Scores for Improvement Activities in MIPS APMs in the 2024 Performance Period

Certain Alternative Payment Models (APMs) include Merit-Based Incentive Payment System (MIPS) eligible clinicians as participants and hold their participants accountable for the cost and quality of care provided to Medicare beneficiaries. This type of APM is called a "MIPS APM." All Advanced APMs are also MIPS APMs so that if an eligible clinician participating in the Advanced APM does not meet the threshold of having sufficient payments or patients through an Advanced APM in order to become a Qualifying APM Participant (QP), the eligible clinician will be scored under MIPS. As finalized in the Quality Payment Program rule, under MIPS, CMS will assign scores to MIPS eligible clinicians in the Improvement Activity performance category for participating in MIPS APMs. For the 2024 performance period, the list of MIPS APMs include:

- ACO Realizing Equity Access and Community Health (REACH)
- Bundled Payments for Care Improvement (BPCI) Advanced [all Tracks]
- Comprehensive Care for Joint Replacement Model (CJR)
- Enhancing Oncology Model (EOM)
- Kidney Care Choices (KCC) Model [Comprehensive Kidney Care Contracting (CKCC) Options and CMS Kidney Care First (KCF)] [all Options]
- Maryland Total Cost of Care Model [Care Redesign Program] (MD TCOC CRP)
- Maryland Total Cost of Care (MD TCOC) [Maryland Primary Care Program (MDPCP)] [Tracks 2 and 3]
- Medicare Shared Savings Program [all Tracks]
- Primary Care First (PCF)
- Value in Opioid Use Disorder Treatment (ViT) Demonstration
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

Table 1 below provides examples of how each of the MIPS APM met a selection of the Improvement Activities for the 2024 performance year. It is followed by Table 2, which shows the Improvement Activities performance category score CMS will assign participants in each MIPS APM for the 2024 performance year. MIPS eligible clinicians must earn 40

points in the Improvement Activities performance category to receive full credit in that performance category, and this category is weighted at 15 percent of the final MIPS score for the 2024 performance year. Note that all APM Entity groups in a MIPS APM will automatically receive at least 50 percent (20 points) in the Improvement Activities performance category score. As shown below, all APM Entities participating in any of the MIPS APMs listed above will receive a full score for the Improvement Activities performance category in performance period 2024, and therefore will not need to submit additional improvement activity information under MIPS.

CMS derived the assigned points for each MIPS APM by reviewing the MIPS APM's participation agreement and/or relevant regulations to determine the improvement activities required as a function of participation in the MIPS APM. The list of required activities for each MIPS APM was compared to the MIPS list of improvement activities for the 2024 performance period. Consistent with MIPS scoring, each improvement activity conveys either 10 points for a medium activity or 20 points for a high activity, and the points for required improvement activities within each MIPS APM were summed to derive the total improvement activities performance category score for each MIPS APM.

We understand that many MIPS eligible clinicians in a MIPS APM may, in the course of their participation, perform improvement activities other than those explicitly required by the MIPS APM's terms and conditions. However, because all MIPS APMs require sufficient improvement activities for us to assign them a full score in 2024, MIPS APM participants will not have any need to independently attest to additional activities. In the event that CMS amends the improvement activities scoring or assessment required to reach the maximum score through future rulemaking or if new MIPS APMs are created such that CMS does not assign participants in a MIPS APM full credit in this category, APM Entities may choose to submit additional improvement activities to reach the maximum score.

Table 1. Example of how MIPS APMs met a Selection of Improvement Activities (IAs) in Performance Period 2024

IA ID	ACO REACH	BPCI Advanced	CJR	EOM	KCC (KCF)	KCC (CKCC)	MDPCP	MD TCOC CRP	Medicare Shared Savings Program	PCF	ViT	VT ACO
IA_EPA_3 (Medium)	✓	✓	✓	✓			✓	✓	✓	✓		✓
IA_PM_12 (Medium)	✓				✓	✓	✓	✓	✓	✓	✓	✓
IA_PM_13 (Medium)	✓			✓	✓	✓	✓		✓	✓		✓
IA_PM_14 (Medium)	✓			✓	✓	✓	✓	✓	✓	✓		✓
IA_PM_15 (Medium)	✓			✓			✓	✓	✓	✓	✓	✓
IA_CC_8 (Medium)	✓			✓	✓	✓	✓		✓		✓	✓
IA_CC_9 (Medium)	✓				✓	✓	✓	✓	✓	✓		✓
IA_CC_10 (Medium)	✓			✓	✓	✓	✓		✓	✓		✓
IA_CC_12 (Medium)	✓		✓	✓	✓	✓	✓	✓				✓
IA_BE_6 (High)		✓		✓			✓	✓	✓	✓		✓

