2020 MIPS Data Validation – Improvement Activities Performance Category Criteria

ID	Subcategory Name	Activity Name	Activity Description	Activity Weighting	Validation	Suggested Documentation (inclusive of dates during the selected continuous 90 day or year long reporting period)	First PY	Examples of Additional Activities that Qualify for Attestation
IA_EPA_1	Expanded Practice Access	Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record	Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (For example, eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: • Expanded hours in evenings and weekends with access to the patient medical record (For example, coordinate with small practices to provide alternate hour office visits and urgent care); • Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as telehealth, phone visits, group visits, home visits and alternate locations (For example, senior centers and assisted living centers); and/or • Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management.	High	Demonstration of patient care provided outside of normal business hours through 24/7 or expanded practice hours with access to medical records or ability to increase access through alternative access methods or same-day or next-day visits	1) Patient Record from EHR - A patient record from an EHR with date and timestamp indicating services provided outside of normal business hours for that clinician (a certified EHR may be used for documentation purposes, but is not required unless attesting for the Promoting Interoperability [formerly ACI] bonus); or 2) Patient Encounter/Medical Record/Claim - Patient encounter/medical record claims indicating patient was seen or services provided outside of normal business hours for that clinician including use of alternative visits; or 3) Same or Next Day Patient Encounter/Medical Record/Claim - Patient encounter/medical record claims indicating patient was seen same-day or next-day to a consistent clinician for urgent or transitional care.	2017	

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IA_EPA_2	Expanded Practice Access	Use of telehealth services that expand practice access	Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults or teleaudiology pilots that assess ability to still deliver quality care to patients.	Medium	Documented use of telehealth services and participation in data analysis assessing provision of quality care with those services NOTE: For the purposes of this IA, telehealth services include a "real time" interaction and may be obtained over the phone, online, etc. and are not limited to the Medicare reimbursed telehealth service criteria.	1) Use of Telehealth Services - Documented use of telehealth services through: a) claims adjudication (may use G codes to validate); b) EHR or c) other medical record document showing specific telehealth services, consults, or referrals performed for a patient; and 2) Analysis of Assessing Ability to Deliver Quality of Care - Participation in or performance of quality improvement analysis showing delivery of quality care to patients through the telehealth medium (e.g. Excel spreadsheet, Word document or others). NOTE: For the purposes of this IA, telehealth services include a "real time" interaction and may be obtained over the phone, online, etc. and are not limited to the Medicare reimbursed telehealth service criteria.	2017	
IA_EPA_3	Expanded Practice Access	Collection and use of patient experience and satisfaction data on 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	Development and use of access to care improvement plan based on collected and stratified patient experience and satisfaction data	1) Access to Care Patient Experience and Satisfaction Data - Patient experience and satisfaction data on access to care; and 2) Improvement plan - Access to care improvement plan.	2017	Please note: CMS examples of stratification may include, patient demographics such as race/ethnicity, disability status (if available), sexual orientation (if available), sex, gender identity (if available), and geography

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IA_EPA_4	Expanded Practice Access	Additional improvements in access as a result of QIN/QIO TA	As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services or improve care coordination (for example, investment of on-site diabetes educator).	Medium	Implementation of additional processes, practices, resources or technology to improve access to services or improve care coordination, as a result of receiving QIN/QIO technical assistance	1) Relationship with QIN/QIO Technical Assistance - Confirmation of technical assistance and documentation of relationship with QIN/QIO; and 2) Improvement Activities - Documentation of activities that improve access or improve care coordination, including support on additional services offered.	2017	
IA_EPA_5	Expanded Practice Access	Participation in User Testing of the Quality Payment Program Website (https://qpp.cms.gov/)	User participation in the Quality Payment Program website testing is an activity for eligible clinicians who have worked with CMS to provide substantive, timely, and responsive input to improve the CMS Quality Payment Program website through product user-testing that enhances system and program accessibility, readability and responsiveness as well as providing feedback for developing tools and guidance thereby allowing for a more user-friendly and accessible clinician and practice Quality Payment Program website experience.	Medium	Evidence of user participation and implementation of website testing for the Quality Payment Program (QPP)	1) Documentation of input to improve the CMS Quality Payment Program website through product user-testing aimed at enhancing system and program accessibility, readability and responsiveness and 2) Provide feedback for developing tools and guidance for a more efficient and accessible clinician and practice QPP website experience.	2018	
IA_PM_2	Population Management	Anticoagulant management improvements	Individual MIPS eligible clinicians and groups who prescribe anti-coagulation medications (including, but not limited to oral Vitamin K antagonist therapy, including warfarin or other coagulation cascade inhibitors) must attest that for 75 percent of their ambulatory care patients receiving these medications are being managed with support from	High	Documented participation of patients being managed by one or more clinical practice improvement activities. Could be supported by	1) Patients Receiving Anti-Coagulation Medications - Total number of outpatients prescribed oral Vitamin K antagonist therapy; and 2) Percentage of that Total Being Managed By a Clinical Practice Improvement Activity - Number of outpatients prescribed oral Vitamin	2017	

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			one or more of the following improvement activities: • Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, or patient self-management program); • Patients are being managed by an anticoagulant management service, that involves systematic and coordinated care, incorporating comprehensive patient education, systematic prothrombin time (PT-INR) testing, tracking, follow-up, and patient communication of results and dosing decisions; • Patients are being managed according to validated electronic decision support and clinical management tools that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; • For rural or remote patients, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care, incorporating comprehensive patient education, systematic PT-INR testing, tracking, follow-up, and patient communication of results and dosing decisions; or • For patients who demonstrate motivation, competency, and adherence, patients are managed using		claims. Anticoagulation services may consult with patients over the phone, recommending dosage changes and setting dates for follow-up lab work and may also consult with the patient's personal physician or specialty physicians in complex cases.	K antagonist therapy and who are being managed by one or more of the four activities in the described in the activity description; and 3) Documentation plan to address patients' language and communication needs, literacy level, and cognitive and functional limitations.		

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			either a patient self-testing (PST) or patient-self-management (PSM) program.					
IA_PM_3	Population Management	RHC, IHS or FQHC quality improvement activities	Participating in a Rural Health Clinic (RHC), Indian Health Service Medium Management (IHS), or Federally Qualified Health Center (FQHC) 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 (IHS), as an improvement activity, 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 over time.	High	Participation in RHC, IHS, or FQHC occurs and clinical quality improvement occurs	1) Name of RHC, IHS or FQHC - Identified name of RHC, IHS, or FQHC in which the practice participates in ongoing engagement activities; and 2) Continuous Quality Improvement Activities - Documented continuous quality improvement activities that contribute to more formal quality reporting, and that include receiving quality data back for broader quality and benchmarking improvement that ultimately benefits patients.	2017	
IA_PM_4	Population Management	Glycemic management services	For outpatient Medicare beneficiaries with diabetes and who are prescribed antidiabetic agents (e.g., insulin, sulfonylureas), MIPS eligible clinicians and groups must attest to having:

For the first performance year, at least | High | Report listing patients who are diabetic and prescribed antidiabetic agents and have documented | 1) Diabetic Patients Prescribed Antidiabetic Agents - Total number of outpatients who are diabetic and prescribed antidiabetic agents; and 2) Documented Percentage of Total and each demographic group with Glycemic Treatment Goals and | 2017 | Please note: CMS examples of stratification may include, patient demographics such as race/ethnicity, disability status (if |

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			60 percent of medical records with documentation of an individualized glycemic treatment goal that: a) Takes into account patient-specific factors, including, at least 1) age, 2) comorbidities, and 3) risk for hypoglycemia, and b) Is reassessed at least annually. The performance threshold will increase to 75 percent for the second performance year and onward. Clinician would attest that, 60 percent for first year, or 75 percent for the second year, of their medical records that document individualized glycemic treatment represent patients who are being treated for at least 90 days during the performance period.		glycemic treatment goals based on patient-specific factors	Assessed at Least Annually - Number of outpatients, stratified by demographic groups, who are diabetic and prescribed antidiabetic agents, with documented glycemic treatment goals ; and the goals take into account patient-specific factors, including at least age, comorbidities, and risk for hypoglycemia; and are flagged for reassessment in following year.		available), sexual orientation (if available), sex, gender identity (if available), and geography
IA_PM_5	Population Management	Engagement of community for health status improvement	Take steps to improve health status of communities, such as collaborating with key partners and stakeholders to implement evidenced-based practices to improve a specific chronic condition. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist MIPS eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.	Medium	Activity to improve specific chronic condition for specific, identified population within the community is being undertaken	1) Documentation of Partnership in the Community - Screenshot of website or other correspondence identifying key partners and stakeholders and relevant initiative including specific chronic condition and target population; and 2) Steps for Improving Community Health Status - Report detailing steps being taken to satisfy the activity including, e.g., timeline, purpose, and outcome that is in compliance with the local QIO.	2017	
IA_PM_6	Population Management	Use of toolsets or other	Take steps to improve healthcare disparities, such as Population Health	Medium	Activity to improve health disparities	1) Resources Used to Improve Disparities - Resources used, e.g.,	2017	

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		resources to close healthcare disparities across communities	Toolkit or other resources identified by CMS, the Learning and Action Network, Quality Innovation Network, or National Coordinating Center. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.			Population Health Toolkit; and 2) Documentation of Steps - Report detailing activity as outlined by the local QIO with a statement outlining a plan of action to address specific identified disparities including evidence of disparity targeted and how this disparity is changing over time.		
IA_PM_7	Population Management	Use of QCDR for feedback reports that incorporate population health	Use of a QCDR to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.	High	Involvement with a QCDR to generate local practice patterns and outcomes reports including vulnerable populations	Participation in QCDR for population health, e.g., regular feedback reports provided by QCDR that summarize local practice patterns and treatment outcomes, including vulnerable populations.	2017	
IA_PM_11	Population Management	Regular review practices in place on targeted patient population needs	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	Participation in reviews of targeted patient population needs including access to reports and community resources	1) Targeted Patient Population Identification - Documentation of method for identification and ongoing monitoring/review for a targeted patient population; or 2) Report with Unique Characteristics - Reports that show unique characteristics of patient population and identification of vulnerable patients including tailored clinical treatments/medical records demonstrating how clinical treatment is meeting unique needs, and community resources where	2017	Sub-IA-1: Participate in prospective peer review of clinical cases

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						applicable. This documentation of improvements (intended or realized) should provide evidence of tailored clinical treatments that meet the patient's unique needs.		
IA_PM_12	Population Management	Population empanelment	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	Functionality of patient population empanelment including use of panels for health management	1) Active Population Empanelment - Identification of "active population" of the practice with empanelment and assignment confirmation linking patients to MIPS eligible clinician or care team; and 2) Process for Updating Panel - Process for review and update of panel assignments.	2017	

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IA_PM_13	Population Management	Chronic care and preventative care management for empaneled patients	In order to receive credit for this activity, a MIPS eligible clinician must manage chronic and preventive care for empaneled patients (that is, patients assigned to care teams for the purpose of population health management), which could include one or more of the following actions: • 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; and plan of care for chronic conditions; • Use evidence based, condition-specific pathways for care of chronic conditions (for example, hypertension, diabetes, depression, asthma, and heart failure). These might include, but are not limited to, the NCQA Diabetes Recognition Program (DRP) and the NCQA Heart/Stroke Recognition Program (HSRP). • Use pre-visit planning, that is, preparations for conversations or actions to propose with patient before an in-office visit to optimize preventive care and team management of patients with chronic conditions • Use panel support tools, (that is, registry functionality) or other technology that can use clinical data to identify trends or data points in patient records to identify services due; • Use predictive analytical models to	Medium	Management of empaneled patients' chronic and preventive care needs via an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; and plan of care for chronic conditions (could use EHR or medical records)	1) Individualized Plan of Care - Annual opportunity for development and/or adjustment of an individualized plan of care appropriate to age and health status; or 2) Condition-Specific Pathways - Use of condition-specific pathways for chronic conditions with evidence-based protocols, or 3) Pre-visit Planning - Use of pre-visit planning to optimize preventive care and team management; or 4) Panel Support Tools - Use of panel support tools to identify services that are due; or 5) Reminders and Outreach - Use of reminders and outreach to alert and educate patients about services due; or 6) Medication Reconciliation - Use of routine medication reconciliation; or 7) Document the predictive analytical models used to predict risk, onset and progression of chronic diseases.	2017	Sub-IA-1: Add disease-specific services in an individualized plan of care, such as Diabetes Self Management Education and Support (DSME/S) services and Medical Nutrition Therapy (MNT)

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			predict risk, onset and progression of chronic diseases; and/or • Use reminders and outreach (for example, phone calls, emails, postcards, patient portals, and community health workers where available) to alert and educate patients about services due; and/or routine medication reconciliation.					

