be awarded even if the measure may not be scored for achievement points.
[d] Assumes end-to-end CEHRT reporting for all eligible measures submitted by APM entities.
[e] Assumes the maximum Quality Performance Category Improvement Score of 10%.
[f] Total Quality Performance Category Percent Score is capped at 100%.

Table 4.3 Comprehensive Primary Care Plus Quality Performance Category Percentage Score Calculation

Measure title	High-priority measure? (# bonus points)	Eligible for CEHRT bonus (1 point ea.)	Benchmark available?	CPC+ Model Max. points scenario		CPC+ Model Hypothetical points scenario	
				Scored?	Achievement points earned	Scored?	Achievement points earned
Controlling High Blood Pressure	Yes (0 points; first outcome required)	1	Y	Yes	10	Yes	5.4
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	Yes (2 points; outcome)	1	Y	Yes	10	Yes	5.4
Falls: Screening for Future Fall Risk	Yes (1 point; Patient Safety)	1	Y	Yes	10	Yes	5.4
Diabetes: Eye Exam	No	1	Y	Yes	10	Yes	5.4
Dementia: Cognitive Assessment	No	1	Y	Yes	10	Yes	5.4
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	No	1	Y	Yes	10	Yes	5.4
Closing the Referral Loop: Receipt of Specialist Report	1 (Patient Safety)	1	Y	Yes	10	Yes	5.4
Cervical Cancer Screening	No	1	Y	Yes	10	Yes	5.4
Colorectal Cancer Screening	No	1	Y	Yes	10	Yes	5.4
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	No	1	Y	No	N/A	No	N/A
Breast Cancer Screening	No	1	Y	No	N/A	No	N/A

Measure title	High-priority measure? (# bonus points)	Eligible for CEHRT bonus (1 point ea.)	Benchmark available?	CPC+ Model Max. points scenario		CPC+ Model Hypothetical points scenario	
				Scored?	Achievement points earned	Scored?	Achievement points earned
Preventive Care and Screening: Influenza Immunization	No	1	Y	No	N/A	No	N/A
Pneumonia Vaccination Status for Older Adults	No	1	Y	No	N/A	No	N/A
Diabetes: Medical Attention for Nephropathy	No	1	Y	No	N/A	No	N/A
Ischemic Vascular Disease (IVD): Use of Aspirin or Another	No	1	Y	No	N/A	No	N/A

(continued)

Measure title	High priority measure? (# bonus points)	Eligible for CEHRT bonus (1 point ea.)	Benchmark available?	CPC+ Model max. points scenario		CPC+ Model hypothetical points scenario	
				Scored?	Achievement points earned	Scored?	Achievement points earned
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	No	1	Y	No	N/A	No	N/A
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	No	1	Y	No	N/A	No	N/A
Inpatient Hospital Utilization (IHU)	Yes (2 points; outcome)	0	Y	No	N/A	No	N/A
Emergency Department Utilization (EDU)	Yes (2 points; outcome)	0	Y	No	N/A	No	N/A
CAHPS	Yes (2 points; Patient Experience)	0	Y	No	N/A	No	N/A
(A) Total Possible Measure Achievement Points[a]					90		90
(B) Maximum Earned Measure Achievement Points[b]					**90.0**		**48.6**
(C) Maximum Earned High Priority Bonus Points[c]					9		9
(D) Maximum Earned CEHRT Bonus Points[c,d]					9		9
(E) Total Bonus Points = [(C)+(D)]					**18**		**18**
Total possible Quality Performance Category points = [(B)+(E)]					108.0		66.6
(F) Quality Performance Category Achievement Score= [(B)+(E)]/(A)*100%]					120.0%		74.0%
(G) Quality Performance Category Improvement Percent Score[e]					10.0%		10.0%

Measure title	High priority measure? (# bonus points)	Eligible for CEHRT bonus (1 point ea.)	Benchmark available?	CPC+ Model max. points scenario		CPC+ Model hypothetical points scenario	
				Scored?	Achievement points earned	Scored?	Achievement points earned
(H) Total Quality Performance Category Percent Score[f] = [(F)+(G)]					**100.0%**		**84.0%**
(I) Weight of the Quality Performance Category					0.5		0.5
Total Quality Performance Category Points Toward Final Score = [(H)*(I)]					**50.0%**		**42.0%**

N/A = not applicable.