IA ID	ACO REACH	BPCI Advanced	CJR	EOM	KCC (KCF)	KCC (CKCC)	MDPCP	MD TCOC CRP	Medicare Shared Savings Program	PCF	ViT	VT ACO
IA_BE_15 (Medium)	✓			✓			✓	✓	✓	✓		✓
IA_PSPA_18 (Medium)	✓	✓	✓		✓	✓		✓	✓	✓	✓	✓
IA_BMH_4 (Medium)	✓			✓	✓	✓	✓	✓	✓			✓

Table 2. Improvement Activity Category Scoring for MIPS APMs in Performance Period 2024

	ACO REACH	BPCI Advanced	CJR	EOM	KCC (KCF)	KCC (CKCC)	MDPCP	MD TCOC CRP	Medicare Shared Savings Program	PCF	ViT	VT ACO
Number of 'medium' weighted IAs	19	7	5	18	17	18	21	20	20	14	7	22
Number of 'high' weighted IAs	3	1	2	7	1	1	5	2	3	3	2	3
Total number of IAs	22	8	7	25	18	19	26	22	23	17	9	25
Subtotal score from IAs	250	90	90	320	190	200	310	240	260	200	110	280
Base score for being an APM	20	20	20	20	20	20	20	20	20	20	20	20
(a) Total Number of Points Earned by the APM	270	110	110	340	210	220	330	260	280	220	130	300
(b) Total possible points earned	40	40	40	40	40	40	40	40	40	40	40	40
IAs category score [(a)/(b)] x 100% **	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Improvement Activity Evidence

Improvement Activity ID: IA_EPA_3 (Medium)
Strategy/Activity Name: Expanded Practice Access: Collection and use of patient experience and satisfaction data on access

MIPS APM	Improvement Activity Evidence
ACO REACH	The ACO REACH participants are responsible for procuring a CMS-approved vendor to conduct the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS®) or other patient experience surveys.
BPCI Advanced	CMS requires the administration of a BPCI Advanced beneficiary experience survey.
CJR	Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS®) scores are used both to support payment and for public reporting.
EOM	Participants are required to administer the Modified CAHPS® survey.
MDPCP	The State will measure patient experience using results from the clinical and group CAHPS® survey (CG-CAHPS®).
MD TCOC CRP	The State will measure patient experience using relevant measures from hospital CAHPS® survey, home health CAHPS®, nursing home CAHPS®, and the clinical and group CAHPS® survey.
Medicare Shared Savings Program	ACOs must administer the CAHPS for MIPS survey.

Improvement Activity ID: IA_PM_12 (Medium)
Strategy/Activity Name: Population Management: Population empanelment

MIPS APM	Improvement Activity Evidence
ACO REACH	Beneficiaries are aligned to the ACO for each performance year to determine the population of REACH beneficiaries for which the ACO will assume accountability for the total cost of care.
KCC (CKCC)	CKD and ESRD beneficiaries are eligible for alignment and may remain aligned to a KCE or KCF Practice for a performance year if they meet criteria.
KCC (KCF)	CKD and ESRD beneficiaries are eligible for alignment and may remain aligned to a KCE or KCF Practice for a performance year if they meet criteria.
MDPCP	Each Participant Practice will ensure that all empaneled beneficiaries are risk stratified and receive care management as appropriate.
MD TCOC CRP	Beneficiaries are aligned to the Model if they receive services from a participating hospital or if they reside in a participating hospital's service area.
Medicare Shared Savings Program	ACOs may select either of the following for beneficiary alignment: (i) Preliminary prospective assignment with retrospective reconciliation, or (ii) Prospective assignment.
PCF	Participants are required to provide risk-stratified care management for all empaneled patients.
ViT	Participants will create OUD teams—at least one primary care physician, at least one practitioner to provide primary care or addiction treatment services, and practitioners to provider behavioral and mental health care—to provide care to participating beneficiaries.
VTO ACO	Beneficiaries are aligned to the ACO for each performance year based on their receipt of services from a VT ACO initiative professional.