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IA_PM_14	Population Management	Implementation of methodologies for improvements in longitudinal care management for high risk patients	Provide longitudinal care management to patients at high risk for adverse health outcome or harm that could include one or more of the following: • Use a consistent method to assign and adjust global risk status for all empaneled patients to allow risk stratification into actionable risk cohorts. Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification; • Use a personalized plan of care for patients at high risk for adverse health outcome or harm, integrating patient goals, values and priorities; and/or • Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients.	Medium	Longitudinal care management to patients at high risk for adverse health outcome or harm	1) High Risk Patients - Identification of patients at high risk for adverse health outcome or harm; and 2) Use of Longitudinal Care Management - Documented use of longitudinal care management methods including at least one of the following: a) empaneled patient risk assignment and risk stratification into actionable risk cohorts; or b) personalized care plans for patients at high risk for adverse health outcome or harm; or c) evidence of use of on-site practice based or shared care managers to monitor and coordinate care for highest risk cohort.	2017	
IA_PM_15	Population Management	Implementation of episodic care management practice improvements	Provide episodic care management, including management across transitions and referrals that could include one or more of the following: • Routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings, including symptom and disease management, and medication reconciliation and management; and/or • Managing care intensively through new diagnoses, injuries and exacerbations of illness.	Medium	Provision of episodic care management practice improvements (could use medical records or claims)	1) Follow-Up on Hospitalizations, ED or Other Visits and Medication Management - Routine and timely follow-up to hospitalizations, ED or other institutional visits, and medication reconciliation and management (e.g. documented in medical record or EHR); or 2) New diagnoses, Injuries and Exacerbations - Care management through new diagnoses, injuries and exacerbations of illness (medical record).	2017	

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IA_PM_16	Population Management	Implementation of medication management practice improvements	Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following: • Reconcile and coordinate medications and provide medication management across transitions of care settings and eligible clinicians or groups; • Integrate a pharmacist into the care team; and/or • Conduct periodic, structured medication reviews.	Medium	Inclusion of medication management practice improvements	1) Documented Medication Reviews or Reconciliation - Patient medical records demonstrating periodic structured medication reviews or reconciliation; or 2) Integrated Pharmacist - Evidence of pharmacist integrated into care team; or 3) Reconciliation Across Transitions - Reconciliation and coordination of mediations across transitions of care; or 4) Medication Management Improvement Plan - Report detailing medication management practice improvement plan and outcomes, if available.	2017	Sub-IA-1: Implement "AHRQ Create a Safe Medicine List Together" strategy.
IA_PM_17	Population Management	Participation in Population Health Research	Participation in federally and/or privately funded research that identifies interventions, tools, or processes that can improve a targeted patient population.	Medium	Evidence supporting participation in a federally and/or privately funded research initiative to identify systems, tools, or strategies that improve patient outcomes for a targeted population.	1) Documentation of participation in a federally and/or privately funded research initiative; and 2) Documentation of the interventions, tools, or processes used in the research; and 3) Documentation of the identified target population, and health outcomes targeted.	2018	

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IA_PM_18	Population Management	Provide Clinical-Community Linkages	Engaging community health workers to provide a comprehensive link to community resources through family-based services focusing on success in health, education, and self-sufficiency. This activity supports individual MIPS eligible clinicians 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	Evidence of engagement with community health workers to provide a comprehensive link to community resources and family-based services with an emphasis on improving health, education, and self-sufficiency	1) Documentation of engagement with community health workers; and 2) A demonstrated link to community resources that promote family-based services i.e. paper work, notes, etc.; and 3) Documentation of coordination with primary care and other clinicians to engage and support patients, use of health information technology, and employ quality measurement and improvement processes, e.g. NCQA Patient-Centered Connected Care (PCCC) Recognition Program or similar programs.	2018	Sub IA_1: Provide Community Linkages for Patients with HIV+ Status
IA_PM_19	Population Management	Glycemic Screening Services	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the 2018 performance period and 75 percent in future years, of electronic medical records with documentation of screening patients for abnormal blood glucose according to current US Preventive Services Task Force USPSTF) and/or American Diabetes Association (ADA) guidelines.	Medium	Evidence supporting implementation of systematic preventive approaches in clinical practice for abnormal blood glucose	1) Total stratified number of Medicare patients at risk for abnormal blood glucose; and 2) Percentage of each demographic group and the total screened for abnormal blood glucose as outlined by the US Preventive Services Task Force USPSTF) and/or American Diabetes Association (ADA) guidelines.	2018	Please note: CMS examples of stratification may include, patient demographics such as race/ethnicity, disability status (if available), sexual orientation (if available), sex, gender identity (if available), and geography

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IA_PM_20	Population Management	Glycemic Referring Services	For at-risk outpatient Medicare beneficiaries, individual MIPS eligible clinicians and groups must attest to implementation of systematic preventive approaches in clinical practice for at least 60 percent for the CY 2018 performance period and 75 percent in future years, of medical records with documentation of referring eligible patients with prediabetes to a CDC-recognized diabetes prevention program operating under the framework of the National Diabetes Prevention Program.	Medium	Evidence supporting implementation of systematic preventive approaches in clinical practice for prediabetes	1) Total stratified number of Medicare patients at risk for abnormal blood glucose; and 2) Percentage of each demographic group and the total screened for abnormal blood glucose as outlined by the US Preventive Services Task Force USPSTF) and/or American Diabetes Association (ADA) guidelines.	2018	Please note: CMS examples of stratification may include, patient demographics such as race/ethnicity, disability status (if available), sexual orientation (if available), sex, gender identity (if available), and geography
IA_PM_21	Population Management	Advance Care Planning	Implementation of practices/processes to develop advance care planning that includes: documenting the advance care plan or living will within the medical record, educating clinicians about advance care planning motivating them to address advance care planning needs of their patients, and how these needs can translate into quality improvement, educating clinicians on approaches and barriers to talking to patients about end-of-life and palliative care needs and ways to manage its documentation, as well as informing clinicians of the healthcare policy side of advance care planning.	Medium	Evidence supporting implementation of practices/processes to develop advance care planning, with evidence taking into account a patients' literacy level, language, communication preferences, and cognitive or functional limitations	1) Documentation of process implementation for advance care planning/policy or living will development within the medical record; and 2) Documentation of clinician education about advance care planning to address advance care planning needs; and 3) Documentation illustrating how care plan needs were translated into quality improvement; and 4) Documentation of how clinicians are educated regarding strategies for addressing end-of-life and palliative care needs.	2018	
IA_CC_1	Care Coordination	Implementation of use of specialist reports back to referring clinician or group to close referral loop	Performance of regular practices that include providing specialist reports back to the referring MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which	Medium	Functionality of providing information by specialist to referring clinician or inquiring clinician receives and	1) Specialist Reports to Referring Clinician - Sample of specialist reports reported to referring clinician or group (e.g. within EHR or medical record); or 2) Specialist Reports from Inquiries in Certified EHR - Specialist reports	2017	

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			could be documented or noted in the EHR technology.		documents specialist report	documented in inquiring clinicians certified EHR or medical records.		
IA_CC_2	Care Coordination	Implementation of improvements that contribute to more timely communication of test results	Timely communication of test results defined as timely identification of abnormal test results with timely follow-up.	Medium	Functionality of reporting abnormal test results in a timely basis with follow-up to streamline the communication process between the provider and patient	EHR reports or medical records demonstrating timely communication of abnormal test results to patient (capturing the communication rate and working toward improvement of that rate.)	2017	
IA_CC_5	Care Coordination	CMS partner in Patients Hospital Engagement Network	Membership and participation in a CMS Partnership for Patients Hospital Engagement Network.	Medium	Active participation in Partnership for Patients Hospital Engagement Network (HEN) initiative	Confirmation of participation in the Partnership for Patients Hospital Engagement Network (HEN) initiative for that year (e.g. CMS confirmation email) https://innovation.cms.gov/initiatives/Partnership-for-Patients/.	2017	
IA_CC_7	Care Coordination	Regular training in care coordination	Implementation of regular care coordination training.	Medium	Inclusion of regular care coordination training in practice within the attestation period Note: The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care. This means that the patient's needs and preferences are	Documentation of implemented regular care coordination training (within the attestation period) within practice, e.g., availability of care coordination training curriculum/training materials and attendance or training certification registers/documents NOTE: The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care. This means that the patient's needs and preferences are known and communicated, and that this information is used to guide the	2017	

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					known and communicated, and that this information is used to guide the delivery of safe, appropriate, and effective care.	delivery of safe, appropriate, and effective care.		
IA_CC_8	Care Coordination	Implementation of documentation improvements for practice/process improvements	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	Processes and practices are implemented to improve care coordination	Documentation of the implementation of practices/processes that document care coordination activities, e.g., documented care coordination encounter that tracks clinical staff involved and communications from date patient is scheduled through day of procedure.	2017	
IA_CC_9	Care Coordination	Implementation of practices/processes for developing regular individual care plans	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	Individual care coordination plans including a discussion on care are regularly developed and updated for at-risk patients and shared with beneficiary or caregiver	1) Individual Care Plans for At-Risk Patients - Documented practices/processes for developing regularly individual care plans for at-risk patients, e.g., template care plan; and 2) Use of Care Plan with Beneficiary - Patient medical records demonstrating care plan being shared with beneficiary or caregiver, including consideration of a patient's goals and priorities, social risk factors, language and communication preferences, physical or cognitive limitations, as well as desired outcomes of care.	2017	
IA_CC_10	Care Coordination	Care transition documentation practice improvements	In order to receive credit for this activity, a MIPS eligible clinician must document practices/processes for care transition with documentation of how a MIPS eligible clinician or group carried out an	Medium	Patient-centered, care transition action plan with evidence of implementation for	Documentation of improved care practices such as staff involved care transition; phone calls conducted in support of transition; accompaniments of patients to	2017	Sub-IA-1: IA may apply to fracture-related care.

