Scores for Improvement Activities in MIPS APMs in the 2018 Performance Period

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

MIPS APMs for the 2018 Performance Period:

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

The table below shows the improvement activities performance category score Centers for Medicare & Medicaid Services (CMS) will assign participants in each MIPS APM for the 2018 performance year. MIPS eligible clinicians must earn 40 points in the improvement activities performance category in order to receive full credit in that performance category for the 2018 performance year. As shown below, APM Entities participating in MIPS APMs will receive a full score for

[1] 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.

the improvement activities performance category in 2018 and therefore will not need to submit additional improvement activity information for MIPS. All APM Entity groups in a MIPS APM will receive the same baseline improvement activities score that we assign for the MIPS APM in which they participate.

CMS derived the assigned points for each MIPS APM by reviewing the MIPS APM's participation agreement and/or relevant regulations to determine the improvement activities required as a function of participation in the MIPS APM. The list of required activities for each MIPS APM was compared to the MIPS list of improvement activities for the 2018 performance period. Consistent with MIPS scoring, each improvement activity conveys either 10 points for a medium weighted activity or 20 points for a high weighted activity, and the points for required improvement activities within each MIPS APM were summed to derive the total improvement activities performance category score for each MIPS APM.

We understand that many MIPS eligible clinicians in a MIPS APM may, in the course of their participation, perform improvement activities other than those explicitly required by the MIPS APM's terms and conditions. However, because all MIPS APMs require sufficient improvement activities for us to assign them a full score in 2018, MIPS APM participants will not have any need to independently attest to additional activities in order to achieve the maximum improvement activities performance category score. In the event that the assigned score does not represent the maximum score--for example, if CMS amends through future rulemaking the improvement activities scoring or assessment required to reach the maximum score or if new MIPS APMs are created such that CMS does not assign participants in a MIPS APM full credit in this category--APM Entities may choose to submit additional improvement activities to reach the maximum score.

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

Medicare Shared Savings Program

The Medicare Shared Savings Program is a voluntary program that encourages groups of doctors, hospitals, and other health care providers to come together as an accountable care organization to give coordinated, high quality care to their Medicare patients. Some of the ongoing required improvement activities include collaborating with key partners and stakeholders to implement evidenced-based practices aimed at improving specific chronic conditions, collecting and following up on patient experience and satisfaction data on beneficiary engagement, as well as practice improvements that engage community resources to support patient health goals. CMS determined that the condition for participation under the Shared Savings Program exceeds the requirements in the improvement activities performance category.

ACO Track 1+

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. CMS determined that the condition for participation under ACO Track 1+ exceeds the requirements in the improvement activities performance category.

Next Generation ACO

Similar to their Medicare Shared Savings Program counterparts, participants in the Next Generation ACO model are encouraged to improve care for their patients by adopting care improvement activities. For example, participants are mandated to engage eligible clinicians or groups in prevention and interventions for patients with co-occurring conditions of behavioral or mental health conditions, such as depression screenings and follow-up plans. NGACOs also conduct annual patient and caregiver experience survey to ascertain patient experience. CMS determined that the condition for participation under the NGACO model exceeds the requirements in the improvement activities performance category.

Oncology Care Model

Oncology Care Models practices are required to implement Practice Redesign Activities to improve the quality of healthcare delivered. Eligible improvement activities carried out by OCM participants fall under different subcategories and include the provision of enhanced services like 24/7 access to MIPS eligible clinicians or groups who have real-time access to patient's medical record, practice improvements that engage community resources to support patient health goals, the promotion of patient-reported outcomes, and the use of certified EHR to capture patient reported outcomes. CMS determined that the condition for participation under the OCM exceeds the requirements in the improvement activities performance category.

Comprehensive ESRD Care model

The Comprehensive ESRD Care model mandates improvement activities aimed at creating a cohesive coordinated care effort for patients. One example includes the CEC model’s coordination with Rural Health Clinics (RHCs), Indian Health Services, or Federally Qualified Health Services in ongoing engagement activities that contribute to formal quality scoring and feedback on quality and benchmarking improvement. CEC participants also implement fall screening and assessment programs to identify at-risk patients and risk factors, as well as strategies to prevent future

falls. CMS determined that the condition for participation under the CEC model exceeds the requirements in the improvement activities performance category.

In the 2018 performance year, the improvement activities performance category for all MIPS APMs is weighted at 20 percent under the APM scoring standard.