Improvement Activity ID: IA_PM_13 (Medium)
Strategy/Activity Name: Population Management: Chronic Care and preventative care management for empaneled patients

MIPS APM	Improvement Activity Evidence
ACO REACH	The Model emphasizes care delivery for beneficiaries with complex, chronic and serious illnesses.
EOM	Participants document a care plan for each eligible beneficiary and treats beneficiaries following nationally recognized guidelines.
KCC (CKCC)	CKCC participants provide access to qualifying chronic disease management programs for which practices may offer beneficiaries an incentive for their participation.
KCC (KCF)	KCF participants provide access to qualifying chronic disease management programs for which practices may offer beneficiaries an incentive for their participation.
MDPCP	Each Participant Practice will ensure that all empaneled beneficiaries are risk stratified, receive care management as appropriate, and in track 2, ensure that MDPCP beneficiaries in longitudinal care management are engaged in a personalized care planning process and have access to comprehensive medication management.
Medicare Shared Savings Program	The ACO must define, establish, implement, evaluate, and periodically update processes to promote patient engagement; coordinate care across and among primary care physicians, specialists, and acute and post-acute providers and suppliers; and implement an individualized care program that promotes improved outcomes for, at a minimum, the ACO's high-risk and multiple chronic condition patients.
PCF	Participating practices develop personalized care plans and ensure that beneficiaries receive appropriate services from other providers.
VT ACO	The ACO will promote the use of individual care plans and evidence-based care and guidelines in patient care.

Improvement Activity ID: IA_PM_14 (Medium)
Strategy/Activity Name: Population Management: Implementation of methodologies for improvements in longitudinal care management for high risk patients

MIPS APM	Improvement Activity Evidence
ACO REACH	Allowable primary care services focused on longitudinal care management covered in the Model include care management home visits, chronic care management (CCM) services, and transitional care management services.
EOM	EOM participants are required to provide patient navigation for eligible beneficiaries as appropriate.
KCC (CKCC)	Allowable nephrology care services focused on longitudinal care management covered in the CKCC Model include complex chronic care coordination services, transitional care management services, and chronic care management services.
KCC (KCF)	Allowable nephrology care services focused on longitudinal care management covered in the KCF Model include complex chronic care coordination services, transitional care management services, and chronic care management services.
MDPCP	Each Participant Practice will make sure that all empaneled beneficiaries are risk stratified, receive care management as appropriate, and in track 2, ensure that MDPCP beneficiaries in longitudinal care management are engaged in a personalized care planning process and have access to comprehensive medication management.
MD TCOC CRP	Allowable interventions under the Hospital Care Improvement Program (HCIP) track include care alerts or care plans completed for high risk patients, and patients with a high risk of readmission are identified and connected with transitions of care services. For the Episode Care Improvement Program track, allowable interventions include patient risk assessment/stratification and assignment of a care manager/coordinator/navigator to follow patients across care settings (e.g., to help coordinate follow-up appointments and to connect patient to needed community resources).
Medicare Shared Savings Program	The ACO must define, establish, implement, evaluate, and periodically update processes to promote patient engagement; coordinate care across and among primary care physicians, specialists, and acute and post-acute providers and suppliers; and implement an individualized care program that promotes improved outcomes for, at a minimum, the ACO's high-risk and multiple chronic condition patients.
PCF	Participating practices are required to provide risk-stratified care management for all empaneled patients.

MIPS APM	Improvement Activity Evidence
VT ACO	The ACO must implement beneficiary care coordination and care transitions processes (e.g., sharing of electronic summary records across providers, telehealth, remote beneficiary monitoring, and other enabling technologies), and ensure individualized care for beneficiaries.

