Advancing Care Information Performance Category Fact Sheet

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) replaced three quality programs (the Medicare Electronic Health Record (EHR) Incentive program, the Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier (VM) with the Quality Payment Program. This one program will give Medicare physicians and clinicians a chance to be paid more for giving better care. There are two ways to take part in this program:

- Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (APMs)

Under MIPS, there are four connected pillars that affect how you will be paid by Medicare – Quality, Clinical Practice Improvement Activities (referred to as "Improvement Activities"), Certified EHR Technology (referred to as "Advancing Care Information"), and Resource Use (referred to as "Cost"). At its core, the Quality Payment Program is about improving the quality of patient care.

In determining a total score, specific weights are assigned to each of the four performance categories for 2017:

Transition Year Weights

Quality

60%

Cost

0%

Improvement Activities

15%

Advancing Care Information

25%

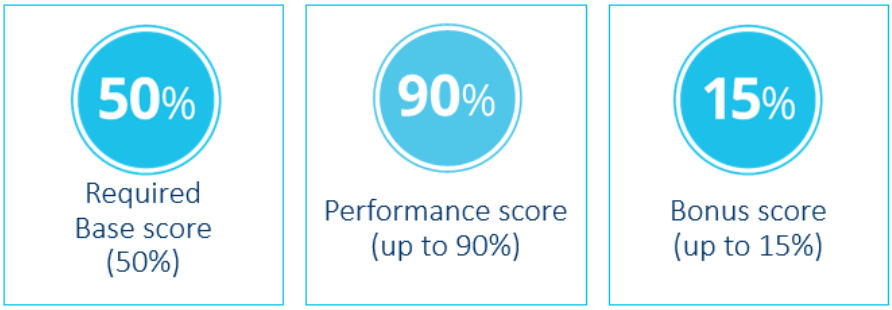
For 2017, or the "transition" year, Cost will not be counted towards the final score to allow clinicians more time to gain familiarity with the MIPS program before they are assessed on Cost in the second year.

The Advancing Care Information performance category replaces the Medicare EHR Incentive Program for eligible professionals, also known as Meaningful Use.

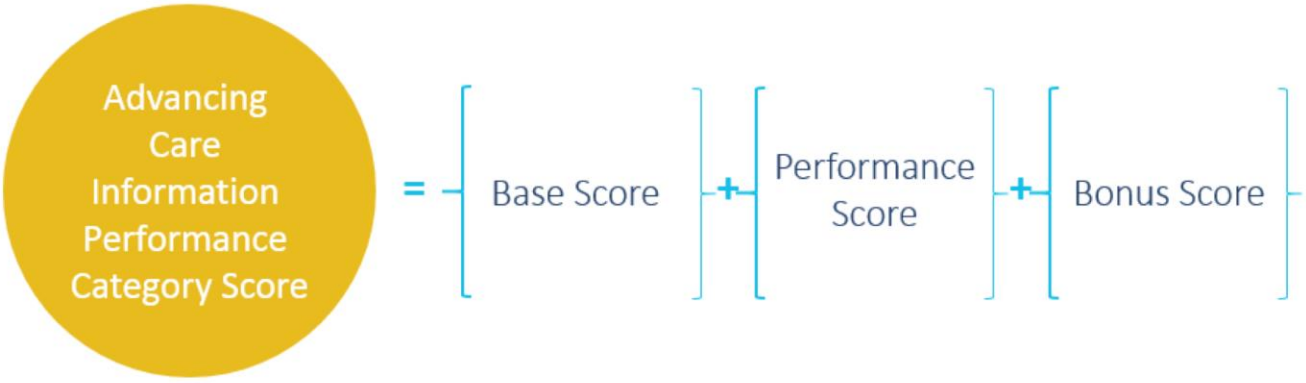
How is the Advancing Care Information Performance Category Score Calculated?

For scoring purposes, in the Advancing Care Information performance category (weighted at 25% of the total score), MIPS eligible clinicians may earn a maximum score of up to **155%**, but any score above 100% will be capped at **100%**. This structure was deliberately created to ensure that clinicians have flexibility to focus on measures that are the most relevant to them and their practices.

The Advancing Care Information score is the combined total of the following three scores:



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



The total Advancing Care Information performance category score will then be multiplied by the 25% Advancing Care Information category weight with the result adding to the overall MIPS final score.

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

When is the Advancing Care Information Score Reweighted?

MIPS eligible clinicians must use certified electronic health record technology (CEHRT) to report to the Advancing Care Information performance category. If they do not have a certified EHR, they must meet certain criteria in order to qualify for a reweighting of the performance category to 0% so that it is not included in the total score. Simply lacking CEHRT is not sufficient to qualify to have the Advancing Care Information performance category weight to be set at 0% of the MIPS final score.