[a] Assumes measure performance data are available for scoring, the 20-case minimum has been met, and benchmarks are available; assuming nine of the highest-scoring measures will be scored for CPC+.
[b] Assumes data completeness requirements have been met and a maximum score of 10 on all measures.
[c] Bonus points are capped at 10% of the Total Possible Measure Achievement Points (A). Any bonus points earned by an APM entity reporting on measures beyond the minimum number of measures required by the model will still be awarded even if the measure may not be scored for achievement points.
[d] Assumes end-to-end CEHRT reporting for all eligible measures submitted by APM entities.
[e] Assumes the maximum Quality Performance Category Improvement Score of 10%.
[f] Total Quality Performance Category Percent Score is capped at 100%.

Table 4.4 Oncology Care Model Quality Performance Category Percentage Score Calculation

Measure title	High-priority measure? (# bonus points)	Eligible for CEHRT bonus (1 point ea.)	Benchmark available?	Oncology Care Model max. points scenario		Oncology Care Model hypothetical points scenario	
				Scored?	Achievement points earned	Scored?	Achievement points earned
Patient-Reported Experience of Care	Yes (2 points; Patient Experience)	0	Y	Yes	10	Yes	5.4
Risk-adjusted proportion of patients with all-cause hospital admissions within the 6-month episode	Yes (0 points; first outcome required)	0	Y	Yes	10	Yes	5.4
Risk-adjusted proportion of patients with all-cause ED visits or observation stays that did not result in a hospital admission within the 6-month episode	Yes (2 points; outcome)	0	Y	Yes	10	Yes	5.4
Proportion of patients who died who were admitted to hospice for 3 days or more	Yes (2 points; outcome)	0	Y	Yes	10	Yes	5.4
(A) Total Possible Measure Achievement Points[a]					40		40
(B) Maximum Earned Measure Achievement Points[b]					**40.0**		**21.6**
(C) Maximum Earned High Priority Bonus Points[c]					4		4
(D) Maximum Earned CEHRT Bonus Points[c,d]					0		0
(E) Total Bonus Points = [(C)+(D)]					**4**		**4**
Total possible Quality Performance Category points = [(B)+(E)]					44.0		25.6
(F) Quality Performance Category Achievement Score= [(B)+(E)]/(A)*100%]					110.0%		64.0%
(G) Quality Performance Category Improvement Percent Score[e]					10.0%		10.0%

Measure title	High-priority measure? (# bonus points)	Eligible for CEHRT bonus (1 point ea.)	Benchmark available?	Oncology Care Model max. points scenario		Oncology Care Model hypothetical points scenario	
				Scored?	Achievement points earned	Scored?	Achievement points earned
(H) Total Quality Performance Category Percent Score[f] = [(F)+(G)]					**100.0%**		**74.0%**
(I) Weight of the Quality Performance Category					0.5		0.5
Total Quality Performance Category Points Toward Final Score = [(H)*(I)]					**50.0%**		**37.0%**

[a] Assumes measure performance data are available for scoring, the 20-case minimum has been met, and benchmarks are available.
[b] Assumes data completeness requirements have been met and a maximum score of 10 on all measures.
[c] Bonus points are capped at 10% of the Total Possible Measure Achievement Points (A). Any bonus points earned by an APM entity reporting on measures beyond the minimum number of measures required by the model will still be awarded even if the measure may not be scored for achievement points.
[d] Assumes end-to-end CEHRT reporting for all eligible measures submitted by APM entities.
[e] Assumes the maximum Quality Performance Category Improvement Score of 10%.
[f] Total Quality Performance Category Percent Score is capped at 100%.