Improvement Activity ID: IA_PM_15 (Medium)
Strategy/Activity Name: Population Management: Implementation of episodic care management practice improvements

MIPS APM	Improvement Activity Evidence
ACO REACH	Primary care services focused on episodic care management include care management home visits, chronic care management (CCM) services, and transitional care management services.
EOM	Participants must provide patient navigation for eligible beneficiaries as appropriate.
MDPCP	Each Participant Practice will make sure that all empaneled beneficiaries are risk stratified, receive care management as appropriate, and in track 2, ensure that MDPCP beneficiaries in longitudinal care management are engaged in a personalized care planning process and have access to comprehensive medication management.
MD TCOC CRP	Participants are expected to report on care transitions from the hospital and coordination of care provided with primary care and other settings of care to the state.
Medicare Shared Savings Program	The ACO must define, establish, implement, evaluate, and periodically update processes to promote patient engagement; coordinate care across and among primary care physicians, specialists, and acute and post-acute providers and suppliers; and implement an individualized care program that promotes improved outcomes for, at a minimum, the ACO's high-risk and multiple chronic condition patients.
PCF	Provide risk-stratified care management for all empaneled patients. Ensure all PCF Beneficiaries receive timely follow-up contact from the PCF Practice after ED visits and hospitalizations.

MIPS APM	Improvement Activity Evidence
ViT	OUD treatment services include the treatment of OUD in an outpatient setting (medication-assisted treatment; treatment planning; psychiatric, psychological or counseling services) as well as the provision of social support, care management and coordination services with other providers and suppliers that are not on the OUD team.
VT ACO	The ACO must implement beneficiary care coordination and care transitions processes (e.g., sharing of electronic summary records across providers, telehealth, remote beneficiary monitoring, and other enabling technologies), and ensure individualized care for beneficiaries.

Improvement Activity ID: IA_CC_8 (Medium)
Strategy/Activity Name: Care Coordination: Implementation of documentation improvements for practice/process improvements

MIPS APM	Improvement Activity Evidence
ACO REACH	The ACO and its ACO Participant Providers are required to use Certified Electronic Health Record Technology (“CEHRT”).
EOM	Participants are required to use Certified Electronic Health Record Technology (“CEHRT”) and to implement and use Electronic Patient Reported Outcomes for continuous quality improvement.
KCC (CKCC)	The KCE and its KCE Participants are required to use Certified Electronic Health Record Technology (“CEHRT”).
KCC (KCF)	Practices and KCF professionals are required to use Certified Electronic Health Record Technology (“CEHRT”).
MDPCP	Participants are required to connect to the State’s designated Health Information Exchange (HIE), and the interdisciplinary care management team is required to use Certified Electronic Health Record Technology (“CEHRT”).
Medicare Shared Savings Program	The ACO must define, establish, implement, evaluate, and periodically update processes to coordinate care across and among primary care physicians, specialists, and acute and post-acute providers and suppliers.

MIPS APM	Improvement Activity Evidence
ViT	Payment is based on the delivery of care coordination or management services, so it is expected that participants document their care coordination activities.
VT ACO	The ACO is required to implement processes and protocols that relate to the coordination of beneficiaries' care and care transitions (e.g., sharing of electronic summary records across providers, telehealth, remote beneficiary monitoring, and other enabling technologies).

Improvement Activity ID: IA_CC_9 (Medium)
Strategy/Activity Name: Care Coordination: Implementation of practices/processes for developing regular individual care plans

MIPS APM	Improvement Activity Evidence
ACO REACH	Primary care services focused on individual care plans include establishing, implementing, revising and monitoring comprehensive care plans.
KCC (CKCC)	CKCC participants are expected to conduct assessments and care planning for patients required chronic care services.
KCC (KCF)	KCF participants are expected to conduct assessments and care planning for patients required chronic care services.
MDPCP	Each participating practice will ensure that all empaneled beneficiaries are risk stratified, receive care management as appropriate, and in track 2, ensure that MDPCP beneficiaries in longitudinal care management are engaged in a personalized care planning process and have access to comprehensive medication management.
MD TCOC CRP	For the Episode Care Improvement Program track, hospitals and care partners are expected to document and communicate clinical care with patients and other health care professionals. Allowable interventions under the Hospital Care Improvement Program (HCIP) track include care alerts or care plans completed for high risk patients.

MIPS APM	Improvement Activity Evidence
Medicare Shared Savings Program	To be eligible for participation, ACOs must submit a description of their individualized care program, with a sample individualized care plan and describe populations that would benefit from individualized care plans.
PCF	Participants must collaborate with all high-risk PCF beneficiaries to develop and maintain documented personalized care plans addressing their goals, preferences, and values.
VT ACO	The ACO is required to implement processes and protocols that relate to ensuring individualized care for beneficiaries, such as through personalized care plans.