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_EPA_1	Expanded Practice Access	Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (e.g., MIPS eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: • Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care); • Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits, and alternate locations (e.g., senior centers and assisted living centers); and/or • Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management	High				√	√	√

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_EPA_2	Expanded Practice Access	Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or tele-audiology pilots that assess ability to still deliver quality care to patients.	Medium	√	√				√
IA_EPA_3	Expanded Practice Access	Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs.	Medium	√	√	√	√	√	√
IA_EPA_4	Expanded Practice Access	As a result of the Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services (e.g., investments of on-site diabetes educator).	Medium	√					
IA_PM_3	Population Management	Participating in Rural Health Clinic (RHC), Indian Health Services, or Federally Qualified Health Center in ongoing engagement activities that contribute to more formal quality reporting, and that include receiving quality data back for broader quality improvement and benchmarking improvement which will ultimately benefit patients. Participation in Indian Health Service, as a CPIA, requires MIPS eligible clinicians and groups to deliver care to federally recognized American Indian and Alaska Native populations in the U.S. and in the course of that care implement continuous clinical practice improvement including reporting data on quality of services being provided and receiving feedback to make improvements	Medium			√	√		

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_PM_7	Population Management	Use of a Qualified Clinical Data Registry (QCDR) to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.	High				√		
IA_PM_9	Population Management	Participation in research that identifies interventions, tools or processes that can improve a targeted patient population.	Medium		√	√			
IA_PM_10	Population Management	Participation in a QCDR, clinical data registries, or other registries run by other government agencies such as the FDA, or private entities such as a hospital or medical or surgical society. Activity must include use of QCDR data for quality improvement (e.g., comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcome).	Medium				√		
IA_PM_11	Population Management	Implementation of regular reviews of targeted patient population needs, such as structured clinical case reviews which, includes access to reports that show unique characteristics of eligible clinician's patient population, identification of vulnerable patients, and how clinical treatment needs are being tailored, if Necessary, to address unique needs and what resources in the community have been identified as additional resources.	Medium				√	√	√

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_PM_12	Population Management	Empanel (assign responsibility for) the total population, linking each patient to a MIPS eligible clinician or group or care team. Empanelment is a series of processes that assign each active patient to a MIPS eligible clinician or group and/or care team, confirm assignment with patients and clinicians, and use the resultant patient panels as a foundation for individual patient and population health management. Empanelment identifies the patients and population for whom the MIPS eligible clinician or group and/or care team is responsible and is the foundation for the relationship continuity between patient and MIPS eligible clinician or group /care team that is at the heart of comprehensive primary care. Effective empanelment requires identification of the "active population" of the practice: those patients who identify and use your practice as a source for primary care. There are many ways to define "active patients" operationally, but generally, the definition of "active patients" includes patients who have sought care within the last 24 to 36 months, allowing inclusion of younger patients who have minimal acute or preventive health care.	Medium	√	√	√	√	√	√

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_PM_13	Population Management	Proactively manage chronic and preventive care for empaneled patients that could include one or more of the following: • Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; • Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target; such as a CDC recognized diabetes prevention program; • Use pre-visit planning to optimize preventive care and team management of patients with chronic conditions; • Use panel support tools (registry functionality) to identify services due; • Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due; and/or routine medication reconciliation.	Medium	√	√	√	√	√	√

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_PM_14	Population Management	Provide longitudinal care management to patients at high-risk for adverse health outcome or harm that could include one or more of the following: • Use a consistent method to assign and adjust global risk status for all empaneled patients to allow risk stratification into actionable risk cohorts; • Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification; • Use a personalized plan of care for patients at high-risk for adverse health outcome or harm, integrating patient goals, values and priorities; and/or • Use on-site, practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients.	Medium	√	√		√	√	√
IA_PM_15	Population Management	Provide episodic care management, including management across transitions and referrals that could include one or more of the following: • Routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings, including symptom and disease management, and medication reconciliation and management; and/or • Managing care intensively through new diagnoses, injuries and exacerbations of illness.	Medium				√	√	√

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_PM_16	Population Management	Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following: • Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups; • Integrate a pharmacist into the care team; and/or • Conduct periodic, structured medication reviews.	Medium	√	√		√	√	√
IA_PM_17	Population Management	Participation in federally and/or privately funded research that identifies interventions, tools, or processes that can improve a targeted patient population.	Medium				√		
IA_PM_18	Population Management	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. This activity supports individual MIPS eligible clinicals or groups that coordinate with primary care and other clinicians, engage and support patients, use of health information technology, 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.	Medium				√		