A MIPS eligible clinician's performance score may be reweighted for the following reasons:

1. They apply for reweighting, citing one of three specified reasons:
   - Insufficient Internet Connectivity
   - Extreme and Uncontrollable Circumstances
   - Lack of Control over the Availability of CEHRT

   These MIPS eligible clinicians must submit an application for CMS to reweight the Advancing Care Information performance category to 0%. More information about the application will be available in 2017.

2. They are one of the following MIPS eligible clinicians that qualify for an automatic reweighting:
   - Hospital-based MIPS clinicians
   - Physician assistants
   - Nurse practitioners
   - Clinical nurse specialists
   - Certified registered nurse anesthetists
   - Clinicians who lack face-to-face interactions with patients

   These MIPS eligible clinicians can still choose to report if they would like, and if data is submitted, CMS will score their performance and weight their Advancing Care Information performance accordingly.

For these two groups of MIPS eligible clinicians, CMS will reweight the category to 0% and **assign the 25% to the Quality performance category** to maintain the potential for participants to earn up to 100 points in the MIPS Final Score.

What are the Options for Advancing Care Information Reporting using Certified EHR Technology?

In 2017, there are two measure set options for reporting:

- Advancing Care Information Objectives and Measures
- 2017 Advancing Care Information Transition Objectives and Measures

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

MIPS eligible clinicians can report the Advancing Care Information objectives and measures if they have:

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

In 2017, MIPS eligible clinicians can alternatively report the **2017** Advancing Care Information **transition** objectives and measures if they have:

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

See Appendix A for the full list of Advancing Care Information measures and **2017** Advancing Care Information transition measures. Detailed guidance outlining each element of each Advancing Care Information measure and 2017 Advancing Care Information transition measure can be found in the Advancing Care Information Measure Specification Sheets.

How is the Base Score Calculated?

MIPS eligible clinicians need to fulfill the requirements of all the base score measures in order to receive the 50% base score. If these requirements are not met, they will get a **0** in the overall Advancing Care Information performance category score.

In order to receive the 50% base score, MIPS eligible clinicians must submit a "yes" for the security risk analysis measure, and **at least a 1** in the numerator for the numerator/denominator of the remaining measures. The base score Advancing Care Information measures are:

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

The base score **2017** Advancing Care Information **transition** measures are:

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

As explained above, all of the base score requirements must be met in order to receive the 50% base score and be able to receive a score in the Advancing Care Information category.

In addition, it is important to note that some of the base score measures can also contribute towards the performance score.

How is the Performance Score Calculated?

The performance score is calculated by using the numerators and denominators submitted for measures included in the performance score, or for one measure, by the yes or no answer submitted.

The potential total performance score is 90%. For each measure with a numerator/denominator, the percentage score is determined by the performance rate. Most measures are worth a maximum of 10 percentage points, except for two measures reported under the 2017 Transition measures, which are worth up to 20 percentage points.

Performance Rates for Each Measure Worth Up to 10%	
Performance Rate 1-10 = 1% Performance Rate 11-20 = 2% Performance Rate 21-30 = 3% Performance Rate 31-40 = 4% Performance Rate 41-50 = 5%	Performance Rate 51-60 = 6% Performance Rate 61-70 = 7% Performance Rate 71-80 = 8% Performance Rate 81-90 = 9% Performance Rate 91-100 = 10%

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

The only performance score measure that is yes/no is the Immunization Registry Reporting measure. MIPS eligible clinicians in active engagement with a public health agency to submit immunization data who submit a "yes" for this measure would receive the full 10%.

How is the Bonus Score Calculated?

MIPS eligible clinicians can earn bonus percentage points by doing the following:

- Reporting "yes" to 1 or more additional public health and clinical data registries beyond the Immunization Registry Reporting measure will result in a 5% bonus.
- Reporting "yes" to the completion of at least 1 of the specified Improvement Activities using CEHRT will result in a 10% bonus.

  See Appendix B for the list of Improvement Activities that may be completed using certified EHR technology to qualify for the bonus.

MIPS eligible clinicians who meet both requirements will receive a 15% bonus score.

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

When reporting as a group to the Advancing Care Information performance category, the group would combine their MIPS eligible clinicians' performances under one Taxpayer Identification Number (TIN). Therefore, they are not calculated based upon one MIPS eligible clinician's performance.

If reporting as a group, hospital-based MIPS eligible clinicians do not need to be included in the group calculation for the Advancing Care Information performance category.

Detailed guidance regarding Advancing Care Information group reporting will be provided in future sub-regulatory guidance.

APPENDIX A: Advancing Care Information Performance Category Measures and Scores

This chart identifies the full list of Advancing Care Information measures and 2017 Advancing Care Information transition measures. Detailed guidance outlining each element of each Advancing Care Information measure and **2017** Advancing Care Information **transition** measure can be found in the Advancing Care Information Specification Sheets.