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			action plan for the patient with the patient's preferences in mind (that is, a "patient-centered" plan) during the first 30 days following a discharge. Examples of these practices/processes for care transition include: staff involved in the care transition; phone calls conducted in support of transition; accompaniments of patients to appointments or other navigation actions; home visits; patient information access to their medical records; real time communication between PCP and consulting clinicians; PCP included on specialist follow-up or transition communications.		the first 30 days following a discharge. Action plan and patient communication that could take into account patient communication and language preferences, available supports and services (as outlined in the CMS suggested documentation), and patients' discharge environment.	appointments or other navigation actions; home visits; patient information access to their medical records; real time communication between PCP and consulting clinicians; PCP included on specialist follow-up or transition communications with a patient-centered plan must be demonstrated during the first 30 days following a discharge.		
IA_CC_11	Care Coordination	Care transition standard operational improvements	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	Functionality of information flow during transitions of care to ensure seamless transitions	1) Communication Lines with Local Settings - Documentation of formal lines of communication to manage transitions of care with local settings (e.g. community or hospital-based transitional care services) in which empaneled patients receive care to ensure documented flow of information and seamless transitions; or 2) Partnership with Community or Hospital-Based Transitional Care Services - Documentation showing partnership with community or hospital-based transitional care services.	2017	Sub-IA-1: Implement Warm Handoff Plus strategy
IA_CC_12	Care Coordination	Care coordination agreements that	Establish effective care coordination and active referral management that could include one or more of the	Medium	Functionality of effective care coordination and	1) Care Coordination Agreements - Sample of care coordination agreements with frequently used	2017	

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		promote improvements in patient tracking across settings	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 specialist through the entire process; and/or • Systematically integrate information from referrals into the plan of care.		referral management	consultant that establish documented flow of information and provides patients with information to set consistent expectations; or 2) Tracking of Patient Referrals to Specialists - Medical record or EHR documentation demonstrating tracking of patients referred to specialists through the entire process; or 3) Referral Information Integrated into the Plan of Care - Samples of specialist referral information systematically integrated into the plan of care.		
IA_CC_13	Care Coordination	Practice improvements for bilateral exchange of patient information	Ensure that there is 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	Functionality of bilateral exchange of patient information to guide patient care	1) Participation in an HIE - Confirmation of participation in a health information exchange (e.g. email confirmation, screen shots demonstrating active engagement with Health Information Exchange; or 2) Structured Referral Notes - Sample of patient medical records including structured referral notes.	2017	
IA_CC_14	Care Coordination	Practice improvements that engage community resources to support patient health goals	Develop pathways to neighborhood/community-based resources to support patient health goals that could include one or more of the following: • Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information; and/or provide a guide to available community	Medium	Availability of formal links to community-based health and wellness programs potentially including availability of resource guides that address identified social determinants of health	1) Community-Based Chronic Disease Self-Management Programs - Documentation of community-based chronic disease self-management support programs, exercise programs, and other wellness resources (including specific names) with which practices have formal referral links and have potential bidirectional flow of information; or 2) Provision of Community	2017	

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			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 feasible and available as part of such tool; and/or • Provide a guide to available community resources.			Resource Guides - Medical record demonstrating provision of a guide to community resources to meet identified social determinants of health (e.g., safe housing, transportation, social support).		
IA_CC_15	Care Coordination	PSH Care Coordination	Participation in a Perioperative Surgical Home (PSH) that provides a patient-centered, physician-led, interdisciplinary, and team-based system of coordinated patient care, which coordinates care from pre-procedure assessment through the acute care episode, recovery, and post-acute care. This activity allows for reporting of strategies and processes related to care coordination of patients receiving surgical or procedural care within a PSH. The clinician must perform one or more of the following care coordination activities: • Coordinate with care managers/navigators in preoperative clinic to plan and implementation comprehensive post discharge plan of care; • Deploy perioperative clinic and care processes to reduce post-operative	Medium	Evidence of participation in a Perioperative Surgical Home (PSH) model that provides a patient-centered, physician-led, interdisciplinary, and team-based system of coordinated patient care	1) Coordinate with care managers/navigators in preoperative clinic to plan and implement comprehensive post discharge plan of care that could take into account patients' post discharge environment and support system out of the hospital; and 2) Deploy perioperative clinic and care processes to reduce post-operative visits to emergency rooms; and 3) Implement evidence-informed practices and standardize care across the entire spectrum of surgical patients; and 4) Implement processes to ensure effective communications and education of patients' post-discharge instructions, taking into account patients' literacy level, language and communication	2018	Sub-IA-1: Participate in a Perioperative Surgical Home

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			visits to emergency rooms; • Implement evidence-informed practices and standardize care across the entire spectrum of surgical patients; or • Implement processes to ensure effective communications and education of patients' post-discharge instructions.			preferences, and cognitive or functional impairments.		
IA_CC_16	Care Coordination	Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients	The primary care and behavioral health practices use the same electronic health record system for shared patients or have an established bidirectional flow of primary care and behavioral health records.	Medium	Evidence of collaboration and bidirectional flow between the primary care physician and behavioral health practices where EHRs share common patients.	1) Documentation of established bidirectional flow between primary care and behavioral health practices that share common patients or use the same EHR systems.	2018	
IA_CC_17	Care Coordination	Patient Navigator Program	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	Evidence of participation in a Patient Navigator Program (PNP), including engaging with Community Health Workers or Promotoras, designed to assist patients with communicating with health care providers regarding their questions, obtain information about their procedures/treatments and arrange for	1) Documentation of evidenced-based resources and tools to reduce avoidable hospital readmissions; and 2) Utilization of a patient-centered and team-based approach leveraging evidence-based best practices to improve care for patients by making hospitalizations less stressful; and 3) Implementation of systems, tools and strategies that encourage a more supportive recovery period.	2018	

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					test or appointments. PNP should take into account patients' language and communication preferences, literacy level, and cognitive and physical disabilities.			

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IA_CC_18	Care Coordination	Relationship-Centered Communication	In order to receive credit for this activity, MIPS eligible clinicians must participate in a minimum of eight hours of training on relationship-centered care tenets such as making effective open-ended inquiries; eliciting patient stories and perspectives; listening and responding with empathy; using the ART (ask, respond, tell) communication technique to engage patients, and developing a shared care plan. The training may be conducted in formats such as, but not limited to: interactive simulations practicing the skills above, or didactic instructions on how to implement improvement action plans; monitor progress; and promote stability around improved clinician communication.	Medium	Evidence that a minimum of eight hours of training focused on relationship-centered care, open-ended inquiries, patient perspectives, and storytelling with an emphasis on active listening, empathy, and patient engagement is required. Demonstration of the ART (ask, respond, tell) communication technique should be utilized by the MIPS eligible clinician to engage patients and encourage them to participate in the development of a shared plan of care. Training to promote patient engagement in a shared plan of care may include interactive simulations and didactic instructions on how to	1) MIPS eligible clinicians and groups must demonstrate a minimum of eight hours of training utilizing the ask, respond, tell (ART) communication technique and; 2) Provide documentation promoting relationship-centered care, open-ended inquiries, patient perspectives, and storytelling the emphasizes active listening, empathy, and patient engagement in the development of a shared plan of care.	2019	

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					implement improvement action plans while promoting improved clinician communication.			

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IA_CC_19	Care Coordination	Tracking of clinician's relationship to and responsibility for a patient by reporting MACRA patient relationship codes.	To receive credit for this improvement activity, a MIPS eligible clinician must attest that they reported MACRA patient relationship codes (PRC) using the applicable HCPCS modifiers on 50 percent or more of their Medicare claims for a minimum of a continuous 90-day period within the performance period. Reporting the PRC modifiers enables the identification of a clinician's relationship with, and responsibility for, a patient at the time of furnishing an item or service. See the CY 2018 PFS final rule (82 FR 53232 through 53234) for more details on these codes.	High	MIPS eligible clinicians and groups must attest that they reported MACRA patient relationship codes (PRC) using the applicable HCPCS modifiers on 50 percent or more of their Medicare claims for a continuous 90-day minimum reporting period within the performance year. Reporting the PRC modifiers enables the identification of a clinician's relationship with, and responsibility for, a patient at the time of furnishing an item or service.	The MIPS eligible clinician or group must demonstrate with documentation that the provider implemented Patient Relationship Codes (PRC) applicable to HCPCS modifiers within their processes of care. Documentation could be captured in the patient chart or EHR note that the MIPS eligible clinician reported MACRA PRC using the applicable HCPCS modifiers on 50 percent or more of their Medicare claims for a continuous 90-day minimum reporting period within the performance year.	2020	
IA_BE_1	Beneficiary Engagement	Use of certified EHR to capture patient reported outcomes	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	Functionality of patient reported outcomes in certified EHR	1) Patient Reported Outcomes in EHR - Report from the **certified** EHR, showing the capture of PROs or the patient activation measures performed; or
2) Separate Queue for Recognition and Review - Documentation showing the call out of this data for clinician recognition and review (e.g. within a report or a screen-shot).	2017	

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						Patient Activation Measures (PAM) assesses an individual's knowledge, skill, and confidence for managing one's health and healthcare. You can learn more about the development of the original Patient Activation Measure (PAM) on the Wiley Online Library site: http://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2004.00269.x/full		
IA_BE_3	Beneficiary Engagement	Engagement with QIN-QIO to implement self-management training programs	Engagement with a Quality Innovation Network-Quality Improvement Organization, which may include participation in self-management training programs such as diabetes.	Medium	Use of QIN-QIO to implement self-management training programs	Documentation from QIN-QIO of eligible clinician or group's engagement and use of services to assist with, e.g., self-management training program(s) such as diabetes.	2017	
IA_BE_4	Beneficiary Engagement	Engagement of patients through implementation of improvements in patient portal	Access to an enhanced patient portal that provides up to date information related to relevant chronic disease health or blood pressure control, and includes interactive features allowing patients to enter health information and/or enables bidirectional communication about medication changes and adherence.	Medium	Functionality of patient portal that includes patient interactive features	Documentation through screenshots or reports of an enhanced patient portal, e.g., portal functions that provide up to date information related to chronic disease health or blood pressure control, interactive features allowing patients to enter health and demographic information (e.g., race/ethnicity, sexual orientation, sex, gender identity, disability), and/or bidirectional communication about medication changes and adherence.	2017	

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IA_BE_5	Beneficiary Engagement	Enhancements/regular updates to practice websites/tools that also include considerations for patients with cognitive disabilities	Enhancements and ongoing regular updates and use of websites/tools that include consideration for compliance with section 508 of the Rehabilitation Act of 1973 or for improved design for patients with cognitive disabilities. Refer to the CMS website on Section 508 of the Rehabilitation Act https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/Section508/index.html?redirect=/InfoTechGenInfo/07_Section508.asp that requires that institutions receiving federal funds solicit, procure, maintain and use all electronic and information technology (EIT) so that equal or alternate/comparable access is given to members of the public with and without disabilities. For example, this includes designing a patient portal or website that is compliant with section 508 of the Rehabilitation Act of 1973	Medium	Practice website/tools are regularly updated and enhanced and are Section 508 compliant	1) Regular Updates and Section 508 Compliance Process - Documentation of regular updates and Section 508 compliance process for the clinician's patient portal or website; and 2) Compliant Website/Tools - Screenshots or hard copies of the practice's website/tools showing enhancements and regular updates in compliance with section 508 of the Rehabilitation Act of 1973. Find 508 compliance information at https://www.section508.gov/	2017	
IA_BE_6	Beneficiary Engagement	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.	High	Patient experience and satisfaction data on beneficiary engagement is collected and follow up occurs through an improvement plan	1) Follow-Up on Patient Experience and Satisfaction - Documentation of collection and follow-up on patient experience and satisfaction (e.g. survey results) which must be administered by a third party survey administrator/vendor; and 2) Patient Experience and Satisfaction Improvement Plan - Documented patient experience and satisfaction improvement plan.	2017	