Improvement Activity ID: IA_CC_10 (Medium)
Strategy/Activity Name: Care Coordination: Care transition documentation practice improvements

MIPS APM	Improvement Activity Evidence
ACO REACH	Participants offer services that focus on practices and processes in support of care transitions (and are documented for purposes of reporting), including care management home visits, chronic care management (CCM) services, and transitional care management services.
EOM	EOM participants must document comprehensive cancer care plans for all eligible beneficiaries.
KCC (CKCC)	Allowable nephrology care services that focus on longitudinal care management covered in the Model and are documented for purposes of reporting (and billing) include complex chronic care coordination services, transitional care management services, and chronic care management services.
KCC (KCF)	Allowable nephrology care services that focus on longitudinal care management covered in the Model and are documented for purposes of reporting (and billing) include complex chronic care coordination services, transitional care management services, and chronic care management services.
MDPCP	Participants are required to connect to the State's designated Health Information Exchange (HIE), and the interdisciplinary care management team is required to use Certified Electronic Health Record Technology ("CEHRT") in part to support

MIPS APM	Improvement Activity Evidence
	care documentation, such as ensuring that beneficiaries in longitudinal care management are engaged in a personalized care planning process, which includes at least their goals, needs, and self-management activities.
Medicare Shared Savings Program	The ACO must define, establish, implement, evaluate, and periodically update processes to coordinate care across and among primary care physicians, specialists, and acute and post-acute providers and suppliers. The ACO must define its methods and processes established to coordinate care throughout an episode of care and during its transitions, such as discharge from a hospital or transfer of care from a primary care physician to a specialist and have a written plan to encourage and promote use of enabling technologies for improving care coordination for beneficiaries.
PCF	Ensure all PCF beneficiaries receive timely follow-up contact from the PCF Practice after ED visits and hospitalizations.
VT ACO	The ACO shall implement processes and protocols that relate to processes to ensure beneficiary/caregiver engagement; the use of shared decision making processes by Initiative Participants that consider beneficiaries' unique needs, preferences, values, and priorities; and coordination of beneficiaries' care and care transitions (e.g., sharing of electronic summary records across providers, telehealth, remote beneficiary monitoring, and other enabling technologies).

Improvement Activity ID: IA_CC_12 (Medium)
Strategy/Activity Name: Care Coordination: Care coordination agreements that promote improvements in patient tracking across settings

MIPS APM	Improvement Activity Evidence
ACO REACH	Participants offer services that focus on practices and processes in support of care transitions (and are documented for purposes of reporting), including chronic care management (CCM) services, and allowing for additional care coordination time for especially complex patients.
CJR	CJR participants are expected to provide care coordination services to beneficiaries during and/or after patient admissions.
EOM	EOM participants must document comprehensive cancer care plans for all eligible beneficiaries and provide patient navigation as appropriate.

MIPS APM	Improvement Activity Evidence
KCC (CKCC)	Allowable nephrology care services that focus on care coordination covered in the Model and are documented for purposes of reporting (and billing) include complex chronic care coordination services, transitional care management services, chronic care management services, and the assessment and planning for patients requiring chronic care management services.
KCC (KCF)	Allowable nephrology care services that focus on care coordination covered in the Model and are documented for purposes of reporting (and billing) include complex chronic care coordination services, transitional care management services, chronic care management services, and the assessment and planning for patients requiring chronic care management services.
MDPCP	Short-term (episodic) care management must be provided to all empaneled MDPCP beneficiaries (in track 2 and 3) who have received follow-up after ED, hospital discharge, or other triggering event, and coordinated referral management must be provided to all MDPCP beneficiaries (in track 1) seeking care from high-frequency referral and/or high-cost specialty care providers as well as EDs and hospitals.
MD TCOC CRP	The state is required to monitor it's performance on quality and outcomes related to enhancing care transitions from the hospital, and coordination with primary and other care settings.
VT ACO	The ACO shall implement processes and protocols that relate to processes to patient centered care including the coordination of beneficiaries' care and care transitions (e.g., sharing of electronic summary records across providers, telehealth, remote beneficiary monitoring, and other enabling technologies).