Advancing Care Information Measures and Scores

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

Measures for Performance Score	% Points
Provide Patient Access*	Up to 10%
Send a Summary of Care*	Up to 10%
Request/Accept Summary Care*	Up to 10%
Patient Specific Education	Up to 10%

2017 Advancing Care Information Transition Measures and Scores

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

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

Measures for Performance Score	% Points
Provide Patient Access*	Up to 20%
Health Information Exchange*	Up to 20%
View, Download, or Transmit (VDT)	Up to 10%
Patient-Specific Education	Up to 10%

View, Download or Transmit (VDT)	Up to 10%
Secure Messaging	Up to 10%
Patient-Generated Health Data	Up to 10%
Clinical Information Reconciliation	Up to 10%
Immunization Registry Reporting	0 or 10%

Secure Messaging	Up to 10%
Medication Reconciliation	Up to 10%
Immunization Registry Reporting	0 or 10%

Requirements for Bonus Score	% Points
*Report to 1 or more of the following public health and clinical data registries: • Syndromic Surveillance Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting	5%
Report certain improvement Activities using CEHRT	10%

Requirements for Bonus Score	% Points
*Report to 1 or more of the following public health and clinical data registries: • Syndromic Surveillance Reporting • Specialized Registry Reporting	5%
Report certain improvement Activities using CEHRT	10%

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

This chart identifies the set of Improvement Activities from the Improvement Activities performance category that can be tied to the objectives, measures, and CEHRT functions of the Advancing Care Information performance category and would thus qualify for the bonus in the Advancing Care Information performance category if they are reported using CEHRT. While these activities can be greatly enhanced through the use of CEHRT, we are not suggesting that these activities require the use of CEHRT for the purposes of reporting in the Improvement Activities performance category.

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
Expanded Practice Access	Provide 24/7 access to eligible clinicians or groups who have real-time access to patient's medical record	Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent and emergent care (for example, eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: Expanded hours in evenings and weekends with access to the patient medical record (for example, coordinate with small practices to provide alternate hour office visits and urgent care); Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternative locations	High	Provide Patient Access Secure Messaging Send a Summary of Care Request/Accept Summary of Care

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
		(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.		
Population Management	Anticoagulant management improvements	MIPS eligible clinicians and groups who prescribe oral Vitamin K antagonist therapy (warfarin) must attest that, in the first performance period, 60 percent or more of their ambulatory care patients receiving warfarin are being managed by one of more of these Improvement Activities: 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 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 INR testing, tracking, follow-up, and patient	High	Provide Patient Access Patient-Specific Education View, Download, Transmit Secure Messaging Patient Generated Health Data or Data from Non-Clinical Setting Send a Summary of Care Request/ Accept Summary of

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
		communication of results and dosing decisions; and/or For patients who demonstrate motivation, competency, and adherence, patients are managed using either a patient self-testing (PST) or patient-self-management (PSM) program. The performance threshold will increase to 75 percent for the second performance period and onward. Clinicians would attest that, 60 percent for first year, or 75 percent for the second year, of their ambulatory care patients receiving warfarin participated in an anticoagulation management program for at least 90 days during the performance period.		Care Clinical Information Reconciliation Exchange Clinical Decision Support (CEHRT Function Only)
Population Management	Glycemic management services	For outpatient Medicare beneficiaries with diabetes and who are prescribed antidiabetic agents (for example, insulin, sulfonylureas), MIPS eligible clinicians and groups must attest to having: For the first performance period, at least 60 percent of medical records with documentation of an individualized glycemic treatment goal that: a) Takes into account patient-specific factors, including, at least 1) age, 2) comorbidities, and 3) risk for hypoglycemia, and b) Is reassessed at least annually.	High	Patient Generated Health Data Clinical Information Reconciliation Clinical Decision Support, CCDS, Family Health History (CEHRT functions only)

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
		The performance threshold will increase to 75 percent for the second performance period and onward. Clinicians would attest that, 60 percent for first year, or 75 percent for the second year, of their medical records that document individualized glycemic treatment represent patients who are being treated for at least 90 days during the performance period.		
Population Management	Chronic care and preventative care management for empaneled patients	Proactively manage chronic and preventive care for empaneled patients that could include one or more of the following: Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning; Use condition-specific pathways for care of chronic conditions (for example, hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target; Use pre-visit planning to optimize preventive care and team management of patients with chronic conditions;	Medium	Provide Patient Access Patient-Specific Education View, Download, Transmit Secure Messaging Patient Generated health Data or Data from Non-Clinical Setting Send A Summary of Care