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IA_BE_7	Beneficiary Engagement	Participation in a QCDR, that promotes use of patient engagement tools.	Participation in a Qualified Clinical Data Registry (QCDR), that promotes patient engagement, including: • Use of processes and tools that engage patients for adherence to treatment plans; • Implementation of patient self-action plans; • Implementation of shared clinical decision making capabilities; or • Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement.	Medium	Participation in a QCDR that promotes patient engagement tools (e.g., patient portal, secure email, and online mobile scheduling)	Participation in QCDR that promotes use of patient engagement tools (e.g., regular feedback reports provided by the QCDR detailing activities promoting the use of patient engagement tools). These feedback reports provide evidence that the MIPS eligible clinician or group has met the intent of the IA by providing evidence that a QCDR was utilized to engage providers in the use of patient engagement tools to improve processes of care.	2017	
IA_BE_8	Beneficiary Engagement	Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.	Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive.	Medium	Participation in QCDR promoting collaborative learning network interactive opportunities	Participation in QCDR that promotes interactive collaborative learning network opportunities, e.g., regular feedback reports provided by the QCDR that promote interactive collaborative learning networks.	2017	
IA_BE_12	Beneficiary Engagement	Use evidence-based decision aids to support shared decision-making.	Use evidence-based decision aids to support shared decision-making.	Medium	Use of evidence based decision aids to support shared decision-making with beneficiary	Documentation (e.g. checklist, algorithms, tools, screenshots) showing the use of evidence-based decision aids to support shared decision-making with beneficiary.	2017	
IA_BE_13	Beneficiary Engagement	Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.	Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.	Medium	Conduct of regular assessments of patient care experience, taking into account specific populations served and including them in this assessment,	Documentation (e.g. survey results, advisory council notes and/or other methods) showing regular assessments of the patient care experience to improve the experience, taking into account specific populations served and including them in this assessment, such as identified vulnerable	2017	

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					such as identified vulnerable populations	populations. Surveys should be administered independently to the best extent possible.		
IA_BE_14	Beneficiary Engagement	Engage patients and families to guide improvement in the system of care.	Engage patients and families to guide improvement in the system of care by leveraging digital tools for ongoing guidance and assessments outside the encounter, including the collection and use of patient data for return-to-work and patient quality of life improvement. Platforms and devices that collect patient-generated health data (PGHD) must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient, including patient reported outcomes (PROs). Examples include patient engagement and outcomes tracking platforms, cellular or web-enabled bi-directional 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	High	Functionality of methods to engage patients and families, which may include patients and families that need additional support due to disability, in improving the system of care by leveraging digital tools for ongoing guidance and assessments outside the encounter and with the use of active feedback loops	1) Documentation showing patient and family engagement using digital collection and use of patient data, which may include patients and families that need additional support due to disability, for return-to-work and patient quality of life improvement; and 2) Documentation of 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), (e.g., meeting agendas and summaries where patients families have been engaged, survey results from patients and/or families; and improvements made in the system of care; surveys should be administered by a third party survey administrator/vendor to the best extent possible).	2017	Sub-IA-1: Engage in Non-face-to-face chronic care management using remote monitoring and/or telehealth technology; Sub-IA-2: Leverage digital tools for ongoing guidance/assessments outside the encounter; Sub-IA-3: Implement Manage My Surgery ™ (MMS); Sub-IA-4: Report Patient Reported Outcomes Also known as Patient Reported Outcome Measures (PROMs); Sub-IA-5: Utilize mobile remote monitoring to facilitate CHF management; Sub-IA-6: Send medication reminders through mobile phones for hypertension medication adherence; which may include collection and use of patient data for return-to-work and

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			clinically endorsed real or near-real time automated feedback to the patient (e.g. automated patient-facing instructions based on glucometer readings). Therefore, unlike passive platforms or devices that may collect but do not transmit PGHD in real or near-real time to clinical care teams, active devices and platforms can inform the patient or the clinical care team in a timely manner of important parameters regarding a patient's status, adherence, comprehension, and indicators of clinical concern.					patient quality of life improvement; Sub-IA-7: Conduct non-face-to-face chronic care management using remote monitoring and/or telehealth technology; Sub-IA-8: Implement Sonar MD; Sub-IA-9: Conduct remote monitoring of empaneled chronic care management patients
IA_BE_15	Beneficiary Engagement	Engagement of patients, family and caregivers in developing a plan of care	Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the electronic health record (EHR) technology.	Medium	Inclusion of patients, family and caregivers in plan of care and prioritizing goals for action, as documented in EHR	Report from the certified EHR, showing the plan of care and prioritized goals for action with engagement of the patient, family and caregivers, if applicable.	2017	Sub-IA-1: Use electronic platform to systematically capture patient preferences/value through validated patient experience measure instrument
IA_BE_16	Beneficiary Engagement	Evidenced-based techniques to promote self-management into usual care	Incorporate evidence-based techniques to promote self-management into usual care, using techniques such as goal setting with structured follow-up, Teach Back, action planning or motivational interviewing.	Medium	Functionality of evidence based techniques to promote self-management into usual care	Documented evidence-based techniques to promote self-management into usual care; and evidence of the use of the techniques (e.g. clinicians' completed office visit checklist, EHR report of completed checklist, copies of goal setting tools or techniques, motivational interviewing script/questions, action planning tool with patient feedback).	2017	Sub-IA-1: Implement Teach-back strategy to ensure patient's understanding of medical information shared during an encounter

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IA_BE_17	Beneficiary Engagement	Use of tools to assist patient self-management	Use tools to assist patients in assessing their need for support for self-management (e.g., the Patient Activation Measure or How's My Health).	Medium	Use of tools to assist patient self-management	Documentation in medical record or EHR showing use of Patient Activation Measure, How's My Health, or similar tools to assess patients need for support for self-management. Patient Activation Measures (PAM) assesses an individual's knowledge, skill, and confidence for managing one's health and healthcare. You can learn more about the development of the original Patient Activation Measure (PAM) on the Wiley Online Library site: http://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2004.00269.x/full	2017	
IA_BE_18	Beneficiary Engagement	Provide peer-led support for self-management.	Provide peer-led support for self-management.	Medium	Use of peer-led self-management	Documentation in medical record or EHR of peer-led self-management program. Peer-led self-management requires peer groups that include beneficiaries with the same condition or disease.	2017	
IA_BE_19	Beneficiary Engagement	Use group visits for common chronic conditions (e.g., diabetes).	Use group visits for common chronic conditions (e.g., diabetes).	Medium	Use of group visits for chronic conditions. Could be supported by claims	Medical claims or referrals showing group visit and chronic condition codes in conjunction with care provided.	2017	
IA_BE_20	Beneficiary Engagement	Implementation of condition-specific chronic disease self-management support programs	Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community.	Medium	Use of condition-specific chronic disease self-management programs or coaching or link to community programs	1) Chronic Disease Self-Management Support Program - Documentation from medical record or EHR showing condition specific chronic disease self-management support program or coaching; or 2) Community Chronic Disease Self-Management Support Program - Documentation of referral/link of	2017	

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						patients to condition specific chronic disease self-management support programs in the community.		
IA_BE_21	Beneficiary Engagement	Improved practices that disseminate appropriate self-management materials	Provide self-management materials at an appropriate literacy level and in an appropriate language.	Medium	Provision of self-management materials appropriate for literacy level and language	Documented provision in EHR or medical record of self-management materials, e.g., pamphlet, discharge summary language, or other materials that include self management materials appropriate for the patient's literacy and language.	2017	
IA_BE_22	Beneficiary Engagement	Improved practices that engage patients pre-visit	Implementation of workflow changes that engage patients prior to the visit, such as a pre-visit development of a shared visit agenda with the patient, or targeted pre-visit laboratory testing that will be resulted and available to the MIPS eligible clinician to review and discuss during the patient's appointment.	Medium	Pre-visit agenda shared with patient	1) Documentation of a letter, email, portal screenshot, etc. that shows a pre-visit agenda was shared with patient; and 2) Documentation of the practice's patient engagement workflow.	2017	Sub-IA-1: Implement strategies to engage patients and their family members to co-create a visit agenda
IA_BE_23	Beneficiary Engagement	Integration of patient coaching practices between visits	Provide coaching between visits with follow-up on care plan and goals.	Medium	Use of coaching between visits with follow-up on care plan and goals. Could be supported by claims	Documentation of: 1) Use of Coaching Codes - Medical claims with codes for coaching provided between visits; or 2) Coaching Plan and Goals - Copy of documentation provided to patients (e.g. letter, email, portal screenshot) that includes coaching on care plan and goals; or 3) coaching scripts, tools, materials.	2017	

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IA_BE_24	Beneficiary Engagement	Financial Navigation Program	In order to receive credit for this activity, MIPS eligible clinicians must attest that their practice provides financial counseling to patients or their caregiver about costs of care and an exploration of different payment options. The MIPS eligible clinician may accomplish this by working with other members of their practice (for example, financial counselor or patient navigator) as part of a team-based care approach in which members of the patient care team collaborate to support patient-centered goals. For example, a financial counselor could provide patients with resources with further information or support options, or facilitate a conversation with a patient or caregiver that could address concerns. This activity may occur during diagnosis stage, before treatment, during treatment, and/or during survivorship planning, as appropriate.	Medium	Demonstration by eligible clinicians and groups that their practice provides an estimate of the cost to the patient of the types of health care services it will furnish in advance (for services that can be scheduled in advance) and financial counseling to patients or their caregiver about cost of care with evidence that an exploration of different payment options were discussed. Financial counseling may occur during diagnosis stage, before treatment, during treatment, and/or during survivorship planning, as appropriate.	Demonstration by eligible clinicians and groups that their practice provides an estimate in advance of the cost to the patient of the types of health care services it will furnish (for services that can be scheduled in advance) and financial counseling to patients or their caregiver about costs of care with evidence that an exploration of different payment options, e.g. documented work with a financial counselor or patient navigator as part of a team-based care approach in which members of the patient care team collaborate to support patient- centered goals were discussed. **Please note**: a financial counselor could provide patients with resources with further information or support options, or facilitate a conversation with a patient or caregiver that could address concerns.	2019	
IA_BE_25	Beneficiary Engagement	Drug Cost Transparency	To receive credit for this improvement activity, MIPS eligible clinicians must attest that their practice provides counseling to patients and/or their caregivers about the costs of drugs and	High	MIPS eligible clinicians and groups will provide counseling to patients and/or	1) Documentation could include an EHR note that the MIPS eligible clinician provided counseling to patients and/or caregivers about the costs of drugs including the	2020	

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			the patients' out-of-pocket costs for the drugs. If appropriate, the clinician must also explore with their patients the availability of alternative drugs and patients' eligibility for patient assistance programs that provide free medications to people who cannot afford to buy their medicine. One source of information for pricing of pharmaceuticals could be a real-time benefit tool (RTBT), which provides to the prescriber, real-time patient-specific formulary and benefit information for drugs, including cost-sharing for a beneficiary. (CMS finalized in the Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out of Pocket Expenses final rule (84 FR 23832, 23883) that beginning January 1, 2021 Medicare Part D plans will be required to implement one or more RTBT(s).)		their caregivers regarding the cost of drugs and the patients' out-of-pocket expenses related to their prescribed medications. When applicable, the MIPS eligible clinician or group must discuss with patients the availability of alternative drugs and the patients' eligibility for patient assistance programs that provide free medications for patients that are unable to afford to buy their medicine, i.e. real-time benefit tool (RTBT).	patient's out-of-pocket costs for the drugs; and/or 2) The MIPS eligible clinician or group must demonstrate with documentation within the RTBT or EHR that a discussion/counseling regarding the availability of alternative drugs, and (when applicable) a patient's eligibility for patient assistance programs that provide free medications for patients occurred. **NOTE:** For the purposes of this IA, patient assistance programs pertain to financially needy patients that require assistance to purchase necessary medications, i.e. www.rxassist.org/providers. Additional information pertaining to real-time benefit checks and its impact on patient care can be reviewed here: www.covermymeds.com/main/insights/rtbc-scorecard/ (CMS finalized in the Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out of Pocket Expenses final rule (84 FR 23832, 23883) that beginning January 1, 2021 Medicare Part D plans will be required to implement one or more RTBT(s).		
IA_PSPA_1	Patient Safety & Practice Assessment	Participation in an AHRQ-listed patient safety organization.	Participation in an AHRQ-listed patient safety organization.	Medium	Participation in an AHRQ-listed patient safety organization	Documentation from an AHRQ-listed patient safety organization (PSO) confirming the eligible clinician or group's participation with the PSO. PSOs listed by AHRQ are	2017	

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						here: http://www.pso.ahrq.gov/listed.		
IA_PSPA_2	Patient Safety & Practice Assessment	Participation in MOC Part IV	In order to receive credit for this activity, a MIPS eligible clinician must participate in Maintenance of Certification (MOC) Part IV. Maintenance of Certification (MOC) Part IV requires clinicians to perform monthly activities across practice to regularly assess performance by reviewing outcomes addressing identified areas for improvement and evaluating the results.