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_PM_21	Population Management	Implementation of practices/processes to develop advance care planning that includes: • Documenting the advance care plan or living will within the medical record; • Educating clinicians about advance care planning motivating them to address and 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 way to manage its documentation, as well as; • Informing clinicians of the healthcare policy side of advance care planning.	Medium				√		
IA_CC_1	Care Coordination	Performance of regular practices that include providing specialist reports back to the referring individual MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the certified EHR technology.	Medium	√			√		
IA_CC_2	Care Coordination	Timely communication of test results defined as timely identification of abnormal test results with timely follow-up.	Medium		√				

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_CC_6	Care Coordination	Participation in a QCDR, demonstrating performance of activities that promote use of standard practices, tools and processes for quality improvement (e.g., documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups).	Medium				√		
IA_CC_8	Care Coordination	Implementation of practices/processes that document care coordination activities (e.g., a documented care coordination encounter that tracks all clinical staff involved and communications from date patient is scheduled for outpatient procedure through day of procedure).	Medium	√		√			
IA_CC_9	Care Coordination	Implementation of practices/processes including a discussion on care to develop regularly updated individual care plans for at-risk patients that are shared with 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	√	√		√		
IA_CC_10	Care Coordination	Implementation of practices/processes for care transition that include documentation of how a MIPS eligible clinician or group carried out a patient-centered action plan for first 30 days following a discharge (e.g., staff involved, phone calls conducted in support of transition, accompaniments, navigation actions, home visits, patient information access, etc.).	Medium	√	√		√	√	√

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_CC_11	Care Coordination	Establish standard operations to manage transitions of care that could include one or more of the following: • Establish formalized lines of communication with local settings in which empaneled patients receive care to ensure documented flow of information and seamless transitions in care; and/or • Partner with community or hospital-based transitional care services.	Medium				√	√	√
IA_CC_12	Care Coordination	Establish effective care coordination and active referral management that could include one or more of the following: • Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and MIPS eligible clinician or MIPS eligible clinician group expectations between settings; • Provide patients with information that sets their expectations consistently with the care coordination agreements; • Track patients referred to a specialist through the entire process; and/or • Systematically integrate information from referrals into the plan of care.	Medium				√	√	√

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_CC_13	Care Coordination	Ensure that there is a bilateral exchange of necessary patient information to guide patient care, such as Open Notes, that could include one or more of the following: • Participate in a Health Information Exchange if available; and/or • Use structured referral notes.	Medium	√			√	√	√
IA_CC_14	Care Coordination	Develop pathways to neighborhood/community-based resources to support patient health goals that could include one or more of the following: • Maintain formal (referral) links to the 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 preferably health IT 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.	Medium	√			√		

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_CC_17	Care Coordination	Implement a Patient Navigator Program that offers evidence-based resources and tools to reduce avoidable hospital readmissions, utilizing a patient-centered and team-based approach, leveraging evidence-based best practices to improve care for patients by making hospitalizations less stressful, and the recovery period more supportive by implementing quality improvement strategies.	High				√		
IA_BE_1	Beneficiary Engagement	In support of improving patient access, performing additional activities that enable capture of patient reported outcomes (e.g., home blood pressure, blood glucose logs, food diaries, at-risk health factors such as tobacco or alcohol use, etc.) or patient activation measures through use of certified EHR technology, containing this data in a separate queue for clinician recognition and review.	Medium				√		
IA_BE_6	Beneficiary Engagement	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.	High	√	√	√	√	√	√
IA_BE_9	Beneficiary Engagement	Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.	Medium				√		
IA_BE_12	Beneficiary Engagement	Use evidence-based decision aids to support shared decision-making.	Medium	√					

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_BE_13	Beneficiary Engagement	Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.	Medium	√	√	√	√	√	√

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_BE_14	Beneficiary Engagement	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 including 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 back on glucometer readings). Therefore, unlike passive platforms or devices that may collect do not transmit PGHD in real or near-real time to clinical care teams, active devices and platforms can inform the patient of the clinical care team in a timely manner of important parameters regarding a patient's status.	High	√	√			√	√

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_BE_15	Beneficiary Engagement	Engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the certified electronic health record (EHR) technology.	Medium	√	√		√		
IA_BE_20	Beneficiary Engagement	Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community.	Medium				√	√	√
IA_PSPA_7	Patient Safety & Practice Assessment	Use of QCDR data, for ongoing practice assessment and improvement to patient safety.	Medium			√			
IA_PSPA_11	Patient Safety & Practice Assessment	Participation in the Consumer Assessment of Healthcare Providers and Systems Survey or other supplemental questionnaire items (e.g., Cultural Competence or Health Information Technology supplemental item sets).	High	√	√	√	√	√	√
IA_PSPA_17	Patient Safety & Practice Assessment	Build the analytic capability required to manage total cost of care for the practice population that could include one or more of the following: • Train appropriate staff on interpretation of cost and utilization information; and/or • Use available data regularly to analyze opportunities to reduce cost through improved care.	Medium	√			√		√