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
		Use panel support tools (registry functionality) to identify services due; Use reminders and outreach (for example, phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due; and/or routine medication reconciliation.		Request/Accept Summary of care Clinical Information Reconciliation Clinical Decision Support, Family Health History (CEHRT functions only)
Population Management	Implementation of methodologies for improvements in longitudinal care management for high risk patients	Provide longitudinal care management to patients at high risk for adverse health outcome or harm that could include one or more of the following: Use a consistent method to assign and adjust global risk status for all empaneled patients to allow risk stratification into actionable risk cohorts. Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification; Use a personalized plan of care for patients at high risk for adverse health outcome or harm, integrating patient goals, values and priorities; and/or Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients.	Medium	Provide Patient Access Patient-Specific Education Patient Generated Health Data or Data from Nonclinical Settings Send A Summary of Care

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
				Request/Accept Summary of Care Clinical information reconciliation Clinical Decision Support, CCDS, Family Health History, Patient List (CEHRT functions only)
Population Management	Implementation of episodic care management practice improvements	Provide episodic care management, including management across transitions and referrals that could include one or more of the following: Routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings, including symptom and disease management, and medication reconciliation and management; and/or Managing care intensively through new diagnoses, injuries and exacerbations of illness.	Medium	Send A Summary of Care Request/ Accept Summary of Care Clinical Information Reconciliation
Population Management	Implementation of medication management practice improvements	Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following: Reconcile and coordinate medications and provide medication management across transitions of	Medium	Clinical Information Reconciliation

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
		care settings and eligible clinicians or groups; Integrate a pharmacist into the care team; and/or conduct periodic, structured medication reviews.		Clinical Decision Support, Computerized Physician Order Entry Electronic Prescribing (CEHRT functions only)
Care Coordination	Implementation or use of specialist reports back to referring clinician or group to close referral loop	Performance of regular practices that include providing specialist reports back to the referring MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the CEHRT.	Medium	Send A Summary of Care Request/Accept Summary of Care Clinical Information Reconciliation
Care Coordination	Implementation of documentation improvements for practice/process improvements	Implementation of practices/processes that document care coordination activities (for example, 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	Secure Messaging Send a Summary of Care Request/Accept Summary of Care Clinical Information Reconciliation

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
Care Coordination	Implementation of practices/processes for developing regular individual care plans	Implementation of practices/processes to develop regularly updated individual care plans for at-risk patients that are shared what the beneficiary or caregiver(s).	Medium	Provide Patient Access (formerly Patient Access) View, Download, Transmit Secure Messaging Patient Generated Health Data or Data from Non-Clinical Setting
Care Coordination	Practice improvements for bilateral exchange of patient information	Ensure that there is bilateral exchange of necessary patient information to guide patient care that could include one or more of the following: Participate in a Health Information Exchange if available" and/or Use structured referral notes	Medium	Send A Summary of Care Request/ Accept Summary of Care Clinical Information Reconciliation
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 (for example, home blood pressure, blood glucose logs, food diaries, at-risk health factors such as tobacco or	Medium	Provide Patient Access Patient-specific Education

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
		alcohol use, etc.) or patient activation measures through use of CEHRT, containing this date in a separate queue for clinician recognition and review.		Care Coordination through Patient Engagement
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	Provide Patient Access Patient-specific Education
Beneficiary Engagement	Engagement of patients, family and caregivers in developing a plan of care	Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the CEHRT.	Medium	Provide Patient Access Patient-specific Education View, Download, Transmit (Patient Action) Secure Messaging
Safety and Practice Assessment	Use of decision support and standardized treatment protocols	Use decision support and protocols to manage workflow in the team to meet patient needs.	Medium	Clinical Decision Support (CEHRT function only)
Achieving Health Equity	Leveraging a QCDR to standardize	Participation in a QCDR, demonstrating performance of activities for use of standardized	Medium	Patient Generated Health Date or

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
	processes for screening	processes for screening for social determinants of health such as food security, employment and housing. Use of supporting tools that can be incorporated in the CEHRT is also suggested.		Data from a Non-Clinical Setting Public Health and Clinical Data Registry Reporting
Integrated Behavioral and Mental Health	Implementation of integrated PCBH model	Offer integrated behavioral health services to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions that could include one or more of the following: Use evidence-based treatment protocols and treatment to goal where appropriate; Use evidence-based screening and case finding strategies to identify individuals at risk and in need of services; Ensure regular communication and coordinated workflows between eligible clinicians in primary care and behavioral health; Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment; 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	High	Provide Patient Access Patient-Specific Education View, Download, Transmit Secure Messaging Patient Generated Health Data or

Improvement Activity Performance Category Subcategory	Activity Name	Activity	Improvement Activity Performance Category Weight	Related Advancing Care Information Measure(s)
		through co-location of services when feasible.		
Integrated 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 (for example, capture of additional BH data results in additional depression screening for at-risk patient not previously identified).	Medium	Patient Generated Health Data or Data from Non-clinical Setting Send A Summary of Care Request/ Accept Summary of Care Clinical Information Reconciliation