Improvement Activity ID: IA_BE_6 (Medium)
Strategy/Activity Name: Beneficiary Engagement: Regularly assess patient experience of care and follow up on findings

MIPS APM	Improvement Activity Evidence
BPCI Advanced	CMS requires the administration and analysis of a BPCI Advanced beneficiary experience survey.
EOM	Participants are required to administer the Modified CAHPS® survey.

MIPS APM	Improvement Activity Evidence
MDPCP	The state will work on continuous improvement efforts on key outcomes, including beneficiary experience.
MD TCOC CRP	The state will measure changes and improvements in patient satisfaction in different settings, including hospital, home health, nursing home and ambulatory care.
Medicare Shared Savings Program	ACOs must define, establish, implement, evaluate, and periodically update processes to promote patient engagement, including administering patient experience of care surveys.
PCF	The PCF Practice must procure a CMS-approved vendor to conduct the CAHPS® survey.
VT ACO	The ACO will implement processes and protocols to conduct routine assessments of — and improve where possible — beneficiary, caregiver and/or family experience of care.

Improvement Activity ID: IA_BE_15 (Medium)
Strategy/Activity Name: Beneficiary Engagement: Engagement of patients, family and caregivers in developing a plan of care

MIPS APM	Improvement Activity Evidence
ACO REACH	Relevant ACO REACH activities referenced in the participation agreement include the promotion of evidence-based medicine and patient engagement and communicating clinical knowledge and evidence-based medicine. Additionally, "Patient/Caregiver experience" is one of the measures required for ACO REACH.
EOM	EOM participants are required to develop a plan of care for all eligible beneficiaries that contains the 13 components in the Institute of Medicine (“IOM”) Care Management Plan (the IOM Care Management plan encourages patient engagement).
MDPCP	Participating practices must convene a Patient-Family/Caregiver Advisory Council (PFAC) at least annually and integrate PFAC recommendations into care and quality improvement activities. In addition, track 2 participants must engage

MIPS APM	Improvement Activity Evidence
	MDPCP Beneficiaries and caregivers in a collaborative process for advance care planning and ensure MDPCP beneficiaries in longitudinal care management have access to comprehensive medication management.
MD TCOC CRP	One of the Episode Care Improvement Program track allowable interventions includes the use of shared decision-making processes and/or tools to help patients assess treatment options. One of the Hospital Care Improvement Program track allowable interventions includes the use of comprehensive, individualized patient/family education (considering health literacy, preferred method of education, use of Teach Back).
Medicare Shared Savings Program	ACOs must define, establish, implement, evaluate, and periodically update processes to promote patient engagement. These processes must address beneficiary engagement, and shared decision making that considers the beneficiaries' unique needs, preferences, values, and priorities.
PCF	Practices are expected to engage high-risk PCF beneficiaries in health care planning and ensuring that PCF beneficiaries receive appropriate services. PCF practices must collaborate with all high-risk PCF beneficiaries to develop and maintain documented personalized care plans addressing their goals, preferences, and values.
VT ACO	The ACO is required to implement processes and protocols that relate to ensuring individualized care for beneficiaries, such as through personalized care plans.

Improvement Activity ID: IA_PSPA_18 (Medium)
Strategy/Activity Name: Patient Safety & Practice Assessment: Measurement and Improvement at the Practice and Panel Level

MIPS APM	Improvement Activity Evidence
ACO REACH	CMS will provide ACOs with operational reports on a regular basis. These reports may include Quality Performance Scoring Data, Aggregated Benchmark Data, and Beneficiary Alignment Data.
BPCI Advanced	CMS requires the administration of a BPCI Advanced beneficiary experience survey.

MIPS APM	Improvement Activity Evidence
CJR	Quality Measures used for reporting in the CJR Model include (1) Hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty and (2) Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS®).
KCC (CKCC)	CKCC options use risk-adjusted benchmarking methodology (based on claims data) to measure changes in participant performance.
KCC (KCF)	KCF practices must establish reporting mechanisms and ensure compliance with program Model requirements, including but not limited to reporting on quality measures. CMS will assess the Practice's quality performance using the two categories of quality measures: 1.) Quality Gateway Measure (gains in patient activation and depression response in 12 months) and 2.) Utilization Measures.
MD TCOC CRP	Participants are required to use health information technology to support the review of quality measurement data, compare the quality measurement data to benchmarks, and identify the providers providing care to beneficiaries and the quality of that care.
Medicare Shared Savings Program	ACOs must develop an infrastructure to report on both cost and quality metrics that can be used to monitor and evaluate participating providers' performance. These data should be used to improve care over time.
PCF	PCF Practice must meet the national benchmark thresholds – established by CMS – for each quality measure included in the Model.
ViT	Participants and the Participant's OUD Care Team members must participate in all applicable CMS quality reporting initiatives.
VT ACO	CAHPS® measures and utilization measures (e.g., screening measures, treatment measures, etc.) are used to establish measure improvement standards.