Some examples of activities that can be completed to receive MOC Part IV credit are: the American Board of Internal Medicine (ABIM) Approved Quality Improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Performance Improvement Module or American Society of Anesthesiologists (ASA) Simulation Education Network, for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program; specialty- specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE); American Psychiatric | Medium | Participation in MOC Part IV including a local, regional, or national outcomes registry or quality assessment program and performance of monthly activities to assess and address improvement in medical practice | 1) Documentation of participation in Maintenance of Certification (MOC) Part IV from an American Board of Medical Specialties (ABMS) member board such as the American Board of Internal Medicine (ABIM) Approved Quality improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Improvement Module or American Society of Anesthesiologists (ASA) Simulation Education Network, including participation in a local, regional or national outcomes registry or quality assessment program; and specialty-specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE); American Psychiatric Association (APA) Performance in Practice modules; and 2) Monthly Activities to Assess Performance - Documented performance of monthly activities across practice to assess performance in practice by reviewing outcomes, addressing | 2017 | Sub-IA-1: Implement Performance Improvement Module (Performance Improvement in Practice or Practice Biopsy); Sub-IA-2: Use of the NCDR Clinical Quality Coach; Sub-IA-3: Participate in the Quality Oncology Practice Initiative (QOPI) Sub-IA-4: Certification Program (QCP); Sub-IA-5: Participate in the American Board of Optometry's Performance in Practice activities. |

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			Association (APA) Performance in Practice modules.			areas of improvement, and evaluating the results.		
IA_PSPA_3	Patient Safety & Practice Assessment	Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or other similar activity.	For MIPS eligible clinicians not participating in Maintenance of Certification (MOC) Part IV, new engagement for MOC Part IV, such as the Institute for Healthcare Improvement (IHI) Training/Forum Event; National Academy of Medicine, Agency for Healthcare Research and Quality (AHRQ) Team STEPPS®, or the American Board of Family Medicine (ABFM) Performance in Practice Modules.	Medium	Participate in IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS® or other similar activity	Certificate or letter of participation from an IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS®, or the American Board of Family Medicine (ABFM) Performance in Practice Modules, or other similar activity, for eligible clinicians or groups not participating in MOC Part IV.	2017	Sub-IA-1: Institute protocols supporting AHRQ's Team STEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety)
IA_PSPA_4	Patient Safety & Practice Assessment	Administration of the AHRQ Survey of Patient Safety Culture	Administration of the AHRQ Survey of Patient Safety Culture and submission of data to the comparative database (refer to AHRQ Survey of Patient Safety Culture website http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html) Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a yearly basis but over 4 years there would be reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance score.	Medium	Administration of the AHRQ survey of Patient Safety Culture and submission of data to the comparative database	Survey results from the AHRQ Survey of Patient Safety Culture, including proof of administration and submission. Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a yearly basis but over 4 years there would be reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance score.	2017	

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IA_PSPA_6	Patient Safety & Practice Assessment	Consultation of the Prescription Drug Monitoring program	Clinicians would attest to reviewing the patients' history of controlled substance prescription using state prescription drug monitoring program (PDMP) data prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription lasting longer than 3 days. For the transition year, clinicians would attest to 60 percent review of applicable patient's history. For the Quality Payment Program Year 2 and future years, clinicians would attest to 75 percent review of applicable patient's history performance.	High	Provision of consulting with PDMP before issuance of a controlled substance schedule II opioid prescription that lasts longer than 3 days	1) Number of Issuances of CSII Prescription - Total number of issuances of a CSII prescription that lasts longer than 3 days over the same time period as those consulted; and 2) Documentation of Consulting the PDMP - Total number of patients for which there is evidence of consulting the PDMP prior to issuing an CSII prescription (e.g. copies of patient reports created, with the PHI masked).	2017	
IA_PSPA_7	Patient Safety & Practice Assessment	Use of QCDR data for ongoing practice assessment and improvements	Participation in a Qualified Clinical Data Registry (QCDR) and use of QCDR data for ongoing practice assessment and improvements in patient safety, including: • Performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups); • Use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment); • Use of standardized processes for screening for social determinants of health such as food security,	Medium	Use of QCDR data for ongoing practice assessment and improvements in patient safety (e.g., evidence of intended improvements in patient safety for specific targeted populations)	Participation in QCDR that promotes ongoing improvements in patient safety (e.g., regular feedback reports provided by the QCDR that demonstrate ongoing practice assessment and improvements in patient safety). The MIPS eligible clinician or group should document how the practice is using QCDR data, and intended improvements in patient safety for the specific populations targeted (e.g., documentation of standard tools, processes for screening, use of standard questionnaires, or use of QCDR data that is used for quality improvement, such as population-level analysis to assess for adverse outcomes).	2017	

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			employment, and housing; • Use of supporting QCDR modules that can be incorporated into the certified EHR technology; or • Use of QCDR data for quality improvement such as comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcomes.					

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IA_PSPA_8	Patient Safety & Practice Assessment	Use of patient safety tools	In order to receive credit for this activity, a MIPS eligible clinician must use tools that assist specialty practices in tracking specific measures that are meaningful to their practice. Some examples of tools that could satisfy this activity are: a surgical risk calculator; evidence based protocols, such as Enhanced Recovery After Surgery (ERAS) protocols; the Centers for Disease Control (CDC) Guide for Infection Prevention for Outpatient Settings predictive algorithms; and the opiate risk tool (ORT) or similar tool.	Medium	Use of systems, tools and strategies implemented by specialty practices, for tracking specific meaningful patient safety and practice assessment (e.g., ORT or similar tools are permitted).	Documentation of the use of patient safety tools, e.g. surgical risk calculator, evidenced based protocols such as Enhanced Recovery After Surgery (ERAS) protocols and ORT or similar tools are permitted. The CDC Guide for Infection Prevention for Outpatient Settings, or predictive algorithms, that assist specialty practices in tracking specific patient safety measures meaningful to their practice to meet the intent of the IA.	2017	Sub-IA-1: Use of clinical assessment modalities and diagnostic screening tools in specialty medicine (e.g., WHO Fracture Risk Assessment (FRAX) Tool); Sub-IA-2: Use ACC Surviving MI; Sub-IA-3: Use ACP Practice Advisor;ACP Quality Connect; Sub-IA-4: Conduct Disease Activity Measurement to Optimize Treating to Target.; Sub-IA-5: Improve Informed Consent and Shared Decision-Making with Evidence-Based Risk Stratification Strategies; Sub-IA-6: Implement AGA Clinical Guidelines Mobile App; Sub-IA-7: Participate in public health emergency disease outbreak control efforts; Sub-IA-8:Participate in voluntary surveillance activity;Sub-IA-9:Conduct population management strategies within a Perioperative Surgical

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								Home (PSH); Sub-IA-10:Use of AUA Symptom Index (AUA-SI) to increase patient engagement.; Sub-IA-11: Provide leadership of Infection Prevention and Control Program; Sub-IA-12: Conduct therapeutic drug monitoring for inflammatory bowel disease patients that are on anti-TNF therapies; Sub-IA-13: Deploy predictive analytical models to manage chronic disease in patients; Sub-IA-14: Perform review of Enhanced Recovery after Surgery (ERAS) protocol and implement improvement plan
IA_PSPA_9	Patient Safety & Practice Assessment	Completion of the AMA STEPS Forward program	Completion of the American Medical Association's STEPS Forward program.	Medium	Completion of AMA STEPS Forward program	1) Certificate of completion from at least one AMA STEPS Forward program module; and 2) Documentation of implementation from the module into the processes of care of your practice.	2017	

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IA_PSPA_10	Patient Safety & Practice Assessment	Completion of training and receipt of approved waiver for provision of opioid medication-assisted treatments	Completion of training and obtaining an approved waiver for provision of medication -assisted treatment of opioid use disorders using buprenorphine.	Medium	Completion of training and obtaining approved waiver for provision of medication assisted treatment of opioid use disorders using buprenorphine	1) Waiver - SAMHSA letter confirming waiver and physician prescribing ID number; and 2) Training - Certificate of completion of training to prescribe and dispense buprenorphine dated during the selected reporting period.	2017	
IA_PSPA_11	Patient Safety & Practice Assessment	Participation in CAHPS or other supplemental questionnaire	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	Participation in CAHPS or other supplemental questionnaire	1) CAHPS - CAHPS participation report; or 2) Other Patient Supplemental Questionnaire Items - Other supplemental patient safety questionnaire items, e.g., cultural competence or health information technology item sets must be administered by a third party administrator/vendor.	2017	
IA_PSPA_12	Patient Safety & Practice Assessment	Participation in private payer CPIA	Participation in designated private payer clinical practice improvement activities.	Medium	Participation in private payer clinical practice improvement activities	Documents showing participation in private payer clinical practice improvement activities (e.g., quality measure documentation or feedback reports, practice workflow redesign tools developed for or with the payer as part of practice improvement).	2017	
IA_PSPA_13	Patient Safety & Practice Assessment	Participation in Joint Commission Evaluation Initiative	Participation in Joint Commission Ongoing Professional Practice Evaluation initiative	Medium	Participation in Joint Commission Ongoing Professional Practice Evaluation initiative	Documentation from Joint Commission's Ongoing Professional Practice Evaluation initiative confirming participation in its improvement program(s).	2017	