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_PSPA_18	Patient Safety & Practice Assessment	Measure and improve quality at the practice and panel level, such as the American Board of Orthopedic Surgery (ABOS) Physician Scorecards, that could include one or more of the following: • Regularly review measures of quality, utilization, patient satisfaction and other measures that may be useful at the practice level and at the level of the care team or MIPS eligible clinician or group (panel); and/or • Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.	Medium	√	√	√	√	√	√

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_PSPA_19	Patient Safety & Practice Assessment	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities that could include one or more of the following such as: • Multi-Source Feedback; • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practice changes; • Designate regular team meetings to review data and plan improvement cycles; • Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff; and/or • Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families including activities in which clinician's act upon patient experience data.	Medium						√

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_PSPA_20	Patient Safety & Practice Assessment	Ensure full engagement of clinical and administrative leadership in practice improvement that could include one or more of the following: • Make responsibility for guidance of practice change a component of clinical and administrative leadership roles; • Allocate time for clinical and administrative leadership for practice improvement efforts, including participation in regular team meetings; and/or • Incorporate population health, quality and patient experience metrics in regular reviews of practice performance.	Medium	√					
IA_PSPA_21	Patient Safety & Practice Assessment	Implementation of fall screening and assessment programs to identify patients at risk for falls and address modifiable risk factors (e.g., Clinical decision support/prompts in the electronic health record that help manage the use of medications, such as benzodiazepines, that increase fall risk).	Medium	√	√	√			
IA_AHE_1	Achieving Health Equity	Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare. A timely manner is defined as within 10 business days for this activity.	High				√		

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_AHE_3	Achieving Health Equity	Demonstrate performance of activities for employing patient-reporting outcome (PRO) tools and corresponding collection of PRO data such as the use of PQH-2 or PHQ-9, PRO MIS instruments, patient reported Would Quality of Life (QoL), patient reported Wound Outcome, and patient report Nutritional Screening.	High				√		
IA_AHE_5	Achieving Health Equity	MIPS eligible clinician leadership in clinical trials, research alliances or community-based participatory research (CBPR) that identify tools, research or processes that can focus on minimizing disparities in healthcare access, care quality, affordability, or outcomes.	Medium				√		
IA_BMH_2	Behavioral and Mental Health	Tobacco use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including tobacco use screening and cessation interventions (refer to NQF #0028) for patients with co-occurring conditions of behavioral or mental health and at-risk factors for tobacco dependence.	Medium	√	√	√	√		
IA_BMH_4	Behavioral and Mental Health	Depression screening and follow-up plan: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including depression screening and follow-up plan (refer to NQF #0418) for patients with co-occurring	Medium	√	√	√	√		
IA_BMH_5	Behavioral and Mental Health	Major depressive disorder: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including suicide risk assessment (refer to NQF #0104) for mental health patients with co-occurring conditions of behavioral or mental health conditions.	Medium	√	√		√		√

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_BMH_7	Behavioral and Mental Health	Offer integrated behavioral health services to support patients with behavioral health needs who also have conditions, such as dementia or other poorly controlled chronic illnesses. The services 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 MIPS 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 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; • Participate in the National Partnership to Improve Dementia Car Initiative, which promotes a multidimensional approach that includes public reporting, state-based coalitions, research, training, and revised survey or guidance.	High	√					√

Improvement ActivityID	Subcategory Name	Activity Description	Activity Weighting	Shared Savings Program (Tracks 1, 2, 3)	Next Generation ACO	CEC	OCM	CPC+ Track 1	CPC+ Track 2
IA_BHM_8	Behavioral and Mental Health	Enhancements to an electronic health record to capture additional data on behavioral health (BH) populations and use that data for additional decision-making purposes (e.g., capture of additional BH data results in additional depression screening for at-risk patient not previously identified.)	Medium		√				√
Number of 'medium' weighted Improvement Activities				23	18	12	31	14	19
Number of 'high' weighted Improvement Activities				4	3	2	7	4	5
Total number of Improvement Activities				**27**	**21**	**14**	**38**	**18**	**24**
Subtotal score from Improvement Activities				310	240	160	450	220	290
Base score for being an APM				20	20	20	20	20	20
(a) Total Number of Points Earned by the APM				330	260	180	470	240	310
(b) Total possible points earned				40	40	40	40	40	40
Improvement activities category score [(a)/(b)] x 100%[2]				**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

[2] Since (a) is actually capped at 40, the IA category score cannot exceed 100%