Improvement Activity ID: IA_BMH_14 (Medium)
Strategy/Activity Name: Depression Screening

MIPS APM	Improvement Activity Evidence
ACO REACH	Allowable primary care services include annual depression screening.
EOM	Care plans must address a patient's psychosocial health needs, including psychological, vocational, disability, legal, or financial concerns and their management.
KCC (CKCC)	CKCC requires quality performance scoring, which including Depression Response at 12 Months—Progress towards Remission (Depression Response).
KCC (KCF)	KCF requires quality performance scoring, including Depression Response at 12 Months—Progress towards Remission (Depression Response).
MDPCP	Patient reported outcome measures include screening for depression.
MD TCOC CRP	An allowable population health intervention includes documenting screenings for depression/substance use and referring beneficiaries to appropriate community resources.
Medicare Shared Savings Program	One of the preventive care and screening quality measures is screening for clinical depression and follow-up plan.
VT ACO	The Depression and Follow-Up Plan measure is used to establish quality performance standards.

Sources

	Documents Reviewed
ACO REACH	Accountable Care Organization Realizing Equity, Access and Community Health (ACO REACH) Model: Model Performance Period Participation Agreement (2023 Starters) (December 12, 2022). Accountable Care Organization Realizing Equity, Access and Community Health (ACO REACH) Model: First Amended and Restated Participation Agreement (2022 Starters) December 14, 2022) • Accountable Care Organization Realizing Equity, Access and Community Health (ACO REACH) Model: Second Amended and Restated Participation Agreement (2021 Starters) (December 9, 2022)
BPCI Advanced	Bundled Payments for Care Improvement Advanced Amended and Restated Participation Agreement: Fourth Amended and Restated Participation Agreement for 2020 Starters Fifth Amended and Restated Participation Agreement for 2018 Starters (September 21, 2023) Bundled Payments for Care Improvement Advanced Participation Agreement (September 21, 2023)
CJR	Comprehensive Care For Joint Replacement Model 42 CFR 510: up to date as of April 25, 2023.
EOM	Enhancing Oncology Model Participation Agreement (April 27, 2023)
KCC (CKCC)	Centers for Medicare & Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI). (Last Modified November 29, 2021). Kidney Care Choices (KCC) Model Comprehensive Kidney Care Contracting (CKCC) Options. Baltimore, MD.
KCC (KCF)	Centers for Medicare & Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI). (n.d.). Kidney Care Choices Model CMS Kidney Care First Option (KCF) Participation Agreement. Baltimore, MD.
MDPCP	Centers for Medicare & Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI). (n.d.). Maryland Total Cost of Care Model Maryland Primary Care Program First Amended and Restated MDPCP Practice Participation Agreement. Baltimore, MD.
MD TCOC CRP	Care Redesign Program Participation Agreement (2022) Maryland Total Cost of Care Model State Agreement (2018)

	Documents Reviewed
Medicare Shared Savings Program	Medicare Shared Savings Program. 42 CFR Part 425 (up to date as of 7/31/2023).
PCF	Centers for Medicare & Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI). (Last Modified August 31, 2021) Primary Care First (PCF) Model PCF Component Amended and Restated PCF Practice Participation Agreement (Cohort 1). Baltimore, MD. Centers for Medicare & Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI). (Last Modified August 9, 2021) Primary Care First (PCF) Model PCF Component Practice Participation Agreement (Cohort 2). Baltimore, MD.
ViT	Centers for Medicare & Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI). (Last updated March 25, 2021). Value in Treatment. Baltimore, MD.
VT ACO	Vermont All-Payer ACO Model: Vermont Medicare ACO Initiative Participation Agreement (2018) Vermont All-Payer ACO Model: Vermont Medicare ACO Initiative Participation Agreement Amendments to Sections I, II, X, XVIII and Appendices B, J and K 2022 Amendment No. 3.