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IA_PSPA_15	Patient Safety and Practice Assessment	Implementation of Antimicrobial Stewardship Program (ASP)	Leadership of an Antimicrobial Stewardship Program (ASP) that measures the appropriate use of antibiotics for several different conditions (such as but not limited to upper respiratory infection treatment in children,-diagnosis of pharyngitis, Bronchitis Rx treatment in adults) according to clinical guidelines for diagnostics and therapeutics. Specific activities may include: • Develop facility-specific antibiogram and prepare report of findings with specific action plan that aligns with overall facility or practice strategic plan. • Lead the development, implementation, and monitoring of patient care and patient safety protocols for the delivery of ASP including protocols pertaining to the most appropriate setting for such services (i.e., outpatient or inpatient). • Assist in improving ASP service line efficiency and effectiveness by evaluating and recommending improvements in the management structure and workflow of ASP processes. • Manage compliance of the ASP policies and assist with implementation of corrective actions in accordance with facility or practice compliance policies and facility or practice medical staff by-laws. • Lead the education and training of professional support staff for the purpose of maintaining an efficient and	Medium	Leadership of an antibiotic stewardship program	Documentation of leadership of an antibiotic stewardship program that measures the appropriate use of antibiotics for several different conditions according to clinical guidelines for diagnostics and therapeutics and identifies improvement actions: 1) Documentation of the report of findings and specific action plan; or 2) Documentation of the development, implementation, and monitoring of patient care and safety protocols; or 3) Documentation of the on-going evaluation and monitoring of the management structure and workflow of ASP processes; or 4) Records of presentation of ASP education and training including curriculum and presentation dates; or 5) Documentation of communications regarding ASP compliance; or 6) Documentation of preparation of and/or participation in payer audits, government inquiries, or professional inquiries pertaining to the ASP; or 7) Documentation of evidence-based policy or practice aimed at improving antibiotic prescribing practices for high-priority conditions; or 8) Documentation of developing and implementing evidence-based	2017	Sub-IA-1: Provide leadership of a Bio-Security, Bio-Preparedness, & Emerging Infectious Diseases (BBEID) Program; Sub-IA-2: Provide leadership of an Antimicrobial Stewardship Program; Sub-IA-3: Provide leadership of Outpatient Parenteral Antimicrobial Therapy Hospital Admission/Readmission Avoidance Program

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			effective ASP. • Coordinate communications between ASP management and facility or practice personnel regarding activities, services, and operational/clinical protocols to achieve overall compliance and understanding of the ASP. • Assist, at the request of the facility or practice, in preparing for and responding to third-party requests, including but not limited to payer audits, governmental inquiries, and professional inquiries that pertain to the ASP service line. • Implementing and tracking an evidence-based policy or practice aimed at improving antibiotic prescribing practices for high-priority conditions. • Developing and implementing evidence-based protocols and decision-support for diagnosis and treatment of common infections • Implementing evidence-based protocols that align with recommendations in the Centers for Disease Control and Prevention's Core Elements of Outpatient Antibiotic Stewardship guidance			protocols and decision-support for diagnosis and treatment of common infections; or 9) Documentation of the alignment of evidence-based protocols with recommendations in the Centers for Disease Control and Prevention's Core Elements of Outpatient Antibiotic Stewardship guidance.		

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IA_PSPA_16	Patient Safety and Practice Assessment	Use of decision support and standardized treatment protocols	Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.	Medium	Use of decision support and treatment protocols to manage workflow in the team to meet patient needs	Documentation (e.g. checklist, algorithm, screenshot) showing use of decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.	2017	
IA_PSPA_17	Patient Safety and Practice Assessment	Implementation of analytic capabilities to manage total cost of care for practice population	In order to receive credit for this activity, a MIPS eligible clinician must conduct or build the capacity to conduct analytic activities to manage total cost of care for the practice population. Examples of these activities could include: • Train appropriate staff on interpretation of cost and utilization information; • Use available data regularly to analyze opportunities to reduce cost through improved care. An example of a platform with the necessary analytic capability to do this is the American Society for Gastrointestinal (GI) Endoscopy's GI Operations Benchmarking Platform.	Medium	Use of analytic capabilities to manage total cost of care for practice population (e.g. the American Society for Gastrointestinal (GI) Endoscopy's GI Operations Benchmarking Platform is a sufficient example of a tool used for identifying opportunities to reduce cost).	1) Staff Training - Documentation of staff training on interpretation of cost and utilization information (e.g. training certificate); or 2) Cost/Resource Use Data - Availability of cost/resource use data for the practice population that is used regularly to analyze opportunities to reduce cost.	2017	Sub-IA-1: Engage with local Regional Health Improvement Collaborative (RHIC) to measure and utilize Total Cost of Care (TCoC) to identify practice improvement opportunities, create a practice improvement plan(s), and execute on the plan(s)

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IA_PSPA_18	Patient Safety and Practice Assessment	Measurement and improvement at the practice and panel level	Measure and improve quality at the practice and panel level, such as the American Board of Orthopaedic 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	Measure and improve quality at the practice and panel level. Practice and panel performance benchmarks and goals may also include benchmarks/goals for specific populations (for example, racial and ethnic minorities, individuals with disabilities, sexual and gender minorities, individuals in rural areas) to drive overall improvements, and individuals with certain chronic conditions or risk factors	1) Quality Improvement Program/Plan at Practice and Panel Level - Copy of a quality improvement program/plan or review of quality, utilization, patient satisfaction (surveys should be administered by a third party survey administrator/vendor) and other measures to improve one or more elements of this activity; or 2) Review of and Progress on Measures - Report showing progress on selected measures, including benchmarks and goals for performance using relevant data sources at the practice and panel level.	2017	Sub-IA-1: Obtain diagnostic Imaging Center of Excellence (DICOE) designation; Sub-IA-2: Participate in Endoscopy Unit Recognition Program (EURP); Sub-IA-3: Participate in Simulation Education Courses approved by the ASA Simulation Education Network

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IA_PSPA_19	Patient Safety and Practice Assessment	Implementation of formal quality improvement methods, practice changes or other practice improvement processes	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: • Participation in multisource feedback; • Train all staff in quality improvement methods; • Integrate practice change/quality improvement into staff duties; • Engage all staff in identifying and testing practices 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; • 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 clinicians act upon patient experience data; • Participation in Bridges to Excellence; • Participation in American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.	Medium	Documentation/Evidence of the implementation of a formal model for quality improvement and creation of a culture in which staff actively participates in one or more improvement activities (e.g., formal QI models are used by clinicians to develop systems, tools, and interventional strategies to improve processes of care for their patient population. An example of a formal QI model would be the "Model for Improvement:" http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx, which requires a Plan, Do, Study, Act (PDSA) approach to improvement to promote change.	1) Adopt Formal Quality Improvement Model and Create Culture of Improvement - Documentation of adoption of a formal model for quality improvement and creation of a culture in which staff actively participate in improvement activities; and 2) Staff Participation - Documentation of staff participation in one or more of the six identified; including, training, integration into staff duties, identifying and testing practice changes, regular team meetings to review data and plan improvement cycles, share practice and panel level quality of care, patient experience and utilization data with staff, or share practice level quality of care, patient experience and utilization data with patients and families.	2017	Sub-IA-1: Participate in Peer Review (MSF-360)process; Sub-IA-2: Participate in a psychometrically scored clinical peer review program in medical imaging and interventional procedures; Sub-IA-3: Conduct technical image quality review, with documentation of all imaging views; Sub-IA-4: Use a clinical peer review tool to assess and accelerate quality improvement processes

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IA_PSPA_20	Patient Safety and Practice Assessment	Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes	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	Functionality of leadership engagement in regular guidance and demonstrated commitment for implementing improvements	1) Clinical and Administrative Leadership Role Descriptions - Documentation of clinical and administrative leadership role descriptions include responsibility for practice improvement change (e.g. position description); or; 2) Time for Leadership in Improvement Activities - Documentation of allocated time for clinical and administrative leadership participating in improvement efforts, e.g. regular team meeting agendas and post meeting summary; or; 3) Population Health, Quality, and Health Experience Incorporated into Performance Reviews - Documentation of population health, quality and health experience metrics incorporated into regular practice performance reviews, e.g., reports, agendas, analytics, meeting notes.	2017	
IA_PSPA_21	Patient Safety and Practice Assessment	Implementation of fall screening and assessment programs	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	Functionality of fall screening and assessment programs	1) Implementation of a Falls Screening and Assessment Program - Implementation of a falls screening and assessment program that uses valid and reliable tools to identify patients at risk for falls and address modifiable risk factors, for example, the STEADI program for identification of falls risk; and 2) Implementation Progress- Documentation of progress made on falls screening and assessment after implementation of tool.	2017	

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IA_PSPA_22	Patient Safety and Practice Assessment	CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain	Completion of all the modules of the Centers for Disease Control and Prevention (CDC) course "Applying CDC's Guideline for Prescribing Opioids" that reviews the 20 16 "Guideline for Prescribing Opioids for Chronic Pain." Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.	High	Completion with a passing score of all the modules of the Centers for Disease Control and Prevention (CDC) course "Applying CDC's Guideline for Prescribing Opioids" that reviews the 2016 "Guideline for Prescribing Opioids for Chronic Pain"	Documented participation in and completion of all Centers for Disease Control and Prevention (CDC) course "Applying CDC's Guideline for Prescribing Opioids" that reviews the 2016 "Guideline for Prescribing Opioids for Chronic Pain." NOTE: The CDC continues to develop additional training modules. With this in mind, all modules available at the stated start date of the eligible clinician or group's attestation period must be completed in order to attest to this IA.	2018	Sub-IA-1: Implementation of an opioid stewardship program
IA_PSPA_23	Patient Safety and Practice Assessment	Completion of CDC Training on Antibiotic Stewardship	Completion of all modules of the Centers for Disease Control and Prevention antibiotic stewardship course. Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.	High	Completion with a passing score of all modules of the Centers for Disease Control and Prevention antibiotic stewardship course. NOTE: Eligible clinicians and groups cannot attest to both IA_PSPA_23 and IA_PSPA_24 for the same QPP Year.	Documented participation in and completion of all modules of the Centers for Disease Control and Prevention antibiotic stewardship course. Find course at https://www.train.org/cdctrain/course/1075730/compilation. NOTE: Eligible clinicians and groups cannot attest to both IA_PSPA_23 and IA_PSPA_24 for the same QPP Year.	2018	

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IA_PSPA_25	Patient Safety and Practice Assessment	Cost Display for Laboratory and Radiographic Orders	Implementation of a cost display for laboratory and radiographic orders, such as costs that can be obtained through the Medicare clinical laboratory fee schedule.	Medium	Demonstration of transparency of costs at the point-of-order for ordering providers for laboratory and/or radiographic orders	Documentation (screen shot, report from EHR, written display procedure) of laboratory and radiographic costs at the point-of-order.	2018	
IA_PSPA_26	Patient Safety and Practice Assessment	Communication of Unscheduled Visit for Adverse Drug Event and Nature of Event	A MIPS eligible clinician providing unscheduled care (such as an emergency room, urgent care, or other unplanned encounter) attests that, for greater than 75 percent of case visits that result from a clinically significant adverse drug event, the MIPS eligible clinician provides information, including through the use of health IT to the patient's primary care clinician regarding both the unscheduled visit and the nature of the adverse drug event within 48 hours. A clinically significant adverse event is defined as a medication-related harm or injury such as side-effects, supratherapeutic effects, allergic reactions, laboratory abnormalities, or medication errors requiring urgent/emergent evaluation, treatment, or hospitalization.	Medium	Demonstration of communication from the eligible clinician/group providing unscheduled care for a clinically significant adverse drug event to the patient's primary care provider	1) Documentation of an unscheduled clinically significant adverse event, defined as a medication-related harm or injury such as side-effects, supratherapeutic effects, allergic reactions, laboratory abnormalities, or medication errors requiring urgent/emergent evaluation, treatment, or hospitalization. 2) Documentation of communication of the event to the patient's primary care clinician within 48 hours of the unscheduled event.	2018	

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IA_PSPA_27	Patient Safety and Practice Assessment	Invasive Procedure or Surgery Anticoagulation Medication Management	For an anticoagulated patient undergoing a planned invasive procedure for which interruption in anticoagulation is anticipated, including patients taking vitamin K antagonists (warfarin), target specific oral anticoagulants (such as apixaban, dabigatran, and rivaroxaban), and heparins/low molecular weight heparins, documentation, including through the use of electronic tools, that the plan for anticoagulation management in the periprocedural period was discussed with the patient and with the clinician responsible for managing the patient's anticoagulation. Elements of the plan should include the following: discontinuation, resumption, and, if applicable, bridging, laboratory monitoring, and management of concomitant antithrombotic medications (such as antiplatelets and nonsteroidal anti-inflammatory drugs (NSAIDs)). An invasive or surgical procedure is defined as a procedure in which skin or mucous membranes and connective tissue are incised, or an instrument is introduced through a natural body orifice.	Medium	Implementation of a process to treat an anticoagulated patient undergoing a planned invasive procedure for which interruption in anticoagulation is anticipated, e.g. including patients taking vitamin K antagonists (warfarin)	1) Documentation of a process to target specific oral anticoagulants (such as apixaban, dabigatran, and rivaroxaban), and heparins/low molecular weight heparins, including through the use of electronic tools, that the plan for anticoagulation management in the periprocedural period was discussed with the patient and with the clinician responsible for managing the patient's anticoagulation; and 2) The plan should include the following: discontinuation, resumption, and, if applicable, bridging, laboratory monitoring, and management of concomitant antithrombotic medications (such as antiplatelets and nonsteroidal anti-inflammatory drugs (NSAIDs)). Note: an invasive or surgical procedure is defined as a procedure in which skin or mucous membranes and connective tissue are incised, or an instrument is introduced through a natural body orifice.	2018	

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IA_PSPA_28	Patient Safety and Practice Assessment	Completion of an Accredited Safety or Quality Improvement Program	Completion of an accredited performance improvement continuing medical education (CME) program that addresses performance or quality improvement according to the following criteria: • The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity; • The activity must have specific, measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information. An example of an activity that could satisfy this improvement activity is completion of an accredited continuing medical education program related to opioid analgesic risk and evaluation strategy (REMS) to address pain control (that is, acute and chronic pain).	Medium	Documentation/ Evidence of the completion of an accredited performance improvement continuing medical education program that addresses performance or quality improvement (e.g., http://www.astho.org/Accreditation-and-Performance/Accreditation-Readiness-and-Performance-Improvement-Technical-Assistance-to-States/)	Documentation that the activity addresses a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of a needs assessment as part of the activity; • The activity must have specific, measurable aim(s) for improvement; • The activity must include interventions intended to result in improvement; • The activity must include data collection and analysis of performance data to assess the impact of the interventions; and • The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements and provide participant completion information.	2018	Sub-IA-1: Completion of a Performance Improvement Module, such as Asthma IQ: Patient Management and Outcomes; Asthma IQ: Patient Assessment; PI Pro: Food Allergy; Self-Directed Practice Improvement Module; Sub-IA-2: Participate in Accredited Continuing Medical Education (CME) or continuing nurse education activities; Sub-IA-3: Participate in simulation to develop technical and procedural skills; Sub-IA-4: Participate in Micrographic Surgery & Dermatologic Oncology (Mohs) Fellowship Program; Sub-IA-5: Participation in voluntary surveillance activity; Sub-IA-6: Participate in ASGE Skills Training Assessment Reinforcement (STAR) Certificate Program; Sub-IA-7: Participate in the

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								ASCO Quality Training Program; Sub-IA-8: Teach students, residents, and allied health professionals in accredited programs; Sub-IA-9: Demonstrate strengthening Systems and Team-Based Quality of Care; Sub-IA-10: Tackling Community Level Diabetes: Overcoming Local Challenges to Patient Health; à Using Community-Based Resources to Address Diabetes; Sub-IA-11: Engage Patient and Stakeholder Partners using Guidance from the PCORI Engagement Rubric; Sub-IA-12: Participate in AHRQ's Making Informed Consent an Informed Choice: Training for Health Care Professionals

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IA_PSPA_29	Patient Safety and Practice Assessment	Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging	Clinicians attest that they are consulting specified applicable AUC through a qualified clinical decision support mechanism for all applicable imaging services furnished in an applicable setting, paid for under an applicable payment system, and ordered on or after January I, 2018. This activity is for clinicians that are early adopters of the Medicare AUC program (2018 performance year) and for clinicians that begin the Medicare AUC program in future years as specified in our regulation at §414.94. The AUC program is required under section 218 of the Protecting Access to Medicare Act of 2014. Qualified mechanisms will be able to provide a report to the ordering clinician that can be used to assess patterns of image-ordering and improve upon those patterns to ensure that patients are receiving the most appropriate for their individual condition.	High	Documentation of attestation and consultation of specified applicable AUC through a qualified clinical decision support mechanism	Documentation of consulting specified applicable appropriate use criteria (AUC) through a qualified clinical decision support mechanism for all applicable imaging services furnished in an applicable setting, paid for under an applicable payment system, and ordered on or after January 1, 2018. • Evidence of early adoption of the Medicare AUC program (PY2018 Performance Year); or • Copies of reports (paper copy, screen shots, etc.) to the ordering clinician that can be used to assess patterns of image-ordering and improve upon those patterns to ensure that patients are receiving the most appropriate imaging for their individual condition.	2018	
IA_PSPA_30	Patient Safety and Practice Assessment	PCI Bleeding Campaign	Participation in the PCI Bleeding Campaign which is a national quality improvement program that provides infrastructure for a learning network and offers evidence-based resources and tools to reduce avoidable bleeding associated with patients who receive a percutaneous coronary intervention (PCI). The program uses a patient-centered and team-based approach, leveraging evidence-based best practices to improve care for PCI patients by	High	Documented participation in the PCI Bleeding Campaign which is a national quality improvement program that provides infrastructure for a learning network and offers evidence-based resources and tools to reduce avoidable	1) Documentation of participation in the PCI Bleeding Campaign.	2018	

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			implementing quality improvement strategies: • Radial-artery access; • Bivalidruin, and • Use of vascular closure devices.		bleeding associated with patients who receive a percutaneous coronary intervention (PCI)			
IA_PSPA_31	Patient Safety and Practice Assessment	Patient Medication Risk Education	In order to receive credit for this activity, MIPS eligible clinicians must provide both written and verbal education regarding the risks of concurrent opioid and benzodiazepine use for patients who are prescribed both benzodiazepines and opioids. Education must be completed for at least 75 percent of qualifying patients and occur: (1) at the time of initial co-prescribing and again following greater than 6 months of co- prescribing of benzodiazepines and opioids, or (2) at least once per MIPS performance period for patients taking concurrent opioid and benzodiazepine therapy.	High	Eligible clinicians and groups must provide both written and verbal education regarding the risks of concurrent opioid and benzodiazepine use for patients who are prescribed both benzodiazepines and opioids.	Education must be completed for at least 75 percent of qualifying patients and occur as follows: 1) at the time of initial co-prescribing and again following greater than 6 months of co- prescribing of benzodiazepines and opioids, or (2) at least once per MIPS performance period for patients taking concurrent opioid and benzodiazepine therapy.	2019	
IA_PSPA_32	Patient Safety and Practice Assessment	Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support	In order to receive credit for this activity, MIPS eligible clinicians must utilize the Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain via clinical decision support (CDS). For CDS to be most effective, it needs to be built directly into the clinician workflow and support decision making on a specific patient at the point of care. Specific examples of how the guideline could be incorporated into a CDS workflow include, but are not limited to: electronic health record (EHR)-based prescribing prompts,	High	MIPS eligible clinicians and groups must utilize the Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain via clinical decision support (CDS).	1) Eligible clinicians or groups utilizing CDS must build the capability directly into the clinician workflow and document the support decision making on patients during the 90 day or year-long attestation period at the point of care; and 2) Document specific examples of how the guideline is incorporated into a CDS workflow. This may include, but is not limited to: electronic health record (EHR)-based prescribing prompts, order sets that require review of	2019	

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			order sets that require review of guidelines before prescriptions can be entered, and prompts requiring review of guidelines before a subsequent action can be taken in the record.			guidelines before prescriptions can be entered, and prompts requiring review of guidelines before a subsequent action can be taken in the record.		
IA_AHE_1	Achieving Health Equity	Engagement of new Medicaid patients and follow-up	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	Functionality of practice in seeing new and follow-up Medicaid patients in a timely manner including patients dually eligible. "Engaging" patients may include, but is not limited to: Establishing patient-provider relationship, assisting patient with care management plan, medication management and reconciliation, use of patient portal, use of community health worker or other provider(s) to help patients navigate health care services	1) Timely Appointments for Medicaid and Dually Eligible Medicaid/Medicare Patients - Statistics from EHR or scheduling system (may be manual) on time from request for appointment to first appointment offered or appointment made by type of visit for Medicaid and dual eligible patients; and 2) Improvement Activities - Assessment of new and follow-up visit appointment statistics and other patient-level data to identify and implement improvement activities. Documentation should include planned and in-progress improvement activities and intended aims.	2017	
IA_AHE_3	Achieving Health Equity	Promote use of Patient-Reported Outcome Tools	Demonstrate performance of activities for employing patient-reported outcome (PRO) tools and corresponding collection of PRO data such as the use of PHQ-2 or PHQ-9, PROMIS instruments, patient reported Wound-	High	Demonstrated performance of activities to promote use of patient-report outcome tools and	Use of patient-reported outcome tools (e.g., feedback reports demonstrating use of patient-reported outcome tools and corresponding collection of PRO	2017	

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			Quality of Life (QoL), patient reported Wound Outcome, and patient reported Nutritional Screening.		corresponding collection of PRO data	data (e.g., use of PHQ-2 or PHQ-9 and PROMIS instruments)).		
IA_AHE_5	Achieving Health Equity	MIPS Eligible Clinician Leadership in Clinical Trials or CBPR	MIPS eligible clinician leadership in clinical trials, research alliances or community-based participatory research (CBPR) that identify tools, research or processes that can focuses on minimizing disparities in healthcare access, care quality, affordability, or outcomes.	Medium	Participation in clinical trials, research alliances or community-based participatory research (CPBR), documentation of research aims and results	1) Documentation of participation by clinician leadership in clinical trials, research alliances, or community-based participatory research (CBPR) to identify tools, research or processes focused on minimizing disparities in healthcare access, care quality, affordability, or outcomes; and 2) Documentation of intended or actual aims and outcomes.	2018	
IA_AHE_6	Achieving Health Equity	Provide Education Opportunities for New Clinicians	MIPS eligible clinicians acting as a preceptor for clinicians-in-training (such as medical residents/fellows, medical students, physician assistants, nurse practitioners, or clinical nurse specialists) and accepting such clinicians for clinical rotations in community practices in small, underserved, or rural areas.	High	Participation as a preceptor for clinicians-in-training that encourage clinical rotations in community practices in small underserved, or rural areas	Documentation of participation as a preceptor for clinicians-in-training that encourages clinical rotations in community practices in small underserved, or rural areas. Examples of eligible clinicians anticipated to serve as a preceptor would include; medical residents/fellows, medical students, physician assistants, nurse practitioners, or clinical nurse specialists.	2018	
IA_AHE_7	Achieving Health Equity	Comprehensive Eye Exams	In order to receive credit for this activity, MIPS eligible clinicians must promote the importance of a comprehensive eye exam, which may be accomplished by providing literature and/or facilitating a conversation about this topic using resources such as the "Think About Your Eyes" campaign and/or referring patients to resources providing no-cost eye exams, such as the American	Medium	Documentation of patient engagement by non-ophthalmologists/o ptometrists on the importance of comprehensive eye examinations targeted at	1) Documentation providing evidence that targeted, underserved, and/or high-risk populations are engaged in their ocular health with the aim of improving their access to comprehensive eye exams; and/or 2) Documentation that a discussion with the patient regarding the significance of annual	2019	

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			Academy of Ophthalmology's EyeCare America and the American Optometric Association's VISION USA. This activity is intended for: (1) non-ophthalmologists / optometrist who refer patients to an ophthalmologist/optometrist; (2) ophthalmologists/optometrists caring for underserved patients at no cost; or (3) any clinician providing literature and/or resources on this topic. This activity must be targeted at underserved and/or high- risk populations that would benefit from engagement regarding their eye health with the aim of improving their access to comprehensive eye exams.		underserved and/or high risk populations or documentation of ophthalmologists/o ptometrists providing care for patients at no-cost for underserved and/or high risk populations.	comprehensive eye exams (when indicated) with evidence that ophthalmic resources were distributed to promote ocular health; and/or 3) Demonstrated promotion of the significance of comprehensive eye exams (referring patients to resources and providing no-cost eye exams) via ophthalmic resources with evidence that a conversation about this topic was conducted using resources such as the "Think About Your Eyes" Campaign, American Academy of Ophthalmology's EyeCare America, and the American Optometric Association's VISION USA. Evidence of use of these resources in support of this Improvement Activity may include screenshots of a notation in the medical chart, or copies of the ocular literature provided to the patient; and/or 4) Documentation of providing a free eye exam to the patient.		
IA_ERP_1	Emergency Response & Preparedness	Participation on Disaster Medical Assistance Team, registered for 6 months.	Participation in Disaster Medical Assistance Teams, or Community Emergency Responder Teams. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and MIPS eligible clinician groups must be registered for a minimum of 6 months as a volunteer for disaster or emergency response.	Medium	Participation in Disaster Medical Assistance Team or Community Emergency Responder Team for at least 6 months as a volunteer	Documentation of participation in Disaster Medical Assistance or Community Emergency Responder Teams for at least 6 months including registration and active participation, e.g., attendance at training, on-site participation, etc.	2017	

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IA_ERP_2	Emergency Response & Preparedness	Participation in a 60-day or greater effort to support domestic or international humanitarian needs.	Participation in domestic or international humanitarian volunteer work. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups attest to domestic or international humanitarian volunteer work for a period of a continuous 60 days or greater.	High	Participation in domestic or international humanitarian volunteer work of at least a continuous 60 days duration	Documentation of participation in domestic or international humanitarian volunteer work of at least a continuous 60 days duration including registration and active participation, e.g., identification of location of volunteer work, timeframe, and confirmation from humanitarian organization.	2017	
IA_ERP_3	Emergency Response & Preparedness	COVID-19 Clinical Trials	In order to receive credit for this activity, a MIPS eligible clinician must participate in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection and report their findings through a clinical data repository or clinical data registry for the duration of their study. For more information on the COVID-19 clinical trials we refer readers to the U.S. National Library of Medicine website at https://clinicaltrials.gov/ct2/results?cond=COVID-19	High	Proof of participation in the COVID-19 clinical trial may include a screenshot capture of the MIPS eligible clinician or groups submission to the participating clinical data repository/registry	Evidence of submission of clinical data to the clinical data repository or registry supporting the COVID-19 clinical trial (i.e. screenshot from the participating clinical data repository or clinical data registry).	2020	The type of clinical trial could include designs ranging from the traditional double-blinded placebo-controlled trial to an adaptive design or pragmatic design that flexes to workflow and clinical practice context. It may be conducted in large organized clinical trials led by academic medical centers or healthcare systems. In addition, we intend for this activity to be applicable to MIPS-eligible clinicians that are reporting their COVID-19 related patient data to a clinical data repository, such as Oracle's COVID-19 Therapeutic Learning System

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								(https://covid19.oracle.com/) Examples of data registries include, but are not limited to: • Healthcare Worker Exposure Response & Outcomes (HERO) Registry: https://protect2.fireeye.com/url?k=b5fdaaa2-e9a9b3de-b5fd9b9d-0cc47adc5fa2-990d9a8e6607466a&u=http://www.heroesresearch.org/ • American Heart Association (AHA) COVID-19 cardiovascular disease (CVD) registry: https://www.heart.org/en/professional/quality-improvement/covid-19-cvd-registry
IA_BMH_1	Behavioral and Mental Health	Diabetes screening	Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication.	Medium	Performance of diabetes screening for patients with schizophrenia or bipolar disease who are using antipsychotic medication	Report from EHR, documentation from medical charts, or claims showing regular practice for diabetes screening of patients with schizophrenia or bipolar disease who are using antipsychotic medications.	2017	

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IA_BMH_2	Behavioral and Mental Health	Tobacco use	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	Performance of regular engagement in integrated prevention and treatment interventions including tobacco use screening and cessation interventions for patients with co-conditions of behavioral or mental health and at risk factors for tobacco dependence	Report from EHR, QCDR, clinical registry or documentation from medical charts showing regular practice of tobacco screening for patients with co-occurring conditions of behavioral or mental health and at risk factors for tobacco dependence.	2017	
IA_BMH_4	Behavioral and Mental Health	Depression screening	Depression screening and follow-up plan: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including depression screening and follow-up plan (refer to NQF #0418) for patients with co-occurring conditions of behavioral or mental health conditions.	Medium	Performance of regular engagement in integrated prevention and treatment interventions including depression screening and follow-up plan for patients with co-conditions of behavioral or mental health	Report from EHR, QCDR, clinical registry or documentation from medical charts showing regular practice for depression screening and follow-up plan for these patients with co-conditions of behavioral or mental health.	2017	

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IA_BMH_5	Behavioral and Mental Health	MDD prevention and treatment interventions	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	Performance of regular engagement in integrated prevention and treatment interventions including suicide risk assessment for mental health patients with co-conditions of behavioral or mental health	Report from EHR, QCDR, clinical registry or documentation from medical charts showing regular practice for screening including suicide risk assessment for mental health patients with co-occurring conditions of behavioral or mental health conditions.	2017	
IA_BMH_6	Behavioral and Mental Health	Implementation of co-location PCP and MH services	Integration facilitation, and promotion of the colocation of mental health and substance use disorder services in primary and/or non-primary clinical care settings.	High	Integration of facilitation and promotion of mental health and substance use disorder services in primary and/or non-primary clinical care settings	Documentation of integration and promotion of the colocation of mental health and substance use disorder services in primary and/or non-primary clinical care settings, e.g., list of NPIs that participate as behavioral health specialists, mental health clinicians or primary care clinicians in co-located setting or patient claims showing mental health and substance use disorder services collocated in primary and/or non-primary clinical care settings.	2017	

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IA_BMH_7	Behavioral and Mental Health	Implementation of integrated PCBH model	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 certified health information technology functionality to support active care management and outreach to patients in treatment; and/or • Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible. • Participate in the National Partnership to Improve Dementia Care Initiative, which promotes a multidimensional approach that includes public reporting, state-based coalitions, research, and revised surveyor guidance.	High	Provision of integrated behavioral health services to support patients with behavioral health needs and poorly controlled chronic conditions (May use certified EHR, QCDR, clinical registry or medical records)	Documented integration of behavioral health services with primary care to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions program and services including one or more of the six activities described in the activity description. Documentation could include EHR note that shows that the patient saw a BH professional and communicated with PCP or practice team; referral to BH; or staffing or BH co located in primary care practice.	2017	Sub-IA-1: Participate in Improving Dementia Care Initiative; Sub-IA-2: Participate in Comprehensive Obesity Prevention and Intervention Program; Sub-IA-3: Participate in National Partnership to Improve Dementia Care in Nursing Homes

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IA_BMH_8	Behavioral and Mental Health	Electronic Health Record Enhancements for BH data capture	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	Use of EHR to capture additional data on behavioral health populations and use data for additional decision-making	Screen shots from certified EHR or from other software/tools integrated with the certified EHR and reports showing how additional behavioral health data is captured and used for additional decision-making.	2017	
IA_BMH_9	Behavioral and Mental Health	Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Abuse and Ambulatory Care Patients	Individual MIPS eligible clinicians or groups must regularly engage in integrated prevention and treatment interventions, including screening and brief counseling (for example: NQF #2152) for patients with co-occurring conditions of mental health and substance abuse. MIPS eligible clinicians would attest that 60 percent for the CY 2018 Quality Payment Program performance period, and 75 percent beginning in the 2019 performance period, of their ambulatory care patients are screened for unhealthy alcohol use.	High	Demonstration by MIPS eligible clinicians and groups that integrated prevention and treatment interventions with documented screening and brief counseling occurred on a regular basis. Documentation of referral or feedback/acknowledgment from referred provider	Screen shots from certified EHR or from other software/tools demonstrating integrated prevention and treatment interventions (i.e., evidence of screening and brief counseling for patient with co-occurring conditions of mental health and substance abuse). For the intent of this IA,-co-occurring conditions are defined as the diagnosed coexistence of both a mental health and a substance use disorder.		
IA_BMH_10	Behavioral and Mental Health	Completion of Collaborative Care Management Training Program	To receive credit for this activity, MIPS eligible clinicians must complete a collaborative training program, such as the American Psychiatric Association (APA) Collaborative Care Model training program available to the public, in order to implement a collaborative approach that provides comprehensive training in the integration of behavioral health into the primary care practice.	Medium	Completion of a collaborative care management training program by eligible clinicians or groups such as the American Psychological Association (APA) Collaborative Care	1) MIPS eligible clinicians and groups must complete a collaborative care management training program, such as the American Psychological Association (APA) Collaborative Care Model training program and; 2) Documented implementation of a collaborative care management approach that provides comprehensive training in the	2019	

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					Model training program	integration of behavioral health into the primary care practice.		
IA_PCMH	NA	Implementation of Patient-Centered Medical Home model	Implementation of the patient-centered medical home model to continually improve comprehensive care coordination and accessibility within the primary care setting. This may include implementing a wide range of practice and patient focused standards that pertain to the care coordination, patient-centeredness, comprehensiveness of care, systems based on safety and quality, among others.		Performance of standards and expectation that pertain to the patient-centered medical home model	1) Documented implementation of patient-centered medical home activities and improvements that pertain to care coordination, patient-centeredness, or comprehensiveness of care, among others; and 2) Documented recognition as a patient-centered medical home from a regional or state program, private payer or other body that certifies at least 500 or more practices for patient-centered medical home accreditation or comparable specialty practice certification; and 3) Documentation of continual improvements.	2017	NOTE: A practice is certified or recognized as a patient-centered medical home if it meets any of the following criteria: (A) The practice has received accreditation from a nationally recognized program. (B) The practice is participating in a Medicaid Medical Home Model or Medical Home Model. (C) The practice has received certification or accreditation from other certifying bodies that have certified a large number of medical organizations and meet national guidelines, as determined by the Secretary. The Secretary must determine that these certifying bodies must have 500 or more certified member practices, and require practices to include the following: (1) Have a personal

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								physician/clinician in a team-based practice. (2) Have a whole-person orientation. (3) Provide coordination or integrated care. (4) Focus on quality and safety. (5) Provide enhanced access.